

CRAZIES IN THE COMMUNITY:
AN ETHNOGRAPHIC STUDY OF EX-PSYCHIATRIC CLIENTS IN
CANADIAN SOCIETY--STIGMA, MANAGEMENT STRATEGIES, AND
IDENTITY TRANSFORMATION

By

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ABSTRACT

This dissertation deals with the social world(s) of former psychiatric patients in Canadian society. Adopting a symbolic interactionist perspective, specifically a labelling approach, this study, in an effort to fill a neglect in the literature, seeks to discover what the everyday world(s) of Canadian ex-mental patients are really like. Specifically, this research focusses on stigma as it applies to long-term chronic and short-term non-chronic ex-psychiatric patients, the manner by which such persons discover that they possess a stigmatizable attribute, the strategems ex-patients develop in order to mitigate the stigma potential of mental illness, and the implications of adopting such strategies for identity transformation.

Using an exploratory, qualitative approach, data were collected through participant observation and informal and semi-formal interviewing on a stratified, disproportionate, random sample of two hundred and eighty-five former psychiatric patients living in Canadian communities.

The data indicate that ex-patients categorize "mental illness" as a stigmatizable attribute through: (a) societal reaction, official labelling and processing, (b) through negative interactions with "normals," and through self-labelling

The findings indicate that ex-patients deal with the stigma potential of mental illness in a variety of ways having profound implications for identity transformation.

The long-term chronics, who not only conceive of their deviant identities as "permanent fixtures," but receive no support from others in transforming their identities, and anticipate stigmatizing responses from normals, employ the following strategies of stigma management: institutional retreatism, societal retreatism, dissociation, passing, capitulation, and subcultural participation--strategies having negative implications for identity transformation. The short-term ex-patients, who conceive of their deviant identities as "temporary fixtures," receive support from others in transforming their identities, adopt the following strategies of stigma management: selective concealment, therapeutic telling, preventive telling, normalization and political activism--strategies having positive implications for identity transformation.

In this research, it is demonstrated that actors are not passive entities, but are active in dealing with the stigma accompanying their deviant labels and identities by eliciting preferred societal reactions through their own behaviour, through the images that they project, and in attempting to transform their deviant conceptions of self. The implications of this study for labelling theory, the sociology of mental illness and for the topic of deinstitutionalization are considered.

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INTRODUCTION

In the name of "humane treatment," I'm outside
at last
Waiting and watching this world fly past.
Lying alone in my two by six bed
Wishing and praying to God that I'd soon be dead.

With perpetual visions and nightmares of cruel
strangers running through my mind
I run, I try to escape, but solice and safety
I can't find.

Alone, alone, all alone in this world,
No one to help, no one to give a hoot
Down on the corner, I'm considered an old coot
--"A mental, a mental" they persecute me.
I run and I hide but they never seem to let me be.

The doctors, the big-shots all speak of success
But all I see is that us ex-patients are in a
real big mess.
They conned us with their speeches on "rehabilitation"
and "humane care" on the outside
They made us believe them, but oh how they lied.
For life's just a bitch.

While some may be lucky enough to make it on the
outside, for most of us, we've long since tried
To be normal, to be normal, to blend in the crowd
To be accepted, to get a job, to make life worth
living after all.
But most have forsaken us; our chances for happiness
grow slim
Our hopes of being normal are growing oh so dim.
We plea, we implore society to dispel your fear and
hate
Help us, oh help us, before it's too late.

(Poem verbally dictated in
Observation #212, June 4,
1984).



In almost every society throughout history,¹ man has designated, on the basis of cultural conceptions of what constitutes normal and abnormal behaviour, along with a number of other social factors,² certain behaviours to be "acts of madness" or "insanity." Upon such designations, societal members have developed and employed various methods for dealing with those committing acts of madness. Historically, for the most part,³ such techniques or methods have functioned to isolate and exclude those labelled as "mentally ill" from the dominant society. As scholars have well-documented (Deutsch, 1974; Foucault, 1965; Redlich and Freedman, 1966; Rosen, 1968; and Rothman, 1971, 1980) in their research on the history of mental health care, such techniques, at times, were developed largely for the "convenience"⁴ of society--cruel, inhumane methods such as banishment outside medieval towns, death or even forced passage on the "ship of fools"⁵ were employed. At other times in history, however, based upon benevolent, therapeutic ideological foundations--times during which "conscience," using Rothman's (1980: 5) terminology, reigned over "convenience," seemingly more humane and therapeutic techniques were developed such as the development of the asylum and its concomitant in-house therapeutic tools to deal with those defined as "mentally ill." Nevertheless, in all of these instances, on the basis of culturally and historically-specific conceptions about the mentally ill and mental illness in general--whether this phenomenon has been perceived in a benevolent manner or in a malevolent manner--

whether such persons are viewed as a nuisance, an economic liability or victims of a disease entity in need of treatment and care, the predominant method for dealing with the mentally ill has been to segregate and exclude such persons from the mainstream of society. The history of the mental health care system, can, in fact, be viewed largely as a study in the segregation, isolation and internment of those labelled as "mentally ill."

From the seventeenth century, up until the late 1950's, those defined as possessing mental disorders were primarily dealt with through the adoption and employment of various segregating and exclusionary methods--specifically, confining such afflicted persons in asylums or mental hospitals. However, beginning in the late 1950's, radical changes occurred in the philosophy and treatment of the mentally ill. According to some, such alterations occurred as a response to changes in societal attitudes toward the mentally ill (Rothman, 1980), due to the development of a humanitarian conscience on the part of psychiatric professionals (Bellak, 1964; Bloom, 1973; Ganser, 1975; Yolles, 1969, 1975), or were the result of the development and widespread adoption of psychotropic drugs (Bloom, 1973; Bassuk and Gerson, 1978). For still others, such alterations occurred as a purposive attempt on the part of psychiatric professionals to gain personal wealth and professional power and prestige (Burrow, 1969; Chu and Trotter, 1974; Fischer and Weinstein, 1971;

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Magaro et al., 1968), as a result of the development of industrial psychological techniques (Ralph, 1980, 1981); for economic reasons (Scull, 1977; Brown, 1979), or as a technological extension of clinical psychiatric oppression (Cooper, 1967; Leifer, 1966, 1967; Szasz, 1960, 1978). Despite the reason(s), over the past twenty-five years, there has been a marked shift away from the mental hospital to the community. As a result of the ideological movement toward de-institutionalization, literally hundreds of thousands, if not millions of persons who were institutionalized for long periods in mental hospitals in Canada,⁶ the United States, and Great Britain, have been released into the community. Moreover, with this shift in policy and treatment of the mentally ill, newly-diagnosed or defined mental patients are no longer being sent directly to the government or state institutions, but rather, are being treated primarily on an out-patient basis in community mental health centres⁷, or are admitted on a short-term basis to psychiatric wards in general hospitals, and are only admitted to mental institutions as a "last resort." In short then, with the movement toward deinstitutionalization, we now have living among us, significant numbers of de-institutionalized psychiatric patients (patients once institutionalized in government psychiatric facilities or on psychiatric wards of general hospitals), and non-institutionalized psychiatric patients (treated in the community at various community mental health



centres). Accordingly, Freeman and Simmons (1963:1) have contended that: "At the present time, it is no exaggeration to observe that the major problem in the field of mental illness is not the hospitalized patient but the formerly hospitalized patient." I would argue that this statement, made over twenty-five years ago, is even more pertinent today.

Since the advent of the movement toward deinstitutionalization and development of community psychiatry, its ideological foundations, background philosophy, treatment programmes and social and psychological consequences have been the subject of both praise and severe criticism. Abounding in the academic literature are arguments supporting the development, potentials and goals of the deinstitutionalization movement (Bellak, 1974; Bachrach, 1978; Dunham, 1969; Bassuk and Gerson, 1978; Bloom, 1973); so too, are there numerous academic writings emphasizing the negative aspects of this phenomenon (Chu and Trotter, 1974; Fischer and Weinstein, 1971; Magaro et al., 1968; Scull, 1977; Denner, 1974; Brown, 1979). Moreover, there exist, in the literature, numerous descriptive, outcome and follow-up studies of community mental health treatment programs and therapeutic tools (Arce, 1978; Anthony et al., 1972; Fenton et al., 1979; Greenblatt and Budson, 1976; Pasamanick et al., 1967; Gaylin and Rosenfeld, 1978; Segal and Aviram, 1978, among others). Although a multitude of research studies exist on the deinstitutionalization phenomenon and development of community psychiatry, the majority of such studies have

been conducted from an objectivist point of view, with only a dearth of ethnographic research focussing upon this phenomenon from a subjective point of view--specifically, from the perspectives of the ex-psychiatric patients who are themselves directly affected by this movement toward deinstitutionalization.⁸ Further, I would argue that, with respect to Canadian research studies on this phenomenon, little research has been undertaken on the Canadian ex-psychiatric patient from a subjective point of view.⁹

I would contend that while all of the prior studies (conducted from an objective stance) have contributed, in certain respects to our knowledge concerning deinstitutionalized mental patients and the deinstitutionalization phenomenon in general, it is of equal, if not greater importance to understand this phenomenon from the points of view of the ex-clients themselves. It is the purpose of this dissertation to fill such a neglect in the literature. Specifically, this study seeks to obtain an understanding of the social world(s) of Canadian deinstitutionalized ex-psychiatric clients. It is the aim of this project not to assess or evaluate treatment facilities, care or policies associated with the deinstitutionalization movement, but rather, to document the everyday world(s) of Canadian ex-patients.

Adopting a symbolic interactionist perspective, this study seeks to discover the meanings that the ex-patients themselves define and determine to be important and real.

Behaviour is viewed and understood not from within the context of the researcher's own frames of reference and experiences, but from the actors' points of view. Data are collected through participation with ex-psychiatric patients in an attempt to gain an empathetic understanding of their world(s)--by "sharing in their definitions of the situation" (Thomas, 1931) and "constructions of reality" (Berger and Luckmann, 1966). As Berger (1975), discussing the nature of this approach states:

To try to understand the experience of another it is necessary to dismantle the world as seen from one's own place within it, and to reassemble it as seen from his.

My interest in pursuing this topic evolves from two sources. Firstly, as was stated above, few ethnographically-based investigations have been conducted on deinstitutionalized psychiatric clients. Moreover, few such studies have focussed on the social worlds of Canadian deinstitutionalized patients. It was my desire to attempt to fill such a neglect. Secondly, my interest in this topic evolved directly from my Master's thesis, an ethnographic study of the processes and consequences of institutionalization upon the self-images and identities of Canadian mental patients (Herman, 1981). The data indicated that once mental patients are discharged from psychiatric facilities, many attempt to rebuild a more positive self-identity. Such persons desire to forget their hospital experience(s), the identity and social status they were forced to adopt, and begin life anew. However, due to numerous social

barriers, such persons often find it difficult to transform their deviant identities. Due to the widespread negative social definition accorded mental patients, such individuals are persons with a stigma--a stigma that threatens their social status as "normal" members of society. Mental illness, comes to be perceived by many ex-patients as an attribute that is potentially-discreditable to their identities. Thus, their task centres on the management of this undisclosed, potentially-discreditable information about their selves in order to control the stigma potential of mental illness--thereby, enabling them to "pass" as normal members of society. This exploratory study indicated that while some ex-patients deal with their post-hospital situations in the aforementioned manner, others do not. Due to structural and time constraints, I was not fully able to examine all facets of what may, in fact, be the varying social worlds of Canadian deinstitutionalized psychiatric patients. This previous study functioned to generate a number of questions and queries, areas and avenues that needed to be examined subsequently. It is the purpose of this present study to fully explore such areas of interest and concern. Thus, this empirical investigation deals with the deinstitutionalized psychiatric client in terms of the following: identity transformation, stigma, subsistence strategies, employment, formal and informal support, the role of political activism, self-help groups, sub-cultural groups and strategies for "making it on the outside."

It is important to stress at the outset that it is

not the primary intention of this study to discuss the strengths and shortcomings of the deinstitutionalization movement, this study does not laud or criticize various community based practices (or the apparent lack thereof); rather, this study attempts to place primary importance on the social actors themselves--to present to the reader a picture of what the everyday lives of Canadian ex-patients is really like, based upon what the ex-patients themselves define or determine to be important and real. However, certain social implications arising from the data will be addressed at the end of this dissertation.

Moreover, it is important to note that by "taking the role of the deinstitutionalized patient" does not mean that I am, in any way, denigrating the psychiatric professionals or treatment programmes. Through this study, I am attempting to portray the ex-patients' social worlds and how they, themselves, perceive it--even though such perceptions may vary markedly from that of mental health professionals.

Further, the reader should note at the outset that the terms "deinstitutionalized psychiatric patient," and "ex-psychiatric patient" are used interchangeably throughout the dissertation and are defined strictly in the sociological sense. Specifically, for the purpose of this study, these terms refer to individuals who were once defined as possessing any of the various conditions described in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (1978), once treated within the confines of

a psychiatric institution in a psychiatric unit of a general hospital facility, as out-patients in a psychiatric clinic, or privately by psychiatric professionals.

This dissertation then, is an empirical investigation of deinstitutionalized psychiatric clients attempting to "make it on the outside"--a term frequently used by ex-patients in reference to the manner by which they not only attempt to physically survive in society, but also the techniques and strategies that such persons employ in their efforts to cope with the outside world. The next chapter presents a discussion of previous theoretical approaches to the study and understanding of the deinstitutionalization phenomenon. Upon discussing the strengths and weaknesses of each approach, the advantages of adopting a symbolic interactionist approach for the understanding of deinstitutionalized psychiatric patients is detailed. Chapter Three presents a review of the relevant literature on the phenomenon of deinstitutionalization, the deinstitutionalized or discharged mental patients, and the therapeutic treatment programmes developed and employed by psychiatric officials in their treatment of the ex-patients in the community setting. The fourth chapter turns to a discussion of the methodological orientation of this study. Specifically, it presents a discussion concerning the decision to employ participant observation and informal interviewing techniques for the purposes of data collection. Moreover, this chapter includes a discussion of

the specific settings and sample chosen, background characteristics of the research subjects, the manner by which access was obtained, and the tactics and strategies employed by the researcher in the research process. Chapters Five through Eight present data on the social worlds of Canadian deinstitutionalized or discharged psychiatric clients.

Specifically, such chapters focus on the manner by which such ex-patients attempt to "make it on the outside"--the various tactics they employ to physically survive in the community, along with the techniques and strategems adopted and employed to deal with the outside world. These chapters examine the self-images and identities of ex-psychiatric patients--

whether such persons, once discharged attempt to transform their deviant conceptions of self, and if so, the strategems they employ to do so. The study examines the issue of employment, re-employment or non-employment with respect to ex-mental patients and its role in aiding or hindering successful identity transformation. Further, this study addresses such other factors as: psychiatric diagnostic labels, type of post-hospital housing, formal and informal support, medications, political activism and their effect on identity transformation. The final chapter provides a summary of the empirical findings and discusses the overall implications of the dissertation and suggestions for future research.

Although this investigation is restricted to the general and exploratory level, it provides a significant contribution to our understanding of the processes and consequences

of the deinstitutionalization movement from the subjective viewpoints of the ex-patients themselves--a grassroots level understanding that has been neglected, for the most part, up to this point, in the academic literature on deinstitutionalization. Such an approach--that is, focussing on this phenomenon from the subjective viewpoints of the ex-patients themselves is worthy of investigation and has importance, not only for those interested in the sociology of mental illness, but also has importance for mental health professionals who deal with ex-mental patients, and for those involved in present and future mental health social policy formation and implementation.

NOTES

1. See Wittkower and Dubreuil (1973) for a discussion concerning the universal recognition of mental illness and the various ways that societies, both present, and past have dealt with the mentally ill--that is, identifying, confining, isolating, treating, or rejecting such persons.
2. Such factors may include: the severity of the act committed, the visibility of the act, the power of the actor committing the act in relation to the audience, the tolerance level of the community, and the availability of the community to channel the societal reaction to something other than labelling (Scheff, 1975:10).
3. One such notable historical exception is Ancient Greece where the status of the mad was dealt with largely on the basis of custom. Specifically, during this period, madness was generally conceived as the result of some supernatural beings which entered the body, or exerted an effect from the outside. As Rosen (1968) and others note, in both classical Greece and Roman times, the mad were allowed to live out their everyday lives, not within the confines of an institution or asylum, but in the community, with their care being provided, not by asylum personnel, but rather, by family and friends. In short then, instead of segregating, isolating or excluding the mentally ill, such persons during this time were allowed to remain a part of the society.
4. Rothman's (1980:5) phrase.
5. During Medieval times in Europe certain exclusionary methods were employed, such as banishing mental patients from towns and cities to wander about in the countryside. Often, as Rosen (1968) notes, such persons were handed over to shipmen who transported and subsequently dropped them off on uninhabited islands.
6. See the National Health and Welfare Annual Statistical Reports concerning the numbers of persons discharged from psychiatric institutions and psychiatric wards of general hospitals in Canada.

7. For a discussion concerning the nature and role of the community mental health centre, see: Aanes et al. (1975); Bachrach (1974); Barten (1973); Beigel et al. (1973); Beigel et al (1979); Bennett (1978); Cooper et al. (1975); Dear and Wittman (1980); Gaylin and Rosenfeld (1978); Cameron (1965); Doyon (1971); Freeman (1970); Hiller et al. (1971); Lafave and VandenHam (1979).
8. There are a few notable exceptions, however: Estroff (1981); Reynolds and Farberow (1977); Cheadle et al. (1978); Lamb and Goertzel (1977); Slavinsky et al. (1976).
9. One such notable exception is: Dear et al. (1980).

CHAPTER TWO

THEORETICAL ORIENTATION

This chapter serves to introduce the reader to the major theoretical framework underlying the present investigation. Specifically, this chapter focusses upon the following:

(1) the four conflicting theoretical perspectives dominating the literature concerning the origins, rise and consequences of the 'movement toward deinstitutionalization' or 'community psychiatry phenomenon';

(2) the fundamental ideological premises upon which each of these theoretical perspectives is constructed;

(3) the relative strengths and weaknesses of each perspective;

(4) the advantages of adopting a symbolic interactionist perspective for the examination and understanding of the deinstitutionalization phenomenon in Canadian society--the theoretical approach underlying the present study;

Over the past two decades, a number of theories have been proposed to account for the advent of what has been termed variously as the "Community Mental Health Movement" (Bassuk and Gerson, 1978), the "Decarceration Movement" (Scull, 1977) or the "Deinstitutionalization Movement" (Lowe,

1980)--a movement designed to empty government psychiatric hospitals in favour of the "community alternative."

Four conflicting theoretical perspectives generally dominate the literature concerning the origins, rise and effects of the deinstitutionalization movement: (1) the "enlightened revolution" or "humanitarian theory;" (2) the "mental health lobby theory;" (3) the "social control theory;" and (4) the "labour theory" of community psychiatry. Each theoretical perspective posits different reasons for this shift from institutional to community-based care, ranging from humanitarian concerns, the attainment of personal wealth and power by professional interest groups, economic reasons, or to increase worker productivity respectively. Moreover, within each theoretical framework, research has focussed on different aspects of the community mental health phenomenon ranging from the benefits of such community-based programmes and facilities, the role of the psychiatric professionals within the system, the negative consequences of this movement, or macroscopic, historical analyses of the deinstitutionalization movement in general.

THE ENLIGHTENED REVOLUTION THEORY

Proponents of the "enlightened revolution" (Ralph, 1980) or "humanitarian theory" contend that the deinstitutionalization movement and concomitant development of community psychiatry represent a more advanced stage in the evolution

of psychiatric services the advent of community psychiatry represents a humanitarian gesture on the part of the government to reintegrate the mentally ill back into the community. In this perspective, community psychiatry is conceived as a logical extension of pre-World II traditional clinical psychiatry with little shift in policy. In short, for proponents of this perspective, post-World War II public psychiatry simply became more advanced through scientific progress.

Specifically, advocates of the enlightened revolution theory (Bellak, 1964; Bloom, 1973; Ganzer, 1975; Mechanic, 1969; and Yellies, 1969 and 1975), in their respective discussions concerning the deinstitutionalization of mental patients and development of community psychiatric centres, contend that subsequent to World War II, certain social, economic and medical developments occurred which led to a reassessment of the delivery of psychiatric services.

The rejection of large numbers of men from the military due to psychiatric illness sparked social awareness and concern regarding the apparent prevalence of mental illness. Moreover, it increased awareness and concern regarding the lack of adequate and effective forms of treatment. Such concerns stimulated research in the field of psychiatric illnesses:

The new awareness of /the prevalence of mental disorders and the lack of treatment/ led to more funding of research and training programs in the area of mental health. Then came a major medical development: the widespread and effective intro-

duction of antipsychotic drugs in the early 1950's. The possibility arose that thousands of patients previously considered manageable only within the confines of an institution could now be treated as outpatients. That possibility increased the growing pressure for the development of comprehensive programmes of community-based treatment. (Bassuk and Gerson, 1978:47).

As Bloom (1973:5) notes:

... the field of psychopharmacology began its current period of rapid growth with the development of new tranquilizing drugs for the care of the mentally ill. These drugs were demonstrated to be much more effective than any treatments previously known because they were able to reduce the anxiety, discomfort, and bizarre behavior of many psychiatric patients so that discharge from psychiatric hospitals could take place more quickly. These drugs had the capability to modify the emotional components of psychiatric disorders without impairing intellectual capabilities and in this sense were far superior to the sedating drugs that had been in use until that time. Not only was recovery accelerated by the use of these medications, but many patients were able to be maintained in the community by continuing the use of these drugs at home.

For the enlightened revolution theorists then, the large number of mental casualties among the military led to expansion and reform in the delivery of mental health services. With the discovery of antipsychotic "wonder" drugs, patients previously conceived as manageable only within the confines of an institution, could now be maintained in the community.

A second major element that provided impetus for reform in the delivery of mental health services was the widespread adoption of the "therapeutic community" philosophy.¹ Representing an alternative approach to traditional

psychiatric treatment, the "therapeutic community" concept began with the fundamental premise that therapeutic potential rested within patients and psychiatric staff alike. Through the formation of a democratic community on the hospital ward, this therapeutic potential could be utilized to increase the effectiveness of psychiatric treatment. The adoption of this alternative therapeutic approach served to make the clinical decision-making processes more democratic in nature, thereby providing one of the foundational elements for the rise of community psychiatry (Bloom, 1973:6).

A third factor, that sparked a reassessment in the delivery of psychiatric services was the phenomenon of geographic decentralization in the government hospitals. Prior to geographic decentralization, hospital wards were generally organized around treatment modalities. As Bloom (1973:6) notes, "there were electric shock treatment wards, insulin treatment wards, wards for patients with special dietary restrictions or certain physical diseases, wards for elderly patients, wards for alcoholics, etc." Hospital personnel were assigned to these wards on the basis of their training. The most highly-trained staff were assigned to work on the acute and admission wards, while the minority of less-skilled personnel were assigned exclusively to the chronic "back wards." On the chronic wards both the staff and patients were dissatisfied with the lack of therapeutic progress. The staff disliked working on these custodial wards with the same patient population, many of whom remained institutionalized

for life.

The advent of geographic decentralization then, was an attempt to reorganize the structure and composition of psychiatric treatment wards. Patients were no longer segregated on the basis of their psychopathologies but were housed according to their geographic areas in which they abided. Psychiatric personnel (both highly-skilled and less-skilled) were equally distributed among these geographic units. This administrative reorganization led to the development of closer working relationships between the hospital and the community, and provided one of the foundational elements for the development of community psychiatry:

The community had a particular section of the hospital with which it could identify. Hospital personnel had a rationale for spending part of their time in the community they were serving, first in providing after-care services and later in providing alternatives to hospitalization in collaboration with community-based agencies (Bloom, 1973:6).

In summary, proponents of the enlightened revolution theory argue that the post-war awareness of the prevalence of mental disorders led to the discovery of new tranquilizing drugs. This, combined with the implementation of new "progressive" therapeutic approaches provided the impetus for reassessment and reorganization of the delivery of mental health services. The deinstitutionalization movement and development of community psychiatry, represent a "third psychiatric revolution" (Bellak, 1964:1)--it is the latest phenomenon in a progressively enlightened and humane evolution

of psychiatric services." Roberts (1966:4) aptly sums up the enlightened revolution position:

The past two decades have seen an explosion of scientific knowledge unparalleled in history... Human dignity has assumed a higher place as a right of man.... Following World War II, the philosophical premises of existentialism became increasingly prominent in Western Europe and spread to the United States. Simultaneously, new trends arose in the care of the mentally ill as persons who retained humanity, and who therefore should be dealt with as continuing members of the society from which they came, emerged as a premise of their treatment. This placed a premium on community care and treatment in the patient's home locale rather than in a distant and isolated setting.... The development of psychotropic drugs succeeded in altering patterns of institutional care. Programs of day care and night care, vocational rehabilitation, and continuity and coordination of aftercare resources emerged, resulting in a progressive decrease in the numbers of persons confined in public mental hospitals. In the midst of this, attention has shifted from institutional psychiatry to psychiatric practice within the community; the community has become a focal point of prevention, therapy and rehabilitation.

In terms of the strengths of this perspective, we can credit its proponents with attempting to situate the community psychiatry phenomenon within an historical context. However, there exist a number of shortcomings with this model. Firstly, I would contend that the logic upon which this perspective is constructed is flawed--it assumes that scientific discoveries related to psychiatric treatment therapies are necessarily "progressive" or "beneficial" in nature. Secondly, the enlightened revolution theory is written within a narrow, psychiatric framework. Couched within the narrow boundaries of clinical psychiatry, this perspective fails to examine the influence of political and economic factors on the development of clinical

psychiatry. Proponents of the enlightened revolution theory fail to examine the influence that the shift in scope and function of the state had on the development of community psychiatry. A further shortcoming of this perspective is its failure to examine or explain the shift in emphasis from pre- to post-World War II community psychiatry. Specifically, this theory does not account for the shift in target population from those with psychotic and organic disorders, to the treatment of fairly "normal," employable individuals. A final shortcoming of this perspective centres on its failure to discuss the deinstitutionalization movement and development of community psychiatry from the perspectives of the ex-psychiatric clients themselves--those individuals who are directly affected by such a shift in care and treatment.

THE MENTAL HEALTH LOBBY THEORY

In contrast to the enlightened revolution theorists who conceive of the deinstitutionalization of mental health services as a progressive stage in the evolution of psychiatric services, advocates of the mental health lobby theory view this movement as a retrogressive stage in the development of psychiatry. Proponents of this perspective (Burrows, 1969; Chu and Trotter, 1974; Connery, 1968; Fischer and Weinstein, 1971; and Magaro et al., 1968), in accordance with the enlightened revolution theorists, agree insofar that community psychiatry evolved from traditional, clinical psychiatry with

little change in policy. However, each perspective differs widely in its assessment of the movement toward community mental health. According to mental health lobby theorists, the deinstitutionalization movement does not represent a humanitarian gesture on the part of psychiatrists to reintegrate the mentally ill back into the community as enlightened revolution theorists would argue. Rather, it represents an active, purposive attempt on the part of the psychiatric profession to gain legitimation and professional power. Fischer and Weinstein (1971:41), chastising psychiatrists for pressuring governments to finance community psychiatry in order to increase personal wealth and professional status-- for "jumping on a bandwagon" to the neglect of patient care, state:

Psychiatrists in their search for the prestige and respect given to physicians in other medical fields, have tended to be overenthusiastic in their acceptance of current 'stylish' methods and techniques. It is their responsibility however, to seek out the most effective methods of treatment for each patient as an individual, and to disregard the 'image of enlightenment' where this conflicts with the needs of the patient.

Similarly, Burrows (1969:105), discussing the desire of the psychiatric profession to attain power and legitimation through the employment of the latest concepts with little regard for the patients states:

[The]...enthusiasm which is typically American [is] the almost total commitment with which our profession [the psychiatric profession] tends to embrace 'new' concepts. This character has a positive effect, resulting in growth and development; the negative effect, however, can be and frequently is a sort of tunnel vision which restricts efforts

and energy to one area and delays progress in the field as a whole.

In their discussions concerning the rise of the community psychiatry phenomenon, mental health lobby theorists state that the post-war awareness of the prevalence of mental illnesses, the lack of adequate treatment therapies, and the ideological shift against custodial "warehousing" of patients, led to the development and widespread adoption of such new concepts as the "therapeutic community." While the enlightened revolution theorists conceived of this concept as a "progressive" therapeutic ideal that set the stage for the development of better psychiatric services in the form of community mental health, mental health lobby theorists, by contrast, view the adoption of the therapeutic community concept and the advent of community psychiatry as an effort on the part of psychiatrists to fight their way into the mainstream of "real scientific medicine." Beneath the guise of an humanitarian rhetoric, mental health lobby theorists charge that community psychiatry and its "tools" are used by psychiatrists not to benefit the patients they purport to treat, but function to increase the professional status of psychiatrists. As Magaro et al. (1978:188) contend, psychiatrists are aware that the therapies they employ may not be beneficial but continue to advocate them for reasons of self-esteem and prestige--psychiatrists "use [their] hammer artfully, sympathetically--but inevitably on jobs that require other tools."

Our thesis, with respect to the current state of institutional treatment has been a unthought administration attacking "nuts" with a hammer. The irony of the situation is emphasized by extending the analogy; among the plethora of therapies and therapists available today a great number of "tools" exist, but the typical mental health institution continues to apply its own "hammer," no matter what the condition or the problem... (Magaro et al., 1978:188).

In terms of the strengths of the mental health lobby theory, we can credit its advocates for attempting to explain the rise of the community psychiatry phenomenon through an examination of the relationship between the ideology or doctrine of the psychiatric profession and the attainment of social power and prestige. Despite this significant contribution however, there are certain weaknesses in this perspective.

Specifically, the major weaknesses of the mental health lobby theory (similar to the enlightened revolution theory) are its failure to explain the shift in treatment population (from chronic, unemployable mental patients to non-chronic, potentially-employable individuals) which characterizes community psychiatry; its failure focus on the impact of certain economic and political forces on the movement toward deinstitutionalization of mental patients and the development of community psychiatry; and on its failure to examine the influence that the shift and function of the state exerted on the development of community psychiatry. Community psychiatry is backed by government funds and functions under the policies of state agencies. It is therefore, important to analyze this phenomenon within the context of the

expanding scope and operations of the state in our society, specifically with reference to labour and to the unemployed (Ralph, 1980:4).

A final criticism may be levelled against both those perspectives and the research endeavours employing such perspectives. Specifically, I would argue that the examination of the community psychiatry phenomenon solely through an analysis of the psychiatric profession neglects an important dimension--namely the ex-patients who are directly affected by such a shift in policy and treatment--their subjective feelings and conceptions of reality.

SOCIAL CONTROL THEORY

Social control theorists, in their discussions concerning the advent, rise and consequences of the deinstitutionalization movement and community psychiatry phenomenon, divide into two wings: antipsychiatric and Marxist.

The Antipsychiatric Perspective

Advocates of the antipsychiatric perspective (Cooper, 1967; Leifer, 1966, 1967; Szasz, 1960, 1970, 1978), in reaction to enlightened revolution theorists, contend that the rise of community psychiatry represents not a "beneficent reform" rooted in scientific comprehension and/or medical technological developments, but rather, represents a technological extension of clinical psychiatric oppression:

The crusading ideology of utopian reform, long typical of Institutional Psychiatry...now animates the proponents of the movement for community mental health centres. Their spirit is characterized by boundless benevolence and reforming zeal, together with the stubborn insistence on treating mental patients, and sometimes even medical patients, as defective objects in need of repair by omniscient technocrats. The alleged patient is thus transformed from a person, who happens to be sick and seeks treatment from a physician of his choice, into a thing, whose malfunctioning is diagnosed by experts commissioned and paid for by the State. Implicit in this perspective is a demand from the physician for the same unserving loyalty to the modern state as a priest owed to the medieval church. We know that this obedience is already being exacted from the physician in totalitarian countries; what we are now being asked, and told, is to accept it as a great leap forward in medical ethics for free societies as well.... In open as well as in closed societies, the institutional psychiatrist has long been in the business of putting under lock and key deviant citizens categorized as mentally ill. The community mental health centres movement proposes to expand and extend the traditional police power of the psychiatrist. It does so by asserting that the mental health worker has a responsibility not only to the patient who comes for help, but also to those who do not come because they do not consider themselves sick but who must nevertheless be "serviced." (Szasz, 1970:207).

For the antipsychiatric theorists, the development of the community psychiatry phenomenon is conceived as a form of "violence" that the sane perpetuate against the labelled mad-man for the purposes of social control--acts of violence that are infringements of individual liberties:

Community psychiatry is a quasi-political movement which, by means of social intervention and state-sanctioned social power, attempts to palliate personal troubles, to foster the orderly and productive functions of individuals in their community, to alleviate certain disturbances of domestic

tranquility, to organize and integrate community programs, to implement the dominant social ideology, and, in accordance with this ideology, to promote the development of social conditions which are thought to be maximally compatible with human desires and requirements. However, this movement, undertaken with the instrument of social power, is the greatest enemy of the open society. It is more likely to lead to homogenization than to individuation, to the extinction of human resources rather than to their development, and to obedience rather than to freedom and responsibility. (Leifer, 1966:22).

As Thomas Szasz (1970:xvii) states:

We have been warned time and time again, an injustice done to one--especially in a society that aspires to be free--is an injustice done to all. In my opinion, the "mental health"--in the sense of spiritual well being--cannot be improved by slogans, drugs, community mental health centers, or even with the billions of dollars expended on a "war on mental illness." The principle problem in psychiatry has always been, and still is, violence: the threatened and feared violence of the "madman," and the actual counterviolence of society and the psychiatrist against him. The result is the dehumanization, oppression, and persecution of the citizen branded "mentally ill,"

The Marxist Perspective

In reaction against traditional explanations for the origins, rise and consequences of the deinstitutionalization movement and community psychiatry phenomenon (such as those posited by enlightened revolution theorists) which centre on a critique of custodialism, the 'beneficent' discovery of psychotropic drugs, and the 'humanitarian' concern for patient rights, proponents of the Marxist perspective contend that such explanations are merely "ideological," not actual.

"Given the failure to explain what is considered a progressive policy, the ideological approach cannot possibly explain the failures of that policy" (Brown, 1979:646).

Marxist theorists (Sculi, 1977; Brown, 1979), in their discussions concerning the discovery of psychotropic drugs in the 1950's contend that conventional accounts detailing the rise of community psychiatry have greatly exaggerated the therapeutic achievements that these drugs represent. According to proponents of this perspective, the therapeutic achievement of these drugs is empirically inaccurate and deficient.² Such theorists admit that the discovery of these drugs facilitated the policy of earlier discharge through the reduction in the incidence of blatant symptoms, thereby easing management problems. However, they contend that their discovery is not the main reason contributing to the rise of community psychiatry. For the Marxist theorists then, the discovery of these psychoactive drugs is more accurately conceptualized as a discovery providing a medium for profit-making by psychiatric drug manufacturers.³

Just as Marxist theorists dismiss the development of psychotropic drugs as an adequate explanation for the rise of community psychiatry, so too, do they dismiss the notion that community psychiatry arose as a response to the ideological shift concerning the treatment of the mentally ill. While the enlightened revolution theorists contend that the policy shift in the care and treatment of mental patients developed as a result of the emergence of a renewed humanitarian

concern on the part of the government for patient rights, the rehabilitative promise of community care, and due to increased tolerance limits of mental patients on the part of society, Marxist theorists, however, argue that each of these arguments contains serious flaws. As Scull (1977:99) asserts, one of the major flaws of the enlightened revolution theory is its failure to discuss where this increased tolerance toward mental patients originated. Neither is there any empirical evidence offered to support this claim of increased tolerance. Moreover, proponents of this perspective dismiss the explanation that the development of the deinstitutionalization movement and community psychiatry was the result of a renewed concern for patient rights, or due to the anticipated therapeutic benefits of community-based care. As Wolpert and Wolpert (1974:19) state: "the massive release of patients to facilities in residential neighbourhoods preceded substantial data collection and analysis" on the effects of deinstitutionalization.

In reaction to the enlightened revolution theory, which through its structural analysis, has merely reproduced the ideology of community mental health movement's members, Marxist theorists have attempted to develop a more plausible theory to account for the deinstitutionalization phenomenon. Adopting a broader, macroscopic framework that places this movement in historical context, Marxist theorists contend that community psychiatry developed as a result of the fiscal crisis of the State. Specifically, "the attempt to manage an

increasing proportions of the 'deviant' within the community is seen as a response to the changing exigencies of domestic pacification and control under welfare capitalism" (Scully, 1977:134).

Marxist theorists, in their political-economic analyses of post-World War II mental health policy contend that the interplay between two factors led to the development of community psychiatry: (1) the effect to curtail expenditures for the control of deviant populations; and (2) the simultaneous expansion of the state to increase the funding of welfare programmes. As Scully (1977:135) states:

...with the coming of the welfare state, segregative modes of social control became...far more costly and difficult to justify. This is particularly clear in the case of...the mentally disturbed, who were formerly confined in "monasteries of the mad." Until well into the twentieth century, there had been little or no alternative to keeping the chronically disabled cases of insanity in the asylum; for although the overwhelming majority were harmless, they could not provide for their own subsistence, and no alternative sources of support were available to sustain them in the outside world. However, with the advent of a wide range of welfare programs providing just such support, the opportunity cost of neglecting community care in favour of asylum treatment--inevitably far more costly than the most generous scheme of welfare payments--rose sharply. Simultaneously, the increasing socialization of production costs by the state, something which has been taking place at an increasing pace during and since the Second World War, and of which modern welfare measures are merely one important example, produced a growing fiscal crisis, as state expenditures continuously threatened to outrun available revenue....It is precisely the expansion of one which made both possible and desirable the contraction of the other.

In their discussions concerning the genesis of the welfare state and its relationship to the modifications in

mental health care policy, advocates of the Marxist perspective assert that the welfare state originated largely as a result of three factors: (1) lessened opposition against such legislation by societal members--members of the capitalist class were led to believe that "human faculties are as important a means of production as any other kind of capital" (Marshall, 1920:229, in Scull, 1977:136); (2) political struggles on the part of organized labour movements. The prevalent unionization of state employees and the "advent of the eight-hour day and forty hour week in state institutions...virtually doubled unit costs" (Dingman, 1974:48, in Scull, 1977:150). Moreover, the number of class action suits filed on behalf of institutionalized mental patients over the past two decades resulted in the formation of minimum standards of treatment and the elimination of unpaid labour in the functioning of the institution; (3) the state expansion of expenditures, not only for the social services, but also, for private industry and programs designed to develop the economic infrastructure. These three factors, according to Marxist theorists led the government to the realization that its present policy regarding the social control of mental patients was far too costly. Thus, in an attempt to decrease expenditures, patients were discharged from psychiatric institutions to private, profit-making nursing homes and boarding homes. This housing was not only less costly, but through alterations in social security laws during the 1950's in the United States, ex-patients were able to collect such benefits and were there-

fore supported in these facilities by federal funds (Sculi, 1977:140). With the further increase in welfare service expenditures, the expansion of devices used to divert mental patients from entering psychiatric facilities, combined with stricter regulations regarding the involuntary commitment of potential mental patients, the movement toward deinstitutionalization of the mental health services skyrocketed. Sculi (1977:152) aptly sums up this Marxist perspective concerning the origins and consequences of the deinstitutionalization phenomenon:

Placing the decarceration movement in historical context...this shift in social control styles and practices must be viewed as dependent upon a reflection of more extensive and deep-seated changes in the social organization of advanced capitalist societies. In particular, it reflects the structural pressures to curtail sharply the costly system of segregative control once welfare payments, providing a subsistence existence for elements of the surplus population make available a viable alternative to management in an institution. Such structural pressures are intensified by the fiscal crisis encountered in varying degrees at different levels of the state apparatus; a crisis engendered by advanced capitalism's need to socialize more and more of the costs of production--the welfare system itself being one aspect of this process of socialization of costs. It is the pervasiveness and intensity of these pressures, and their mutually reinforcing character, which account for most of the characteristic features of the new system of community "care and treatment," and which enable us to comprehend the continued adherence to this policy even where it provokes opposition.

We can credit proponents of this social control theory (specifically the Marxist perspective) for providing an in-depth analysis that places the origins and rise of community psychiatry in its historical and structural context. Despite

providing this significant contribution to our understanding of the community psychiatry phenomenon, both wings of social control theory do possess certain shortcomings. Social control theory (similar to the two theoretical perspectives discussed previously) fails to acknowledge or explain the post-war shift in emphasis that pervades community psychiatry. Specifically, this theory fails to explain why community psychiatry would cut treatment programmes for unemployable, severely chronic patients while at the same time, increase treatment programmes for relatively "normal," employable and potentially-employable individuals. A second major shortcoming of this perspective centres on its failure to examine the community psychiatry phenomenon from the subjective points of view of the patients themselves who are directly affected by this movement toward deinstitutionalization or decarceration.

THE "LABOUR" OR PRODUCTIVITY MAXIMIZING THEORY

In reaction against the three theoretical perspectives discussed above, which assume that the deinstitutionalization movement and development of community psychiatry (despite whether being viewed as a more humanitarian, more powerful, more oppressive, or more economical form of psychiatric treatment), evolved directly from pre-World War II traditional clinical psychiatric with little shift in policy, labour theorists (Ralph, 1980, 1981) contend that such a view is largely incorrect. According to proponents of the labour

theory, community psychiatry differs from pre-war clinical psychiatry in some important respects: post-war community psychiatry treats a different target population, for "different illnesses," using different therapies, in different locations. This suggests then, that community psychiatry did not emerge directly from traditional clinical psychiatry, as others would suggest, and that it provides radically different social functions.

In an attempt to provide a more adequate explanation for the rise of the community psychiatry phenomenon, Ralph (1980, 1981) advances what she terms, the "labour theory" of community psychiatry--a theoretical perspective that attempts to explain the dramatic shift in emphasis from pre- to post-World War II public psychiatry that characterizes community psychiatry. Advocating the labour theory, Ralph (1980:4) states:

Western states have produced the mass psychiatric industry largely to control the effects of worker alienation on productivity. It suggests that community psychiatry's consistent function has been to produce a compliant, reliable work force, and a passive, flexible pool of employable, potential workers. According to this perspective, community psychiatry represents a major qualitative policy shift from the pre-World War II focus on custodial care of unemployable people, to an emphasis on mass treatment of workers and potential workers. Rather than growing out of clinical psychiatry, this theory proposes, community psychiatry's roots lie far more in industrial psychology's tradition of labour relations.

As Ralph (1980:5), and others (Deutsch, 1949; Edginton, 1973; Foucault, 1965 and Rosen, 1968) suggest, pre-war

clinical psychiatry dealt with populations comprised primarily of psychotic, brain-damaged and retarded individuals--chronic patients "whose employability was, at best, marginal" (Ralph, 1980:5). However, the advent of industrial psychology early in the twentieth century played a central role in transforming the policy and delivery of psychiatric services. In contrast to traditional clinical psychiatry, industrial psychology centred on treating a different population--namely, employable, non-psychotic individuals. The purpose of industrial psychology was to "increase worker productivity by eliminating the problems of restriction of output, lack of cooperation, apathy, and worker-management conflict" using non-stigmatizing, short-term therapies (Bucklow, 1976:389, in Ralph, 1980:6)--a philosophy and methodology that laid the foundation for community psychiatry as we know it today.

Ralph, in her historical examination of the relationship between industrial psychology and community psychiatry, states that prior to World War II, employers attempted to control labour unrest and worker breakdown through the employment of various industrial psychological techniques.⁴ In the aftermath of this surge in labour militancy, private philanthropies such as the Rockefeller Foundation provided substantial economic backing for the development of a National Committee for Mental Hygiene--a committee established for the expressed purposes of controlling labour unrest, increasing worker efficiency, and to prevent criminal behaviour. As

Ralph (1981:8) suggests, the National Committee provided much of the infrastructure upon which community psychiatry is founded. Specifically, the ideology of the Committee stressed the importance of isolating and treating disobedient and unhappy workers, the need to develop teams of mental health workers, and develop a unified national programme of mental hygiene (Ralph, 1981:9).

As pre-war labour militancy increased, employers turned to industrial psychology for aid. In response, Elton Mayo developed a 'human relations movement' for industry-- a movement centred on destroying worker unity through the formation of bonds between individual employees and management. In order to achieve this goal, Mayo developed 'non-stigmatizing, short-term, non-directive interviews conducted by non-professional counsellors' (Ralph, 1981:10). This technical innovation was subsequently adopted as a major element of community psychiatry therapy.

Just as Ralph (1980, 1981) asserts that the majority of therapies used by community psychiatrists have their roots in industrial psychology, so too, does she contend that the discovery and development of mood-altering drugs has similar roots. Specifically, Ralph (1981:13) states that research toward the development of psychotropic drugs were undertaken by industrial psychologists in order to increase the working capacity of both soldiers and civilian employees.

Moreover, during the Second World War, industrial psychologists expanded the definition of "mental illness",

placing greater emphasis on inefficient, non-productive, non-psychotic behaviour. In short, according to industrial psychologists, the definition of mental illness was expanded to include any type of behaviour that interfered with profits (Ralph, 1981:11).

According to proponents of the labour theory, during this time, the foundations were laid to nationalize the industrial psychological approach to treat the labour force as a whole. A number of prominent industrial psychologists⁵ were recruited to direct mass psychiatric screening of potential draftees, the War Manpower Commission, and the United States Army and Navy psychiatric programmes (Ralph, 1981:11).

Moreover, the United States government in alliance with the National Committee for Mental Hygiene, constructed various out-patient "community clinics", staffed by mental health teams for the treatment of both civilian and enlisted persons. Further, the American Psychiatric Association officially adopted a new classificatory system for mental disorders that placed weight on behavioural disorders and neuroses which were prevalent among civilians as well as the military. Military industrial psychologists tested a variety of short-term, inexpensive therapeutic methods such as group therapy, modified electro-shock treatments for non-psychotic patients, brief-talking therapies, along with various mood-altering drugs--methods developed and employed for the sole purpose of "improving the working efficiency of normal people under stress" (Ralph, 1981:13). According to advocates of

the labour theory, it was precisely such therapeutic techniques that provided the technical infrastructure upon which community psychiatry was constructed.

As labour militancy escalated toward the end of the war, labour theorists (Ralph, 1981:14) state that the military, employers and political leaders began to pressure government into developing a national mental health programme for the treatment of non-psychotic workers. For Ralph (1981:14) then:

...the war 'called dramatic attention to the problem of mental disorders among soldiers and employees, pointing to the need for a national mental health program.' By contrast, facilities to treat chronic mental patients had, by the end of the war deteriorated even more than they had during the Depression. The stage had been set for public community psychiatry to supplant custodial care of chronic mental patients.

After the war, numerous strikes occurred in the Western countries and the unions possessed great political power. While both government and business leaders agreed that the labour force had to be controlled, the latter group pressed that such control measures should be organized at a national level by the government. As a result, in 1946, the federal government passed the National Mental Health Act, developed the National Institute of Mental Health for training, research and treatment specifically related to non-psychotic individuals to the sole exclusion of chronic, unemployable mental patients. The passing of this act, is conceived of as the "Birth of community psychiatry" (Ralph, 1981:15).

In summary then, according to the labour theory of community psychiatry, the post-war shift of mental health services from within hospitals to the community setting represents the combined interests of mental health professionals, employers and the government to expand innovative trends created in pre-war industrial psychology to the general population--specifically, to treat those individuals' problems developing out of alienating working conditions, and quickly return them to the labour force:

Community psychiatry represents a nationalized form of industrial psychology. Operating at public expense, under a more neutral cover than management-run mental health programs, community psychiatry mass produces and markets industrial psychology methods to treat the labour force as a whole. Community psychiatry's central task is identical with that of industrial psychology: to "help" workers and their dependents to adjust to increasingly alienated, degraded and pressured conditions, in order to prevent labour unrest and worker breakdown (Ralph, 1980:7).

We can credit the proponent of the labour perspective for developing a more comprehensive theory of community psychiatry that transcends the narrow boundaries of clinical psychiatry when explaining the origins and rise of community psychiatry, and attempts to explain its origins through a detailed analysis of historical, political and economic factors. Instead of assuming that community psychiatry developed directly out of pre-World War II clinical psychiatry with little shift in policy (as the other theoretical perspectives suggest), Ralph, through her detailed, historical examination discovers that its roots lie in industrial and management

psychology.

Moreover, we can credit this theory for providing an examination of the impact exerted by economic and political forces on the development of community psychiatry. Since community psychiatry facilities do treat employable individuals (although I would not go as far as Ralph to assert that all such facilities primarily treat employable individuals), it is important, nevertheless, to examine patterns in labour relations and their subsequent effect on national policy.


A third and final strength of this theory is its analysis of the rise of community psychiatry in the context of the increasing scope and functions of the state in Western society, specifically in relation to labour and unemployable individuals.

Despite these strengths, this perspective, like the others suffers a particular shortcoming. I would argue that although such an historical examination focussing on political and economic factors adds to our understanding of the community psychiatry phenomenon, such a macroscopic analysis misses an important dimension--namely, those individuals affected by the movement toward deinstitutionalization and who are using the community psychiatric services. Whether they be potentially-employable individuals, non-employables, or a mixture of both types, it is nevertheless important to examine the social worlds of these persons from a subjective point of view:

In this chapter, I have discussed the four major

theoretical perspectives dealing with the deinstitutionalization movement and development of the community psychiatry phenomenon. For the enlightened revolution theorists, community psychiatry is conceived as a beneficent reform that developed directly out of traditional, clinical psychiatry. For the mental health lobby theorists, community psychiatry represents a purposive attempt on the part of the psychiatric profession to gain legitimation and professional power. For the social control theorists, the advent of community psychiatry is conceived either as a technological extension of clinical psychiatric oppression (as anti-psychiatrists contend), or as a government attempt to decrease spending on the care of chronic mental patients and to increase private profits (as the Marxists contend). For proponents of the labour perspective, community psychiatry is viewed as a nationalized form of industrial psychology functioning to control the effects of worker alienation on productivity.

While I would argue that no one theory is holistic in itself, each theoretical perspective, however, does contribute to our knowledge concerning different aspects of the community psychiatry phenomenon.⁶ Specifically, Ralph's labour theory provides us with a comprehensive, macroscopic, historical examination of the origins of community psychiatry that does not merely presume that this phenomenon evolved out of clinical psychiatry as the other theorists argue. Secondly, both the labour and Marxist perspectives can be credited for providing analyses of various economic and



political factors contributing to the development of community psychiatry. Thirdly, we can credit mental health lobby theorists for contributing to our understanding of the community psychiatry phenomenon, specifically, through a sociological study of the profession by psychiatry itself. While each of these theories has contributed (in different respects) to our understanding of the deinstitutionalization movement and development of community psychiatry, none of these theoretical approaches focusses on the other side of the coin--namely, on those individuals directly affected by the movement toward deinstitutionalization--those "psychotic," "unemployable" individuals once institutionalized but are now living in the community and receiving "treatment" in the community psychiatric setting. Neither does any theory focus on the "non-psychotic," "employable" individuals who may have never been institutionalized but are receiving psychiatric treatment within the community setting. I would argue that the utility of a social psychological perspective, specifically a symbolic interactionist perspective lies in its ability to fill such a neglect. While I am not discounting the importance of these theoretical perspectives for the understanding of the deinstitutionalization phenomenon, I would contend that it is of equal importance to focus on the psychiatric ex-patients themselves from a micro-subjective point of view--to gain a subjective understanding of the social worlds of those persons who are directly affected by this movement toward deinstitutionalization.

This chapter will now turn to a discussion of the symbolic interactionist perspective. Specifically, this discussion will focus on the following: (1) the basic underlying assumptions of symbolic interactionism; (2) the basic concepts of this theory such as: meaning, symbols, mind, self, generalized other, identity, and society--concepts which are utilized in the present study; (3) the underlying assumptions of labelling theory--a theory of deviant behaviour rooted in interactionist theory which has subsequent importance for the present investigation.

SYMBOLIC INTERACTIONISM⁷

Examination of the symbolic interactionist perspective reveals that it is based upon six fundamental assumptions:

1. Man lives in a symbolic world of learned meanings. For interactionists, the objective world with its independent laws has no meaning; rather, subjective reality has primary importance. Reality then, is mediated through symbols.
2. Meanings are derived from symbols which arise in the social process and are universal.
3. Symbols have motivational significance. How individuals define a situation aids in determining how they will respond. In this sense, symbols are themselves motives.
4. Mind is a functional, volitional, purposive sensory process that emerges out of the social process and is wholly social in nature.
5. If the world of objects is mediated through symbols, then other objects can only be experienced in the same manner. Self is constructed from meanings arising in symbolic interaction. Self is a linguistic construct arising in the social process.

6. Society is a symbolic construct arising in the social process.⁸

A fundamental assumption underlying symbolic interactionism is that humans live in a world of meanings. We respond to objects and events on the basis of the meanings that we have attributed to them. For symbolic interactionists, meanings of events are neither static in nature; nor are the meanings of certain objects merely bestowed upon the individual and learned by habituation. Rather, meanings of objects and events can be altered through the creative acts of individuals and such persons may be both influenced by such meanings as well as playing an active role in influencing the numerous meanings that form their culture. Meanings, according to symbolic interactionists are social products arising from the defining activities of individuals as they interact with one another.

These culturally-shared meanings arising from an interpretive process shed light on the collective nature of the process. While an individual has the ability to engage in this interpretive process alone, through thinking, individual thought however, is not the origin of socially-shared definitions. According to symbolic interaction theory, thinking is made possible through social interaction with others. In this sense then, what constitutes thinking is basically a social activity.

Moreover, these culturally-shared meanings which have arisen in the social process aid in determining the behaviour

of individuals. In this sense, symbols are said to possess motivational significance.⁹ According to Blumer (1969:2-3):

Human beings act toward things on the basis of the meanings that the things have for them.... To ignore the meaning of the things toward which people act is seen as falsifying the behaviour under study. Symbolic interaction... sees meaning as arising in the process of interaction between people. The meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing. Their actions operate to define the things for the person. Thus, symbolic interactionism sees meanings as social products, as creations that are formed in and through the defining activities of people as they interact.... These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters.

In short then, for symbolic interactionists, human behaviour is conceived not as a direct response to biological needs, stimuli, or cultural forces. Rather, it is viewed by interactionists as a product of communication. Human behaviour is a process in which individuals act toward and in response to various objects depending upon the culturally-derived meanings of those objects. Social interaction then, is a crucial component for the meanings we construct, whether the objects be people, ideas, things or behaviours.

Explicit in interactionist theory is the notion that individuals are self-conscious beings; they possess selves and minds which although absent at birth, emerge and develop as a result of the individuals' participation in society.

Turning firstly to the nature of mind, symbolic interactionists contend that the mind is a uniquely human characteristic arising in the evolutionary process when the subjective,

impulsive behaviour of individuals is hindered as they attempt to adapt to the environment. According to symbolic interactionists, the lower animals respond to the environment, but in so doing, they are neither able to understand various factors that affect their behaviour; nor are they able to conceive of alternative behaviours. However, human beings possess the capacity to select out and indicate to themselves and others the meanings of certain features of the environment to which they are responding. In this sense, individuals are able to gain control over the stimuli to which they wish to respond. Mind then, according to symbolic interactionists, is a mechanism of control over meaning. It functions to serve the needs of individuals in their environmental adjustments.

C According to symbolic interactionists, the mind is a social product emerging out of the social process and is made possible by meanings and symbols which are themselves social in character. This is made possible through language. When an individual has acquired a fully-developed self and gains facility with significant symbols, he is able to exercise mind in relation to certain objects. In this sense then, social consciousness is ontologically prior to physical consciousness. Mind and social consciousness emerge when gestures stimulate implicitly in the actor the same response as in others explicitly.

Just as symbolic interactionists conceive of mind as

a social product arising through social interaction, so too, do they conceive of self in a similar manner.¹⁰ Specifically, interactionists contend that the self is not initially present at birth; rather, it emerges and develops in the social process and undergoes continual development throughout the lifespan of the individual. For interactionists, the distinctive nature of the self is found in the ability of the individual to be both a subject and object unto itself by "taking the role of the other." As Blumer (1969:13) states:

The human being is seen as an organism that not only responds to others on the non-symbolic level but as one that makes indications to others and interprets their indications. He can do this... by virtue of possessing a "self." ...It merely means that a human being can be an object of his own action...he is an object to himself only by taking the organized attitudes of other individuals toward himself.

According to symbolic interaction theory, consciousness of self occurs when the individual is able to take the organized attitudes of others toward himself. Consciousness of self occurs through a type of communication referred to by Mead (1934:67) as "significant symbols--gestures that stimulate implicitly in oneself the same response that they stimulate explicitly in others. For interactionists then, self is conceived as a social process made possible by language. An individual develops a self and becomes conscious of his self through the application of meanings and words to his being that he obtains from society:

It is within the social process that self emerges; the self is wholly a social product emerging from social interaction (Blumer, 1969:12).

Having discussed the general character of the self, this chapter will now turn to an outline of the conditions under which self originates and develops. According to symbolic interactionists, the self is a product of social interaction, which during the initial stages of one's life is unconscious. In the case of a newborn infant, his basic needs of food and shelter are met within a social context. Both mother and baby interact with each other but only at a biosocial level. At this stage, the infant is merely engaging in unconscious social behaviour--behaviour to which Mead (1934:167) refers to as a "conversation of gestures." Self, according to interactionist theory, develops out of this unconscious behaviour. As the child gets older, he acquires the ability to take the organized attitude of others toward himself. Significant symbols and language emerge when the child is able to complete an inhibited action on the level of his imagination. Just as meaning and consciousness develop out of unconscious communication within interaction, so too, does self develop out of the same process.

In accordance with ideas first expounded by Mead (1934), symbolic interactionist theory makes the distinction between two stages in the genesis and development of the self: the play stage and the game stage. Genesis of the self entails the individual gaining the ability to order experiences in terms of social roles. Specifically, during the early stage in childhood development (the play stage), the child "plays at" being various people. So, for example, the child plays

at being mother, teacher, pirate, etc. During this stage, the child takes the role of "particular others." It is during the play stage then, that the child gains facility in organizing the attitudes of particular others in terms of social roles.

Not only must the individual learn to take the role of particular others separately, but he must also learn to take the attitudes of the organized group. During what interactionists refer to as the "game stage," the child is placed in various social situations where he is forced to take on a number of social roles simultaneously--he is forced to respond to the expectations of many persons at once all of whom stand in formalized relationships with one another. The child must not only acquire a conception of what others will do in a certain situation, but also must know what others expect of him. In contrast to the play stage, in which only the child's wishes mattered, in the game stage, the child must learn to abstract a general role of particular roles--a "generalized other" that represents the organization of the entire social group. Only when individuals are able to take the organized attitudes of the generalized other toward himself will he be able to possess a fully developed self:

In the play stage, the individual's self is constituted simply by an organization of the particular attitudes of other individuals toward himself and toward one another in the specific social acts in which he participates. But at the second stage, the self is constituted not only by an organization of these particular individual attitudes, but also by an organization of the social

attitudes of the generalized other or social group as a whole to which he belongs. These social...attitudes are bought within the individual's field of direct experience and are included as elements in the structure or constitution of his self, in the same way that the attitudes of particular other individuals are... So the self reaches its fullest development by organizing these individual attitudes of others into the organized social attitudes, and by thus becoming an individual reflection of the general systematic pattern of social or group behaviour in which it and its others all are involved (Mead, 1964:222).

Just as symbolic interactionists distinguish between two stages in the genesis and development of self, so too, do they make a distinction between different phases of the self. Specifically, they contend that the self is not merely an importation of the organized set of attitudes of others; rather, within the self, there exists a response of the person whose self it is. Distinguishing between the "I" and the "me" as two phases of the self, interactionists refer to the former as the response of the individual to the attitude of the community and includes the novel; the latter, for interactionists represents the organized attitudes of the community, an importation of the social organization of the outer world. It is the conventional phase that maintains the individual in the community. According to symbolic interactionists, these two phases of self evolve in symbolic communication:

The "I" is the response of the organism to the attitudes of the others; the "me" is the organized set of attitudes of others which one himself assumes. The attitudes of the others constitute the organized "me," and then one reacts toward that as an "I" (Mead, 1964:230).

Self then, for interactionists is conceived as a social process moving in and out of these two phases. The "I" represents the subjective aspects of social life; it symbolizes the illusive and unpredictable aspects of the person and provides the basis for novelty and change. The "me", by contrast, represents a reflection of the existing social process; this phase allows the person to orient his behaviour toward the organized attitudes of others.

In sum then, for symbolic interactionists, there exists two distinct phases of the self; self arises through the individuals' ability to take the attitude of the other. Through the employment of language and the use of "significant symbols," people assume the perspective of others; by so doing, such persons take the same attitude toward themselves that is taken by society. For interactionists, this is the major way that individuals both organize and exert social control over themselves.

Since conceptions of self are intricately linked to the impressions that social others have of us, at certain times, and in certain situations, we will attempt to guide and control such impressions. According to symbolic interactionists,¹¹ in the course of social interaction with others, we actively attempt to determine what type of behaviour is needed to sustain a specific definition of self or identity. For symbolic interactionists, identities are not entities that are merely bestowed upon an individual by some social audience; rather, the construction of identities is considered

a joint activity in which both the actors and the social audience come to some agreement and share in the "definition of the situation" (Thomas, 1931:41).

When individuals present themselves to others in the context of social interactions, such persons usually possess the expectation that their identities will not be openly challenged. It is generally assumed that social others will accept the individuals' proffered images and treat them accordingly. However, in the event that some discrediting information is discovered about the individuals, the social others will no longer support or validate the individuals' present self-conceptions; such a discovery, according to interactionists, may lead the audience to redefine the individuals' in a negative light--a new conception of self that the individuals' will reluctantly accept. As Goffman (1959:252) states:

...the performed self [is] seen as some kind of image, usually creditable, which the individual on stage and in character effectively attempts to induce others to hold in regard to him. While this image is entertained concerning the individual, so that a self is imputed to him, this self itself does not derive from its possessor, but from the whole scene of his action.... Conceptions of self are maintained as long as the actor on stage does not trip up during the performance. If some discrediting information is discovered about the actor, the working agreement between the actor and his audience to support each others' self-conceptions breaks down. In such cases, a new conception of self is likely to be imputed to the actor.

Just as mind and self are conceived by symbolic interactionists as being symbolic constructs arising in social interaction, so too, do they conceive of the nature of society

in a similar manner.

For interactionists, society is viewed not as a static structure or system, but as a process of on-going activity and different interactions--it is comprised of individuals engaging in interaction. According to this perspective mind, self and society arise out of human symbolic interaction. Society is conceived as a co-ordinated series of human actions. Human societies are structured with reference to the generalized attitudes of others--attitudes that will dictate similar responses. Social institutions, in the interactionist view, are comprised of a grouping of such common responses. In turn, society is thus comprised of such institutions. In short, for symbolic interactionists, society is conceived as an arrangement of the generalized attitudes of others:

...human groups or society exists in action and must be understood in terms of action.... The life of any human society consists necessarily of an on-going process of fitting together the activities of its members. It is this complex of on-going activity that establishes and portrays structure or organization.... Human society is to be seen as consisting of acting people, and the life of the society is to be seen as consisting of their actions. The acting units may be separate individuals, collectivities whose members are acting together on a common quest, or organizations acting on behalf of a constituency.... Social organization is a framework inside of which acting units develop their actions and is not a determinant of that action. Structural features such as "culture," "social systems," "social stratification," or "social roles," set conditions for their action but do not determine their action. People--that is, acting units--do not act toward culture, social structure; they act toward situations. Social organization enters into action only to the extent to which it shapes situations in which people act, and to the extent to which it supplies fixed sets of symbols

which people use to interpret their situations
(Blumer, 1969:87-88).

THE LABELLING PERSPECTIVE OF DEVIANT BEHAVIOUR

The emergence of the labelling perspective in 1960 developed out of ideas first expounded by Tannenbaum (1938) and later more systematically developed by Lemert (1951). Rejecting the traditional norm violation approach to deviance--¹² an approach with the underlying assumptions of consensus and normative stability which constitute a reference point from which behaviour is judged as deviant or non-deviant, labelling theorists, instead, emphasize the emerging, changing and conflicting nature of social norms. Normative violations, in this perspective then, are seen as definitionally problematic in nature. For labelling theorists, deviance is conceived as a social definition, a label bestowed upon certain individuals by an audience reacting to a specific act:

From this point of view, deviance is not a quality of an act a person commits but rather a consequence of the application by others of rules and sanctions to an 'offender.' The deviant is one to whom the label has successfully been applied; deviant behavior is behaviour that people so label (Becker, 1963:9).

Outlining the general theoretical orientation of the labelling perspective Lemert (1951:23) states:

...we start with the idea that persons and groups are differentiated in various ways, some of which result in social penalties, reaction and segregation. These penalties and segregative reactions of society or the community are dynamic factors which increase, decrease and condition the form which the initial differentiation or deviation takes.... The deviant person is one whose role,

status, function and self-definition are importantly shaped by how much deviation he engages in, by the degree of its social visibility, by the particular exposure he has to the societal reaction, and by the nature and strength of the societal reaction.

Examination of the underlying assumptions of the labelling perspective indicates that it is clearly oriented within an interactionist framework.¹³ A basic tenet of this perspective, corresponding with symbolic interactionism, posits that one cannot fully understand deviant behaviour with sole reference to the actions themselves, but only if it is realized that deviant behaviour, like "normal" behaviour involves social interaction with others. For proponents of the labelling approach, deviance is conceived of as a product of social interaction between an individual committing an act and social others who respond to such behaviour. In short, for labelling theorists, not action per se, but societal reaction is of primary consideration:

Forms of behaviour per se do not differentiate deviants from non-deviants; it is the response of conventional and conforming members of society who identify and interpret behaviour as deviant which sociologically transforms people into deviants. (Kitsuse, 1962:253).

Conceiving of deviant behaviour as a "reaction process" of society leads to a second underlying assumption of the labelling perspective which asserts that the demarcation between deviant and non-deviant behaviour is often ambiguous and disputable. What are considered to be acceptable and unacceptable behaviours is relative. Whether one comes to be defined as a deviant is dependent upon a number

of criteria such as the severity of the behaviour, the visibility of the act, the tolerance level of the community, the power of the audience members responding to the act, and the availability of society to channel the reaction to something other than labelling. In sum, the labelling perspective posits a reciprocal process operating between an individual and his/her audience. Rather than viewing deviant behaviour as "objectively given"¹⁴ and attempting to gather data on rule-violators from official records, labelling theorists, by contrast conceive of deviant behaviour as a subjectively problematic phenomenon. In this respect, labelling theorists examine the processes of social interaction, specifically in terms of the conditions under which deviance is defined and the subjective consequences of the application of a deviant label upon self-identity.

In their conceptualization of deviant behaviour as a subjectively problematic phenomenon, proponents of this perspective focus their research on the following: (1) the social audience who define an individual as deviant; and (2) the individual him/herself who has been negatively labelled. Specifically, in terms of the former, labelling theorists focus upon (a) the social conditions under which an individual is segregated and defined as being deviant; (b) the manner by which the individual is cast into the deviant role; (c) the actions of others toward the redefined individual; and (d) the positive or negative value that social others place upon the act of deviance. In terms of the latter concern,

labelling theorists focus upon the individual who has been negatively labelled a deviant. Specifically, proponents of this perspective focus on (a) the subjective reaction(s) of the individual who has been labelled; (b) the manner by which he/she adopts/accepts the deviant role; (c) the extent to which the individual adopts this new conception of self; (d) the transformation of this deviant identity (Rubington and Weinberg, 1973:3).

CAREER, STATUS, DEVIANT SUBCULTURE AND IDENTITY TRANSFORMATION

Advocates of the labelling perspective frequently employ the concept of "career" in their discussions of deviant socialization processes. In contrast to the traditional conception of the concept of career,¹⁵ labelling theorists conceive of this concept in terms of the temporal sequencing of behaviours in any sphere of life. According to Erving Goffman (1961:168):

The moral career of a person of a given social category involves a standard sequence of changes in his way of conceiving of selves, including, importantly his own. These half-buried lines of development can be followed by studying his moral experiences--that is, happenings which mark a turning point in the way in which the person views the world--although the particularities of this view may be difficult to establish...By taking note of the moral experiences and overt personal stands, one can obtain a relatively objective tracing of relative subjective matters. Each moral career, and behind this, each self, occurs within the confines of an institutional system.... The self then, can be seen as something that resides in the arrangements prevailing in a social system for its members.... The self dwells in the pattern of social control that is exerted in

connection with the person by himself and those around him. This special kind of institutional arrangement does not so much support the self as constitute it.

For labelling theorists then, the concept of career may be viewed as a movement of individuals through a structure of society. The different stages in an individual's career symbolize the transformation of his/her status and identity; moreover, it allows the person to view him/herself as moving along a continuum. In this perspective, the concept of career has a double-sided nature:¹⁶ from an objective sense, this concept can be conceived as a passage through various statuses and roles. From a subjective standpoint, this concept can be conceived as being comprised of an individual's self-images and identities as he/she moves through various institutions, and the permanence of such identities once outside the institutional frameworks.

According to labelling theorists, moral careers originate and develop within institutional frameworks where individuals are processed or socialized into various statuses and roles--which in turn, affect the individuals' conceptions of self. Specifically, according to this perspective, in the confines of what are termed as "people-processing institutions,"¹⁷ deviant identities and moral careers are molded, shaped and sustained. According to labelling theorists, the labelled deviants are not active in shaping and negotiating their deviant identities. In the confines of these social institutions, the labelled deviants are forced by institutional

dictates to accept deviant identities, with little latitude for negotiation. In the context of these institutions then, individuals take on deviant roles and statuses.¹⁸


Once the deviants separate themselves from the institution, there begins for them the task of attempting to return to a life of normality. Such persons attempt to transform their deviant identities and begin life anew. However, according to labelling theorists, ex-deviants discover that being publically labelled as deviant and officially processed in various institutions, is socially stigmatizing, adversely affecting social relationships and opportunities.¹⁹ In terms of the latter, it decreases job opportunities, for employers are not prone to hire deviants. In terms of the former, it affects social relationships with normals as normals are not prone to associate with deviants. According to proponents of labelling theory then, the social definition of "deviant" is generally a permanent label and stigma affecting the person's future participation in society. Given that such persons are blocked from re-establishing conventional roles and statuses, this increases the probability of engaging in future deviant activities on the part of the deviant. For some ex-deviants, this involves entering and participating in deviant sub-cultures²⁰--groupings of individuals suffering a common fate and sharing common interests. Deviant sub-cultures possess sets of norms to regulate group behaviour, provide its members with a set of values and beliefs, and teach its members how to "do" deviance. Within each subcul-

ture, certain members will exhibit more commitment to the deviant lifestyle than do others. According to labelling theorists, how dependent deviants are to a particular subculture, their self-identities and subjective perceptions of reality, are all factors influencing their commitment to the subculture. Rubington and Weinberg (1973:272), speaking of the nature of deviant subcultures state:

A subculture is apt to come into being when people are in contact with one another, suffer a common fate, and have common interests. These common interests generally arise from their social situations and are shared because these people face more or less the same dilemma.... Subcultures have beliefs, values and norms that are supposed to regulate conduct.... Deviant groups vary in the extent to which they organize their activities and define them by subcultural rules: some have elaborate rules that specify beliefs and actions; others have simpler codes.... Within a subculture some members show more commitment to the deviant way of life than do others. How dependent the person is on the deviant subculture, the person's identity, how much the person shares the viewpoints of others in the subculture--all these seem to be factors influencing a person's commitment to the subculture.

In short then, proponents of labelling theory emphasize the importance of societal reaction to behaviour that violates normative standards or customs, rather than the behaviour itself. Using Lemert's (1950) terms, "primary deviance"--that is, the actual rule violations are considered to be important, for labelling theorists only insofar as they are visible, reacted to in a negative manner, leading to an alteration in identities, roles and statuses--that is, "secondary deviance" (Lemert, 1951). Once individuals,

engaging in acts of primary deviance, are formally reacted against by others, such persons are processed through various official organizations and institutions--career routes that shape and create deviant identities. For labelling theorists, these socially-created deviant identities structure the course of future interaction between deviants and normals. Such identities may function as "master statuses" (Hughes, 1958; cf. Becker 1967)--statuses overriding other conventional statuses and exerting a negative effect on the course and pattern of interaction. Part of the difficulty encountered by deviants in attempting to transform their deviant identities is related to the fact that being defined as deviant is a master status with certain master and auxiliary traits--traits often blocking the deviants' passage back to normality. In addition, while there exist a set of rites of passage demarcating the individuals' passage from normal to deviant roles, there is no such similar process to reinstate the reformed deviants. The reformed deviants may wish to "start life over" again, but societal members fail to recognize that they have been reformed. Given the great number of social penalties incurred by these persons in their attempts to resume lives as normal citizens--given the stigmatizing responses, the rejection, the ridicule, the discrimination related to employment, such penalties may facilitate the pursuit of deviant careers in various deviant subcultures.



STRENGTHS AND CRITICISMS OF THE LABELLING PERSPECTIVE

The labelling approach can be credited for focussing on the social processes by which individuals come to be defined and treated as deviant, and the negative effects of such labelling. Such reactions to rule violations, combined with institutional processing, serve to create the very deviant identities that society desires to stamp out.

In addition, this perspective can be credited for focussing on the role of the deviants from their points of view. That is, adopting the perspective of the individuals adjudged as deviant, proponents of this approach examined how the individuals responded to this label, their definitions of the situation as they were processed through the institution, and their self-conceptions upon release from the facility. Despite these strengths however, this perspective does suffer from certain shortcomings. Specifically, since the mid-sixties, the labelling perspective has been criticized on a number of levels. Such criticisms are as follows:

- (i) The labelling approach focuses primarily on secondary deviance to the neglect of primary deviance (Davis, 1980; Fine, 1977, Gibbs, 1966; Gove, 1976; Hirschi, 1973; Rains, 1976). In this regard, critics charge that labelling theorists pay too much attention to the societal reaction component, and neglect the "actual" deviance.

- (2) The labelling perspective fails to distinguish adequately between deviance and non-deviance (Gibbs, 1966).
- (3) The labelling perspective has a narrow focus (Davis, 1972, 1980; Gibbs, 1966; Nettler, 1974; and Simon and Gagnon, 1967)--an overly microscopic approach neglecting macroscopic concerns of structure, power and social change.
- (4) The labelling perspective fails to explain certain types of deviance (Gove, 1970; Gibbs, 1966). Critics charge that a number of violations exists for which there is widespread normative consensus--violations lending themselves less readily to labelling analyses than do other violations which are borderline forms of deviance, largely subject to interpretation.
- (5) Labelling theorists have been criticized for assuming moral positions in their research. Specifically, in this regard, some critics charge that these theorists are: (a) either overly sympathetic to the deviants they are studying (Glassner and Corzine, 1978; Hirschi, 1974; Schervish, 1972); or (b) that these theorists, in their studies, support the status quo (Davis, 1980; Liazos, 1972; Thio, 1978).
- (6) In terms of methodological criticisms, critics take issue with the interpretation of deviance

as a subjective phenomenon, and the "manner" by which deviance is "measured" (Akers, 1968; Gibbs, 1966; Hirschi, 1973; and Gove, 1975). Specifically, such persons contend that the labelling perspective fails to provide "objective" criteria for defining deviance. These critics reject the subjective, relativistic stance adopted by labelling theorists, and instead, call for official statistics to measure deviant behaviour.

- (7) Critics charge that labelling theorists portray deviants as powerless, innocent, passive recipients of deviant labels, identities and statuses -- persons relatively uninvolved in the labelling process (Gibbs, 1966; Davis, 1975; Gove, 1975; Hirschi, 1973; Schervish, 1972). Critics contend that labelling theorists speak of deviant identities as being "imposed" upon individuals rather than being negotiated.

It is beyond the scope of this dissertation to respond to all of the criticisms cited above.²¹ I wish only to address the latter criticism as it has particular relevance for my research.

I would argue that the critics are partially correct in their assessments of the portrayal of deviants as passive entities, on the part of labelling theorists. Many early studies utilizing the labelling perspective tended to portray

deviants in this manner (Goffman, 1961; Scheff, 1968)-- studies focussing on "total institutions" (Goffman, 1961) where individuals are forced to accept identities enforced by institutional dictates. However, more recent studies (Hewitt and Stokes, 1975; Goffman, 1963; Leviton, 1975; Prus, 1975) on deviants, and on those with physical disabilities (Levitin, 1975; Miall, 1984; and Schneider and Conrad, 1980), have portrayed such persons, not as powerless victims, but as active participants in the creation of their identities, and in shaping deviant outcomes.

Following these more recent studies, the present investigation on ex-psychiatric clients, adopts a labelling approach that conceives of human beings as complex social actors--as persons having an active role in eliciting responses through their actions and through the expectations and images that they project--as individuals who play active roles in shaping their identities (although not always successful), and in dealing with deviant outcomes through the employment of various techniques of information management and negotiation of various definitions of situations.

SUMMARY AND CONCLUSIONS

In summary, this chapter served to introduce the reader to the four theoretical perspectives dominating the literature concerning the origins, rise and consequences of the movement toward deinstitutionalization of psychiatric

patients. While it was argued that each theoretical perspective, has, in different respects, contributed to our understanding of the deinstitutionalization phenomenon, none have focussed on the individuals themselves who are directly affected by this shift in treatment. I have argued that the utility of a symbolic interactionist perspective, specifically a labelling approach, lies in its ability to fill such a neglect. While I am not discounting the importance of macroscopic, historically-based theories--those analyses focussing on political and economic factors, or theories focussing on the psychiatric profession itself, I would argue that it is of equal importance to examine the effects of deinstitutionalization from the subjective points of view of the ex-patient themselves--their meanings, symbols, post-treatment social situations, conceptions of self and participation in deviant subcultures. Admittedly, while much research (from an interactionist perspective) has previously focussed upon mental patients prior to hospitalization,²² and within the hospital,²³ fewer studies have focussed on such persons after hospitalization.²⁴ Since the movement toward deinstitutionalization in favour of the community alternative, few studies have been conducted which focus on those affected by such a movement.²⁵ Adopting an interactionist perspective, the purpose of this study then, seeks to examine the social world(s) of Canadian ex-psychiatric patients from their points of view--by examining their "definitions of the situation"

(Thomas, 1928) and "constructions of reality" (Berger and Luckmann, 1966).

The next section will present a review of the existing literature on the deinstitutionalization phenomenon and on ex-psychiatric patients.

NOTES

1. For a detailed discussion of the "therapeutic community" concept and philosophy, see: Maxwell Jones (1952), (1968).
2. See Brown (1979:82-89) for a detailed discussion concerning inaccuracies of the empirical evidence.
3. For a discussion of the profitability of psychotropic drugs and their negative implications for the patients, see: Scull (1977); Brown (1979); and Szazey (1974).
4. One such technique, "Taylorism" was a direct response to the upsurge in labour militancy and unionization of the 1890's.
5. Such individuals include: Francis Braceland, Luther Woodward, William Menninger and Fritz Roethlisberger.
6. The enlightened-revolution theory is (in my opinion): one notable exception--its proponents present an uncritical, idealistic and distorted picture, for the most part, concerning the rise of community psychiatry.
7. The symbolic interactionist perspective was not systematically formulated by one person. It can be traced back to the writings of Baldwin (1897), Dewey (1896), James (1890), W.I. Thomas (1928), Cooley (1964), Znaniecki (1936), Mead (1932), (1934), (1936), Blumer (1969), Strauss (1956), and Lindesmith (1968), among others.
8. Traditionally it has been assumed by both advocates and critics alike that the theoretical and methodological orientations of Blumer's version of symbolic interactionism is basically an extension and manifestation of Meadian symbolic interactionism. Recently, however, scholars (Brymer, 1980; Lewis, 1976; McPhail and Rexroat, 1979) have revealed the divergence between Meadian and Blumerian interactionism. This dissertation adopts a Blumerian interactionist approach.

9. Not only do social groups provide persons with meanings and definitions about appropriate forms of behaviour, but they also function to provide rationales for such acts. According to C. W. Mills (1940:907), "motives are accepted justifications for present, future, or past progress of acts." In this sense, motives are conceptualized as socially-learned expressions that serve to provide the individual and others with rationalizations for behaviours.
10. Charles Horton Cooley (1964), in his work, and George Herbert Mead (1934) are responsible for the interactionist conception of self and the notion that individuals can be the object of their own actions.
11. See Goffman (1959) for a detailed discussion concerning impression management.
12. Traditionally, the sociology of deviance has been identified with the study of normative violations. Specifically, structural functionalists such as: Durkheim (1951); Merton (1938); (1957); Cloward and Ohlin (1964).
13. For a detailed discussion of the various criticisms of the labelling perspective, see: Gibbs (1966); Gove (1975); Mankoff (1971); Davis (1975).
14. Rubington and Weinberg (1973) provide an elaboration of the different approaches to the study of deviant behaviour. See also: Liska (1981).
15. Traditionally, this concept referred exclusively to one's occupation or profession.
16. See Hughes (1958) for a detailed discussion concerning the concept of career.
17. This term, originating with Goffman (1961) has been utilized by others including Freidson (1966); Cicourel and Kitsuse (1963); and Bittner (1967).
18. See Scheff (1968), Goffman (1961).
19. See Barkett et al. (1953); Davis (1961); Edgerton (1967); Goffman (1963); Hunt (1966); and Wright (1960).
20. For a discussion on deviant subcultures see: Cohen (1955); (1966); Simmons (1969); Yablonsky (1959); Matza (1955).

21. For detailed discussions of the various criticisms of the labelling perspective and rebuttals to such criticisms see: Fine (1970); Gove (1970); Davis (1972, 1980); Gibbs (1966); Hirschi (1970); Nettler (1971); Petrunik (1980); Schurr (1971, 1975); Lemert (1972); Becker (1973); Kitsuse (1975); Cullen and Cullen (1978); Suchar (1978).
22. Mechanic (1962); Sampson et al. (1962); Scheff (1964); and Goffman (1961); Denzin (1966).
23. Goffman (1961); Sobel and Ingalls (1964); Denzin (1968); Scheff (1966), (1967) (1975); Dinitz et al. (1959).
24. See for example: Freeman and Simmons (1963); Cumming and Cumming (1956); Whatley (1959).
25. In particular, Estroff (1981); and Reynolds and Farberow (1981).

CHAPTER THREE

LITERATURE REVIEW

In this chapter, I will present a review of relevant research findings and literature on deinstitutionalized and discharged psychiatric clients and on the phenomenon of community psychiatric treatment in general.

Examination of the wealth of literature on (ex-) psychiatric patients and on the deinstitutionalization phenomenon reveals the complicated nature of the topic under investigation. Researchers and theoreticians in disciplines ranging from: epidemiology, physiology, psychiatry, psychology, psychopharmacology, to geography, anthropology and sociology, employing a number of theoretical approaches and methods, have conducted numerous studies on various aspects of this phenomenon.¹ While a large portion of the existing literature has been devoted to theoretical analyses of the origins, development, goals, nature, strengths and weaknesses of the deinstitutionalization or community psychiatry phenomenon (that I discussed in the previous chapter), a significant portion of the literature has also been devoted to: (a) outcome and follow-up studies on various types of discharged patients; and (b) studies focussing on the plausi-

bility, implementation and evaluation of various "therapeutic" treatment programmes in the community and community psychiatric "tools." Moreover, relative to the theoretical, follow-up and treatment-oriented studies, there exist only a few studies that have focussed on the discharged/deinstitutionalized psychiatric patient in the community from his/her point of view. Specifically, upon examination of the literature, I would argue that the majority of related writings in the field may be classified as follows:

(1) THEORETICAL DISCUSSIONS

Theoretical discussions concerning the origins, development, goals and strengths and weaknesses of the community psychiatry phenomenon (Bachrach, 1978; Bassuk and Gerson, 1978; Bellak, 1964; Bloom, 1973; Ganser, 1975; Burrows, 1969; Fischer and Weinstein, 1971; Chu and Trotter, 1974; Magaro et al., 1968; Ralph, 1980; Scull, 1977; Brown, 1979).²

(2) EXPERIMENTAL FOLLOW-UP STUDIES

Controlled, experimental follow-up studies on groups of various discharged psychiatric patients with various clinical diagnoses (Beard et al., 1978; Burvill and Mittelman, 1971; Clayton, 1970; Fakhruddin et al., 1972; Fenton et al., 1979; Freeman et al., 1979; Glick et al., 1976; Hargreaves et al., 1977; Herz et al., 1979; Mattes et al., 1977; Richards, 1971; Sartorius et al., 1977; Schwartz et al., 1975; Wooley and Kane, 1977).

(3) STUDIES FOCUSING ON COMMUNITY PSYCHIATRY TREATMENT PROGRAMMES AND TOOLS

Discussions concerning the implementation of various community treatment programmes and rehabilitative practices for the discharged patient such as: day care, living skills programmes, drug maintenance therapy, self-help groups, social support systems, rehabilitative housing placements, volunteers as a resocializing tool, home care programmes, etc.

(Anthony, 1977; Anthony et al., 1972; Astrachan et al., 1970; Ban, 1978; Barten, 1973; Becker and Bayer, 1975; Becker, 1971; Bennett, 1980; Berry and Lukens, 1975; Bigelow and Beiser, 1978; Blume et al., 1979; Boothe et al., 1978; Brook et al., 1976; Capstick, 1973; Cometa et al., 1979; Cutler and Beigel, 1978; Davies, 1972; Davis, 1975; Dubin and Ciavarelli, 1978; Easton, 1974; Elpers et al., 1971; Engelhardt et al., 1978; Fox and Potter, 1973; Goldsten et al., 1978; Hansell and Willis, 1977; Hersen and Bellack, 1976; Muller, 1966; Sherman and Johnston, 1967; Smith, 1967).

(4) QUALITATIVE, ETHNOGRAPHIC STUDIES ON EX-PSYCHIATRIC PATIENTS

Descriptive, qualitative, ethnographic studies placing those "afflicted with" psychiatric "disorders" within their cultural contexts. Adopting a cultural relativist position, such studies conceive of mental illness not as a disease entity located within the individual,

but rather, as a social product--a label ascribed to individuals committing certain "bizarre" acts. Health, illness and mental illness are seen as culturally-defined conditions reflecting certain social circumstances and ideologies concerning what constitutes "normality" and "abnormality." Such studies focus on the consequences of the application of this social definition and institutional processing in terms of the labelled individual's self-conception and future participation in society. Moreover, such studies deal with the consequences and impact of the deinstitutionalization movement on the family and the communities affected by it, and its meaning(s) for the ex-patients themselves--their social constructions of reality (Estroff, 1981; Herman, 1981; Edgerton, 1967; Cheadle et al., 1978; Selby, 1974; Scheper-Hughes, 1979; Reynolds and Farberow, 1977; Dear et al., 1980; Slavinsky et al., 1976).

EXPERIMENTAL, FOLLOW-UP AND OUTCOME STUDIES

Just as much of the literature on this topic has been devoted to theoretical discourses on the origins, nature, development, goals, and strengths and criticisms of the deinstitutionalization phenomenon (that I discussed in Chapter Two), so too, have scholars devoted much attention

to conducting scientific, experimental, follow-up and outcome studies on various ex-psychiatric patients. To date, such existing studies (adopting a medical model approach to the study of mental illness),³ have analysed, using objective, scientific techniques,⁴ various ex-patients with specific clinical diagnoses, in order to ascertain whether (or if) such persons are able to cope, adapt and remain outside of the hospital, and what criteria, programmes and factors are important for the prevention of rehospitalization. Moreover, such studies have followed groups of psychiatric patients undergoing treatment in non-institutional, community-based settings. In terms of the former, some of the recent follow-up studies, such as Burvill and Mittleman (1971), Clayton (1970), Davis et al. (1973), Greenblatt and Budson (1976), Morrison et al. (1973), Query (1980), and Sartorius et al. (1977), among numerous others, upon choosing a research population [such as a population of long-term chronics or shorter term schizophrenics], obtaining a sizeable sample using rigorous sampling techniques, have statistically analysed the outcome of the sample. Specifically, such studies, using available records, typically examined what percentage of the sample are remaining outside the hospital and for what period of time, what percentage have been rehospitalized, and what factors or criteria may be predictors of rehospitalizations such as age, sex and psychiatric illness.

While some follow-up studies have centred on concerns discussed above, others, have focused on examining whether groups of ex-psychiatric clients are utilizing community psychiatric services upon discharge and thereafter. Specifically, Freeman et al., (1979) conducted a follow-up study on a group of chronic schizophrenic patients in England and discovered that the amount of utilization of such services was statistically uncorrelated with severity of psychiatric disorder. These scholars found that the heaviest users of psychiatric services were those who were also involved with other social service agencies. Fakhruddin et al., (1972) conducting a five-year follow-up study on five hundred chronic patients found that fifty-five percent of the sample remained continually in the community during this period. Such long-term maintenance, was deemed by the researchers to be the result of patients' receiving continuous aftercare from local community mental health centres. Wooley and Kand (1977) conducted a follow-up study on patients discharged from a Utah State Hospital in which they assessed whether discharged psychiatric clients followed recommended courses of aftercare treatment. Specifically, the researchers found that eighty-seven percent of their sample were referred for community aftercare treatment; of these seventy percent actually had contact with the treatment facilities. Upon following this sample for a period of one year, it was discovered that only thirty percent of the ex-patients in the sample were still

receiving aftercare treatment. LePage et al., (1980) conducted a follow-up study on forty-four subjects who requested and received psychiatric treatment at an out-patient clinic, but withdrew from treatment prior to the fifth session. Upon statistically examining the questionnaire data, the researchers discovered that a significant relationship existed between the source of referral and the degree of satisfaction. Those clients who referred themselves to the clinic tended to be significantly more satisfied with the service than those referred by others. Moreover, LePage et al., (1980) found that a significant relationship existed between the client's degree of satisfaction and their perception of the suitability of therapy, and also between level of satisfaction and the perception of the amount of assistance received. Those individuals who were dissatisfied with the service were significantly more likely to view the therapeutic experience as unsuitable and that they received little assistance.

Other studies have focussed on specific groups of discharged psychiatric patients as they enter into and remain in various rehabilitative community-based programmes. Such research attempted to assess whether rehabilitative treatment significantly lowers rehospitalization rates. Beard et al., (1978), conducting a comparative study on the influences of psychiatric rehabilitation services upon rehospitalization, found that subjects receiving rehabilitative therapy had lower readmission rates relative to those receiving no treat-

ment at all. Nevertheless, the results indicate that rehabilitation did not prevent, but rather, only delayed rehospitalization.

Other follow-up studies have focussed upon the issue of (re-) employment for discharged psychiatric patients. Conducting a nine-month follow-up investigation on the relationship between demographic characteristics of ex-patients and post-hospital employment, Lorei and Gurel (1973) found that certain background characteristics, most notably, "extent of work in the preceding five years," was the best predictor of post-hospital employment. Richards (1971), conducting a follow-up study on one hundred psychiatric clients who had attended a rehabilitative day centre, found that only eleven of these were employed steadily since leaving the centre. Richards suggests that the apparent failures to secure employment on the part of ex-patients are offset by improvements in their quality of life arising from the rehabilitative efforts. Davies (1972), in another study of this kind, found that six months after attendance in a rehabilitation programme, one-third of his sample had obtained employment, and one-quarter were still employed. Davies concluded that if employment is not secured within twelve months after attending the programme, it is not likely to be achieved through further attendance.

Just as some of the follow-up studies have centred on the employment of discharged patients, others have focused

on the effects of family structure, support and interaction upon post-hospital adjustment. Mannino and Shore (1974), conducting a controlled, follow-up investigation found that there exists a correlation between family structure and post-hospital adjustment, with those ex-patients holding positions of high status and having clear familial expectations performing best.

Moreover, other follow-up studies have examined ex-patients that, upon release from the hospital, were placed in various residential care facilities. In a two-year follow-up study of chronic ex-patients living in "Task Oriented Communities," a non-transitional society, Vannicelli et al., (1979) point to effectiveness of this type of residential care providing the clients with long-term support, stability and employment. Similarly, Gomez (1978) in a three and one half year follow-up study on discharged schizophrenics, reports that those individuals who were discharged to small supportive treatment units where living quarters were shared with fellow ex-patients fared better in terms of post-hospital adjustment, employment, responsibility and readmission rates compared to those ex-patients discharged and living alone in the community. Murphy et al., (1976), conducting an eighteen-month follow-up investigation of adult ex-psychiatric clients placed in foster families, found that such environments facilitate a sense of community, well-being and contribute toward the development of a positive self-image on the part of the ex-patient.

A number of the follow-up studies found in the literature have also comparatively examined the effects of brief versus standard hospitalization upon patient outcome, post-hospital adjustment, and its effects on the families of patients. Hargreaves et al. (1977), conducting a two-year follow-up study concerning the effectiveness of short- versus long-term hospitalization for schizophrenics, reported that the findings indicated the relationship between pre-hospital functioning and length of hospital stay, such that clients with good prehospital functioning do better when assigned to long-term institutionalization. Conversely, the researchers contended that those clients with poor pre-hospital functioning do better with shorter term institutionalization. Mattes et al. (1977), in a similar comparative, follow-up study of three years, concluded upon evaluation of patient psychopathology and social adjustment (in terms of both self and family) that short-term hospitalization is more beneficial than long-term hospitalization. Glick et al. (1976) in their two-year follow-up study comparing the effectiveness of long-term versus short-term hospitalization for non-schizophrenics, found that there were no statistically significant differences in post-hospital functioning associated with the term of hospitalization. The researchers concluded that long-term hospitalization is not necessary for non-schizophrenic patients.

A final type of follow-up study evident in the existing literature focusses upon alternatives to traditional hospital treatment for mental patients. Fenton et al., (1979), conducting a follow-up study of individuals treated at home,

concluded that such community based care may be an effective alternative to in-patient care for many, but not all, severely ill patients. Similarly, Smith et al. (1978), in a one-year follow-up study on home-care treatment for acutely ill psychiatric patients reported that treatment was successful for eighty-three percent of the sample. The researchers concluded that the success of home treatment is dependent upon the psychosocial supports available to the patient, and the relationship between the patient, his/her family and the home care treatment staff. Grad and Sainsbury (1968) conducted a study in which psychiatric patients were admitted either to community-based treatment programmes or to conventional hospital facilities. Upon following the samples for two years, the researchers assessed the amount of burden that was placed upon the families in light of the respective treatment modalities in which their relatives were placed. The results indicated that community treatment left the patients' families significantly more burdened than did conventional treatment in the majority of cases. The researchers concluded that the results are due to the failure of community psychiatric services to provide sufficient social support for relatives of non-hospitalized patients.

DESCRIPTIVE AND EXPERIMENTAL STUDIES OF VARIOUS COMMUNITY
PSYCHIATRIC TREATMENT PROGRAMMES

While much of the existing literature on the topic of deinstitutionalization and community psychiatry has been devoted to theoretical discussions concerning the origins and rise of this phenomenon along with follow-up and outcome studies of various ex-psychiatric clients, so too, have numerous studies been conducted on various community based treatment modalities and practices. For example, a number of studies have focussed on the efficacy of home care as an alternative to psychiatric hospitalization. Langevin et al. (1966), Smith (1967), Brook et al. (1976), Polack (1978), Brosost (1978) in their studies, conclude that, in general, home care is not only able to successfully maintain clients in the community setting, but also proves to be more effective in providing intensive care than traditional psychiatric hospitalization. Some researchers have examined and evaluated the effectiveness of specific forms of home care such as: residential care facilities (Fairweather et al., 1969; Mosher and Menn, 1978; Hewett et al., 1975), group homes (Capstick 1973; Sambu and Steinfeldt-Foss, 1974), half-way houses (Glasscote et al., 1971; Britten, 1974; Budson, 1973; Cometa et al., 1979; Holman and Shore, 1978; Ozarin and Witkin, 1975; and Wilder and Gadlin, 1977), boarding homes (Dubin and Claverelli, 1978), "Homes for Special Care" (Holling, 1969; Leppman, 1981; Sylph et al., 1976), congregate living

facilities (Burger et al., 1978), foster care facilities (Linn et al., 1977, 1980; Murphy et al., 1972, 1976), hostels (Mickleburgh, 1970), and nursing homes (Schmidt et al., 1977). In general, such types of home care are seen by the researchers to be effective alternatives to inpatient care. Other researchers (Lieberman et al., 1978; Chien and Cole, 1973; Fenton et al., 1982; Murphy and Dattel, 1976; Sharfstein and Nafziger, 1976; Sheehan and Atkinson, 1974; Weisbrod et al., 1980), conducting cost-benefit analyses on home care and on community treatment in general, come to the same conclusion: namely that such programmes of treatment and care are financially feasible and provide substantial monetary savings as compared with traditional in-patient treatment and care.

Other researchers (Creer and Wing, 1975; Garrison, 1978; Hibler, 1978; and Pasamanick et al., 1967) have conducted evaluative studies on family care as one form of community-based care for psychiatric patients. Such studies have concluded that, despite problems of emotional strain placed upon relatives, home care, nevertheless, represents a feasible approach for treating persons who might have otherwise been hospitalized.

Just as much of the existing literature has focussed on alternative care facilities, so too, have many studies centred on the benefits of such forms of community treatment as: volunteers as help-givers and resocializing agents

(Weinman et al., 1970; Blum-Devor, 1982), home-visiting services (Yurtcu, 1970), therapeutic social clubs (Allodi et al., 1968), the psychiatric day hospital (Cameron, 1965; Astrachan et al., 1970; Blume et al., 1979; Dudley et al., 1970; Finzen, 1974; Fried, 1972; Gootnick, 1971), psycho-social rehabilitation centres (Bigelow and Beiser, 1978; Weintraub and Harnois, 1981; Lecker et al., 1971) and the role of the counselling group as a rehabilitative tool (Comtois et al., 1982).

Further, there exist numerous studies that have described and/or evaluated the implementation of such community psychiatry "tools" and programmes as: daily living skills programmes (Anthony, 1977; Berry and Lukens, 1975; Byers et al., 1979; Cutler and Beigel, 1978; Hersen and Bellack, 1976; Hofmeister et al., 1979), drug maintenance therapy (Bart 1978; Davis et al., 1980; Engelhardt et al., 1978; Goldberg et al., 1977; Goldstein et al., 1978; Hansell and Willis, 1977; Hogarty et al., 1974, 1979), various rehabilitation programmes (Wing, 1960; Walker et al., 1977; Menuck, 1978; Jensen et al., 1978), work skills programmes (Wilder, 1976; Littman, 1976; Davies, 1972), and evaluative studies on community mental health care in general (Lipscomb, 1970; Kirk and Therrien, 1975; Astrachan, 1978; Becker and Schulberg, 1976; Bennett, 1978; Berlin et al., 1981; Gaylin and Rosenfeld, 1978; Sharfstein and Wolfe, 1978).

DESCRIPTIVE, QUALITATIVE, ETHNOGRAPHIC STUDIES ON (EX-),
(DE)-INSTITUTIONALIZED MENTAL PATIENTS

In contrast to the deluge of theoretical, evaluative and scientific studies that have been conducted on community psychiatry, its related "tools of the trade," deinstitutionalized and discharged patients, and on the deinstitutionalization phenomenon in general, there exists relatively little research focussing on the consequences and impact of this movement from the subjective points of view of the ex-psychiatric clients themselves--those persons directly affected by this shift in policy, treatment and care.

Sociologists (Lemert, 1961; Erikson, 1962; Goffman, 1961; Scheff, 1963, 1966, 1967, 1975; Szasz, 1961), beginning in the early sixties, rejected the traditional psychiatric paradigm of mental illness--a paradigm in which mental illness is conceived as a "disease" entity located within the individual; in place of this paradigm, scholars developed a "demedicalized" conceptual framework that placed the phenomenon of mental illness under the heading of deviant behaviour and treated it as an arbitrary label attached by others to persons committing certain forms of behaviour. Research stemming from this framework, thus began with the proposition that mental illness is a label that is ascribed to individuals as a function of the reaction and definition given to certain types of acts by social audiences. So, for example, such studies have focussed on the social processes by which an individual

comes to be labelled "mentally ill"--the social conditions under which a person is so defined (Mechanic, 1962; Yarrow et al., 1955; Phillips, 1963; Scheff, 1964, 1966; Bittner, 1967; Szasz, 1961; Sampson et al., 1962; Miller and Schwartz, 1966; and Wenger and Fletcher, 1969), the institutional processing of the "in-patient" (Goffman, 1961; Scheff, 1963; Loeb, 1956; Sobel and Ingalls, 1964; Denzin and Spitzer, 1966; Braginsky and Braginsky, 1967; Herman, 1981), and the effects of institutionalization upon the self-images and identities of mental patients, and upon their future participation in society (Edgerton, 1967; Cumming and Cumming, 1965; Herman, 1981; Zusman, 1966).

Since the advent of the movement toward deinstitutionalization, abounding in the literature are theoretical discussions on various aspects of this phenomenon, objective, scientific experiments on community psychiatric tools, and studies focussing on the merits and criticisms of this shift in the treatment and care of the mentally ill; however, there are only a dearth of community-based, ethnographic studies focussing on the impact and consequences of this movement on the relatives of patients, on the community into which the ex-patients are "placed," and on the ex-patients themselves--the socially-constructed features of ex-patienthood as they have created, defined and experienced it. One of the few ethnographic studies focussing upon such concerns is Estroff's (1981) research on forty-three chronic, deinstitutionalized patients participating in a "model" community aftercare facil-

ity in Wisconsin. Adopting an ethnographic approach, the researcher sought to discover what the everyday world of the chronic ex-mental patient was really like. Through extensive participation with such persons during their employment in sheltered workshops, during their leisure time, and in their day-to-day experiences, combined with her own experimentation with a six week course of Proloxin (a common psychotropic substance frequently used in psychiatric aftercare), Estroff not only obtained a subjective, empathetic understanding of the social world of the American ex-chronic mental patient, but she also discovered contradictions inherent in the after-care treatment of mental patients--treatment that prevented individuals from transforming their deviant identities and social roles. Specifically, one such contradiction, reported by Estroff centred on the issue of (re-) employment for the ex-patients. On the one hand, in an effort toward achieving "normalization," the aftercare staff encouraged the ex-patients to seek and secure permanent jobs; however, in actual fact, the only work that such persons were able to obtain was menial and boring jobs in sheltered workshops--low-paying, low-status (or deviant-status) jobs that did not contribute toward the development of a non-deviant, "normal" identity, but actually functioned to maintain the individual's deviant identity. Moreover, Estroff found that medications served the same function. Almost all of the researcher's subjects were on medications--"meds" that they were told they would be on for

- the rest of their lives. Such statements regarding "meds" as being a permanent fixture of their lives, contributed to the maintenance of the individual's deviant identity.

Further, Estroff (1981) found that such paradoxes existed with respect to the purposes for aftercare medication. While psychotropic or mood-altering substances, ideally were supposed to reduce psychotic tendencies--ideally, to allow the individual to behave more "normally" in the community. In reality, the side effects of these substances--the leg shaking, nervous tics, the weird gestures, only served to publically reinforce the person's deviant aspects of self.

A final contradiction discussed by the researcher centred on the fact that deinstitutionalization, ideally was supposed to release and provide "freedom" for chronic mental patients; in actual fact, such persons are constrained by intangible institutional controls; these ex-patients did not see themselves as "normal," "real" individuals; as a result, they retreated from social contact with "normal" others and from society in general. The similarities between Estroff's study and my own research are indeed striking.

In a similar study on psychiatric aftercare facilities in California, Reynolds and Farberow (1977), obtained a subjective understanding of the social world of the discharged client. By assuming a patient identity and living in various aftercare homes, Reynolds was able to acquire a subjective understanding of the social world of discharged patients--the loneliness, boredom, peacefulness, etc. The

researchers discovered that while much of the residential care was inadequate in the sense that it was "too caring" or "too impersonal," it is concluded by Reynolds and Farberow that, while a friendly environment cannot only comfort the ex-patient, but also aid in rebuilding a more positive self-image, nevertheless, a balance must be struck between the care and nurture of an ex-patient and encouraging him/her to accept personal responsibility.

Scheper-Hughes (1979) focussed upon the social conditions that either contributed to, or decreased the chances of the rural Irish to become schizophrenic. Combining two models--a medical model approach to the study of mental illness with a cultural deterministic model, the researcher examined specific cultural features that contributed to the development, course, and maintenance of schizophrenia in this community. Such features included the lively verbal play among normals, verbal deficiencies and confusion among schizophrenics, and the "safety" of institutionalization.

In an ethnographic study on over thirteen hundred ex-psychiatric patients housed in foster homes in Geel, Belgium, Roosens (1979), focussed his observation on interactions between the ex-patient and his/her foster family. Roosens also examined interactions between the ex-patient and the community at large. In terms of the former, the researcher discovered that although the ex-patients became "permanent" residents of their foster homes (with some staying for as long as fifty years), their status never reaches that of full family membership. Instead, the ex-patients are given the

statutes of children or servants. Because most of the foster families were comprised of elderly individuals, the motivations for "taking on" an ex-patient as a boarder were frequently more for economic reasons and not humanitarian. According to Roosens, ex-patients also represented a free source of labour—providing housekeeping, babysitting, entertainment, etc. for the foster families. In terms of the latter, Roosens observed that the normal members of the community of Geel, effectively distanced themselves from the ex-patients with humour and condescending behaviour directed toward the "crazy." Community members, in general, tolerated the bizarre behaviour of the ex-mental patients, but did not tolerate sexual behaviour or actions disrupting the community. Much like the family pet, ex-patients in this community were tolerated as long as they remained obedient, well-behaved and passive in nature. If the ex-patients became disruptive, disobedient, or if they reacted negatively to the exploitative nature of the system of aftercare, they were immediately returned to the hospital.

Other studies such as Cheadle et al. (1978), Lamb and Goertzel (1977) and Slavinsky et al. (1976) have conducted phenomenological studies on various aspects of the post-discharge lives of schizophrenics and chronic ex-patients from their perspectives. Such studies have centred on the living conditions, social activities (or lack of), and employment of these ex-patients. Similar to studies by Estroff (1981) and Reynolds and Farberow (1977), these studies also pointed

to the loneliness, isolation and boredom experienced by many ex-patients.

Dear et al. (1980) have conducted a phenomenological study on the needs of Canadian ex-psychiatric clients. Specifically, these researchers found that upon discharge into the community and thereafter, ex-patients are faced with the following problems: lack of adequate housing, lack of public awareness about mental illness, chronic unemployment, poverty, lack of recreational and social services and loneliness and isolation.

Dear et al. advocated the creation of more sheltered workshops, greater opportunities for social activity, and policy changes leading to better quality and choice in housing. Dear and Taylor (1980) focussed on the impact of de-institutionalization on the community, specifically the relationship between public attitudes toward the mentally ill and reactions toward community mental health centres. The researchers found that neighbourhoods with low social cohesion, especially those areas in the inner city with a highly mobile population and mixed land use were either unaware of the presence of a community mental health care facility in their areas, or were "accepting" of this facility. By contrast, the researchers found that those neighbourhoods with high social cohesion, in stable suburban areas were typically "rejecting" of this facility.

The ethnographically-based literature discussed above can be credited for providing us with a fresh outlook on the

phenomenon of deinstitutionalization and on deinstitutionalized mental patients--an approach that places this phenomenon within its cultural context and focusses on the impact of this movement upon the relatives of ex-patients, upon the community, and upon the ex-patients themselves. However, I would argue that such studies have only just begun to explore the social impact of this movement. We need to conduct more research along these lines in order to obtain a holistic understanding of the deinstitutionalization phenomenon. Moreover, with the exception of Dear et al. (1980) and Dear and Taylor (1980), little research has been conducted on the impact of deinstitutionalization on Canadian families, communities, and ex-psychiatric patients. It is the purpose of this dissertation to fill such a neglect. Specifically, this study seeks to obtain a subjective understanding of the impact of the deinstitutionalization movement upon Canadian ex-mental patients. This study seeks to find out what the everyday lives of Canadian ex-patients is really like. Moreover, this study addresses whether (or how) ex-patients "make it in the community"--the strategies by which such persons physically survive, and the manner/strategies ex-patients employ in dealing with the outside world. Further, this research addresses the issues of "identity" and "identity transformation"--whether, upon discharge from the hospital, such persons possess a "deviant", "abnormal" conception of self, and if so, whether these persons merely accept this

redefinition of self and its corresponding social status, or do they, actively attempt to change this deviant identity.

SUMMARY

This chapter has surveyed the literature pertaining to the topic of deinstitutionalization and deinstitutionalized psychiatric clients. In so doing, the theoretical approach was clarified, and major questions guiding the research were elucidated. The methodology employed to answer such questions will be presented in Chapter Four.

NOTES

1. Each discipline has compiled bibliographic reviews of the existing literature in their area. See, for example: Bloom, 1968; Driver, 1972; Pearsall, 1963; Stewart, 1982; Lieban, 1973; Fabrega, 1972; Test and Stein, 1978.
2. Given that I have detailed the theoretical literature in Chapter Two, I will limit my discussion here to the experimental, follow-up, evaluative and ethnographic research on the topic.
3. For a discussion of the medical model approach to the study of mental illness see: Herman (1981); Lewis (1967); Seigler and Osmond (1974); and Whybrow (1972).
4. For example, operational definition of variables, and statistically testing apriori hypotheses using interview data or data obtained from official records.

CHAPTER FOUR

METHODOLOGICAL ISSUES

The preceding chapters discussed the primary areas of concern of this thesis, the general theoretical orientation within which it is conducted, relevant concepts, followed by a discussion of previous research findings and literature on deinstitutionalized and discharged mental patients, and on the deinstitutionalization phenomenon in general.

This chapter focuses attention upon some of the methodological issues involved in the study. It begins with a discussion concerning the decision to employ certain qualitative research methods for the purpose of data collection, the specific social settings and sample chosen, background characteristics of the research subjects, the manner by which access was obtained, and the tactics and strategies employed by the researcher in the research process.

We can, and I think must, look upon human life as chiefly a vast interpretative process in which people, singly and collectively guide themselves by defining the objects, events and situations which they encounter.... Any scheme designed to analyze human group life in its general character has to fit this process of interpretation (Blumer, 1956:686) (emphasis added).

In reaction against certain scholars (most notably,

Merton, 1967) who advance the argument that there exists little connection between theorizing, research methods and research topic, this dissertation, maintains as do Becker (1970); Blumer (1931), (1940), (1954), (1956) and (1969a); and Garfinkel (1967), that such phenomena are inextricably connected. Theoretical perspectives cannot be judged without reference to research activities. So too, are research methods rendered useless unless they are viewed with reference to specific theoretical perspectives. Furthermore, one's research topic and findings are of little importance unless such information is firmly planted within a particular theoretical approach and collected using reliable and valid research methods. In short then, theory, methodology, and problem do not stand at some distance from each other, but rather, are interrelated in nature.

As was stated in Chapter Two, the symbolic interactionist perspective assumes that: (1) reality as we know and comprehend it, is entirely a social product. Interacting individuals collectively create and define their definitions of situations; (2) moreover, humans are assumed to be capable of engaging in "minded," "self-reflexive" behaviour. As such, individuals are not only capable of shaping and guiding their own actions but also the actions of others. (3) Interaction is conceived by interactionists to be an emergent, negotiated phenomenon; interaction is symbolic in the sense that it involves the creation, utilization and manipulation of words, meanings and symbols. According to the symbolic

interactionist perspective, in order to gain an understanding of human behaviour, one must take the role of the other. That is, one must attempt to understand behaviour, not from within the context of his/her own experiences and frames of reference, but from the actors' point(s) of view. Understanding, in this perspective, entails being socialized into the group that one desires to understand. It is only in this manner, according to interactionists, that one acquires a knowledge of the symbols, meanings and referents of a particular social group. The data described in this dissertation were collected through participation with ex-mental patients while attempting to gain an understanding of their world--by sharing in their definitions of the situation and constructions of reality.

In order to learn the meanings that the ex-psychiatric patients define as being important and real, an open-ended scheme was chosen and employed. The underlying interactionist orientation led the researcher to adopt and utilize a qualitative and inductive methodological approach--primarily, participant observation¹ supplemented with informal and semi-structured interviewing techniques.²

Severyn T. Bruyn (1966:14) discussing the method of participant observation states:

The participant observer... considers the interpretations of his subjects to have first importance... What is especially distinctive about the method of participant observation is the manner by which the researcher gains knowledge. By taking the role of his subjects he re-creates in his own imagination and experience the thoughts and feelings which are in the minds of those he

studies. It is through a process of symbolic interpretation of the "experienced culture" that the observer works with his data and discovers meanings in them... The intent of the participant observer is to "catch the process as it occurs in the experience of those he studies.

In short then, rather than adopting a positivist/empiricist stance and beginning with a priori theories and hypotheses, operationalizing variables and statistically examining the relationships among certain variables--examining phenomena "objectively," this study approaches the topic of deinstitutionalized mental patients without any preconceived theories or notions; hypotheses and theories are not statistically tested but are generated as a result of intense participation and observation, on the part of the researcher, with the subjects in their natural settings. In contrast to the natural empiricist approach, the methodological approach adopted for the present study seeks to gain a "subjective understanding."³ Descriptive, qualitative data are collected on the nature of life of the deinstitutionalized mental patient. Through the adoption of this qualitative and inductive methodology, this study seeks to gain an empathetic understanding of the everyday world of the deinstitutionalized psychiatric client. It seeks to grasp the reality of these persons as they, themselves, construct, define and experience it. Advocating a methodological approach that engages in a direct examination of the empirical social world, Blumer (1969:34, 39) states:

...what is needed is direct examination of the empirical world.... This world is the actual group life of human beings. It consists of what they experience and do, individually and collectively, as they engage in their respective forms of living; it covers the large complexes of interlaced activities that grow up as the actions of some spread out to affect the actions of others; and it embodies the large variety of relations between the participants.... The empirical social world, in short, is the world of everyday experience, the top layers of which we see in our lives and recognize in the lives of others. The human life of a human society... consists of the action and experience of people as they meet the situations that arise in their respective worlds. Ongoing group life... is the empirical social world of the social and psychological sciences... the researcher has to get close to this life to know what is going on in it.... The task of scientific study is to lift the veils that cover the area of group life that one proposes to study. The veils are not lifted by substituting, in whatever degree, preformed images for firsthand knowledge. The veils are lifted by getting close to the area and by digging deep into it through careful study. (emphasis added)

RESEARCH SETTINGS, SAMPLE EMPLOYED, INTERVIEWING SCHEDULE AND DATA ANALYSIS

This study is based on approximately twelve hundred and twenty hours of participant observation, informal and semi-formal interviewing⁴ with two hundred and eighty-five subjects living in the Southern Ontario area.

In terms of research settings, descriptive data on the nature of deinstitutionalized patient social life were gathered from January, 1981 to September, 1981 during weekly group therapy sessions, arts and crafts sessions and various social activities in the community psychiatry department of

a large, general hospital. Moreover, from September, 1981 to September, 1984, descriptive data were gathered on de-institutionalized mental patients in such social settings as drop-in centres, self-help group meetings, activist group headquarters, sheltered workshops for the emotionally-disabled, non-sheltered places of employment, psychiatric hospital canteens, boarding homes and in individuals' homes.

Turning to the sample itself, upon receiving consent from the Ethics Committee of a large, general hospital, a disproportionate, stratified random sample of three hundred former mental patients was obtained from a listing of discharged psychiatric clients.⁵ The rationale behind this decision to obtain a disproportionate, stratified random sample was two-fold: (1) firstly, I was concerned with sampling issues to ensure that the findings/observations discovered would be typical not only of those ex-patients studied, but could also be generalized to other ex-patients in the population; (2) secondly, this sampling technique was adopted and employed not only to increase the generalizability and theoretical relevance of the behaviours to be observed. A disproportionate, stratified sample of ex-mental patients was obtained based upon interest and prior field-work on the part of the researcher.⁶ Specifically, my own prior research seems to indicate that when we speak of "de-institutionalized psychiatric clients," we cannot merely assume that they are one homogeneous grouping of individuals with similar characteristics; similar post-hospital social

situations, experiences and perceptions of reality. Rather, preliminary research leads me to believe that, we may, in fact, be dealing with distinct sub-groups of individuals with varying perceptions of reality and experiences. Thus, in an effort to acquire a more complete picture of what may or may not be the varying social worlds of deinstitutionalized mental patients, I sought to obtain a stratified sample that would include various types of ex-patient, and hence, provide the basis for a comparative examination. In short then, disproportionate, stratified random sampling techniques were employed not solely for the purpose of generalizing the data to the level of the population, but by stratifying the sample disproportionately, this would allow the researcher to be able to make meaningful comparisons among certain subgroups of ex-mental patients--to compare definitions of situations and constructions of reality of various ex-patients in Canadian society.

On the basis of prior research, theoretical considerations, and present research concerns, the research population (discharge list) was divided into the following strata of subgroups according to age,⁷ chronicity,⁸ and type of hospitalization:^{9, 10}

- (A) SUBGROUP A. ELDERLY, LONG-TERM INSTITUTIONALIZED EX-PATIENTS
- (B) SUBGROUP B. MIDDLE-AGED, LONG-TERM, INSTITUTIONALIZED EX-PATIENTS---

- (C) SUBGROUP C. YOUNG, LONG-TERM, INSTITUTIONALIZED
EX-PATIENTS
- (D) SUBGROUP D. ELDERLY, SHORTER-TERM, HOSPITALIZED
EX-PATIENTS
- (E) SUBGROUP E. MIDDLE-AGED, SHORTER-TERM, HOSPI-
TALIZED EX-PATIENTS
- (F) SUBGROUP F. YOUNG, SHORTER-TERM, HOSPITALIZED
EX-PATIENTS

A random sample of 50 persons was subsequently obtained for each subgrouping. While a total of three hundred persons were selected for this study, it is important to point out that only two hundred and eighty-five such persons actually participated in the study. Due to reasons of refusal, death, inability on the part of the researcher to locate subjects, and bureaucratic mix-ups, fifteen potential subjects could not be studied. (See Table 1 for specific details.) In short, then, those who were interviewed, and upon whom subsequent participant observation was conducted (among several others), constituted 95 percent of the original sample.

I initially interviewed 285 ex-psychiatric clients, mostly in their homes or after group meetings. The interviewing was unstructured and varied somewhat with each interviewee, according to the apprehension encountered in overcoming the subject's initial fear and distrust in speaking to me. In general, the interviews lasted approximately one and a half hours.

Arrangements for an interview were made by telephone. The potential subjects had received a letter prior to the

TABLE 1

SUBGROUP A. ELDERLY, LONG-TERM, INSTITUTIONALIZED, EX-PATIENTS

	<u>N</u>	<u>%</u>
Informal Interviews and Participant Observation.....	46	92
Refusals.....	1	2
Letter Requesting Participation not received.....	0	0
Deceased.....	3	6
Unable to locate.....	0	0
	<u>50</u>	<u>100</u>

SUBGROUP B. MIDDLE-AGED, LONG-TERM, INSTITUTIONALIZED

	<u>N</u>	<u>%</u>
Informal Interviews and Participant Observation.....	47	94
Refusals.....	0	0
Letter Requesting Participation not received.....	0	0
Deceased.....	0	0
Unable to Locate.....	3	6
	<u>50</u>	<u>100</u>

(CONTINUED...)

SUBGROUP C. YOUNG, LONG-TERM, INSTITUTIONALIZED EX-PATIENTS

	<u>N</u>	<u>%</u>
Informal Interviews with Participant Observation.....	46	92
Refusals.....	1	2
Letter Requesting Participation not received.....	0	0
Deceased.....	1	2
Unable to locate.....	<u>2</u>	<u>4</u>
	50	100

SUBGROUP D. ELDERLY, SHORTER-TERM, HOSPITALIZED EX-PATIENTS

	<u>N</u>	<u>%</u>
Informal Interviews and Participant Observation.....	47	94
Refusals.....	1	2
Letter Requesting Participation not received.....	0	0
Deceased.....	2	4
Unable to locate.....	<u>0</u>	<u>0</u>
	50	100

(CONTINUED...)

SUBGROUP E. MIDDLE-AGED, SHORTER-TERM, HOSPITALIZED EX-PATIENTS

	<u>N</u>	<u>%</u>
Informal Interviews and Participant Observation.....	49	98
Refusals.....	0	0
Letter Requesting Participation not received.....	0	0
Deceased.....	0	0
Unable to Locate.....	1	2
	<u>50</u>	<u>100</u>

SUBGROUP F. YOUNG, SHORTER-TERM, HOSPITALIZED EX-PATIENTS

	<u>N</u>	<u>%</u>
Informal Interviews and Participant Observation.....	50	100
Refusals.....	0	0
Letter Requesting Participation not received.....	0	0
Deceased.....	0	0
Unable to Locate.....	0	0
	<u>50</u>	<u>100</u>

phone call outlining the aims of the project; voluntary participation (see Appendix C) and my academic credentials.

I would call up a person, introduce myself and ask if they had received the letter. I would then generally discuss the nature of the study, the short duration of the interview, and would ask if they would be willing to participate in the study.

The interviews were conducted using a written questionnaire (see Appendix A), orally administered to the subjects. In addition, initially, I used a tape recorder but discovered that most subjects were intimidated or distracted by its presence, therefore, I disbanded the practice. Upon completion of the interview, I would go to my car and write down verbatim additional information that I did not have time to write down on the questionnaire during the session.

If the subject responded positively to myself and the study, I would ask if he/she would allow me to attend various functions and activities in which he/she was involved in the community. In addition to the interview date, this allowed me to gather both observational data and participant-observational data on the ex-psychiatric patients with other ex-patients and with "normal" societal members. In fact, many of the persons interviewed, allowed me to tag along with them, sponsored me into various ex-patient groups, and allowed me to talk with many other ex-psychiatric patients.

Without such sponsorship, it would have been far more difficult, if not impossible, for me to conduct participant observation on so many persons.

With respect to the field settings, I did not use a tape recorder because I felt that it would be equally distracting. Whenever important information was provided and I wanted to ensure that I would record the statement verbatim, I would excuse myself, go to the washroom and write it down in a small notebook. Each time, I left the field, (approximately after 3 hours) detailed fieldnotes were typed up on my experiences and observations in the field.

The qualitative data analysis for this study, (as with other inductive studies) occurred both during and after the investigation had been completed. In terms of the former, everytime I left the field, typed my fieldnotes, I sat back and appraised the data, determined the directions it was taking me, and determined if and how it might be integrated with the data I had previously collected. The analytical data served to provide me with a guide for the kind of information to be sought next. This joint collection, coding of themes, development of classes and linkages, and data analyses allowed me to formulate a substantive theory as it emerged from the data, in addition to providing support for the theory's credibility.

Upon leaving the field, the themes, patterns, processes and their meanings, which were analysed simultaneously

with the collection of data, were then subjected to further analysis, pieced together, organized, upon which descriptive and analytic conclusions were drawn.

ETHICAL CONSIDERATIONS

Examination of the literature reveals that a great deal has been written on ethical issues associated with qualitative research methodologies. In specific, addressed extensively in the literature are questions concerning ethics of concealment,¹¹ violations of the investigator's code of ethics,¹² the value-laden nature of sociological research,¹³ alterations in research interests and activities,¹⁴ accountability,¹⁵ and issues related to confidentiality.¹⁶

In terms of the present study, the researcher was faced with a number of ethical decisions prior to, during, and after the fieldwork had been completed. Specifically, in the pre-fieldwork stage of research, a decision had to be made regarding whether to engage in overt or covert research. While some scholars¹⁷ vehemently oppose concealment in favour of overt research, others,¹⁸ advocate, and make justifications in favour of covert research. Admittedly, while there are both advantages and disadvantages of adopting each approach,¹⁹ it is up to the researcher, in the final analysis, to weigh the pros and cons of each approach, in conjunction with his/her own code of ethics, and make a decision concerning the manner by which the topic will be investigated. The

decision to conduct overt research on deinstitutionalized mental patients was made after a careful consideration of the following:

- (1) my personal definition of what is "ethical;"
- (2) the pursuit of knowledge at what price?
- (3) the responsibilities of the researcher to the subjects;
- (4) prior research experiences with mental patients;
- (5) guidelines set forth by the University Ethics Committee and Hospital Ethics Committee.

Examination of my personal ideas concerning what constitutes "ethical" research, reveals that I do not fall firmly in the camp of "ethical absolutism"²⁰ in the sense that I do not believe that one set of ethics should uniformly apply to all social researchers in all social situations; adopting a more relativist stance, I believe that ethical decisions should be left up to the conscience of the individual investigator. My position on ethical research is as follows--I believe that, I, as a researcher, do not have the "right" to invade the personal privacy of any individual or social group; as a result of this stance, covert research strategies could not be "ethically" used to gather data. While some researchers (e.g. Denzin, 1978; Dalton, 1964) justify the use of covert research strategies by stressing the primary importance of "science for science's sake," or "knowledge for knowledge's sake,"--a position in which the rights of the subject take a subordinate role and emphasis is, instead, placed on the

advancement of scientific understanding, I feel that I do not have the right to know--to pursue knowledge (even if it is for science's sake) without the knowledge and expressed consent of the subjects that I desire to study. Covert research, according to my own moral code, denies potential subjects individual freedom to choose, autonomy, and represents an invasion of privacy on the part of the researcher. In short then, this personal view of what constitutes ethical research along with a consideration of what my responsibilities as a researcher are to potential subjects--such issues were major factors influencing my decision to conduct overt research on deinstitutionalized mental patients.

Another factor influencing my decision to conduct unconcealed research rests not on ethical concerns, but rather, centres on my prior research experiences with institutionalized mental patients.²¹ For my Master's thesis, partially as a result of personal definitions of "ethical" research, combined with my supervisor's view on open/disguised research, I conducted research on institutionalized patients overtly. While a number of difficulties arose prior to, during and after the fieldwork had been completed, such problems were not related to the subjects under investigation; rather, they were associated with the psychiatric gatekeepers and institutional staff--the former who continually tried to gain "control" over the study, and the latter who, despite my repeated efforts to inform them, conceived of me as a "spy" who was

there to "expose them." Despite bureaucratic problems with psychiatric officials, access was obtained to the psychiatric wards; after a period of passive observation, I gradually began to establish rapport with the patients. From the outset of the study, all of the subjects were informed about my identity and my purpose for being at the hospital; upon gaining their trust and establishing relationships, I was subsequently able to collect a wealth of information on the moral career of the mental patient. For this reason, I felt that I would also be able to conduct overt research on de-institutionalized mental patients--be able to establish relationships, develop rapport and obtain detailed information on their post-hospital experiences and constructions of reality.

Just as my decision to conduct overt research was influenced by my personal ethical code, a consideration of my responsibilities as a researcher to the subjects under investigation, and my previous research experiences with mental patients, so too, was this decision influenced by one final factor--namely, the Ethics Committee of the hospital from where the list of potential subjects was obtained, and the Ethics Committee of the university where I was earning my doctorate. These committees would allow the project to proceed only if certain "ethical" conditions were met:

- (a) only overt research would be done by the researcher;
- (b) the obtainment of written and verbal consent from the subjects prior to the investigation; (c) protection of the

identities and rights of non-participants; (d) guarantee and maintenance of confidentiality with respect to the subjects under investigation. In conjunction with the conditions set forth by the two committees, and in accordance with my own ethical code, the following conditions were mutually agreed upon:

(1) The researcher would use overt research methods for the purposes of data collection;

(2) In order to fully protect the rights and identities of ex-patients who may not desire to participate in the study, it was agreed that the researcher would not initially view the names of those individuals on the hospital discharge list. Specifically, each name on the list was assigned a number²² and a stratified random sample was subsequently obtained. Upon drawing the sample, a letter was sent on my behalf to potential subjects outlining the general nature of the study, the identity and affiliation of the researcher, and asking for the subjects' permission to interview them. The letter stressed that participation was strictly voluntary and their refusal to do so would, in no way, affect their ability to secure future psychiatric treatment. Moreover, the letter emphasized that all materials gathered from the interviews would be strictly confidential, and in no way, would their identities be revealed (See Appendix C for copy of letter of introduction).

After approximately two weeks, a follow-up telephone call was made to the potential subjects asking whether they

received the letter, and if so, would they be willing to participate in the study. A list of the names of those agreeing to be studied was subsequently given to the researcher.

(3) In accordance with my own ethical code and in compliance with the ethical guidelines set forth by the two Ethics Committees, upon contacting the subjects, I explained the nature of the study, my identity, that subjects were being interviewed on a voluntary basis and that it was not mandatory to talk with me. The maintenance of confidentiality was verbally expressed to the subjects. If, upon verbal explanation of these issues, subjects desired to participate, they were given a written consent form to sign (see Appendix D). Subsequently, I was able to gather data by informally-interviewing and conducting participant observation on each subject.²³

Just as I was forced to make several ethical decisions such as those discussed above during the pre-fieldwork stage of research, so too, were ethical decisions made in the field, and even after having left the field. Specifically, in the course of my data collection, a number of ethical decisions related to the issue of confidentiality arose. On a number of occasions, and in a number of different social situations, "normal" others (i.e., psychiatric caseworkers, family members, boarding home managers) wanted me to inform or "squeal on" my subjects. For example, on one of my visits to a boarding home for ex-mental patients, the home manager took me aside and said: "Billy's been acting quite weird lately. He's been

violent with the other patients and he's talking about running away. If he tells you about escaping, be sure to notify me at once" (Observation #161, May 1984:4). On another occasion, in the home of a former patient, a family member told me: "My wife _____ is not the same as she used to be; one day she is higher than a kite and the next she's down in the dumps--when she gets like this she wants to kill herself. I'm afraid that she is close to the edge right now. Has she given you any hints or told you anything?" (Observation #276, August 4, 1984:17). In both these instances, and in other similar situations, I was faced with an ethical dilemma: (1) on the one hand, I realized that I had made a bargain with the subjects--whatever was told to me would be kept in strictest confidence; I felt that I, therefore, had an obligation to uphold this bargain; (2) on the other hand, the sensitive nature of some of the information told to me made part of me desire to intervene or prevent a phenomenon from occurring. In each of the situations, this ethical dilemma was ultimately resolved through the employment of non-interventionist strategies. Although, at times, such an approach was difficult to adopt, I chose not to intervene for two reasons: (1) I felt a higher sense of obligation to the subjects under investigation above and beyond my own personal code to intervene, if possible, to avert tragedy; (2) from a pragmatic point of view, I felt that such intervention may have been conceived by other subjects as "traitor-

ous", destroyed the rapport that I had established with them, and ultimately have led to the downfall of the research.

In sum, there are no quick and hardfast rules to follow when dealing with ethical problems related to field research. Each investigator, throughout the research endeavour, is confronted with a number of different ethical problems--problems for which solutions must be found. Since the fieldwork literature reveals that there exists no shared consensus concerning the researcher's ethical duties and responsibilities to both the respondents and to the discipline of sociology, it is up to the individual researcher then, to define what constitutes his/her ethical code, to clarify how much, if any, responsibility is owed to the discipline and to the subjects under investigation, to clarify the researcher's stance concerning the "rights" of the researcher to investigate all phenomena in the ultimate pursuit of knowledge, and to deal with ethical issues--to make ethical decisions in accordance with the individual-scientific conscience of the researcher.

GAINING ACCESS, LEARNING THE ROPES AND MAINTAINING RELATIONS, AND LEAVING THE FIELD: TACTICS, STRATEGIES AND PROBLEMS

Gaining Access

One of the major problems shared by all field researchers is "getting in"--obtaining permission to undertake a study and gaining access to those individuals with

whom you wish to interact and observe.

In my particular case, I needed to obtain a list of discharged psychiatric patients in order to be able to conduct the study--the acquirement of such a list and the subsequent access to the subjects was dependent upon approval of my project by the gatekeepers of a large, general hospital.²⁴ As Becker (1964:272) correctly notes, there exists an irreconcilable dichotomy between the interests of the researcher, on the one hand, and the interests of the gatekeepers representing the institution, on the other hand. It is thus, not surprising, given this dichotomy, that gatekeepers attempt to define, constrain and control the researcher's investigation: Institutional gatekeepers seek to ensure that the researcher's findings will place the institution and its activities in a positive light.

Based on prior experiences with psychiatric gatekeepers,²⁵ I prepared myself for a long and arduous series of negotiations with the official gatekeepers. However, to my surprise, I was granted relatively easy access to the list of potential subjects. Specifically, to receive official permission to obtain a list of ex-psychiatric clients, I attended an initial meeting with one high-ranking psychiatric official. I identified myself and explained that for my Ph.D. dissertation I was interested in examining deinstitutionalized mental patients. I described the theoretical underpinnings of the study and the methodological approach, emphasizing such ethical issues as: voluntary participation

in the study, non-violation of ex-patients' rights to privacy and non-identification, guaranteed confidentiality of data collected and anonymity of the subjects. I then handed the gatekeeper a research proposal detailing the issues discussed above. Upon reading the proposal, the psychiatric gatekeeper responded in a very positive manner. He suggested that in order to ensure that permission was not only granted, but also granted in an expedient manner, he would personally send a letter of approval on behalf of my research project to the Ethics Committee of the hospital. Upon submitting a cover letter and a copy of my research proposal to the Ethics Committee, I received, approximately one month later, written notification that my project had been conditionally approved--providing that the researcher would agree not to have free access to the names on the overall discharge list. In order to protect the identities of those not wishing to participate in the study--those individuals who desire not to be exposed, and in order to avoid litigation initiated on behalf of ex-psychiatric clients against the hospital for violating the right of confidentiality, the hospital gatekeepers requested that the researcher view and be given access only to the names of those individuals agreeing to participate in the study. In dealing with certain subjects, in certain social settings, some researchers have found that the nature of the bargain that is finally struck between themselves and the gatekeepers functions to constrain maneu-

verability within those settings, may sometimes sabotage the study, and in some cases, may force the researchers to discard the entire project.²⁶ In my particular case, however, even though I was forced to comply with the gatekeepers' request, such an alteration in my methodological design did not interfere with the aims and goals of the study.

In retrospect, the ease with which the researcher was able to obtain a list of ex-psychiatric clients was due to two key factors: (1) sponsorship from a high-level psychiatric official; and (2) the researcher's acquired knowledge of learning how to "play the game." In terms of the former, that whenever possible, having someone associated with the institution "on your side"--someone from the inside to sponsor you, greatly facilitates one's chances of gaining access to various settings and subjects. In terms of the latter, I learned from previous experiences with psychiatric gatekeepers that obtaining access was facilitated by "playing the game"--that is, by learning to phrase my study in "scientific terms", by talking about "hypotheses" and "variables", and by constructing the type of research proposal with which the gatekeepers were used to dealing. This is not to say that I lied to the gatekeepers about my study; rather, I learned that in order to obtain access, it was vital to choose my phrases very carefully--by emphasizing the "open-ended" nature of the study, such an approach would inevitably be equated, on the part of the gatekeepers with

"un-scientific" research "lacking clarity and scientific rigor." Thus, I decided that to ensure access, the best strategy to employ was to avoid my "sociological jargon,"-- to leave such phrases as "open-ended, theory generation, subjective understanding, hanging around, participant observation, definitions of the situation and constructions of reality" at home, and attempt to phrase my study in a more "scientifically-acceptable manner."

Learning the Ropes and Maintaining Relations: In the Field

As Lofland (1976:8) notes, once the researcher obtains access to the social setting and subjects, there begins for him/her the task of attempting to "learn the ropes"--to attain an "intimate familiarity with the subjects under investigation. Some scholars contend that learning the ropes is either a process occurring prior to the commencement of the "real fieldwork," or that it is a process occurring simultaneously with the "real fieldwork." However, as Kleinman (1980:171) correctly emphasizes, "learning the ropes of fieldwork is not only coincident with doing the 'real fieldwork' of field research... but also a part of that process." Thus, there is analytical value in examining how a group responds toward the investigator; conversely, it is important to examine the researcher's feelings toward his/her subjects. During the initial stages of field research, and even thereafter, the researcher may experience feelings

of discomfort, self-consciousness or threat--such are important data as it allows the researcher to remain aware of his/her biases, preconceptions and subsequent role alterations as he/she begins to learn the ropes. In short then, learning the ropes is an integral part of the researcher's analysis of field data.

In order to learn the ropes, it is imperative that the researcher interact and participate in the lives of the subjects--to talk with, observe, to participate in various activities, to "hang around" (Becker, 1961; Glaser and Strauss, 1967; Whyte, 1955). In my study, I learned the ropes by conducting a number of informal and semi-formal interviews with the subjects, and by observing them and participating in their daily lives.

Turning firstly to the informal and semi-structured interviews, in an effort to learn the ropes, I adopted certain strategies or tactics. Specifically, upon initially meeting an ex-patient, every effort was made on my part to "take it slow." I introduced myself and outlined the general nature of the study; I emphasized that participation in the study was entirely voluntary, but that I would appreciate their participation. Moreover, I ensured confidentiality and anonymity. If the ex-patient desired to proceed, he/she was given an informed consent form to sign. During our initial meeting, I tried to put the subject at ease; we would generally talk about unrelated issues or issues that were non-threatening.

ing or impersonal in nature. By taking it slow during the first couple of meetings, I was able to establish rapport, to establish a relationship with the subjects--from there, I was able to proceed by asking more pertinent questions. While the majority of informal and semi-formal interviews went well in the sense that they provided me with a significant amount of information on the worlds of ex-psychiatric clients, there were, however, a few exceptions. For example, in my "zeal" to learn the ropes on three separate occasions, I "came on too strong" at the outset. In these instances, I inadvertently began asking "too personal" questions without first establishing my trustworthiness with the subjects. As a result of these faux pas, one person asked me to leave and the other two informed me that such questions were "too personal to talk about." Despite these instances, the overall interviewing not only provided me with a wealth of information but most of my interviewees allowed me to participate and observe them in various social settings. Specifically, upon establishing rapport with the subjects, many invited me to attend and participate in such group activities as: activist group meetings, self-help group meetings, interact at drop-in centres, interact with subjects during breaks and lunch periods at a sheltered workshop, and interact with ex-patients who met on a regular basis at a local restaurant. Entering such settings with an ex-patient with whom I had developed trust and established a relationship facilitated

the fieldwork process; having someone "on the inside" sponsor me--to tell other subjects that I was "okay", allowed me to quickly develop rapport with such persons, and afforded me opportunities to begin to learn the ropes.

As researchers have noted,²⁷ during the first few days in the field, we often feel uncomfortable and anxious--such feeling result more frequently from preconceived ideas rather than from actual problems. In my particular case, anxieties during the first few days in the field (and even thereafter), were not primarily due to preconceived notions about mental patients or about being rejected; such anxieties were, instead related to constant confusions about my identity and role in the field. Despite my continual efforts to inform and re-inform ex-patients about my identity as a sociologist, many, nevertheless, conceived of me as a "social worker," and thus, on the basis of this misidentification, often asked me for advice and to solve specific problems they were facing. Similar to the problems experienced by Lopata (1980) in her study on American widows, I also found that, in the course of interviewing, some subjects would expect direct help or that I should offer advice regarding a particular problem with which they were faced. In these instances, I found it particularly difficult to face subjects in need--a need that I was neither trained to help with, nor was I able to intervene as such intervention would influence the reality that I was seeking to discover. In these situations,

I was forced to remain passive--not to offer advice of any kind, and to answer a question posed to me with another question--I asked the ex-patients how they thought they should solve their particular problems.

Just as problems arose throughout the course of the study regarding misidentification of my role as a sociological researcher, so too, did my identity as "female" pose problems with certain subjects. As Mann (1970) states, the researcher's identities of sex, race, perceived class, and other factors may influence his/her ability to collect data during the course of the project. My identity of being female was both a liability and an asset. Since over 55% of the subjects were male, my gender served to facilitate access to the subjects--such persons were "curious" and "interested" at the outset, but my gender subsequently functioned, in certain cases, to create problems. Some of the male subjects had never had a platonic relationship with a woman, and my academic interest in their lives was sometimes misconstrued as sexual interest on my part. When I responded to their sexual advances in a negative manner, such persons became confused and withdrew in some cases.²⁸ For the most part, however, in dealing with the male ex-patients, gender was not a problem.

Turning to the females in the study, my gender was, in general, an asset.²⁹ Given that we shared the identification of being female--this shared identification provided common ground, and thus, things to talk about during initial

encounters--i.e., such as relationships with men. This identity then, which was irrelevant to my researcher role, became a relevant part of the subjects' acceptance of me.

In summary, although I was faced with numerous problems in the field, by consciously attempting to take it slow at the outset, by respecting the ex-patients, by taking their ideas, goals and problems seriously, my subjects allowed me to learn the ropes--to achieve a subjective understanding of their social world.

Leaving the Field

Guided by a number of considerations, including time constraints, and even monetary constraints, the researcher, upon collecting sufficient data, makes the decision to leave the field, engages in a period of intensive data analysis and begins to write up the findings. While much has been written in the academic literature concerning strategies for "getting in", and what to do with the subjects once you have obtained access, less attention has been devoted to strategies and problems related to "leaving the field."³⁰ For me, leaving the field was prompted by two factors: (1) time constraints--I needed to leave in order to begin writing the dissertation, and thus, complete all my Ph.D. requirements by the Fall of 1985; (2) repetitions in the data--after being in the field for approximately three years, the data was becoming repetitious in nature; I had asked all the questions that I wanted;

I felt that I had a detailed understanding of the social world(s) of the ex-patients and that it was now time to leave the field. At the time, I thought that a complete break from the subjects was necessary in order to be able to conduct a systematic sociological analysis of the data. However, such a strategy led to certain problems. Specifically, approximately three weeks after saying good-bye to the subjects, I met one ex-patient during a chance meeting at which time he chastized me for "abandoning them" and for "making their lives empty." Needless to say, I was overcome with feelings of guilt and remorse. I realized that despite my repeated efforts to inform the subjects, throughout the study, that I was only going to be interacting with them for a specified amount of time, some ex-patients obviously expected me to continue to live up to my commitments on a permanent basis. Subsequent to this incident, I returned to the various settings and groups which I had been previously frequenting on a weekly basis, and apologized to the subjects. I re-explained my reasons for leaving the field, told them that I could not continue to participate and observe them indefinitely, but that I had not "abandoned" them. I agreed to keep in touch with the subjects and promised to visit various social settings from time to time--a bargain that I have kept thusfar.

In retrospect, the problems discussed above could have been avoided if I had not simply said good-bye and left.

the settings altogether at one time. Had I left the settings gradually--conducted participant observation less frequently and for shorter time-periods, and prepared the subjects (more than I did) for my final exit, such problems could have been averted, or at least, diminished.

WHOSE SIDE WAS I ON?

While the preceding discussions have centred on the tactics, strategies and techniques by which the data were collected for this study, I would argue that methodology encompasses other dimensions as well. Inherent in any methodological approach are the researcher's philosophies, values, and beliefs--such phenomena influence the way a study will be approached. The researcher's values and ideological beliefs determine the questions that are asked. In this study, I have attempted to let the ex-patients themselves determine what is important to understand. At the same time however, my own assumptions about out-patient housing and treatment facilities influenced the types of questions that I asked.

Although we, as sociologists, strive to employ technically-perfect methods for our studies, we will always achieve variance in our observations because we are social creatures subject to different ideologies, values and belief systems. According to Becker (1967), sociologists must face up to our problems; we must realize that throughout the fieldwork endeavour, we are forced to make numerous value

decisions. According to Becker (1967:239-47), the best that sociologists can hope for is to publically state our values and ideologies at the outset of a study and then to wait for the criticisms from others that will probably result:


We take sides as our personal and political commitments dictate, use our theoretical and technical resources to avoid the distortions they might introduce into our work, limit our conclusions carefully, recognize the hierarchy of credibility for what it is, and field as best we can the accusations and doubts that will surely be our fate.

According to Becker (1967), we state our beliefs and values publically for future researchers to examine; through cumulative research on the same topic, previous biases will either be supported or negated. In the end, all sides of a topic will be uncovered.

SUMMARY AND RESTATEMENT OF THE TOPIC

Throughout this chapter, I have devoted space to providing a description of the infrastructural elements upon which my study is constructed. In an effort to orient the reader, I have outlined the rationale behind using qualitative methods, specifically participant observation and informal interviewing, described the settings and sample obtained, provided a description of my relationships with the subjects, and addressed certain ethical considerations.

To recapitulate, this dissertation centres on the



social world(s) of Canadian deinstitutionalized ex-psychiatric patients. Adopting a symbolic interactionist perspective, specifically, a labelling approach, this study seeks to discover the meanings that the ex-patients themselves define to be important and real--an interactionist orientation leading the researcher to adopt and utilize a qualitative and inductive methodological approach. As was discussed in Chapter Two, a number of theoretical approaches have been employed to analyse the origins, rise and consequences of the movement toward deinstitutionalization. While each of these perspectives has contributed, in different respects, to our understanding of this phenomenon, I would argue that it is of equal importance to examine the impact of this movement from the points of view of the ex-patients themselves--those persons directly affected by this shift in policy and treatment. The utility of a symbolic interactionist perspective, lies in its ability to fill such a neglect.

As was discussed in Chapter Three, a multitude of research has been conducted on different aspects of the deinstitutionalization phenomenon ranging from its strengths, criticisms, origins, and goals, to follow-up studies of various ex-patient programmes and psychiatric tools. However, as I pointed out, little research has focussed on the consequences and impact of this movement from the subjective points of view of the ex-mental patients. With the exception of two studies, no ethnographic research has been conducted on Canadian ex-psychiatric patients. It is the purpose of

this dissertation to attempt to fill such a neglect. Specifically, this study seeks to obtain a subjective understanding of the impact of the deinstitutionalization movement upon Canadian ex-psychiatric patients.

If there is one major question that this dissertation seeks to answer is, "How or do persons, once defined and treated for mental illness, "make it on the outside?" By "making it," I am referring not only to the manner or strategies by which such persons physically-survive in the community--how they manage to meet basic human needs for food, shelter and clothing, but also, the manner by which ex-patients attempt to cope or deal with "normals" in the community. This study addresses the issues of "stigma," "deviant identity" and "identity transformation"--whether upon completion of their psychiatric treatment: (1) do all ex-patients possess conceptions of self as "deviant"? If so, (2) do such persons accept this redefinition of self permanently? Or, do they, instead, actively attempt to alter their deviant identities? (3) How do ex-mental patients become aware that they possess a stigma? (4) What strategies of stigma management are employed and adopted by ex-patients? (5) What are the implications of adoption of such strategies for identity transformation?

This study will now turn to a presentation of the ethnographic material on the social world(s) of Canadian ex-psychiatric clients. Chapter Five will deal with the career paths of Canadian psychiatric patients--the processes

by which short-term and long-term ex-patients came to be defined as "mentally ill," the type, nature and duration of their psychiatric treatments, and subsequently deal with the effects of such career paths on identity transformation.

Chapter Six will address the issue of stigma as it relates to ex-psychiatric patients--its nature and the processes by which such persons became aware that they possess a stigmatizing attribute.

Chapters Seven and Eight will deal with issues of stigma, techniques of stigma management and identity transformation as it relates to short-term and long-term ex-psychiatric patients respectively.

The final chapter will present an overview of the data on long-term and short-term Canadian ex-mental patients. The conclusions drawn from this study are presented, the contributions, limitations of the research, the implications for the sociology of deviance and for the sociology of mental illness are discussed, and suggestions are offered for future research.

NOTES

1. For a detailed discussion of the methodology of participant observation and qualitative methodology in general see: Bruyn (1966); Babchuck (1962); Bogdan and Taylor (1975); Clourel (1964); Filstead (1970); and Vidich (1955).
2. See Appendix A for copy of the interview schedule.
3. It was the aim of this investigator to enter into the lives of the subjects and obtain a personal understanding of their positions. Rejecting my ideas and beliefs as the primary source of knowledge, emphasis was, instead, placed on the interpretations of my subjects. By taking the role of the subjects, I was able to re-create in my mind and experience those same feelings and thoughts as my subjects.
4. I decided to employ both participant observation and informal and semi-formal interviewing techniques for the following reasons; in terms of the participant observation, although time-consuming and sometimes exhausting, I felt that it was absolutely essential that I get close to the subjects--participate and observe them in their natural settings over a period of time. Only in this manner would I be able to achieve a detailed, subjective understanding of the ex-patients' social world. I also employed informal, personal interviewing techniques and semi-formal interviewing techniques in this study. The former techniques were employed because of their flexibility--they allowed the researcher to use non-verbal cues such as facial and body expressions, tone of voice etc., to assist in the communication process and thus, avoid misinterpretation. Moreover, such techniques allowed the researcher to replace questions that are not understood or misinterpreted (both of which happened frequently with many ex-patients). Further, informal interviewing, allowed me to explore my areas or issues. Semi-formal interviewing techniques--cases in which the researcher administered a set list of questions to all subjects were employed in order to provide background information of the ex-patients and also acted as a check--a verification of data collected in the field.

5. The research population upon which the sample was subsequently drawn included all patients discharged from a government psychiatric facility in Southern Ontario between 1975 up to, and including 1981; moreover, the population included all patients discharged from psychiatric wards in general hospital facilities, and those treated as out-patients in community psychiatric clinics between 1978 to, and including 1981. Further, the population included a listing of all clients treated privately by a psychiatric team associated with a university hospital. Upon defining the research population, and given the comparative theoretical intentions on the part of the researcher, it was decided to include in the sample, the following types of ex-patients: elderly, middle-aged and young, long-term male and female ex-patients; and elderly, middle-aged and young, short-term ex-patients. The sample was stratified disproportionately to obtain an equal number of each type of ex-patient, and hence, allow meaningful comparisons to be made. Consult Appendix B for chart listing background characteristics of the sample.
6. Such fieldwork, occurring between 1979-1981 seemed to indicate that different types of ex-mental patients had different post-institutional experiences, conceptions of reality, and varied in terms of their ability to alter deviant self-conceptions. It was the researcher's desire, in this present study, to fully examine whether such differences exist.
7. For the purposes of this study, AGE was trichotomized in the following manner:

ELDERLY	=	60 years and up
MIDDLE-AGED	=	30 to 59
YOUNG	=	16 to 29
8. CHRONICITY, for the purposes of this study is defined not in diagnostic terms, i.e., "chronic schizophrenic;" rather, it is defined in terms of duration, continuity and frequency of hospitalizations. Specifically, chronicity is dichotomized into:

<u>LONG-TERM</u> (<u>Chronic</u>)	=	hospitalized for time-periods of two years or more
	=	hospitalized on a continual basis
	=	hospitalized on five or more occasions.

- SHORT-TERM = hospitalized for time-periods of
(Non-chronic) less than two years
- hospitalized on a discontinuous basis
 - hospitalized on less than five occasions

9. For the purposes of this study, HOSPITALIZATION refers to: those individuals treated primarily within the confines of a psychiatric ward in a general hospital (although such persons may have been treated, at one time or another, in a government psychiatric facility); the term INSTITUTIONALIZED refers to those individuals treated primarily within the confines of government psychiatric facilities.
10. In contrast to stratified random sampling techniques where upon dividing the population into strata, a random sample is obtained from each strata according to its percentage in the population at large--proportionate sampling, this study, instead, utilized disproportionate sampling techniques. That is, upon dividing the population into strata and then obtain a random sample of equal cases from each strata. The goal in this case is to select an equal number of cases to allow for meaningful comparisons to be made.
11. See Becker (1964); Dalton (1964); Douglas (1976); Erikson (1967); Fichter and Kolb (1953); Gold (1958); Hoffman et al. (1970); and Shils (1959).
12. See Denzin (1970); Barnes (1963); Habenstein (1970); Johnson (1975); Schatzman and Strauss (1973).
13. See Denzin (1970); Becker (1967).
14. See Denzin (1970), (1970a); Johnson (1975).
15. See Denzin (1970), (1970a); Shils (1959); Rainwater and Pittman (1967); Voss (1966).
16. See George and Jones (1980); Johnson (1975); Denzin (1970); and Schatzman and Strauss (1973).
17. For example Gold (1958); Erikson (1967); and Davis (1961).
18. Most notably Douglas (1976).

19. The covert approach provides access to certain research settings that would probably be defined if the subjects knew of the researcher's aims. It is also argued that if subjects are aware that they are being studied they will try to manipulate or change their behaviours--thus, justification for conducting covert research. While covert research allows the researcher to enter the setting without having to explain the study, scholars argue that there may be certain difficulties--specifically, undercover research unlike overt research may limit the range and depth of data collected. For detailed discussions concerning the advantages and disadvantages of both approaches, see: Erikson (1967); and Lofland (1961).
20. This is not to say that I condemn all those researchers who engage in covert research investigations. For me, however, covert research is personally unethical. I firmly believe decisions regarding whether one conducts overt or covert research, should be left up to the consciences of the individuals. Moreover, as Becker (1964) correctly notes, the social circumstances surrounding a study, may not only influence a researcher's choice concerning what type of research to engage in, but also may force the researcher to conduct a specific type of research.
21. See my M.A. thesis, Herman (1981) for details.
22. In order to protect the hospital from legal proceedings, gatekeepers requested that I not see the names of the individuals on the overall list; thus, the hospital could not be accused of violating patients' rights with respect to confidentiality.
23. During the course of personal and semi-formal interviews with the subjects, I was able to establish rapport and develop a trust with many of them--such a trust enabled me to subsequently enter into their worlds, to participate and observe them in their natural settings.
24. This particular hospital was an accredited teaching facility, affiliated with a number of general hospitals in the area--thereby having access to discharge records at these facilities. Obtaining permission to undertake the study at this particular hospital would grant me access to the sublists of clients discharged from all of these facilities.
25. See Herman (1981) for specific details.

26. See, for example: Haas and Shaffir (1978); Diamond (1964); Habenstein (1970).
27. See, for example: Geer (1964); Wax (1971); Gans (1968); Hughes (1960), among others.
28. In these particular instances, team research may have been helpful--specifically, a male member of the research team may have had greater success in detailing with some of the male ex-patients with whom I had encountered difficulties.
29. There was one exception--a female ex-patient saw me as a threat. During my interactions with a number of male patients at a drop-in centre, one female thought that I was invading her territory--that I "was trying to steal all her boyfriends away." As result of this misperception, the woman refused to speak with me--even after my repeated efforts to explain my identity and reasons for being at the drop-in centre.
30. One notable exception is Shaffir et al. (1980).

CHAPTER FIVE

CAREER PATTERNS OF EX-PSYCHIATRIC PATIENTS: SHORT-TERM VS. LONG-TERM

It will be the purpose of this chapter to discuss the career paths of the subjects of this study--the processes by which such persons come to be defined as "mentally ill," (by whom and under what conditions), and the type, duration and nature of their psychiatric treatment. Subsequently, I will deal with the effect of career path on identity transformation.

Traditionally, the concept of "career" is used in relation to an occupation or profession where it refers to the phases of a person's expected or actual occupational activities. In this sense, career refers to the advancements or promotions accorded an individual within a certain occupation or profession.¹

Sociologists, particularly in the field of deviance, have expanded the meaning of this concept to refer to the temporal sequencing of actions in any sphere of life (both deviant and non-deviant), and not solely with reference to occupations and professions.² Erving Goffman (1961:168) discussing the nature of career states:

The moral career of a person of a given social category involves a standard sequence of changes in his way of conceiving of selves, including, importantly, his own. These half-buried lines of development can be followed by studying his moral experiences--that is, happenings which mark a turning point in the way in which the person views the world--although the particularities of this view may be difficult to establish.... By taking note of the moral experiences and overt personal stands, one can obtain a relatively objectively tracing of relatively subjective matters. Each moral career, and behind this, each self, occurs within the confines of an institutional system.... The self then, can be seen as something that resides in the arrangements prevailing in a social system for its members... the self dwells in the pattern of social control that is exerted in connection with the person by himself and those around him. This special kind of institutional arrangement does not so much support the self as constitute it.

The concept of career then, may be conceptualized as a movement of individuals through a social structure. The emphasis on sequence and process, invites explanations of how people move from one stage to another--the different stages symbolizing the transformation of their self-identities, social roles and statuses and, in this case, from "normals," to "deviants." At the same time, such stages allow persons to view themselves as moving along a continuum. Both Hughes (1958) and Goffman (1961) contend that the concept of career is two-sided in nature--that is, objectively, it can be conceived as a passage through various social roles and statuses. Subjectively, this concept refers to individuals' self-images and identities as they move through different institutions and organizations:

One value of the concept of career is its two-sidedness. One side is linked to internal matters held dearly and closely, such as image of self and felt identity; the other side concerns the official position, jural relations, and style of life; and is part of a publicly accessible institutional complex (Goffman 1961:127).

For sociologists the objective emphasis is placed on those social processes by which an individual committing an act (or acts) of non-conformity, comes to be defined as "deviant"--the type of rule-violations committed, the social audience viewing the individual, their responses, the role of official third parties in labelling and processing the person (i.e., the police, physicians, clergy, etc.), and the institutional processing to which the labelled individual is subjected. From a subjective standpoint, attention is directed toward the labelled individual him/herself--their feelings prior to, during, and after labelling and institutional processing--their self-conceptions.

It was the interest of the researcher, for the purposes of this investigation, to examine the moral careers of Canadian psychiatric patients not solely to gain an understanding of the processes and dynamics involved in the pre- and in-patient phases of their careers,³ but in order to ascertain whether the type of career path such persons follow affects the adoption of a deviant identity, and in turn, exerts an effect on the transformation of such an identity.

The data indicate that the ex-psychiatric patients in this study experienced one of two career paths:

- (1) SHORT-TERM CAREERS; or (2) LONG-TERM CAREERS:

I. SHORT-TERM CAREERS AS MENTAL PATIENTS

As a direct result of the ideological shift in policy and treatment of the mentally ill arising from the movement toward deinstitutionalization, significant numbers of individuals enter into short-term careers as "psychiatric patients." By "short-term," I am referring to individuals receiving psychiatric treatment on an out-patient basis, those entering into private therapy with a psychiatrist, those hospitalized for brief periods on the psychiatric ward of a general hospital, or those hospitalized for a short time in a psychiatric institution.⁴ Approximately one half of those in my study entered into such short-term careers. In general, I was interested in exploring the following: (1) the conditions under which individuals commence short-term careers; (2) the nature of the short-term career; (3) the social experiences of the individuals during the pre-patient and in-patient phases of their careers; and (4) the effects of such processing in terms of internalization and adoption of the deviant identity of "mental patient."

The short-term career of the mental patient begins when societal members react or respond--express discontent and/or take action against an individual committing a culturally-inappropriate act, and subsequently define him/her as "mentally ill." As Goffman (1961), Scheff (1975), Mechanic

(1962) and others have noted, labelling or defining an individual is not an automatic process-- a large proportion of culturally-inappropriate behaviour goes undetected, or even if it is acknowledged, it is rationalized by the social audience. Whether a person becomes defined as mentally ill is contingent upon several factors including the tolerance level of the social others, the social status of the rule violator in relation to his/her audience, the severity of the violation, and its visibility (Scheff, 1975:10).⁵

In my study, I discovered that the short-term career of the psychiatric patient began when various members of society reacted to individuals committing such inappropriate behaviours as: walking nude in the street, repeatedly providing inappropriate responses in the context of social interaction with others, threatening to harm oneself or others, entering into depressive states and failing to communicate with the outside world; damaging various household items, acts of arson, and violence against others for "no apparent reason." The mother of a young man committed after she discovered him walking nude along a highway near her home states:

My son never did anything like that before, or at least, I wasn't aware of it. But one night last summer, it was so hot that I couldn't sleep so I got up and went out on the porch. I know that "Dick" had been having some problems but I thought they were just growing pains and that he'd work things out. At that time, I had no idea of how sick he was. My daughter got up out of bed and told me that Dick was gone. We had no idea where he'd gone but we got in the car and started looking for him.... We looked high and low and finally after about an hour, just before

I was going to call the police, we found him on the QEW highway walking without a stitch of clothing on...he was so mixed up that he didn't even recognize us at first...that's when I knew that he must be mentally ill so I called my doctor to get him some help. (Observation # 46, October 3, 1981:2).

A number of agents and/or agencies play a role in the definitional process and subsequent hospitalization/treatment of the individual. As Goffman (1961:135) aptly states, these "circuit of agents--and agencies--participate faithfully in his passage from civilian to patient status." The data indicate that five such agents participated in the definitional process and subsequent treatment of the individual:

- (1) Self as Agent
- (2) Relatives as Agents
- (3) Friends as Agents
- (4) The Legal System as Agent
- (5) The Family Physician as Agent

Self as Agent

A number of individuals in the study began their short-term careers upon self-labelling their behaviours as instances of mental illness. Specifically, one-third of the sample,⁶ upon self-examination, defined themselves as being mentally ill above, and apart from, any societal reaction from others. Such a realization frightened such persons--a threatening self conception leading them to seek some sort

of psychiatric help. A middle-aged male, recounting his experiences during the pre-patient phase of his career states:

I knew I had mental problems for a long time. No one had to tell me... I started to forget things; I'd block out things that I didn't want to think about... I'd get all confused when someone would call upon me to do something on the spot... I'd be abusive and cranky... Everything bugged me... I was depressed all the time. It frightened me to no end. I was scared shitless about what was happening to me. This was the first time in my life that I wasn't fully under control. (Observation # 53, October 21, 1981:21).

Similarly, another individual states:

My problems started six years ago... I kept hearing people talking in my head--day and night, no matter where I was. I didn't know what was happening to me. It was so strange... These voices would tell me that my friends were turning against me... that they were going to hurt me... I was so frightened... I knew that these voices were just in my head but they also seemed so real. I was confused. I thought I was going "loony," and that scared me. When I realized this, I had to get help so I called my doctor. He was the one who would help me get the psychiatric help I needed. (Observation # 152, April 5, 1982:3).

In short then, for those individuals who were frightened by the strange or bizarre behaviour they were exhibiting, such persons, upon self-labelling, actively sought psychiatric help--that is, they entered into various forms of treatment voluntarily.

While some pre-patients enter into treatment voluntarily as a result of self-labelling, others, in the study, were forced into treatment involuntarily by a number of agents and agencies. This discussion will now turn to the

various agents and agencies that participate in such an endeavour, and subsequently, deal with the individuals' responses/reactions to such treatment.

II. Relatives as Agents

The data indicate that a number of individuals mark the beginning of their short-term careers as psychiatric patients when family members react and take action against an individual committing "strange" acts, or repeatedly failing to respond to the interpersonal demands of the other in the situation.

Specifically, during the pre-patient phase of his short-term career, the individual gradually discovers that his family members--those persons in whom he places complete trust, have begun to doubt his sanity; moreover, the pre-patient discovers, that in many instances, steps have been taken (behind his back) to "get him committed," or to enlist the help of various official third parties as the mental health officials, family physician, clergy, etc. in order to secure psychiatric treatment for the alleged mentally ill person. Such action, on the part of the relatives, is viewed by the majority of pre-patients as traitorous and conspiratorial in nature:

I'll never forget the events leading up to my hospitalization. It was awful. I thought that my mother and father loved me. I thought that I could trust them but I was wrong. They had

been planning to get me locked up for a long time. I didn't know nothing about what they were going to do to me, until one day I overheard my mother on the phone with the doctor talking about how she'd have to get me over to the doctor's office and then he'd take it from there. They were plotting against me all along. I never did anything to hurt them and that's how they reward me! (Observation # 153, April 6, 1982:4).

An elderly male ex-patient, recalling his experiences prior to hospitalization, states:

My wife and the kids were responsible. They were wheeling and dealing with all those so-called professionals to get me hospitalized--they did all of this behind my back. They really duped me! Just because I didn't want to sign over all my property and money to the kids, they decided to get me committed--they said I was abusive and violent. I never touched any of them in my life. My wife told me one day that I should go to the doctor for a "check-up." After we got there there was no turning back. The doctor who I had known for forty years turned on me also and said that they were going to send me to the hospital for tests. Before I knew it, they had me locked up on the psychiatric ward of _____ Hospital. No one told me what they had planned for me... no one consulted me...they did all of this behind my back... (Observation # 169, May 10, 1982:6).

In short then, many individuals discover, during the initial stages in their short-term careers, that relatives function as part of the "betrayal funnel" (Goffman, 1961:140)--the ones upon whom they thought they could depend and trust, have betrayed them, a betrayal that is not easily forgotten:

I know that I was only in the hospital for about a year but it was the principle of the thing that I can't forget. All your life you think that your wife and kids respect you--they believe in you and care about your feelings, but then, all of a sudden, they turn on you...All of a sudden you're reduced from a full-fledged person with rights to an object that everyone pushes around--

an object that has no rights at all. These people who I thought I could trust conspired against me and they betrayed me. I'll never be able to forgive them for that.... They could have told me what they were up to or asked what I felt about the situation,, because, after all, it was my life that we were dealing with, but they completely ignored me...I hate them for that! (Observation #200, October 1, 1983:32).

III. Friends as Agents

Many individuals in this study began their short-term careers as mental patients as a result of self-labelling or societal reaction from relatives, some also begin their careers as a result of reaction on the part of friends.

While friends may, for a time, rationalize or justify the individual's "strange" behaviour, at some point, such accommodative patterns break down. Specifically, when friends were confronted with an unmanageable emergency--crisis situation, they moved toward defining the individual as "mentally ill."

A neighbour of a young man hospitalized for exhibiting strange behaviour recalls:

I watched "Jack" for a couple of months. At first I thought he was just over-worked--that's why he was so grumpy--that's why his temper would flare-up over nothing. At first I just kept making up excuses for why he was acting weird... It wasn't until about a month and a half later that I met up with him on the back stairs one day and he went "berserk"--he said that I was the Devil's son and I was trying to kill him. He cursed me--he called me every name under the sun. He kicked and punched me around so much that I thought he was going to kill me for sure. It was then that me and my wife realized that the guy had gone

"mental" so we called in the police and had him committed. (Observation # 202, October 3, 1983:12).

Similarly, a girlfriend of an individual hospitalized on a psychiatric ward of a general hospital, recalls the events prior to such hospitalization:

"Victor" and I had a good thing going for a while. We lived together for eight years before I realized that he had serious problems. He used to be moody and not talk for days at a time, but each time this happened, I thought that something was bugging him on the job--that he was under too much pressure from the foreman. So I just let things go. Even when he got into more of a depression, I just shrugged it off--I chalked it up to the job... but then there came a time when he didn't talk for a long time and I asked him about it and he just blew up--he got real violent and picked me up and threw me against the wall. He cracked my elbow and I got a concussion. It was at that time that I finally woke up and realized that he had "gone nuts," so I decided to get him help before it was too late. (Observation # 10, September 25, 1981:4).

Another respondent recalls the circumstances leading to her friend's hospitalization:

"Miriam" used to be so happy all the time. She was a wonderful woman. All the children on the street liked her and she liked them. But after her husband died, she became introverted. She went outside less and less. She used to love to sit outside on the porch but then she became afraid. At first the neighbours, we thought that she was just grieving her husband's passing, so we let her be; but then we noticed that she would never answer the door when people called on her. Never would she turn a light on in her house at night...she retreated from the real world. One day, the gas people knocked on my door saying that we had to leave the house because of an apparent gas leak...I rushed over to Miriam's and called on her to open the door but she wouldn't. I looked through the window and saw her sitting there in

her chair. I knew she heard me but wouldn't answer. It was then that I called the emergency number for help. I called her daughter who lives in _____ and told her that her mother had gone insane. (Observation # 201, February 1, 1984:15).

While some friends move toward defining an individual as mentally ill as a result of a crisis, others, may, come to the same conclusion as a result of repeated failures, on the part of the pre-patient, to respond to the interpersonal demands of the others in the situation. As one friend, recalling the social experiences with the pre-patient prior to hospitalization, states:

Mike eventually went off into his own little world. I would ask him a question, and either he wouldn't answer, or he'd give me an answer that did not fit the question at all...He'd laugh when he was supposed to cry...He'd be quiet when he was supposed to talk...When I'd try to talk to him about work, he'd talk to me about church.... Things just didn't fit.... After putting up with that for a few months, I came to the conclusion that he was going "bonkers" so I took it upon myself to call up his priest who, in turn, called his family and they sent him for help. (Observation # 34, September 30, 1981:7).

Similarly, another friend recalls:

I gradually realized that something must be wrong with Mary. Nothing clicked. She wasn't making sense anymore. She'd say the most inappropriate things. It was so embarrassing at times. When we'd go out for a drink after work just to unwind, she'd play up to guys at the bar and when they'd come on to her, she'd call rape right there and then. Then she'd turn to me and said that I enticed them over.... At work, I'd cover for her when she said she couldn't cope, thinking that she'd get better soon, but things just got worse.... I finally realized that she needed psychiatric help so I told my boss who took it from there... (Observation # 238, May 15, 1984:2).

In short then, the short-term career of many mental patients begins when friends notice and react to "strange" or "peculiar" behaviour exhibited by a person. Although friends may initially rationalize or minimize the peculiarity, however, if the person repeatedly fails to respond appropriately to the interpersonal demands of the other in the situation, or if a crisis develops, such persons move toward defining the individual as "mentally ill" and take action.

How does the pre-patient feel about the action being taken by his "friends" during the initial stages of his moral career? The data indicate that, similar to the case where family members act as agents, friends who take such action against the individual are also seen as "traitors." One individual, discussing the circumstances under which he discovered that his "long-time" friend had "betrayed" him states:

Joe and I had been friends for as long as I can remember. We did everything together. We bowled every Tuesday night, worked at the same factory ... that's why it was so hard for me to believe that he "turned on me." He went behind my back like a "Benedict Arnold" to the boss and told him that I couldn't do the job--that I was acting weird and that I was getting confused.... A couple of times I saw him whispering something to the boss and then they'd just stare at me.... Then I found out that the bugger "told on me." It was after that that the company put me on "sick leave." That meant that I had to get psychiatric help at _____ Hospital and they'd hold my job for me.... It wasn't so much that I had to get help that hurt me, but the fact that all of this was arranged behind my back. (Observation # 282, June 3, 1984: 17).

Similarly, a second person, discussing his feelings states:

You have no idea of what it means to have your best friend go behind your back and have you committed. I don't know why she did it... I never did nothing to hurt her or her family. She told me that I should go to the doctor with her because she had a sore back but when we got there I found out that she didn't need to see the doctor at all.... It was for me... the doctor wanted to find out about my actions. My friend told him that I was acting strange--I was confused all the time and forgetting things... From the sound of the conversation, it was obvious that those two had gotten together before and planned the whole thing--they conspired to put me away, and even though I objected, they put me in the psychiatric ward for three months... I can't get over what an evil thing they did... I thought I could trust my so-called "friend." (Observation # 3, September 4, 1981:3).

IV. The Legal System as Agent

A number of persons mark the beginning of their short-term careers as psychiatric patients when legal authorities interpret their actions as evidence of mental illness and subsequently take action to admit them for observation/treatment. In this study, thirty-two individuals began such careers when legal authorities responded to the committing of "bizarre" or "bizarre criminal" acts. Specifically, legal authorities play a role in the transformation of the individual from "normal" to "deviant" status in two ways: (a) a person exhibiting "strange" behaviour is apprehended by the police and admitted directly to a psychiatric hospital; (b) a person committing an illegal offense (which may be bizarre in nature) is apprehended by the authorities and incarcerated. At a subsequent hearing, it is decided by the court to transfer the prisoner to a psychiatric hospital for evaluation.

On the first path, some persons, committing various residual rule violations, are apprehended by the police. According to a provision in the legal mandate, the police are given the authority to apprehend and hospitalize persons acting in a bizarre manner. While such a mandate functions to protect the alleged patient from harming himself or others, from the point of view of the person himself, the apprehension and involuntary commitment into a mental hospital is seen in a negative light. One individual, discussing the conditions under which he was committed and his moral outrage, states:

It was just awful. I never spoke any law. I was just sitting in a park. They had no right to touch me. One minute I'm free and the next, I tied up being taken to the mental ward...they never should have done that to me...It makes me so mad. Under the Charter of Rights, they can't do that to me and I told them so but they didn't listen. They're worse than Communists.... (Observation # 55, November 2, 1981:7).

Similarly, a second individual, recalls her experience with the police as a pre-patient:

I was at the bus station in _____ when they (the police) picked me up. They had no reason for doing it. I was sitting in the ladies' wash-room with my suitcases. I wasn't bothering anyone.... The cops didn't say much to me--I kept asking where I was going and what I had done wrong...the only thing they said was that I was probably mentally ill and that they were going to take me to a place where they would "help me." Little did I know what type of "place" they were taking me. How could they do that to me/against my will? (Observation # 18, September 10, 1981:23).

A third person, discussing his experiences with the police prior to hospitalization states:

It was the funniest thing. I was sitting in this shopping mall in Toronto right by a fountain. It was something I used to do from time to time. All of a sudden the security man and some cops came up to me and asked me my name and where I was from. Then they turned away and talked to each other so as I couldn't hear. They asked me to come with them and I said I didn't want to. I was really scared and started to cry. Why did they want me--I didn't do nothing wrong--I never broke no law. That's when they grabbed me and put me in cuffs and took me off to _____ hospital. I was so scared when they did that, especially because I wasn't doing nothing illegal.... They had no right! (Observation # 284, June 2, 1984:3).

Individuals interviewed in this study who were admitted to the psychiatric hospital by the police as a result of committing some residual rule violation generally felt that such action was not only unjust but outrageous in nature.

The data indicate that while some persons mark the beginning of their short-term careers when they are apprehended by the police for what they, themselves, feel is no apparent reason and are subsequently hospitalized, others, by contrast, mark such a beginning when legal authorities arrest them for committing various illegal offenses. Specifically, in this study, thirty-eight persons began their short-term careers upon being apprehended by the police for such offenses as: assault and battery, arson, rape, and vandalism. During a subsequent court hearing, upon hearing the details of the case, the sanity of the person is made an issue and they are transferred to a mental hospital for a psychiatric assessment in an effort to ascertain whether they are "fit to stand trial."

The moral experiences of these pre-patients are, in general, negative in nature. Most of these persons expressed feelings of fear, rage, objectification and hatred. One middle-aged male, recalling his experiences states:

I know that I burned down that store. And I also know that I was real mixed up at the time. But I hated what the cops did to me. They called me all kinds of names when they caught me. Then they started treating me as if I "wasn't all there." From the time they arrested me, people looked at me funny--I heard people whispering about me being "nuts." Even at the hearing, everyone treated me as if I wasn't even there right in front of them. When they said that I'd have to get checked out by a shrink--that I'd have to go to the "nut factory" I just about hit the roof.... After all, I wasn't nuts, I was just "mixed up." (Observation # 39, October 3, 1981:17).

Similarly, a second person recalls:

The cops caught me downtown beating up on some people. I really don't remember the details but I knew that I had to punch them out. I just couldn't stop myself. They cuffed me and took me to the station. Right from the start, they handled me with "kid gloves;" the one cop said they had to be careful with me because "nuts crack easily." They laughed and made a big joke out of it. But I wasn't laughing. I remember starting to cry at the time...I got so confused that I couldn't even remember my name or nothing... After the hearing they whisked me to the shrink hospital...I was so scared...I didn't know what was going to happen to me, and I sure didn't like going to a place full of "crazies." (Observation #8, September 11, 1981:10).

A third, female individual, recalling her experiences with the police states:

It was just awful. When they caught me stealing that meat from the store the cops were so mean. They frisked me all over to see if I was hiding anything more. They laughed. When they asked

me all these questions about who I was and where I was from, I got so confused. They made me cry. I just couldn't stop. One guy said I must be "mentally ill." When he said that it made things worse--it was like he put a knife through my heart. What a terrible thing to say! They moved me to the jail and later up to the hospital for treatment. All the time, it was like I was a piece of furniture--like I didn't know what was going on! (Observation # 220, April 2, 1984:3).

V. The Family Physician as Agent

Such careers begin when the family physician, upon viewing the person, officially labels him/her as mentally ill. The data indicate that twelve of those with short-term careers as psychiatric patients began their careers in such a manner. Some individuals, upon questioning their own sanity were diagnosed by their family physician for purposes of confirmation:

For a long time I knew that I wasn't quite "normal." I'd get confused and do things that I shouldn't be doing--or do things that made no sense at all. After I ended up in a place I had never seen before and couldn't remember how I got there, I decided I needed help. So I made an appointment to see my doctor. I had known him for years and he seemed to take me seriously. He suggested that I go for a few treatments at _____ Hospital in the psychiatric ward. (Observation # 233, May 12, 1984:23).

A second individual, discussing her decision to visit the family physician states:

I gradually began to unravel. I used to be a super cook; my house always used to be spotless. Then I began to let things go. Nothing seemed to be important anymore. I used to sit in my chair all day long worrying about things that happened

twenty years ago--things I couldn't change even if I wanted to. My mind was constantly spinning. At night, I couldn't sleep...After putting up with it for six months, I decided to visit Dr. _____. I confided all of this in him and he took it real well. He told me that I needed to talk my problems out and set me up with a good psychiatrist. (Observation # 118, March 23, 1982: 4).

For such persons, confirmation of their presumed "illness" on the part of the family physician and the suggestion of psychiatric "treatment" are seen in a positive manner:

You may not believe this but when the doctor told me that I had an emotional illness, I was so happy. I began to feel better right away. You see, for months before, I kept wondering--wondering if I was going nuts or not--did I have this or that? I kept all of this inside of me; I was like a time-bomb ready to explode at any moment. Not knowing was just about killing me. When the doc suggested I enter into therapy I was happy as a lark. (Observation # 8, September 6, 1981:3).

A second male patient, discussing his pre-patient experiences with the family physician states:

It was the happiest day of my life when Dr. _____ told me that I had a psychological "sickness." You know, it's the hardest thing going around day after day not knowing what's wrong--you may suspect what you've got, but you're not sure. Or even then, you may suppress the truth from yourself. I was so relieved when he confirmed my suspicions and ordered me to get help. (Observation # 111, January 5, 1982:32).

In contrast however, those individuals, who had not questioned their sanity or labelled themselves prior to hospitalization, and were taken to the doctor by a friend or relative, conceived of their situations as pre-patients in a different manner:

What the hell did they think they were pulling? There was nothing wrong with me back then. Frannie, my wife took me to the doctor one day and then they started firing all these questions at me. They expected me to respond right on the spot there. They were just waiting to trip me up. It was awful. My wife and that no-good quack tried to put me away--and in the end--they succeeded.... They said I was "psychotic" and a bunch of mumbo-jumbo big words and that I needed help right away or something bad would happen... I begged and pleaded with Fran and with the doctor too, but they signed me in against my will to the hospital. How could they do that to me? (Observation # 9, September 7, 1981:2).

Another individual, speaking of her feelings of resentment and betrayal states:

My mother and the doctor were in on it all the time right from the beginning. How could anyone do that behind someone's back. They planned the whole thing--mother said I should have another polio shot so she'd set up an appointment. When we got to the doctor's he started asking me all the questions; I wondered what was going on so I started to yell. But that only made matters worse--he told me not to "excite myself" and that I was a "very sick girl"; who was he trying to kid. There wasn't nothing wrong with me. I finally got it out of him that they were going to put me in the hospital--that he decided that was the best place for me... What a farce--here I came in to get a shot and the next thing I knew, he was sending me away to get "help." I trusted him all my life and he did that! I still can't believe it. I asked him, I begged not to go, but he didn't listen... no one listened... (Observation # 28, October 29, 1981:17).

In summary, the data indicated that the short-term career of the psychiatric patient begins when various societal members--in this case, the family, friends, legal agents, the family physician (and sometimes the individual him/herself) react and take action against a person committing various culturally-inappropriate acts. What happens to these persons once they are defined by others as being "crazy" or "mentally

ill"? This section will now turn to a discussion of the various types of psychiatric treatment to which short-term mental patients are subjected, and the effects of such treatment on the adoption of a new deviant identity, role and status.

SHORT-TERM PSYCHIATRIC TREATMENT AND DEVIANT IDENTITIES

Examination of the data on patients with short-term careers reveals that once such individuals are defined by themselves and/or others as being mentally ill, they subsequently follow one of four career paths:

- (1) Out-patient psychiatric counselling/therapy
- (2) Private psychiatric help
- (3) Short-term hospitalization and treatment on the psychiatric ward of a general hospital
- (4) Brief institutionalization and treatment in a psychiatric hospital

1. Out-patient psychiatric Counselling and Therapy

Forty-three persons in this study, upon official labelling were sent for treatment as out-patients at various community mental health centres or out-patient psychiatric units of general hospital facilities. In general, such treatment included periodic psychiatric counselling with a social worker, infrequent private sessions between the individual and his/her psychiatrist, and weekly or bi-weekly psychi-

atric group-therapy sessions. The data indicate that patients entered and remained in therapy for periods of two months to two and a half years (with many dropping out prior to completion of their program). One young man, describing his experiences as an out-patient states:

I've only had psychiatric counselling twice in my life--once about 15 years ago, after I came back from the war and last year. The first time I went in for help, it was at the advice of my home doctor who saw that I couldn't cope with life. I went to this psychiatric unit where they treat you but you don't have to stay there--you can stay outside and just drop by for appointments. That stint lasted for about two years and then I was OK again. They put me on this medication and trained me how to deal with stress in my life and how to look at things more positively... This last time I went for help, it was for the same problem, but this time, my boss at work sent me. I've been in therapy ever since and I'm not able to go back to work yet... I really don't like the treatment. Sometimes the nurse or social worker talks down to me; sometimes, I feel that they don't really give a damn about me--that they're just being nosey--finding out about my sex life--or lack of it, and why I hate my mother, and stuff like that... the main thing I've learned in therapy is that I have a medical illness in my head--that I'm sick but they can help me to function more normally with medication. (Observation # 44, November 27, 1981:5).

Similarly, a middle-aged female recalls her experiences at a community mental health centre:

I went there thinking that I was going to be cured but I was wrong. There's no cure for what I've got. Some of the people there care about you, but others don't. It's just a job to them. They prodded around my mind asking so many personal questions and they wrote everything down--maybe so they could use it against me some time in the future. I felt most of the time that they were two-faced. I mean, that they would be as sweet-as-pie to my face, then talk about me behind my back. Their main concern about me wasn't whether I had enough to eat or that no one was beating up on me, but that I was taking

my medication--that's all they were concerned about! Each Friday, we'd have our group that would meet in the big room on the third floor at 2 o'clock. Sally, the nurse and Donna would ask us to talk about things and everyone was supposed to be free and open. No way was I going to tell them things. That's why I dropped out of the group... it didn't help me. The only thing it did was make you feel sicker--they kept bringing up the past--about when you were really sick --and that's just what I wanted to forget! (Observation # 46, November 29, 1981:23).

For the majority of persons whose short-term careers consisted of therapy/counseling sessions as outpatients, such persons, felt that while the treatment may have been beneficial, in certain aspects, it nevertheless, was detrimental in the sense that it served to alter their conceptions of self--specifically, as a result of out-patient therapy, persons, who previously possessed positive, non-deviant self-conceptions, were forced to accept a new deviant identity--that of mental patient:

I'm telling you the truth--that therapy is for the birds. OK, the medication did calm me down and help me make it through the day but when they keep poking into your past and rehashing things, they want to break your spirit and make you realize that something mental is wrong with you. They tell you that unless you admit that, you'll never get better. I remember--one day, I came in for help and I thought of myself as an OK kind of guy--but when they get through with you they make you sound like some kind of monster or freak or weirdo--they got me all confused about who I am and what I stand for, and what it means to be mentally sick ... (Observation # 158, November 2, 1983:14).

A second person adds to this viewpoint when she states:

It wasn't the fact that the therapy was long or that they scared me--that didn't bother me so much. What bugged me most was the fact that from the moment you go there, they pick on you--I went in there with my head high up in the air, but they pushed me right into the mud...I mean,

they made me feel like I was only worth 2 cents. They'd look at me and act sympathetic, but I knew they weren't. They make you into what you become--they make you, they create you--they keep telling you that you're sick--that you need all these pills--they keep telling you how important it is to come to the sessions--to bare your soul--to tell them everything. They tell you that you're like the other patients around here. You look around and see some pretty strange people but you know, after a year listening to all of this, you believe them hook, line and sinker. (Observation # 33, October 31, 1981:7).

For the most part, the out-patient psychiatric treatment, while it may be short in duration, is nevertheless intense in nature. Such treatment is perceived by the majority of the "patients" as both positive and negative--the former referring to the fact that the medications aided in stabilizing them, and the latter referring to the fact that probing on the part of the psychiatric staff, combined with structural elements of the therapeutic group functioned to force the individual to accept⁷ a new deviant conception of self as "mental patient"--an identity that is incompatible with their prior conceptions of self:

The worst thing that happened to me in group was during one of the first sessions when I overheard the nurse and one of the psychiatric residents talking and he mentioned something about me--saying that what I had was very common with psychiatric patients. No one had referred to me that way before. At least I hadn't heard them say that. It was a real blow... But as I got into the therapy, that new name for me "stuck." That's the way it works--you first have to realize that you are sick--you have to accept that fact--you have to realize that you aren't who you once were--in my case, the boss of a tool and die company.... But even to this day, I can remember when they first called me a "mental." I felt sick. It really offended me. At first, I wouldn't accept it. I fought them all the way on it,

but the way the group works, the other patients gang up on you and so does the social workers-- they make you see the truth about yourself! (Observation # 67, December 15, 1981:24).

II. Private Psychiatric Treatment

While some persons, in the context of their short-term careers, are treated as out-patients in community mental health centres and out-patient psychiatric clinics, others, with available funds, obtain private psychiatric help from psychiatric professionals. Specifically, the data indicate that twelve individuals entered into such treatment for periods of time ranging from one month to two years. Private psychiatric treatment is seen by some of the patients as beneficial:

Dr. _____ is the greatest guy in the world. He helped me to see my problems more clearly, to deal with the stresses in my life, to recognize my weaknesses, to strive to meet my goals, to realize my potential, and not to let my husband get in my way of achieving my goals.... After six months in treatment, I was a new woman. (Observation # 209, December 29, 1983:22).

A second male individual, discussing his short-term therapy with a psychiatrist states:

I only had about ten sessions with him. For the most part, it was helpful. Before I went my life was difficult. At times, I felt as if I didn't want to go on with my life--that I wanted to end all the confusion and madness.... But the shrink helped me to take each day one at a time. (Observation # 80, December 27, 1981:5).

While some consider the treatment with a psychiatrist to be beneficial in nature, others, however, deem it to be useless, and sometimes detrimental in nature:

For me, the entire treatment was just a waste of time. It didn't help me at all. The only thing it did was drain my bank account. Do you know how much an hour those crooks charge? It's ridiculous. All I did was go in and talk about my past for an hour and the guy wouldn't say a word. He'd just scribble down a few notes from time to time. But he never did anything constructive to help me! (Observation # 72, December 16, 1981:2).

A second individual adds:

The whole thing was a waste of time and money. I never learned anything about myself--how to help myself or deal with my life situation. The only reason he desired me to be in therapy was so that I could help pay for his new Mercedes... (Observation # 283, June 4, 1984:25).

A third person, speaking of what she deemed to be the detrimental effects of private therapy states:

The fee didn't bother me so much, but what upset me most was the fact that after two years in therapy, he had me right where he wanted me. I mean, when I first came in, he had to overhaul me--he had to remold me like a piece of clay. For me, the whole process involved many painful experiences being rehashed--talking about my relationship with my mom and dad and my sisters. You know, it was my husband's idea for me to go to Dr. _____ for help; I didn't think that I needed any help. If anything, he was the one that needed help. I wasn't crazy.... But after two years in therapy, and he dredges up all these things from your past--and he keeps referring to you that you're "sick,"--from what he says and how he acts toward you. I didn't like that; he kept twisting the things I'd say all the time and misinterpreting them--he did this to show me and everyone else that I had mental problems.... Actually, I think that he made me sick from all that talk and the way that he thought of me--as a "sick person." (Observation # 110, January 4, 1982:23).

The data indicate that, given the nature and short duration of such treatment sessions, the majority of such persons do not fully redefine themselves as mentally ill--they do not

completely conceive of themselves as being deviant; rather, the data suggest that, as a result of such treatment, patients come to call into question their identities as "normal" members of society:

I'm not sure anymore, exactly where I stand. On the one hand, I've never been institutionalized with "crazy" people--so in that sense, I am not really "nuts;" but on the other hand, due to the therapy and from what the psychiatrist said about me, I'm not like the average person out there--sometimes, I do things that I shouldn't be doing in that situation.... So, I guess, if I had to put a label on me, I'd say that I'm a "somewhat normal, crazy person" or maybe a "sort of crazy, normal person." (Observation # 113, January 7, 1982:14).

Another person, discussing the effect of private psychiatric treatment on his self-conception states:

Before I went into treatment I thought that I knew who and what I was--I thought of myself as a well-educated, well-liked and well-respected academic. I was a good father, husband and upstanding citizen of the community. However, when I entered into treatment and thereafter, this view of my being as a positive person was called into question.... From the type of questions asked by the psychiatrist, and the answers I was obliged to give, a new figure of myself surfaced--a being that was a radical departure from my previous view of myself. I never conceived of myself, before therapy, as an aberrant individual.... So you see, if someone asked me what I am, or who do I think I am, I would honestly reply that I think of myself along a continuum--I'm somewhere along a continuum, between my old view of self as a positive, normal fellow, to a negative view of myself as an aberrant, sometimes somewhat abnormal person. I'm somewhere between the two... (Observation # 199, December 30, 1983:21).

In short then, in contrast to those participating in outpatient therapy sessions at a community mental health centre--those individuals who have come to accept a redefinition

of self as deviant, the data indicate, that in the case of those entering into private psychiatric treatment, such persons, by virtue of the private, non-institutionalized nature of the treatments, no longer see themselves as completely "normal," but neither do they see themselves as completely "deviant"--that is, they do not come to see themselves as "mentally ill"; rather, such persons see themselves as being situated on a continuum somewhere in-between the two extremes.⁸

III. Hospitalization on a Psychiatric Ward of a General Hospital

Just as some persons, in the context of their short-term careers, are treated as out-patients in community mental health centres or clinics, and others, with available financial resources, are treated privately by psychiatrists, still others, are treated within the confines of a psychiatric ward of a general hospital facility. Specifically, the data indicate that fifty-two persons entered into this type of psychiatric treatment for relatively short periods of time ranging from three to twelve weeks. During this period, the patients are subjected to various types of psychiatric assessments, interviews, counselling and therapy sessions, and drug treatment therapy. The majority of persons in this study conceived of their in-patient experiences on the psychiatric ward in the following manner:

I hated being locked up in there. At first they brought me in the ambulance and they had me all

tied up. Then they put me in this room and I was still tied up. I was so frightened. They kept asking me questions about if I knew who I was and what I was doing there. They said that they would help me and to calm down but I couldn't. I went through this three times before, only it was at another hospital. Every time they brought me in and then they'd put all these pills into me--sometimes I'd feel so sick, or I'd just konk right out.... It was terrible to go through that...and all the time, the doctors kept coming around talking to me like I was a little kid--"We'll make you feel better Johnny"--sure they did!! (Observation # 233, May 15, 1984:29).

Similarly, a second individual states:

I didn't enjoy being incarcerated in that place at all. They did it against my will. I tried to get out but they kept catching me. I hated the people there--not only the doctors and the social workers, but the other patients. I didn't like to be near them. Some of them acted weird. I used to go by their rooms and see them tied down--it was awful. When I was there, there was this guy that howled like a dog--he never stopped. In the meetings with the shrink, he used to ask me questions, but I don't think that he really listened to me. I don't think he cared at all. (Observation # 118, January 13, 1982:34).

A third person, discussing her in-patient experiences recalls:

I just want to forget the whole ordeal. I've been on the psych ward twice before and each time it gets progressively worse--especially the treatment. The first thing they do is pump you full of drugs--meds, meds, meds; they doze you out of your mind. After that, they begin to do numbers on your head--you know, make you believe what they want--that you're really "sick" and that you "need their help." They tell all your visitors--your mom, your sister, and your boyfriend that you're a "psychotic" and other fancy words like that. Then everyone's afraid of you.... Then they get student doctors and student nurses coming around every day to "bug you." They pick on you and ask you all these personal questions. They want to know things about you but they sure won't tell you anything about them! (Observation # 3, September 4, 1981:12).

The data suggest that, despite the short duration of their hospitalization, given that: (1) the majority of these persons had been previously hospitalized for psychiatric treatment, (2) in the hospital, such persons are forced to interact with "mental patients" twenty-four hours a day, and (3) doctors, nurses, social workers and other psychiatric professionals redefine the individuals as "psychiatric patients," such persons, ultimately accept this deviant redefinition of self:

You fight it when you first go in. That's what I did the first time. But this is my third time on the old psychiatric tread-mill. Everyone in there made me realize that I'm mentally ill--why else would I have to go in there then? A person is sick when they tie him up on the bed or else he would kill himself. A person is sick when he has to take all kinds of medication. A person is sick when all the important doctors study you and tell you that you're sick but that they will help cure you. They helped me to see how sick I really was! (Observation # 117; January 12, 1982: 34).

Similarly, another individual, discussing the conditions under which she came to accept her new identity of mental patient, states:

Sometimes when I think about the past, it is fuzzy but I remember what happened before I went into hospital. Fred, my husband, and my sister Rose were worried about me. I even remember them saying that I was having a nervous breakdown. But at that time, I wouldn't believe them. I just thought that they were all against me. When they put me in the hospital, it was awful at first. I didn't like all the questions, tests and gawking people did. And I didn't like the woman in my room--she was really "nuts." You know though, due to the therapy--what the doctors and the social worker kept pounding into me, I finally realized that I must really be sick if everyone really says that I am. And the

doctor told me that the only way I was ever going to get better would be to recognize my sickness and to take my pills all the time... Finally, it dawned on me that I was just like the other woman I shared my room with--I was mentally ill, just like her! (Observation # 273, June 14, 1984:3).

Similar to the experience of individuals in my study who were treated as out-patients--those persons, who, through their psychiatric treatments, came to adopt a new conception of self as "mental patient," the data indicate that, those persons hospitalized on a psychiatric ward of a general hospital, also, by virtue of the treatment to which they were subjected, came to see themselves in a similar light.

IV. Institutionalization in a Psychiatric Hospital

The data indicate that thirty-nine persons in this study received psychiatric treatment as in-patients in three psychiatric institutions in Southern Ontario.⁹ Given that virtually all of these persons were reacted to, defined by others as "mentally ill," and were subsequently committed against their will, their hospital experiences were generally seen in a negative light:

I'd been sent to the hospital three times now even though I was against it. But I was powerless. My wife signed me in with the help of Dr. Smith, my doctor. Every time, I didn't want to go in but they forced me. My wife threatened to kill me unless I'd follow her wishes... I just hated being in the hospital... I didn't like the nurses. Most of the time, they'd be too busy talking to each other--they'd never want you to bother them. The whole system in there stinks--they treat you like children--all these rules and regulations. But the

worst part is that you're locked up--just like a prisoner. (Observation # 251, April 27, 1984: 26).

A second male individual, discussing his experiences as an in-patient in a psychiatric hospital states:

It was awful. Just awful. The police came and took me away. My brother and his wife wouldn't put up with me no longer. I didn't want to go. I was brought to the insane hospital. I was scared out of my wits. They kept me in the side-room for a long time--the room with padding all over. Being locked up was enough to drive a person crazy. I was dozed up for a while with the needles they kept giving me but when I came around, and they let me out of the sideroom, I was scared of the other patients at first. But what I hated most was the social worker and the doctor. I didn't like the way they talked to me--they blamed me for my problems. Every day, they kept at me--trying to show me that I was sick and that I needed all those pills.... The first time, they put me in hospital, I didn't really "buy" what they were telling me, but after the second or third time I was in, I believed it--I now know I'm sick. (Observation # 254, May 1, 1984: 13).

The data indicate that such persons in this study were institutionalized for an average of six and three quarters months (the majority being institutionalized between one to three occasions). Upon admission to the institution, and thereafter, the in-patients are subjected to various "admission procedures" or "stripping processes,"¹⁰ which function to alter or curtail a positive conception of self. One middle-aged female patient, recalling her feelings of degradation and objectification as an in-patient, states:

My God, it was terrible. When they bring you in--in my cases, it was always with an ambulance, no one gives you any respect. They treat you not like a living person--but like some inanimate object.

They'd leave me on the stretcher all tied up so tight that I couldn't move; they'd ask the ambulance driver about who I was and all the circumstances. Everyone would be staring at me as they walked by and I was helpless, just like a little child. Then they'd take me up to a ward and you'd go through an embarrassing examination--you'd have to take everything off--sometimes the male nurses would make fun of me or make remarks. I didn't like that. They'd take away all my rings and my wallet and my money--all for "my own good" so they said. They even took my locket away with my husband's picture inside of it--it was the only thing I had to remember him by...and they leave you with nothing. (Observation # 1, September 2, 1981:2).

A second male individual, speaking of his experience as an in-patient in a psychiatric facility says:

From the moment you go in there, you're no longer a person--they treat you like you're less of a human being now. It's a real shock when that first happens to you. They take away all your personal items and lock them up and they put you in a bedroom with other mental patients. A doctor makes you undress yourself and he looks you all over--I felt like shit. I was so embarrassed. He even looked up my ass! What really bugged me was that the doctor would talk to the nurse like I wasn't even there--like I couldn't even understand what was going on--What did he think I was? They make you feel like a nothing. Even when I was in jail, I was treated better--with more respect... (Observation # 163, February 10, 1983:12).

Upon admission and thereafter, then, individuals find that it is virtually impossible to maintain their old, non-deviant identities. Specifically, upon entering, such persons are separated from the individuals and structures which validated their behaviours as "normal" societal members. Moreover, such persons are separated from their material possessions--

money, identification, jewelry etc. which represents a major attack on the self. So too, does the enforcement of various rules and regulations and a forced deference pattern toward the staff, exert the same attack on the self. Further, the data indicate that the self is attacked through what Goffman (1961) refers to as "contaminative exposure". In the outside world, individuals were able to segregate objects of self-feeling and their physical beings from certain contaminating items; by contrast, upon institutionalization, the boundaries of self are violated. In this regard, their informational preserve relating to self is infringed upon. During entrance procedures, information is gathered about the patients' roles, statuses, and their prior actions (including discrediting information) and is synthesized in the form of case histories. Such files are made readily available to all staff members. The patients then, have no control over who is allowed to learn such information about themselves. In this sense then, their territories of self are violated.¹¹ One middle-aged male, recalling his in-patient experience states:

Your life is like an open book when you get in here. Everyone knows that you did these bad things--even the cleaning women find out. All the other patients learn about it because the nurses never fail to bring that stuff up in the therapy sessions--they love to see you squirm! (Observation # 147, February 12, 1983:3).

Just as individuals during the pre-patient phase of their careers undergo mortification of self due to contaminative exposure of the type discussed above, so too, do they

undergo alterations of self through interpersonal contamination--contamination by forced interpersonal contact not only with the institutional staff, but also, with undesirable fellow patients. Speaking of the former, a female individual states:

When I got in there, I no longer had complete control over me like I did before. That was left up to the staff. They could do whatever they liked to me whenever they liked. They can make you sleep in the sideroom; they can strip you when they like; they can search through all your things--they did that to me. This one attendant used to come into my room a lot and touch me. A couple of times he tried to force himself on me but I managed to get away before he could do anything real bad! (Observation # 78, November 13, 1981:7).

Speaking of contamination as it related to forced interaction with undesirable in-patients, a former mental patient recalls:

You have no idea of what it's like when you're hospitalized. You lose all your rights and freedoms. They force you to do things that you would not ordinarily do. Like, for example, they assigned me to a room which I was supposed to share with a nigger and a chink. And the other guy babbled day and night--he looked like Jesus and he stunk real bad. I just detested the whole thing! (Observation # 81, November 18, 1981:24).

In short then, the data suggest that upon admission to a psychiatric institution and thereafter, various admission and hospital procedures such as those discussed briefly above, serve to strip the individuals of their prior non-deviant self-conceptions. In its place, the institution offers such persons an alternative conception of self as "mental patient"--a deviant identity and status which the persons gradually begin to accept.¹²

Before I came in, I didn't think nothing was wrong with me but after all the sessions in group therapy with the nurse telling me that I was sick but that she could help me get better; and after spending six months on the ward with other patients, you gradually come to realize what the doctors have been telling you all along--that you do have a psychological problem. I'm just now beginning to see the real truth about me! (Observation # 19, September 10, 1981:3).

A second person, recalling the manner by which she came to accept a conception of self as deviant, states;

I was in the hospital about eight months. For the first few months, I fought and kicked against being considered as a "psychiatric patient." No way did I think of myself as one. In fact, I thought that everyone else was "nuts." But after getting into the therapy, talking to the psychiatrist, the case worker and getting told by the other patients--I gradually began to realize that all these people couldn't be wrong--there must be something wrong with me. Even my family saw me as a patient but it was mostly by living on the ward day and night and even on the weekends and through all the therapy that I realized I was "sick." (Observation # 6, September 5, 1981:1).

II. LONG-TERM CAREERS AS MENTAL PATIENTS

Especially prior to, and to a lesser extent, during and after the movement toward deinstitutionalization, significant numbers of individuals enter(ed) into long-term careers as psychiatric patients. By "long-term," I am referring to persons institutionalized in a psychiatric hospital on a continual basis for periods of two years or more, those institutionalized a significant number of times in their lives, or those persons who have received psychiatric treatment on numerous occasions firstly on the psychiatric

ward of a general hospital and subsequently transferred for further treatment in a psychiatric institution. Approximately one half of the sample entered into such long-term careers. Just as with the short-term patients, I was interested in examining the nature of the long-term career, the social conditions under which such a career path commences, the social experiences of these persons as pre- and in-patients, and the effects of such long-term processing on the internalization and adoption of the deviant identity of "mental patient."

Similar to the commencement of the short-term career, the data indicate, in the case of the long-term career of the mental patient--such a career path begins when an audience reacts to an individual committing a culturally-inappropriate act and defines him/her as being "mentally ill." While such "bizarre" behaviours may be, for a time rationalized, when an individual repeatedly fails to respond to the interpersonal demands of the other in the situation, or if the individual commits a severe rule violation, the social audience moves toward defining the individual as mentally ill, and take action against him/her.

The data indicate that a number of agents and agencies play a role in the definitional process and subsequent institutionalization of the individual. Specifically, similar to those in the study who entered into short-term careers, those who entered into long-term careers began such

careers when friends, relatives, the police, employers, the family physician and the clergy reacted to, and took action against them.¹³ What happens to these persons once they are defined as mentally ill? Do they enter into the same types of psychiatric treatment as do those in short-term careers? This chapter will now turn to a discussion of the various types of psychiatric treatment to which long-term mental patients are subjected, and the effects of such treatment on the acceptance of a new conception of self as deviant.

LONG-TERM PSYCHIATRIC TREATMENT AND THE ACCEPTANCE OF DEVIANT IDENTITIES

The data indicate that, in the case of individuals with long-term careers, once such persons are defined by others as being mentally ill, they subsequently follow one of the following career paths:

- (1) Continual Long-Term Institutionalization in a Psychiatric Hospital
- (2) Consecutive Long-Term Institutionalization in a Psychiatric Hospital
- (3) Short-Term Hospitalization in a General Hospital with Transfer to a Psychiatric Institution

I. Continual Long-Term Institutionalization in a
Psychiatric Hospital

Forty-nine persons in this study, upon official labelling were sent for psychiatric treatment as in-patients in a psychiatric hospital. Given that virtually all of the persons in the subsample were hospitalized prior to the de-institutionalization movement with its ideological emphasis on community psychiatric treatment or short-term in-patient treatment, such persons were, thus, institutionalized for long periods of time ranging from four to seventeen years. Such persons, once institutionalized, were subjected to various types of treatment ranging from electric shock, insulin shock, drug therapy, and in some cases, surgery in the form of lobotomies. Discussing his early experiences as an in-patient, one individual states:

It was over twenty-five years that I went into that place. My father and mother had me committed because I was an embarrassment to them. I was twenty-three at the time. I spent a lifetime in that place. I went in as a young man and they let me out as an old, defected thing... I was on Ward 8 when I went in. In those days, you really had to "tow the mark." The attendants would box your ears if you didn't follow orders. I hated being in there at first--an awful lot of bad things happened to me. They were always filling me full of pills and they'd beat up on me. But the worst thing was the operation I had--see the mark on my head--I had no say in whether I wanted it. I been mixed up worse since it happened to me! (Observation # 119, January 17, 1982:4).

Another elderly female ex-patient, recalling her experiences

in the psychiatric hospital states:

My daughter and her husband had me sent to the hospital. I didn't want to come. I remember that clear as a bell. I remember the early days when all the ladies was by themselves on the ward--no other men patients, but that's changed now. Before we had to sleep in big rooms with a whole bunch of other people but that changed too. Later, we got to sleep with only a couple of other people... I hated Dottie for locking me up--she never came to see me once. Everyone just forgot about me. They wiped me off the face of this planet! Even when I was real sick and they was being "shocked" all the time, no one came near me. I still don't know why they did that to me. Who gave them the permission? I never wanted those shock treatments. Especially in those days, they could do anything they wanted to you... (Observation # 117, January 15, 1982:2)

The data indicate that the in-patient phase of their moral careers is retrospectively seen for some in a negative light; for others however, the experience is remembered to be quite positive in nature. Speaking of the former, one ex-patient states:

The whole eight and a half years I was in was shitty. I just can't describe it in words; it was worse than going to hell. First you're abandoned, then you're tortured, they play with your minds, abuse you. Then they release you. (Observation # 53, December 2, 1981:11)

A second individual, discussing the negative aspects of institutionalization states:

Right from the beginning, when you get sent there, you lose all your rights! They take all those things away from you. You don't vote, they take your money away. And they make you obey the rules or else! It's really like a jail but I think that in jail, you have more rights. You have to go to bed at a certain time, take your pills or else they'd put you in the sideroom. They treat you like kids in kindergarten... (Observation # 146, May 2, 1982:3)

Remembering her in-patient experiences as positive ones, a former mental patient says:

All in all, it was pretty good. They treated me fairly. As long as I followed the rules, everything was OK. Once you got to know them the other patients on my ward were OK. I met this girl, and we became best friends. We used to sit and talk for hours. (Observation # 100, December 30, 1981:6).

Comparing his present post-hospital experience with that of his prior in-patient social experiences, an individual reflects:

I'll tell you the truth. The hospital was like a hotel compared to where I live now. Before I used to get good food to eat, and a clean bed to sleep in. And they used to have games to play and things to do on the ward--sometimes even dances. But now, I live in a boarding home and I got nothing. The hospital wasn't so bad at all. I liked being in there. (Observation # 199, November 29, 1983:12).

Similar to previous studies,¹⁴ the data suggest that during the in-patient phase of their moral careers, such persons are stripped of their positive, non-deviant self-conceptions. Once stripped to liminal beings, the institution offers them alternative identities of "mental patients." Through the context of the institution's system of rewards and punishments, the enforcement of interaction with other "mental patients," and re-inforcement of this new identity from the institutional staff--over a long duration, the data indicate that such persons come to accept this redefinition of self as deviant and its corresponding status. Given the long durations of their stays, such persons have fully internalized the new identity of mental patient and its corresponding role and status:

I was in the hospital for over-fifteen years. I was in _____ Psychiatric Hospital. I was given drugs, needles and all kinds of things. They did everything. But they just showed me how "sick" I am--that I have problems. The nurses used to call me "Crazy Harry" all the time and that name just stuck.... When I was in there they gave me over thirty shock treatments to try to help me. They said the more I had the better I'd feel. They may have helped a bit but I'm not sure. You know, when you have a sickness like mine, you never get better--at least that's what my doctor told me. But if I take all my medications like they told me, that will "keep me under control." I won't hear the voices so much and I won't get so mixed up! (Observation # 223, March 1, 1984:3).

Another ex-patient states:

After nine years in there I learned that I have a mental sickness. But at least I'm not as bad off as some of them in there. Some are totally gone. They put me on a bunch of drugs in there. Now I'm only on 4 different ones, but I think that the Lithium has helped me the most. When I was in there, Mary my social worker, and even the doctor kept telling me that I was different--not like my brother--I had a problem. I remember thinking that they were the ones who were wrong but then I realized that they were right all along! I am a "paranoid schizophrenic." What that means is that I can't possibly measure up to other people in the world--I have a disability, a handicap! (Observation # 55, December 2, 1981:7).

A third ex-patient states:

All I know is that after so many years in that place and everyone telling you that you're a "psychotic" patient, and them pumping me full of medication to make me feel better, a person has to realize that he or she is really sick. Not only that he or she has to realize what that means to be mentally sick--it means that you're not like other people--you're not as smart and people don't like you very much. (Observation # 255, June 10, 1984:4).

11. Consecutive Long-Term Institutionalization in a Psychiatric Hospital

While some persons, in the context of their long-term careers, are treated on a long-term continuous basis in a psychiatric hospital, others, are institutionalized for long periods of time, released, and then reinstitutionalized-- a circular path repeated several times in their lives. The data indicate that fifty-eight persons in this study followed circular career paths. In the course of their lives, they were institutionalized on a number of occasions (mean number of times institutionalized being six times) for periods of time of two years or more (the mean length of time being three years). For the most part, their experiences as psychiatric patients are conceived as being on a "psychiatric merry-go-round:"

You go into the hospital--you stay for a few years--they drug you up, give you "therapy". They shake up all your brains and then they discharge you. You go out and stay out for awhile. Then things get rough. You don't feel good; you don't get enough to eat; people are mean to you--they kick you, right where it hurts. You feel poorly and they send you back to the hospital. And the whole thing starts all over again.... (Observation # 147, November 26, 1983: 24).

Conceiving of his situation as being on a "psychiatric treadmill", one male ex-patient states:

I've been in over ten times in my life already and I'm only fifty-one. I expect I'll be back in a few more times before I die. I first went in in 1959 I think and stayed there for about five years, and since then, I've been in and out. It's like we're all on this psychiatric treadmill.... You get on it--you go to the hospital and

they do those things to you and then you get off it--you leave the hospital for a while. But then, before you realize it, you're right back on that old treadmill again. You do something wrong on the outside, or you get sick again, and you end up back on the treadmill--right back in the hospital.... That's been the story of my life! (Observation # 244, May 11, 1984:5).

Similar to those in this study who were institutionalized continually for years at a time--those persons who fully accepted a redefinition of self as "mental patient" and its corresponding role and status, the data indicate that the same process occurs with respect to those institutionalized on a number of occasions. One middle-aged male, discussing the context of which he accepted this redefinition of self and its corresponding role, states:

I remember the first time I was hospitalized. I fought and kicked and said that I wasn't sick. I did that for a long time, but it wasn't until after many sessions with the doctor and talking with the nurses, and the priest that used to come onto the ward that I finally recognized my sickness. I used to say that nothing was wrong with me but I was just kidding myself. All the treatment taught me to believe what the doctors tell you. After all, they went to school for a long time so they must know! I've been in and out the hospital about 6 or 8 times now, so even if I start forgetting that I'm sick, when I go back in, all the people there remind me once again. After eight times, you might call me a veteran of the mental hospital--a life-long mental patient. (Observation # 243, May 9, 1984:12).

Similarly, another ex-patient states:

I used to think that I wasn't mental but that's all changed now. I told my wife that nothing was wrong with me. I told that to all the doctors and psychologists and everyone. But after going through this for over twenty years on and

off--being hospitalized and then discharged and then hospitalized once more--after going through this revolving door and all those treatments, a guy can't help but see himself the same way that other people see him. (Observation # 333, January 31, 1984:11).

In short then, the data suggest that given the nature of the psychiatric treatment, the duration and number of times institutionalized, these individuals fully accept a redefinition of self as "mentally ill."

III. Short-Term Hospitalization in a General Hospital with Transfer to a Psychiatric Institution

The data indicate that thirty-two individuals in this research project received on a number of occasions (mean number of five times) treatment within the confines of a psychiatric ward of a general hospital, and were subsequently transferred for further long-term psychiatric treatment to a mental hospital (mean length of stay of three years). Such persons view their long-term career paths, for the most part, in a negative light. Recalling her experiences as an in-patient, a middle-aged female states:

First they took me to _____ General Hospital. I didn't want to go but my mother called the ambulance and they took me away. After a few weeks, I guess they thought I was a hopeless case so they sent me to _____ --you know the mental hospital. I was up there for over two years and then they let me out. I hated both of the hospitals. Everybody treated me like I was a kid--they either talked down to me all the time or talked about me as if I wasn't even present. They made all the decisions for me--I never wanted to go to the mental hospital but the doctor

decided for me. It was a nightmare--but it's the type of nightmare that I had to live over and over again. I've gone that route five times now--from the hospital over to the mental hospital. I try so hard to stay out but I end up going through that nightmare all over again! It's like I'm on a carousel going around and around. I try to get off the crazy thing but I can't! (Observation # 222, October 27, 1983:14).

Similarly, a second ex-patient recalls:

I've been in the psych. ward and onto the mental hospital so many times that I've lost count. In and out; out and in. Sometimes I can't tell if I'm coming or going. It's really a tiring experience--in fact, I'm sick of the whole damn thing. My whole life's been spent in and out of those places. Those doctors are vultures preying on me--doing all their tests and then sending me for more tests and then doing treatments and drugs, and then, after all that, sending me to another place for more treatment. Sometimes, I get so upset that I want to yell "That's enough" but I know no one will listen. It's like I'm on this assembly line in a factory--first they use their tools to get into your head and then down the line they monkey around--give you drugs and shock treatment, then they try to put you back together again. Once they've put you back together, they release you. But the funny thing is that this assembly line is like a circle. You think you've gotten off but you really haven't because, after a while you're right back where you've started. Psych. ward to Mental Hospital to Release and then back to Psych. ward all over again--there's just no end to it! (Observation # 178, March 13, 1983:2).

The data indicate that, given the repeated occasions upon which such persons have received psychiatric treatment in both general hospital facilities and in psychiatric institutions, such persons, (similar to the other long-term individuals in this study) have fully accepted and adopted a new conception of self as mental patient.

One ex-patient, speaking of his acceptance of a new identity and role, says:

At first, thinking of myself in that way was almost unthinkable. But after the long road I've gone on in and out of hospitals for years and years you finally resign yourself to the fact that you're not normal--you have mental problems. In my case, its Schizophrenia. I guess I knew I was sick but it was hard to admit. But after the treatments, I saw the light about me--in fact, it was one day about four years ago in the hospital when I was talking to the nurse that it dawned on me that I was just like the other patients on the ward--I was mentally ill just like them. Those patients that I thought were so different from me were so much the same as me--we were like a bunch of peas in a pod! (Observation # 124, March 1, 1982:2).

In short then, examination of the data indicate that persons hospitalized on a number of occasions on a psychiatric ward and then transferred to a psychiatric institution for further treatment, due to the frequency, duration and nature of their treatments, fully accept and adopt a deviant redefinition of self.

In summary, this chapter has dealt with the career paths of Canadian psychiatric patients. Specifically, attention has been given to the nature of the short-term and long-term career paths, the conditions upon which persons commence such careers, the role of various agents and agencies in defining and processing these individuals, the varying experiences of the processes, and the effect of the length, nature and frequency of treatment on the acceptance of an alternative deviant identity--that of mental patient. Given that the data has suggested that such persons, depending upon their career paths, vary in terms of the level of internalization of their deviant identities, the researcher sought to examine: (1) whether patients, once they are released,

accept their deviant identities as permanent fixtures; or (2) whether such persons attempt to alter such identities; (3) do persons with short-term careers differ from those with long-term careers in their attempts at, and in their success in transforming their deviant identities; (4) what criteria are important for successful identity transformation.

Such concerns will be addressed fully in subsequent chapters.

NOTES

1. Hughes (1958); and Hall (1948).
2. See for example: Sykes (1958); Bryan (1965); Weinberg (1966); and Crespo (1973).
3. For a detailed discussion of the pre- and in-patient phases of the moral career of the mental patient, see: Herman (1981).
4. In particular, "short-term" refers to those individuals who have received psychiatric treatment for periods of less than two years at a time, and on less than five occasions.
5. A significant number of inappropriate acts go undetected, or if such behaviours are recognized, they are "normalized" by others. Such accommodative patterns break down in cases where the individual repeatedly fails to respond to the interpersonal demands of the other in the situation (Becker, 1962; Gough, 1949) or in crisis situations (Smith et al., 1963). In such cases, societal members move toward defining an individual as mentally ill.
6. That is, of those individuals with short-term careers as psychiatric patients.
7. Such persons accept this redefinition of self, at least temporarily, until completion of their treatment.
8. Given that these persons go through treatment on a one-to-one basis with a psychiatrist (and do neither go through institutional processing or are forced to interact with other deviants); thus, most attempt to keep their treatment secret from as many people as possible. By so doing, they conceive of themselves differently from those hospitalized or institutionalized--they don't see themselves as "mental patients" but rather, as "semi-normal persons with psychological problems" or "somewhat abnormal" persons.
9. Since the ideological shift in treatment and care of the mentally ill, increasing numbers of individuals are treated either as out-patients or, if deemed necessary,

treated briefly on the psychiatric ward of a general hospital facility, and are then released. In some cases, however, it is decided that the patient requires specialized treatment and is transferred to a psychiatric institution for fairly brief time-periods.

10. This is what Goffman (1961) refers to as "mortifying experiences"--the acts of signing in, physical examinations, psychiatric assessments, storage of personal items such as wallets, money, jewelry, forced interaction with other deviants--experiences which function to strip the in-patients of their non-deviant conceptions of self.
11. See Herman (1981) for a detailed discussion of how self is altered in the confines of a psychiatric institution.
12. This new deviant identity is reinforced by fellow patients and institutional staff alike.
13. Given that persons with long-term moral careers as psychiatric patients commence such careers when various persons respond and take action against them--agents such as the police, family, the clergy, friends and employers (the same group of agents that play a role in the processing of individuals with short-term careers), these agents will not be discussed here.
14. See Goffman (1961) and Herman (1981).

CHAPTER SIX

STIGMA

Our images of self are facilitated and restrained by the expectations of others; we are sensitive to the expectations of those who are most significant to us. But our selection of significant others is limited by our positions in the varied institutions of which we are members. Within these institutional limits, however, we will generally turn toward those whom we believe will confirm the desired image we would have of our self. And, if others' expectations and images of us are contrary to our desired image, we will try to reject them, and seek only confirmation among more congenial ones. (Gerth and Mills, 1953:102).

As was stated in Chapter Two, much of the criticism¹ surrounding the labelling school of deviance, and mental illness,² centres on the portrayal of the individual merely as a passive recipient of a deviant identity and status. Indeed, much of the research has examined the ways in which deviant identities are created and perpetuated through the formal organizational responses to different behaviour-- studies conceiving of the individual as overly passive in a deterministic societal reaction model.³ As Davis (1975:206), in criticizing this conceptualization states:

Typifying deviants as passive receptors in an all-powerful social mechanism, labeling theory views actors as more acted upon than acting. (emphasis mine).

Similarly, Cullen and Cullen (1978:27) contend:

...man is treated as an "empty organism" pushed by control procedures, without a murmur one way or the other, into career rule breaking. Ignored...is any view of actors resisting designation and treatment as deviant.

While much of the research in the fields of deviance and mental illness have conceptualized labelled individuals as passive recipients of such identities and roles, some studies in the area of physical disability, have focussed on the role of the disabled as active in shaping societal responses to their "failing" through the development and employment of various techniques of information management.⁴ So for example, Schneider and Conrad (1980), in their study on epileptics, illustrate that such persons employ various information management techniques ranging from "selective telling" to "preventive disclosure." Levitin (1975), in his study on the physically disabled, found that such persons engaged in active bargaining with various social control agents in an effort to acquire more positive self-conceptions. Anspach (1979), in her study on ex-psychiatric patients discovered that such persons do not passively accept their deviant identities as permanent fixtures, but rather, many adopt the tactic of political activism as a positive response in dealing with the stigma potential in mental illness, and by so doing, seek to transform their deviant self-conceptions.

I would argue that it is more accurate to conceptualize deviants in the latter manner; that is, to conceive of such

persons as strategists, as negotiators--those who play active roles not only in the generation of their deviant identities, but also, in dealing with the stigma accompanying the label and identity by eliciting preferred (positive) societal reactions through their own behaviour, through the images that they project, and in attempting to transform their deviant conceptions of self. It will be the concern of this chapter to deal with the latter point. Specifically, it will focus on stigma as it applies to former psychiatric clients--what constitutes stigma, its characteristics, the processes by which ex-mental patients become aware that they possess stigma, and the implications of such knowledge in terms of strategies of information management and identity transformation.

MENTAL ILLNESS AS STIGMATIZING

As Goffman (1963:3) suggests, the Greeks employed the term "stigma" to denote bodily signs designed to expose something strange or undesirable about the moral status of the individual--a symbol burnt into the forearm of a slave, for example, signifying a blemished or spoiled person. In modern times, however, the term stigma is applied to the disgrace itself as opposed to the bodily evidence of it. Goffman (1963:3), in discussing the nature of a stigma states:

While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind--in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive; sometimes it is also called a failing, a shortcoming, a handicap...it refers to an attribute that is deeply discrediting... (emphasis added).

According to Goffman (1963), any deeply discrediting attribute is conceived as a stigma and constitutes a "special discrepancy between 'virtual' and 'actual' identity"--the former referring to the societal expectations we have of a person, and the latter referring to the attributes that a person actually possesses.

Goffman (1963:3) further distinguishes between attributes that are "discrediting"--those immediately apparent to others, and those which are "discreditable"--those attributes not visibly/readily apparent to others. In terms of those defined as "ex-mental patients," their attributes, for the most part are discreditable--their differentness or failing is not immediately apparent. It was the interest of the researcher to explore how ex-psychiatric patients come to define their identities as "discreditable," "objectionable," or "spoiled", and subsequently, to explore the strategems or techniques that such persons develop and employ in order to deal with the threat of stigma.⁵

THE PERCEPTION OF MENTAL ILLNESS AS STIGMA

Previous research on the moral career of the mental patient⁶ indicates that the individual enters the mental institution with a positive, non-deviant self-conception that was made possible by the stable societal arrangements around him/her. However, during admission procedures and thereafter, the patient comes to the realization that it is virtually impossible to maintain a positive conception of self. The in-patient is subjected to various admission procedures which serve to alter and/or destroy his/her self-conception. Once stripped to a liminal entity, the mental hospital and its staff offer the patient an alternative identity of "mental patient." While the patient may initially attempt to reject such a label and status, previous studies indicate that, through the consistent reactions of the psychiatric staff, combined with the processing of the institutional system, the patient is ultimately forced to accept this redefinition of self as a deviant identity and status affecting the person's future participation in society.

Given that persons officially labelled as "mental patient" and treated within the confines of a mental hospital or on the psychiatric ward of a general hospital have accepted this redefinition of self as deviant, what happens to them once they are discharged? The data indicate that once mental patients are discharged or released, there begins for them

the task of attempting to rebuild a more positive self-conception. However, such persons quickly discover the problems of changing a career in midpassage. Specifically, ex-psychiatric patients come to realize that they possess an attribute that is deeply discreditable to their identities. How do ex-patients come to define their conditions as discreditable?

The data indicate that discharged psychiatric clients learn that they possess a potentially stigmatizing attribute in three manners: (1) as a result of societal reaction, official labelling and institutional processing; (2) through post-hospital negative reactions from "normals;" and (3) through self-labelling.

I. Societal Reaction, Labelling, Institutional Processing And the Perception of Mental Illness as Stigma

One of the major processes by which ex-psychiatric clients learn that they possess a stigmatizing attribute is through societal reaction, official labelling of their behaviour as "mental illness" and subsequent institutional processing. In the context of the pre-and in-patient phases of their moral careers, such persons, not only acquire a new conception of self as mental patients, but also learn about the stigma associated with this attribute.

In the pre-patient phase, the data indicate that some individuals learn such information through official labelling

by such persons as the clergy, police, family physician etc., while others, through unofficial, informal labelling by family, friends and co-workers. One male ex-patient, discussing the role of official labelling in "educating" him about his identity and the stigma associated with it states:

They watched me for a time, thought I was acting weird, stepped in and called me "crazy". From that moment on things changed. How? Before I was considered a fairly normal fellow. I never hurt nobody. I just went about my own business. But from the time that they pinned that new name on me--"mental patient"--"mentally sick" they made others see me differently. And it even got me to thinking about me as "sick" as well. But that didn't bother me too much. So I was sick so they told me. I'd get treatment and be cured, so I thought. At first I was so naive. I thought that having a mental sickness is just like having a broken leg. I mean you go to the hospital, get treated and they release you as good as new. But when people stuck that label on me, I soon learned what I was in for--I mean what came along with the label. I found that mental illness is a disgrace--your family and friends and the doctors treat you like you've got leprosy--when they call you mental and put you in the hospital, you realize you now have a pock that makes people act weird toward you. (Observation # 268, May 12, 1984:2).

Another ex-patient, speaking of the role of unofficial, informal labelling by family and friends, states:

You learn a great deal about what you've got and what it means after your family, the next door neighbour and the others all call you mentally ill. They tell you that you're sick and in need of treatment but at first you may not totally agree. You may have some doubts.... But as soon as someone steps up and defines you in this way, things change. People start acting strange toward you and you realize that you now have something, some trait (even though it may be beyond your own control) that makes you less human...you have something that is not desired by other people... (Observation # 3, September 2, 1981:13).

Moreover, much of what mental patients learn about their stigma is transmitted to them during prolonged interaction with others in the institution who are also being transformed into mental patients. Calling attention to the role of institutionalization in educating him that he has an attribute that is deeply discreditable, a former ex-psychiatric patient states:

I learned that I had a defiling trait--that's what mental illness is, you know. I learned this information from the moment I was hospitalized at _____ Hospital. When you go into a place like that, you really learn the ropes. I mean, they not only want you to believe that you're sick, in order that you get better, but by virtue of the fact that you are on the ward every day with 50 other "mental" patients--they are the ones who teach you what it means to be mentally ill--I mean, that you now have a mark of Cain, a blight that will affect the way everyone acts towards you... (Observation # 34, September 15, 1981:21).

In short then, many ex-psychiatric patients in this study came to perceive their conditions as discreditable--that mental illness is an attribute that is deeply discreditable as a result of pre-hospital societal reaction, labelling by official third parties and subsequent institutionalization.

II. Post-Hospital Experiences with "Normals" and the Perceptions of Mental Illness as Stigma

A second manner by which ex-psychiatric patients come to see their conditions as discreditable is through direct exposure with members of society who reject or disapprove of them. One male ex-patient, emphasizing that he

learned the social meaning of his falling through interaction with others who responded to him with a mixture of fear, disapproval and rejection, states:

It really didn't sink in until I left the hospital what it means to have been treated for mental illness. I never really realized that I now had a mark on me--everyone treated me differently who knew that I had been hospitalized. They thought of me as a "crazy lunatic." Most of them remained cold and silent. People who once used to be close to me, now completely rejected me flat out.... Once you've been treated in the "luney bin" as they call it, your friends and relatives treat you like you've got the plague.... After I'd been treated like this a few times, it finally sunk in that I had something that my friends and others thought was disgusting...like I was now soiled or dirty. (Observation # 39, September 20, 1981:4).

An elderly chronic ex-patient learns the social meaning of her falling upon release through experiences with her family:

When I was released from the hospital, I thought that I could resume with the "good times" once again. I was treated--I payed my dues. I thought I could start over with no problems. But I was wrong. From the first moment I set foot back onto the streets of _____ (city), and I tried to return to my family there, but they didn't want me. They never came to visit me when I was in the hospital but I thought they were just "busy." But I learned the hard way, once I was discharged, that my family want nothing to do with me--they're scared I might do something.... You know, having mental illnesses is like having any other illness like heart trouble or appendix problems, but people do sure treat you different. If you have heart problems, you go to the hospital, get treated and then you come out good as new and your family still loves you. But that's not so with mental sickness; you go in the hospital, get treated and then come out but you find out that other people shun you--they treat you worse than a dog! (Observation # 101, October 21, 1981:4).

Just as family members sometimes "teach" ex-psychiatric patients that they possess a stigmatizing attribute, so too,

do co-workers, neighbours and friends sometimes provide such information:

I worked as a chartered accountant for several years with this firm in _____. When I had my breakdown, my doctor suggested that I take treatment in an institution as opposed to taking treatment on an out-patient basis. After seven months, I was released and I felt better than ever; however, to my amazement, my fellow colleagues treated me differently. We all used to go to lunch together, but after my release, they said they no longer eat lunch; neither do they play golf or go out for a few drinks after work--the very things we used to do together. They used to huddle in the doorway near the water-cooler whispering but when I came along they clammed up...no one wanted anything to do with me after my release.... After a number of these rejections from my "former" friends, I finally realized the stigma attached to be mentally ill... (Observation # 267, June 2, 1984:5).

In short then, many ex-psychiatric clients in this study found out that they possessed a stigmatizing attribute through direct exposure with various "normals"--family members, friends, neighbours and co-workers--persons who were fearsome of the ex-patients, or responded to them with rejection or disapproval.

III. Self-Labeling and the Perception of Mental Illness as Stigma

Just as many ex-psychiatric patients discover the social meanings of their falling as a result of public labelling and institutional processing, and others, through direct negative experiences with "normals" in the community after hospitalization, still others, learned such information in yet

another manner--through self-labelling.⁷ Schneider and Conrad (1980:35), describe the importance of self-labelling when they say:

Most sociological work on stigma assumes that the stigmatized learn the meaning of their attribute or performance primarily through direct exposure to rejection and disapproval from others. Less understood is the place of the perception of stigma--of what the putatively stigmatized think others think of them and 'their kind' and about how these others might react to disclosure.

Approximately one-eight of the sample indicated that they subjectively perceived mental illness to be personally stigmatizing; that is, likely to lead to personal debasement if discovered by others. The data indicate that such persons labelled themselves as possessing some sort of "mental illness" or "psychological sickness" above and apart from any formal or informal reaction and official labelling. Similar to Scheff's (1984) study, the data indicate that ex-psychiatric patients learned and internalized, early in life, stereotypical imagery of mental illness and insanity--imagery that was constantly reaffirmed throughout their adult lives in the context of social interaction with others, and by the mass media. So too, did such persons learn and internalize stereotypical images of normality early in life--images that were constantly reaffirmed in ordinary social discourse. In short then, by incorporating the stereotypes of "normal" and "crazy," some individuals defined their behaviour as "mental illness"; moreover, upon such self-definitions, these

persons also realized the discreditable nature of the attribute of mental illness. One young ex-mental patient, recalling the manner by which she defined herself as being mentally ill, and her perception of mental illness as personally stigmatizing, states:

For me, I knew about mental illness and the stigma that goes along with it long before anyone had to hospitalize me, or even said that I might be "sick." You see, I've lived in the world for twenty odd years before going to the hospital; during that time, I learned from the kids on the block, my school friends, and on TV, and even from my parents what is supposed to be normal behaviour and what is weird--or a sign of crazy, mental behaviour--like what is OK and what isn't. I watched so many movies on TV where there were escaped mental patients, and people on those soap operas who had nervous breakdowns--so I knew in my heart, from watching these things, I judged myself that I was starting to act a bit mentally sick. Each day, it was getting harder and harder for me to do simple things--like get up and take a bath, make breakfast, go to work, etc. It was me who was the first one who saw my sickness--no one else.... And no one had to reject me before I knew the consequences of being mentally sick--I knew that my family and others would treat me badly if they found out about me--if you live around a bunch of familiar people, and you watch TV, you just know! (Observation # 10, December 29, 1981:3).

Similarly, a second, middle-aged ex-chronic states:

To tell you the truth, I knew I was sick for a long time before anyone discovered it. I wasn't quite right and I was doing strange things and I didn't even know why.... How did I know they were strange? Well, when you're growing up, you learn right from wrong--what is appropriate and what is not. Your friends and parents teach you. You read books and watch movies and you just know how to act. So, on that basis, you just know when you're doing something--acting "wrong" or "strange." So, it was me who first realized that something must be wrong with me--not the doctors, not my wife, and not the neighbours.... I knew I was sick for six months before

anyone else discovered it.... A voice always kept badgering me telling me to do violent and weird things. It reminded me of that movie, "The Exorcist." I knew that something was wrong with me--it wasn't God or the Devil talking to me but that I must be going insane--I was like that guy in "One Flew Over the Cuckoo's Nest."... And I also knew how people would treat me like a freak if they knew about my sickness... That's the way all people treat mentally ill persons.... They're either afraid of them or treat them as if they're something out of this world.... No one had to spit me in the eye outright or shy away from me for me to realize what it means to be mentally ill; I realized this because of living in the world most of my life--you learn these things--it's something you just absorb and digest! (Observation # 121, January 5, 1982:15).

In short then, through internalization of stereotypical images of normality and insanity, many ex-psychiatric clients (prior to official or unofficial labelling), define themselves as being mentally ill; moreover, such stereotypes provide these ex-patients with self-definitions of discreditability. Lorber (1967:303) commenting on the role of self-labelling states:

...even though his social group assumes his innocence, the deviant either sees himself as doing wrong according to his own reference group, or, condoning his own behaviour, he realizes that others will condemn his actions according to their standards. In either case, to avoid the consequences he feels will occur if his deviance comes out into the open (is officially labelled), he pretends to be conforming to the standards of the group in a position to condemn him for what he is doing secretly. In short, in response to his self-label of his behaviour as apt to incur sanctioning, he acts in such a way as to achieve a social label of conformity.

OFFICIAL LABELLING, INSTITUTIONAL PROCESSING, POST-HOSPITAL
NEGATIVE RESPONSES, SELF-LABELLING AND THE PERCEPTION OF
MENTAL ILLNESS AS STIGMA

While some ex-psychiatric patients learn the social meaning of their failing--that they possess a stigmatizing attribute largely through one of the ways discussed previously, the data indicate, that many, however, discover such information in combination. Specifically, some ex-patients in this study learned that they possessed a stigmatizing attribute through (1) self-labelling and through (2) negative post-hospital experiences with "normals" who reject and disapprove of them. One female ex-psychiatric patient, discussing the processes by which she learned the social meaning of her failing, states:

I learned what it means to have mental illness--I mean that it is somewhat of a stigma in a couple of ways. First, after being discharged from the hospital and I returned to the city of my landlady and most of the neighbours would have nothing to do with me. That was the first indication that I had "something"--a condition that was worse than having A.I.D.S. People treat you with fear. Others laugh and ridicule you. But I also learned what it means to be a mental patient way before I even went into the hospital... I guess I was getting sicker each day... everything became confusing... I knew that something must be not quite normal, because after all, in health class and on television, we are taught about "the signs" of mental illness... And I also knew how people would act if they knew that I might be sick... that the people next door and even my sisters would want nothing to do with me... that's why I tried to hide it for awhile.... (Observation # 150, March 3, 1982:5):.

Similarly, a male chronic ex-patient states:

I felt that I might be not normal long before they sent me to the hospital. I just knew inside of me that things weren't "right." I would do "strange" things like light up matches and set fires in different places.... Sometimes I would get so angry that I'd want to lash out at the first person that came by.... But I didn't know what to do. After all, if I let other people "know," they would do something to put me away. You know what people think of "mental patients." They treat them meanly.... I also learned the consequences of being mentally sick from exposing myself to people after I got out of the hospital. Everyone in my family treated me weird or they told me that I'm not wanted there. That's the curse of mental illness--the "accessories" that come along with the illness that you never bargained for.

Just as some ex-patients learned that they possessed a stigmatizing attribute through both self-labelling and post-hospital experiences with "normals," others, in this study, learned such information through a combination of (1) self-labelling, and (2) official labelling and subsequent institutional processing. One middle-aged female ex-patient, discussing the processes by which she learned that she possessed a stigmatizing attribute states:

I learned that I had acquired a condition that is defiling--a shortcoming that is considered abominable by people by living with people, by listening to them, by watching the T.V. and things like that. When I first started to get sick, I realized that I was getting sick--that I wasn't quite "normal." How did I realize this? Well, you know what is normal behaviour and what is not due to the fact that you live in society and I was beginning to do some things that weren't quite normal. I was beginning to doubt my sanity.... But I was afraid of what the consequences would be; I mean, what it would mean for me socially if others found out.... I knew what the negative things were associated with "craziness" from what I learned through the years but all of this was reinforced--was solidified when my husband and my mother called the doctor and had me committed.... From that time on and all the time I was in hospital on the wards

--the nurses and the other patients--the O.T. staff (occupational therapy) and all the rest drummed it into me the negative effects of being mentally ill--the negative effects of being "branded." (Observation # 23, October 1, 1981:2).

A somewhat similar tale is told by an elderly male ex-psychiatric patient:

Being mentally ill sucks. You get treated like a piece of shit--like a nothing by the rest of the people. The people don't understand me... But I knew all of this was coming my way... I realized what it meant to be called "mental patient" before they hauled me away to the hospital. We used to have this fellow in our neighbourhood years ago when I was just a boy.... He was a little simple but all the kids, and lots of the adults too, used to ridicule him--some used to even hit him with a stick. So I knew what people would think of me and how they would treat me if they found out I was sick. I knew it--or I supposed it but I did everything in my power to hide it as long as I could--I wanted to avoid that!... Too, I learned. I had a blight of humanity after I finally got out of the hospital and people looked at me funny --they stared at me; one time, I was on the bus and a guy tripped me and everybody laughed. They called me retard and made faces at me. That's when it really hit home what it all meant to have been in the hospital for mental illness--it's something bad that follows you wherever you go! (Observation # 179, June 1, 1982:3).

SUMMARY

When psychiatric patients are discharged from the hospital and re-enter the community, their problems are far from being over. Although such persons desire to abandon the negative, deviant self-conceptions of "mental patient" bestowed upon them in the hospital and begin the restoration of a more positive, non-deviant identity, they discover that

problems of stigma hinder such aspirations. Specifically, the ex-patients discover, either through self-labelling, official labelling and institutional processing, through negative post-hospital experiences with "normals", or through a combination of the above, that they possess a stigma--a stigmatizing attribute that limits or impedes the rebuilding of a more positive identity and also limits their participation in normal social roles. How do ex-psychiatric patients deal with the stigma potential of mental illness? What techniques/strategems do such persons develop and employ? Do chronic ex-patients differ from themselves and from their short-term counterparts in terms of the strategems they develop? What are the implications of adopting these strategies for identity transformation? Such concerns will be addressed in the next two chapters.

NOTES

1. Davis (1975), Gibbs (1972), Hagan (1973), Nettler (1974) and Schervish (1973), among others.
2. Gove (1980) and Rotenberg (1975) in particular.
3. Such studies include Scheff (1975), Mercer (1965), Pillavin and Briar (1964), Wallace (1968), among countless others.
4. Schneider and Conrad (1980), Sagarin and Kelly (1980), Hanks and Poplin (1981), Smith (1980).
5. Such issues will be fully explored in chapters seven and eight.
6. See Goffman (1961), Herman (1981) and Scheff (1967) for details.
7. Other studies such as: Lorber (1967), Robins (1980), Schur (1979), Sagarin and Kelly (1980), and Morash (1982) have focussed on self-labelling as the major cause of a deviant identity and the manner by which such persons learn that they possess a discreditable attribute.

CHAPTER SEVEN
LONG-TERM EX-PSYCHIATRIC PATIENTS
STIGMA AND IDENTITY TRANSFORMATION

In general, the existing literature suggests that, upon release from "total"¹ or "people-processing"² institutions, the deviants' problems are far from being over. In fact, numerous problems lie ahead for such individuals attempting to return to a life of normality or conventionality. As Erikson (1966) and others have noted, in their studies on the reintegration of deviants into society, there exist virtually no formal rights of passage to mark the ex-deviants' passage out of deviant identities and roles. While society has developed and employed various "degradation ceremonies" (Garfinkel, 1956) marking the passage of individuals from "normal" to "deviant" identities and statuses, there are no such comparable ceremonies to re-instate the "reformed" or "ex-deviant." The literature suggests that, in actuality, ex-deviants discover, upon their release, not only that no such ritualistic ceremonies exist to "transform them back" to their old self-conceptions of normality, but rather, that they possess a mark—a stigma or blemish that is potentially stigmatizing, serving as a threat to their social statuses as "normal" societal members.

As was stated in Chapter Five, stigma, although having an objective basis in the "real world" can also be conceptualized as a subjective feeling arising from an individual's perception of self as possessing some discreditable attribute or condition. While some stigmatized persons come to see their conditions as discreditable as a result of interaction with others who respond to their conditions with fear, curiosity, and discourteousness, the literature suggests that others learn the social meaning of their difference as a result of their acquired knowledge of societal conceptions concerning "people of their own kind." In either case, deviants, in general, upon their return to the community, find out that they possess a "mark of Cain"--a physical or non-physical attribute leading to subsequent stigmatization on the part of societal members--stigmatization preventing such persons from transforming their deviant identities. In short then, many ex-deviants find it extremely difficult to cast off their deviant identities and begin life from where they left off prior to official labelling and institutional processing. Their ancillary deviant aspects of self function so as to block or impede the deviants' way back to a life of normality. The fear of recidivism on the part of societal members, for example, serves to limit the ex-deviants' access to economic opportunities, alters familial relationships, and serves to limit social relationships with certain normal others. Given that society effectively blocks off the route

to normality--opposes reintegration, many deviants are thus, forced to retain their deviant self-conceptions, and engage in further deviant activities,³ sometimes leading to the formation and participation in deviant subcultures.

In the case of long-term chronic ex-psychiatric patients, in particular, the researcher was interested in examining what happens to such persons when they are released into the community. Specifically, in this study, the following questions were addressed: (1) Upon release, do long-term, chronic ex-mental patients passively accept/adopt permanently the identity and role pro-offered and imposed upon them in the psychiatric institution (as the previous literature has suggested)⁴? or (2) Do such persons, upon discharge, actively attempt to alter such deviant conceptions of self? (3) If so, do they succeed or fail in their endeavours? (4) What factors are important for successful identity transformation? (5) How do long-term chronic ex-patients deal with the stigma potential of mental illness? (6) Do elderly, middle-aged and young chronic ex-patients differ in terms of their desire to, and their success in, achieving a more positive, non-deviant identity, and in the strategies they develop and employ to deal with the stigma potential of mental illness on their daily rounds?

ELDERLY,⁵ LONG-TERM CHRONIC EX-MENTAL PATIENTS: STIGMA AND
RETREAT

The data indicate that the elderly long-term chronic ex-patients in this study, make no attempt to transform their deviant identities upon release into the community. Given that such persons have been hospitalized for a number of years, or a multitude of times in their lives, these individuals, in the context of institutional processing, have fully internalized the role of "mental patient" and its corresponding status. Their deviant identities are conceived by virtually all elderly long-term chronics to be permanent. As one elderly male, chronic ex-patient states:

I've been sick for forty-nine years now. I first went into the institution when I was seventeen and I was in for nine years. Then they let me out for a while, but I got sick again and they sent me back. I've been in ever since until last year when they released me and put me into one of those boarding homes...I've been "mental" for most of my life you know--it's not the way I wanted to live my life but what could I do? It's who I am and I guess I'll be that way until I die. I guess it was meant to be. (Observation \$ 282, June 15, 1984:28).

Another elderly female ex-patient, stressing the permanence of her deviant identity states:

I'm a real sick woman you know. That's what I've been told by everyone--the priest, my teachers, my doctor, my mother, my brother and even my friend Max. They've put me in the hospital, probably over eighty times in my life--I'm not sure, I've stopped counting. I've been in so many times. Now they've released me and they want me to do things on my own. But I can't. I just can't. I'm sick and I'll always be sick. I just can't be like everyone else out there going to work or raising a family. It would be too much for me. They want me to work but

I can't. I have a "mental sickness" you know, and I'm never going to get better--never. So I don't even try! (Observation # 11, October 12, 1981:4).

A third elderly chronic ex-patient adds:

It's like this. After you've been in hospital for years and years they start referring to you as "crazy." You've been tarred and feathered with that new name. No matter what you do, you can't get it off. Over the years, it's become hardened--hardened so much that there's no use in even trying. That bunch of tar and feathers becomes part of your skin--it becomes a part of you. It's as permanent as the nose on your face... I'm mentally ill--I have been for twenty-nine years now and there's nothing I can do to change that! I'll be that way forever! (Observation # 13, October 15, 1981:13).

The data indicate that such a perception of self as being permanently deviant is reinforced by three factors:

(1) the type of deviant label bestowed upon them; (2) the medication taken and their side-effects; and (3) the disability cheques received by such persons. Turning firstly to the type of label, the data suggest that, in general, those elderly long-term ex-patients, defined in the hospital as being "chronic" and "psychotic", tend to see themselves as the "bottom of the psychiatric barrel"--as possessing serious, incurable, permanent psychiatric disorders. As one elderly male ex-patient states:

I was in the hospital for about twenty-five years. It's been so long now that I'm not even sure anymore. I came in when I was a young man and now look at me! I was treated on almost every ward. I was given all kinds of treatments--shocked many a times, given all kinds of drugs. Through all those years, sometimes I thought I was completely OK--I really felt tip-top, and knew everything going on. But other times, I must have been really sick--things are blurred now but I knew the devil was trying to get me.... They said it was no devil but

that I had a serious case of some kind of psychosis--something that even God can't cure ...when I read about it I found that I'll always have it, no matter what! If I had a nervous breakdown or a case of schizophrenia like some of my other friends,--those people in the hospital, then things would be different! When you got a major sickness like men, there's just no cure. There's not much hope for me! (Observation # 192, October 31, 1983:14).

A second elderly chronic ex-patient, supporting this viewpoint states:

I've had mental problems my whole life. I've been in and out of trouble since I was a teenager. I kept hearing voices all the time telling me to set fires to places or do things to hurt people. The voices got louder and louder until I couldn't think straight anymore and that's how I ended up in the hospital. They told me that I was real sick--that I had some type of disorder called a psychosis or psychopath, I think. Anyways, all the nurses were told I was "dangerous" and what they called "unstable." At first, I didn't believe what those head-shrinkers were telling me, but after eight years of treatment, I believe it is true... Now since I've been let out, I went back to the hospital three more times and now I'm out again... I find it hard to get along--it's hard to manage your life and do the right thing when you have a serious sickness like mine. I'm not one of those patients who just had a little problem once in their life and then was cured. I'm real sick and it will be forever a part of me--I can't escape it and live a normal life like those people you see on TV! (Observation # 202, February 2, 1984:23).

Just as the chronic ex-patients' perceptions regarding the permanency of their deviant identities are reinforced by the type of psychiatric label affixed to them, so too, are they influenced by their perceptions of the nature, duration and amount of medication they are taking, and the associated side-effects. One elderly chronic ex-patient, discussing his medications, states:

When I got out of the hospital about a year and a half ago, they put me on more medications than I had been taking in the hospital. Right now, I'm on six different kinds--I take a handful of pills four times a day--some red ones, some blue ones and some white ones. I've taken Librium, and a whole bunch of other meds. Some are uppers, some are downers, some are inners and some are outers.... The thing about the meds is that I'll be on them for the rest of my life since there's no cure for what I've got. Every time I take a handful of pills, I am reminded of how sick I am--that this is the way it will always be...and more than that, the jitters and shaking I get from taking the pills reminds me of this! (Observation # 236, April 28, 1984:12).

Similarly, a second elderly chronic ex-patient remarks:

Shit, all those medications I have to take--it's a crying shame, but what can I do? I've been on Librium, Valium, Cogentin, Ritalin--you name I've either been on it or am on it now. So you see my situation. I've been sick for so long now. I must be the sickest man in Ontario. The doctor says to take my medications so that they can help me--calm me down and stop my mind from moving. They may help me a bit--I don't get as depressed. But they also make my hands and feet shake. And sometimes they make me feel more mixed up! (Observation # 84, January 8, 1982:3).

In short then, the majority of elderly, long-term chronic ex-psychiatric patients in this study were consistently receiving numerous medications--drugs designed to stabilize such persons, and by so doing, enabling them to remain in the community. However, the duration over which such drugs are taken, the dosages, and the large numbers of medications, coupled with the associated side-effects, function to reinforce the permanence of their deviant identities:

It's obvious that it's all over for me. Look at all the meds I've been taking. I am sick--I've been taking these meds for years and years. And over the years, the amounts of the meds have increased--and they give me more and more drugs to take. I've taken thousands of drugs in my life. The drugs help put me on an even keel but they

can't cure me--nothing can--I've got a disease like cancer--it'll be with me for as long as I live.... Once in a while I get the silly idea that maybe, just maybe I'm not going to be that way forever, but then I see the pill bottles all lined up in a row on the kitchen table and I say to myself--"You crazy fool, if you weren't so sick, do you think you would be taking all those drugs for such a long time? (Observation # 88, January 11, 1982:3).

A third factor reinforcing the permanent nature of their deviant identities centres on the disability pensions that such elderly chronic ex-patients are receiving. Specifically, the data indicate that, such pensions, represent the only money these persons have on which to survive;⁶ thus, their monthly cheques are welcomed with open arms. However, at the same time, the notion of receiving a "disability" pension functions to remind these persons that they possess some sort of psychiatric disability--a permanent disability in their eyes. An elderly male chronic ex-patient, discussing the advantages and disadvantages of receiving a disability pension states:

I've been on disability for about three and a half years now. They give me so much a month--it isn't much but I get by. I live in this one room on _____ Street. I have this little hot-plate and sometimes I cook. It's good getting this cheque each month or else I could never make a go of it. But the money isn't enough to eat decent food. Sometimes I scrounge for food in the alleys.... But I also feel kind of sad when I get my cheque because it reminds me that I am "disabled"--it's not a fleeting thing, but something that I'll be all the time. I don't like taking money without working, but what can I do? I'm mentally sick in the head! (Observation # 180, November 3, 1983:5).

Similarly, a second elderly ex-patient states:

I get this cheque every month but the boarding home lady takes most of it and I just get \$50.00 back to spend on cigarettes. It's the only money in the world that I got to my name. Nothing else. When you have a disability like me--something that's not your fault and can't do nothing about, they give you a disability pension. Not just anybody can get one--you have to prove that you're really disabled--either in a wheelchair or have an arm missing or part of your mind screwed up like me--something that you can't cure even if you wanted to. Every time you get a cheque, you know that the government still thinks you are mentally sick... (Observation # 59, November 13, 1981:8).

The data indicate that, of those elderly chronic, long-term ex-patients interviewed, the majority believed they were permanently mentally ill; thus they did not even attempt to return to a life of normality. However, in four cases, upon release, such persons made an initial attempt to alter their deviant identities, but failed. Speaking of his failure to achieve a more positive, non-deviant self-conception through employment in a non-deviant occupation, an elderly chronic ex-patient states:

About seven years ago when they let me out I was so pumped up--I believed what the social workers and therapists were telling me about how I could go out and find a decent job if I tried; forget about my past and start over. Well, forget it. I pounded on doors... I tried bakeries, drygood stores, meat markets, and all the factories I could think of but no one would take me on. They asked where I had been the last ten years--what job had I been doing before I applied for this one. When they found out that I had been up to the you-know-where (mental hospital), they threw me out on my ear.... So what's the use. Ninety-nine percent of me knew I'd never be able to start over, but one percent just wanted to try--it was a longshot and I lost.... Never again. After that

experience, I told myself that my sickness is a part of me--it's here to stay. That's what the doctors told me, and that's what all those bosses told me when I went looking for a job. So I guess it's the truth! (Observation # 280, June 10, 1984:12).

A second chronic ex-patient, speaking of her failure to attain a more positive non-deviant conception of self says:

Boy, was I ever naive when I got out three years ago. I had been in for so long I guess I became stupid as well as "crazy." For all the time I spent in the hospital I knew that I had a sickness that was very bad. My mother told me that it was incurable. I accepted that.... But then something happened when I got out--I knew in my heart that I wasn't normal--and everyone said I'd always be like that, but something inside of me wanted to try--to try to change and live my life like Mary Tyler Moore did on TV. I thought maybe I'd meet a friend like Rhoda and get a job like Mary did and have friends and do fun things. I was fifty-six then but I didn't look my age. But it never worked out that way. I moved in this room upstairs from a grocery. On the other side of the hall was this girl. One day, I went over but she didn't want anything to do with me. She said she heard I was a "nut" and told me she would call the police if I bothered her. I never did anything to her. I just wanted to make friends and live my life like Mary did, but people don't let you.... After that time, I never tried again. I hid away from everyone. (Observation # 239, April 23, 1984:6).

For virtually all of the elderly chronic, long-term ex-patients in this study, they have come to the realization that their deviant identities are permanent fixtures. While some persons, in the past, attempted to alter their identities, they have all been unsuccessful; such persons have given up hope of ever living a "normal" life--they have abandoned their hopes and dreams:

You know, once I thought that if I got out of the hospital, I would apply for the police force. That was my life-long dream. But I was in the hospital for so many years that it's too late now. I don't even belong in the city anymore... I thought that one day I might like to get married, but that'll never happen now.... People out there don't like me. They hate me and I'm afraid of them. Since I became sick, everything changed--my life has been ruined.... Who would want to marry a mental patient?... Life is a bitch! (Observation # 190, March 21, 1984).

Similarly, another chronic ex-patient states:

I always had this dream of becoming a person who would help his fellow man--like a teacher or a nurse or a social worker. But look what happened. I've been sick for a number of years. I haven't become anything. I've just been a burden on everyone--that's what everyone tells me. It's all over for me now--I can't be of use to anyone. I wouldn't even try to be because I know in my heart of hearts that I would be shot down. My doctor at the hospital said that I'm doing OK as long as I don't over-stress myself and take my medication. That way I can be "maintained." That's fine and good but it still makes me mad because all my dreams have been shot to hell! (Observation # 191, January 3, 1984:2).

The elderly chronic ex-patients interviewed in this study felt that, upon return to the community, they were "unwanted aliens" or "outsiders." Over ninety percent of these persons received neither support from family or non-deviant friends; the other ten percent received only weak and inconsistent support from one or two family members.⁷ In effect then, the data indicate that the elderly chronics are alone in the community--often the victims of ridicule, exploitation, hatred and fear. Some of these individuals are living in boarding homes for ex-psychiatric patients; others were living in missions, cheap hotels or on the streets.

Given that such persons had been institutionalized for years at a time where all their basic needs for food, clothing and shelter were met, such persons, upon release, find great difficulty in carrying out everyday affairs, and in making decisions. The data indicate that these ex-chronics lack basic social living skills that are taken for granted. Many are unable to cook for themselves, budget their disability cheques, use public transportation and in general, live in the community. Despite attempts at re-acquiring these basic social living skills through various "day-care" programmes, many admit defeat. These ex-chronics consider themselves to be permanently mentally ill, and that it is "impossible to teach old dogs new tricks"--it is impossible to resocialize them, in their opinions. Either through direct negative stigmatizing experiences with normals in the context of social interactions, their subjective perceptions of the permanence of their disabilities, through the difficulties encountered in re-learning basic social living skills, through their previous unsuccessful attempts at transforming their deviant identities, or through a combination of the above, these elderly chronic ex-patients realize that reintegration is impossible. How do elderly long-term ex-patients deal with their undesirable social situations? The data indicate that they generally adopt the following negative strategies: (1) institutional retreatism; and (2) societal retreatism.

Institutional Retreatism as a Management Strategy

One such strategy, termed here as "institutional retreatism," is frequently adopted by many elderly chronic ex-patients. These persons have fully and permanently accepted the identity of mental patients, its corresponding role and status, feel estranged or isolated from the larger society, have experienced great difficulty in carrying out everyday tasks, and have experienced stigma of various sorts; as a result, many chronic ex-patients in this study, on a number of occasions, actively sought to return to the psychiatric hospital from which they were discharged--their "home," their secure environment, a location where all their basic needs are met, where no responsibility is placed upon them, a place of familiarity in which their status and role is clearly defined and where the stigma potential of mental illness is diminished. One elderly male, discussing this strategy states:

I've done it a few times now. I just can't make it out there. I know who I am and they know who I am--most of the people out there won't come near me or laugh at me. I'm just like a leper in their eyes. They treat most mentals like that. They're prejudiced you know. I've seen it a thousand times. They're either afraid or they hate us. I don't feel good when I'm out. I don't belong. They know it and I know it. That's why I go back to the hospital every chance I get. Pretty soon, I'm going to try to go back in again. But it's not so easy. What I'll have to do is "act up" or something. Either start a fight at the boarding home, do something, and then the cops will pick me up, or make a scene at King and James. Then they'll take me back to the hospital--my "home sweet home." (Observation # 41, November 12, 1981:3)

Another elderly chronic, long-term ex-patient, outlining his method says:

I can't stand being out. It's not for me. I belong in the hospital. It's safe there. I know what they want from me and I give it to them. No problems. No one bugs me or makes fun of me. I get fed three squares a day.... Last time I wanted to go back I set fire to this church...that's how they realized that I should be looked after. You can't just go up and walk in anymore--you gotta be sick or act sick. I'd do it again too. I just don't like being out-- I belong on the ward. The nurses are my family and I have all my friends up there. (Observation # 4, October 4, 1981:21).

A third, elderly female ex-patient, recounting her technique says:

It's not that hard to get back in the hospital. I usually just go to the bus or train station and make a scene. I go wild and start to cry or laugh funny. Someone comes up and asks if I'm alright and I say I'm talking to God. Pretty soon they call the police and soon I'm back at the hospital. I tell them I been in for a long time and they take me back. Why do I do it? Well I can't stand being alone out there--I'm afraid. There's so many things to do and I get mixed-up. I'm sick so I can't work--I'm on disability, so I spend my days downtown; but sometimes people are mean to me--they try to steal my money and push me down... I belong in the hospital... I like it there. I feel at ease there--it's a place where people can't hurt me! (Observation # 40, November 1, 1981:15).

Societal Retreatism as a Management Strategy

Just as many elderly chronic ex-patients adopt and employ the strategy of institutional retreatism to minimize the stigma potential of mental illness, so too, some adopt a strategy termed here as "societal retreatism" or "self-

segregation"--a strategy whereby such individuals remain in society but actively retreat to its outermost fringes. By so doing, they are able to avoid what they conceive to be potentially-stigmatizing reactions from normal others. Such elderly ex-patients then, accept the fact that they will never "measure up"⁸--they see their deviant identities as permanent entities affixed to them; thus, many elderly chronics decide that the best strategy to employ is one where they attempt to "hide away" from normals. One such chronic ex-patient, discussing this strategy states:

Since they let me out of the hospital, life has been hell. Nobody gives a damn about you--nobody is willing to give you a break. They treated me like a piece of shit. I know that it's impossible for me to be like the rest of them--you know, like a Trudeau or a Johnny Carson--I know that I'll never be as good as them. After all, I have this mental illness and I have to take these pills or I'll really get sick again and hear those voices... But I don't like it on the outside. I feel so alone.... Lots of times people make fun of the way I am; some kids chase me; other people hate me, and others rip me off. What can I do? I stayed at this boarding home for awhile but they made me go out everyday up-town. They didn't want me around. And that's where everyone at the mall would chase and make fun of me. I'd had it. Now I'm away from all of that as far as possible. I live in this room by the docks. I lock myself away from the dirty, filthy world--that way, they can't hurt me anymore. (Observation # 38, November 2, 1981:14).

In short then, for many elderly, long-term chronic ex-psychiatric patients, their self-images and identities are profoundly negative in nature. Such persons (by virtue of the institutional processing) see themselves as permanently mentally ill--an identity reinforced by the "chronic" label attached to them, the nature, dosages and number of medications taken,

and the receipt of a disability pension; thus, most of these persons do not even aspire to normal attainments. Such persons accept societal values of "normalcy" and "abnormality" and realize that, according to these, they fail to measure up. Unable to deal with such failure and in an effort to minimize the stigma associated with it, many elderly chronic ex-patients withdraw from the "real world" to live in cheap hotels, flop houses, in abandoned buildings and other marginal locations or to take steps to gain readmission to the protective environment of the asylum.

MIDDLE-AGED, LONG-TERM, CHRONIC EX-PATIENTS: STIGMA, DISSOCIATION, PASSING AND CAPITULATION

Similar to the elderly chronic ex-psychiatric clients, the data reveal that, in the case of middle-aged chronic ex-patients, their post-hospital worlds are filled with sorrow and despair. However, in contrast to the elderly chronics (who, with the exception of a few, do not even try to transform their deviant identities), most middle-aged, long-term ex-patients in this study, for a period of time, attempt to aspire to a normal life; however, virtually all fail in such endeavours. Although such persons desire to obtain a more positive self-image and identity, they discover that a number of obstacles impede such a transformation of self. Specifically, the data suggest that middle-aged

chronics are faced with a paradoxical situation upon release from the psychiatric facility. On the one hand, such persons are told by therapists, social workers, and significant others, to strive for a life of "normality." In the case of (re)-employment, for example, ex-patients are told to go out and find a job. But the reality of the situation is such that the only places that will hire such persons are "sheltered workshops" for the mentally handicapped--workshops requiring these individuals to perform menial and sometimes, degrading tasks for low wages, thereby impeding the rebuilding of a more positive non-deviant self-image:

When I got out about two and a half years ago, I tried to change my life. I'd been in the hospital a few times--once for three years, another time for two years, a third time for about a year, and the last time for about a year or so. My social worker placed me in a lodging home downtown and told me to try to look for work--that I shouldn't waste my time away. At first I wanted to find a job --I thought maybe, just maybe, if I had a chance, maybe I could make a go of it. I could start fresh. Bull. I pounded the pavement looking for work everywhere. I went to Manpower and when I tried to fill out an application and they saw that I didn't work for over ten years because I was in the hospital in and out, they just looked at me funny. One girl there suggested that I try Industries--a place where people with disabilities work. They pay you about thirty cents an hour. I didn't want to work in a place like that, but I tried to get work everywhere else but they turned me down. I tried but failed, so I was forced to work at that Industries for a few cents.... The boss down there told me that I was lucky that he even hired me--that former patients don't even deserve to be paid anything at all! In other words, we're useless, disabled pieces of garbage! (Observation # 199, November 29, 1983:2).

Similarly, a second middle-aged chronic ex-patient states:

Ever since I was discharged in '82, I went out looking for work. I tried everywhere. They stressed that I should go out and look for something--that it would help me to "make it out there." Do you know how difficult it is for us to find a decent job? It's almost impossible today. And the reason behind this is not because I got no skill or experience, but it's because of that pock--that black mark that's on my forehead. I mean, being in a mental hospital ruins you for life. That fact turns employers right off. I tried to get a job but they all turned me down. They were afraid to take a chance--afraid of what I might do. The only place I could finally get work was at one of those "sheltered workshops" where I put a bunch of bolt in a carton. And for that great job they pay me 45¢ an hour. Don't get me wrong, I wanted to get a real job but no one would give me a break! Now I guess I'll have to spend the rest of my life working with other defectives for peanuts. (Observation # 101, February 2, 1982:3).

Just as the stigma of mental illness limits employment opportunities and impedes successful identity transformation, such stigma is also experienced when middle-aged chronics attempt to develop interpersonal relationships with normals:

My doctor told me to go out and mingle with people. So I went and joined the art gallery. It has a number of events--exhibits and socials to attend. But one day, I let a piece of information slip about me being in the hospital and they realized I was a mental patient. Well that ended the friendship I had built with these people. Before they found out, they treated me with respect; but afterwards, they treated me like I had the plague! I tried but I failed! (Observation # 284, June 1, 1984:5).

A second, female middle-aged chronic ex-patient, discussing her post-hospital experiences with normals states:

I know that I was in the hospital for a long time, but I thought when they let me out finally that I might be able to wipe my slate clean and start

over, but I was wrong. I found out the hard way when I tried to make friends in the neighbourhood where I went to live. Somebody who worked as a cleaner at the hospital lived on that block and he told everyone about me. I went up to them and tried to make friends but they didn't want nothing to do with me--they wouldn't let their kids talk to me and when I came around they called their dogs and cats in the house... So even though I wanted to start over, they (society) wouldn't let me! (Observation # 127, March 9, 1982:19).

Moreover, over ninety percent of the middle-aged chronics in this study experienced the stigma of their "failing" with respect to family members. The data indicate that many middle-aged ex-patients, upon release from the institution, discover that their relatives treat them with fear, hatred or ridicule. Many such ex-patients are faced with divorce, separation, or are asked to maintain social distance from familial members. Such an experience of rejection from these significant others not only causes the chronics considerable pain, but also functions to impede the rebuilding of a more positive self-image.

It almost killed me when I got out and returned home to "Terrytown." I thought that my relatives would support me but they did just the opposite. My wife and daughter and her husband didn't want me around. They didn't even want me to come back and live in Terrytown. So they got a court order to keep me away. It was on that day that I also found out that my wife had filed for divorce. It damned near killed me to think that my loved ones would turn on me like that. I never gave them no cause to turn on me. When something like that happens to you, it makes you feel worthless--you feel as low as a snake. (Observation # 120, March 1, 1982:23).

Another middle-aged chronic ex-patient, speaking of rejection from her relatives, states:

I got out two years ago but I couldn't go back home like I planned. No one wanted me. My mom and dad said they were too old to care for me and my sisters wanted no part of me neither. It was a real shocker to find out that my own flesh and blood would do that to me. They didn't want to have a "mental" on their hands--that's what they said. They said that it would be best if I stayed away--that way, they wouldn't be bothered by me... I thought I could count on them to help me start again but they let me down. (Observation # 77, November 3, 1981:14).

Upon rejection from relatives,⁹ many middle-aged chronics are placed in boarding homes--facilities for "people of their own kind." Such forced association with other deviants on a day-to-day basis, also impedes the rebuilding of a more positive non-deviant identity:

Since I couldn't go back home, they put me in this boarding home in _____. What could I do? I had no power. I sure don't like this place. The food is awful and there is never enough to eat, but even worse than that is the fact that I have to live with a bunch of patients from the hospital. I want to start my life over again, but how can I when I live with 12 other mental patients? (Observation # 42, October 2, 1981:13).

A second middle-aged chronic, discussing the boarding home in which she lives, states:

I just hate it. I'd like to leave right now but my caseworker won't let me. If I run, then they'll put me back in the hospital. I wanted to go back to my own house but my husband divorced me. He didn't want to be married to a wife who is a mental. If he had given me a second chance, things would have been different. I would have been able to put all of this in the past and forget all about the hospital and start over, but now I can't. I'm living with ten other patients in this boarding home--I have to eat with them, share my room with them and even share the toilet...I didn't want to end up like this...I wanted to start fresh again--just one more time! (Observation # 96, February 3, 1982:14).

Given that these middle-aged chronics are blocked from re-establishing normal identities and social roles--that they have experienced stigma with respect to employment, family and friends, and anticipate further stigmatizing responses from others, such persons develop and employ the following strategies to deal with the stigma potential of mental illness: (1) dissociation from normals; (2) passing; and (3) capitulation;

Dissociation from Normals as a Management Strategy

One strategy of stigma management frequently employed by middle-aged long-term chronic ex-patients is that of dissociation.¹⁰ These persons generally accept the prevailing societal conceptions regarding normalcy, and realize that, according to them, they are disqualified. For a time, these middle-aged chronics attempt to alter their deviant identities--attempt to become "re-qualified," but fail in such endeavours. In response to the stigma associated with their deviant identities, many middle-aged chronics in this study, while still remaining in society,¹¹ attempt to avoid all contact with "normals." By so doing, such persons are able to mitigate the stigma potential of mental illness on their daily rounds:

After trying to get a job for so long and failing every time, and after being kicked in the teeth by almost everyone around me, I now realize that I can never change who I am. No one will let me. It seems to me that everyone wants "ex-patients" to always be "patients." So I make it on the

outside not by trying to change, but by avoiding all those strangers out there.... That way I don't get hurt! (Observation # 32, October 25, 1981:2).

A second middle-aged chronic, discussing the technique of dissociation states:

I learned it through trial and error--and believe me, what an error I did make! I knew ever before I left the hospital what society thinks about people with mental illness--I knew that in my heart. And I knew that I was a mental patient, and because of that, I was not normal like everybody else, but when I got out, I still tried to change things and I wanted to live a normal life, but that was impossible. People just don't know how to deal with former mental patients--I got a lot of shit from them. I tried and tried but couldn't make it. I tried to make new friends but they found out about me and not to come around no more. I tried to get a job, but it was the same story--no mental patients allowed. How could I start my life over if that was the case--finally, I just gave up. I just want to stop all the hurting people have done to me. They made jokes, they laughed, they were afraid--finally, I made up my mind and just stopped dealing with people out there. I still go to the industrial therapy workshop every day, but I don't talk to anybody outside of work that isn't a patient like me! It's the only way I know how to protect myself. (Observation # 122, March 3, 1982:16).

A third, middle-aged ex-patient adds:

You learn about how to "make it out there." It ain't easy--most people don't like you--they're afraid of you; if your neighbours find out about you, they want you to move. Let's face it--no one wants mentals around. I learned that the only thing to do is to avoid them at all costs. You don't need them; all they do is cause you heartache. I don't want to get attached to them and then have them desert me--I can't take that pain no more. So I just avoid everyone altogether! The only people I talk to are at the boarding home and my social worker. (Observation # 61, November 24, 1981:17).

"Passing" as a Management Strategy

Just as some middle-aged long-term chronics employ the strategy of dissociation to deal with the stigma potential of mental illness, so too, do many, attempt to "pass" ¹² as normals; by so doing, such persons hope to avoid the stigma potential of mental illness. Given that their deviant identities are not readily apparent to others, ¹³ some ex-patients attempt to "hide" their failings and pass as normal societal members.

One component, crucial for passing, involves the concealment of institutional histories, by the ex-patients--concealment of a "record", that if discovered, would be deeply discrediting. Concealment of these discreditable aspects of self involved the construction and memorization of detailed "life stories"--tales that such persons can tell to normals inquiring about their pasts. These tales serve to provide ex-patients with culturally-acceptable reasons for their prior absence(s) from society. One female ex-patient who developed a "story" about foreign employment to justify her absence, states:

What I do is tell people this story I made up. I tell them that I used to work in Atlanta, Georgia in a hotel. I told them that I worked there for nine years as a registration clerk and that I married this southerner down there but things didn't work out, so I came back to Canada. (Observation #.237, March 23, 1984:26).

Similarly, another middle-aged chronic ex-patient, discussing his method of concealment, says:

When people in my apartment started asking questions about my past, I came up with this story that I was in the merchant marines for over fifteen years and that I had travelled everywhere--that's why I'd been away from Canada for awhile--and that's why things are "new" to me. I told them that the reason I can't work now is because I got hurt aboard ship and the marines put me on disability. To emphasize the point, sometimes, I even limp a little. (Observation # 50, October 30, 1981:17).

Just as some ex-patients come up with "stories" about employment to conceal the fact that they have been institutionalized in a psychiatric institution, others, construct "stories" about their "incarceration in prison facilities":¹⁴

I was in the Kingston Pen for twelve years--that's what I tell nosey people who ask me questions. I say that I got in with the wrong crowd when I was a kid and we robbed a store and they put me away. I tell them that I was only eighteen when it happened, and they locked me up for such a long time with no parole. (Observation # 156, January 3, 1983:38).

Similarly, a second middle-aged ex-patient states:

In order to fool people, you have to hide your past. I did. But you have to be clever, because, they'll discover the truth about you if you're not careful. I thought up this story to tell them about me being in jail for twenty years for a crime I didn't commit. That way, when I tell them that, I hid the truth, and I also get their sympathy as well. (Observation # 133, July 4, 1982:26).

Still others, develop stories about their past physical illnesses to account for their absence(s) from society:

I say that I had tuberculosis twenty years ago and they put me in a sanatorium to recuperate but I was very sick, so they left me there for such a long time. Then I got some other complications with my heart and they had to do many operations--that's what I tell them I've been doing most of my life. (Observation # 39, October 3, 1981:4).

Another middle-aged chronic, discussing the construction and employment of a fictitious history involving physical illness, states:

When the neighbours started asking questions about where I came from and what I've been doing the last few years, I tell them, that I've spent most of my life in the hospital--being treated for lung cancer. I tell them about the chemotherapy and the other treatments, and they feel sorry for me.... When you have a story like that ready to tell them, you can hide the fact where you've really been the past six years. If you play your cards right they don't find out the truth. (Observation # 249, May 3, 1994:28).

In short then, through the construction of fictitious past histories and their subsequent "telling" to normals, many ex-patients are able to conceal the fact about their prior institutionalization(s), thus, enabling them to pass as normals, thereby, avoiding the stigma potential of mental illness.

Just as many of the middle-aged chronics in this study, constructed such fictitious tales for the expressed purposes of hiding or concealing their past, the data indicate that others, (whose stigma or aspects of it, are more readily visible), construct such "tales" to account for these potentially-stigmatizing aspects of self. Specifically, in the case of four ex-patients, with visible scars on their foreheads resulting from lobotomies, such persons, developed "tales" to explain such marks:

When people start staring at my head, or come right out and ask me about it, I tell them that when I was a kid, I fell off my bike and hit my head on the sidewalk and my head split open like a watermelon. The mark on my head is from the stitches--that's what I say. (Observation # 148, June 3, 1982: 29).

A second, middle-aged ex-patient states:

Sometimes, people will ask me what happened to my head and they point to the mark. I tell them that about six years ago, they found out that I had a brain tumour so they had to operate on me to remove it. I say that the mark left is where the stitches were.... When I tell them that story, they are satisfied, and I don't get hurt! (Observation # 66, December 4, 1981:32).

Moreover, such fictitious stories are constructed and utilized by some middle-aged chronics to account for their excessive hand tremours, jerking movements, jitters, etc.--the side-effects of the medications they are taking:

Sometimes people look at me funny when my hands shake. Mrs. "Smith" came up to me and wanted to know what was wrong. I didn't want to tell her that it's from the medication I was taking--drugs to control my mental problems, so, I told her that I was an "alcoholic" and that I was trying to stay off the booze, and that's why I was shaking. It's better to be thought of as a "drunk" than a "nut", the way I see it! (Observation # 240, April 16, 1984:43).

Another middle-aged chronic, discussing her "story", states:

When I sometimes jerk when I walk and do things, people will question me about what I got--what disease it is. I have an answer ready for them--I say that I have muscular dystrophy, like all those kids you see on the Jerry Lewis telethon. They know what I'm talking about, and I get sympathy and niceness from them. If I told them that I had mental illness and I was on medication, they sure wouldn't act the same way! (Observation # 36, October 12, 1981:5).

In addition to the development and utilization of detailed cover stories to hide their past histories and apparent deviantness, the data indicate that many middle-aged chronics, being strategists, develop various techniques to conceal or divert attention away from the problems that they experience in attempting to carry out everyday activities.

Specifically, many of the middle-aged chronic, ex-psychiatric patients in this study, have difficulty using public transportation--such persons are afraid for fear of "getting lost."¹⁵ However, living in the community, at times, necessitates the use of such transportation. In order to divert attention away from this management difficulty, some middle-aged chronics develop various cover stories:

Ever since I got out, I'm scared to go anywhere. I hate going on the bus, because I get confused and mixed up a lot, and before you know it, I'm lost. But sometimes, I have to go and get groceries, so I call on my neighbour, Mr. "Jones" to come with me on the bus. I tell him that I want him to come with me because I lost my glasses and I won't be able to see what street to get off at. If he comes with me, he can tell me when to get off. (Observation # 97, February 22, 1982:23)

Similarly, a second middle-aged chronic states:

I can't go on a bus alone. It makes me so nervous--my heart beats so hard that I think I'm going to die. From time to time, I have to go up-town for things--for food and things, but I won't go alone. I told my landlady that I have epilepsy and my doctor says I shouldn't go out alone and I asked her if she would go with me. She's a nice lady, so she goes with me every time--just in case I have a "seizure." (Observation # 87, January 13, 1982:35)

Just as using public transportation poses a problem for the "passing" ex-patient, so too, do similar problems arise with respect to comprehending letters received in the mail. Such ex-patients deal with this problem in the following manner:

Once the landlord came up to my apartment waving this piece of paper around. He was calling me every name under the sun and why hadn't I responded. It was true that he sent me out some big long form because I couldn't understand what it meant,

but I couldn't tell him that, so I said that I couldn't read my mail because I broke my glasses. I use that excuse lots of times when I'm about to be found out! (Observation # 285, June 10, 1984:28).

In general, in order to "pass" successfully, chronic ex-patients must conceal their past hospitalizations, develop fictitious life-histories, develop "tales" accounting for apparent deviant aspects of self, and employ various techniques to conceal continuing incapacities associated with their failing. Such persons attempt to "fake" competence and normality during interactions with other normals:

The name of the game is "faking it." You have to be a Richard Burton or a Hal Linden. You have to pretend you're just like them--you have to act "normal." Sometimes, it's pretty tough--you have to lie to them and you constantly have to hide the fact that you were hospitalized. You have to be on your toes when you're with people. If they start moving the conversation in a direction that might expose you, you have to think quick and change the topic. You have to be ready for them all the time with answers thought up--you do all these things so they will think that you're one of them. (Observation # 203, February 2, 1983:27).

Another middle-aged chronic adds:

You have to watch everything you say and do because one slip and it could be all shot to hell. You can't say nothing about the hospital or use hospital terms or they'll catch on. You gotta have stories ready in case they ask questions about your past. You gotta pretend you know what they're talking about, even if you don't. You gotta act just like them to make it. (Observation # 79, December 3, 1981:7).

Just as successful passing involving interpersonal competence with normals, the data suggest that, it also entails avoidance or secret interaction with other ex-mental patients. As one middle-aged chronic ex-patient states:

If you're trying to hide the facts about you, you stay away from other patients. You just can't be seen with them; you can't go to drop-in centres for mental patients, or go to the dances they hold up at the hospital every month. You have to not associate with any of them--it's too dangerous--someone may see you and then the truth would be out! (Observation # 57, November 11, 1981:36).

Another middle-aged chronic states:

Hanging around with the old crowd causes problems. Once in a while I used to go to the drop-in centre, but one night, my new friend Joe saw me going into that place. The next day he asked me about it. I almost died. I thought fast and said that I went in there by mistake and that I was really looking for the restaurant next door. I made a joke about "mentals" and then I left. I think he believed me. I never went to that drop-in centre again! (Observation # 37, October 27, 1981:9).

Capitulation as a Management Strategy

One final method employed by some middle-aged chronics to deal with the stigma potential of mental illness is that of capitulation. Such a negative response is generally employed when other techniques of stigma management fail, and persons "give in" to the stigma. The data indicate that three middle-aged chronics in this study succumbed to the stigma of their failing by committing suicide. According to a friend of one such person:

"Rose" tried to change her life around after she got out of the _____ Hospital, but it was just too much for her. She found that most people aren't very sympathetic to mental patients. Many a time was she hurt by people; it got so bad that she used to avoid talking to people unless she could trust them. When she tried to get a job in

a towel factory, she was turned down because they found out about her "illness." Rose was so upset--she used to rant and rave about how unfair it was that people discriminated against her--treated her like a second class citizen--she got so frustrated that one night she went up on the bridge and jumped off! She broke her neck and died shortly after. She told me that one day she was going to escape the cruel world and be at peace, and that's just what she did! (Observation # 21, September 28, 1981:4).

Similarly, the father of another person who capitulated to the stigma of mental illness in the same extreme manner, states:

One day she was alive and the next day dead. She'd had problems all her life and had been in hospital for a long time. But they let her out on her forty-fifth birthday. We couldn't take care of her so she went into one of those supervised boarding homes. She never liked living there; she felt that she didn't belong there. She tried to get a job working in a department store but they didn't want her. Then I tried to get her a job down at the place where I work but someone tipped them off that she had been in the psychiatric hospital, and they wouldn't hire her. She was so dismayed; she was laughed at by the kids on her block, so she told me.... She tried to keep to herself, but I guess she was so sad, that she decided to end her life. They found her last spring floating in the bay. She left a note in her room at the boarding home saying that she wanted to end the pain and hurt she was feeling... (Observation # 170, March 4, 1983:2).

In short then, the data indicate that, some chronic ex-patients, upon exhausting other methods of avoiding stigma, decide to succumb to such stigma by ending their lives. Such persons have tried in the past to transform their deviant identities, but have failed in such endeavours; on the basis of acquired cultural conceptions about mental illness and/or direct nega-

tive stigmatizing reactions from others, these persons become aware that they possess a stigma. In an effort to avoid being stigmatized by others, some middle-aged chronics employ such strategies as dissociation and passing--stigma-reducing techniques which fail. When no other solutions present themselves, such persons capitulate to the stigma in the manner discussed above.

YOUNG, CHRONIC, LONG-TERM EX-MENTAL PATIENTS: STIGMA, PASSING, SUB-CULTURAL FORMATION AND CAPITULATION

The data indicate that, similar to many middle-aged chronic, long-term ex-psychiatric patients, the younger chronics also make a number of unsuccessful attempts at transforming their deviant identities. Such younger persons, upon discharge from the psychiatric institution, seek reintegration; however, they too discover that certain social penalties are handed down in their efforts to abandon deviant identities. In their efforts to secure non-sheltered employment, such persons discover that the stigma of mental illness serves as a major impediment: 16

I got out of the hospital about four years ago. Before I got sick I was working as a mechanic's apprentice--so I did have some skills to offer. But when I went for the interview, they asked where I had been working after the apprentice job. At first, I hedged around and tried not to answer the question, but then I just said that I had some psychological problems. When he heard that, I was finished. I tried to make something up in a hurry, but I couldn't think

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on my feet, and the truth did me in!
(Observation # 51, November 28, 1981:23).

A second, young chronic ex-patient, discussing the stigma of mental illness as it related to her attempts at re-employment, states:

I went into the hospital about nine years ago and got out three years ago. Before I went in, I had this job at a plumbing supply house, working in the office. When I got sick, I took a leave of absence but I didn't tell them I was going in for psychiatric help; they were supposed to hold my job for me, but when I got out and returned to the office, they wouldn't give me my job back. Apparently, one of the other girls in the office found out about me and told the boss. He told me that because I had been sick, I no longer could take the pressures of working there, so he told me to go home and take it easy. (Observation # 195, November 4, 1983:37).

Given that society effectively blocks ex-patients from securing or returning to a mainstream occupation, such persons, desiring to work, are channelled into employment in various sheltered workshops for the mentally disabled--jobs involving mental tasks for which persons are paid token wages:

I tried getting a job all over.... But everywhere I went it was the same old story.... They'd ask about my past or find out about it some how. But I didn't want to sit around all day on my bum doing nothing.... But when I couldn't get a job no where else, I finally went to the Rehab. Workshop--you know, where mental patients and some retarded people work. I don't like it very much at all. I just pack bandages and kotex in boxes all day--it's nothing to be over-joyed about. In fact, it's embarrassing sometimes. A grown man doing that kind of work! They pay me thirty-five cents an hour--you can't do much with that. I think that paperboys make more money than that. (Observation # 219, January 4, 1984:21).

A second, young, chronic ex-patient adds:

I used to work for this cleaning company for a couple of years before I got sick. But then when I was released and wanted to get my job back, they wouldn't give it to me.... Nobody else would hire me.... The only place that I did get hired was at the Amity. They pay me about forty cents an hour to sort through used clothes and iron things. It's hard work. Sometimes I burn myself on the iron. It seems that the Amity is the only place where patients can get a job--there's a whole bunch of us there... (Observation # 173, September 16, 1983:12).

Just as the stigma of mental illness limits employment opportunities and impedes successful identity transformation, such stigma is also experienced when young chronics attempt to develop interpersonal relationships with normals:

I should have know better, but I didn't. Whe I left _____ Hospital, I tried to start out fresh. I wanted to meet a nice girl, go out on dates, and maybe, someday, marry and have a bunch of kids. But I didn't want to marry another patient neither. I wanted somebody better. I used to go to the bars on Fridays and Saturdays looking for someone. One day I met Sheila. She was really pretty and smart too. We went out for about a month--I was beginning to fall in love with her, then everything, all of a sudden came to standstill. She saw the medications I was taking and on the label it said, "Clarksville" Psychiatric Hospital Pharmacy. She put two-and-two together and didn't want nothing to do with me no more. I phoned her over and over trying to get her back--she used to hang up on me or make up excuses about why we couldn't go out anymore. Finally, on the last time I phoned her, she said that she didn't want to go out with a "nut." After that, I never phoned her again. (Observation # 129, March 11, 1982:13).

A second young chronic ex-patient, discussing her post-hospital experiences with normals, states:

I just wanted to get on with my life. I wanted to forget the hospital, get a job, and make some new friends. But it's real hard, you know. People don't take kindly to ex-mentals. I know that. I joined this church because I thought I

could meet nice people who would kind of take me under their wing and act Christian-like, but they did the opposite. They used to have coffee-hours in the church basement after the Sunday services, where everyone would mingle around and join in fellowship. At first, when they didn't know that I had just come out of the hospital, they were nice to me. I thought I could trust them, so I told them about me. But they didn't like hearing that piece of information. It was like I had A.I.D.S. or something--people started moving away from me and treating me coldly. And they started whispering behind my back... (Observation # 121, February 27, 1982:18).

Moreover, over eighty-five percent of the young chronics in this study experienced the "stigma" of their failing with respect to old friends and family members. The data indicate that many young chronics, upon discharge, discover that old friends and relatives treat them with a mixture of fear, curiosity, ridicule and rejection. Such an experience of rejection from significant others not only causes these young chronics considerable pain, but also serves to impede the rebuilding of a more positive self-image:

I was in the psych. ward of "St. Mary's" for a month on a few occasions, and I was in the Springville Psychiatric Hospital for about two years. When I finally got out, I wanted to go back home to live with my parents, but they wouldn't let me. They said I had caused enough trouble and that my emotional problems upset the whole family. They told me to find a place of my own, and they hoped it would be in another town from them. I think that my dad was ashamed at having a son who was in a mental hospital--his buddies at work used to joke about it. My younger sister, Katie, didn't want me at home either. Her friends at school bugged her about having a "looney for a brother." So, what they did was to have me move away from them. It still hurts to think that they rejected me that way because I had a sickness.... Somehow, it just isn't fair! (Observation # 163, September 5, 1983:18).

Another young chronic, speaking of rejection and ridicule from her relatives, states:

It's really funny how people who you think love you and who you love, can all of a sudden turn their backs on you just because you have a sickness like mental illness. We were such a close family, or so I thought. But then I had a nervous breakdown from too much schoolwork and I had to go to the hospital for treatment. After I got out, I noticed that my Auntie May and Uncle George and all the cousins changed in the way they acted towards me. Some of the cousins snickered behind my back; I heard Uncle John make jokes about "mental" people. They even talked my own mother into rejecting me--telling me that I'd have to move into a boarding home because she couldn't "afford" to keep me around. Do you know how awful it is when your own family--the people you trusted and loved, do that to you? (Observation # 43, October 1, 1981:25).

A third young chronic ex-patient, discussing her post-hospital experiences with "old friends" states:

Brenda and Mary were my closest friends. We had grown up together; we went to the same high school. We were just like sisters. But when I had to go into the hospital because of my hearing voices, the two of them never acted the same towards me. They never came to see me while I was in the hospital. And when I got out, they never came over. Once I called Mary up and asked her to come over but she made some excuse that she was going to a wedding. I knew she was fibbing to me though because ten minutes later, I saw her riding her bike down the street. And it was the same with Brenda too. I overheard her at the grocery store talking to the cashier about me and how she didn't want to be friends with a "nut." It really hurt me to hear her say that. All my friends weren't my friends anymore! (Observation # 47, November 29, 1981:29).

Given that these young chronics are blocked from returning to a life of normality--that such persons have experienced stigma with respect to (re)-employment, friends,

family and new acquaintances, and anticipate further stigmatizing responses from normal others, young chronic ex-patients develop and employ the following strategems to deal with the stigma potential of mental illness: (1) passing; and (2) subcultural formation.

"Passing" as a Management Strategy

Similar to the middle-aged chronics, the young chronics in this study also employ the strategy of "passing" to mitigate the stigma potential of mental illness on their daily rounds. Specifically, the data indicate that one-third of the sub-sample of young chronics accept cultural conceptions of normalcy, and are cognizant of the fact that they fail to measure up to such standards. The post-hospital stigma such persons encounter also serves to reinforce their "falling." Yet, instead of responding to the stigma of mental illness by retreating from society (as do most elderly chronics), or dissociating themselves from normals (as do some middle-aged chronics), or even capitulating to the stigma (as do some middle-aged chronics), the data suggest that many young chronics (specifically, those living on their own), actively attempt to conceal their identities. So, for example, such young chronics, attempt to conceal their institutional histories from normals, and in its place, offer a "more respectable life story":

I don't tell people about me being in the hospital. You have to hide that if you want them to treat you normally. So what I do is tell them that I was in the Peace Corps the last five years overseas in Africa. I tell them that I came back because a war broke out over there and it wasn't safe to be over there anymore! (Observation # 73, December 14, 1981:28).

Similarly, another young chronic, discussing her employment of a fictitious life history, states:

If you want to hide your past from neighbours and other people, you gotta have a story made up to tell them when they start asking you questions. I thought up this one and rehearsed it many times in front of the mirror. I tell them that I'm new in town and I just came from England where I worked as a nanny for six years. I tell them that the pay wasn't very good and the weather was too cold over there, so I came back. I even have a picture on my coffee table of two children--a boy and a girl and I tell people that these are the children I used to take care of in England. I call the boy, Michael and the girl, Becky. I don't really know who these children are. I just found their picture in the garbage one day! (Observation # 69, November 26, 1981:27).

Still others, similar to the middle-aged chronics, construct fictitious life stories about their "incarceration" in penal institutions for various criminal activities. Such persons conceive of the identity of "ex-criminal" to be less stigmatizing than their true identity--that of "ex-mental patient":

When people ask me about myself and poke around asking about my past, I tell them that I was in jail for five years--that I was falsely accused of shoplifting and that actually, it was my friend that stole some goods. I was only an innocent bystander. When I tell them that, they usually say that I was given a bum rap and support me. No one has ever doubted my story so far! (Observation # 114, February 3, 1982:23).

Just as many of the young chronics in this investigation, developed, rehearsed and told such fictitious tales

to account for aspects of their stigma that are readily apparent--specifically, the side-effects associated with the medications they are taking:

The meds I'm on make me shake sometimes. And some times, I'm dizzy, too. When friends look at the way I'm shaking, I tell them that I'm a heroin addict, and that I'm trying to withdraw! This story keeps them from finding out the truth about me! (Observation # 35, October 10, 1981:8).

Similarly, a second young chronic adds:

I'm aware of the fact that the drugs I'm on make me jerk my arms and legs. Lots of people notice that about me. So, what do I do? Well, I tell them that I have cerebral palsy--I inherited it from my mother and that I'm going for therapy once a week. When I tell them that, people are satisfied. They show compassion and treat me nicely, and I don't get shunned because of what I really have! (Observation # 98, February 24, 1982:32).

Moreover, in their attempts to pass, the data indicate that many young chronics, develop various methods for diverting attention away from the problems that they experience in attempting to carry out routine activities. It will be recalled that, for the middle-aged chronics, such problems included the utilization of public transportation and comprehending written documents. For the young chronics in this study, such problems included balancing and managing their budgets, comprehending written documents, carrying out basic household chores such as cooking, shopping, and cleaning. Such young chronics, deal with these problems in various manners. One person, speaking of her problem carrying out household chores, states:

I just don't know where to begin when it comes to cleaning and cooking and all that stuff. I eat out when I can, but that gets expensive. In the hospital, all the meals were provided. Before, my mother used to do the cooking. I have this hotplate in my room; sometimes, I heat up a can of beans or a weiner, but that's about it. I don't know how to clean either. I know that a girl is supposed to know these things, but I don't. I do know how to dust though.... When the lady next door came over to my house and asked why it was so messy, I couldn't tell her that I didn't know how and that my mental condition makes it hard for me to get things done, so I made up this story about how I came from a rich family as a kid and we had a maid and a cook who did everything. I said that I never had to do anything as a kid which accounts for things now! (Observation # 56, November 12, 1981:19).

Another ex-patient, speaking of his problem regarding the management of his financial affairs, states:

Ever since my sickness, I just can't think straight. That's my main disability. I have trouble adding and subtracting now, and I can't even figure out how to manage paying all my bills and how to make my bank account balance. It's just too much for me. But you know as well as I do that most people are able to do this with no problems. But if I wanted to act like other people, I had to pretend that I could do these things. What I did was go to my bank manager at the Bank of _____, and I told him that I had an eye problem that prevented me from seeing small print and I couldn't pay my bills, because I couldn't see them clearly. He helped me out by taking this problem over, and now he pays all my bills--tells me how much I've got in my account. I don't have to worry about anything! (Observation # 204, February 3, 1983:41).

A third young chronic, discussing the problem of comprehending written documents, states:

I don't understand things that are sent to me in the mail all the time. So I have to ask people what is meant. But people start to get suspicious of you if you keep asking. Well, I tell them that

I came from Poland and I don't read English very well and could they help me out what the letter means. I don't want them to think that I am retarded, so I make up this excuse. (Observation # 266, May 3, 1984:31).

In short then, through the development and employment of fictitious life histories to conceal their pasts, the development and employment of fictitious tales accounting for deviant aspects of self that may be visible, and the employment of certain techniques to conceal the continuing incapacities associated with their failing, such young chronics attempt to pass as normal societal members, and if successful, avoid the stigma of mental illness.

SUBCULTURAL FORMATIONS AS A MANAGEMENT TECHNIQUE:

Just as a number of young chronics employ the strategy of passing in an effort to avoid the stigma potential of mental illness on their daily rounds, so too, do many deal with such stigma by developing, entering into, and participating in a deviant subculture--specifically, a subculture of chronic ex-mental patients.¹⁸ The data indicate that two-thirds of the young chronics in this investigation were, at the time of the study, or had, participated in such a cultural form.

In general, subcultures come into being when individuals come into contact with one another, when they suffer a common fate--when such persons have acute problems

with social-psychological adjustment. According to Albert Cohen (1955:59): "the crucial condition for the emergence of new cultural forms is the existence, effective interaction with one another, of a number of actors with similar problems of readjustment." The data indicate that, in many urban locales in Southern Ontario, many younger, some middle-aged, and a few elderly chronic ex-psychiatric patients are entering into and participating in newly-formed ex-mental patient subcultures--loosely knit, disparate cultural units still in their infancy. One young chronic, discussing his discovery of the "group" states:

I was walking in an alley one day behind Queen Street and saw two or three guys I had been with on the ward in the hospital. They recognized me and I nodded. They called me over and we got to talking about the stinking hand that life had dealt us--the problems we all had--the shit we'd been taking, the problems we had in making ends meet. These guys told me that they got together almost every day and figured out what they could do. Soon I met a few more people in my same predicament and we've been getting together ever since. They taught me the ropes--how to manage being who I am in this stinking world! (Observation # 270, June 8, 1984:21).

Another ex-patient, discussing his role in the formation of an ex-mental patient subculture, states:

At first I thought I was the only one out there experiencing the problems after I was let out--you know, the stigma of being in the hospital for mental illness for a long time. No matter how I tried to get on with my life--everyone out there kept hitting me below the belt. It wasn't fair. At first, I kept pretty much to myself, but then one day, I met a few patients at a coffee shop and I opened up to them and they opened up to me. I found out that they were having the same problems as me. So we got

to thinking that we weren't going to take this lying down--we were going to do something and we've been banded together ever since. (Observation # 271, June 9, 1984:2).

The above quotation suggests that four stages are important for the development of an ex-mental patient subculture:

- (1) subjectively experiencing a problem; (2) communicating such a problem to others; (3) subsequent interaction with others in similar situations; and (4) the development of strategems to provide solutions to the problems.

Research on deviant subcultures¹⁹ indicates that subcultures develop in order to provide the deviants with information about how to think, feel and act, how to "do" deviance, and the consequences of doing deviance. In the case of ex-mental patient subcultures, in particular, such cultural formations have arisen to: (1) deal with the social isolation ex-patients are experiencing; (2) to help ex-patients neutralize or rationalize their deviant aspects of self, (3) to deal with the stigma potential of their "differentness" or "failing"; and (4) to provide practical strategems for "making it on the outside."²⁰ Speaking on the role of the subculture in eliminating alienation and social isolation, one young ex-patient states:

Until I found these others, I thought I was all alone. I felt like I was from Mars and everyone saw me as an alien. At least now I know that there are others who have the same problems on the outside as I do. It makes me feel alot better to know that I'm not alone. It really boosts me up, you know. (Observation # 151, January 5, 1982:12).

Another young chronic, discussing the role of the subculture in eliminating social isolation, states:

Ever since I got out of the hospital, I was so lonely--nobody to talk to, nobody who cared about me. Just a big hostile, old world to deal with. Most of the time, I just hid. But since I met that group of patients who hang out on the corner near _____ and _____ Streets, and we go for coffee to the restaurant and talk about our problems and what we can do about them, I don't feel so alone anymore! (Observation # 2, September 5, 1981:31).

Just as the subculture provides solutions to problems of alienation and social isolation, the data indicate that this cultural formation also serves to provide solutions to problems of stigma encountered by ex-patients:

That group of people taught me what to do about normals picking on me or making fun of me. Everyone in the group has experienced that treatment in one way or another, so they all had ideas on how to deal with it. One of the main ways is to avoid going near those people--stay away as far as possible. That way, you don't give them the chance to hurt you! Another way is to fight back. If someone starts picking on you and calling you names because you live with "mentals" in a boarding home, you can warn them and punch them in the gut! Usually these people are all mouth, and after the first punch, they back down! (Observation # 3, September 7, 1981:21).

A second, ex-patient adds:

Other patients teach you how to deal with nasty people--those who make fun of you or kick you, or try to steal your money. I learned that you gotta stand up for yourself. There's no use running or those people will chase you all the more. You can't let 'em know you're afraid--you gotta stand tall and face 'em square on. If they insult you, you tell 'em that you ain't going to take that kind of language. You act tough and they'll usually back down. All in all, I learned to stand up for myself when strangers pick on me; but in the case of dealing with my relatives--when they rejected me, I was real sad.... But I learned

from the other patients that you can't please everybody all the time and I should stop worrying about them. If they can't understand or accept me, then I might as well stay away from them. I don't need to get hurt by 'em. (Observation # 86, December 23, 1981:12).

Moreover, the data indicate that this deviant sub-culture functions to provide its members with a self-image that refutes stereotypical beliefs about mental patients held by conventional society. The ex-mental patient sub-culture serves to provide its members with rationalizations and justifications for their illnesses--specifically, that such persons are not responsible for their conditions;²¹ thereby, enabling such persons to redefine themselves in a more positive, although still deviant light. As one young male ex-patient states:

Since I met these people, they reminded me of the fact that I wasn't some crazy, lunatic on the loose--the vision that everyone else in the neighbourhood seemed to have of me. My fellow patients made me realize that I was a person, someone with psychological problems--an illness that was not my fault. It was beyond my control. They helped me realize that I had been pressured all my life by my family and it was them picking on me that made me crack. My friends helped me realize that I'm really not a bad guy. And you know, since they've been telling me this, that it wasn't my fault, I think more highly of myself. (Observation # 281, June 14, 1984:25).

Another ex-patient, discussing this neutralizing technique, states:

They told me that I wasn't responsible for my situation. How could I be? They reminded me that an illness is something that just happens. It's not anybody's fault. They helped me see

that I got sick because of a lot of things that were out of my hands--too much pressure from teachers, and my parents were always on my case. They helped me see that my sickness was caused by society, and that's what I try to convince other people into believing that it wasn't my fault. (Observation # 101, March 3, 1982:6).

In short then, such persons accept the cultural conceptions of normalcy, and realize, that according to these, they fail to measure up. However, in the context of the deviant subculture, members are provided with rationalizations and justifications for their conditions--neutralizing techniques which: (1) hold others accountable for the persons' deviance, (2) serve to provide the ex-patients with a more favourable, although still deviant self-image, and (3) function to provide such persons with a more favourable and acceptable account of themselves that they may reveal to normals, thereby lessening what otherwise could be stigmatizing responses.

In addition to providing the functions discussed above, the data indicate that this deviant subculture functions in one final respect: specifically, it serves to teach its members various methods for "making it on the outside"--how to capitalize²² on their deviant identities. By "making it on the outside", ex-patients, through interaction with other members of the subculture, learn how to make the most of their deviant identities--they are taught where, how and when they can pick up "quick cash," "free eats," where to get a "free place to crash." So, for example, the neophyte

entering this ex-patient subculture is taught that he/she can pick up "quick cash" by: selling their "meds" for money, and selling their bodies (not only where to sell these commodities, but for how much):

When I first started hanging around with those guys, they showed me the ropes. I was pretty green about things, but they told me that if I run short of bucks, I can pick up an extra fifty by selling my meds. They showed me this group of guys who will pay pretty good for certain pills.... They also told me that if I'm desperate, I can engage in, you know, sexual favours, for a few bills. I'm not gay or nothing, but there's a few guys in the area who will pay you if you blow them! (Observation # 272, May 29, 1984:35).

Similarly, a second chronic states:

Joe and Bruno learned me a lot of things--like if I need a fast buck, I can just sell my pills--they'll take anything you got. Joe told me how much I should get and to try and hold out for that, but you get the best you can. I just go down to the corner and wait, and pretty soon, some people come up asking for it. (Observation # 221, February 18, 1984:27).

A third female chronic adds:

I sell my wares when I need to. I'm not a prostitute, don't get me wrong. But when I need the money for cigarettes--something important, then I don't mind doing it once in a while. There's nothing wrong with it--Jean and Kerry do it too. I get about ten bucks each time, but I won't do that oral sex stuff. That's dirty. (Observation # 24, October 5, 1981:6).

In short, this subculture provides ex-patients with important information about how and where to make a "quick buck,"-- some practical strategies for "making it on the outside."

Moreover, in the context of the ex-patient subculture, members learn which religious and social agencies give "hand-outs"-- where agencies are located, how much

they may give, and who is the best person to approach:

Dave and Sam took me to the places that give handouts. There's one church right down the street--if you ask for the pastor, and tell him a hear-sob story, he's usually good for ten bucks. Then there's the welfare people, and this other community service place. If you know when to hit these places and who to call upon, it helps a lot! (Observation # 6, September 10, 1981:4).

Similarly, another young chronic states:

The key is knowing who to ask for and going to these places at the right time. You gotta look pathetic, like you're going to cry--you tell them that you just need a little to get some food and shelter and most of the time, you're luck to get something...But you can't pester them everyday or they'll get wise. You gotta space yourself out! (Observation # 17, October 24, 1981:26).

~~Further~~, ex-patients learn through participation in their subculture, which agencies and missions provide such things as free food, clothing and shelter:

At first, I didn't know nothing. But my friends taught me where I could get free food whenever. I wanted it--down at this mission. You gotta put up with their praying and singing, but that's OK. They also showed me where to go to this church if I needed some new threads and some lady will give you whatever you need...and if I ain't got a place to crash--like if I get kicked out of my room, I learned that I can go to the mission on Tenth Street and spend the night. (Observation # 211, January 28, 1984:32).

Through participation in the ex-patient subculture, persons not only learn the "in's and out's" of the system and how to use it to their advantage, but some also learn to capitalize on their deviant identities by becoming "professional crazies":

I learned that if I want to make some real money, I just have to act pitiful on a certain street corner and hold out my hand and say, "I need money to help with my treatment. I have emotional problems. Please help me." Sometimes, I get a quarter. Sometimes, the businessmen will throw in a dollar or two. On a good day, and in a good location, I can make twenty bucks. (Observation # 230, March 2, 1984:35)

A second young chronic, discussing this technique, states:

I usually go down to the subway at rush hour and act all confused, saying that I'm sick and I'm trying to get back to the _____ Psychiatric Hospital but I have no money. Usually someone will give me the money to buy a token--but I just pocket the money. Last night, I made six dollars doing that! That was one time, when being mental works to your advantage! (Observation # 99, April 3, 1982:43).

In short then, the data reveal that many young chronic ex-psychiatric patients, upon their release and subsequent stigmatization, have turned to participating in ex-patient subcultures--cultural formations not only providing much-needed social support, but also providing a body of shared solutions to problems, methods for "making it on the outside," providing ex-patients with a self-image refuting stereotypical conceptions held by conventional societal members, and in providing an ideology justifying their post-hospital actions and experiences.

SUMMARY

In summary, this chapter has dealt with issues of stigma, management strategies, and identity transformation as it relates to chronic, long-term ex-psychiatric patients.

The data indicate that ex-patients are not passive objects, played upon by various forces beyond their control. Such persons, as strategists, negotiators, and expert managers, attempt to alter their social fates--to negotiate their situations and identities--to make effective use of various techniques to manage information about selves, thereby mitigating the stigma potential of mental illness.

As the data has indicated, elderly, middle-aged, and young chronics differ not only in their desires to achieve more positive non-deviant selves, but also in the kinds of stratagems such persons develop to deal with the stigma potential of mental illness. In the case of the elderly chronics, such persons, for the most part, have given up, or do not try to rebuild more positive self-conceptions. Such persons accept societal standards of normalcy, and realize that, according to them, they fail to measure up. In response to the social isolation and stigma associated with their failing, most elderly chronics adopt retreatist strategies.

For the middle-aged chronics, life is also one of isolation, pain and rejection. Such persons desire to transform their deviant identities--they seek reintegration, but problems of lack of support and stigma prevent such an occurrence. In response, middle-aged chronics adopt such strategies as: dissociation, passing, and capitulation to avoid or minimize the stigma potential of mental illness on their daily rounds.

In the case of the young chronics, the data indicate that such persons, upon discovering the difficulties in attempting to transform their deviant identities, some respond by attempting to "pass" as normals (as do some middle-aged chronics); others, respond by entering into, and participating in, ex-mental patient subcultures--loosely-organized and disparate cultural units (subcultures that were at the time of the study, in their early formative stages). Such units provide the four-fold function of: (1) combatting social isolation and alienation; (2) dealing with the stigma potential of mental illness; (3) helping ex-patients neutralize or rationalize their deviant aspects of self, thereby, elevating their self-esteem, and (4) providing practical strategems for "making it crazy"--how to capitalize on their deviant identities.

The elderly, middle-aged and young chronics developed and employed different strategies--strategies which effectively minimized or alleviated the stigma potential of mental illness on their daily rounds, but had negative implications for identity transformation.

The next chapter will turn to a discussion of deviant identities, stigma, techniques of stigma management and their implications for identity transformation, as they relate to non-chronic, short-term ex-psychiatric patients.

NOTES:

1. Goffman (1961).
2. This term, originating with Goffman (1961) has been employed by Freidson (1966), Cicourel and Kitsuse (1963) and Bittner (1967), among others.
3. Referred to as "secondary deviation" by Lemert (1951).
4. In particular, Scheff (1966).
5. It will be recalled that for the purposes of this study AGE was divided into the following categories:

ELDERLY: = 60 years and over

MIDDLE-AGED: = 30 to 59 years

YOUNG: = 16 to 29 years

This division applies to both chronic and short-term ex-patients.
6. There were a few exceptions--persons receiving nominal private pensions, and some receiving old age security.
7. Rejection from familial others, or weak support, inhibits successful identity transformation.
8. Such persons cannot "measure up" to societal standards of normalcy.
9. Or if they have no relatives.
10. See also Davis (1972) and Anspach (1979) for a further discussion of this technique.
11. Such persons live in boarding homes, go to mental-patient drop-in centres in the community. Whereas these middle-aged chronics remain in society, but just avoid normals, the elderly chronics, retreat from society--they try not to associate with anyone.
12. For a discussion of "passing", see: Goffman (1963), Davis (1972), Weinberg and Williams (1975); and Edgerton (1967).

13. Their identities are, for the most part, not readily apparent in comparison with those afflicted with blindness, paraplegia, etc.
14. Such persons conceive of the identity of "criminal" to be less stigmatizing than that of "mental patient."
15. Such persons, given that they have been institutionalized for long periods of time or on numerous occasions, they have to relearn basic life skills that most of us take for granted.
16. The same form of stigma related to employment encountered by middle-aged chronic ex-patients.
17. Similar ingenious techniques were employed by retardates. See Edgerton (1967) for details.
18. These ex-mental patient subcultures, at the time of this investigation, were still in their early formative stage. Such groups were comprised of approximately twenty to thirty persons, who met and interacted on an irregular basis at such locations as street corners, mental patient drop-in centres, and coffee shops. (These ex-patient subcultures are not to be confused with ex-mental patient political activist groups--highly organized, formal groups with political concerns. These activist groups will be discussed in the next chapter.
19. See: Cohen (1955), Rubington (1967), Rains (1982), among others.
20. Such strategies enable these ex-patients not only to "get by," but also teach them how to capitalize on their deviant identities.
21. See Sykes and Matza (1957) for a discussion of similar neutralizing techniques employed by juvenile delinquents.
22. See Goffman (1963), and Scott (1969) for discussions on capitalization on the part of blind persons.

CHAPTER EIGHT

SHORT-TERM EX-PSYCHIATRIC PATIENTS, STIGMA, AND IDENTITY TRANSFORMATION

The last chapter focussed on stigma, management strategies and identity transformation as they relate to long-term, chronic ex-psychiatric patients. This present chapter turns to an examination of stigma, strategies of information management, and identity transformation as it relates to short-term, non-chronic ex-psychiatric patients. Given that today in Canada, patients are primarily treated on a short-term basis, whenever possible and psychiatric professionals and mental health policy makers espouse that such treatment will "undoubtedly be a trend of the future" (Heseltine, 1982:37), I was particularly interested in finding out what happens to these persons upon completion of their "treatment." Specifically, in my investigation on short-term ex-patients, I addressed the following questions: (1) Do short-term ex-psychiatric patients conceive of their "deviant" or "abnormal" identities as "permanent fixtures", and thus, not attempt to change them? (2) If so, do they adopt the role of "ex-mental patient" and its corresponding status? (3) If not, what methods do such short-term ex-

patients use to alter their deviant identities? (4) Are they successful or unsuccessful in their endeavours? (5) What criteria are important for successful identity transformation? (6) How do short-term ex-psychiatric patients deal with the stigma potential of mental illness? (7) Does a relationship exist between strategies of stigma management employed by ex-patients and their success in transforming deviant identities? (8) Do elderly, middle-aged and young short-term ex-patients differ in terms of their desire to, and ability in transforming their deviant identities, and in the strategies they develop and employ to deal with the stigma potential of mental illness? (9) Do short-term, non-chronics differ from their long-term chronic counterparts with respect to identity transformation, and the methods that they respectively employ to deal with the stigma potential of mental illness?

ELDERLY, SHORT-TERM, NON-CHRONIC, EX-PSYCHIATRIC PATIENTS:
STIGMA, SELECTIVE CONCEALMENT, THERAPEUTIC TELLING,
PREVENTIVE TELLING AND NORMALIZATION

The data indicate that the elderly short-term ex-patients in this study, upon completion of their psychiatric treatment (primarily as in-patients in a general hospital or psychiatric institution), attempt to resume a life of normality. As was discussed in Chapter Five, by virtue of the nature of their short-term treatment, such persons come

to accept a redefinition of self as deviant; however, this acceptance of self is conceived to be temporary in nature. Upon completion of treatment, elderly, short-term ex-patients, actively seek to redefine themselves in a more positive, non-deviant light. In contrast to the elderly chronics, who for the most part, conceive of their deviant identities as "permanent fixtures," the data indicate that, in the case of elderly short-term, non-chronic ex-patients, such persons conceive of their identities as "temporary fixtures":

The way I see it is this: I was in the psych. ward of "Maryvale" Psychiatric Hospital for a little while. All the while they kept trying to instill in me the fact that I had a "mental illness." In all the therapy--the occupational therapy, the interviews with the shrinks, the time in art therapy class--everyone tried to make me see that I had problems. OK, so I had problems. I admit to that. But because I was only in about eight months, and they let me out, that's proof to me that my sickness was just a passing thing. It's like the flu; you've got for awhile, you take medication, and soon you're over it. That's what it was like for me. Once I got help, I was cured and they let me out to get on with my life! (Observation # 53, October 21, 1981:21).

A second, short-term non-chronic adds:

I know they put me in a psych. ward at "Pinesville" General Hospital for a couple of months. I was in a place with some people who were really crazy. At first, I didn't think I should be locked up with crazies, but by the time you're finished all the therapy, you know that you've got some form of mental illness, or why else would they have kept you in there. But with me, my illness is not a permanent thing--it only took

a few months out of my life. When I was in the hospital, I was a "mental patient;" now that I'm discharged and on my own, I want to get rid of that label--I don't want to be thought of myself in that way--I want people to think of me as John Smith--normal human being! (Observation # 200, October 1, 1983:13).

A third, short-term ex-patient, speaking of the transitory nature of her "condition," states:

When I was in the hospital, even though it was only for a little while, the treatment is so intense that they bombard you left and right. They try to make you realize why it is you're in there. The nurses do it, so do the doctors and the other therapists. They make you see that you have a "mental condition." At first, I didn't want to believe it myself, but gradually, after about a month in there and going into psychotherapy and psychodrama and other things, I finally believed what they said about me. Maybe I knew it all along but just didn't want to believe it. Anyways, it's not an illness that is forever. They helped me a lot, and now that I'm discharged, I'm going to try to get on with my life. That's what I'm doing right now--I'm trying to forget the past--forget that I had a "mental condition," and no longer think of myself as "mentally ill." (Observation # 233, May 15, 1984:5).

Such a perception of self as possessing a temporary deviant identity is influenced not only by the nature, duration and type of psychiatric treatment into which these elderly short-term ex-patients entered, but also, is influenced by two factors: (1) the type of psychiatric or deviant label bestowed upon them; and (2) the minimal number of medications such persons were taking subsequent to their discharge. Turning to the former, the data indicate that, in general, those elderly short-term ex-patients, labelled

in the hospital as being "non-chronic," possessing "affective" disorders, those with "episodic illnesses," etc., these persons see themselves as "better off than the chronics," as "having a good chance of overcoming their illnesses," --at the "top of the psychiatric barrel." According to one elderly female, short-term ex-patient:

I thank my lucky stars that I only had an episodic case of mental delusions. They put me in hospital for a little while; they got me straightened around, and then they released me. If I had been diagnosed as having something real serious, like a chronic case of schizophrenia or chronic psychosis, I wouldn't have been so lucky. People who have those sicknesses can't be cured--they're doomed--they're at the bottom of the heap! But I'm not like that. In my case, I'm much better off. I can see things clearly now; my life is under control--I once was mentally ill, but it was only a "minor" sickness. Now, I'm going to try to live a normal life! (Observation # 152, April 5, 1982:32).

Similarly, a second male short-term ex-patient states:

I was never on a back ward or nothing where they put the "chronics." I was on one of the front wards where they put the people who aren't chronics--the people who got a chance to turn their life around once they get out. After the therapy, I realized that I did have some kind of neurosis, but I wasn't a chronic case, so I had a chance. I wasn't a hopeless case. Ever since I got out, it's been my task in life to start over--to leave this previous identity of a "psychiatric patient" behind and take back my old, normal identity! (Observation # 252, April 28, 1984:12).

Just as the elderly, short-term ex-patients' perceptions regarding the temporary nature of their deviant identities are influenced by the type of psychiatric label affixed to them, so too, are they influenced by their perception of the nature, dosage, and number of medications

that these persons are taking once released from the hospital. Speaking of the miniscule dosage of medication, he is now taking, one male short-term ex-patient states:

When I was in the hospital, I was on about four different kinds of drugs. I'd have to take some of them four times a day. But since I was released, the doctor has gradually cut down the medication. Right now, I'm only on one kind of drug--for depression, and I no longer take it four times a day--but just once! So, you see, that is proof to me that my illness is not permanent, or why else would he take me off most of the medication? (Observation # 9, September 12, 1981:29).

Similarly, a second short-term ex-patient adds:

When I was admitted to the hospital, the doctors put me on a variety of medications--sometimes, I was really "out of it." It seemed that every time I'd turn around, the nurse would be there with a handful of pills for me to take. I was on them for about seven months but then when they released me, they took me off most of them. Now, I'm only on two and I only have to take them twice a day. When the doctor decreased my pills, I took it as a sign that I wasn't a hopeless case--that I was getting better--that I wasn't going to be mentally impaired forever! (Observation # 1, September 2, 1981:34).

In short then, through the context of their short-term institutional processing, the elderly non-chronics in this study, did not internalize the role of mental patient (proffered by the institutional staff). While such persons, during their psychiatric treatment, come to accept a redefinition of self as "deviant"--such a view of self is only accepted temporarily. Once released, these elderly non-chronics, make active attempts to reobtain their prior, non-deviant, "normal" identities--former identities that were

stripped from them in the institution:

My first objective once I was released was to "peel off" that part of me that they had called "psychiatric patient," and take back that part of me that was a retired veteran, an elder in the church, a "normal" upstanding member of the community... (Observation # 119, March 20, 1982:22)

Another elderly short-term ex-patient, recalling her post-hospital desires, states:

When I left "Branthaven" Hospital, I set some goals for myself. I said to myself, "Esther, you've got to get on with your life; don't dwell in the past. Try to leave that image of yourself as a mental patient--leave that image behind. Go out into the world and take back your old image--that positive image of yourself as a devoted grandmother, church-goer, and good, caring human being!" That's what I told myself. And that's what I tried to do once I got released! (Observation # 78, November 13, 1981:43)

A third elderly non-chronic adds:

It's like this--when you go in, they try to show you that you've got psychological problems--they help to show you that you are mentally ill. And after a while, you come to accept that you're a sick person. They treat you, you get better and then you leave. But there's no way that I want to continue thinking of myself as mentally ill; or to have others think of me in that way. I just want to forget it all! When I got out of the hospital, I tried to leave that part of my identity behind--I tried to leave it at the hospital door, and try to resume my life from where I was before I was sent into the hospital. (Observation # 129, March 12, 1982:48)

In contrast to the middle-aged and young chronics in this study, who, upon their release, made a number of unsuccessful attempts at transforming their deviant identities, the data indicate, in the case of elderly non-chronics, that such persons make attempts at rebuilding more positive, non-deviant identities, and are largely successful in their

endeavours. What factors aid in the successful identity transformation of elderly short-term ex-patients?

Examination of the data indicate that approximately ninety percent of the elderly non-chronics in this study, upon discharge, were placed not in boarding homes, homes for special care, or in apartments by themselves (as were the majority of chronics in the study); rather, such persons returned to their own homes upon discharge--places of familiarity with no reminders of the psychiatric institution:

It was so good to go back home. I cried when I got back. There were my rose bushes in the front yard; I remembered how I used to care for them each and every day. I went through the front door and saw my children's pictures hanging on the wall. I saw the little sweater I started to knit for my granddaughter. Just going home and being around my own things again, helped me tremendously to begin to see myself in a more positive and normal way. (Observation # 1, September 2, 1981:53).

A second, short-term ex-patient states:

When I returned to my own home, it was like I was reborn. After being in the hospital for over a year and a half, I had some negative feelings about me as a psychiatric patient and all that. But once I got out and returned home, and saw all my precious things there--my two cats who love me so much, my houseplants, my embroidery--all those things and nothing to remind me of the hospital, I started to feel better right away. I started to think of myself in a better light--like the way I used to think of myself before I went into the hospital. (Observation # 251, April 27, 1984:49).

A third, non-chronic adds:

The best part about going home is that you can begin to forget ever having been hospitalized. There are no nurses or doctors there; there's no other patients who you have to eat your meals

with and share a bathroom with. At home, you can begin to forget that whole part of your life--pretend it never happened--or at least, try to. (Observation # 273, June 14, 1984:32).

During the in-patient phase of their moral careers, in an effort to destroy their prior, non-deviant conceptions of self, individuals are stripped of various material possessions and their identity kits; however, upon returning home, these elderly, short-term ex-patients, once again, have all of their material possessions at their fingertips--possessions enabling such persons to present their prior (non-deviant) images of self:

In the hospital, it was so awful. They took away most of my makeup. They wouldn't let me have a nailfile, tweezers, my scissors or my nail polish remover, or even my bubblebath. They even took away the gel that I use to set my hair with. The whole time I was in there, I looked a hundred years old. I looked just like some of those other patients on the ward. But there was nothing I could do. But when I got out of that place and went back home to Spring Falls, it was such a treat for me to sit in the bathroom having a bubble bath for an hour, filing and painting my fingertips and setting my hair the way I used to. Once I got back home, I could make myself up the way that I used to--so that I'd look exactly the same as I did before the breakdown and my hospitalization. (Observation # 2, September 4, 1981:56).

A second short-term ex-patient, discussing the importance of returning home, states:

When you're in the ward, you've got little control over anything. Like me, I guess they thought I could be suicidal so they took away my handmade belt that my son Joey gave to me; they took away my straight razor; they took away my scissors so I couldn't even clip my moustache. They wouldn't let me wear a tie--they took all

of them away too. They even took my belt to my housecoat away and my shoe laces. It felt so much better when I got home again. I could do what I wanted--and I had all my things around me--I could wear what I wanted and dress the way I used to before I was hospitalized. (Observation # 233, May 15, 1984:62).

Not only does the action of returning home to familiar, non-deviant surroundings facilitate identity transformation--a location containing various personal possessions, enabling elderly non-chronics to present a desired image of self, but the data suggest that, returning home to the company of supportive family members also aids in such an endeavour. Speaking of the role of his family in helping him transform his deviant identity, an elderly short-term ex-patient states:

If it wasn't for my family--the support that they gave me, I don't know what I would have done. My wife was with me all the way. And so were my kids and even the grandchildren. When I got released from the hospital, I was feeling pretty low--I felt ashamed of myself for having had a mental illness. I might have just crawled under a rock somewhere and hid if it weren't for the family telling me to get on with my life. They kept saying, you can do it--go back and start your life again and pretend that nothing happened to you. They kept saying over and over to forget the past and think of the future. After hearing their pep talks and speeches so many times, I gradually began to believe what they were saying and started thinking of myself as an OK person--as "normal" as most other people walking the streets! (Observation # 199, December 30, 1983:51).

A second elderly ex-patient adds:

When I got out, I wanted to forget the hospital and not think of myself as sick anymore. I couldn't have succeeded on my own though. I was real nervous. But my husband was just

fantastic--he embraced me like nothing had happened. My kids were just great too. Nobody treated me with kid gloves--like they did in the hospital. Everyone treated me just like they used to. I fit right back into the family. I solved family arguments, I cooked their meals and cleaned the house. At least once a day one of my kids would come up to me and give me a big hug and tell me how great I was doing and how they thought I was the greatest--that I was back to my old self--just like nothing happened! That kind of behaviour and talk from them really helped me to think of myself as "normal" again! (Observation # 109, January 2, 1982:31).

Just as supportive family members aid in successful identity transformation, so too, do supportive friends facilitate such a transformation. Specifically, the data indicate that over three quarters of the elderly non-chronic received post-hospital support from friends. One elderly female, speaking of the support she received from her bridge club, states:

The girls were wonderful to me. I could hardly believe it. At first, I was quite apprehensive about seeing them. I didn't really know how they would respond to me--whether they'd embrace or shun me. But they each kissed me and welcomed me home and said that as far as they were concerned, I was as normal as any of them. They told me not to feel ashamed or embarrassed at all--that a nervous breakdown could easily have happened to any one of them and that it wasn't my fault... They told me to forget the past and carry on as if nothing happened and that they were behind me one hundred percent! Their support really helped me a great deal to see myself in a more positive light! (Observation # 113, January 7, 1982:29).

A second elderly male non-chronic, speaking of the support he received from friends adds:

To my surprise, the guys in the neighbourhood were very supportive of me when I returned home.

My first idea when I got back was to stay away from these fellows. I don't know, but I felt somehow ashamed or something. I was always the kind of guy that prided himself of being a "real man"--a guy in full control of his life, and my friends knew that too! I thought that they'd be cracking jokes behind my back, or, that they wouldn't want to go golfing with me anymore, but I was completely wrong. All six of my buddies came over to my house with a case of beer and celebrated my "homecoming." They made toasts to me, they sang songs, and it was their continuing support that helped me to believe in myself again--to see myself as the same guy that I used to be! (Observation # 80, December 27, 1981:22).

A third, female ex-patient adds:

My friends were life-savers. If it weren't for them, I could have never made it! There they were waiting for me when I got back home--Sally, Mabel and Joan all brought me welcome home presents. They all treated me just the same--no one acted differently towards me, as I thought they would. They helped me to get "back to normal"--to believe in myself again--to see myself as completely cured--to think of myself the same way as I used to... (Observation # 72, December 16, 1981:39).

Just as informal support groups (such as those mentioned above) aid in successful identity transformation, the data indicate that, participation in formal support groups, on the part of elderly on-chronics, also aids in such an endeavour. Specifically, approximately one quarter of the elderly short-term ex-patients in this study participated in self-help groups,² such as "Recovery Inc."--groups in which ex-patients can collectively share experiences with others of "their own kind." These self-help groups provide ex-patients with a place where they can find consola-

tion and receive support from others sharing similar post-hospital situations:

I started going to the group because I needed something in my life. Everyone in the group shares a common denominator--we've all had psychiatric treatment; most have been hospitalized for a time and we're now released, confronting a hostile world. Especially when I first left the hospital, I was feeling kind of low at times. I didn't know how the world would treat me; I ran into one bad experience with a neighbour--he made a remark about me being let out of the "nut house" and I almost broke down and cried. But the group really boosted me up. They held my hands and told me that everything was going to be alright. And the people there told me of similar experiences that they had gone through--that I wasn't alone! And that made me feel better right away! (Observation # 67, December 15, 1981:49).

A second, female elderly non-chronic, speaking of the benefits of participating in a self-help group, states:

I can turn to them when I'm down in the dumps. During the first few months after I was discharged, that was the hardest time for me. Don't get me wrong, my family were just great with me but I needed to talk to someone--someone who knew exactly what I had gone through--someone who had an inside understanding of what I was experiencing. I found these people at the group. They really knew about the feelings that I was having because they all had actually gone through the very same thing. When I would tell them about my feelings of anxiety and nervousness, they calmed me down and told me that they felt the same way too, when they were released. (Observation # 33, October 31, 1981:7).

Moreover, the data indicate that self-help groups function as a bridge between the hospital and the community--specifically, it serves to emphasize to the ex-patients that their deviant identities need not be permanent in nature,

and urge its members to resume normal identities and take on normal roles:

After about a month in the group, I was still feeling sorry for myself. I felt resentment toward my husband for committing me, and I didn't think of myself very highly. But two of the people at the group--Barbara and Sharon, while they cuddled me for awhile, told me to stop feeling sorry for myself. They told me that I had to get on with my life--to forget the hospital, to forget that I was once a psychiatric patient--that I wasn't like a permanently disabled person--that I could change things. So, I finally got off my ass and slowly tried to go back being a wife, mother, and part-time cashier. (Observation # 46, November 29, 1981:45).

Similarly, a second elderly ex-patient states:

It was the group who really "hit home" the fact that I could go back and be who I was before the hospitalization. I somehow got it into my mind that everyone would refer to me as "psychiatric patient" forever. But the group showed me that since I was released, that meant that I wasn't permanently mentally ill--it was just a one-time thing.... It was at the meetings that they prodded me to go back to the bowling league, go back and do volunteer work at Shamrock Lodge and in general, to do the things I used to do--to get on with my life! (Observation # 158, November 2, 1983:36).

A third, short-term non-chronic adds:

This group does a lot of good for everyone. I'm telling you, in my case, I couldn't have done without them. They agree with you that you were mentally ill at one time. They know that you were sick, but they motivate you to shed that sick role and identity--they point out that your illness isn't permanent--it doesn't have to affect you the rest of your life. So they motivate you to start living again--to go out and do all the things you used to do.... Everyone in the group tries to treat each other as "completely normal" and after awhile, you begin to believe it yourself! (Observation # 44, November 27, 1981:42).

Just as the factors previously discussed³ aid elderly non-chronic, short-term ex-patients in developing more positive, non-deviant identities, so too, does the manner by which such persons deal with the stigma of mental illness--the "management work" in which they engage, aid in such a transformation of self. It will be recalled that, in the case of chronic ex-mental patients, these persons dealt with actual and perceived stigma by employing strategies ranging from: retreatism, dissociation, capitulation, passing, to subcultural participation--strategies carrying negative implications for identity transformation. While such techniques functioned in reducing or alleviating the stigma of mental illness on their daily rounds, they nevertheless, inhibit the rebuilding of more positive, non-deviant identities. In contrast, however, the data reveal that elderly non-chronics deal with actual and perceived stigma by developing and employing different strategies--strategies carrying with them profound positive implications for identity transformation. Examination of the data indicates that elderly non-chronics develop and employ the following strategies: (1) selective concealment; (2) therapeutic telling; (3) preventive telling; (4) normalization.

Selective Concealment as a Management Strategy

One strategy of stigma management employed by many elderly, short-term ex-patients is that of selective concealment.⁴ Especially during the time-period subsequent to their psychiatric treatment, most elderly non-chronics had a marked desire to conceal such information about their selves from others--specifically, from those defined as "untrustworthy."

Examination of the data indicate that these non-chronic ex-patients segregate societal members in terms of those who can be trusted and those who cannot. In general, close friends and immediate family members were thought to be trustworthy:

When I got out of the hospital, I sat down and carefully considered who I should tell and who I should hide it from. I made up a list in my head. Out of all the people I knew, I only thought of two people--my brother and my godson, Nick--these were the only ones that I would tell! (Observation # 28, October 29, 1981:29).

Similarly, a second individual states:

I don't know, but when I first left the hospital, I didn't want everyone finding out about me. So I had to consider which people to tell and which to hide it from. Not everyone understands what it is like to be mentally ill--I was afraid of the negative feedback I would receive from some people--like, my lodge buddies, so I decided just to let two friends in on my secret. (Observation # 9, September 7, 1981:48).

Just as these persons revealed that they made decisions about concealment and disclosure on the basis of their perception of others--whether they were "safe others" or "risky others", the data indicate that prior, negative encounters with certain "types" of normals also influences such decisions:

After I got out of St. Mary's Hospital--out of the psych. ward and came home, I had a couple of bad scenes with people down the block from me. It seems that there are certain types of people out there who believe that mental patients are raving lunatics like you see on the television all the time. They told their kids to stay away from me, and they made a series of unkind remarks to me one night when I was taking out the garbage So, I learned about which people to avoid--which people I shouldn't be telling anything to. You learn the hard way! (Observation # 111, January 5, 1982:55).

Another elderly non-chronic adds:

I guess I was somewhat naive when I left the hospital. I didn't hide the fact about my hospitalization--not even to my buddies at work. But I should have known better. These two jerks started cracking disgusting and insulting jokes after I told them. They wouldn't let up for weeks. It made me feel so bad. After that, I learned which "types" of morons to stay away from and not tell nothing about myself to. It's much safer that way, and a lot less pain. (Observation # 113, January 8, 1982:18).

The utilization of the strategy of selective concealment by elderly non-chronics took the following forms: (1) avoidance of selected normals; (2) deception. In terms of the former, a large number of elderly non-chronics, upon deciding to selectively conceal their discreditable aspects of self, do so by avoiding, at all costs, those perceived

to be "risky others"--those who may uncover the truth and react negatively:

Those people at work and in the neighbourhood who I thought shouldn't know about me, I stayed away from them as far as possible. I didn't want to give them a chance to poke around and maybe I'd let something slip, and then I'd be up a creek without a paddle! It was best that I just stayed away from those troublemakers. (Observation # 8, September 6, 1981:36).

A second individual, discussing her attempts at avoiding risky others states:

There are these two girls that work in the same mall as I do. We all went to school together a number of years ago. These girls are the nosiest women. I don't trust them at all. I'd never let on why I was away from work. When they ask me to come over and spend my coffee breaks with them, I know that they're just interested in pumping me--finding out personal things about me, but I don't give them the chance. I don't go to coffee with them anymore--I go earlier than them and I'm back even before they go... (Observation # 198, November 26, 1983:39).

Another ex-patient, discussing her attempts at concealing her discreditable aspects of self through deceptive practices states:

I hide the truth about myself by making up little fibs. If they ask me questions about my past, I make up a little story to cover myself. It covers my past and they believe it, and no one is the wiser! (Observation # 118, March 23, 1982:4).

Similarly, a second elderly non-chronic adds:

I hide the fact that I was mentally ill from certain people who wouldn't be sympathetic to me. I lie to them, which I'm not real proud of, but I make up these lies to cover my tracks. If they ask why I've been away for the last two years, I tell them that I was on a world

cruise for seniors--that's what I told the neighbours. I told some of the people at church that I went to Arizona to visit my sister because she was sick. I tell people these stories so they won't know the truth! (Observation # 220, April 2, 1984:33).

It is interesting to note that the strategy of selective concealment is employed by elderly non-chronics solely and primarily during the early stages of their post-hospital lives. However, as time passes, such persons no longer feel such a strong desire to conceal such information about their selves--they are tired of hiding these facts, keeping such information inside of themselves; thus, they develop alternative strategies for stigma management--strategies having positive implications for identity transformation. This chapter will now turn to a discussion of such strategies.

Therapeutic Telling as a Management Strategy

A second strategy employed by elderly non-chronics is that of "therapeutic telling" or "therapeutic disclosure"⁵--selective disclosure to certain "trusted", empathetic, supportive others of their discreditable aspects of self.

The data indicate that the elderly non-chronics in this study felt that speaking about their "mental illness"--getting it off their chests in a cathartic fashion, functioned to alleviate much of the burden of their loads:

At first, I was apprehensive to talk about it. But keeping it inside of you--all bottled up is no good either. So, one day I sat down with my two closest friends, and I let everything out. I let out all my anxieties and fears and both of them really listened to me. Mary's husband had been a psychiatric patient a long time ago, so I figured that she knew what I was talking about.... Once I got it all out, I felt much better! (Observation # 39, October 3, 1981:47).

Another elderly non-chronic, speaking of the value of having supportive relatives with whom to discuss her "condition," states:

If it wasn't for my sisters, Becky and Esther, I don't know if I could have released my emotions. After I got out of the hospital, there were so many things swimming around in my mind. I'm a widow, so I didn't have my husband to talk to about these things. But when my sisters came up to visit me, I let everything out. I talked about my feelings of inadequacy--how I must have shamed the family--all the things I kept inside of myself. And after telling them I felt so much better. (Observation # 18, September 10, 1981:52).

A third, elderly non-chronic, speaking of the cathartic value of therapeutic telling, says:

I was never the kind of man to be very emotional. I used to keep everything inside of myself. And that's just what I did even after I came back from the hospital. But it's quite a burden to keep everything inside all of the time. When my old fishing buddy from Toronto came into town one weekend, I opened up to him and let everything out. I couldn't believe I was doing it at first, but it felt so good. I chose him because I knew he would be understanding. (Observation # 282, May 31, 1984:32).

The data indicate that therapeutic telling functions not only to relieve the anxieties that such persons possess, but also,

allows for renegotiation of personal perceptions of mental illness as discreditable attributes. Speaking of the manner by which she came to re-define herself in a more positive, non-deviant light, one elderly non-chronic states:

When I finally opened up and started talking to people about my past sickness, it really wasn't so bad at all. The pastor of our church was very supportive and he helped me to put my mind at rest--to realize that having mental illness isn't so bad--after all, it's not like having cancer. He told me that thousands and thousands of people go into hospital each year for psychiatric treatment and that over 60 people in our congregation alone, have done so. He told me to look on it as a learning experience, as something positive in my life--something for which I am better off now! After hearing him talk like that, I really saw the light and realized that I wasn't that bad off. I shouldn't think of myself as less of a person--but rather, consider myself mentally stronger for having gone through the therapy. (Observation # 53, November 1, 1981:42).

A second elderly non-chronic, recalling how telling his closest friends about having mental illness, allowed him to redefine mental illness in his own mind, as a stigmatizing attribute:

I kept it inside for a long time, but then finally God gave me the courage to come out of the closet to my two old friends. When I told them I had been in a psychiatric hospital, they took it extremely well. I talked to them about my shame, and how I just wanted to stay away from people. But they helped me to put things into perspective--to realize that it's not the end of the world. The more and more I talked to them, the better I felt. They didn't treat me differently--they acted the same towards me--they said I was as "normal" as them.... They were the ones that finally convinced me that having mental illness isn't what I had made it out to be--that it would ruin the rest of my life. (Observation # 22, October 8, 1981:14).

In short then, the data indicate that through the employment of the strategy of therapeutic telling, elderly non-chronics, not only mitigate the stigma potential of mental illness on their rounds, but also, relieve their anxieties and frustrations, renegotiate personal perceptions of mental illness as discreditable, and adopt more positive definitions of self.

Preventive Telling as a Management Strategy

Just as some elderly non-chronic made use of the strategies of selective concealment or therapeutic disclosure (or both) in order to manage information about themselves, and in so doing, enhance their personal self-esteem and identities, the data indicate that these ex-patients also make use of the strategy of preventive telling to achieve the same aims. Preventive telling involves a disclosing on the part of ex-patient to a selected audience in order to: (1) mitigate the stigma potential of mental illness on their daily rounds; and (2) influence other's ideas and behaviours toward themselves, and toward mental illness in general.

The data indicate that disclosure of their mental illness occurred when elderly non-chronics anticipated future rejection on the part of normals. Thus, in order to minimize the pain of subsequent rejection, many ex-patients decide that the best strategy to employ is one of preventive disclosure early in their relationships with others. As one elderly non-chronic states:

It's not the easiest thing in the world to tell people that you were once institutionalized in a "crazy house." But if you don't tell them and they find out later and reject you, you put yourself through a lot of unnecessary pain--you've wasted all that time building up a friendship for nothing! That's why, if I go to one of those senior citizens' dances, and find a nice lady, I don't wait until we have feelings for each other, and she finds out about my secret and then drops me--I like to tell them early on. (Observation # 237, May 13, 1984:33).

Similarly, a second person adds:

I've learned the hard way--if you don't want to set yourself up for a big fall, you've got to find a time to tell certain people about you. Especially if you want to make close friends with them. Before, when I wouldn't say anything about my past, and they would somehow find out, I'd be "up a creek without a paddle." They'd "drop me like a hot potato." The best advice I can give anyone is to tell people right off the bat--you avoid yourself a lot of heartache that way! (Observation # 3, September 7, 1981:48).

Just as preventive telling is used by elderly non-chronics to avoid future stigma, so too, do such persons employ this technique when they desire to influence normal others' attitudes toward themselves and toward mental illness in general. Specifically, the data indicate that elderly non-chronics accomplish this aim through: (a) "medical disclaimers" (Hewitt and Stokes, 1978); and (b) education. In terms of the former, similar to Schneider and Conrad's (1980) study of epileptics and their strategies of stigma management, elderly non-chronic, ex-psychiatric patients also frequently make use of medical disclaimers--"blameless, beyond-my-control medical interpretations" to evoke sympathy from normal others and to ensure that they will be

treated in a charitable manner:⁶

I tell people about me being in a psychiatric hospital for depression. But I emphasize that what I've got is an illness that is not my fault--it's something that I just can't help. I tell them that it's just like being hit with the measles or the mumps or any other kind of disease--only this one hits your mind. Usually when I tell this story, people will be sympathetic--they will treat me with pity, but also respect me. You have to make people realize that it's through no fault of your own that you ended up in those circumstances--it was just plain biology, I guess! (Observation # 35, September 30, 1981:33).

A second, short-term ex-patient, speaking of his use of medical disclaimers along with deceptive practices, adds:

You see, most people treat ex-mental patients as if it was their fault that they got sick. I've seen that happen a few times; it even happened in my case. So, what you have to do, is remind people that it's not your fault that this happened to you--you didn't want to go to the hospital--it happened just like you get the flu. It's out of your hands! That's what I try to tell people--I give them that little speech and hope that they act favourably towards me. To enhance the story, I often lie a little bit--I stretch the truth about the circumstances surrounding my hospitalization--I don't tell them that I ended up in the hospital after exposing myself in church, but if you can get them to buy your story, they will treat you more kindly. (Observation # 169, May 10, 1982:40).

A second manner by which elderly non-chronics attempt to influence others' perceptions of themselves is through education. Similar to the epileptics in Schneider and Conrad's (1980) study who disclosed their epilepsy in an effort to educate others about the nature of their illness, so too, do many elderly, short-term ex-patients disclose such information about their selves for the same educating purposes.

According to one elderly ex-patient:

"I don't automatically try to educate every-one I meet about mental illness. With some people it would be useless. But if I think that it's worthwhile, I'll give it a try. I guess that I feel that it's kind of my job to educate people about what mental illness really is--and not let them believe it's like the kind of people they usually see on TV--those people who are violent, complete morons. Once I set people straight, they usually treat me more normally than before. (Observation # 53, October 21, 1981:43).

Similarly, another individual states:

"I have this urge inside of me to teach people out there--to let them know that they've been misinformed about mental illness and mental patients--we're not the way the media has portrayed us. That's why people are afraid of you. They don't know what you're all about. I feel very strongly that someone has to tell people the truth. I try to give them the facts--to tell it to them straight how I ended up in the hospital. And when they hear it, they're amazed sometimes and they act toward me without fear--they treat me nice! (Observation # 152, April 5, 1982:30).

In short then, the data reveals that through the employment of preventive disclosure, these elderly non-chronics, not only lessened the stigma potential of mental illness, but also, influenced others' perceptions of them, in specific, and toward mental illness, in general, thereby enhancing their self-images.

Normalization as a Management Strategy

One final strategy of stigma management employed by about one-third of the elderly, short-term ex-patients is that of "normalization"--a process whereby ex-patients not

only lessen or alleviate the stigma of mental illness, but also, attempt to negotiate definitions of situations. In terms of the latter, these ex-patients attempt to project images, attitudes and non-deviant conceptions of self in an effort to encourage others to respond to them as "normals." Such persons then, rationalize, explain away and downplay their stigma, engage in various normal activities, and aspire to normal attainments. By presenting themselves as "normals," these elderly non-chronics hope to elicit desired responses from those whose reactions are deemed to be important. Achieving more positive, non-deviant self-conceptions is accomplished when others accept and reinforce the non-deviant images of self pro-offered by the elderly non-chronics in the context of social interaction. Speaking of his use of the technique of normalization, an elderly male, short-term, ex-patient states:

I try to fit right in--I play tennis at the club twice a week; I go in and play a game of billiards with the boys. I go to church meetings every Thursday night. If you want to succeed, you've got to go out and do ordinary, taken-for-granted, normal things. You can't hid. You've got to show everyone that you're no different--well, not really. When people ask me if I have to limit my activities so that I don't exhaust myself mentally--they're hinting that I might have another breakdown, I tell them that I'm just as well mentally as any of them--I say that we all have the same genetic predisposition toward mental breakdowns, and that it could have just as easily been them that had to go to the hospital, and that there's nothing really different from me and them. It was just the set of circumstances that caused my breakdown to surface--like a pimple coming to a head and bursting.... In order to make them think of me differently--and not only as a

"former mental patient", I do everything that they do--I play their sports, etc. I try to make them put themselves in my shoes--to see that I'm capable of doing the very same things just as well as they do. And after a while, most people begin to see you, not as former mental patient, but as "normal" Joe Blow! (Observation # 12, September 16, 1981:40).

Similarly, a second, short-term ex-patient adds:

When I got out, I tried to act as normally as possible. I went back and joined church activities. I went back to volunteering at the school once a week. I tried to show everyone that I could do everything they could do, but do it, even better! When people would bring up about my "mental illness," I would tell them that I was sick before, but now I was cured and that it was no big deal--that millions of persons in this world have psychological problems--look at most of the movie stars. I'd tell them that I was in the company of Liz Taylor, Liz Minnelli and lots of other people. I'd tell them that they could easily get what I had--that no one was immune but that I was now healthy and normal. If you go around with that attitude and act accordingly (and pray alot), most people will treat you as an equal. (Observation # 14, September 14, 1981:26).

A third ex-patient, speaking of the two-fold function of normalization, states:

When you attempt to act normally in front of people--you do all the things that they're doing; you talk intelligently--you act just like them. At first, they're probably puzzled--they don't know how to react to you--they start treating you differently--they handle you with care because they're afraid you'll fall to pieces if they say a wrong word. The key to success is making them believe that you're just as normal as them--that you won't crumble or fall apart. If you take the initiative, you can change the way others think of you--you've just got to show them in the things you do and what you say, that you're perfectly OK. It might take some time, but if you persist,

you can usually get people to think of you as more normal. So, they think of you as normal, you keep acting normal, and pretty soon, everyone believes it to be true, including yourself The added advantage is that you reduce the stigma that's a part of having been in the mental hospital... (Observation # 54, December 2, 1981:13).

In short then, through employment of the strategy of normalization, many elderly short-term ex-patients, not only eliminated the stigma potential of mental illness, but allowed such persons to create and retain more positive, non-deviant identities.

MIDDLE-AGED, NON-CHRONIC, SHORT-TERM EX-PSYCHIATRIC PATIENTS: STIGMA, SELECTIVE CONCEALMENT, THERAPEUTIC TELLING, AND POLITICAL ACTIVISM

Similar to the elderly short-term ex-patients, the data indicate that middle-aged short-term ex-patients, upon completion of their psychiatric treatment (treated as out-patients, as in-patients in general hospital facilities, and treated privately by psychiatrists), also seek to resume a life of normality. Given the short-term duration of their treatment, these persons may come to accept a redefinition of self as "deviant," or "somewhat abnormal", this acceptance is only temporary in nature. Upon completion of their psychiatric treatment, middle-aged short-term, ex-patients (similar to their elderly counterparts), make active attempts to rebuild more positive, non-deviant identities. Speaking of her identity as "mental patient" as being a temporary

fixture, one middle-aged ex-patient states:

I was only in the psych. ward for a few months, so, I really didn't freak out all that much. I saw some pretty strange patients while I was in there, though. Some of them were pretty sick, but luckily, I wasn't one of them. Through the therapy, they helped me to confront my problems--to recognize my neurosis--it was a sickness that only happened to me once in my life--it wasn't something that I'd had a thousand times before--I wasn't permanently crippled. They put me on medication that helped a great deal. Being a mental patient was a temporary thing for me--it wasn't no life-long career! (Observation # 94, March 21, 1982:31).

Similarly, a second individual, speaking on the temporary nature of his deviant identity, adds:

OK, so what if I went into a mental hospital. It was only for a short time. I know that I was mentally ill--I accept that fact--but it's not something that I'll always be identified as. Once I was discharged, I started going about my business again. It was just a one-shot illness in my case--I got help--and I was cured. I'm not like those other patients who stay mental patients all of their lives--they're the ones with permanent illnesses. (Observation # 68, January 6, 1982:29).

A third individual states:

When you get treatment, in my case, I went to a shrink for treatment at his office, you go in for your sessions and he works on your mind--he gets you thinking about your abnormal ways--and you begin to question why you acted the way you did. Anyways, you come out, seeing things the same way the doctor sees them--that you've got some sort of mental condition, but it's not hopeless. You stay on medication that stabilizes you--and you try to forget the "therapy experience"--bury it in the back of your mind, and get on with your life! (Observation # 119, June 2, 1982:31).

Just as it was for the elderly, short-term ex-patients, the data indicate that, in the case of middle-aged short-term

ex-patients, their perceptions of self as possessing temporary deviant identities, are influenced not only by the nature, short duration and type of psychiatric treatment into which these persons entered, but also by: (1) the type of psychiatric label affixed to them; and (2) the minimal number of medications such persons were prescribed upon completion of their treatment.

In terms of the psychiatric or deviant label placed upon them in the context of treatment, the data indicate that (similar to the elderly non-chronics), those middle-aged, short-term ex-patients, labelled by professionals as being "non-chronic," as possessing "affective" disorders, see themselves as "better off" than the chronic cases, as having "less serious" "temporary" illnesses--as being able to transform their negative definitions of self:

I was hospitalized because of my neurotic actions. But I was real lucky--if I had been diagnosed as having a real serious problem, like, psychosis or something, then my sickness would have been more permanent. But as it was, I just had a mild case of mental illness--it wasn't a chronic, non-curable case.... So what that means is that I'm able to get on with my life--to leave my life as a psychiatric patient behind and go back to being just a normal guy! (Observation # 20, October 10, 1981:13).

Similarly, a second individual adds:

Being diagnosed as having "episodic mental illness" meant to me that it wasn't going to be a major deal in my life. I was a hell of a lot better off than those psychotic morons on the ward--they're permanently impaired. Those guys don't have any chance of ever making a normal life for themselves. But in my case, since I only have this illness for a short time--because it's episodic, I'm able to get on with my life and forget all about my exper-

iences as a patient in the hospital. (Observation # 115, June 10, 1982:49).

Just as the middle-aged, short-term ex-patients' perceptions regarding the temporary nature of their deviant identities are influenced by the type of psychiatric label affixed to them, so too, are they influenced by their perception of the nature, dosage, and numbers of medications that they are taking subsequent to their psychiatric treatment. Speaking of the small number of pills he is now taking, one middle-aged short-term ex-patient states:

When I was being treated as an out-patient, they had me on six different kinds of pills. I'd have to take them three times a day. And at one point in my treatment, the doctor even put me on another pill--all of these pills were necessary to help make me better, so I was told. But when my treatment was finished, he gradually cut me back so that I was only taking two kinds of pills, two times a day.... When he did that it proved to me that I wasn't permanently sick--and that gave me impetus to go back to living a normal life--and not sit around and feel sorry for myself. (Observation # 73, February 25, 1982:34).

A second individual, speaking of the uplifting effect of being told to discontinue all medication, states:

...when the doctor told me that I need not take the pills anymore, I felt that I was "home free." It was like a first step in my rebirth...no more psychiatrists, no more therapy, no more pills--it was a first step in trying to abandon my hospital experiences, and the recollection of me as a psychiatric patient from "Oakhaven". I wanted to try to get on with my life--to pick up from where I had left off! (Observation # 208, March 23, 1984:39).

In short then, through the context of their short-term psychiatric treatments, the middle-aged non-chronics in this study (similar to the elderly non-chronics), did not fully internalize the role of mental patient and its corresponding

status (pro-offered by psychiatric officials). While such persons, during their psychiatric treatment, come to accept a redefinition of self as "deviant," for in the very least, come to consider themselves to be "somewhat abnormal",⁸ this view of self is accepted temporarily. Upon completion of their treatment, these middle-aged non-chronics, actively seek to abandon their deviant identities and rebuild more positive, non-deviant conceptions of self.

In contrast to the young and middle-aged chronic ex-patients who, upon their discharge, made numerous unsuccessful attempts at rebuilding more positive identities, the data reveal that, (similar to the elderly non-chronics), middle-aged non-chronics also make similar attempts at rebuilding more positive, non-deviant identities, and are, by and large, successful. What factors aid these middle-aged ex-patients in successful identity transformation?

The data indicate that approximately eighty-two percent of the middle-aged short-term ex-patients, upon completion of their psychiatric treatment, returned to their own homes (and were not placed in boarding homes or other housing facilities for discharged psychiatric patients). Their homes offer a warm, comforting environment, with virtually no reminders of past experiences to psychiatric treatment.

When I got back home it was so great. All the things that I loved the most were there. I made a fire in the fireplace in the living room.

I put on my slippers and laid down on the couch. I turned on the stereo and played a mellow album. But the best part about being home was the fact that there was no more nurses, no more doctors and no patients around--nothing in my house reminded me of that.... (Observation # 142, December 21, 1982:26).

Similarly, a second person adds:

I know that I was only in the hospital for a little while but somehow, it felt like an eternity. When the doctor said I was better and finally let me out and I went back home, I just cried--I was so happy. It was like a wonderful dream from the moment I stepped through the front door. It was like my house was happy to see me. I know that I was sure happy to see it. My little kitty, Bonzo, came running up to me and licked my hand. It wasn't too hard to put my hospitalization out of my mind--at least temporarily, because there was nothing in my house to remind me of it..... (Observation # 115, November 26, 1982:24).

As well as providing ex-patients with a warm, comforting, secure environment, their homes also contain many important material possessions--in particular, identity kits, which enable such persons to present their prior, "normal" conceptions of self:

When I was in the hospital, sometimes I thought that I really looked like a mental patient--my hair would be unruly, my eyebrows were bushy and my nails were unmanicured. In the hospital, the nurses take away your scissors and your tweezers. Maybe, at the time, they were trying to protect me, but it sure didn't make me feel very good about my appearance. When I got back home, I was so relieved--I was free to use my scissors when I wanted, or use anything else that I needed. Nobody prevented me from looking my best. Just having my hair done professionally again and having my nails painted, and wearing what clothes I wanted, was such a big boost to my self-esteem! (Observation # 207, February 24, 1984:13).

Another person, speaking of the benefits of returning home states:

In the hospital, I had to use their towels and washcloths--they were rough and thin. Often, the nurses would make me stay in my pajamas--punishment for breaking rules. They took away my shaving kit and anything of monetary value. After just two months in there, I was looking pretty shabby--One day, I looked in the mirror and I couldn't believe how I looked. I used to look quite sharp, you know, but it was real hard to do that in the hospital when they take away most of your gear. That's why I was so happy when I was released and went back to my apartment--there I could dress up the way I used to; I had all my stuff right in front of me--I was able to make myself look like I did before--like a real, cool dude! (Observation # 52, October 22, 1981:38).

While returning home to non-deviant surroundings--locations containing various material possessions, enables middle-aged short-term ex-patients to present to others, a more desired image of self, the data further suggests that, returning home to the company of supportive loved ones also facilitates identity transformation. One female individual, discussing the support she received from her immediate family says:

My husband Tom, and my two little girls were just great. They were always there for me when I needed them. I was afraid that Tom wouldn't think of me in the same way--after all, who would want a wife who had just had a nervous breakdown? I'm not sure that I would. But Tom didn't mind. He kept telling me over and over that it didn't matter, and that, anyways, it was all over now, and we could get on with our life. He wasn't going to let it get in the way of our happiness, and told me that neither should I. It was Tom and the girls who helped me to resume a normal life...to cast off my doubts and inhibitions and get on with living! (Observation # 5, September 8, 1981:28).

A second, short-term individual adds:

It's not easy after you're discharged from treatment. I had mixed feelings about taking treatment. On the one hand, I felt good, but on the other hand, I felt sort of ashamed. I wasn't sure how people would act with me. But at least I didn't have to worry about my family--my wife and three kids gave me the support that I did need. They listened to my problems and made suggestions about how to go on with my life--they were the ones that put me back on a "normal" track... (Observation # 45, November 3, 1981:21).

Another person, recalling her post-hospital experiences, and the role her family played in rebuilding a more positive self-conception, states:

After I got out of the hospital, my husband and step-children were right there. So was my mom and dad. I could never have made it without them. At first, I felt ashamed of myself--I didn't think very highly of myself for having been in a psychiatric hospital. I had fears about my sickness coming back or getting worse. I was mixed up. I thought that my friends and relatives would treat me "differently"--like I was dangerous or something. But they did just the opposite. They talked to me, listened to me, offered suggestions, and helped me to think of myself as being completely "normal" again--just someone who had some problems but successfully solved them! (Observation # 239, April 9, 1984:26).

Just as supportive family members aid middle-aged non-chronics in rebuilding more positive, non-deviant identities, the data suggest that supportive friends also facilitates such an endeavour. Similar to the elderly non-chronics in this study, the data indicate that over two-thirds of the middle-aged non-chronics received post-hospital support from friends. Speaking of the support she received from a close friend, an individual states:

Betty helped me to regain positive feelings for myself. She brought me home from the hospital, had me over to dinner two or three times a week. She went out of her way to be a friend to me. She was the one who encouraged me to start back participating in my activities--she said it would be good for me...It was Betty who helped me to think of myself as OK--she helped me to start believing in myself again! (Observation 3 144, September 30, 1982:29).

A second, middle-aged non-chronic, speaking of similar support says:

My life-long friend, Howard, helped me the most. I've helped him a few times in my life, and I guess that he felt it was his turn to help me, this time. Howard was very supportive--especially in the early days after I first got released. He'd talk to me day and night. He took me out bowling and to a few clubs--especially if they were playing jazz. Howard helped to ease me back into the swing of things--to make me feel like the man I used to be--a respectable, healthy, normal human being! (Observation # 193, January 28, 1983:31).

While family and friends aid middle-aged short-term ex-patients in rebuilding more positive identities, the data indicate that being able to return to, or secure, mainstream occupations or professions, also helps these ex-patients to see themselves in a more positive light. One ex-patient, speaking of his re-employment at a major steel company states:

The first day that I returned to work at the foundry, I felt a little queezy in my gut. At first, I hid out in the toilet, but I knew I couldn't stay in there forever. But the guys I work with, including the bosses, were great about everything. The company even held my job open for me while I got help. But they sympathized with me and told me that it could have been anyone in that room that had to go into the hospital for psychiatric help.... It was really great for the company to hold my job for me.... It really felt good going back to work--being given a second chance to do a man's job for a

decent wage. It made me feel like I used to feel--damned-good about myself again! (Observation # 228, December 10, 1983:14).

Moreover, the data indicate that just as being given the chance to return to a mainstream occupation contributes to successful identity transformation, on the part of these ex-patients, so too, does being able to secure a mainstream occupation have similar effects. A female, ex-patient, discussing the conditions surrounding her procurement of a secretarial position, states:

When I got out of the hospital, things were somewhat difficult. I didn't have a job to go to, but I didn't want to sit around and do nothing--it would give me too much time to think. But luckily, I applied for this job in the steno pool of the hospital where I got my treatment. I never thought they would hire someone who had psychiatric problems--I mean, I would have been scared off if someone came in who had been released from the hospital and asked for a job. To my amazement, the personnel boss, decided to give me a chance. After I got that break, I began not to think of myself as "sick," or as a "loser"--I began to see myself as a worthwhile human being. I was no longer Peggy, the mentally sick girl, but Peggy, the secretary! (Observation # 66, November 4, 1981:49).

A second individual, speaking about obtaining a mainstream occupation states:

Getting a job reading meters for the gas company was the best thing that could have happened to me. I went for an interview and about three weeks later they hired me. I didn't tell them that I had been in a psychiatric hospital because I figured it was none of their business. And besides, they never asked me about it. But getting this job was uplifting for me. It helped me to overcome my feelings--the negative feelings I was having about myself, and made me feel more worthwhile again! (Observation # 277, June 10, 1984:38).

In short then, given that a person's occupation or profession is an integral component of his/her identity, by returning to, or securing a mainstream job, and interacting with co-workers who treat them "normally," middle-aged non-chronics are able to redefine themselves in a more positive, non-deviant manner.

While the factors discussed in the previous pages facilitate the middle-aged short-term ex-patients in developing more positive, non-deviant identities, so too, does the manner by which these persons deal with the stigma potential of mental illness aid in such an endeavour. It will be recalled that, elderly non-chronic ex-patients dealt with perceived and actual stigma through the development and employment of such strategies as: normalization, therapeutic telling, and preventive telling--strategies having the two-fold function of lessening the stigma, and, contributing to the rebuilding of more positive, non-deviant identities. The data indicate that middle-aged short-term ex-patients deal with actual and perceived stigma by developing and employing the following strategies: (1) selective concealment and therapeutic telling; and (3) political activism--strategies not only alleviating the stigma potential of mental illness, but carrying profound implications for identity transformation.

Selective Concealment as a Management Strategy

One strategy of stigma management employed by middle-aged short-term ex-patients is that of selective concealment. Similar to the findings of Edgerton (1967) and Schneider and Conrad (1980) in their studies on the mentally retarded and epileptics respectively, the data indicate that some middle-aged non-chronics, at certain times, and in certain situations actively seek to conceal their discreditable aspects of self; however, at other times, and in other situations, freely disclose such information about themselves. When these persons choose to conceal or disclose their discreditable features of self is contingent upon such factors as their perception of the stigma of mental illness, previous negative experiences with others, the social situation, and their perception of how others may react to them.

Examinations of the data indicate that the majority of middle-aged short-term ex-patients segregate societal members in terms of those who are "trustworthy", and those who are not. In general, some relatives and close friends were considered by the non-chronics to be trustworthy:

I thought about it for awhile before I told anyone. I had to sit down and assess who I could trust and who I couldn't. It's not that you feel good about being secretive, but you don't want people to freak out on you, if you tell them. That's why I think it through very slowly before making a decision to tell them.
(Observation # 177, November 3, 1982:46)

Similarly, a second individual adds:

The only people I told, at first, were the ones I was sure would be understanding--the ones that wouldn't "run for the hills" when they'd be told, or "make wisecracks." That's why, when I got discharged, I only told two or three of my long-time friends... (Observation # 109, February 26, 1982:43).

Another individual, speaking of his use of "psychic powers" with which to judge the trustworthiness of others:

I had to watch out for people. Especially in the beginning, when I first got out of the hospital. I know that people think that having mental illness is worse than the plague. I had to tune myself in to other people--I had to use my psychic powers to judge whether people could be trusted or not. Only a few people could be trusted in my mind, but the rest, I just hid it from them. (Observation # 222, March 8, 1984:36).

While certain individuals are considered by these ex-patients to be "safe others"--people who will be understanding, compassionate, and will respond positively, others, however, are classified as "risky others." As a result of previous negative responses from certain "types" of normals, and/or due to their perceptions that certain others may respond with rejection and disapproval, such persons decide to conceal their discreditable aspects of self, thereby mitigating the stigma potential of mental illness on their daily rounds:

I had two or three bad experiences with people when I first completed my treatment. They were the "Archie Bunker" type--no brains upstairs, just full of stereotypical garbage. They made a few unkind and hurtful statements to me. So I learned fast that those are the type of people that you don't tell... It has disastrous effects for you if you do! (Observation # 90, January 23, 1982:33).

Similarly, a second ex-patient, discussing the rationale behind her decision to engage in selective concealment:

I realized right off the bat that I would have to hide it from certain people. It wasn't so much that I had bad experiences with people, but that I was afraid I might in the future. There was this guy and his wife who live in my building--I just knew inside of myself that I'd have to try to hide it from them. They're the type that just wouldn't understand. They're the kind that would go right up to a cripple and start asking why he wasn't able to walk. They're insensitive morons...those are the type of people you hide it from. (Observation # 23, September 20, 1981:26).

The employment of selective concealment as a management strategy on the part of middle-aged non-chronics took the form of: avoidance of selected normals and "redirection of conversations." Speaking of the former, an individual states:

When I figured out those who I could trust--those who were too risky, I then try to avoid them whenever and wherever possible. Like, if I see them at the supermarket, I duck down one of the other isles. That way, I'm safe. (Observation # 190, November 22, 1982:14).

Similarly, a second ex-patient, discussing her attempts at avoidance states:

I used to not place myself in certain situations where the truth may come out. So, when there were banquets to go to, or neighbourhood get-togethers--if there were going to be people there who were of the prying, nosey nature, I'd just avoid going to those affairs. (Observation # 5, September 4, 1981: 51).

A third individual, discussing his attempts at concealing his discreditable aspects of self, through the "redirection of conversations" states:

If I'm at a party, and the conversation starts moving toward a discussion of mental illness or patients--or if a patient has escaped from the hospital and made headlines, I try to change the subject--begin talking about something else. Actually, I've become quite adept at shifting peoples' attentions to another subject.... It's the same thing when friends start getting interested in me personally and are getting close to the truth--I also redirect the conversation--of if I can't do that, I make some excuse to leave! (Observation # 167, September 2, 1982:23).

Similarly, a second ex-patient states:

Sometimes I think of myself as a traffic director. By that, I mean, sometimes when I'm with a group of people and someone brings up something about mental patients or schizophrenia, I have to do something about it. I usually try to direct the flow of words--I mean, channel the conversation into another direction. In most cases, it works. (Observation # 71, November 28, 1981:43).

It is important to note that selective concealment as a management strategy on the part of middle-aged non-chronics, is used by such persons primarily and exclusively during the time-period directly following their psychiatric treatment. However, the data indicate that, over time, their desires for concealment are diminished, and alternative strategies for stigma management are developed and employed. Attention will now be given to these other such strategies--strategies having profound, positive implications for identity transformation.

Therapeutic Telling as a Management Strategy

Similar to the elderly, short-term ex-patients in this study who employ the strategy of therapeutic disclosure to

mitigate the stigma potential of mental illness, relieve anxieties, and renegotiate personal perceptions of mental illness as discreditable, the data indicate that middle-aged non-chronics utilize this strategy to achieve the same ends.

Examination of the data reveals that speaking to sympathetic others about their "mental illness" was cathartic in nature:

For a long time, I kept all my feelings inside of myself--my feelings of low worth, my self-doubts, my inadequacies. But then when I finally opened up and told my friend Sally, it was like a two-ton weight had been lifted off my shoulders. She was understanding, and it was so nice to have someone to talk things over with. (Observation # 77, December 4, 1981:34).

Similarly, a second, middle-aged ex-patient, speaking of the cathartic value of therapeutic telling says:

By sitting down with my sister-in-law and spilling out my guts about my illness and hospitalization, I felt so much better. Before, I was always on guard--to try to hide the facts about me, but as soon as I told Mary, and everything was out in the open, I felt so much better. A big load was lifted off me. (Observation # 202, February 3, 1984:62).

A third person speaking of the value of having a friend who had gone through similar experiences, states:

The reason I confided in Sybil was that she had gone through the same ordeal two years before me. She would know what I was going through. I sat down with her and we talked for hours. She was a real help--she let me pour out all of my feelings. It's not easy to find supportive friends like her. (Observation # 44, October 3, 1981:59).

Moreover, the data suggests that, beyond releasing anxieties to supportive others, therapeutic telling allows the ex-patients to renegotiate personal perceptions of mental illness.

as discreditable. Discussing the manner by which he came to see himself in a more positive, non-deviant light, one middle-aged ex-patient states:

I talked to my friend Bill about my "breakdwn" one day after a game of tennis. It was the first time that I had really opened up to anyone outside of my shrink. Bill was just great when I told him; he even confided in me that he was close to a breakdown at one time. He helped me to look at things more realistically--not to pity myself, but to learn and grow from my experiences. So, I took his advice--Bill was treating me normally, with respect, so I acted accordingly. (Observation # 166, October 4, 1982:36).

Similarly, a second individual states:

By talking to supportive friends, they can give me insight--an objective opinion. The trouble was that I was too close to my problems to be objective. But they helped me to consider myself "mentally healed"--normal, just as normal as them. It was them that helped me feel good about myself again! (Observation # 113, March 4, 1982:54).

In short then, the data suggest that through the use of therapeutic telling, middle-aged short-term ex-patients (similar to the elderly, short-term ex-patients in this study), not only mitigate the stigma potential of mental illness on their daily rounds, but also, release built-up anxieties and tensions, renegotiate personal perceptions of mental illness as discreditable, and adopt more positive non-deviant definitions of self.

Political Activism as a Management Strategy

Just as some of the middle-aged short-term ex-psychia-

tric patients in this study employ the strategies discussed previously, so too, do others, deal with the stigma potential of mental illness in another manner--specifically, through joining and participating in ex-mental patient activist groups. Such groups with their goal of self-affirmation, represent what Kitsuse (1980:9) aptly terms as "tertiary deviation"--"referring to the deviant's confrontation, assessment, and rejection of the negative identity imbedded in secondary deviation, and the transformation of that identity into a positive and viable self-conception."

Examination of the data indicates that political activism has a three-fold function: (1) it repudiates standards of normalcy, and the deviant labels placed on mental patients; (2) it provides ex-mental patients with a new, positive identity; and (3) it functions to propagate this new, positive image of ex-mental patients to individuals, groups and institutions in society.

Similar to such activist groups as the Gay Liberation Front, the Gray Panthers, the Disabled in Action, and others,⁹ the ex-mental patient activists reject prevailing societal values of normalcy--such persons repudiate the deviant identities, roles and statuses placed upon them. Moreover, such persons reject the stigma associated with such identities. One ex-patient, speaking of her rejection of societal standards of normality, states:

I'm rejecting the whole damned thing. I mean, the fact that society has set up a set of rules regarding what is normal and what isn't. It's a balck and white type of thing--either you're this, or you're not. It's too narrow, and I don't buy it any more! (Observation # 139, April 1, 1982:38).

Similarly, a second ex-patient activist states:

I say, "to hell with societal values." They are so ridiculous, I can't believe it. I reject the ludicrous standards that society has set up--you have to be this and this to be considered "normal", and according to these standards, all of us ex-patients are "weirdo's." Well, I refuse to be judged by these standards any longer. Just because we're different, doesn't necessarily disqualify us! (Observation # 232, April 3, 1984:29).

Upon repudiating prevailing cultural values and the deviant identities bestowed upon them, ex-patient activists, collectively redefine themselves in a positive, non-deviant light, according to their own set of standards. Speaking of his rejection of deviant labels, a middle-aged male states:

We've been degraded long enough--they call us psychotics, manic-depressives, schizophrenics--labels that make us feel less than human. Well, we don't accept these labels any more. Just because we don't fit into the narrow standards of "normal and not normal," that doesn't make us outsiders. Those boundaries need changing. To hell with those boundaries, because we have made up a set of boundaries and all of us ex-patients have defined us as respectable, human beings--people who should be treated the same as everybody else, and not like they're some creatures from outer space, or people that they exploit to make a quick buck. We are human beings and should be treated "humanely." (Observation # 10, September 9, 1981:28).

Another ex-patient activist, discussing her repudiation of societal standards and negative self-definitions, and her

embrace of a new, non-deviant, positive identity:

I no longer agree to accept what society says is normal and what is not. It's been so unfair to psychiatric patients. Who are they to say, just because we don't conform, that we're rejects of humanity. It just isn't so, and I am really mad. The labels that they've given us are degrading and make us feel sick--I'd rather be called a person with VD, than someone with schizophrenia--it has a terrible, negative connotation to it. I know what it's like to be shunned by others; to be treated like an object in the hospital. That's why mental patients aren't going to take it anymore. So we've gotten together and liberated ourselves. We've thrown away the old labels, and the negative images of self-worth that go along with them, and we give ourselves new labels and new, positive images of self-worth--as human beings who should be treated with decency and respect --just like everyone else in the world!
(Observation # 116, February 27, 1982:35),

The data suggest that these ex-patients, through involvement in activist groups, come to see their "problems", not as "personal failings" (as do many chronic ex-patients) --as possessing potentially-stigmatizing attributes; rather, these ex-patients come to see their "problem" as societal problems. To the extent that ex-patients can view their situations in this manner, allows them to develop more positive self-images. Speaking of this process as one of "stigma conversion," Humphreys (1972:142) states:

In converting his stigma, the oppressed person does not merely exchange his social marginality for political marginality, although that is one interpretation the socially dominant segments of society would like to place upon the process. Rather, he emerges from a stigmatized cocoon as a transformed creature, one characterized by the spreading of political wings. At some point in the process, the politicized "deviant" gains a new identity, an heroic self-image as crusader in a political cause. (Observation # 33, September 23, 1981:36).

One activist, placing "blame" on society for her social situation, states:

It's not any of our faults that we ended up the way we did. I felt guilty for a long time--like it was my fault. I felt ashamed and hid my past so I wouldn't be treated harshly by people. But I learned in the activist group that none of it was my fault--it was society's fault--they're the ones who can't deal with anything that is "different." Now I realize that having mental illness is nothing to hide--it's nothing to be ashamed of--I don't have to hide or try to fit into a mold and act like "normal" people--I'm now proud to be "different." (Observation # 56, November 2, 1981:40).

Another ex-patient activist adds:

For a long time, I tried to fit into society's structures--to make myself as "normal" as possible. But I finally realized that there's no point in it. Why should I have to change--after all, it wasn't through any fault of my own that I am the way I am. And what's so bad about that? I used to think that having mental illness was like having a blemish--a mark indicating that you're less than human. But now, I know that I don't have any blemish or stigma--I'm just somewhat different from some people out there. And different doesn't mean inferior--but rather, equal. It's society's problem to deal with us--it's their hang-up--they've been just too rigid in setting up standards. (Observation # 122, March 2, 1982:19).

Just as political activism, as contrasted with other responses to stigma discussed previously, seeks, in repudiating societal values, to provide its participants with positive, non-deviant identities, and raised statuses, so too, does it function to propagate this new positive image of ex-psychiatric patient to others in society. Thus, through such activities as protest marches, rallies, attendance at conferences on Human Rights, lobbyist activities, and production of news-

letters--activities enhancing the self-concepts of its participants, and also serving to present to society an image of former mental patients as "human beings" capable of self-determination and political action. One ex-patient activist aptly sums up the aim of political activism:

Simply put, we're tired of being pushed around. We reject everything society says about psychiatric patients, because it's not true. We reject the type of treatment we get when we're in the hospital, and from the people, when we're out. We don't like the meaning of the words they use to describe us--"mentals, nuts, and crazies." We find it offensive. We see ourselves differently--and just as good as any people out there. In our newsletters, we're trying to get across the idea that we're not the stereotypical mental patient they see in the movies. We're real people and we don't act like that. People victimize some of us; we're often exploited; most people don't understand about mental illness. We're trying to lobby to be treated equally under the charter of rights. We want to make our case known to everyone. We're not sitting back now, but we're fighting back! (Observation # 102, February 10, 1982:22).

In short then, those middle-aged ex-patients participating in political activist groups, internalized an ideology that repudiates societal values and conventional normative standards, and by so doing, obtained more positive, non-deviant identities.

YOUNG, SHORT-TERM EX-MENTAL PATIENTS: STIGMA, NORMALIZATION AND POLITICAL ACTIVISM

Similar to the elderly and middle-aged short-term ex-psychiatric patients, the data indicate that, young short-

term ex-patients, upon completion of their psychiatric treatment, also seek to resume normal lives. By virtue of their short-term hospitalization (or no hospitalization at all), such persons (similar to the elderly and middle-aged short-term ex-patients), conceive of their deviant identities as "mental patients" to be "temporary fixtures" that they can "alter":

I saw it this way--I was in the hospital only a couple of times in my life--each time for about a year or so. They made me see that I was a schizophrenic--I bought that part, but, I didn't want to be that way forever. That's why I decided to try to make a new start for myself this time. I wanted to shake off that view of myself as a patient, and take on a new image as a normal, average guy! (Observation # 152, October 2, 1982:33).

Similarly, a second individual, speaking on her desires to transform her deviant aspects of self:

In the hospital, they make you accept the fact that you're sick, and I did--at the time. But now that I'm out, I just want to forget the past and get on with my life. I'm tired of being referred to as a patient--I want to be thought of as something else--someone better, who gets respect and gets treated equally and not like a kid or even worse! (Observation # 169, October 27, 1982:45).

Just as it was for both the elderly and middle-aged non-chronics in the study, the data indicate that young non-chronics' perceptions as possessing deviant identities that are not permanent fixtures, are influenced not only by the nature and duration of their psychiatric treatment, but also by the type of psychiatric label affixed to them. Specifically, those young non-chronics, defined by psychiatric pro-

professionals as possessing such disorders as "schizophrenia," "depression," as having various "non-chronic," such persons conceived themselves to possess "curable, temporary, mild afflictions"--perceptions providing an impetus for attempting to rebuild more positive identities:

In my case, I only had a mild mental breakdown--it wasn't that serious. I was incapacitated for about over a year, but just knowing that I didn't have "chronic depression" or something serious like that, gave me the strength to try to get on with my life one more time! (Observation # 100, January 27, 1981:27).

Similarly, a second, young non-chronic adds:

I was in out-patient therapy for over a year. Before that, I was in the hospital for a little while. But I wasn't chronically ill, like some people were. I just had a nervous disorder--it could be controlled. So, after the therapy, I decided I could overcome my problems--to get on with my life. I wasn't disabled permanently. Realizing that helped me to make the first move to get back into the swing of things again. (Observation # 96, February 3, 1982:14).

In short then, through the context of their short-term psychiatric treatments, the young non-chronic ex-patients in this study (similar to their middle-aged and elderly counterparts) did not fully internalize the role of mental patient and its corresponding status as did the elderly chronics in the context of their long-term treatments. While the young non-chronics, during their treatments, come to see themselves in the image that the psychiatric officials have of them--that is, as "mental patients", such a self-image is accepted only temporarily. Upon completion of treatment, such persons

actively seek to discard this view of self and rebuild a more positive, non-deviant identity.

It will be recalled that the elderly chronics in this study, for the most part, did not attempt to transform their deviant identities; while their middle-aged and younger counterparts did make such attempts, they were virtually unsuccessful. However, in the case of elderly and middle-aged short-term ex-patients, such persons actively attempted to rebuild more positive identities and were largely successful in their endeavours. Upon examination of the young short-term ex-patients, the data indicate that these persons make similar attempts at transforming their deviant identities, and just like their elderly and middle-aged counterparts, succeed in their endeavours. What factors aid these non-chronics in successful identity transformation?

The data indicate that over three-quarters of the young, non-chronics, prior to, during, and upon completion of their treatment received support from relatives. Such informal support systems serve to help these persons dispose of their deviant identities and adopt more positive, normal self-conceptions:

2. My family was there with me through the whole thing. They were there when I got signed in, they came to visit me in the hospital and give me encouragement and strength, and they were there when I got out. Some of the patients I met in the hospital had been abandoned by their family, but I wasn't. They helped me a lot. They made me feel good about myself again. By talking and talking, they helped me to go out and start making a life for myself. (Observation # 126, August 18, 1982:31).

Another person, recalling his post-hospital experiences, and the role his family played in helping him to rebuild a more positive, self-conception, states:

My father and mother were very helpful to me right throughout the treatment. They'd come and visit me every Sunday at the hospital--and it meant a ninety mile drive to visit me. They encouraged me--they told me to take each day at a time. When I was released, my parents let me come back home, and they really helped me to muster up the strength to go back to school. They helped me to see myself as AOK again. They told me that as far as they were concerned, I was OK--they believed in me, so I started believing in myself again--that I was worth something! (Observation # 127, August 20, 1982:42).

Just as informal support groups comprised of family members aid young, short-term ex-patients in rebuilding more positive, non-deviant identities, the data indicate that other informal support groups comprised of friends also facilitates such an endeavour. Approximately, sixty percent of the young non-chronics received post-hospital support from various friends. Discussing the support and comfort she received from a close friend, one young non-chronic states:

Maggie helped me tremendously. She held my hand gave me strength. She did everything she could for me. She'd visit me at the hospital and bring me little presents. When I got out, she came over to my apartment and stayed for a couple of weeks. After that, she'd phone me every day to help me get my spirits up. She was the only one who really cared about me. She helped to make me feel that I had something to contribute in life--she helped me to put aside my hospital treatment, and to think of myself positively again--to forget that I was a mental patient! (Observation # 215, March 1, 1984:58).

Another, young ex-patient, speaking of the support he received from friends says:

My neighbours--Dick and John helped me to get over the rough times. They picked me up from the hospital and brought me home. They'd come over and have a couple of beers and they would talk to me about how I should forget the past and go on with my life. They were the ones who quieted down my fears and my anxious feelings; they told me that they thought of me as completely OK--normal, you know.... You know, if people act around you like you're normal, you gradually begin to believe it too. (Observation # 3, September 6, 1981:13).

A third person adds:

If it wasn't for the help and support I got from three of my closest friends, I couldn't have got on with my life--they showed me that I had something to offer--that I was a worthwhile human being--they made me feel good about myself, and pushed me to go out and live! (Observation # 198, February 21, 1984:41).

Just as family and friends aid young non-chronics in rebuilding more positive identities, the data indicate that being able to secure, or return to mainstream (non-deviant) occupations or professions also helps such persons to see themselves in a more positive light. One young, non-chronic, speaking of her re-employment at a major department store states:

It was such a boost to my esteem to go back to work at department store. You have no idea of how great it felt. My boss was so supportive of me--she welcomed me back and said that she really missed me. And I went back to doing the very same job that I had done before in the childrens' clothing department. After about a week back at my old job, all the self-doubts and inadequate feelings I was having,

somehow just disappeared, and I began to think more highly of myself again! (Observation # 208, January 7, 1984:42).

A second individual, speaking about returning to a mainstream occupation and the effects on his identity, states:

After my breakdown had been "healed," and I got out of the hospital, I was able to go back to my old job at the accounting firm. I had worked there for almost three years before my temporary sickness. But I was real lucky because the boss left my job open until I got well enough to come back. I think I would have died if, on returning home, I had no job to go to--I'm not the type of guy that can sit around the house all day. Getting back to my old job was so beneficial--it quickly made me forget that I was in a psychiatric hospital--it got me back to feeling the same way about myself as I used to! (Observation # 217, March 6, 1984:23).

Moreover, the data indicate that being able to secure a mainstream occupation or profession contributes toward successful identity transformation. A male ex-patient, discussing the effects of obtaining a teaching position at a local college on the transformation of his identity, states:

I had this breakdown right at the end of graduate school, so I never ended up finishing my Ph.D. After I was released from the hospital, I wanted to hide. I didn't conceive of myself in a very positive manner. But gradually I came to the realization that I couldn't just sit home watching soap operas all day long--it became very frustrating. So, I decided that I had to do something with my life. I didn't think I could go back and finish my doctorate at that point, but I did want to do something. So, I applied for a teaching position at _____ College. I went for the interviews, and with little trouble I was hired. Teaching has been so therapeutic for me...the students treat me with respect and dignity.... It took some time, but gradually I began to feel good about myself again... (Observation # 93, December 20, 1981:42).

A second person, speaking about obtaining a job in a restaurant, states:

Getting a job waitressing was the best thing for me. It stopped me from sitting around pitying myself. But more than that, when customers treated me nicely, and the manager respected my opinions and trusted me, that gave me a new feeling of self-worth--something that I had lost somewhere down the line when I was in the hospital! (Observation # 117, August 5, 1982:39).

In short then, given that an individual's occupation is an integral component of his/her identity, the act of returning to, or obtaining employment, and interacting with "respectful others," functions to facilitate young non-chronics in transforming their deviant identities.

A final factor important for successful identity transformation, on the part of young non-chronics, involves the manner by which they deal with the stigma potential of mental illness. It will be recalled that the chronic ex-patients in this study developed and employed certain strategies (i.e., retreatism, passing, dissociation, and capitulation) which served to lessen the stigma potential of mental illness on their daily rounds, but had negative implications for identity transformation. By contrast however, the data revealed that elderly and middle-aged non-chronics, developed and employed rather different strategies (i.e., normalization, selective concealment, therapeutic telling, preventive telling, and political activism--strategies not only alleviating actual or perceived stigma, but also, carrying profound, positive implications for identity transformation.

Examination of the data reveal that young, short-term ex-patients deal with actual and/or perceived stigma through the development and employment of the following strategies: (1) normalization; and (2) political activism--strategies lessening the stigma, and also, contributing to the rebuilding of more positive, non-deviant identities.

Normalization as a Management Strategy

One management strategy employed by many young, short-term ex-patients is that of normalization--a strategy whereby such persons attempt to alleviate the stigma potential of mental illness, and also, attempt to project images, attitudes and normal self-conceptions in an effort to encourage others to respond to them in a normal manner. Such persons then, (in contrast to middle-aged short-term political activists) while remaining committed to cultural conceptions of normalcy, and aware that according to such conceptions, they are disqualified, they nevertheless, attempt to rationalize and downplay the stigma attached to their failing. These young, short-term ex-patients, like their elderly counterparts, participate in a full round of normal activities and aspire to normal attainments. By presenting themselves as "normals," these young, short-term ex-patients hope to elicit positive responses from those persons whose reactions are deemed to be important. When others accept and reinforce the non-deviant images of self pro-offered by the young non-

chronics, this allows such ex-patients to achieve more positive, non-deviant conceptions of self. Discussing the utilization of the technique of normalization, one young ex-patient states:

I decided the best thing to do was not to hide from people once I got out of the hospital. Life's too short for that. Lots of people knew that I was in a mental hospital anyways, so there was no use in trying to hide the fact. For those who don't know, I don't keep it a secret from them--that would be too strenuous and anxiety-provoking. I let the truth be known about me but not because I'm on a bandwagon trying to educate the world like some former patients are, but I just want to show people--people that I deal with, that Joe Smith is able to do the same things that they do--just as well, or even better. Having had mental illness hasn't crippled him. It's something that happened in the past and it's now over. I try to act normally just like them, and sooner or later, they start treating me that way! (Observation # 219, March 10, 1984:56).

A second, young, short-term ex-patient adds:

I thought that I had one of two choices after I finished my treatment--I could either hide the fact or not hide it. At first, my inclination was to make up a story for why I had been away from school--like I had gone on an exchange program to Spain or somewhere. But then I thought I should try to get on with my life--making up lies would be tiring. My father always told me to approach things "head on," so I decided to deal with my mental illness in that way. I knew some people aren't very understanding when it comes to mental illness, and I knew that I'd be in for a rough time, but I thought that if I go back doing the things that I normally did, and people would see that I was behaving normally, they would eventually not see me as a former mental patient, but as a normal guy. (Observation # 9, September 11, 1981:51).

A third, young non-chronic, aptly sums up the advantages of adopting the strategy of normalization:

When you've left the hospital and go out into the world again, you've got to learn to survive in this harsh world. By acting "normally," we former patients are trying to fit in--we're asking for tolerance and acceptance. We're trying to show the people we care about that we can participate in all the activities that they do--that we can take the same stresses and strains as they do in everyday living. Also, we're trying to show them that we can hold down responsible jobs, just like them. By sticking to our guns, we hope that we can convince people to think of us not as "ill" people, but as "healthy, normal" people. If they will treat us that way, we'll feel a lot better about ourselves, and it sure would make life a lot easier! (Observation # 225, March 30, 1984:49).

Political Activism as a Management Strategy

While a number of young, short-term ex-psychiatric patients in this study employed normalization as their primary strategy of stigma management, the data indicate that, others,¹⁰ deal primarily with such stigma by joining and participating in former mental patient activist groups. In contrast to the young non-chronics adopting the strategy of normalization--persons who are firmly committed to societal conceptions of normalcy, and seek to explain away the stigma attached to their failing, the young non-chronics, adopting the strategy of political activism repudiate societal standards of normalcy. While the normalizers seek friendship and acceptance from normals, the activists demand social equality. One female ex-patient activist, speaking of her rejection of societal values states:

I no longer believe the things society has been cramming down our throats. It's all garbage. If you sit down and think, you'll come to realize that no one on this whole earth is really "normal." But somebody creates this image of what a normal person should be--and everyone else, doesn't fit in. Mental patients are left out in the cold because of it. But, I will not be put into an abnormal mold--I won't. I reject the labels and the negative connotations that go along with them... (Observation # 116, August 3, 1982:33).

Similarly, a second activist adds:

This is the way it is. I totally reject the way that people think of us--the way they see us-- the labels they've put on us. We've been treated so unfairly and now it's our turn to react. We're like people with physical disabilities--we're up in arms--we don't like the corner society has painted us into. We're not inferior to other people--we may be different, but that doesn't mean we're abnormal. (Observation # 11, September 15, 1981:26).

Upon rejecting prevailing societal values and conceptions of normalcy, and the negative, deviant identities accorded to them by society, these young non-chronic activists (similar to the middle-aged non-chronic activists), collectively redefine themselves in a more positive, non-deviant light, according to their own, newly-devised set of standards:

I now judge myself not according to what society says is right or wrong, what is normal or not; I judge myself according to different standards that myself and others have set up--we're less rigid. Before, I used to go around feeling bad about my illness--being ashamed--feeling sub-human according to what society thought of me. But now, that's all over. I think of myself in a whole different light. I've defined myself according to a different set of standards--standards which define me as OK--actually, more than OK. I feel a hell of a lot better, too! (Observation # 29, September 27, 1981:24).

Another ex-patient activist, discussing the rejection of conventional societal standards and values, the repudiation of deviant labels, and his adoption of a new, more positive conception of self:

Some people may agree what society says is normal and what isn't. But I don't. I don't like to be forced into one camp--the abnormal camp just because I had a psychological illness. It isn't fair. And I'm not going to try to fit into the normal camp--try to make people think I'm like them. Why should I have to try? I'm me and why should I have to change? To hell with the names they put on me--paranoid schizophrenic--it's a term they use to make me feel inferior. Forget it. Since I joined the group, they made me see that I don't have to judge myself--follow those standards--we made up a new set and judged all of us differently. We see ourselves as good, normal citizens who may be different due to illness--but we don't see ourselves in the same way that others do. (Observation # 14, September 18, 1981:46).

Similar to the middle-aged non-chronic activists, who, by virtue of their participation in activist groups, came to see their "problems" not as "personal failings," but "societal problems"--problems related to rigid societal standards of normalcy. By shifting the "blame" from themselves to society, allows these young non-chronics to develop more positive self-images and identities:

It's sort of funny, you know. On the one hand, I knew that having been mentally ill was not my fault, it was just something that happened. But on the other hand, I was being stigmatized by some people, as if it was my fault. Then I began to realize that that's the way society is set up--they have these stupid demarcations between what is normal and what is deviant--and those who are of the deviant persuasion are naturally stigmatized by others. I finally realized that I wasn't to blame, but that the problem lied in society--it's narrow ideology.... When I realized that, a big burden had been lifted...I felt much better (Observation # 38, October 16, 1981:41).

Similarly, a second ex-patient activist adds:

For a while, I, like many other ex-patients, went around thinking that I had this personal problem--a deficiency in my mind that a lot of people would react negatively to, if they knew. When I joined the activist group, I came to realize that having mental illness is nothing to hide. Society has problems dealing with any people who are different--look at the homosexuals and the tough time they had--and so do crippled people. They stigmatize different people and treat them harshly or like inferiors. But they're wrong to do that--we may be physically or mentally different, but that doesn't give them the right to treat us the way they do! (Observation # 248, April 2, 1984:13).

Just as political activist groups, in rejecting societal values and standards of normalcy, provide its members with more positive, non-deviant identities and elevated statuses, the data suggest that it also serves to propagate this new, positive, enhanced image of former mental patients to others in society. Through various activities such as conferences, media presentations, rallies, marches, lobbyist activities, and their monthly newsletters, these activists attempt to destroy the predominant, largely-stereotypical, negative images of ex-mental patients, and replace such images with an alternative one--one that portrays them as respectable, human beings, who are capable of both self-determination and political action. One young ex-patient activist, discussing such activities:

We're trying to change things--in our newsletter, we try to bring up problems in need of change--we need to be treated humanely both in and out of the hospital. We have to have our rights as citizens ensured. We want to be treated as equals and not inferiors or weirdo's. We demand

more money for those ex-mental patients living in poor exploitive housing conditions. We want to be thought of in a more realistic, benevolent manner. Just as the people marched against slavery, so are we marching against the same sort of injustices that have been done to us. We want people to see us as OK! (Observation # 280, June 4, 1984: 30).

In short then, through participation in ex-mental patient activist groups, young non-chronics, upon internalizing a group ideology that repudiates conventional standards of normalcy, redefine themselves in a more positive light; moreover, such persons acquire a sense of group solidarity--that many are striving for social change--change that will provide personal benefits for themselves and for ex-mental patients in general.

SUMMARY

In summary, this chapter has centred on issues of stigma, strategies of stigma management, and identity transformation as it relates to non-chronic, short-term ex-psychiatric patients. The data indicate that these short-term ex-patients, (similar to their long-term, chronic counterparts), are also strategists and negotiators, who, upon completion of their treatment, actively attempt to negotiate their social situations and identities, and by so doing, attempt to avoid or counter the stigma potential of mental illness. In contrast to the elderly chronics in this study who conceived of their deviant identities as "permanent fixtures" and thus, had given up, or did not attempt to rebuild more positive identities, the data indicate that, in

the case of elderly, middle-aged and young, short-term ex-patients, such persons conceived of their deviant identities as "temporary fixtures." Upon completion of their treatment, these short-term ex-patients, desired to obtain more positive, normal identities. It will be recalled that for the elderly chronics such a perception of self as possessing a permanent deviant identity was reinforced by such factors as the long-term duration of their hospitalization, the nature of their hospitalization, the psychiatric label bestowed upon them, and the dosages and numbers of medications received. So too, for the short-term ex-psychiatric patients, such perception of self as possessing a temporary deviant identity is reinforced by the same factors.

While the middle-aged and young chronics in this study, who, upon their release from treatment, made a number of unsuccessful attempts at transforming their deviant identities, the data indicate that the elderly, middle-aged and young short-term ex-patients made similar attempts and were largely successful in their endeavours. Specifically, such factors as: returning to a home environment, the presence of informal and formal support groups, and returning to or securing a mainstream occupation or profession aided in such transformations of self--resources that were either not at the disposal of, or utilized by the chronic ex-patient in this study.

Further, the data indicate that the manner by which

short-term ex-patients dealt with the stigma potential of mental illness had positive implications for identity transformation. In contrast to the chronics who employed largely defensive tactical maneuvers--strategies having negative implications for identity transformation, the short-term ex-patients developed and employed offensive tactical maneuvers--maneuvers or techniques whereby such persons not only mitigated the stigma potential of mental illness on their daily rounds, but also, served to influence or shape others' perceptions and actions toward themselves, and toward mental illness in general, thereby enabling these short-term ex-patients to achieve more positive, non-deviant identities. For the elderly short-term ex-patients, such strategems or techniques included: selective concealment, therapeutic telling, preventive telling and normalization. For the middle-aged short-term ex-patients, such strategies included: selective concealment, therapeutic telling, and political activism, with most ex-patients progressing from one strategy to the next in the course of their ex-patient careers. In the case of the young short-term ex-patients, some persons employed primarily the strategy of normalization, while others, joined and participated in former mental patient activist groups--strategies that not only functioned to alleviate the stigma potential of mental illness, but also served to aid in the rebuilding of more positive, non-deviant identities.

In this chapter (and the previous one), ex-mental patients, both chronic and short-term, have been depicted

not as passive, powerless, individuals (as much of the labelling literature has suggested), but rather, as active participants--active in the sense of attempting to negotiate their post-hospital situations and identities, and in attempting to counter, avoid or deal with the stigma potential of mental illness on their daily rounds.¹¹

The next chapter will present an overview of the world of the Canadian deinstitutionalized ex-psychiatric patient based on the analysis in the preceding chapters. The conclusions drawn from this study are presented; the limitations of the research, and its implications are discussed, and suggestions for future research are offered.

NOTES

1. These persons have not fully internalized the role of mental patient and its corresponding status proffered by psychiatric officials in the course of their treatment (as did the elderly chronics in this study).
2. In contrast to Parsons (1953) who contends that such groups function to perpetuate the "sick role," the data in this study indicate that self-help groups aid individuals in shedding a deviant, sick role in favour of a healthy, normal conception of self.
3. Such factors were not at the disposal of the chronic ex-patients.
4. This term was employed by Schneider and Conrad (1980) in their study on epileptics and their strategies of stigma management.
5. This strategy was also employed by epileptics (Schneider and Conrad 1980) and infertile persons (Miall 1984), among others in the course of their "management work."
6. Alcoholics adopting disease models, also frequently make use of such medical disclaimers.
7. This term is borrowed from Davis' (1972) study on polio children. In this strategem, the individuals are firmly committed to cultural conceptions of normalcy, but while accepting such standards and aware that they will never measure up to them, such persons make active attempts to downplay or rationalize the stigma associated with their differentness. This strategy was employed by elderly non-chronics when others (family, friends, co-workers, neighbours) were already aware of their psychiatric pasts; such persons could, therefore, not "pass" (cf. Davis, 1972; Edgerton, 1967) as "normals" in their presence; these persons decide that, the best strategy to employ is one of normalization--to exhibit to others that their "disability" does not prevent them from participating in a full round of normal activities.
8. In particular, those in private therapy.

9. Black Power and Coyote (an activist group for prostitutes).
10. It is interesting to note that in contrast to the middle-aged non-chronics who progressed from strategy to strategy (from selective concealment to therapeutic telling to political activism), the data indicate that the young, non-chronics primarily employed normalization or political activism to manage the stigma potential of mental illness.
11. For a detailed discussion of the negotiation of identities and definitions of the situation, see: Strauss (1959), (1962); Goffman (1959), (1963); Scheff (1968); McHugh (1968), among others.

CHAPTER NINE .

SUMMARY AND CONCLUSIONS

SUMMARY OF THE THESIS

This dissertation has investigated the social worlds of Canadian ex-psychiatric patients from their points of view. Specifically, this study has focussed on issues of stigma, strategies of stigma management, and their implications for successful identity transformation on the part of ex-mental patients.

This Ph.D. research was stimulated by a number of factors. Firstly, my interest in this topic evolved from my Master's thesis, an ethnographic study of the processes and consequences of institutionalization upon the self-images and identities of Canadian mental patients. The data indicated that once mental patients are discharged from psychiatric facilities, many attempt to rebuild more positive, non-deviant identities. However, due to numerous social barriers, these individuals often find it difficult to alter their deviant identities. Such persons discover that they possess a stigmatizing condition--a stigma that threatens their social status as normal societal members. Mental

illness comes to be perceived by these ex-patients as an attribute that is potentially-discreditable to their identities. Thus, their task centred on the management of this undisclosed, potentially-discreditable information about their selves in order to avoid the stigma potential of mental illness; by so doing, such methods enabled these ex-patients to "pass" as normal members of society. The data suggested that while some ex-patients dealt with their post-hospital situations in the afore-mentioned manner, others, did not. Due to structural and time constraints, the researcher was unable to examine fully all facets of deviant outcomes. Thus, it was the purpose of the present investigation to fully explore such areas of interest and concern. Secondly, a review of the existing theoretical perspectives accounting for the origins, rise, and effects of the movement toward deinstitutionalization of psychiatric patients (discussed in Chapter Two), indicated that, while such theories have contributed, in certain respects, to our understanding of this phenomenon, they have not provided us with a holistic understanding of the movement toward deinstitutionalization. Specifically, such theories have neglected one important dimension: an examination of the effects of this movement upon the individual actors from their subjective standpoints--those individuals who are directly affected by this shift in treatment and policies. I argued that the utility of a symbolic interactionist perspective, specifica-

ly a labelling perspective, lies in its ability to fill such a neglect. It was noted that as a theoretical approach, the labelling perspective (as opposed to those previously discussed), centres on deviants from a microscopic, subjective standpoint. Labelling theorists focus not only on the social processes by which individuals are defined as "deviant" and are subsequently processed in the context of various organizations and institutions, but also, on the subjective reactions of the individuals who have been so labelled, the manner by which they accept deviant roles, the extent to which they adopt deviant self-conceptions, and their ability to alter deviant identities by shaping societal responses toward them. The employment of a labelling perspective for the present investigation, allowed for a detailed examination of the following individuals directly affected by the shift in policy, care and treatment arising out of the movement toward deinstitutionalization:

- (1) those chronic mental patients institutionalized in a psychiatric hospital for a number of years and were released into the community as a result of this movement;
- (2) those individuals, who, in light of this movement, were treated privately in a psychiatrist's office;
- (3) those persons, who, due to this shift in treatment of the mentally ill, were not hospitalized

but treated as out-patients in a psychiatric clinic;

(4) those individuals, who, as a result of this movement were hospitalized on a short-term basis on a psychiatric ward of a general hospital facility;

(5) those persons, who, in light of the movement toward deinstitutionalization were hospitalized initially in a general hospital, and were subsequently transferred for further, short-term treatment in a psychiatric facility and then released.

Specifically, employment of a labelling approach allowed for the examination of the career paths of these individuals--the social processes by which these persons came to be defined as "mentally ill", the role of self-labelling and societal reaction in the definitional process, the nature, length and duration of treatment, and the consequences of such treatment for self-images and identities. Moreover, such an approach allowed for an examination of the perceptions of the actors themselves--their post-treatment responses to institutional or official labelling, their subjective perceptions of mental illness as a potentially-stigmatizing condition, their post-treatment strategies of stigma management, and its implications for identity transformation. This approach, with its interactionist underpinnings, allowed for an examination of the social relations between ex-mental

patients and "normals," and the role that the former play in "negotiating" their post-treatment identities and situations--in eliciting desired responses through their own behaviour, and also through the expectations and images that they project. Thirdly, this research was stimulated by the observation that the existing literature on the de-institutionalization phenomenon is comprised largely of follow-up studies, outcome studies, theoretical papers, studies focussing on the plausibility, implementation and evaluation of various therapeutic treatment programs and community psychiatric "tools" (as was discussed in Chapter Three). However, there existed only a few ethnographically-based studies that focussed on deinstitutionalized mental patients from their perspectives, with little research having been conducted on Canadian ex-patients. It was the purpose of this dissertation to attempt to fill such a neglect. Specifically, using a labelling-interactionist perspective, this research sought to gather data on the everyday worlds of Canadian ex-psychiatric patients: to discover not only how such persons physically-survive in the community, but also, the manner by which these ex-patients attempt to cope or deal with "normals" in the community. Addressing the issues of stigma, deviant identities, management strategies and identity transformation, this dissertation sought to examine: (a) in the context of short-term and long-term careers, whether psychiatric patients come to accept a re-definition of self as "deviant"

(as the literature suggested); if so, (b) whether such persons accept their deviant identities as "permanent fixtures," and thus, not attempt to alter them; or (c) if ex-mental patients, upon completion of their psychiatric treatment actively attempt to transform their deviant identities; (d) the criteria that are important for successful identity transformation; (e) the manner by which ex-patients discover that they possess an attribute that is potentially-stigmatizing; (f) the strategems employed by ex-patients to mitigate the stigma potential of mental illness, and their implications for identity transformation; (g) whether short-term ex-patients have greater success in transforming their deviant identities than do their long-term counterparts; (h) whether elderly, middle-aged and young chronics differ in terms of their desire to, and their success in, achieving more positive, non-deviant identities, and in the strategies they develop and employ to deal with the stigma potential of mental illness on their daily rounds; and (i) whether elderly, middle-aged and young short-term ex-patients differ from one another (and from their long-term counterparts) in terms of their desire to, and their success in, achieving more positive, non-deviant identities, and in the strategies they develop and employ to deal with the stigma potential of mental illness on their daily rounds.


In Chapter Four, the research methodology employed to address the above concerns was outlined and the nature and selection of the sample was discussed. In terms of the

former, given that the aim of this dissertation was to gain a subjective understanding of the post-treatment worlds of Canadian ex-psychiatric patients, the methodological approach adopted was essentially qualitative and inductive in nature, and involved the use of participant observation, informal and semi-structured interviewing techniques. In terms of the sample itself, a disproportionate, stratified random sample of three hundred former mental patients was obtained from a listing of those receiving various forms of psychiatric treatment from 1978 to 1981. Of these three hundred, two hundred and eighty-five persons took part in the study (or ninety-five per cent of the original sample). The rationale behind the decision to obtain a disproportionate, stratified random sample was two-fold: the researcher was concerned with sampling issues to ensure that the observations would be typical not only of those ex-patients under investigation, but that they could be generalized to other ex-patients in the population; moreover, this sampling technique was adopted in order to allow for meaningful comparisons to be made between and among certain sub-groups of ex-patients --specifically, between and among elderly, middle-aged and young long-term ex-patients, and, elderly, middle-aged and young short-term ex-patients.

The results of the data analysis were presented beginning with Chapter Five where the career paths of Canadian ex-psychiatric patients were examined. Specifically,

attention was directed at the social processes by which individuals came to be defined as "mentally ill," the type, duration and nature of their psychiatric treatment, and the effect of such treatment on self-images and identities. The data indicated that the short-term careers of mental patients began when various societal members (such as family, friends, legal authorities, family physicians, and sometimes even the individuals themselves) reacted and took action against persons committing culturally-inappropriate acts. Once labelled, the data indicated that such persons entered into various forms of psychiatric treatment. Forty-three persons in this study, were sent for treatment as out-patients at various community mental health centres. Such treatments ranged from periods of two months to two and a half years. For the majority of these persons, during the intense group therapy sessions, they were nevertheless forced to accept a new conception of self as "mental patient". Twelve individuals, in the context of their short-term careers, upon official labelling, were sent to psychiatrists for private psychiatric help. The data indicated that given the nature and short duration of such treatment sessions, the majority of such persons did not fully accept a redefinition of self as deviant; these individuals, by virtue of their treatment, began to call into question their identities as "normal" societal members--they no longer see themselves as completely normal but neither do they see themselves as completely deviant. Such persons saw themselves as being situated on

a continuum somewhere in-between these two extremes. Fifty-two persons in this study, in the context of their short-term careers, upon official labelling, were treated within the confines of a psychiatric ward of a general hospital facility for periods ranging from three to twelve weeks. Given that these persons were hospitalized on previous occasions for psychiatric treatment, that during their hospitalization they were referred to as psychiatric patients by hospital staff, and that they were forced to interact on a twenty-four hour basis with other "mental patients" who reinforced this redefinition of self, such persons ultimately accepted a redefinition of self as mentally ill and its corresponding role and status. The data further indicated that some persons, in the context of their short-term careers, received treatment as in-patients in a psychiatric institution. Specifically, thirty-nine persons in this study received such treatment for an average period of six and three quarter months and were then released. The data indicated that these persons, upon admission and thereafter, were stripped of their prior non-deviant self-conceptions. In its place, the institution offered such persons alternative conceptions of self as "mental patients"--identities and statuses that such persons initially rejected, but given the reinforcement from institutional staff and patients, such persons gradually adopted a redefinition of self as "mentally ill" and its corresponding role and status.



Turning to the long-term careers of psychiatric patients, the data indicated that such persons also commenced their careers when various social audience members reacted to individuals committing culturally-inappropriate acts and defined them as being "mentally ill." Once officially defined, such persons followed one of three career paths--paths that were different from those involved in short-term careers. One such career path involved long-term, continual institutionalization in a psychiatric hospital. The data indicated that forty-nine persons in this study were institutionalized for periods of time ranging from four to seventeen years. During this time, such persons were stripped of their prior self-conceptions and offered alternative identities of "mental patients." Through the context of the institution's system of rewards and punishments, the enforcement of interaction with other mental patients, and reinforcement of this new identity from institutional staff over a long duration, these persons came to fully accept and adopt this redefinition of self as mentally ill and its corresponding role and status. A second career path involved being institutionalized for long periods of time, released, and then re-institutionalized--a circular career path followed numerous times. The data indicated that fifty-eight persons in the sample were institutionalized for periods of time of two years or more, released, and then re-institutionalized for similar periods of time. Similar to those in

this study who were institutionalized continually for years at a time--those persons who fully accepted a redefinition of self as "mental patient" and its corresponding role and status, the data indicated that the same process occurred with respect to those institutionalized on a number of occasions. A third career path followed by long-term patients involved being treated in both general hospital facilities and in psychiatric institutions. The data indicated that thirty-two individuals in this study received on a number of occasions treatments within the confines of a psychiatric ward of a general hospital, and were subsequently transferred for further long-term psychiatric treatment to a mental hospital. Given the repeated occasions upon which such persons received treatment, they gradually accepted and adopted a new conception of self proffered by the psychiatric staff--that of "mental patient."

As discussed in Chapter Six, long-term and short-term ex-psychiatric clients categorized "mental illness" as a stigmatizable attribute. The data indicated that these persons discovered that they possessed a potentially-stigmatizing attribute in three manners. One such manner by which ex-patients were "educated", was through societal reaction, official labelling and institutional processing. In the context of the pre- and in-patient phases of their moral careers, such persons, not only acquired a new conception of self as mental patient, but also learned about the stigma associated with this attribute. Much of what they learned

about their stigmatizing attribute was transmitted to them during prolonged interaction with others in the institution who were also being transformed into mental patients. A second manner by which ex-patients came to see their conditions as discreditable, was through direct exposure with "normals" who reject or disapprove of them. A third way that ex-mental patients learned such information was as a result of self-labelling. Approximately one-eighth of the sample indicated that they subjectively perceived mental illness to be personally stigmatizing, that is, likely to lead to personal debasement if discovered. The data indicated that these persons labelled themselves as possessing some sort of psychological disorder above and apart from any formal or informal reaction and official labelling. Similar to Scheff's (1966) study, the data for this present study indicated that ex-mental patients learned and internalized early in life stereotypical imagery of mental illness--imagery that was constantly reaffirmed throughout their adult lives. By incorporating the stereotypes of "normal" and "crazy", these individuals defined their behaviours as "mental illness;" moreover, such stereotypes provided such persons with self-definitions of discreditability. The data further indicated that while some ex-patients learned the social meaning of their "failing" in one of the above manners, many discovered such information in a combination of the above manners.

Linking together concepts of deviant identity, stigma

techniques of stigma management and identity transformation, Chapter Seven sought to examine whether chronic, long-term ex-patients, upon their release, accepted permanently the deviant identities and roles pro-offered in the context of treatment, or, whether such persons actively attempted to alter these identities. Moreover, this chapter discussed the criteria important for successful identity transformation, the stigma management strategies employed by chronic ex-patients, and the implications of such strategies for identity transformation. The data indicated that the elderly, long-term chronics in this study, made no attempt to transform their deviant identities upon discharge into the community. Given that such persons had been hospitalized for a number of years, or on a multitude of occasions, they had fully internalized the role of mental patient and its corresponding status. Virtually all the elderly chronics in this study conceived of their deviant identities as permanent fixtures --a perception of self reinforced by the type of deviant label bestowed upon them in the context of treatment, the medications they were taking and the associated side-effects, and the "disability" cheques they received. While four elderly chronics, in the past, attempted to alter their identities, they were all unsuccessful; such persons abandoned their hopes and dreams of returning to a "normal" life. The elderly long-term ex-patients in this study, upon return to the community, considered themselves to be unwanted aliens. For the most part, such persons received no support from family

or non-deviant friends--they were left alone in the community. The only social ties they developed were with one or two other ex-psychiatric patients. Upon discharge, these ex-patients were placed in boarding homes, nursing homes, homes for special care, or in small one-room apartments. While some persons remained in these housing facilities, others, as a result of exploitation, physical and verbal abuse and stress, left such facilities in favour of back alleys, missions and cheap hotels. The data indicated that some elderly chronics became aware that they possessed an attribute that was potentially stigmatizing through direct negative experiences with "normals," others, through their subjective perceptions of mental illness as personally stigmatizing, and still others, through a combination of the above. In an attempt to avoid or minimize the stigma potential of mental illness on their daily rounds, these elderly chronics made use of two major strategies: institutional retreatism and societal retreatism. In the case of the middle-aged chronics in this study, the data indicated that their post-hospital worlds were also filled with sorrow and despair. In contrast to their elderly counterparts, who for the most part, did not even try to transform their deviant identities, the middle-aged chronics actively attempted to aspire to normal attainments; however, virtually all failed in such endeavours. Just as the elderly chronics experienced the stigma of their failing with respect to friends, family

members, and normals in general, so too, did the middle-aged chronics experience stigma under the circumstances. Such lack of social support from normals, combined with being forced to take jobs in sheltered workshops, and being forced to live in boarding homes with other "deviants," functioned to impede the rebuilding of more positive, non-deviant identities. Given that such persons were blocked from re-establishing normal identities and social roles--that they experienced stigma with respect to employment, family and friends, and anticipated further stigmatizing responses from others, such persons developed and employed three major strategies: dissociation from normals, passing and capitulation. In terms of the young chronics, the data indicated that, similar to the middle-aged chronics, these individuals also made numerous unsuccessful attempts at transforming their deviant identities. The young chronics experienced the stigma of their failing with respect to prospective employers, friends and family members. Such stigmatizing experiences impeded the rebuilding of more positive, non-deviant identities. Upon receiving stigmatizing responses from normals, and anticipating further such responses, these young chronics employed two major strategies: passing and subcultural participation. It is important to note that the elderly, middle-aged and young chronics employed different strategems of stigma management--strategems lessening or alleviating the stigma potential of mental ill-

ness on their daily rounds; however, these strategies (in contrast to those adopted by the short-term ex-patients) had negative implications for identity transformation.

Chapter Eight examined issues of deviant identities, stigma, techniques of stigma management and identity transformation as they related to short-term, non-chronic ex-psychiatric patients. Specifically, this chapter sought to discover whether short-term ex-patients, upon their release, conceived of their deviant identities as permanent fixtures (as did the elderly chronics), or whether such persons actively attempted to alter such images of self. Moreover, this investigation addressed the social criteria important for successful identity transformation, the various stigma management techniques employed by short-term, non-chronics, and their implications for identity transformation. The data indicated, in the case of elderly short-term ex-patients, that such persons, upon completion of their psychiatric treatment, sought to return to a life of normality. In contrast to the elderly chronics who conceived of their identities as permanent fixtures, the elderly short-term ex-patients conceived of their deviant identities as temporary fixtures. Such a perception of self as possessing a temporary deviant identity was influenced not only by the nature, duration and type of psychiatric treatment into which these ex-patients entered, but also, by the type of psychiatric label bestowed upon them and the minimal number of medications such persons

were taking subsequent to their discharge. In contrast to the middle-aged and young chronics who made a number of unsuccessful attempts at transforming their deviant identities (largely as a result of stigmatizing experiences with family, friends and normals in general), the data indicated that elderly short-term ex-patients made similar such attempts but were largely successful in their endeavours. Being able to return home, the presence of supportive family and friends, participation in various formal support groups, --such factors aided the elderly short-term ex-patients in transforming their deviant identities. So too, did the manner by which such persons dealt with the stigma potential of mental illness aid in such a transformation of self. In contrast to the chronic ex-mental patients who dealt with actual and perceived stigma by employing strategies carrying negative implications for identity transformation, the data indicated that the elderly short-term ex-patients employed four major strategies: selective concealment, therapeutic telling, preventive telling and normalization (with the latter three having profound positive implications for identity transformation). In terms of the middle-aged short-term ex-patients, the data indicated that, similar to their elderly counterparts, they also attempted to resume a life of normality upon completion of their psychiatric treatment. Such persons also perceived of themselves as possessing a temporary deviant identity--a perception influenced by the

short duration, nature and type of psychiatric treatment, the type of psychiatric label affixed to them, and by the minimal number and dosages of medications they were taking. Similar to their elderly counterparts, the data suggested that the middle-aged short-term ex-patients made similar attempts at transforming their deviant identities and were largely successful. Such persons, upon completion of their treatment were able to return to their homes, they received support from family and friends, and they were able to return to, or secure a mainstream occupation--factors aiding in successful identity transformation. So too, did the manner by which such persons dealt with the stigma potential and mental illness aid in such an endeavour. Through employment of the stratagems of selective concealment, therapeutic telling and political activism, these middle-aged short-term ex-patients not only alleviated the stigma potential of mental illness, but aid in rebuilding non-deviant identities. In terms of the young short-term ex-patients, the data suggested that these individuals, upon completion of their treatment also sought to resume normal lives. These persons also conceived of their deviant identities to be temporary fixtures--a perception of self influenced not only by the nature, short duration and type of psychiatric treatment received, but also, by the type of psychiatric label affixed to them. Similar to the elderly and middle-aged short-term ex-patients who were able to successfully transform their

deviant identities largely as a result of support from family and friends and being able to return to, or secure a mainstream occupation, the data indicated that such factors also aided young short-term ex-patients in their transformation of self.

A final factor important for successful identity transformation, on the part of young short-term ex-patients, involved the manner by which they dealt with the stigma potential of mental illness. The data indicated that such persons employed two major strategies: normalization and political activism; both strategems not only lessened or alleviated the stigma, but also contributed to the rebuilding of more positive, non-deviant identities.

LIMITATIONS OF THE THESIS

As is the case with any research endeavour, the present investigation possesses certain limitations and must be acknowledged. One such shortcoming centres on the one-sided nature of the study. Due to time constraints, the researcher was unable to focus upon other individuals who are also affected by this movement toward deinstitutionalization: namely, the friends and relatives of the ex-patients, the community-mental health professionals, and the community in general. The conclusions drawn from this study are based on data collected on one aspect of the deinstitutionalization

phenomenon--the subjective perspectives of the ex-patients themselves. In order to achieve a holistic understanding of the deinstitutionalization phenomenon, future research endeavours should focus on the "non-deviant" individuals also affected by the shift in treatment and care of the mentally ill.

A second limitation of this research centres on the retrospective interpretations of the individuals' pre- and in-patient phases of their moral careers, and also, some portions of their ex-patient careers. Although it would have been ideal to gather data firsthand as these individuals moved through different stages in their moral careers, such an aim would have been extremely difficult, if not impossible to accomplish. The researcher, in part, was able to gather data firsthand on various aspects of the post-treatment lives of ex-psychiatric patients, but data on their social experiences prior to, and during treatment, were gathered retrospectively.

A third limitation of this research centres on the sample itself. For the purposes of this study, the researcher drew a disproportionate, stratified random sample of three hundred ex-psychiatric clients within a specific geographical region in Southern Ontario. While such a sampling procedure allowed for a meaningful analysis of specific types of ex-psychiatric clients, and allowed the researcher to generalize the data to the level of the population, (in this case, the

population of ex-patients within a specific geographical locale), this procedure, however, did not allow the researcher to be able to generalize the findings to the level of the larger population of ex-psychiatric patients. A much larger sample, drawn from the entire population of Canadian ex-mental patients would be needed in order to make such generalizations. Despite such limitations, a number of important theoretical and substantive contributions and practical implications have emerged from this research.

In terms of the theoretical contributions, this study has demonstrated that deviants are not overly passive entities, more "reacted upon, than reacting" (as much of the early labelling literature has suggested). Such persons are not powerless victims, uninvolved in the labelling process. Rather, placing importance on the actors' perceptions, this study discovered that ex-psychiatric patients are strategists, expert managers and negotiators who play active (although not always successful) roles not only in shaping deviant identities, but also, in shaping deviant outcomes. In this latter case, the data indicated that, upon completion of their treatment, ex-patients actively attempted to alter their deviant identities; such persons had hands in eliciting desired reactions through their own behaviour, through the techniques of stigma management employed, and through the expectations and images that they projected. In short, the findings presented here challenge the labelling perspective and the sociology of mental illness to create new

conceptions of deviant actors in general, and mental patients, in specific, as individuals who have hands in shaping their own social fates--as individuals who negotiate, respond to, resist, and reject societal labels.

Moreover, the data has demonstrated the relationship between self-labelling and the perception of mental illness as a stigmatizing attribute. As noted in Chapter Six, approximately one-eighth of the sample indicated that they subjectively perceived mental illness to be personally stigmatizing--that is, likely to lead to personal debasement if discovered by others. The data indicated that these persons labelled themselves to be mentally ill above and apart from any formal or informal reaction on the part of others. Similar to Scheff's (1966) findings, the ex-psychiatric patients in this study learned and internalized, early in life, stereotypical imagery of insanity and mental illness--images that were constantly reaffirmed throughout their adult lives by various sources. So too, were stereotypical images of normality learned and internalized in the same manner. By incorporating the stereotypes of "normal" and "crazy," some individuals, upon examining their own behaviour, defined themselves to be mentally ill, apart from any formal or informal reaction from others. Moreover, by virtue of living in society, such persons became aware of societal values, and hence, were aware of the stigmatizing nature of mental illness. While much of the sociological work on the phenomenon of stigma has assumed that the stigmatized

learned the social meaning of their failing through direct negative experiences with others, the findings of this research indicate that, while this may be the case in certain instances, in other cases, in support of a normative paradigm (Wilson, 1970) such information is acquired through participation in society and the internalization of societal norms and values.

Further, this study has demonstrated the effects of non-institutional and/or relatively short institutional processing upon the creation of deviant identities. According to the labelling perspective, individuals officially labelled as deviant, are subsequently processed through various institutions and organizations which serve to strip such persons of their prior, non-deviant conceptions of self; in their place, individuals are offered new, deviant identities, which they come to accept. The findings of this present investigation indicate that deviant identities are also molded, shaped, reinforced and sustained even though some individuals are treated outside the institution (as was the case with those involved in out-patient psychiatric treatment); moreover, such identities are also created despite the short duration of the individuals' hospitalization.

Finally, the labelling perspective has focussed almost entirely on the negative consequences of labelling. Critics have charged (Gove 1976; Birenbaum and Sagarin 1976; Plummer 1979) that labelling and subsequent stigmatization

may have positive consequences. The data in this present study indicate that while stigmatization led to a great deal of pain and frustration on the part of many ex-patients, certain positive consequences of stigmatization also resulted. So, for example, in the case of the young chronics, being an ex-psychiatric patient generated certain opportunities and gratifications. Such identities allowed such persons to obtain small amounts of money from various agencies, obtain free food and clothing from local merchants, and in general, provided a legitimate excuse for all post-treatment behaviour. In terms of the short-term ex-patients, in certain cases, stronger family relationships arose as a result of the stigma experienced not only by the ex-patients, but also, by their families.

A number of substantive contributions have also emerged from this research. As was stated at the beginning of this chapter, abounding in the literature are arguments supporting the development, potentials and goals of the de-institutionalization movement. So too, are there numerous academic writings emphasizing the negative aspects of this phenomenon. Moreover, there exist in the literature, numerous descriptive, outcome and follow-up studies of various groups of ex-patients, community mental health treatment programmes and community psychiatric "tools." Although a multitude of research exists on the deinstitutionalization phenomenon and development of community psychiatry, the majority of studies

have been conducted from an objective point of view, with only a dearth of research focussing on the impact of this movement from the perspectives of the ex-psychiatric patients directly affected by this shift in treatment and care.

This present study has provided ethnographic data on the social worlds of Canadian ex-psychiatric patients. Deinstitutionalization was examined in terms of its meaning for the ex-patients themselves. Focussing upon the concepts of deviant identity, career, stigma, management strategies, and Identity transformation, the following findings emerged:

(a) the short-term careers of psychiatric patients began when various societal members--family, friends, legal agents, the family physician, and sometimes the individuals themselves, reacted and took action against such persons committing culturally-inappropriate acts. Once defined by themselves or others, such persons followed one of four career paths: they entered into private psychiatric treatment, they received out-patient psychiatric therapy, they entered into short-term hospitalization in a general hospital, or were briefly institutionalized in a government psychiatric hospital. Such non- or short-institutional processing, nevertheless, led to the creation and reinforcement of deviant self-images and identities. (b) the long-term careers of psychiatric patients commenced (largely prior to the deinstitutionalization movement) when various societal members reacted and took action against individuals committing cul-

turally inappropriate acts. Once labelled, such individuals followed one of three career paths: some individuals were institutionalized on a continual basis for years in a government psychiatric hospital; some individuals entered into consecutive, long-term institutionalization in a psychiatric hospital; others, in the context of their long-term careers were treated initially within the confines of a psychiatric ward of a general hospital and were subsequently transferred for further, long-term treatment in a mental hospital. Given the long-term nature of their psychiatric treatments, patients in this study came to fully accept and adopt the identity of mental patient and its corresponding status and role. (c) All the ex-patients in this study conceived of mental illness as an attribute that is potentially-stigmatizing. Such persons learned the social meaning of the attribute of mental illness through direct negative experiences with normals, through pre-hospital societal reaction, labelling by official third parties, and subsequent hospitalization, and through self-labelling. (d) The stigma of mental illness had both positive and negative consequences for ex-patients--positive in the sense of providing increased opportunities and rewards, and negative in the sense of leading to stress, fear, frustration and pain on the part of the ex-patients. (e) Long-term ex-patients differ in their desire to transform their deviant identities. Elderly chronic ex-patients make no attempt at transformation: middle-aged and younger chronics make such attempts but, virtually all fail in their endeavours.

(f) In general, such factors as: lack of formal or informal support, stigma experienced from family, friends, and normals in general, employment in sheltered workshops for the mentally handicapped, and forced housing with other ex-patients, impede the rebuilding of more positive, non-deviant identities. (g) The elderly chronic ex-patients dealt with the stigma potential of mental illness through the adoption of such strategies as institutional retreatism and societal retreatism; middle-aged chronics used strategies of dissociation from normals; passing and capitulation in their management work; young chronic ex-patients employed passing and subcultural participation in order to mitigate the stigma potential of mental illness. Such strategies functioned to lessen or alleviate the stigma associated with their failing, but had negative implications for identity transformation. (h) Two paradoxes emerge from this study: (1) chronic ex-patients are encouraged by psychiatric staff to return to lives of normalcy. Presenting reintegration as a possibility, staff tell ex-patients that they are able to become gainfully employed. However, the reality of the situation is such that the only jobs such persons are able to secure are in sheltered workshops for the mentally handicapped--jobs that only reinforce their spoiled identities (and contribute to their careers as deviants). (2) Secondly, according to advocates of the movement toward deinstitutionalization, psychotropic, wonder-drug medications were designed to enable ex-patients to lead "fairly stable, normal lives in the community." How-

ever, in reality, the side-effects associated with these medications--the leg jiggling, facial tics, and strange gestures have served to publically call attention to their deviant conceptions of self and reinforce their deviant identities.

(i) Short-term ex-psychiatric patients differ from their long-term counterparts in terms of their success in transforming deviant identities. (j) Such factors as: their perceptions of self as being "temporarily mentally ill," the presence of formal and informal support systems, being able to return to, or secure a non-deviant occupation aided the individuals in transforming their deviant identities.

(k) The manners by which short-term patients dealt with the stigma potential of mental illness also aided ex-patients in rebuilding more positive identities. The elderly short-term ex-patients dealt with stigma through: selective concealment, therapeutic telling, preventive telling and normalization. The middle-aged short-term ex-patients employed the strategies of: selective concealment, therapeutic telling and political activism in their management work. The young, short-term ex-patients used strategies of normalization and political activism. Such strategies (in contrast to those used by the chronics), not only lessened or alleviated the stigma of mental illness, but also contributed toward the development of positive, non-deviant identities on the part of the short-term ex-patients.

A number of social implications have arisen from this dissertation. Clearly, this research has demonstrated the numerous problems ex-psychiatric patients encounter upon completion of their treatment--problems which not only need to be acknowledged, but for which solutions need to be found.

According to the ideology behind the movement toward deinstitutionalization, individuals would be "freed" from the asylum. However, "stone walls do not a prison make, nor iron bars a cage." The data have indicated that many ex-mental patients (especially the chronic ex-patients) are imprisoned in a metaphorical sense; its guards and wardens are family, friends, potential employers, and society in general who are unable to tolerate mental illness. Despite fruitless attempts on the parts of chronic ex-patients at reintegration, normals continue to stigmatize, segregate and silence these persons; they confine such persons in an "asylum without walls" to live lives of frustration, disappointment, fear and hopelessness. As the data indicated, these chronics spend most of their post-hospital lives devising and employing various techniques to lessen or alleviate the stigma of mental illness on their daily rounds.

The lessons taught by this study are that transforming care for the mentally ill involves more than closing the mental hospitals, discharging patients into the community, and treating new clients within the community. Closure of such institutions without concomitant attention on "opening"

up the communities, only leads to rejection, pain, and anger experienced by the ex-patients. Mental health professionals need to re-think the tenets upon which the movement toward deinstitutionalization was based. Effective deinstitutionalization involves much more than simply discharging or treating mental patients in the community. It can only be successful if (1) chronic ex-patients re-learn basic social living skills and acquire competence in these prior to, and not after discharge; (2) more adequate after-care facilities are provided for ex-psychiatric patients in terms of available, professional support systems; (3) more adequate housing is provided for patients (not able to return to their families), where the emphasis is on rehabilitation and reintegration rather than on profits; and (4) popular negative stereotypes of mental illness pervading society are eliminated, and replaced by more accurate conceptions of mental patients and mental illness in general. Deinstitutionalization can only be successful if the public is educated about mental illness. Such enlightenment would lead to a reduction or elimination of the stigma of mental illness and allow all ex-patients to be reintegrated into society. As one chronic ex-psychiatric patient succinctly stated:

The problem is this: if you have heart disease or muscular dystrophy, or some disease like that, society feels sorry for you. But if you have mental illness, people treat you like it was your fault--that it was something that you brought on yourself. People are so misinformed about mental illness. They have such a distorted idea about it. We have to somehow change this view--we have to teach society about what mental

illness is really like. No one stigmatizes people with heart disease, so no one should stigmatize mental patients either. If we could only teach the public, we might have a chance of making it! (Observation # 77, November 3, 1981; 42).

SUGGESTIONS FOR FUTURE RESEARCH

While the findings presented in this dissertation have contributed to our understanding of the impact of the deinstitutionalization movement on the ex-psychiatric patients themselves, additional research is needed on other individuals who are also affected by this shift in treatment and care of the mentally ill. Specifically, future research should focus on the families of ex-patients, in terms of the dynamics of family interaction with the ex-patients. While some studies (Freeman and Simmons, 1961; Lefton et al., 1962) have focussed on such family interaction patterns as exclusion and rejection, it would be naive to conclude that they are the only responses that develop. Future research needs to examine the family's efforts at cooperation with the ex-patients, and their efforts at attempting to reintegrate him/her into society (as the data for this present study has indicated). So too, should studies focus on the problems and frustrations experienced by family members in their efforts to cope with ex-patients--problems related to lack of after care facilities, little professional support and fatigue. Their problems and dilemmas also merit consideration. Future research

should also concentrate on perceptions of stigma as it relates to the family and friends of ex-psychiatric patients--do such persons possess a "courtesy stigma," (Goffman, 1963:30) and if so, how do they deal with it?

In a similar vein, future studies should concentrate on the impact of the movement toward deinstitutionalization on the social communities that are directly affected by such a shift in the treatment and care of the mentally ill. With only a few exceptions, (in particular, Dear and Taylor, 1980; Armstrong, 1976; Aviram and Segal, 1973; Segal et al., 1980), this area has been relatively unexplored.

Another area of potential research centres on the impact of the movement toward deinstitutionalization upon those mental health professionals involved in the community aftercare of the ex-patients.

Moreover, longitudinal studies on ex-psychiatric patients in the community warrant consideration. Specifically, it would be interesting to examine whether the stigma potential of mental illness lessens over time? Do all ex-psychiatric patients "graduate" from one strategy of stigma management to the next in the context of their post-patient careers?

Another area of potential research centres on inter- and intra-cultural studies on deinstitutionalized patients. What are the everyday worlds of other Canadian ex-patients really like. What are the social worlds of ex-psychiatric patients in Britain and the United States really like? Do

such persons face similar problems of isolation, turmoil and stigma? What strategies of stigma management do these individuals employ? Do such persons, upon completion of their treatment, attempt to rebuild more positive self-images and identities? If so, what criteria aid in such an endeavour? Such questions are worthy of investigation, with respect to ex-patients in other geographical locales.

The qualitative methodological approach utilized in this research provided a wealth of data essential to an understanding of what it is like to be an ex-psychiatric patient. This exploratory approach should now give way to confirmatory, statistical analyses of this phenomenon. Specifically, such quantitative analyses should statistically examine the relationship between stigma, management strategies and identity transformation with respect to long-term and short-term ex-psychiatric patients, and whether such variables as: career pattern, psychiatric label, informal support, formal support and employment exert an effect on identity transformation. Further, such variables as: social class, ethnicity, religion, length of time hospitalized, and length of time discharged should also be statistically-tested in order to ascertain whether such variables affect the way ex-patients deal with the stigma associated with their failing, and their effect on identity transformation. Following Becker (1963:17), presumably, those in positions of power--those having basic resources of social power at

their command, will deal with the stigma potential of mental illness in manners different from those without such power. Those with powerful resources will, likely, be able to achieve more favourable outcomes, than those without such resources. Clearly, such factors merit future consideration with respect to ex-psychiatric patients.

APPENDIX A

PH.D. DISSERTATION

INTERVIEW SCHEDULE

THE DEINSTITUTIONALIZED MENTAL PATIENT
IN CANADIAN SOCIETY

RESPONDENT I.D. NUMBER _____

DATE OF INTERVIEW: _____

PLACE OF INTERVIEW: _____

INTERVIEW SCHEDULE

NUMBER: _____

RESPONDENT: _____

PLACE WHERE INTERVIEW TOOK PLACE: _____

SEX OF RESPONDENT: _____

1. How old are you? _____
2. Where were you born? _____
3. How large a family do you come from? _____

4. Are these family members still alive today? If so, do you see them? _____

5. How often do you visit with your family? _____
6. What is your marital status? (married, single, separated, divorced, widowed). _____

7. If married, how long? _____ (go on to #10)
8. If divorced, how long and what were the circumstances surrounding the divorce? _____
_____ (go on to #15)

9. If separated, how long and what were the circumstances surrounding the separation? _____

(go on to #15)

10. What is your relationship like with your husband/wife? _____

11. Have there been any changes in your relationship either during or after you were hospitalized? _____

12. What is your spouse's age? _____

13. What is your spouse's occupation? _____

14. How many years and what type of formal education does your spouse have? _____

15. Do you have any children? _____

16. What are their ages? _____

17. What is your relationship like with them? _____

18. Do they live with you now? If not, where do they live? How often do you see them? _____

19. How many years of formal education do you have? _____

20. What type of education do you have? (grade school, high

20. What type of education do you have? (grade school, high school, types of certificates, post-secondary education, etc.) _____
21. What ethnic background do you come from? _____
22. What social class background would you say that you belong to? _____
23. Do you have a religious preference? That is, are you either Protestant, Catholic or Jewish or something else? If none, do you consider yourself basically a Christian, atheist or agnostic? _____
24. How many times have you been hospitalized in your life? _____
25. What type(s) of facilities were you hospitalized in? (i.e. psychiatric ward of general hospital or government psychiatric facility). _____
26. What was the longest time you were hospitalized? _____
27. ~~What~~ What was the shortest time? _____
28. ~~What~~ What was the average time? _____
29. How long have you been discharged from the hospital. _____

PART B EMPLOYMENT

Ask the following questions if respondent is presently employed.

30. Where are you working now? _____

31. How long have you been working there? _____
32. How did you get this job? _____
33. Did you have it before your last hospitalization? _____

34. How do you feel about working there? _____

35. How do you feel about working in general? _____

36. How much time did you put in at work this week? _____

37. If you had the time, or opportunity, would you put in additional hours for more pay? _____

38. How much do you get paid an hour? _____
39. How does this compare with salaries from previous jobs? _____

40. What are your duties at this job? _____

41. How do you feel about these duties? _____

42. Do you think that you could find a job as good as this one or even a better job if necessary? _____

43. If you had the opportunity, would you change jobs, and if so, why? _____

44. How would you rate your performance at work? _____

45. Are your present duties ones that make best use of your talents or skills? _____

46. Does the salary you make right now allow you to buy everything you need? _____

47. Do you receive any other monies from government or other sources? _____
48. If so, how much? _____
49. As far as you know, do your co-workers earn the same wages as you? _____
50. Do you have trouble making ends meet with the amount of money that you earn? _____

51. If so, how do you manage? _____

52. How do you think that your co-workers feel about you? _____

- C

53. Do they know that you were previously hospitalized for psychiatric problems? (If yes, how did they find out and react?) _____

54. If not, how do you think they would react if you told them? _____

55. Do you feel that you will try to qualify for a more highly-skilled job in the future? _____

56. Since you've been released from the hospital, how often have you tried to find work? _____

57. Do you think you will find work soon? _____
58. What type of job and salary range are you looking for? _____

59. How do you feel about not working? _____

60. Has anyone helped you to find work? _____

61. Do you think that you are able to work on a full-time basis? _____

62. If you are not working, what types and how much monetary benefit are you receiving? _____

63. If you are not working, how do you spend your days? _____

64. If you've been trying to find work, what are some of the problems that you may have encountered? _____

GENERAL LIVING CONDITIONS

65. Where are you living now? _____

66. With whom do you live? _____

67. Are you living in the same place as you did prior to hospitalization? _____

68. How do you feel about where you live right now? _____

69. How much time do you spend alone at home? _____

70. What do you usually do to occupy your time? _____

71. Do you think that your living circumstances need improvement? _____

NEIGHBOURS

72. Do you know your next door neighbours by name? _____

73. How often do you visit with them? _____

74. In general, how do you feel about your neighbours? _____

75. How would you rate their interest in your experience/problems? _____

76. Do your neighbours know that you were once hospitalized? _____

77. If so, how did they find out, and what was their reaction? _____

78. If not, how do you think they would respond to you if they knew that you were once hospitalized? _____

79. Do you think that you could count on a neighbour for help if you needed it? _____

80. Do you consider any of your neighbours as personal friends? _____

81. Do you think that neighbours should go out of their way to help other neighbours? _____

82. In general, how do people in your neighbourhood act toward one another? _____

FRIENDS

83. Do you have any friends at the present time? _____

84. If so, how many? _____
85. How many of your friends are ex-patients? _____
86. How do you feel toward your friends? _____

87. How do you think that they feel about you? _____

88. Do your friends know about your hospitalization(s)?
If so, how did they find out, and what was their
reactions? _____

89. If not, are you planning to tell them? _____

90. Do your friends give you help when you need it? _____

91. What are the feelings toward the friend with whom you
spend the most time? _____

92. Do you have as many friends as you would like? _____

93. How much time do you spend with friends? _____

94. What kinds of things do you do together? _____

95. How often do you see or talk to your friends? _____

96. In general, what is your social life like? _____

GENERAL SOCIAL LIFE

98. How do you feel about your social life right now? _____

99. In general, how do you feel about participating in social groups or clubs? _____

Ask if single (If not, go on to #105)

100. Do you go out on dates at present? _____

101. How do you feel about being with people of the opposite sex? _____

102. Would you date more if you had the chance? _____

103. How do you feel about getting married? _____

104. Do you think that you will get married one day? _____

105. Do you ever go out to the movies or sporting events? _____

106. How do you feel about these activities? _____

107. Do you think you would do these things more often if you had the chance? _____

108. About how many hours a day do you spend watching television? _____
109. What kinds of things do you watch most on television? _____
110. In general, would you rather spend your free time alone or with others? Why? _____
111. What is your favourite thing to do when you have the time? _____
112. Do you ever attend ex-patient drop-in centres? _____
113. How do you feel about these drop-in centres? _____
114. Do you or have you ever attended self-help groups for discharged psychiatric clients? _____

115. In general, how do you feel about these self-help programs? _____

116. Do you know about newsletters for ex-psychiatric patients? Do you subscribe to these newsletters? _____

117. Have you ever been, or are presently involved with activist groups--groups fighting for the rights of psychiatric and ex-psychiatric patients? _____

118. How do you feel about such groups? _____

RELIGION

119. Do you attend religious services? If so, how often? _____

120. Do you consider yourself a religious person? _____

121. What does religion do for you? _____

ORGANIZATION AND SOCIAL GROUPS

122. Do you belong to any group or organizations? (If so, list) _____

123. How do you feel about participating in groups? _____

124. How often do you go to group activities. _____

125. Did you join these groups prior to, or after, hospitalization? _____

126. Do the people at these groups know that you were previously hospitalized? _____

127. If so, how did they react? If not, are you ever going to tell them? How do you think they would react if they knew? _____

COMMUNICATIONS

128. In general, how often do you read a newspaper? _____

129. How often do you listen to the news on television or radio? _____

130. Is it important to you to know what is going on in politics or with financial news? _____

131. In general, how do you feel about keeping up with current events? _____

HOME ENVIRONMENT (MANAGEMENT)

132. In general, how do you feel about doing household chores--cleaning, shopping, budgeting, etc.? _____

133. What are some of the problems you have encountered since being discharged? _____

134. How much of the household chores are done by persons other than yourself? _____
135. How do you feel that you are managing the household chores? _____

136. In general, how do you feel about shopping? _____

137. Do you generally look for bargains when shopping? _____

138. How many charge accounts do you have? _____
139. How often do you use them for what purposes? _____

140. What are some of the strategies you use when going shopping? _____

141. How do you make ends meet? _____

TRANSPORTATION

142. In general, how do you get to the places you desire to go to? _____

143. When you were released from the hospital, did you have any difficulties/problems related to transportation? _____

144. How often do you use transportation other than walking? _____

145. Do you ever take vacations on holidays or weekends?

FINANCES

146. How much money do you receive each month? _____

147. Are you able to save any money each month? _____

148. Would you say that you have had problems with money lately? _____

149. Have you planned for your old age? _____

150. How do you feel about your system for paying bills each month that are mailed to you? _____

151. How does your income compare with that of your friends? _____

MOVING

152. How do you feel about moving from where you live right now? _____

153. Do you think that you will be moving in the near future? If so, where? _____

154. If planning to move, would you like to move into a new _____

area where people do not know you? _____

RELATIVES

155. Are your parents, brothers/sisters alive? _____

156. Do they live near you? _____

157. How often do you see them? _____

158. What is your relationship with your immediate family members? _____

159. How do you think that your parents/brothers/sisters feel about you? _____

160. How do they feel about your hospitalization(s)? _____

161. How do they treat you since you have been discharged? _____

162. In general, can you count on them for help? _____

163. How many of your relatives do you feel close to? _____

164. How often do you visit them in their home? _____

165. Other than your immediate family, how do other relatives treat you since you have been discharged? _____

SOCIAL AGENCIES/SUPPORT

166. What agencies have you received help from since your release? _____

167. How do you feel about these agencies? _____

168. How often do you see your caseworker? _____

169. How do you feel about your caseworker? _____

170. In your opinion, what things need to be changed to help discharged mental patients? _____

171. If you had the choice, would you rather go back to the hospital or remain in the community? Why? _____

172. What is the best thing that has happened to you since
you were discharged? _____

173. What is the worst thing that has happened to you since
you were discharged? _____

APPENDIX B

APPENDIX B

BACKGROUND CHARACTERISTICS OF SAMPLE

	(N=46)	SUB-GROUP A	(N=47)	SUB-GROUP B	SUB-GROUP C	(N=46)
Mean Age	61		42		25	
Number of Males:	25		24		28	
Number of Females:	21		23		18	
Marital Status:						
Single	40		38		40	
Married	3		1		5	
Divorced	3		8		1	
Other	0		0		0	
Mean No. of Times Hospitalized	7		6		5	
Mean Length of Time Hospitalized (years)	8		7		2.5	
Attendance of Formal/ Informal Support Groups	0		0		0	
Housing Status:						
Boarding Home	43		41		34	
Living With Family	1		0		2	
Living alone	0		0		4	
Homes for Special Care	2		5		3	
Other	0		1		3	
Employment: Sheltered	22		35		24	
Non-Sheltered	0		0		1	

(Continued)

APPENDIX B (Continued)
BACKGROUND CHARACTERISTICS OF SAMPLE

	SUB-GROUP D (N=47)	SUB-GROUP E (N=49)	SUB-GROUP F (N=50)
Mean Age	60	39	22
Number of Males	28	26	29
Number of Females	19	23	21
Marital Status:			
Single	39	30	42
Married	3	2	2
Divorced	4	11	6
Other	1	6	0
Mean Number of Times Hospitalized	4.5	3.5	4.5
Mean Length of Time Hospitalized (years)	1.5	1.5	1
Attendance of Formal/ Informal Support Group (n)	35	36	2
Housing Status:			
Boarding Home	15	12	28
Living with Family	4	23	11
Living Alone	22	14	3
Homes for Special Care	2	0	2
Other	4	0	6
Employment: Sheltered Non-Sheltered	12 0	19 24	22 .11

APPENDIX C

APPENDIX C

September 5, 1981

Dear Sir/Madam:

I am writing to you on behalf of Ms. Nancy J. Herman, a doctoral student in the Department of Sociology at McMaster University. Specifically, I am writing to you in order to request your help in the completion of Ms. Herman's research on discharged psychiatric patients living in the community.

In order to complete this project, Ms. Herman will need to talk with a number of discharged patients--some of whom are working in sheltered workshops, some who are living in boarding homes, some who are now living at home with their families, and some who have returned to work at previous jobs, etc.

This letter is being sent to you among several others asking you to consider helping the researcher with her project. During the next two weeks, a member from my staff will be contacting you to see if you are interested in participating in the study. If you have any questions or fears, please feel free to express them at this time.*

Ms. Herman assures me that all the information that she gathers will be completely confidential and no one other than herself will have access to it.

Please note that participation in this study is voluntary and, if you so refuse, this will, in no way, affect your further access to, or treatment within, _____ Hospital.

Both myself and Ms. Herman should appreciate your co-operation, as it is very important for the completion of her research.

Sincerely yours,

Psychiatrist

* In order to protect your right to privacy, your name will be disclosed to the researcher if you instruct my staff to do so.

APPENDIX D

APPENDIX D

INFORMED CONSENT FORM FOR STUDY:
THE DEINSTITUTIONALIZED PSYCHIATRIC PATIENT IN
CANADIAN SOCIETY

I _____, acknowledge that Nancy J. Herman, principle investigator, has fully explained to me about the nature of this study and the types of questions that will be asked of me. I understand that I have the right not to participate in this study if I so choose, but should I decide to do so, I may withdraw at any time without fear of reprisal. I further realize that this study will be of no direct benefit to me.

I understand that the researcher will take all necessary steps to protect my rights. The information that I will give, will remain entirely confidential. Any published reports stemming from this study will not identify, in any way, who I am.

SUBJECT

INVESTIGATOR

DATE

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