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The Insanity of Place†

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I

FOR MORE THAN two hundred years now the doctrine has been increasingly held that there is such a thing as mental illness, that it is a sickness like any other, and that those who suffer from it should be dealt with medically: they should be treated by doctors, if necessary in a hospital, and not blamed for what has befallen them. This belief has social uses. Were there no such notion, we would probably have to invent it.

However, in the last twenty years we have learned that the management of mental illness under medical auspices has been an uncertain blessing. The best treatment that money has been able to buy, prolonged individual psychotherapy, has not proven very efficacious. The treatment most patients have received—hospitalization—has proven to be questionable indeed. Patients recover more often than not, at least temporarily, but this seems in spite of the mental hospital, not because of it. Upon examination, many of these establishments have proven to be hopeless storage dumps trimmed in psychiatric paper. They have served to remove the patient from the scene of his symptomatic behavior, which in itself can be constructive, but this function has been performed by fences, not doctors. And the price that the patient has had to pay for this service has been considerable: dislocation from civil life, alienation from loved ones who arranged the commitment, mortification due to hospital regimentation and surveillance, permanent posthospital stigmatization. This has been not merely a bad deal; it has been a grotesque one.

Consequently, in the last decade some important changes have been entertained regarding treatment of the mentally ill. There has been marked improvement in living conditions in mental hospitals, albeit no more so than in other backwashes of American society recently penetrated by secular conceptions of man's inalienable right to recreational facilities. More to the point, there has been some pressure to keep the potential patient in the community as long as possible and to return the hospitalized patient to the community as quickly as possible. The legal rights of persons accused of mental illness have been sharpened—in some states, such as California, to the point where involuntary commitment is quite difficult to arrange. And the notion is abroad that the goal is not to cure the patient but to *contain* him in a niche in free society where he can be tolerated. Where a niche is not available one is sometimes built, as in the institutions of family care and halfway house. And if this new approach

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places a burden on the patient's home, neighborhood, or work place, there is a current understanding of mental disorder to help justify this: since the patient has been put upon, since he is merely the symptom carrier for a sick set-up, it is only fair that the whole be made to share the burden; it is only fair that the patient and those with whom he is most involved be encouraged, preferably with psychiatric counsel, to work together to work things out.

Given the life still enforced in most mental hospitals and the stigma still placed on mental illness, the philosophy of community containment seems the only desirable one. Nonetheless, it is worth looking at some implications of this approach for the patient's various "others," that is, persons he identifies as playing a significant role in his life. To do this we must examine closely the meaning of the patient's symptoms for his others. If we do this we will learn not only what containment implies, we will learn about mental disorder.

Before proceeding, I want to introduce one issue and its concepts—an issue regarding the medical world and the doctor-patient relationship.

The ideal behind medical service is much like the ideal behind other legitimate services and, as in their case, is often realized. The patient comes to the doctor on his own, places himself in the doctor's hands, follows the doctor's orders, and obtains results which amply justify the trust and the fee.

Of course there are points of tension. The patient may not know of his need for service; knowing of his need, he may apply to charlatan servers; desiring medical service, he may not be able to afford it; affording it, he may shop around too much before settling on a particular physician; settling on one, he may not follow the advice he gets from him; following the advice, he may find his situation somewhat eased but not basically altered.

More at issue, the two-party dealings and two-party relationship between the doctor and his patient can become complicated in certain ways by other parties. For example: medical group-plans of various kinds can obscure the patient's view of the agency from which he obtains treatment; communicable diseases and suspect wounds oblige the physician to act for the community as well as for the patient. I will focus on

one class of these third parties, the patient's daily circles: his service community, his work place, his friendships, and particularly his family.

Traditionally in medical service the patient's family has been given certain functions. For example, very commonly the family is expected to cooperate, to help out, to mobilize the domestic resources necessary to accommodate the special temporary needs of the patient. When the illness is major, the least the family will do is to use its car to bring the patient to the hospital and fetch him therefrom; at most, the household can become a hospital away from the hospital. Whatever the extent of the family help, the physician will usually have to communicate instructions to the helpers, directly or through the patient.

Another function of the family is guardianship. Adult members of the family can be openly called on to act for the patient, typically because he is below the age of discretion or beyond it, ratifying a medical decision ordinarily requiring the free consent of the person directly affected.

Further, should the patient be a full-fledged adult and his situation desperate, the family may be brought into a secret relation with the doctor, who tells them facts about the patient's condition that they need to know for their

own good or his, but that the physician feels he cannot on humanitarian or medical grounds tell the patient now. A kind of emergency guardianship is involved requiring collusion between the sick person's kin and the physician.

Here definitions might be justified. A "coalition" is a collaborative arrangement minimally between two parties who use it to control the environment of a third, the arrangement itself not being openly established and recognized in these terms. A "collusive net" or "collusive alignment" is a coalition aimed at one kind of control—the third party's definition of the situation.¹ No matter how many persons are actually involved in the various parties, only two basic roles are present: the two or more persons who collude—that is, the colluders; and the one or more persons whose definition of the situation is secretly managed, who might be called the "excolluded." Note that if collusion is to occur, the colluders must be in communication with one another, since independent response will not allow them to concert in the line they are maintaining. This collusive communication takes two forms: in one, the participants are not in the presence of the excolluded and therefore need conceal only that they are in touch; in the other, the communication occurs in the immediate presence of the excolluded, typically by means of furtive signs. The first involves open communication between concealed persons, and the second, concealed communication between exposed persons.²

Collusion involves falseness knowingly used as a basis for action. Something of a conspiracy is therefore entailed, typically in regard to two fundamental matters. The first is reality. Collusion

serves to maintain for the excolluded a definition of the situation that is unstable, one that would be disrupted and discredited were the colluders to divulge what they know, and were they to relax in their management of the evidence available to the excolluded. The second is relationships. The personal relationship that an excolluded individual feels he has in regard to each of the colluders would be undercut if he discovered that they have a collusive relationship to one another in regard to him.³ The adulterous affair, that great training ground for off-stage acting, can be taken as a central example.

A collusive conspiracy of course may be quite benign, may be in the best interests of the person conspired against. Collusion is a normal and no doubt desirable part of social life. Children are raised by it, especially handicapped children. Everywhere egos are preserved by it and faces saved by it. More important, it is probably impossible for interaction to continue among three persons for any length of time without collusion occurring, for the tacit betrayal of the third person is one of the main ways in which two persons express the specialness of their own relation to each other. In fact, stable triads seem always to involve at least a little round-robin collusion, with each of the three possible pairs colluding, and each of the three participants serving a turn as the excolluded.

In ordinary medical practice, collusion is of no great issue. Perhaps this is so even in the case of the dying patient (Glaser and Strauss), where it is very likely that at least for a time he will be put on regarding his future, by the

¹ For a recent treatment of family coalitions, see Haley. A vivid treatment of collusion within the family is provided in the writings of Ronald Laing.

² There is a parallel distinction in intelligence work between a clandestine operation and a covert operation, the first involving total concealment, the second concealment only of intent and method.

³ Once someone begins to suspect collusion and has identified the members of the net, he will no longer be in a position to have his relation to them undercut. Lemert has suggested to me that an adversary process may then emerge, the excolluded attempting to prove publicly that there is a conspiracy against him, and the conspirators attempting to deny the evidence. Of course, a person can learn (whether correctly or not) that his suspicions were unfounded, and then re-credit his relationships.

hospital staff if not by his family. As we will later see, it is in psychiatric care that collusion becomes a questionable and troublesome business.

II

We can begin to consider the insanity of place by reviewing and extending some elementary terms regarding the sociology of place.

The treatment that an individual gives others and receives from them expresses or assumes a definition of him, as does the immediate social scene in which the treatment occurs. This is a "virtual" definition; it is based upon the ways of understanding of the community and is available to any competent member, whether or not such interpretations are actually made and whether or not they are made correctly—that is, in the manner most others could be led to defend. The ultimate referent here is a tacit coding discoverable by competently reading conduct, and not conceptions or images that persons actually have in their minds. Note, a rounded definition requires a collation of relevant conduct and its interpretation, a task a lay person would be competent to do but have no reason for doing.

Virtual definitions of an individual may be "accorded"—that is, readable in the conduct of agencies seen as external to the individual himself. These definitions constitute the individual's "person." Corresponding to these accorded assumptions about him there will be virtually "enacted" ones, projected through what is seen as his own conduct. These assumptions constitute the individual's "self."⁴ Person and self

are portraits of the same individual, the first encoded in the actions of others, the second in the actions of the subject himself.

The individual's enacted definition of himself may be different in various ways from the definition accorded him. Further, the psychological relation he sustains to his accorded and enacted definitions is enormously complex. He will certainly be unaware of some elements of these definitions and erroneously aware of others. He can be variously attached to such definitions as he is aware of, liking or disliking what he perceives is implied about him in his dealings with others, and inwardly accepting or rejecting these assumptions in various degrees. Also, he can employ various devices to press his desires regarding these assumptions about him, or he can passively submit to definitions of him that he feels are undesirable. As Cooley argued, the self-regarding sentiments such as pride and shame will be involved. When these various relations that an individual can have to what can be read about him become patterned and habitual, they can be called his "personality" or "character," comprising what we try to assess when we consider what an individual is really like, what he is essentially like, what he is like as a human being.

It should be plain now that the implicatory aspect of the individual's conduct has a very convoluted and recursive character. Even while his overall behavior can be read for the self-assumptions which inform it, some of his minor gestures will convey what he feels about having a self that is defined in this way and what he feels about others' defining him as a given person; and these gestures in turn will be taken as part of his enacted self by himself

⁴The distinction between accorded and enacted definitions of an individual follows Kai Erikson's distinction between role-validation and role-commitment: "For the purposes of this paper, it will be useful to consider that the acquisition of roles by a person involves two basic processes: *role-validation* and *role-commitment*. Role-validation takes place when a community 'gives' a person certain expectations to live up to, providing him with distinct notions as to the conduct it considers appropriate or valid for him in his position. Role-commit-

ment is the complementary process whereby a person adopts certain styles of behavior as his own, committing himself to role themes that best represent the kind of person he assumes himself to be, and best reflect the social position he considers himself to occupy" (pp. 263-264).

and others, which fact can in turn be taken into consideration in the assessment he or others make of him. The individual stakes out a self, comments on his having done so, and comments on his commenting, even while the others are taking the whole process into consideration in coming to their assessment of him, which consideration he then takes into consideration in revising his view of himself.⁵

Having considered the individual's person and his self, consider now their normative regulation. A social norm or rule is any guide for action recommended because it is felt to be appropriate, suitable, proper, or morally right. Three parties are involved: the person who can legitimately "expect" and demand to be treated in a particular way because of the rule; the person who is "obliged" to act in a particular way because of the rule; the community that supports the legitimacy of these expectations and obligations.

The treatment that is accorded anyone and that he accords others is typically regulated by social norms, and so also, therefore, are the delineative implications of these dealings. When, therefore, an individual becomes involved in the maintenance of a rule, he tends to become committed to a particular set of enacted and accorded definitions of him. If the rule obliges him to do something in regard to others, he

becomes to himself and them the sort of person who would naturally act in this way, correctly delineated by what is expressed in this conduct. If the rule leads him to expect others to do something in regard to him, then he becomes to himself and them someone who is properly characterized by what is implied through this way of treating him. Accepting this delineation of himself, he must then make sure that through his treatment of others and their treatment of him the rule will be followed, allowing him to be what he feels he is.

In general, then, when a rule of conduct is broken, two individuals run the risk of becoming discredited: one with an obligation, who should have governed himself by the rule; the other with an expectation, who should have been treated in a particular way because of this governance. A bit of the definition of both actor and recipient is threatened, as is to a lesser degree the community that contains them both.

Having seen that rules of conduct are fundamental to definitions of a self, we must go on to see that they are just as fundamental to corporate social life. Put simply and quickly, the activities of any organization are allocated to members, and these activities are coordinated by being subsumed under (or being allowed to fall within or be covered by) various rules. Thus, many of the obligations and expectations of the individual pertain to, and ensure the maintenance of, the activities of a social organization that incorporates him.

Let me restate this general sociological position. Through socialization into group living, the individual comes in effect to make assumptions about himself. Although these assumptions are about himself, they nonetheless are delineated in terms of his approved relationship to other members of the group and in terms of the collective enter-

⁵I do not think there is anything like an adequate version of these complications. Little help has been provided by pencil and paper students of the self who start with a subject's verbal description of himself, often based on his selection from verbal trait-lists, instead of starting with the serious ethnographic task of assembling the various ways in which the individual is treated and treats others, and deducing what is implied about him through this treatment. The result has been a trivialization of Cooley, Mead, and social psychology. The self acquires a hopelessly shifting status: in one sentence the student refers to the tacit coding of an individual's conduct, the assumptions in effect that the individual makes about himself, and in the next to a purely subjective mentalistic element—this itself having an inconstant referent. There is a failure to see that the term "conception" can radically shift in meaning, and that an individual's mental conception of self is merely his subjective and partial view of the effective conception he has of himself.

prise—his rightful contribution to it and his rightful share in it. In brief, these assumptions about himself concern his normatively supported place in the group.

The individual tends to organize his activity as if the single key to it all were the assumptions he makes about himself. He thus anticipates that his share of group expectations and obligations will be parceled out to him on the basis of (and as a confirmation of) his particular assumptions about himself. And by and large this self-organization of the individual's activity is effective because others in the group make more or less the same assumptions about him and treat him accordingly. Self and person coincide. His treatment of them and their treatment of him can be read as making the same set of assumptions concerning him, the same except for a difference in point of reference; and this set of assumptions will not be an incidental implication of the reciprocal treatment, but its key.

Here note that the expressive idiom of the individual's society and group will ensure that evidence of his assumptions about himself will be made available not only through his performing his main substantive obligations, but also through expressive means, comprising the way in which he handles himself while in the presence of others or while having dealings with them. Through quite minor acts of deference and demeanor, through little behavioral warning lights, the individual exudes assumptions about himself. These provide others with a running portent, a stream of expression which tells them what place he expects to have in the undertakings that follow, even though at the moment little place may be at stake. In fact, all behavior of the individual, insofar as it is perceived by others, has an indicative function, made up of tacit promises and threats, confirming or disconfirming that he knows and keeps his place.

III

With these elementary concepts to serve as a frame, turn now to a specific matter: the parallel drawn between medical and mental symptoms.

Signs and symptoms of a *medical* disorder presumably refer to underlying pathologies in the individual organism, and these constitute deviations from biological norms maintained by the homeostatic functioning of the human machine. The system of reference here is plainly the individual organism, and the term "norm," ideally at least, has no moral or social connotation. (Of course, beyond the internal pathology there is likely to be a cause in the external environment, even a social cause, as in the case of infectious or injurious situations of work; but typically the same disorder can be produced in connection with a wide variety of socially different environments.) But what about *mental* symptoms?

No doubt some psychoses are mainly organic in their relevant cause, others mainly psychogenic, still others situational. In many cases etiology will involve all of these causal elements. Further, there seems no doubt that the prepatient—that is, the individual who acts in a way that is eventually perceived as ill—may have any of the possible relations to intentionality: he may be incapable of knowing what he is doing; or he may know the effects of his acts but feel unable to stop himself, or indifferent about stopping himself; or, knowing the effects of certain acts, he may engage in them with malice aforethought, only because of their effects. All of that is not at issue here. For when an act that will later be perceived as a mental symptom is first performed by the individual who will later be seen as a mental patient, the act is not taken as a symptom of illness but rather as a deviation from social norms, that is, an infraction of social rules and social expectations. The perceptual reconstituting of an offense or

infracture into a medical, value-free symptom may come quite late, will be unstable when it appears, and will be entertained differently, depending on whether it is the patient, the offended parties, or professional psychiatric personnel doing the perceiving.⁶

This argument, that mentally ill behavior is on its face a form of social deviancy, is more or less accepted in psychiatric circles. But what is not seen—and what will be argued in this paper—is that biological norms and social norms are quite different things, and that ways of analyzing deviations from one cannot be easily employed in examining deviations from the other.

The first issue is that the systems regulated by social norms are not biological individuals at all, but relationships, organizations, and communities; the individual merely follows rules or breaks them, and his relation to any set of norms that he supports or undercuts can be complex indeed—as we shall see, more of a political issue than a medical one.

The second issue has to do with the regulative process itself. The biological model can be formulated in simple terms: deviation; restorative counteractions; reequilibration (associated with the destruction or extrusion of the pathogenic agent); or disorganization, that is, destruction of the system. A realistic picture of social regulation is less tidy.

The traditional sociological answer to the question of regulation and conformance is found in the normative sense of the term “social control” and the corrective cycle that presumably occurs when an offense takes place.

As suggested, through socialization the individual comes to incorporate the belief that certain rules are right and

just, and that a person such as himself ought to support them and feel remorse and guilt if he does not. He also learns to place immediate value on the image that others might obtain of him in this regard; he learns to be decently concerned about his reputation.

Taking the notion of personally incorporated norms as central, one can distinguish three basic forms of normative social control. First, and no doubt most important, there is “personal control”: the individual refrains from improper action by virtue of acting as his own policeman. Finding that he has acted improperly, he takes it upon himself to admit his offense and volunteer such reparative work as will reestablish the norms and himself as a man respectful of them.

Second, there is “informal social control.” When the individual begins to offend, the offended parties may warn him that he is getting out of line, that disapproval is imminent, and that deprivations for continuation are likely. As a result of this more-or-less subtle warning, amplified and sustained until the offense is corrected, the offender is brought to his senses and once again acts so as to affirm common approved understandings. As Parsons has remarked, this corrective feedback is constantly occurring in social life, and is in fact one of the main mechanisms of socialization and learning (p. 303).

Third, the threat that an offender introduces to the social order is managed through “formal” social sanction administered by specialized agents designated for the purpose. Criminals certainly break social rules, but there is an important sense in which they do not threaten the social order, and this by virtue of the risk they accept of apprehension, imprisonment, and harsh moral censure. They may find themselves forced, as we say, to pay their debt to society—the price presumably adjusted to the extent of the offense—which in turn affirms the reasonableness of not breaking the rules at all. In any case,

⁶Of course, some personal conditions, such as loss of memory or intense anxiety or grandiose persecutory beliefs, are very quickly shifted from offense to symptoms, but even here it is often the case that social rules regarding how a person is properly to orient himself or feel about his situation may be what are initially disturbed.

they often try to conceal the act of breaking the law, claim to be innocent when accused, and affect repentance when proven guilty—all of which shows that they know the rules and are not openly rebelling against them. Note that the efficacy of informal and formal social control depends to a degree on personal control, for control that is initiated outside the offender will not be very effective unless it can in some degree awaken corrective action from within.

Personal control, informal control, and formal control are the moral means and the main ones by which deviations are inhibited or corrected and compliance to the norms is assured. But taken together, these means of control provide a very narrow picture of the relation between social norms and social deviations.

For one thing, the agencies of control that have been reviewed can be as effective as they are not because of the offender's moral concern, but because of his expedient considerations. The good opinion of others may be sought in order to render these persons vulnerable to exploitation. A fine may be viewed not as a proclamation of guilt but as a routine cost to be figured in as part of operating expenses.⁷ The point here, of course, is that often what looks like automatic and dependable conformance is to be expected from the actor only over a strictly limited range of costs to him.

Further, the norms may be upheld not because of conscience or penalty, but because failure to comply leads to undesired, unintended complications which the offender was unaware of when first undertaking his offensive action.⁸

But even this expanded base for norm-

ative social control provides a partial view. The control model that is implied—a model that treats social norms somewhat like biological norms—is itself too restrictive. For when an offense occurs it is by no means the case that sanctions are applied, and when negative sanctions or penalties *are* applied, or when unanticipated penalizing consequences occur—that is, when the corrective cycle is begun—it is by no means generally true that diminution of the deviation results.

When the offense occurs, the offended parties may resolve the situation simply by withdrawing from relevant dealings with the offender, placing their social business with someone else. The threat of this sort of withdrawal is, of course, a means of informal social control, and actual withdrawal may certainly communicate a negative evaluation, sometimes unintended. But the process just as certainly constitutes something more than merely a negative sanction; it is a form of management in its own right. As we shall see, it is just such withdrawal which allows those in a social contact to convey glaringly incompatible definitions and yet get by each other without actual discord.

If the offense is such as to make legal action possible, the offended person may yet desist (and withdraw) for practical reasons which sharply limit the application of formal control: the cost and time required to make a formal complaint and appear in court; the uncertainty of the legal decision; the personal exposure involved in taking official action; the reputation that can be acquired for being litigious; the danger of reprisal later by the offender.

There are still other contingencies. The individual who offends expectations can prevail, causing his others to accept him on his new terms and to accept the new definition of the situation that this implies. Children growing up in a family are constantly engaged in this process, constantly ne-

⁷ When the agencies of control take the same expedient view, then we might better speak of social direction rather than social control. It is thus, for example, that a subsidy policy directs crop allocation without reliance on the factor of moral sensibility.

⁸ This is a functionalist argument. See, for example, Nadel.

gotiating new privileges from their keepers, privileges which soon come to be seen as the young person's due. Some of the mutinies that occur in schools, prisons, and ghettos illustrate the same theme. The social changes produced by the labor movement and the suffragette movement provide further examples.

And even when withdrawal from the offender or submission to him does not occur, social control need not result. The negative moral sanctions and the material costs of deviation may further alienate the deviator, causing him to exacerbate the deviation, committing him further and further to offense. And as will be later seen, there may be no resolution to the discord that results thereby. The foreign body is neither extruded nor encysted, and the host does not die. Offended and offender can remain locked together screaming, their fury and discomfort socially impacted, a case of organized disorganization.

These limitations on the social version of the homeostatic model are themselves insufficient, for they are cast in the very assumptions that must be broadened. The issue is that the traditional social control approach assumes an unrealistically mechanistic version of the social act, a restriction that must be relaxed if the close analysis of social control is to be achieved.

As the law suggests, our response to an individual who physically performs an offensive act is radically qualified by a battery of interpretive considerations: Did he know about the rule he was breaking, and if so, was he aware of breaking it? If he did not appreciate the offensive consequences of his act, ought he to have? And if he did anticipate these offensive results, were they the main purpose of his act or incidental to it? Was it within his physical competence to desist from the offense, and if so, were there extenuating social reasons?

The answers to these questions tell

us about the actor's *attitude* toward the rule that appears to have been violated, and this attitude must be determined before we can even say what it is that has happened. The issue is not merely (and often not mainly) whether he conformed or not, but rather in what relationship he stands to the rule that ought to have governed him. Indeed, a significant feature of *any* act is what it can be taken to demonstrate about the actor's relation to such norms as legitimately govern it.

However, the actor's attitude toward a rule is a subjective thing; he alone, if anyone, is fully privy to it. Inevitably, then, an important role will be played by the readings others make of his conduct, and by the clarifying expressions that he contributes, whether to ensure that a proper purpose is not misinterpreted or an improper one is not disclosed. It follows, for example, that if a deviator is suitably tactful and circumspect in his violations, employing secrecy and cover, many of the disruptive consequences of the violation in fact will be avoided. A particular application of the rules is thwarted, but the sanctity of the rule itself is not openly questioned.

A reorientation is therefore to be suggested. An actual or suspected offender is not so much faced with an automatic corrective cycle as with the need to engage in remedial ritual work. Three chief forms of this work are available to him: accounts, apologies, and requests. With accounts he shows that he himself did not commit the offense, or did it mindlessly, or was not himself at the time, or was under special pressure, or did what any reasonable man would have done under the circumstances;⁹ with apologies he shows that if indeed he had intended the offense, he now disavows the person that he was, bewails his action, repents, and wants to be given a chance to be what he now knows he should be; with requests he seeks the kind of offer

⁹ A discussion of accounts is available in Scott and Lyman.

or permission which will transform the act from his offense into the other's boon. With this ritual work, with explanations, propitiations, and pleas, the offender tries to show that the offense is not a valid expression of his attitude to the norms. The impiety is only apparent; he really supports the rules.

Once we see that ritual work bears on the very nature of social acts and considerably loosens what is to be meant by social equilibrium, we can readdress ourselves to the crucial difference between medical symptoms and mental symptoms.

The interesting thing about medical symptoms is how utterly nice, how utterly plucky the patient can be in managing them. There may be physical acts of an ordinary kind he cannot perform; there may be various parts of the body he must keep bandaged and hidden from view; he may have to stay home from work for a spell or even spend time in a hospital bed. But for each of these deviations from normal social appearance and functioning, the patient will be able to furnish a compensating mode of address. He gives accounts, belittles his discomfort, and presents an apologetic air, as if to say that in spite of appearance he is, deep in his social soul, someone to be counted on to know his place, someone who appreciates what he ought to be as a normal person and who is this person in spirit, regardless of what has happened to his flesh. He is someone who does not *will* to be demanding and useless. Tuberculosis patients, formerly isolated in sanatoria, sent home progress notes that were fumigated but cheerful. Brave little troops of colostomites and ileostomites make their brief appearances disguised as nice clean people, while stoically concealing the hours of hellish toilet work required for each appearance in public as a normal person. We even have our Beckett player buried up to his head in an iron lung, unable to blow his own nose, who yet somehow expresses by means of his eyebrows

that a full-fledged person is present who knows how to behave and would certainly behave that way were he physically able.

And more than an air is involved. Howsoever demanding the sick person's illness is, almost always there will be some consideration his keepers will *not* have to give. There will be some physical cooperation that can be counted on; there will be some task he can do to help out, often one that would not fall to his lot were he well. And this helpfulness can be *absolutely* counted on, just as though he were no less a responsible participant than anyone else. In the context, these little bits of substantive helpfulness take on a large symbolic function.

Now obviously, physically sick persons do not always keep a stiff upper lip (not even to mention appreciable ethnic differences in the management of the sick role); hypochondriasis is common, and control of others through illness is not uncommon. But even in these cases I think close examination would find that the culprit tends to acknowledge proper sick-role etiquette. This may only be a front, a gloss, a way of styling behavior. But it says: "Whatever my medical condition demands, the enduring me is to be dissociated from these needs, for I am someone who would make only modest reasonable claims and take a modest and standard role in the affairs of the group were I able."

The family's treatment of the patient nicely supports this definition of the situation, as does the employer's. In effect they say that special license can temporarily be accorded the sick person because, were he able to do anything about it, he would not make such demands. Since the patient's spirit and will and intentions are those of a loyal and seemly member, his old place should be kept waiting for him, for he will fill it well, as if nothing untoward has happened, as soon as his outer behavior can again be dictated by, and be

an expression of, the inner man. His increased demands are saved from expressing what they might because it is plain that he has "good" reasons for making them, that is, reasons that nullify what these claims would otherwise be taken to mean. I do not say that the members of the family will be happy about their destiny. In the case of incurable disorders that are messy or severely incapacitating, the compensative work required by the well members may cost them the life chances their peers enjoy, blunt their personal careers, paint their lives with tragedy, and turn all their feelings to bitterness. But the fact that all of this hardship can be contained shows how clearly the way has been marked for the unfortunate family, a way that obliges them to close ranks and somehow make do as long as the illness lasts.

Of course, the foregoing argument must be qualified. In extreme situations, such as the military, when it can be all too plain that the ill person has everything to gain by being counted sick, the issue of malingering may be seriously raised and the whole medical frame of reference questioned.¹⁰ Further, there is the special problem caused by illness directly affecting the face and the voice, the specialized organs of expression. An organic defect in this equipment may be a minor thing according to a medical or biological frame of reference, but it is likely to be of tremendous significance socially. There is no disfigurement of the body that cannot be decorously covered by a sheet and apologized for by a face; but many disfigurements of the face cannot be covered without cutting off communication, and cannot be left uncovered without disastrously interfering with communication. A person with carcinoma of the bladder can, if he wants, die with more social grace and propriety, more apparent inner social normalcy, than a man with a hare-

lip can order a piece of apple pie.

With certain exceptions, then, persons have the capacity to expressively dissociate their medical illness from their responsible conduct (and hence their selves), and typically the will to do so. They continue to express support of the social group to which they belong and acceptance of their place therein. Their personality or character will be seen to remain constant in spite of changes in their role. This means that the illness may tax the substantive resources of the group, make tragic figures of well members, but still not directly undermine the integrity of the family. In brief, ritual work and minor assistance can compensate for current infractions because an important part of an infraction is what it can be taken to symbolize about the offender's long-range attitude toward maintaining his social place; if he can find alternate ways of conveying that he is keeping himself in line, then current infractions need not be very threatening. Note that the efficacy here of excusing expressions (with the exceptions cited) is due to the fact that medical symptoms involve behavior which is either not an infraction of social norms at all—as in the case of internal tumors of various kinds—or only incidentally so. It is the incidental side effects of the physical deviation that disqualify the person for compliance. When an amputee fails to rise to greet a lady, it is perfectly evident that this failure is only an incidental and unintentional consequence of his condition; no one would claim that he cut off his legs to spite his courtesies. Almost as surely, his disqualification for jobs that require rapid movement can be seen as a side effect of his deviance and not its initial expression. He is a deviator, not a deviant. Here is incapacity, not alienation.

Now turn to symptoms of mental disorder as a form of social deviation. The most obvious point to note is that since there are many kinds of social

¹⁰ Here see the useful paper by Aubert and Messinger.

deviation that have little to do with mental disorder, nothing much is gained by calling symptoms social deviations.¹¹

The position can be taken that mental illness, pragmatically speaking, is first of all a social frame of reference, a conceptual framework, a perspective that can be applied to social offenses as a means of understanding them. The offense, in itself, is not enough; it must be perceived and defined in terms of the imagery of mental illness. By definition one must expect that there always will be some liberty and some dissensus in regard to the way this framework is applied. Many important contingencies are known to be involved, some causing the imagery to be applied to psychologically normal behavior with the consequence of reconstituting it into a mental symptom. But given this necessary caveat, we can ask: In our society, what is the nature of the social offense to which the frame of reference "mental illness" is likely to be applied?

The offense is often one to which formal means of social control do not apply. The offender appears to make little effort to conceal his offense or ritually neutralize it. The infractions often occur under conditions where, for various reasons, neither the offended nor the offender can resolve the issue by physically withdrawing from the organization and relationship in which the offense occurs, and the organization cannot be reconstituted to legitimate the new self-assumptions of the offender—or, at least, the participants strongly feel that these adaptations are not possible. The norms in question are ones which frequently apply and which are constantly coming up for affirmation, since they often pertain to expressive behavior—the behavior which broadcasts to all within range, transmitting warnings, cues, and hints about

the actor's general assumptions about himself. Finally, with the exception of paranoia of primary groups (*folie à deux*, *trois*, etc.), the offense is not committed by a set of persons acting as a team, but rather—or so it is perceived—by an individual acting on his own. In sum, mental symptoms are willful situational improprieties, and these, in turn, constitute evidence that the individual is not prepared to keep his place.¹²

One implication of the offense features I have mentioned should be stressed. Mental symptoms are not, by and large, *incidentally* a social infraction. By and large they are specifically and pointedly offensive. As far as the patient's others are concerned, the troublesome acts do not merely happen to coincide partly with what is socially offensive, as is true of medical symptoms; rather these troublesome acts are perceived, at least initially, to be intrinsically a matter of willful social deviation.

It is important now to emphasize that a social deviation can hardly be reckoned apart from the relationships and organizational memberships of the offender and offended, since there is hardly a social act that in itself is not appropriate or at least excusable in some social context. The delusions of

¹¹ I omit considering the popularists who have tried to establish the psychogenesis of everything that is interesting, from crime to political disloyalty.

¹² Although much of mental symptomatology shares these offense features—thereby allowing us to answer to the argument that mental symptoms are not merely any kind of social deviation—it is the case that many social deviations of the situational kind do not qualify as signs of mental illness. We have been slow to learn this, perhaps because mental wards once provided the most accessible source of flagrant situational improprieties, and in such a context it was all too easy to read the behavior as unmotivated, individually generated aberrancy instead of seeing it as a form of social protest against ward life—the protest having to employ the limited expressive means at hand. In the last few years the nonpsychiatric character of considerable symptomlike behavior has become much easier to appreciate because situational improprieties of the most flagrant kind have become widely used as a tactic by hippies, the New Left, and black militants, and although these persons have been accused of immaturity, they seem too numerous, too able to sustain collective rapport, and too facile at switching into conventional behavior to be accused of insanity.

a private can be the rights of a general; the obscene invitations of a man to a strange girl can be the spicy endearments of a husband to his wife; the wariness of a paranoid is the warranted practice of thousands of undercover agents.

Mental symptoms, then, are neither something in themselves nor whatever is so labeled; mental symptoms are acts by an individual which openly proclaim to others that he must have assumptions about himself which the relevant bit of social organization can neither allow him nor do much about.

It follows that if the patient persists in his symptomatic behavior, then he must create organizational havoc and havoc in the minds of members. Although the imputation of mental illness is surely a last-ditch attempt to cope with a disrupter who must be, but cannot be, contained, this imputation in itself is not likely to resolve the situation. Havoc will occur even when all the members are convinced that the troublemaker is quite mad, for this definition does not in itself free them from living in a social system in which he plays a disruptive part.

This havoc indicates that medical symptoms and mental symptoms are radically different in their social consequences and in their character. It is this havoc that the philosophy of containment must deal with. It is this havoc that psychiatrists have dismally failed to examine and that sociologists ignore when they treat mental illness merely as a labeling process. It is this havoc that we must explore.

IV

The most glaring failure to organize conduct in accordance with assumptions about himself that others accept is to be found in those dramatic cases where the individual, perceived to be in a state of disorganization as an actor, accords himself a personal biographical identity not his own or temporarily reconstitutes himself in accordance

with age, sex, and occupational categories for which he does not qualify. Often this is associated with the individual's imputing quite grandiose personal properties to himself.¹³ He then makes some effort to treat others accordingly and tries to get them to affirm this identification through their treatment of him.

Note that mental hospitals can manage such diffusions and distortions of identity without too much difficulty. In these establishments much of the person's usual involvement in the undertakings of others and much of his ordinary capacity to make contact with the world are cut off. There is little he can set in motion. A patient who thinks he is a potentate does not worry attendants about their being his minions. That he is in dominion over them is never given any credence. They merely watch him and laugh, as if watching impromptu theater. Similarly, when a mental hospital patient treats his wife as if she were a suspect stranger, she can deal with this impossible situation merely by adjusting downward the frequency and length of her visits.¹⁴ So, too, the office therapist can withstand the splashes of love and hate that the patient brings to a session, being supported in this disinvolvement by the wonderfully convenient doctrine that direct intercession for the patient, or talk that lasts more than fifty minutes,

¹³ Corresponding to these expressed overreachings, there will be alterations in the overreacher's subjective sense of himself. Here a very useful paper was contributed by Josiah Royce titled, "Some Observations on the Anomalies of Self-Consciousness," helpfully brought to attention in an abridged reprinting in Edgar Borgatta and Henry Meyer's *Sociological Theory*. Since Royce's statement in 1895, progress in this area has been modest.

¹⁴ A mental hospital in fact can be defined functionally as a place where persons who are still rightfully part of our daily lives can be held at bay and forced to wait for our occasional visits; and we, instead of sharing existence, can ration it. Of course, patients often can manage to hold their kinsmen at bay, too, simply by declining to meet them off the ward or by becoming upset when they visit. However, the cost of this rejection can be very high—for example, loss of an opportunity to get off the ward for a time and to obtain minor supplies. Further, what the patient can hold off is not life with his loved ones, but visits.

can only undermine the therapeutic relationship. In all of these cases, distance allows a coming to terms; the patient may express impossible assumptions about himself, but the hospital, the family, or the therapist need not become involved in them.

Matters are quite different, however, when the patient is outside the walls of the hospital or office—outside, where his others commit their persons into his keeping, where his actions make authorized claims and are not symptoms or skits or something disheartening that can be walked away from. Outside the barricades, dramatically wrong self-identification is not necessary in order to produce trouble. Every form of social organization in which the patient participates has its special set of offenses perceivable as mental illness that can create organizational havoc.

One very important organizational locus for mental symptoms consists of public and semipublic places—streets, shops, neighborhoods, public transportation, and the like. In these places a fine mesh of obligations obtains which ensures the orderly traffic and commingling of participants. Modes of personal territoriality are delineated, and respect for their boundaries is employed as a key means of ordering mutual presence. Many classic symptoms of psychosis are precise and pointed violation of these territorial arrangements. There are encroachments, as when a mental patient visiting a supermarket gratuitously riffles through a shopper's cart, or walks behind the counter to examine what is contained there, or openly advances her place in the check-out line, or leans into an ongoing conversation not her own, or addresses a midpassage statement to someone who has not been brought into a state of talk. There are self-contaminations involving exposure or befoulment, as when a patient is denudative, or too easily invites conversational contact from others, or speaks aloud shameful

admissions, or smears himself with half-eaten food, or openly toys with his mucus, or takes dirty objects into his mouth. There are "hyper-preclusions," as when a patient declines to acknowledge any conversational overture, or shies away from passing glances, or fights off a medical examination, or will not let go of small personal possessions.

From this brief look at public places and social order among the unacquainted,¹⁵ turn to closer social organization involving sustained obligations among sets of acquainted persons. First, formal work organizations. For this I propose to review Edwin Lemert's study of mental patients with paranoid complications whose trouble appeared to be focused on the job (1962).¹⁶

Lemert dates the trouble-career of each member of his sample by suggesting that each had been subjected to a loss, or threat of loss, of status, on or off the job, for which apparently no compensatory alternative could be found. Apparently such an individual can respond by declining to exert control over himself, and by resisting the informal control attempted by others. His willingness to play the game while on the job declines. He begins to intrude into the decision territory of subordinates and makes improper demands upon them, by implication subordinating them to his sphere of operation. He declines to return confidences with equals, thus leaving them with unreciprocated and insecure relations to him. He becomes insulting and arrogant, failing to show expected consideration for the feelings of the others, while exhibiting an improperly elevated view of himself. He attempts to arrogate to himself informal privileges which are part of the status symbolism of the

¹⁵ I have made a more extended effort along these lines in *Behavior in Public Places and Interaction Ritual*.

¹⁶ Lemert extensively studied 31 cases involving paranoid complications: 23 in southern California, 6 in northern California, and 2 miscellaneous cases.

group and otherwise allocated. He attempts to use markers of place without having the place that is customarily marked by them.

The conduct so far cited violates the informal rules for the management of personal place. We see in this a simple interdependency between the actor and his others, where the disturbed boundary is the one between the actor and these others. But in addition to these direct disturbances there are some indirect ones. Given the actor's membership in a work-group which is itself a segment in the total organization, we find he is in a position to disrupt the boundary relations of his segment to other segments. For example, he overrides group cleavages, threatening the working relationship between them. And he exposes the informal power structure, jeopardizing its relationship to the overarching official structure. He uses formal and official means to force his fellows to consider his demands directly, if only because he has forced higher officials to attend to his instituted complaints.

Plainly, then, the actor's failure to keep his place has disruptive consequences for his work associates, undermining their sense that a common understanding concerning everyone's social place exists and is a viable guide for daily activity. An important part of Lemert's analysis is his consideration of the sequence of events that is set in motion by this initial disturbance.

In order to cope with the troublesome colleague, the others avoid him physically when possible and exclude him from joint decisions and joint ventures. This very exclusion begins to color these excluding events, bringing a new meaning to them. When his workmates find that face-to-face interaction with him is unavoidable, they employ a humoring, pacifying, noncommittal style of reply which serves to damp the interaction as much as possible without giving him obvious cause for complaint. In order to be better prepared

for what he might do, they may spy on him, in any case coming together in his absence to share their reaction to his latest move, pool their information, consider his next move, plot out together their next move, and in general celebrate the special solidarity that antagonism to him has created. A counter-group sustained through gossip is thus formed, with him as the negative focus. He becomes the center of distraction.

In consequence of this freeze-out, the actor, recipient now of no corrective feedback, may be forced to relatively violent outbursts as a means of making some impression upon the glossily opaque shell that others have constructed around him. They in turn may find it necessary to form a collusive net so as to inveigle him into receiving psychiatric attention.

Two implications of Lemert's analysis may be suggested. First, a system of informal social control can easily go awry. Tact and secrecy can have the ultimate consequence of constructing a real paranoid community for the paranoid. Secondly, until the individual is hospitalized, or until his reputation becomes widespread so that no one takes his actions seriously (and this latter form of encapsulation is found in large-scale social organizations), his symptoms have a very disruptive effect; it is a great deal to ask that members of the organization respond with understanding and support—it's a wonder, in fact, that organizations are as tolerant as they are.

I have sketched the relation between mental symptoms and two forms of social organization—public order and formally organized work places. Turn now to the final unit of organization to be considered, the domestic or family establishment.

V

Approach the family—say in the American middle-class version—through conventional sociological terms. When

we examine its internal functioning, its internal social economy, we find a legitimated distribution of authority, material resources, work, and free time. There is the obligation of each member to care for and protect the others, insofar as they are in need of this help and a member is able to provide it. There is a normatively established allocation of respect, affection, and moral support. Some common values and special ways of doing things will be maintained. Knowledge of the family biography will be shared, along with memory of joint experiences. A crisscross of personal relationships will be sustained. A common care will be exerted (by all but the very young), so that the damage that could easily occur to the household through fire, water, soiling, and breaking will not occur. And each member will be trusted by the others not to exploit any of the lethal instrumentalities readily available in the house for harming himself or the others. Finally, as the special feature of the family as a social organization, each member commits his own feelings and involvements to what he takes to be the personal interests and personal plight of each of the others.

If the behavior of any one member, especially that occurring in the presence of other members, is examined closely, it reveals an expressive style that affirms this allotting of obligations. The maintenance of this style by each member gives the other members constant assurance that their expectations will be lived up to and that things are as they should be. In brief, the activity of each member tends to express that he knows what his social place is in the family and that he is sticking to it. Of course, if an individual member has medical difficulties, he is likely to make extra demands, but part of the safety here is due to the ritual work he engages in which neutralizes these demands as threats to the family's normative order, ensuring constancy to the members' sense of what the ill individual is like as a personali-

ty. Nonmedical crises, such as the lengthy absence of a member for military service, can similarly be handled, provided only that appropriate ritual work is done.

Turning to the external economy of the family, we find something similar. Resources which have value in the external environment are budgeted among the members in a conserving and perceivedly equitable manner. The fund of private information about the family possessed by the members is preserved, and a united, somewhat false front is maintained before the world—as if there were a family information rule. Finally, the relationships and work/school obligations that link individual members to outside persons and organizations comply with established jurisdictional rulings whereby the family retains some rights. In any case, the family member is pulled out of the family space only by real organizations and real persons who have made a real place for him. In brief, nonfamily claims on family members are limited and regularized.

The maintenance of the internal and external functioning of the family is so central that when family members think of the essential character, the perduring personality of any one of their numbers, it is usually his habitual pattern of support for family-organized activity and family relationships, his style of acceptance of his place in the family, that they have in mind. Any marked change in his pattern of support will tend to be perceived as a marked change in his character. The deepest nature of an individual is only skin-deep, the deepness of his others' skin.

In the case of withdrawals—depressions and regressions—it is chiefly the internal functioning of the family that suffers. The burden of enthusiasm and domestic work must now be carried by fewer numbers. Note that by artfully curtailing its social life, the family can conceal these disorders from

the public at large and sustain conventional external functioning. Quiet alcoholism can similarly be contained, provided that economic resources are not jeopardized.

It is the manic disorders and the active phases of a paranoid kind that produce the real trouble. It is these patterns that constitute the insanity of place.

The beginnings are unclear and varied. In some cases something causes the prepatient—whether husband, wife, or child—to feel that the life his others have been allowing him is not sufficient, not right, and no longer tenable. He makes conventional demands for relief and change which are not granted, perhaps not even attended. Then, instead of falling back to the *status quo ante*, he begins his manic activity. As suggested, there are no doubt other etiologies and other precipitating sequences. But all end at the same point—the manic activity the family comes to be concerned with. We shall begin with this, although it is a late point from some perspectives.

The manic begins by promoting himself in the family hierarchy. He finds he no longer has the time to do his accustomed share of family chores. He increasingly orders other members around, displays anger and impatience, makes promises he feels he can break, encroaches on the equipment and space allocated to other members, only fitfully displays affection and respect, and finds he cannot bother adhering to the family schedule for meals, for going to bed and rising. He also becomes hypercritical and derogatory of family members. He moves backward to grandiose statements of the high rank and quality of his forebears, and forward to an exalted view of what he proposes soon to accomplish. He begins to sprinkle his speech with unassimilated technical vocabularies. He talks loudly and constantly, arrogating to himself the place at the center of things this role assumes. The great events and personages

of the day uncharacteristically evoke from him a considered and definitive opinion. He seizes on magazine articles, movies, and TV shows as containing important wisdom that everyone ought to hear about in detail right now

In addition to these disturbances of rank, there are those related to the minor obligations which symbolize membership and relatedness. He alone ceases to exercise the easy care that keeps household equipment safe and keeps members safe from it. He alone becomes capricious in performing the little courtesy-favors that all grown members offer one another if only because of the minute cost of these services to the giver compared to their appreciable value to the recipient. And he voices groundless beliefs, sometimes in response to hallucinations, which imply to his kin that he has ceased to regulate his thought by the standards that form the common ground of all those to whom they are closely related.

I repeat that the claims and actions of the ill person are not necessarily bizarre in themselves, merely bizarre when coming from the particular patient addressing himself to his particular family. And bizarreness itself is not the issue. Even when the patient hallucinates or develops exotic beliefs, the concern of the family is not simply that a member has crazy notions, but that he is not keeping his place in relationships. Someone to whom we are closely related is someone who ought not to have beliefs which estrange him from us. The various forms of grandiosity can have the same significance.

The constant effort of the family to argue the patient out of his foolish notions, to disprove his allegations, to make him take a reasonable view—an argumentation so despaired of by some therapists—can similarly be understood as the family's needs and the family's effort to bring the patient back into appropriate relationship to them. They cannot let him have his wrong beliefs because they cannot let

him go. Further, if he reverses his behavior and becomes more collected, they must try to get him to admit that he has been ill, else his present saneness will raise doubts about the family's warrant for the way they have been treating him, doubts about their motivation and *their* relationship to him. For these reasons, admission of insanity has to be sought. And what is sought is an extraordinary thing indeed. If ritual work is a means of retaining a constancy of image in the face of deviations in behavior, then a self-admission that one is mentally ill is the biggest piece of ritual work of all, for this stance to one's conduct discounts the greatest deviations. A week of mayhem in a family can be set aside and readied to be forgotten the moment the offender admits he has been ill. Small wonder, then, that the patient will be put under great pressure to agree to the diagnosis, and that he may give in, even though this can mean that he must permanently lower the conception he has of his own character and must never again be adamant in presenting his views.

The issue here is not that the family finds that home life is made unpleasant by the sick person. Perhaps most home life is unpleasant. The issue is that meaningful existence is threatened. The definitions that the sick person tacitly accords the family members are less desirable than the ones they had before and imply that the family members are less connected to him than they had thought. If they accept this revision, then meaningful organization can be re-achieved, as happens, for example, when family cult-formation occurs or *folie à ménage*. But if they do not, there is trouble.¹⁷

¹⁷ Theories of *gemeinschaft* argue that intimates must agree on basic beliefs or break up their relationship, and that, by implication, the willingness of a skeptical member to come around is motivated by a desire to maintain relationships. But there are, of course, exceptions to the rule of agreement. The model here in social science literature is Mr. Keech, who quietly went about his usual business while

Let me repeat: the self is the code that makes sense out of almost all the individual's activities and provides a basis for organizing them. This self is what can be read about the individual by interpreting the place he takes in an organization of social activity, as confirmed by his expressive behavior. The individual's failure to enact, through deeds and expressive cues, a *workable* definition of himself, one which closely enmeshed others can accord him through the regard they show his person, is to block and trip up and threaten them in almost every movement that they make. The selves that had been the reciprocals of his are undermined. And that which should not have been able to change—the character of a loved one lived with—appears to be changing fundamentally and for the worse before their eyes. In ceasing to know the sick person, they cease to be sure of themselves. In ceasing to be sure of him and themselves, they can even cease to be sure of their way of knowing. A deep bewilderment results. Confirmations that everything is predictable and as it should be cease to flow from his presentations. The question as to what it is that is going on is not redundantly answered at every turn but must be constantly ferreted out anew. And life is said to become like a bad dream—for there is no place in possible realities for what is occurring.

It is here that mental symptoms deviate from other deviations. A person who suddenly becomes selfish, heartless, disloyal, unfaithful, or addicted can be dealt with. If he properly shows cause or contrition he can be forgiven; if he is unrepentant but removable he can be redefined. In either case, his others can come to terms with him, in the sense that the expressions he gives off concerning his definition of himself and them are indications that confirm

Mrs. Keech at home was publicly organizing for the end of the world. See Festinger et al., esp. pp. 38-39.

the relationship they feel they now have to him. The grammaticality of activity is sustained. A patient's mental symptoms, however, are something his others cannot come to terms with. Neither he nor they withdraw from the organization or relationship sufficiently to allow his expression to confirm what his status implies. Thus his behavior strikes at the syntax of conduct, deranging the usual agreement between posture and place, between expression and position.

The domestic disorganization created by the ill person points up an important fact about social control in a unit like the family. Any grown member of the family can leave the household against the will and advice of the family, and, except for exacting financial claims against him, there is nothing that the family can do about it. The power of the leavetaker is especially strong if he departs properly, through channels as it were, with an appropriately staged announcement of intentions. On the other side, there are circumstances (varying in America from state to state) in which a family can have a member removed bodily to a place of detention. However, when, for whatever reason, neither of these forms of socially recognized departure occurs, the family and its household prove to be vulnerable in the extreme. For then the standard notion of social control effected through a corrective cycle becomes quite untenable. The simple fact is that when an offender is disapproved of and punished, and warned what will happen if he persists, it is tacitly assumed that he will be sufficiently committed to the life of the group, and to sustaining those who presume authority in it, to *voluntarily* take the sanction to heart and, whether in good grace or bad, desist from the particular offense. If the family offender elects not to heed the warning, there is then really nothing effective that can be done to him. Sheer manhandling that is not responded to by tacit cooperation requires the

full effort of at least two strong adults and even then can only be managed in brief spurts—long enough to remove someone from a house, but not much longer. Even merely to stand watch and guard over a person requires more than a household can usually manage for very long. And the household itself can hardly be run if everything that might be damageable or dangerous must be kept out of an adult's reach.

Households, then, can hardly be operated at all if the good will of the residents cannot be relied on.¹⁸ Interestingly, it is right at the moment of punishment and threat, right when the offender presumably has additional reasons for antagonism, that the family is most clearly dependent on his self-submission to family authority. Punitive action forces the offender either to capitulate and lose face, or to disabuse his opponents of their belief that they have power over him. Just when he is most angry at them he must see that he alone can save their illusions concerning their control over him. Negative sanctions within the context of a household, then, constitute a kind of doomsday machine, forcing the last available opportunity to avoid a breakdown of order upon the stronger of the two parties, who must act as if he is the weaker. Obviously, on occasion he will not be considerate. This vulnerability of family organization is reinforced by the fact that the offender may well give less consideration to his own bodily welfare and his own interests than those who must control him.

I have considered some of the disorganizational consequences of the patient's failure to support the internal order of the family. It is, however,

¹⁸ A useful recent description of the structural contingencies of disciplining an unwilling family member is provided in Louise Wilson, *This Stranger, My Son*. Mrs. Wilson describes in some detail what a child diagnosed as paranoid schizophrenic can accomplish with the domestic equipment at hand. A full picture is also available in the Bettelheim accounts of the Sonia Shankman Orthogenic School, but in this case, of course, the care that requires the staff's full-time effort is their official full-time job.

when the family's external functioning is considered that the full derangement is seen.

The social place of a family in the community at large is a matter of some delicacy, based as it is on personal and informal control that exposes the family to a thousand possible markets for its various resources—markets which the family itself must deal with prudently if it is to maximize its own long-range interests as these are conventionally defined. It is this circumspection, ordinarily self-imposed, that the active patient transcends.

Misplaced enterprise occurs. Family monies are squandered on little examples of venture capitalism. Grand services and equipment are bought or contracted for, nicely illustrating the democratic, accepting attitude of those who sell things and the personal control that all of us ordinarily maintain.¹⁹ Bargains advertised in the newspaper are ordered in excessive quantity by phone.²⁰ The occupational and age-grade structure is dipped into far enough down to find commandeers and hirelings for expansive private projects. An unnecessary office or industrial layout is grafted onto the household. The patient finds that his ordinary job is cramping and gives it up or is fired.²¹

¹⁹ Admittedly, there are some limits due to formal social control. A thirteen-year-old cannot go down to his friendly Ford dealer and negotiate the purchase of a new Thunderbird, although a few years later he can. Similarly, although almost any adult can at will set a real estate agent to work, earnest money will eventually be needed.

²⁰ See Roueché's case study, "Ten Feet Tall." Roueché provides useful details regarding the overreaching social behavior of a man enjoying a brief manic episode due to the side effects of cortisone treatment.

²¹ A manic patient who can become too large for his home can similarly become too large for his job. Starting with a commendable increase in enthusiasm for his work, he begins to offer fellow workers wanted help and advice, extends this to what is seen as interference in the spheres of others, and finally takes to giving unauthorized directives and acting as a spokesman for his work-organization when he is away from it. During this process of becoming a self-appointed boss, he begins to arrogate to himself more and more equipment, space, and subordinate help. And since his private business and convivial enterprise have greatly expanded and are coming to be very ill-received at home,

A flurry of projects is initiated. A press of occupation occurs.

Contacting is accelerated. The telephone is increasingly used. Each call becomes longer and more calls are made. Favorite recipients are called more and more frequently. When the hour renders local calls a gross violation of informal rules, long-distance calls are made into acceptable time zones; when the hour prevents even these, night telegrams are dispatched.²² A flood of letter-writing may occur.

Participation is broadened. Assistance is volunteered to persons and organizations undesirous of receiving it from this quarter—the patient appreciating that an offering is a warrantable means of making contact with the recipient. Public life is entered through its least guarded portals: participation in volunteer work; letters to politicians, editors, and big corporations; celebrity hunting; litigation. Critical national events, such as elections, war policy statements, and assassinations, are taken quite personally. Personal appearances on radio and television may be sought; press conferences and press releases may be engineered. Perceived slights in public places lead to scenes and to the patient's making official complaints to officials.

Associating is intensified. Neighbors are dropped in on at unsuitable hours. Parties are arrived at first and left last. There may be a surge of home entertainment that is unstabilizing: properly related friends attend until other commitments cause them to defect; newly formed friends are substituted, but each set wears out more

he shifts more and more of these activities to the work-place, spends more and more time during and after work thus engaged, and soon violates the very delicate norm governing the penetration of private interests into work. He promotes get-togethers of work personnel, and embarrasses status divisions by trying to bring together for conviviality everyone at work who is remotely within his social reach.

²² Monthly telephone bills that are twenty times normal have an interesting story to tell. Telephone companies, however, are scrupulously detached in these matters. Theirs is not to wonder why but only to collect.

quickly than the last, requiring recruitment from less and less suitable sources; ultimately the gatherings become socially bizarre. Semi-official, public-spirited purposes for home gatherings are increasingly employed, this providing some warrant for the patient's inviting persons he has merely heard about, and for aggregations of persons of widely different social rank. Invitation lists are extended right up to the last minute, as if there were a need to be in touch with all acquaintances and to pack the environment with people. Evenings of commercial recreation and weekend outings are organized repeatedly, involving much recontacting and also the mustering of unacquainted persons into one venture.

Finally, relating is expanded. Courtesy introductions and offhand referrals by others are followed up and made something of, acquaintanceship is presumed upon, and presuming requests are made across affinal lines to spouses of friends. "Middlemanning" occurs, the ill person attempting to bring into contact persons perceived as having use for each other. The functional specificity of service relations is breached. Advice is proffered to and asked of service personnel on many matters; the use of reciprocal first-naming is suggested; social invitations are extended. Corresponding to this diffusion, personal friends are loaded with service requests and enrolled in schemes and projects. Occasional workers, hired by the patient to help in projects, will be transformed into friends to fill the gap that has developed, but these will now be friends who can be ordered to come and go, there resulting a kind of minionization of the patient's social circle.²³ Minor shortcomings in services received from long-utilized professionals, tradesmen, and repairmen lead to run-ins and the immediate establishment of new serv-

ice connections. Family secrets are confidentially divulged at informal gatherings to persons who are merely acquaintances. Newly formed friends are enthusiastically praised to the family, giving the impression that the patient's capacity for deep involvement is being exercised capriciously. If the patient is single, unsuitable mating may threaten to occur across age, race, or class lines; if married, then unsuitable re-mating. And some sexual promiscuity may occur of the kind that can be realized at will because it trades on marked status differences. In all of this, the patient either takes advantage of others or places others in a position to take advantage of him, in either case to the deep embarrassment of his family.

A general point can be detected here about the patient's rage for connectedness and position. Since his movement from his allotted place is to be accomplished entirely by the power of self-inclination, two spheres will be in easiest reach for him. One consists of local persons who are appreciably beneath him socially and who are willing to be approached at will because the association can mean some kind of economic gain or social enhancement. The other sphere consists of powerful and well-known personages. Of course, only the most vicarious and attenuated contact can be made with these notables, the channels here being fan letters, telegrams, attendance at personal appearances, unaccepted party invitations, and the like. Nonetheless, when actual social connections become disturbed and insufficient, these figures are there; they acquire a startling immediacy and come to serve as points of reference for self-organization.

The patient, then, is free to move in two directions: downward by means of social trade-offs; upward by means of vicarious or abortive contact. Interestingly, the more trouble at home, the greater the need to move into the lives of friends; the more this is done, the

²³ A form of social organization sometimes bred by very high office; this is best illustrated today, perhaps, in the Hollywood entourage.

more the second circle will close itself off by virtue of being overtaxed; the more this occurs, the more fully does the patient take flight into unsuitable alliances and vicarious ones. Further, what remains of an inner circle tends to be alienated by what the patient attempts in the next concentric ring; what is there developed is undermined by his antics in a still wider circle. Tentative expansion outward thus reduces what is already possessed, and sharply increases the need to consolidate the new circle. With all of these forces working together, an explosion of dealings results. There is a flight into the community.

Without taking the time to examine in detail any of these overreachings, or to consider the clinical hypothesis that the patient may be seeking every possible external support for an internal state that is collapsing, let it only be said that so far as family organization is concerned, what happens is that the boundary between it and the community is threatened. In the extreme, the family as a unit that holds itself off from the environing world is forcibly washed away, the members literally displaced from the domestic establishment by a flood of nonmembers and by the sick person's organizational activity.

Note that the community context of family life is such that this sort of diffusion is always possible. The patient does not construct his own avenues of access; he merely uses excessively devices available to anyone in his position. To appreciate this fact, we must look at the community as a system of fences and gates, a system for regulating the formation and growth of social relationships.

A relationship cannot form unless two persons can come into personal contact of some kind (whether face-to-face or mediated), and a relationship cannot develop unless its members can interact over a period of time.

Contact itself is organizationally fa-

cilitated in certain basic ways. Contemporary social organization provides that places of residence and work can be reached by phone, telegraph, letters, and personal visits. The necessarily common use of public and semipublic facilities, especially the streets, brings a wide variety of persons within face-to-face reach of one another. The institution of acquaintanceship (established often through introduction) confers preemptive contact rights. Because of such devices, a very wide potential exists for contact, and through contact the development of relationships.

This potential, in turn, is sharply curtailed by various factors. We do not know the appearance or address of many of those we might want to be in touch with. We are bound by rules which proscribe our initiating talk with unacquainted others except on various good grounds. We are likely to be ignorant of where and when those social occasions will occur where those whose acquaintance we seek will be present, and presence itself allows for the initiation of talk. Knowing where and when, we may not be qualified by money, membership, or invitation to go. Beyond this, there are all the devices used for blocking contacts: disguise of personal appearance, avoidance of public places, nonlisting of telephone numbers, the stationing of gatekeepers to intervene at places of residence and work, segregation by cost and ecology, and so forth.²⁴ But note, these various blocks to association cannot be allowed to be complete. Any door that *completely* keeps out undesirables also keeps out some desirables; any means of completely shutting oneself off also shuts out contacts that would be profitable. After all, relationships that come to be close can be traced back to an overture or introduction; service dealings which prove satisfactory can be traced back

²⁴ These devices are most fully used by the famed, apparently in part because they can least rely on the probability that interested members of the public will lack detection information about them.

to an unknown client's or customer's appearing on the telephone; successful projects, to nothing more substantial than announced intentions; valuable publicity for a celebrity, to one among the many phone calls he receives; a warning that one has dropped one's wallet, to a stranger who accosts one on the street. Who knows from whom the next phone call or letter will be and what it will be about? The most careful screening in the world must still expose someone on the staff to *anyone* who bothers to try to make contact. Presentments have to be given a moment's benefit of the doubt, lest that which will come to be desirably realized will not have been able to begin. We must always pause at least for a moment in our oncoming rejection of another in order to check the importuner out. There is no choice: social life must ever expose itself to unwarranted initiations. A screening device would have no functional value if the only persons who got through it were the persons who got to it.

Mechanisms for facilitating and restricting relationship formation are reinforced by formal legal control, in the sense that persons who decline to be drawn into certain negotiations can be forced to do so by the law, as can those who decline to desist from certain importunings. Much more important, the mechanisms are reinforced by personal control and informal control, resulting in a tacit social contract: a person is obliged to make himself available for contacting and relationship formation, in return for which others are obliged to refrain from taking advantage of his availability. He incidentally can retain the illusion that he does not cut people off; they, that they would not be rejected.

This contract of association is made viable by the allowance of prognosticative expression. An open and friendly address conveys that overtures will be welcomed; a wary and stiff mien, that importunement will result in open re-

jection. Anyone wending his way through his daily round is guided not only by self-interest but also by these expressions. He avoids accepting subtle invitations that might lead to unsuitable associations and avoids transgressing where subtle warnings have been issued. He keeps to the straight and narrow. He handles himself ungenerously because on all sides there is something to lose.

It is understandable, then, why the patient finds himself in a disruptable world. Merely by jeopardizing a little more than persons like himself are usually willing to do—through exposing himself either to unsuitable relationships or to insulting rejection—he is in a position to penetrate all social boundaries a little. Whosoever the other, there will always be good reasons to warrant relating to him, and therefore a cover, however quickly discreditable, for the beginning of interaction with him.

A final comment. The manic activity I have described is obviously located in the life of the privileged, the middle and higher classes.²⁵ I think this apparent bias in selecting illustrations is warranted. Social resources must be possessed before they can be handled in

²⁵ Some empirical evidence for this argument is provided in Hollingshead and Redlich, p. 228.

For an analytical illustration, consider an extreme comparison: a black wino and a blond model, he in rough clothes and she in the style of the upper middle class. Compare their public situation—the passage of each across, alongside, or toward the paths of unacquainted others. Consider the eye practices each must face from these walkers-by.

The wino: A walker-by will take care to look at him fleetingly if at all, wary lest the wino find an angle from which to establish eye-to-eye contact and then disturb the passage with prolonged salutations, besmearing felicitations, and other importunements and threats. Should the wino persist in not keeping his place, the discourtesy of outright head-aversion may be necessary.

The model: A walker-by will fix her with an open gaze for as many moments as the passage will allow without his having to turn his head sharply. During this structured moment of staring he may well be alert in fantasy for any sign she makes interpretable as encouraging his attentions. Note that this helter-skelter galantry remains very well in check, no danger to the free flow of human traffic, for long ago the model will have learned her part in this cere-

the manner that has been considered. Therefore mania would seem to be a disease of persons with social advantages—money, lineage, office, profession, education, sexual attractiveness, and a network of social and familial relationships. Perhaps impoverished expansionists, having few goods to exchange for being taken seriously, are soon forced to make ludicrous presentations, and transform everyone around them into skeptical ward attendants. Thus it could be argued that the well-stationed are prone or at least overrepresented; the insanity of place is a function of position.

I have already touched on some features of the family's response to life with the patient. Members feel they are no longer in an easefully predictable environment. They feel bewildered by the change of character and personality that has occurred. Moreover, since the dramatic change has come to a person they feel they should best be able to characterize, cognition itself becomes an issue; the very principles of judgment by which one comes to feel that one knows character and is competent to judge it can become threatened. Consider now some further aspects of the family's response.

mony, which is to conduct her eyes downward and unseeing, in silent sufferance of exposure.

Against this structural view of the public situation of the beast and the beauty (illustrating the boundaries of civil inattention), consider the consequence to each of being apparently possessed by an unsuppressed urge to enter into dealings.

Of himself the wino can make a mild nuisance, but nothing much more disarranging than that is likely to be allowed him. The more he rattles the bars of his cage, the more hurrying-by will be done by visitors to the zoo. Social arrangements are such that his screaming right into the face of an unacquainted other may only complete his treatment as someone who does not exist. The friendly model, in contrast, will find that suddenly there are a hundred takers, that strangers of both colors, three sexes, and several age groups are ready to interrupt their course for an adventure in sociability. Where'er she smiles, relationships begin to develop. A wino leaves a narrow trail of persons more fully busying themselves with their initial plans. A manic beauty may not get far enough to leave a trail. She opens up a world that then closes in on her. She clots and entangles the courses of action around her. The more delicate and ladylike, the more she is the peril the Victorian manuals should have warned the city about.

One issue concerns the structure of attention. Put simply, the patient becomes someone who has to be watched. Each time he holds a sharp or heavy object, each time he answers the phone, each time he nears the window, each time he holds a cup of coffee above a rug, each time he is present when someone comes to the door or drops in, each time he handles the car keys, each time he begins to fill a sink or tub, each time he lights a match—on each of these occasions the family will have to be ready to jump. And when it is not known where he is or it is known that he is behind a locked door, an alert will have to be maintained for any hint of something untoward. The possibility that the patient will be malicious or careless, that he will intentionally or unintentionally damage himself, the household, or the others, demonstrates that standard household arrangements can be full of danger; obviously, it is the presumption of conventional use that makes us think that these conventional arrangements are safe.²⁶

Three points are to be made concerning the family's watchfulness. First, households tend to be informally organized, in the sense that each member is allowed considerable leeway in scheduling his own tasks and diverting himself in his own directions. He will have his own matters, then, to which he feels a need to attend. The necessity, instead, of his having to stand watch over the patient blocks rightful and pleasurable calls upon time and generates a surprising amount of fatigue, impatience, and hostility. Second, the watching will have to be dissimulated and disguised lest the patient suspect

²⁶ Professionals who manage the actively suicidal are acutely alive to the unconventional lethal possibilities of domestic equipment; indeed, in published case records detail is provided. Less clearly appreciated, perhaps, is that a person with any type of actively expressed mental disorder can unhinge the meaning of his domestic acts for the other members of the family. What would ordinarily be an uneventful household routine can come to be seen as a deed through which the patient may intentionally or unintentionally damage the equipment at hand, the persons nearby, or himself.

he is under constant surveillance, and this covering requires extra involvement and attention. Third, in order to increase their efficiency and maintain their morale, the watchers are likely to engage in collaboration, which perforce must be collusive.

The family must respond not only to what the patient is doing to its internal life, but also to the spectacle he seems to be making of himself in the community. At first the family will be greatly concerned that one of its emissaries is letting down the side. The family therefore tries to cover up and intercede so as to keep up his front and theirs. This strengthens the collusive alignment in the family against the patient.

As the dispute within the family continues and grows concerning the selves in whose terms activity ought to be organized, the family begins to turn outward, first to the patient's kinsmen, then to friends, to professionals, to employers. The family's purpose is not merely to obtain help in the secretive management of the patient, but also to get much needed affirmation of its view of events. There is a reversal of the family information rule. Acquaintances or other potential sources of aid who had once been personally distant from the family will now be drawn into the center of things as part of a new solidarity of those who are helping to manage the patient, just as some of those who were once close may now be dropped because apparently they do not confirm the family's definition of the situation.

Finally, the family finds that in order to prevent others from giving weight to the initiatory activity of the patient, relatively distant persons must be let in on the family secret. There may even be necessity for recourse to the courts to block extravagances by conservator proceedings, to undo unsuitable marriages by annulments, and the like. The family will frankly allow indications that it can no longer handle

its own problems, for the family cat must be belled. By that time the family members will have learned to live exposed. There will be less pride and less self-respect. They will be engaged in establishing that one of their members is mentally ill, and in whatever degree they succeed in this, they will be exposing themselves to the current conception that they constitute the kind of family which produces mental illness.

While the family is breaking the informational boundary between itself and society—and an appeal to a therapist is only one nicely contained instance of this—it may begin to add some finer mesh as well as some spread to its collusive net. Some of the patient's telephone calls are tapped and some of his letters opened and read. Statements which the patient makes to different persons are secretly pooled, with consequent exposure of incongruities. Experiences with the patient are shared in a widening circle in order to extract and confirm patterns of impropriety. Discreetly planned actions are presented to the patient as unplanned spontaneous ones, or disguised to appear as if originating from a source still deemed innocent by him. This conspiracy, note, is an understandable result of the family's needing very much to know the patient's next move in order to undo it.

A review of the family's response to the patient easily suggests that members will find much cause to feel angry at him. Overlaid, however, there will be other feelings, often stronger. The damage the patient appears to be doing, especially in consequence of his overreachings outside the family, is seen to hurt his own interests even more than those of the rest of the family. Yet for the family this need not produce grim satisfaction or help to balance things out; rather, matters may be made worse. As suggested, it is the distinctive character of the family that its members not only feel responsible for any member in need, but also

feel personal identification with his situation. Whenever the patient is out alone in the community, exposed and exposing himself to what can be perceived as a contamination of his self and a diminution of his character, whenever the patient must be left alone at home, exposing himself as well as the household to intended and unintended dangers, the family will know anxiety and fear.

I have suggested that a family with mania to contend with is likely to form a collusive net, the patient being excoluded.²⁷ Now turn and take the point of view of the patient.

The family's conspiracy is benign, but this conspiracy breeds what others do. The patient finds himself in a world that has only the appearance of innocence, in which small signs can be found—and therefore sought out and wrongly imputed—showing that things are anything but what they seem. At home, when his glance suddenly shifts in a conversation, he may find naked evidence of collusive teamwork against him—teamwork unlike the kind which evaporates when a butt is let in on a good-natured joke that is being played at his expense.²⁸ He rightly comes to feel that statements made to him are spoken so as to be monitored by the

others present, ensuring that they will keep up with the managing of him, and that statements made to others in his presence are designed and delivered for his overhearing. He will find this communication arrangement very unsettling and come to feel that he is purposely being kept out of touch with what is happening.

In addition, the patient is likely to detect that he is being watched, especially when he approaches some domestic device which could be used to harm himself or others, or which is itself valuable and vulnerable to harm. He will sense that he is being treated as a child who can't be trusted around the house, but in this case one who cannot be trusted to be frankly shown that he is not trusted. If he lights a match or takes up a knife, he may find as he turns from these tasks that others present seem to have been watching him and now are trying to cover up their watchfulness.

In response to the response he is creating, the patient, too, will come to feel that life in the family has become deranged. He is likely to try to muster up some support for his own view of what his close ones are up to. And he is likely to have some success.

The result is two collusive factions, each enveloping the other in uncertainties, each drawing on a new and changing set of secret members. The household ceases to be a place where there is the easy fulfillment of a thousand mutually anticipated proper acts. It ceases to be a solid front organized by a stable set of persons against the world, entrenched and buffered by a stable set of friends and servers. The

²⁷ If the patient is an adult, the consequences for children are especially painful. In order to protect the young from the imperious demands of the patient and from the conception of the patient that would result were his acts taken as serious ones, the young may have to be recruited into the net. This will also facilitate the collusion by reducing the number of others from whom its operation must be concealed. The children may accept this invitation, decline it, or, if careful enough, give each side the impression that its view is being supported. Whatever the response of the young, adult solidarity is clearly broken and idealization of adults undermined. Children's insubordinate treatment of the ill person can result, the other adults being unable to reinforce demands of the patient. Further, the more the ill person becomes a source of unwarranted demands upon the young, the less the other adults feel they can exert parental discipline where discipline is due.

²⁸ For this the patient requires no special perceptiveness, sometimes attributed to the insane. It is an empirical fact that in our society the furtive signs through which a collusive alignment is maintained against someone who is present are often crude and easily available to the excoluded. Ordinarily the colluders do not

discover that they have been discovered because the excoluded wants to support the surface appearance that he is not so unworthy as to warrant this kind of betrayal. Paradoxically, it is exactly such a surface definition of the situation that the colluders require in order to have something to undercut. I want to add that colluders very often decline to stage their collusion as discreetly as they could. As in many other occasions of false behavior, the manipulators half want their dupe to be aware of what is really thought of him.

household becomes a no-man's land where changing factions are obliged to negotiate daily, their weapons being collusive communication and their armor selective inattention to the machinations of the other side—an inattention difficult to achieve, since each faction must devote itself to reading the other's furtive signs. The home, where wounds were meant to be licked, becomes precisely where they are inflicted. Boundaries are broken. The family is turned inside out.

We see, then, that the domestic manic breeds, and is bred in, organizational havoc, and that this havoc is all too evident. Yet here clinical reports have been very weak. I venture a Durkheimian account.

It is frequently the case that hospitalized patients who have behaved at home in the most exotic and difficult fashion are taken back into the family upon release from the hospital, and that however tentatively they are received, they are given some sort of trial acceptance. Also, it is quite generally the case that before hospitalization, the feeling of the family that the troublesome one is mentally ill will come and go: with each outburst the family will have to face anew the idea that mental illness is apparently involved, but with each moment of the patient's wonted and tranquil behavior, sharp new hope will be experienced by the family—hope that everything is coming back to normal. This readiness to oscillate, this resilience of hope on the family's part, should not be taken particularly as evidence of good will or resistance to bad-naming. In other circumstances, I'm sure, most families would be quite ready to form a rigid and stereotyped view of an offender. But the fact is that there is no stable way for the family to conceive of a life in which a member conducts himself insanely. The heated scramble occurring around the ill person is something that the family will be instantly ready to forget; the viable way things once

were is something that the family will always be ready to re-anticipate. For if an intellectual place could be made for the ill behavior, it would not be ill behavior. It is as if perception can only form and follow where there is social organization; it is as if the experience of disorganization can be felt but not retained. When the havoc is at its height, participants are unlikely to find anyone who has the faintest appreciation of what living in it is like. When the trouble is finally settled, the participants will themselves be unable to appreciate why they had become so upset. Little wonder, then, that during the disorganization phase, the family will live the current reality as in a dream, and the domestic routine which can now only be dreamt of will be seen as what is real.

VI

Return now to the earlier discussion of collusive elements in the medical role. Return to the doctor's dilemma.

The traditional picture of mental hospitalization and other psychiatric services involves a responsible person, typically a next of kin, persuading, dragging, conning, or trapping the patient-to-be into visiting a psychiatrist. A diagnostic inspection occurs. It is then that the psychiatrist is likely to begin his collusion with the next of kin, on the grounds that the patient cannot be trusted to act in his own best interests, and that it will not do the patient any good to learn the name and extent of his sickness.²⁹ The patient, of course, is likely to feel betrayed and conspired against; and he may continue to until he is well enough to see that the collusive action was taken in his own best interests.

The great critics of the collusive management of the mental patient

²⁹ Surely this practice is not entirely a bad thing, since this information can deeply affect the patient's view of himself, and yet diagnoses seem to vary quite remarkably, depending on the prevailing diagnostic fashion and the tastes of the practitioner.

have been the psychoanalysts. They act on the assumption that if a real relationship is to be developed with the client, one allowing the therapist and client to work together profitably, then this relation must not be undercut by the therapist's engaging in collusive communication with the client's responsible others. If contact is necessary between therapist and patient's kin, then the kin should be warned that the patient must know what has taken place, and what in substance the therapist said to the kin. Therapists realistically appreciate that information about the patient put into the hands of his loved ones might well be used against him. This communications policy cuts the therapist off from many sources of information about the patient, but there is an answer in the doctrine that the patient's trouble is in his style of projecting and relating, and that this can be well enough sampled by means of what is disclosed during private sessions. A parallel can be noted here to what is called hotel anthropology.

I am suggesting that therapists, especially of the psychoanalytical persuasion, appreciate the collusive implication of their contacts with the third party and go far in protecting the patient from this collusion. However, by this very maneuver they help consolidate another collusive relationship, that between themselves and the patient in regard to the responsible others. The practice of trying to get at the patient's point of view, the effort to refrain considerably from passing obvious moral judgments, and the strict obligation on the patient's part to betray all confidences if these seem relevant—all these factors in conjunction with the privacy of the therapeutic setting ensure collusive coalition formation to a degree unappreciated even by the next of kin. (Whereas ordinary relationships give rise to collusive coalitions, the therapeutic situation is a collusion that gives rise to a relationship.) This resembles a domes-

tic handicapping system, whereby the weakest team in the family tournament is given an extra man. Let me add that collusion for hire seems a rum sort of business to be in, but perhaps more good is done than harm.

What has been considered can be reduced to a formula. Traditionally the psychotic has been treated through a collusive relation between his therapists and his family and ends up excoluded into the mental hospital, while the neurotic (who is so inclined and can afford it) has been treated to a collusive relation with his therapist against his family or boss and remains in the community.³⁰

There is a collusion, then, for psychotics who end up in a mental hospital and for neurotics who stay in the community—the psychiatrist being constrained to engage in one or the other form, depending on his patient and, beyond that, his type of practice. What is to be considered here, however, is the collusion arising when psychotics of the manic kind are managed in the community.

First note that the therapeutic or patient-analyst collusion will have shortcomings. Private talks with the patient will not tell the therapist what is happening to the family or what its urgent needs are. This is indicated by the fact already suggested that psychotherapists have provided hardly any information about the organizational meaning of illness for the units of social organization in which the illness occurs. In any case, since the patient is likely to continue his troublesome activity unabated after beginning therapy, the family will feel that the therapist has become a member of the patient's faction. This is no small matter.

³⁰ Admittedly in recent times some therapists have attempted to treat the same patient in and out of the hospital, in which case the usual alignments are not possible; some have engaged in "family therapy"; and some have attempted a flexible open relationship of access allowing for private and family sessions with the same patient. But even these arrangements, I think, do not prevent collusion problems.

The patient's domestic opponents find themselves pressed to the wall of sanity, having to betray a loved one lest his uncharacteristic assumptions about himself make their life unreal. Their social place is being undermined, and the standards they have always used in judging character and identity are in question. The failure of any other person to confirm their view of the patient, even when this failure merely means declining to take sides, adds weight to the hallucinatory possibility that they might be wrong and, being wrong, are destroying the patient. And persons distant from the family will certainly fail to confirm the family's position. A fact about the wider community must here be appreciated. Unless the patient is very ill, those who know him little—even more, those who know him not at all—may not sense that anything is wrong, and with good reason; at least for a time, all they may notice is that an individual is more friendly and outgoing, more approachable than he might be. Those in the community who *do* develop doubts about the patient are likely to be tactful enough to refrain from directly expressing them. After all, easing themselves out of contact with the troublesome one is all that is necessary. The worst that can happen to them is that they will briefly have to face how conditional their concern for another is—conditional on his being willing to withdraw in response to suggestions and hints.

The other type of psychiatric collusion may not be much better. If the family has psychiatric assurance that it is the patient who is crazy and not the family members, this mitigates somewhat their need for confirmation of their position from friends and associates, and in turn mitigates their flight into the community. But in order to contain and discipline the patient, and through this to preserve the possibility of reestablishing the old relationships later, they will feel compelled to

tell him he is not himself and that so says the psychiatrist. This won't help very much. The family will almost certainly have to use this club. It won't, however, be the right one. The patient will feel that the family members are concerned not about his illness, but about their pinched status. And the patient by and large will be right. The patient then must either embrace the notion of mental illness, which is to embrace what is likely to be a destructive conception of his own character, or find further evidence that his close ones have suddenly turned against him.

In summary, the physician finds that he must join the family's faction or the patient's, and that neither recourse is particularly tenable. That is the doctor's dilemma.

VII

In this paper I have tried to sketch some of the meanings of mental symptoms for the organization in which they occur, with special reference to the family. The argument is that current doctrine and practice in psychiatry have neglected these meanings. To collapse the warfare of social place in a troubled family into such terms as "acting out" or "manic" keeps things tidy, but mostly what such terms accomplish is the splendid isolation of the person using them. A concept such as "hyperactivity," which psychiatrically denotes precisely the behavior I have been considering, seems to connote some sort of mechanical malfunctioning with little suggestion of the social overreaching that are actually involved.

A final complication. Throughout this paper I have spoken of the mentally ill patient and his mental symptoms. That was an optimistically simple thing to do. Medical symptoms and mental symptoms, so-called, are radically different things. As I have pointed out, the malfunctioning that medical symptoms represent is a malfunctioning of the human organism and only very rarely constitutes an elegant deni-

al of social functioning. However impaired physically, the medically ill person can almost always express that he is not intentionally and openly opposing his place in the social scheme of things. So-called mental symptoms, on the other hand, are made up of the very substance of social obligation. Mental symptoms directly express the whole array of divisive social alignments: alienation, rebellion, insolence, untrustworthiness, hostility, apathy, importunement, intrusiveness, and so forth. These divisive alignments do not—in the first instance—constitute malfunctioning of the individual, but rather disturbance and trouble in a relationship or an organization. We can all largely agree that everything should be done to patch up bodies and keep them alive, but certainly not that social organizations of all kinds should be preserved. Further, as already suggested, there is a multitude of reasons why someone who is not mentally ill at all, but who finds he can neither leave an organization nor basically alter it, might introduce exactly the same trouble as is caused by patients.³¹ All the terms I have used to describe the offensive behavior of the patient—and the term “patient” itself—are expressions of the viewpoint of parties with special interests. Quotation marks would have been in order, but too many of them would have been necessary.

The conventional psychiatric doctrine makes a place, of course, for psychiatry. The argument goes that an individual can appear more or less normal to those in his family, his work place, or his neighborhood, and really, underneath it all, be what is called a very sick guy—one who needs some help. The prepatient and his intimates

can refuse to see that anything fundamental is wrong, when to a professional eye it is plain that he is, as they say, quite sick. By the time the prepatient and his others appreciate that something is wrong, he may—the psychiatric argument goes—be very sick indeed. By that time his close others are likely to be penalizing him in all sorts of ways for his illness, and blaming him for something that they probably helped to produce. The solution is to catch things early, before symptoms become florid, the personality deteriorates, and irreparable damage has been done.

This conventional view, however, can be fatefully wrong, and wrong both for the patient and his others. For when someone not in a hospital has a manic episode, the following possibilities should be considered.

On the one hand, there may be very little wrong with the offender's psychological equipment. The psychological significance of the trouble for him may be relatively superficial and may, in fact, be partly understandable in terms of his changing relation to those outside the troubled organization. After all, the mess that the manic makes does not come out of his head. It comes from the vulnerabilities of domestic and community organizations to persons with social resources to expend.³² On the other hand, those who must contain

³¹ An implication is that those who come to the attention of psychiatry are a very mixed bag. Given current admission procedures, and given the current patient-load of nonanalytical office practitioners, I don't see how it is possible for psychiatrists to know whether or not it is mental illness that underlies the symptom with which they are dealing. Not knowing what they are dealing with, they understandably have small success in dealing with it.

³² Similarly, we should appreciate that depression is not something that can be fully understood by looking inside the patient. It seems to me that depressed persons come to appreciate consciously how much social effort is in fact required in the normal course of keeping one's usual place in undertakings. Once an individual feels a little less outgoing than usual for him, a very large part of his social universe can easily become attenuated, simply because such a universe is partly sustained at the constantly exercised option of the actor. At many contact points in the individual's daily round, his others will be on the lookout for signs of disaffection and be ready to begin to withdraw from him in order to protect their own reception. A small hint that he has become less inclined toward them can begin a general letting go of him. It might be added that while the classic notion of manic-depressive cycles is no longer put forward in psychiatry—the current view being that one of the two modes predominates—it is the case that many manics experience periods of

the manic in their social organization may, because of his social behavior, find themselves fighting for their social lives. The social significance of the confusion he creates may be as profound and basic as social existence can get.

The most disruptive thing a well organism can do is to acquire a deadly contagious disease. The most disruptive thing a person can do is fail to keep a place that others feel can't be changed for him. Whatever the cause of the offender's psychological state—and clearly this may sometimes be organic—the social significance of the disease is that its carrier somehow hits upon the way that things can be made hot for us. The sociological significance of this is that social life is organized so that such a way can be found for it.

The manic is someone who does not refrain from intruding where he is not wanted or where he will be accepted but at a loss to what we see as his value and status. He does not contain himself in the spheres and territories allotted to him. He overreaches. He does not keep his place.

But more than place and the self it affords are involved. The manic does

marked depression when to face any moment in the day requires a terrible effort. Again the plight of finding everything just too much of a drag is not to be attributed solely to an intrapsychic factor, but also to the fact that social place is organized so that some special effort is always required to maintain it. Given that much of social life is organized in terms of personal control and informal control, conditions are present for multiplying in every direction a slight increase or decrease in outgoingness. Depression and mania necessarily become ready possibilities, and not surprisingly often in the same person.

not accept tactful treatment as an exchange for not pressing too far. And he not only fails to keep the place which he and his others had allocated to him, but declines, apparently willfully, to engage in the ritual work that would allow his others to discount this failure.

In response, his others feel that his character and personality have suddenly changed, that he is no longer himself, and no longer himself in a way that disallows his close others from being what they feel they must be. Unfitting his self to his person, he unfits the persons of those around him to their selves. Wherever his dealings go, disarranging follows.

The manic declines to restrict himself to the social game that brings order and sense to our lives. Through his antics he gives up "his" self-respect, this being the regard we would allow him to have for himself as a reward for keeping a social place that may contain no other satisfaction for him.

The manic gives up everything a person can be, and gives up too the everything we make out of jointly guarded dealings. His doing so, and doing so for any of a multitude of independent reasons, reminds us what our everything is, and then reminds us that this everything is not very much. A somewhat similar lesson is taught by other categories of troublemaker who do not keep their place.

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