ON IGNORING THE SUBTLE DIMENSIONS OF LABELING:

THE CASE OF MENTAL DISORDER*

Robert J. Antonio
University of Kansas

This article focuses upon Walter Gove's (1970) critique of the labeling approach to mental disorder. However, its implications go beyond this to suggest the weaknesses inherent in the narrow conception of labeling processes. This narrow conception is characterized by an exclusive concern for the direct, public forms of labeling and stigmatization. The argument presented here is that these factors are only part of a much broader process of societal reaction. This more inclusive conception of societal reaction suggests that self-labeling is a crucial dimension of this process. Furthermore, very subtle types of communications which uphold the deviant role may be passed. These validating responses may not be hostile in any direct or intentional sense. Thus, the labeling process does not have to appear as an obvious form of victimization where the person is stigmatized publicly. It is suggested here that the forces of social control work in a much quieter, more efficient, but not necessarily less violent, way.

Walter R. Gove (1970) in his article, "Societal Reaction as an Explanation of Mental Illness: An Evaluation," presents a carefully structured critique of the societal reactionist or labeling approach to mental disorder. Gove suggests that although there has been a considerable amount of theoretical exposition concerning the labeling of deviant behavior, there has been little systematic empirical evaluation of the approach.

Gove's criticisms fall into two major categories. One category focuses upon the entrance of a person into the mentally ill role, while the other concerns the consequences of hospitalization for the individual. In his discussion of the former, Gove focuses upon Scheff's formalization of the effects of labeling on entrance into the role of the mentally ill. Gove criticizes Scheff for underemphasizing the importance of primary deviation (those symptomatic behaviors existing before direct labeling of the deviant); but Gove is not content to stop there, and extends his critique to the general reactionist position that focuses on labeling as the primary factor leading to mental illness. Gove shows (through examination of a limited number of available empirical studies) that it is likely that severe

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psychological disturbances exist prior to the direct labeling of an individual as mentally ill. He suggests that the data indicate that labelers in fact go to great lengths to deny the problem until the time when the behavior is so disordered it can no longer be tolerated. Gove also presents data that suggest that even official labelers perform more of a screening role than the reactionists give them credit for. Gove argues that these data contradict the position of the societal reactionist school, that it is social reaction that causes an individual to adopt the mentally ill role.

Gove also focuses upon what the reactionists have characterized as the consequences of hospitalization. He criticizes the reactionist position that suggests that "...once a person has gone through a public hearing, and has been certified as a deviant and placed in an institution, it is extremely difficult for that person to break out of his deviant status." Gove argues that much of the research supporting this reactionist assertion is based on what goes on in the hospital. He suggests that this may be biased in that it probably focuses on long term patients who make up the minority of the hospital population, and ignores the majority of patients whose hospital stay is short. Gove admits that the hospital stay can be debilitating in some respects, but he asserts that this does not deny the fact that restitutive processes are also operating. Gove relying heavily upon the work of Sampson, et al. (1961, 1964), suggests that there are a number of therapeutic consequences of hospitalization. He concludes that today most patients receive fairly rapid intensive care, and for most of these individuals, the restitutive aspects of hospitalization are likely to outweigh the debilitative.

Gove (1970:880-881) also criticizes the reactionist position that suggests that stigmatization resulting from hospitalization prevents the individual from resuming "... his previous interpersonal and instrumental roles." In summarizing the work of Angrist et. al. (1968), Gove (1970:881) says that "...expectations for poor performance may be determined more by ineffectual behavior than the reverse." Gove citing again the work of Angrist et. al. (1968) states that the data indicate that many patients were not rehospitalized seven years after their initial release, and those readmitted tended to be institutionalized as a last resort. He concludes that the data suggest that stigmatization related to hospitalization does not have as much of an impact as the reactionists assume. Furthermore, when stigma is a problem it is related more to the person's current psychiatric status, or general ineffectiveness, than it is to his having been institutionalized in the past.

Gove (1970:881) argues that those taking the societal reaction position do not view the deviant as one "...who is suffering from intrapersonal disorder but instead as someone who, through a set of circumstances, becomes publicly labeled a deviant and who is forced by societal reaction into a deviant role." The reactionists view the deviant as one who has been victimized. Gove (1970:881) argues that based on available evidence the "...societal reaction formulation of how a person becomes mentally ill is substantially incorrect." He bases this conclusion on his interpretation of the data that suggest that the hospitalized mentally ill are rightfully labeled since they suffer from serious psychiatric disturbances prior to any stigmatizing reaction.

Gove should be commended for his criticism of an extreme reactionist position that would view mental disorder as the exclusive result of direct, negative labeling. Gove is also quite correct in his plea for more research into the causation of primary residual deviation. However, grave questions can be raised with respect to Gove's conclusion that the societal reaction approach is "substantially incorrect."

The Problems of the Mentally Disordered Prior to Labeling

Throughout Gove's paper there is the implicit idea that the reactionists view the labeled mental patient as someone who has no outstanding problems except for the fact that a stigmatizing label carrying negative social and personal consequences has been unjustly affixed to him. Gove's characterization suggests that the reactionists see the labeled person's mental disorder as the result of stigmatization that invariably follows direct, negative, official, public labeling.

In his section regarding entrance into the mentally ill role, Gove relies primarily upon Scheff's interpretation of labeling theory to critique the reactionists[1] school. If Gove had given careful consideration to others associated with the reactionist perspective of mental disorder, such as Sullivan, Boisen, Laing, Cooper, Esterson, Lemert, Goffman, and Szasz, it would have been difficult for him to have arrived at the same conclusions: Those taking the reactionist position generally do not assert that persons labeled mentally ill are likely to be free of severe behavioral problems beyond those that are generated by direct stigmatization. Even to interpret the extreme sociological position of Scheff in this way requires very literal interpretation of his work.[2] Those who take the reactionist orientation to the study of mental illness do not ordinarily deny the fact that persons labeled mentally ill may be suffering from severe disturbances. However, they do not interpret these disorders as resulting from intra-individual pathology (or intrapersonal disorder) as the medical approach suggests.

Individuals associated with the societal reactionist school have referred to the problems of the labeled mentally ill in several different ways. For example, R. D. Laing (1967) sees them not as psychological problems, but instead he characterizes them as disorders in the realm of interexperience, or put more simply -- what goes on between people. Cooper (1967:29) also looks beyond the individual, suggesting that mental disorders are a form of disturbed group behavior. Szasz (1960) probably states it most articulately when he argues that those labeled mentally ill do not suffer from illness, but from "problems of living." Szasz explains that these problems are the result of our often radically unharmonious struggle to coexist with our fellow man. The actual behaviors that lead to becoming labeled insane are interpreted to be reactions to, or even coping devices used to deal with, an extremely disordered interpersonal world (e.g. see Goffman, 1961:305-308). They are not seen as the irrational expressions of internal disorder.

It is being suggested here that Gove is inaccurate in his characterization of the societal reactionist school. Further, it is being argued that the reactionists do recognize the probable existence of severe problems of the mentally disordered prior to labeling. However, the societal reactionists are quite critical of attempts to explain these problems in medical terms

(as intrapersonal disorder). On the other hand, they suggest that the problems of the mentally disordered are interpersonal in nature, and application of medical techniques as "treatment" can only divert attempts at resolution of the "real" problems.

The Narrow Interpretation of Labeling Processes

Schur (1971:22) suggests that a frequent error of the critics of the societal reactionist school is an overly narrow interpretation of labeling processes, "...which considers only direct negative labeling, rather than all diverse societal definitions of and responses to the behavior." In this context he implies that Gove may be guilty of this error. Gove is vulnerable to such criticism because he focuses primarily upon direct, official social reaction processes. This may result from the fact that he centers much of his criticism on Scheff's work, which does not focus upon the more formal aspects of labeling.[3]

As I stated above, there are many scholars who adhere to the reactionist approach to mental illness, but who accept the idea that the labeled persons generally have severe personal problems prior to being labeled. A broader interpretation of the reactionist position, drawing from the work of these scholars, begins with the idea that most persons considered mentally ill suffer from severe "problems of life" prior to being officially labeled.[4] However, these problems are considered in their interpersonal context, and not as the intrapersonal disorder called "mental illness." The societal reactionists argue that since experience, to a great extent, reflects one's social condition (see Laing, 1967:17-45), it follows that disturbing interpersonal contexts generate highly disturbed states of consciousness. In such situations it is likely that the person's symbolic communication and behavior will be disordered. This may result from the fact that intensely disturbing emotional situations are likely to turn the person inward toward contemplation of his problems while reducing his concern for, and sensitivity to, other's expectations. Furthermore, it is unlikely that even his closest associates will share with him his exact social context, with all its complex interrelations. Because of these differences, his associates may be unaware of the exact social relationships that are disturbing to him.[5] Thus they may not see the disturbed person's behavior to be reflective of his interpersonal situation. Instead they are more likely to view it as a personal disturbance resulting from an internal psychological disorder.

The crucial juncture at which social reaction has its impact, is at the point where the disturbance is interpreted and explained by the actor and his audience. The broader reactionist approach attaches much significance to the fact that "problems of life" and the disturbing mental states (and behaviors) they stimulate, can be interpreted in different ways. As Scheff (1966) implies, in most cases such disorders are temporary, that is the "problems of life" are resolved or mitigated and the disturbed mental states (and behaviors) cease. In these cases the disordered behaviors (residual deviance according to Scheff) that did occur, are either ignored or explained away as the result of some temporary condition other than mental illness. However, there are instances when the person's "problems of life" are not resolved, and the disordered experience and behavior continue over an extended period of time. Such chronic "problems of life" involve situations where a person is embroiled in relationships that are deeply disturbing to him, but from which he cannot (or does not wish to) extricate himself. A

person who continues in such relationships may even attempt to maintain the appearance that they are fully satisfying to him. The maintenance of such an illusory definition of situation may be given strong social support by the others involved in the relationship. Support may also be provided by social ideology that tends to validate the relationship (e.g. the happy family man, the contented housewife, the happy worker). Social validation may be so intense that the disturbed person himself may not be able to make a direct connection between his emotional condition and his disturbing interpersonal situation. If his disturbance is severe and he is not aware of its interpersonal origins, then there may be no other definition of situation available (for both him and his associates) that would satisfactorily explain his emotional state, except that of mental illness. Once the attribution of the mental illness label is made, the interpersonal disturbances (if revealed) which the person suffers from, are likely to be viewed as the result, rather than the cause, of his mental disorder. Thus, in the end it is the individual, rather than his interpersonal situation, that is defined in need of change.

At the point where the individual's behavior begins to be interpreted as a result of mental illness, we can say that the insanity model is applied to him. Central to this conception is the idea that the insane person is no longer in control of his consciousness. He is considered to be the victim of bizarre and distorted ideas, images, and perceptions that burst upon his consciouness, preventing him from organizing his behavior in a personally acceptable fashion. Finally the model suggests that the problem results from intraindividual pathology (whether biological, psychological or symbolic) rather than from problems in the person's interpersonal context. The insanity model then is a cultural device that makes understandable disordered behaviors resulting from nonidentified "problems of life." Furthermore, the model offers a rationale for formal social control of the disordered behavior.

The insanity model also provides a context of meaning for the person who is undergoing the disorder. If he is in an intensely disturbed emotional state, and especially if this condition is prolonged, he is likely to be highly confused. The insanity model then, suggests to him symptomatology, causation, and a therapeutic course to be run, while relieving him of the burdens of his instrumental roles (his normal activities, e.g. job). Through this model the person is able to understand his troubled condition, without having to attribute the burden of responsibility for it to himself or significant others. Instead it is the disease which is at fault.

Stimulation to apply the insanity model as a mode of interpretation is ultimately due to social reaction. It is the multiple levels of this reaction that the societal reactionist school should be most interested in.

Application of the insanity model occurs at three levels. First and most obvious is official labeling which involves the intervention of public officials (e.g. police, social workers, psychiatrists) who label the person as insane, who make the label public knowledge and who subject the labeled person to some form of specialized treatment. The possible interpersonal and intrapersonal effects of such labeling have been explicated by Scheff and many others associated with the societal reactionist school.

The insanity model may also be applied through a process of informal labeling where the person learns that he is insane from the informal

communications he receives from others. These communications may go from the overt and verbal, to the covert and gestural. The constant negative sanctioning that may constitute this form of labeling can be a pervasive reminder to the labeled person that he is insane. It is important to point out, that most research concerning labeling processes and deviation has focused upon direct, public, official labeling. The more subtle, yet pervasive informal labeling processes have received less attention from researchers, probably because they are much more difficult to measure empirically.

In the case of mental illness, as in the case of other forms of deviance, there are situations where individuals take a full deviant role without undergoing either formal or informal labeling. In fact Gove (1970: 876-879) points out that in the case of mental illness, potential labelers will often suspend labeling until the person's behavior becomes completely disoriented and highly disruptive. A model purporting to deal with the origins of mental illness must be able to explain how a person can come to think of himself as mentally ill, and even act as a person who is mentally ill before being officially or even unofficially labeled by others.

Deviant acts involve violations of social rules. Social rules are often learned early in life and are stored in memory. These rules do not exist as isolated elements in memory, but are part of a broader definition of situation that includes knowledge of the conditions under which the rules are broken, sanctions for breaking the rules and most importantly images about the nature of the rule breaker. A person engaging in primary deviant acts is likely to know that he is breaking rules, is likely to be aware of the possible sanctions if he is caught, and may even carry on an internal conversation through which he invokes his own punishment in the form of guilt. Finally, he has the potential to apply to himself the relevant social stereotype that embodies the imagery defining the nature of the rule breaker (this may include identity, motives and even personal style). This means that individuals can apply the deviant labels they know, and which they may have applied to others, to themselves. I am suggesting that deviant identity transformation and even the adoption of a deviant role is possible through a third dimension of labeling, self-labeling.[6] Recognizing such a possibility is hardly a revolutionary insight, for awareness of this process flows out of the symbolic interactionist social psychology on which labeling theory is based. This approach recognizes the actor's ability to respond to his own gestures, to carry on a socially patterned internal conversation, and finally to evaluate himself from the standpoint of the group. Self-labeling involves just such processes.

Let us reconsider the person suffering chronic problems of life, who experiences long term emotional disturbances reflecting his disturbing, interpersonal, and personal situation. Being a victim of the myth of social harmony, he may experience intense unhappiness, diffuse anxiety, and feelings of meaninglessness without being able to connect them to the specific context that generates them. This person may be doomed to struggle blindly, trying to manage his feelings and control consciousness, rather than attempting to transform the life situation or interpersonal setting that is at the basis of his misery. If he meets futility in this struggle, and if his social condition does not change for the better, then self-application of the insanity model is likely (if others do not label him first).

The insanity model may be applied by official or nonofficial labelers in a direct fashion (this is what Gove is attacking), it may be transmitted by peers through covert communications, it may come from the individual himself in the process of self-labeling, or more likely it may consist of some combination of the three. In any case mental illness starts when the individual and his social group begin to interpret his behavior through the insanity model. However, this does not mean that there are not problems existent prior to the utilization of this mode of interpretation.

Reactionists are critical of the application of the insanity model because they believe that it perpetuates a self-fulfilling prophecy where fear of insanity further stimulates its actual occurrence (see Lemert, 1951: 430). Goffman (1961:132) states in this respect:

> Here I want to stress that perception of losing one's mind is based on culturally derived and socially engrained stereotypes as to the significance of symptoms such as hearing voices, losing temporal and spatial orientation, and sensing that one is being followed, and that many of the most spectacular and convincing of these symptoms in some instances psychiatrically signify merely a temporary emotional upset in a stressful situation, however terrifying to the person at the time. Similarly, the anxiety consequent upon this perception of oneself and the strategies devised to reduce this anxiety, are not a product of abnormal psychology, but would be exhibited by any person socialized into our culture who came to conceive of himself as someone losing his mind.[7]

It is suggested here that once a person begins interpreting events in the manner Goffman suggests, a self-perpetuating cycle may occur where the person becomes increasingly sensitized to the signs of madness. These signs in turn become the validation of the insanity model.

The events of internal consciousness are generally perceived as insignificant and are largely ignored by the desensitized normal. However, there are times when these events take on additional meaning through such experiences as dreams, fantasy, meditative states, and drug experiences. In most instances, however, the cultural definition and individual experience of these states is not highly threatening, nor anxiety producing (for long periods at least). The insanity model serves to sensitize the individual to the events of consciousness, while also giving him a context to interpret these events. This model suggests that the process of insanity is characterized by losing control of one's thought processes such that unwanted imagery and ideas explode into direct awareness. The stream of consciousness which once constituted reality for the person becomes distorted and profound fear often overwhelms the individual. With the intensification of fear the person turns inward, anxiously looking for symptoms. As he becomes more sensitized to consciousness he becomes aware of internal events he previously ignored. Interpreting them as signs of insanity, his worst fears become reality.

The journey into consciousness stimulated by the insanity model is self-perpetuating because it sensitizes the person to symptoms that he will probably find, that validate the insanity model and which lead to even greater sensitivity to symptoms. This journey must, almost by definition, increase social isolation because man preoccupied by his internal consciousness is not likely to be

terribly sensitive to normative expectations, nor prone to interpersonal interaction. Furthermore, attempts to communicate his experience may be futile. Remember the mentally ill person is likely to be concerned with his inner life. This may be understandable only in terms of the person's unique biographical situation and therefore not easily communicable. The suggestion is being made here that the application of insanity model intensifies personal and interpersonal problems that may have existed prior to its application.

The broader reactionist orientation discussed above is critical of the medically oriented therapeutic approach of those usually responsible for the treatment of the mentally disordered in this society. This approach tends to validate the insanity model. It often suggests that the behavior of the mentally ill is brought about by a disorder internal to the mind. This approach invalidates the experience of the victim for it implies that it is the meaningless expression of internal disorder, rather than the reaction to a highly disturbing interpersonal setting. Medically oriented therapy can be damaging because it often validates the worst fears of the person.[8] It does so, because it suggests to him that his mind has in fact gone out of control indicating that he is insane. Also, although it suggests a therapeutic course, it almost never pinpoints, and permanently eliminates the supposed intraindividual pathogenic agent that causes the disorder. Therefore, recurrence of madness is a perpetual possibility, for the person often remains vigilant, sensitized to symptoms of disorder. This, in itself, may stimulate the onset of madness again. However, the possibilities of recurrence are increased even more by the fact that medically oriented treatment tends to focus upon the individual and his invisible disease process. Thus, it is likely that medical treatment will never lead to the resolution of the interpersonal problems that may be the source of the person's suffering. The medical approach is debilitative because it turns the troubled person inward where he meets the unknown and uncontrollable, rather than sensitizing him to the interpersonal context in which the problems are embedded.[9]

Discussed above is a form of labeling much more subtle than that suggested by Gove in his critique of the societal reactionist school. The labeling process, to be effective, does not have to occur in a conspiratorial framework, nor does it need to be direct and public. Labeling does not have to appear as an obvious form of victimization where the person is stigmatized by overt degradation ceremonials. Labeling can occur in a much subtler way where the person, trying to make sense out of his intense problems of life, and their concomitant state of consciousness, is directed toward application of the insanity model to interpret his behavior. He receives the direction from the socialization process through which he learns the conditions appropriate to the application of the insanity model to his own behavior and the behavior of others. Furthermore, no matter how humane their intentions, the therapeutic agencies operating from the medical perspective also perform a labeling function. They support and validate the insanity model by suggesting that the problem is caused by internal pathology. Finally, all those who pass on subtle communications validating the idea that the disordered person is sick also are involved in labeling. Some of these communications may be extremely subtle and even nonverbal (e.g. all actions which support the persons claim to the rights of the rick role). These forms of labeling are supported further by the more direct public forms of stigmatization and dehumanization of the mentally ill which seem to have made the most impact in the popular literature. It must be remembered that these forces are

significant, but they are only a part of a much broader process that leads to the psychiatric dehumanization of man.

Conclusion

The purpose of this article has not been to refute Gove. In fact the author agrees with Gove's basic point that direct, public forms of labeling and stigmatization do not provide a sufficient explanation of mental disorder. Also I agree with Gove that it is likely that severe problems are existent for the disordered person prior to being labeled.[10] However, I disagree with the implication made by Gove that the reactionist position contradicts these points. Finally, it is suggested that the arguments put forth by Gove are not really relevant to the broader conception of the societal reactionist school discussed above. However, this does not mean that this broader conception of the approach should be accepted as fact. Only future research and application will determine the validity and utility of this perspective.

Footnotes

*I wish to thank George Ritzer who generously offered substantial criticism and advice in the preparation of this paper.

1. It is interesting to note that Scheff (1966:17) is aware of and even cites literature from this tradition.

2. Scheff (1963) implies that he is aware of the fact that the residual deviant may have problems which extend beyond the consequences of direct public labeling. For example, he supports his contention that much residual deviation is unrecorded by discussing work done by Passamanick. In this discussion he indicates that there are unlabeled residual deviants in the community who are severely impaired.

3. It is important to note that Scheff (1966:25-26) seems to be sensitive to the limitations of his approach.

4. It is not being implied here that the person who experiences mental illness must have severe problems prior to the onset of madness. It is possible that the person may undergo some form of intense temporary disturbance which he interprets as symptomatic of madness. This interpretation and the fear that it creates may in itself lead the person into insanity. Becker (1967:163) suggests that this may have been the case with the many reported instances of pot psychosis in the earlier decades of this century. At the time the cultural model suggesting that the experiences brought on by pot are pleasurable and not dangerous was not disseminated widely. Some people who experimented with pot experienced unpleasurable effects and had no other way to interpret them except as symptoms of mental disorder. Becker suggests that the number of cases of pot psychosis diminished as the new cultural stereotype giving definition to the pot experience spread. Becker implies a similar situation may exist with LBB cases of drug psychosis indicating that mental disorder can be initiated at some times by non-chronic factors.

5. Szasz (1970:20) points out that we are often blinded to the personally destructive and conflict-laden interpersonal situations, by an ideology that leads us to believe that social relations are naturally harmonious.

6. Paul Roman and Harrison Trice have discussed this process in their paper "The Self Reaction: A Neglected Dimension of Labelling Theory" presented at the American Sociological Association meetings in 1969.

7. The underlining is mine, not Goffmans.

8. The generalization that all psychiatric treatment is debilitative is not being suggested. This is obviously not true since several of the reactionists (e.g. Laing, Cooper, Esterson, and Szasz) are still practicing psychiatrists. However, they reject the idea that mental illness is an intraindividual disease.

9. It is not being asserted here that there are no rehabilitative aspects to present therapeutic techniques. However, it is being suggested that as a whole, the process may be self-defeating since it reaffirms the person's fear that he is mentally ill. Even if he "recovers", the person may always be fearful that the symptoms of the disease process may return. This inward form of vigilance itself may be able to initiate the return to madness and may account for the high levels of recidivism for psychotics.

10. Although the societal reactionists generally stress interpersonal problems as being at the base of emotional and cognitive disorders, they do not deny the possibility that organic problems can be the cause of some disorders (e.g. obviously they are aware of general paresis).

References

Angrist, Shirley, Mark Lefton, Simon Dinitz and Benjamin Pasamanick
1968 Women After Treatment. New York: Appleton-Century-Crofts.

Cooper, David
1967 Psychiatry and Anti-Psychiatry. New York: Ballantine Books.

Goffman, Erving
1961 Asylums. Garden City, New York: Doubleday and Company.

Gove, Walter R.
1970 "Societal reaction as an explanation of mental illness: On evaluation." American Sociological Review, 35 (October): 873-884.

Laing, R. D.
1967 The Politics of Experience. New York: Ballantine Books.

Lemert, Edwin
1951 Social Pathology. New York: McGraw-Hill.

Sampson, Harold, Sheldon Messinger and Robert Towne
1961 "The mental hospital and marital family ties." Social Problems 9 (Fall): 141-155.

1964 Schizophrenic Women: Studies in Marital Crisis. New York: Atherton.

Scheff, Thomas
1966 Being Mentally Ill. Chicago: Aldine.

Schur, Edwin
1971 Labeling Deviant Behavior. New York: Harper and Row.

Szasz, Thomas
1960 "The myth of mental illness." The American Psychologist, 15 (February): 113-118.

1970 Ideology and Insanity. Garden City, New York: Doubleday and Company.