The Life-World of Madness: Praxis or Paralysis

by

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A thesis
presented to the University of Manitoba
in fulfillment of the
thesis requirement for the degree of
Master of Arts
in
Department of Sociology

Winnipeg, Manitoba

ISBN 0-315-48045-9

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A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF ARTS

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Acknowledgements

I would like to express my deepest appreciation to my committee members, Rod Kueneman, Russell Smandych, and Grant Reid. Each of these individuals have contributed immensely in helping me to broaden my thinking both as an individual and as a sociologist. I will be forever grateful for the patience and encouragement they provided along the way. Thank you for giving me faith in myself during the times I needed it most.

I also owe a great deal to Ed Boldt whose support and vote of confidence helped me to succeed in this venture. A special thanks goes to my friend Teressa Andrewchuk who provided immeasurable insight in the conducting of this research. I thank my friends at the Society of Self-Help, with your help, life for all of us is that much better. Lastly, I thank my mother, my wife Dawn, my children Elaine, Jason, Meesha and Dylan, and my great neighour, Jeanie, for putting up with my frustrations and encouraging me to go on.

ABSTRACT

Mental disorder, has in recent times, been the subject of much debate between the medical model and the labelling perspective. Although both positions have utilized a different conceptual framework to describe this phenonmenon, in neither model is the individual seen as an autonomous agent with any direct control over his or her life; the distrubed are either sick or victims of social labels.

A human agency perspective is introduced as a means of situating the disordered individual within analytic framework which can be employed to understand all human activity. If all humans are socialized in a particular social context then each of us are "twisted" to perceive our reality in a particular way. Some of us are more inept than others in conducting social discourse, yet each of us have developed unique methods of sustaining our self-esteem. This thesis attempts to examine those methods by which post-psychiatric patients experience their reality.

After conducting informal interviews with these individuals it became apparent that although their potential for autonomous activity was severely limited by the impediments of their structured existence in the community, many were capable of conducting preplanned activities in accordance to the designs of personally motivated thought. Most often, these activities involved the cross-fertilization of functions between social agencies whose purpose was to direct the lives of these patients.

It was concluded that these activities did reflect a unique and creative response to a particular set of circumstances. These individuals not only had a sense of what was in their best interest, but further, had developed reliable methods of carrying out their activities.

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INTRODUCTION

The desire to write about the life-world of madness arose from my conflict of fulfilling the role of nursing assistant in a hospital psychiatric unit and my own perspective as a human being. I found that in order to carry out the duties that were expected of me I had to inadvertently deny those under my charge many of the liberties that I took for granted. In essence, I had to strip these individuals of those features which make each of us unique beings. Behind those locked doors, they were not people; they were patients. Perhaps even more startling was the fact that most of them were not there of their own volition, but rather, at the will of others.

Good patients were perceived by hospital staff as those who did what they were told. On the other hand, patients who asserted their will or even questioned the basis of their incarceration became recognized as trouble-makers. The maintenance of harmony in these wards could be achieved only when the spirit of these trouble-makers was sedated. In essence, personalized action had to be stifled in order to prevent others from also questioning their process of medicalized rehabilitation.

After talking with many of these individuals at a personal level, I frequently found myself questioning how families could treat their members the way they do. Blatant violations of human dignities were often the norms, yet here these people were talking to me as if the traumas of their past were episodes from a fictional novel. Was life really this bad for these souls? How different would I be if things

like these happened to me? Now that these people are adults what is their life really like? Their written history most often stated that they suffered from some form of personality disorder: schizophrenia, manic-depression, multiple personalities. And ultimately, the disorder brought them into conflict in their inter-personal exchanges.

Granted some individuals had to be protected from themselves and from society in general but what about those who experienced inter-personal difficulties? Were they sick or did they just express themselves in a different way to others?

I became involved with many of these individuals in the community. I felt that in order to gain some sense of their motives and intentions there was a need to experience the types of structural impediments that are common to many of Manitoba's post-psychiatric patients. Although I could have asked these people what their world was really like I don't believe they could have given any more of an accurate description than anyone else. My concern was not why or how individuals were discharged from institutional settings but rather what it was that they did once they were released.

Unlike institutional life, where all physical needs are catered to, independent or semi-independent living requires some degree of independent action. It was my belief that a component of human agency could be revealed through the individual's autonomous action in conducting the affairs of everyday life. In particular, I focused on the means by which taken-for-granted activities such as, interacting with significant and generalized others, obtaining sheltered accommodations, and maintaining a dietary balance were achieved. The

question which kept nagging my curiosity was that if these people, who are classified as mentally ill, have gone through childhood development filled with such structurally induced trauma, as incestuous relationships, and then later subjected to ongoing institutional confinement, what was left? Out of this barrage of action induced by others was there any residual agency to be found?

That is the task of this thesis; to explore the types of patterns of relationships which exist between post-psychiatric patients residing in Winnipeg and those with whom they interact? The central focus will be on the lived experiences of former mental patients in the community. This research will address the issue of praxis or goal-oriented behavior; does the life of those labelled as chronically mentally ill represent an aimless attempt to pass away the hours, or do their actions reveal a sense of person?

The thesis is structured in the following manner. Chapter One will present an overview of the literature on madness. It will provide a human agency perspective as an alternative to the prevailing medical model and labelling theory approaches. The means of facilitating this approach will be discussed.

Chapter Two will present a case study in order to introduce the mode of analysis for this research. This particular case is selected in order to develop a sense of the personal reality experienced by one mental health care recipient in his interaction with significant others. The case study is designed to illustrate aspects of one individual's life, not to represent all of the experiences of other post-psychiatric patients.

Chapter Three will analyze the interaction of the "beneficiaries" of Manitoba's mental health system and those individuals who comprise this system. The implications of these exchanges will be fully discussed.

Chapter Four will conclude the thesis with a summary of the findings and their significance for future research in the area of madness and the societal response to it.

CHAPTER ONE

UNDERSTANDING UNIQUE HUMAN BEHAVIOR

This chapter is designed to situate a human agency perspective of personalized action in the realm of the existing literature on madness. This alternate approach is expected to enable us to better explore and understand the common-sense reality of mental disorder.

1.1 Contemporary Models

When I began to investigate the theoretical literature on disordered behavior it became abundantly clear that the dominant perspectives are the medical model and the labelling theory. Both perspectives view the "troubled individual" from different standpoints. Selecting either position, however, became highly problematic if the thesis was to research the motivational structure of post-psychiatric patients. The underlying assumptions of both perspectives stripped such individuals of any degree of genuine personhood and the facility for personal agency, from neither perspective are persons viewed as seeking to establish some measure of control in their life.

All perception is a construction. What you see is, in part, the result of how you are trained to see. We wish to examine some of the basic assumptions of both of these perspectives.

1.1.1 The Medical Model

According to Liska (1981), the medical model is a system of belief, as defined by the medical profession, which governs the considerations and procedures by its members in the assessment and treatment of

illness. This model contends that symptoms of physical and mental disorders can be defined in accordance to an established system of medical classification. It stipulates that a diseased state can be diagnosed by observation and testing, which in turn will lead the physician to select the most effective treatment. Lastly, this model adheres to the belief that one's diseased state may worsen if the illness is not treated.

Symptom management is an example of the means by which the medical profession rectifies a dysfunctional condition. The focus is on the action of the individual. It is the individual's behavior--something (s)he did or did not do--which draws attention to the problematic state. The physician's role is to normalize behavior by removing or altering those symptoms classified as pathological.

Parsons (1964) indicates that one's state of sickness is the reflection of an underlying illness. It is a state of being that is not under the person's control. He refers to this condition as an "...imputed generalized disturbance in the capacity of the individual..." (1964:274). In this respect, the condition of sickness is beyond one's own ability to rectify their condition. The disturbance requires medical attention.

While the medical sciences have served to delimit the suffering of many individuals, particularly those afflicted with organically based disorders, it has nevertheless, failed to establish a basis for consistency in determining psychiatric disorder. Coe (1978) suggests that there is frequent disagreement among practitioners surrounding the issue of responsibility. The question arises, does one's behavior

represent an attempt to feign a condition of sickness, for whatever reason, or is it a manifestation of an underlying pathology? The issue immediately questions the authenticity of the actor, and thus, the degree to which one has control of their state of being.

This model contends that disordered behavior is a manifestation of a diseased state, and like all diseased states it must be treated. The definition of disease, however, becomes highly problematic. Does a diseased state underlie the symptoms of disordered behavior or does it refer to a dis-ease; a lack of comfort or a state of distress? What exactly are they symptoms of; organic or interpersonal dysfunction?

Even if the casualty of this process is "cured", the illness is regarded to be in a state of remission; a master status which refuses to restore personhood to the patient. This attribute of having a diseased mind undermines the notion of one's personal ability to reason. In essence, it cuts away at human agency and one's ability for self-control. The medical model views this lack of self-control or inadequate decision making as the trademark of the ill patients and not of all humans. All of us lack self-control and clear vision, so is the difference one of degree or kind between those classified as mentally ill and so-called normals. There is no purpose or intention behind action, perceived by psychiatry, as pathological. The individual is just sick.

1.1.2 The Labelling Perspective

Unlike the medical model which regards disordered behavior as a deviation from a normal state of health, labelling theory generally defines mental disorder as a social definition or label which is applied

by some audience to the behavior of others. Lemert (1951) argues that mental disorder may be more usefully considered to be a social status than a disease, since the symptoms of mental disorder are vaguely defined and widely distributed, and the definition of behavior as symptomatic of mental disorder is usually dependent upon social rather than medical contingencies. According to this theory, the societal reaction to deviant behavior is of fundamental significance.

The social process involved in defining a deviant, is differentiated in accordance with the degree of societal reaction. Central to this issue is Lemert's theory of primary and secondary deviance (1951, 1967). According to Lemert, the insight or motivation attached to any particular behavior is not an issue of concern; it is the reaction of others which is cause for social outcry. Primary deviance refers to behavior which is most often characterized as transitory, and who's response does not adversely affect the taken for granted reality of the individual and his or her conception of self.

Secondary deviance, on the other hand, is that behavior which responds to the societal reaction toward primary deviance. It is "a special class of socially defined responses which people make to problems created by the societal reaction to their deviance" (Lemert, 1967:40). This form of deviance is thought to be a prolonged aspect of one's life, and as such, significantly affects the individual's ability to perform social roles. Secondary deviance is that aspect of social deviance which is of major concern to labelling theorists due to its potential impact of one's definition of self.

This theory asserts that if one is publically recognized as a

disordered individual, then the individual will come to see him/herself as disordered. In essence, it adopts the notion that personal identity and motivated behavior are derived from the consequences of labelling, not from one's continued habits of selection. The labelled actor, according to this theory, is not an equal participant in the process of social interaction. They are just victims.

This perspective portrays the individual as relatively passive, a powerful audience has cast him/her into a new self-concept and social role. There is no discussion of resistance to this new role, yet we know many diagnosed as mentally ill reject the attempt at labelling, and in institutions often violently resist and are sedated, straight-jacketed and confined. It is the social force which overrides the individual who succumbs to a new master status.

While the audience may have such control in total institutions and highly controlled social milieus (status degradation ceremonies) it is problematic to argue that human agency is totally subsumed under the control of self-concept as offered by a social audience. It is equally difficult to use a labelling perspective to understand the etiology of all forms of "mental illness."

1.2 An Alternative Model: Human Agency Perspective

Before attempting to provide a theoretical discussion of behavior which has come to be defined as "disordered", it is necessary to examine the fundamental concepts of a developmental scheme which encompasses the development of all persons. That is, before we can categorize one type of personality as different from others we must come to grips with an understanding of those processes which make each of us uniquely human.

One's personality and sense of self are constructed in the context of a cultural order. In this respect, who we are, and the limitations of what we can do, are determined and shaped, in part, by our social milieu. Humans are social animals. We achieve our sense of being through our perception of how others see us (Cooley:1909). Thus we do not become human by ourselves, but rather, in interaction with others.

The process of becoming a person rather than merely a biological entity begins through the process of socialization. As part of the cultural order, the caregiver nurtures the child with the provision of love and support. Not only are the child's physical needs maintained but the emotional aspect of security is also fulfilled. In its position of dependence, the child has but to submit to the omnipotence of its parent in order to feel good.

The caregiver is in a position of power because of this dependency structure. At the will of the parent the child will be shaped and molded in keeping with the cultural tradition. The child, as it begins to develop knows only of the experiences with its caregiver. It knows only of the means by which it can receive continued affection. But as the socialization process proceeds the child is forced to earn its much needed attention. No longer does the caregiver solely provide love and support unconditionally but subjects the child to varying degrees of frustration by the tasks that are demanded.

This simultaneous exposure to the use of affection and frustration develops the child's mind. Behavior can no longer be spontaneous if the supply of love is to be maintained. It requires that the child rehearse its action before actually performing it. Doing what the parent wants

the child to do in addition to the memory of past experience of previous actions entails the staging of a future theatrical performance. In other words, the child anticipates future action in accordance to the desires of its caregiver.

Humans are not born with a preprogrammed plan of action. We don't have innate characteristics with which to guide our future behavior. Everything has to be learned. But our learning process cannot be developed in a vacuum. It is the caregiver which provides the atmosphere of meaning. Only in the context of love and respect can the child find an identity. The self-identity is internalized with the experience of the caregiver. It is manifest in a fashion that entails: "her desires are my desires, her demands become my demands, and her anxieties are my anxieties." In essence, we incorporate the nature of the provider of attention unto ourselves.

Such is also the case in our association with the generalized other. Our sense of reality entails the larger view of the social group. We don't just do whatever comes "naturally." We act as we perceive others expect us to.

In the process of maintaining value as an object of worth the confrontation of ceaseless frustrations produces great emotional tensions. We don't want to be abandoned by those around us but we're continually prevented from doing things we want to do. Socialization provides the means by which anxiety is overcome. Anxiety is curbed by our use of defense mechanisms. Such mechanisms may be defined as a process by which one's "ego distorts or refuses to acknowledge reality whether internal or external, that would arouse unbearable anxiety

(Bootzin & Acocella, 1984:35). The ego itself is a defense mechanism of the personality structure. By using such mechanisms we actively define the parameters of our own state of being. We internalize the experience and beliefs of others while actively projecting our own thoughts out into those around us. The process is not a uniform experience. We each place different degrees of value on various aspects of our existence, and thus, invest variable amounts of energy into those areas of social life which one finds potentially threatening or rewarding. The result is a life long composite of socially assorted perceptions in which each of us derives our sense of reality.

Our cultural order demands that we learn the significance of its symbolic reality. The training process pressures us to adopt the reality of those to which we are a part. We are forced not only to curtail our own motivations and achieve competency through the goals of others, but further, to make such goals our own. Thus our sense of self, or personality, is a defense mechanism which is shaped, in large part, by significant others. And so there is a price to be paid for our identity as a human being. Our human agency receives a "twist" at the hands of our significant others. We all have to give up internal control of ourselves and learn to function through the guidance of symbolic rituals. Initially, these symbols have no inherent meaning after all, our life styles were established before we knew what was happening. Ultimately however, we are left with a self comprised of a collage of images. Who am "I"? "I" am an assortment of insides and outsides, decentered from any autonomous identity.

Now that you've got the individual with a workable, twisted set of

perceptions, behaviors and schemes, how is (s)he to cope with this confusion?

If the primary caregivers have provided a social environment where things are predictable and success is possible, the child simply follows the twist of his or her personality. It is a neurotic defense mechanism, but since child and parent share the same twist, that is, the twist is a cultural product, then interaction is possible.

Becker (1971) argues that this is, after all, how and why humans construct cultural rituals to complete their open and anxiety-prone biogram. Thus, all cultural solutions are neurotic. But do they provide equal chances of success?

The answer here is no. In some ways following Jim Jones from the ghetto of Los Angeles into the jungles of Guyana is a solution to a personal problem, in other ways it is succumbing to an even greater one. Each person tries to develop a personal strategy to cope and some of the labyrinth solutions of schizophrenics are quite complex and amazing. The multiple personality structuration is an ingenious, albeit debilitating, personal solution in the face of otherwise untenable and insurmountable social odds.

But the fact of the matter is that while all cultural solutions are incomplete and limited failures at developing human agency and human potential (this is why ethnocentrism is a pejorative term), some social milieus produce human agents with very poor solutions and strategies for the demands of interpersonal interaction. They are designed, as are all personal-self-systems, to provide control over anxiety, a sense of self-worth and a sense of identity. But as the work of Becker, Bateson

and Laing all testify, some personal solutions are inept or stupid and merely serve to compound the problems of social interaction.

1.3 "Mental Illness" From a Human Agency Perspective

The various personalities portrayed by human beings functions to preserve survival value to each member of a cultural order. Our techniques of adaptation maintains our level of self-esteem. That is, we buffer our anxieties in an attempt to be an object of social value (Becker, 1971). The maintenance of a positive self-identity would be impossible, however, in situations where there is no right action. Anticipating future behavior would not only be an unbearable task but the anticipation of future frustration would cripple personal development. How can you feel good about yourself if you're continually reminded that "you can't do anything right." There have been numerous examples of the ways in which people have coped with anxieties in situations which exasperate the process of maintaining an identity. R. D. Laing (1964, 1974) suggests that the schizophrenic response to the pathology of family processes is the only sane response to insane circumstances. Bateson (1956) and Becker (1962, 1968, 1971) see the schizophrenic response as a necessary reaction to double-bind and skewed family interaction patterns. Multiple personalities can be viewed as a character defense against abusive situations in childhood (Schreiber, 1973; Bliss, 1985).

Laing, Bateson, Fernandez, Becker and Szasz have described "abnormal" behavior not as a sickness inherent within the individual, nor as one group's definition over another, but rather, as a motivated social action which is based upon, and in reaction to, the patterns of

one's life experience. Although such action may be socially perceived as pathological, it does in fact, represent a phenomenological reality, a reality which is represented by a chosen act--however bizarre--and supported by personal energy (Kaplan, 1964).

Laing (1964, 1974) suggests that craziness is the product of, or response to, social and family contexts which are schizophrenogenic. That is, madness is that behavior and experience which reflects an irrational social structure. Laing sees one's perception of reality as a structure of those interactions which take place between individuals. In this respect, behavior is contingent. It depends on what others are experiencing, and thus, doing. When one selects a course of action and experiences the ramifications of such action there is no guarantee that it will be perceived by others as the same. One's motivations, objectives and pursuit of purpose may be construed as inappropriate and self-defeating. In essence, one's attempts at autonomous action may be interpreted as a symptom of pathology.

When an actor is caught up in the circumstance of situations which prevent him from transcending his way of life, there is an increased possibility that he may begin to doubt the validity of his own experiences. He may, in fact, split the authorship of his own behavior, and place the responsibility of his action on that of another. Such, is often the case in delusional and psychotic behavior, i.e., the voices said it, my body did it, the other personality enacted it. The process removes guilt and social criticism from the actor but the price is an invalidation of one's own sense of self.

Bateson et al (1956) views the disordered individual as

experiencing a way of life which is entangled in a "double bind." This is referred to as a,

> Specific pattern of disturbed communications, detectable within pathological families in which one member is subjected to a pair of conflicting injunctions, or binds, both of them highly unsettling or traumatic; a third injunction implicit in the situation, may prevent the threatened party from leaving the field and so avoiding the conflict. The unfortunate recipient of these messages is lost whatever he does, and if the ordeal is repeated tends to opt out of social interaction and to lose confidence in the accuracy of his perceptions of other people (Laing, 1974:17).

Bateson et al (1956:251) and Fernandez (1977:165) suggests the victim can't win, regardless of what (s)he does. An individual's self-image, i.e. reality, revolves around a systematic pattern of the way (s)he relates to others. Typically, when an individual is caught in a double bind, messages from others, particularly his "particular others," negate the meaning of other messages. An example is a dominant mother figure telling her child, "I want you to go to bed because you're tired." However, the message may imply, "I'm upset with your behavior so I want you to get out of my sight and go to bed." When confronted with an ongoing barrage of conflicting messages the victim's ability to discriminate between meaning begins to breakdown. The result is a systematic distortion of one's own perception; a lack of certainty between the self and those around him.

In this respect, the family is inevitably tied up with the notion of one's "self," regardless of what the victim considers his self to be. It is the family which provides one with their sense of stability and meaning. The victim, in this perspective, while attempting to rationalize a pattern of irrational circumstances, may manifest symptoms

of clinical pathology. Both Bateson et al (1956) and Fernandez (1977) indicate that catatonic and paranoid behavior, may in fact, be sensible reactions to these situations. From this view, it may be determined that the victim does not require re-humanizing for being out of his mind; more appropriately, his circumstances may be understood as being out of our mind.

For Becker, human pathology may be more accurately interpreted as a form of personal stupidity (1971, 1968, 1962). It may be regarded as a necessary reaction to a history of skewed family interaction in which the victim has not gained the ability to selectively choose a culturally appropriate means to selected ends. Rather, the individual relies upon an impoverished background of dependable behavioral patterns. Becker (1971:138) states, "these individuals are for the most part natural histories of poor socialization; inept performers obliged to make their way in a purely theatrical world." For many of these individuals, the value of their own self in a context of other selves has been diminished. It has been stiffled by a socialization process which has surpressed the development of a personal dependable identity.

A consequence of this poverty in personal identification is the inability to sustain the taken for granted rules and rituals which define a given cultural reality. Rather than preserving a taken for granted reality shared by others in society, their behavior may frustrate social discourse (Goffman, 1961), thus failing to maintain an impression of sustained meaning. This is not to imply that the individual's meaning structure is wrong; more accurately, it may be considered as his private considerations.

By failing to present an infallible self in the presence of others, the victim is forced to rely upon the only security, i.e., defense mechanism, (s)he can master: his/her inner world. When interacting with other selves produces condemnation and humiliation, the last foothold of sanctuary is in his/her own fantasies. These individuals have, through lack of opportunity, failed to master the conventional code of rules for interaction by which to sustain their own face and protect the face of others. One's entire sense of purpose and agency, thus, must rely on a suprahuman retreat into one's own sense of reality.

The behavior enacted by these individuals is guided by these privatizations. Such actions, although potentially threatening to the maintenance of a given social order, are nevertheless, organized with a sense of purpose and intentionality. The pathology, according to Becker (1971, 1968, 1962), is not within people, it is between them.

Thomas Szasz (1974) describes mental disorder, not as an illness inherent within the individual, but as those methods of communication which may be considered as inappropriate and frequently ineffective. They are not mad, they have "problems in living." These victims suffer from a lack of social integration with the broader community, and as such, manifest patterns of self-expression which are condemned as morally dubious. That is, one's inability to create an image of self justification in a context of social dialogue is directly contravening to an assumed symbolic reality. Social interaction in this respect, is not only taken for granted, it is engaged in and perpetuated in a manner which is morally binding. This morality, according to Szasz (1974) defines the parameters of our cultural order.

Through its promotion of rules, cultural order fosters dependence and subservience. It encourages individuals to trust and have faith in those with more experience in a given facet of cultural reality. Just as a child relies on its parents for love and support, or an individual coming to a medical specialist in request for guidance, each places faith in the other. In each situation, the feelings of helplessness demand a responsive action. Transference (Freud, 1976), the provision of security, enhances the self-esteem of the provider; it aggrandizes the help provider with feelings of power and security. The consequence of prolonged encounters, however, is that it capitulates into paternalism. The child or adult is frozen into an infantile holding pattern. Their skills of mastering the necessary symbols, rules, roles and games of social interaction are thwarted, sometimes indefinitely, and thus, the competency is lost (Szasz, 1974).

Given this condition of learned helplessness, victims like all human beings must forge their way through life with a twist of personality and with less than a complete store of knowledge. Their functioning within the context of social rituals is hampered by the lack of independent creativity, and thus, are condemned to a life of uncertainty. Since their reality is fixed in an infantile mode of endeavour, the only mechanisms for survival are to rely on this knowledge. Thus we have disturbed individuals creating a sense of reality from their own dreams, rather than from those cues which are culturally provided.

1.4 Contrasting Interpretations of Unique Human Behavior

The theoretical assumptions of both the medical model and the labelling theory isolate the disadvantaged victim from the cultural order to which (s)he is a part. Rather than incorporating the unique quality of ideosyncratic behavior in the realm of all possible human behavior these perspectives focus on the disordered individual as if belonging to a category different to other humans.

The medical model undermines the plausability that all humans are capable of some form of reasoning through its claim that disordered behavior is a manifestation of a diseased state; a condition which is beyond the individual's control. It fails to recognize that all individuals, not just the patients under medical care, have the potential to behave in "peculiar" ways. By focusing on the individual rather than the milieu which created the individual it fails to include why persons behave as they do.

Labelling theory portrays the disordered individual as nothing more than a social puppet whose strings are controlled by the definition of one's own self-concept. Although persons are socialized to see themselves through the eyes of others, they also learn how to provide security for themselves. Individuals do not accept without question the limitations placed against their own status. We accommodate our existence by rejecting or resisting those factors which threaten our security. There's little doubt as to the impact of labelling on the lived experience of psychiatric patients but such processes do not explain the rationale behind all of their actions.

The human agency perspective provides a different vantage point to

these other perspectives. It views all forms of human activity as an attempt to provide security and esteem within a social environment. Although some forms of social action do not enhance one's state of well being as effectively as others, all behavior requires some degree of insight and self-control. This position places the "disordered" individual in the same position as all cultural beings. Like all individuals their activity is conducted through human agency.

Although a robust agency is unlikely in these individuals because of the lack of social development in interaction with others, residual agency is possible. That is, the lack of opportunity in developing a secure sense of self would hamper the possibility of procuring a self-reliant image, yet the activities that are enacted by such individuals would reveal some degree of autonomy.

Unlike the medical model which bears its empirical reality on the individual's lack of self-control to behave in a certain way, or the labelling theory's method of describing why individuals are compelled to act in a manner defined by a larger social audience, the human agency approach explains the autonomous activity of individual actors. It is concerned with intentionality within those structures of everyday social interaction which can be described as,

> a body of common sense knowledge and the range of procedures and considerations by means of which ordinary members of society make sense of, find their way about in, and act on the circumstances in which they find themselves (Heritage, 1984:4).

1.5 The Method of Data Gathering and Analysis

This project has been conducted by utilizing comparative analysis as a framework to guide research (Glaser & Strauss, 1967). It involved the simultaneous useage of both particpant observation and informal interviews in community settings such as: drop-in centres for post-psychiatric patients, Winnipeg's Centennial library, and a variety of local restaurants. This method has been used in an attempt to discover patterns of social conduct which would provide evidence relating to the motivational structure of recipients of Manitoba's community mental health system.

The procedure for gathering information was theoretical sampling. In an attempt to replicate, and thus validate information, I jointly collected and analyzed information in order to find out what degree of residual agency does exist in these individuals. After each day of interviewing I analyzed the data to search for patterns of behavior which related to past information.

In particular, I was concerned with studying the nature of their reality. I wanted to discover what types of activities they were involved with and how exactly did they make sense of their situation. To do so, I proceeded with a phenomenological orientation. Methodologically, it is referred to as ethnomethodology.

As a method, ethnomethodology assumes that there are underlying rules for social conduct. These rules are not always or even often recognized by the participants. Hence, breaching experiments are required to make these rules self-evident.

To our knowledge, ethnomethodology has not examined the life-world

of madness to search for underlying taken-for-granted assumptions, but as a method, it carries no a priori judgement as to the presence or absence of human meaning in this community. If such purpose exists, it can be uncovered.

CHAPTER TWO

A PERSONAL REALITY

The purpose of this chapter is to describe the inter-subjective experience of one of Manitoba's mental health care recipients. The experience emerges from the contextual nature of this individual's interaction with significant others.

2.1 Patient Careers

The person defined as mentally disordered is often caught up in an organizational structure not of their own making. Goffman (1959) describes this structure as the "moral career" of a mental patient. The moral component is derived from the manner in which one's own framework of imagery affects the judgement of both themselves and those they must interact with. The career of this individual is based upon the contruction of their life circumstances as defined by others. Goffman (1959:101) states that such careers are "changes over time as are basic and common to the members of a social category, although occurring independently to each of them."

The focus of this chapter is on the current stage of one individual's career. There is no intent to begin describing past conditions under which this man has existed, but rather, to analyze the present conditions within which he experiences his personal reality.

2.2 A Case Study of One of Manitoba's Mental Health Care Recipients

The analysis of this section will be introduced by an account of those circumstances which play a crucial role in the structuring of one

individual's life. It is the impact of these circumstances which inadvertantly affect his own self-perception. Today, he perceives himself as a post-psychiatric patient, and the life he leads revolves around this title.

The case study is based on this author's account of personal testimonies given by the subject, his family and his friends. It portrays a dramatization of those experiences which reflect the daily life of one of Manitoba's walking wounded. Although the enactment of events were not all witnessed by this author, they do nevertheless portray an authentic re-presentation of some of the features in this individual's life from his vantage point.

My name is Mike Hampton. I'm 45 years old, a bachelor, and I've been called a manic-depressive by a lot of doctors. That's the label they use to treat me. I guess that means I get angry and upset more quickly than I really should.

I've just finished talking to Ray. Who is he? He's this guy that comes around the house where I hang out. He's been asking a lot of questions about mental illness. He wants to know about my life. What am I supposed to say? I don't remember things from a long time ago. I eat, I sleep and I get up in the morning.

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[1]See Schutz's concept "second degree construct" in A. Schutz, 1971, Collected Papers I: The Problem of Social Reality. "Concept and Theory Formation in the Social Sciences":48-66. Martinus Nijhoff: The Hague. Schutz describes second degree constructs as that sequence of events in conducting social research in which the observed phenomena is validated by those under study. It is a confirmation of the authenticity of what actually occurred. This study received secondary validation from the subject involved.

Ray tells me that my story might help other people. He seems like an okay person, but lots of people are nice at first. I know people who tell me of their great intentions. They drill a hole in my head, take what they want and then buggar off. Why should I tell Ray anything?

It's six o'clock, better grab the alarm before she starts again. Time to get up. The darkness is peaceful. It's so quiet. Why can't it be like this all the time?

I'm so thirsty. God, I feel rotten. I don't know if I want to drink first or use the bathroom. My last Diet Pepsi. I'll get mom to buy more.

It's six-ten already. She's still in bed. Where's my smokes? She probably hid them. They're in her bag. She ticks me off with her constant bitching about smoking too much. Her quit smoking program's not for me. How much more do I have that I can give up?

Where's my shirt? Damn it, she's put everything away again. Why doesn't she leave my stuff alone?

"Put some clean clothes on," she yells.

I want my working clothes, they're more comfortable.

"Mike, put some decent clothes on. I paid enough for them. And tuck in your shirt. Don't be a slob all your life."

"I've only worn these for a couple of days. They're still clean."

They're my clothes and I'll wear what I want.

"Wash your hands and face, you can't go around looking like you just got out of bed."

She gets me so mad. Do this, do that. What am I? It's after seven, where's my pills?

"Mom, would you get me my pills. Don't forget, a green one and two of the big white ones. There's no Diet Pepsi left either, I'll have one of your cans of juice."

"I don't want breakfast today by the way, I'm going to McDonalds."

May be Carla and the gang will be there.

"Give me $20.00 mom."

"How far do you think this pension goes every month anyway? I'd like to see you make it on your welfare cheque. What a joke. If your father could see the way you use me, he'd roll over in his grave. I'm seventy-four years old and don't need this abuse."

She's always arguing, she makes me so angry. All I want is to see my friends.

"What about a ride? You said you're going out this morning, you could drop me off on your way."

"Catch a bus for once in your life Mike. Welfare gives you a bus pass, why don't you use it. I'm not your private chauffeur you know. Your friends sure don't have this luxury."

"Maybe you'd start to loose that fat if you exercised more often. You know what the doctor said. You're 120 pounds overweight. I'm sure I'll outlive you. It's no wonder why you've gone through so many doctors. You scare them to death. You're a big bellowing slob. You use your voice like a hammer. They all know what you're like. Some one your age should have more pride and respect for themself.

She talks like a broken record, always the same shit. I grab her purse and find my smokes.

"Take my purse, take it all. You're in my purse more often than I

am anyway. You'll probably have to pay for Carla again. She gets my money by suckering you into thinking she loves you."

"She does!"

I know she does. The last time she took an overdose was because I forgot to meet her at the Sals."

"It's not a man she wants, its a free and easy life she's after. God knows, if it was a man she needed, she sure got short changed with you. I can't imagine any woman, even a crazy like Carla, who would want to be next to someone who smells like you. And what good would it do her anyway?"

Mom's always been mean. She tormented me when she took me there. And then she left without me. She said evil things about me then too. The doctors will understand, she said. But I don't. She's so wicked. My dad always told her that good families look after their own. She's the evil one.

"What about the ride?"

They're usually there around 9 o'clock.

"It's 8:30 already."

"Okay, okay! You're always rushing me Mike. Let's go."

I like being in the car but I don't like driving. She makes me nervous. I never want to get old. She's so slow. Thank God, we made it at last.

"Just drop me off by that door mom. If you're not coming back here I'll meet you over at the house.

"I'm going to one of my friends Mike. I don't need to be around your crowd all the time. Shirley and I are having coffee together.

I'll see you later on."

"Okay that's fine. Just don't forget my Pepsi.

"I hope I can get the clerk to carry it out to the car."

"Stop complaining. Since I switched to the cans you don't have to carry the empties."

She's gone, but I have my friends. How am I supposed to find them? There's so many people here. Where's Carla? There she is, all alone. No coffee. No food. Waiting nervous.

"Hi, whats wrong? You look sick."

"Dr. Mckray told me yesterday afternoon that I should go back into Health Science Centre for a while. He figures the drug program that I'm on now is not working. He's got something else he wants to try. I feel like I'm always buzzing. I'm tired of being wound up. I slept last night, maybe three hours.

"When do you have to go?"

"He told me he'd be there on Monday. He wants to admit me then. I hate that place. Its cold and dirty. And I don't want to be around those those people all the time."

"Why didn't you tell him to change your medication? Lots of people do that and they don't have to go back. Go see him today. Tell him to do something else. I'm coming with you. I'll tell him."

"No way, remember what happened last time you tried that? He wouldn't let you in. He told me that you're not family and that I should talk for myself. Getting mad didn't help either. He said crying wouldn't make me get better."

"Fine, have it your way."

"Where is everyone anyway?"

"I don't know."

Did you know Bob's been put back on the needle?"

"No, I didn't."

"When those bastards don't trust you to take your meds they can do just about anything. I sure wouldn't want to go through that again. It's bad enough to have to see him every six weeks."

I wouldn't want to keep going in every three weeks for a shot.

"Mike, do you want to eat or what?"

"Yea, I'm starved. Get me two Egg McMuffins, two hashbrowns and a large coffee. You get what you want. Here's the money. And I'm getting out of this booth. There's more room at that table."

She looks terrible. I don't want to lose her again. Those damn doctors. Why don't they leave her alone. It's taking her so long. Just too many people. Ah, at last!

"I thought you got lost."

"You try standing in that line."

"Thanks anyway Carla. Is that all you're having? You should eat more. It'll make you feel better.

"This coffee is about all my system can take right now."

"When I'm finished this food I want to go over to the house. Do you want to come?"

"Maybe later, I don't feel up to it now."

"But it's after ten, everyone should be there soon. We'll catch a cab."

"Mike, I feel like taking a walk. The house is only ten minutes

from here. Maybe I'll feel better then."

I think about her feelings but she forgets about me. She's like mom. They ignore what I want.

"You know my legs won't make it. You bloody well walk. Maybe I'll see you there."

"Damn you Mike. Don't you care about how I feel?"

"Of course I do. I thought a ride in a car would cheer you up. It does for me."

"Fine, fine. Let's get a cab. But you have to get it."

Why do I have to do everything for everyone? I'll probably get hit by a car. God I hate this traffic. I'll get struck down dead and no one will even know I'm gone.

"Carla, I've got a ride. Let's go."

"Do you have enough to pay him?

"Look, I'm looking after things. Don't worry."

I'm not a slob. Everyone thinks I can't look after myself. I'll give him a tip.

"Thanks for the ride. Here, keep the change."

"What are you doing? You don't just give money away like that."

Bitch, bitch, you're all the same.

"It's my money. Are you coming or not?"

"I'm coming, I'm coming!"

This place looks more messy everyday. Why the hell doesn't someone clean up around here?

"Carol, have you seen my mom?"

"Not yet."

"Mike, there's no one here yet, let's go somewhere else. I wanna do something."

"Like what?"

"Lets go over to Evanson. They have coffee. Bob might be there."

"What day is it?"

"Thursday."

"No, I'm not going to listen to that crap."

"What are you talking about?"

"It's newspaper morning. Haven't you ever seen it? They ask you to sit around the table, read a newspaper article and talk about it. They look like a bunch of little kids. Remember when you told me about the day program you were in last winter?"

"Yea."

"You told me it was like nursery school except they didn't give you a rope. It's like that. Besides, only nut cases go there. Thats where Josie met Frank. They still go there. No, I want to stay."

"Okay, let's do something else."

"Carla, mom'll be here soon."

I told her I'd be here. I don't leave her behind. She can count on me.

"All you're gonna o is fall asleep. You're on that couch again. I'm going out."

"Do what you want."

She'll be back. She needs me. I do all the running around for everyone. I deserve a rest.

"Carol, wake me up when mom gets here."

"Fine."

"Here, get up Mike. Your soup's getting cold."

"Mom, what time is it? Where's Carla?"

"She told me she'd call you later. She stopped in a few minutes ago. You were still asleep, she said. Here, swallow these with your soup. This one's for blood pressure. Before I forget, I got an appointment with Mr. Lone for one o'clock. So hurry up."

"Did you get my drinks?"

"Yea, and a sore back. They're in the car. You're going to bring them in when we get home."

"I'll walk over to see Mr. Lone, just wait for me here."

"We're going out after, so come straight back. I thought we'd go to the Keg for supper. Don't forget to tell him you don't have a decent suit."

He better help. If Cliff got one, then I want it. I'll just tell him the way it is. He'll understand.

"Tuck in your shirt. Mr. Lone can't see you like that."

"I'm going!"

I hope he's not busy. I hate waiting. Everyone makes me wait. They'll all wait for me one day. It's so warm. These pills make me sweat all the time. I'll take the elevator. I hope it's not that bitchy secretary again. Where is she? To hell with her. I can't see her. I'll just go in.

"Excuse me! Mr. Lone has someone in with him at the moment. Would you take a seat Mr. Hampton?"

"How long will he be? I'm in a hurry."

"He won't be long. Just have a seat."

I spend my life waiting. They should wait for me. Doctors, social workers; they're all the same. He's leaving. Mom'll be waiting.

"Go ahead Mr. Hampton."

"Come in Mike. How are you?"

"Not bad."

"It's been a couple of months. How's everything? Are you still at home?"

"Yea. Mom 'n I settled our differences. We're still in St. James. I help her with the rent and stuff. It's okay."

"Good, good. So what can I do for you?"

"Well, I thought you could help me get some clothes. I don't have a lot and I thought I should get something better than just these. Mom says winter's coming so I should get something warmer."

"Just what exactly do you need?"

"I thought of getting something tidy. Maybe pants, a jacket or even a suit. Mom thinks someone might even give me a job if I had better clothes. What do you think?"

"Mike, you know that isn't my department. Why don't you talk to your worker on Broadway?"

"I have! You know the policy. Miss Breem doesn't see this as a special need. I don't know what else to do. That's why I'm here. I know if I can look good I'll feel much better. Besides, mom said she could afford a shirt and shoes if I get a suit.

"Have you been looking for a job Mike?"

"Yea, I'd like to work for C.M.H.A. or someone like that. I know I

can volunteer. That's a good start. Mom figures if I dress good I might even get paid. I don't want a lot Mr. Lone, just a suit."

"How much are we talking about Mike?"

"Mom says mine has to be made because I'm big. Maybe three, four hundred dollars."

"That's a lot of money. No promises, okay. I'll talk to Miss Breem. Same phone number?"

"Oh yes. Will you let me know soon? I think I might know of an opening coming up."

"After I've discussed it I'll let you know."

"Thanks for the time."

"And Mike."

"Yea?"

"Behave yourself."

"Always."

I better hurry.

Where's the elevator? Mom's waiting. Maybe Carla too.

"Mike, you look flushed. I could have driven you." The car's right outside.

"It was only a couple of blocks. I'm alright.

"So, what did he say? Are you getting it?"

"He told me he'd let me know. He said he'd call."

I'm gonna call him tomorrow.

"What about Dr. Franks? He knows I need better clothes."

"Mike, just leave it for now. If you get it they'll probably end up in the closet with the rest of the clothes I bought you anyway. I

want to get tidied up. It's time to go home."

"Does Carla know we're gonna be at home?"

"I don't care. I think I told her."

"I better call her. She's probably over at her sisters."

"I'm leaving Mike - now! She'll call you after."

Always a rush. I hope she's alright. I don't want her back in the hospital. That place scares her. She's not strong. She'll make herself sick.

"Drive faster mom. I want to call Carla. Just let me off by the door before you go to the parking spot."

"The two of you are as bad as each other. You're both crazy. If you have to get out in such a rush take these drinks with you. I don't drink the stuff.

"Later. I'll get them after.

Where's my keys. It's our phone ringing. It must be Carla. Damn it. There's no one there. Maybe she's at her sisters place. Where's her number. How the hell can you find anything in this mess? Mom's coming she'll know.

"Where's the phone list?"

"Where it always is, in the closet."

I hope she's there. Answer the phone. I can't wait forever.

"Call her later Mike. Let's get tidied up."

Maybe she'll call me. She better not do anything stupid. I can't loose her.

"Yea, I'm coming. What clothes shall I wear?"

"If I'm taking you out for supper then get in the tub first. I'll

get your clothes after you get rid of those you're wearing."

Get in the tub. This water takes forever. I bet that's what Simone and Julie hoped. They just wanted to cool off. Why didn't he just leave them alone. He wouldn't let them go to the pool. There's nothing wrong with cooling off in the tub, especially a nice big one. Dragging them out in front of everyone. "Lesbian, lesbian." I wouldn't say it. I'd kill him. Selkirk's a horrible place. And she wouldn't believe me. I told her over and over. And to think that orderly didn't know her. He thought she was one of us. It was ages till I saw her again. Mom finally brought me home.

"Mike, I left your clothes out on the bed for you. Carla called. I told her we're busy tonight and that you'd phone her tomorrow."

"Why the hell did you do that? She needs me. She's sick. Where is she?"

"Leave her alone. You have enough to look after. She's always sick. Sick in the head if you ask me."

Where's her sister's phone number?

"Is Carla there?" Are you okay?"

"Susan's making us supper. Are you too busy to see me? I thought we'd go to bingo. You can win alot at the Buffalo bingo.

"Mike, let's get ready. I want to go."

"Mom and I are leaving for supper."

"Go with your mom. I don't give a shit. Susan's boyfriend is coming over. Maybe he'll bring some friends."

"If you don't get off that phone I'll leave without you."

"Shut up!"

"Do what you want. You're all enough to drive me crazy. Just remember, I won't always be here for you to come running to. I'm going!"

"It's about time! What did she say? She probably wanted you to take her out again. Well, you can forget getting more money. You either come with me or you can sit at home."

They're all like this. Why don't they leave me alone. I'd like to just get away. If I lived in the mountains no one would bother me. I could live in peace and quiet.

"Leave Carla out of this. I want to stop by after supper."

If there's someone with her then that's it. I'll go away without her. There's lots of others out there.

"I'm not going there Mike. You can see her tomorrow."

"We're going, so there."

"You yell and scream all you want. You're just like your father. I just want a pleasant supper. I guess it's too much to ask you to get the car for me so let's just go."

"Which Keg are we going to?"

"The one downtown. I hope I can park close to the building. Here's a spot."

"It doesn't look like there's a line up.

"Good. I don't think I could stand for long."

"A table for two please. Away from the kitchen."

"You're so quiet Mike. Do you feel sick?"

"I'm just quiet. And I'm not very hungry."

They all make me so angry. They're just like kids. They all want

my attention. What about what I want?

"Eat Mike. Get the T-bone. You know how much you like it. And here, swallow these. I don't know what you'd do without me to remind of taking your pills. Here's some water.

"I guess I'll have the T-bone."

"Good. It'll make you feel better."

"Doesn't the food smell good in here? Remember the nice dinner we had when my sisters' family came by last year. Everyone commented on the delicious smell."

I remember the smell of the cafeteria. It was always the same. Gravy on this, gravy on that. And when I was locked up I didn't even get a choice. You used to tell me the places you went to. But I couldn't go. God I hate gravy.

"I think that's ours. Your steak looks good."

I wish Carla was here. She wouldn't see someone else.

"This food is filling. Have some of mine Mike. I can't eat it all".

"No, I'm full. Let's get going. I want to make sure Carla's okay."

"I want coffee. Carla's probably out with her sister. Forget her."

"I'm going. Are you coming or not?"

"Alright, just let me pay the man."

"I'm gonna drive this time. I'm in a rush."

"Just don't get us killed. You know you shouldn't drive after taking medication."

"There's her sister's house. I'll be back in a minute."

"That was fast. Well, what happened?"

"There's nobody home."

Where is she? She better be alone.

"She's probably out chasing men again."

She wouldn't. I know she loves me. She told me that she only wants me. Why would she give me her dad's watch if she didn't?

"I'm gonna phone her later."

"I'm tired, let's go home. I'll make us some hot chocolate."

"The phone Mike."

"Carla, where were you."?

"I went for some smokes. Susan's gone out with Jeff to the bar. How was supper?"

"Fine, but I wasn't that hungry. Is everything alright?"

"Oh yea, but I wish we could have gone out. I needed to see you."

"It's nearly nine-thirty but how about breakfast? I'll bring the car and pick you up at home. Is that okay?"

"Maybe we could go somewhere nice?"

"I'll see you around eight."

"Okay, bye."

"So did you kiss and make up? I still think you're better off without her."

You think I'm better off without anyone. What about Margie? How long did it last? You screwed it up. I never saw anyone else. Her mom told me you said I did. Why? What's wrong with you?

"I'm going to bed. Turn everything off when you come Mike. And you forgot your drinks. You'll have to go to the car if you want them.

What can I say about mental illness? What should I tell Ray?

2.3 A Deconstruction of Mike Hampton's Reality: Pharmacological Debilitation

Perhaps the most revealing aspect of Mike's experience is the sheer banality of his daily existence. There's virtually nothing going on that would give reason to excite or draw the attention of an onlooker. One might even go as far as to say that his life has no real meaning; its dry, mundane and basically sedated. This is a far cry from the type of excited behavior which Mike claimed to be the source of his initial difficulty. Today, Mike's behavior is managed by a steady intake of medication.

The effects of medication play an integral part in the structuring of Mike's life, most profoundly, it affects the nature of his social relationships. Everything he does, everything he plans on doing, even the format of his conversation with others revolves around the issue of medication. From the time he gets up in the morning to the point at which he retires for the night his routine has to be structured in a manner which allows for certain predictable activities.

Mike can never be very far from bathroom facilities. One of his medications his mother refers to as a "water pill" constantly produces the need to urinate. Before Mike goes anywhere he has to be sure there are such facilities.

Mike is pre-occupied with his need to drink. He consumes large amounts of soft drinks in order to satisfy an almost insatiable thirst. Mike informed me that his doctor told him that being thirsty was a common side effect of a particular medication. He's been on this

medication intermittently for the last six years.

A further side effect of medication is the frequent need of sleep. Each afternoon, Mike sleeps between two to three hours. His day time activities most often revolve around where he sleeps and when he will wake up. Likewise, in the evening, the potential for social activities are curtailed by the onset of drowniness. By nine to nine-thirty in the evening, Mike is usually in bed for the night.

Mike's ability to function sexually is impaired by the prolonged useage of medication. He told me that this condition tends to occur sporadically, depending on the types and dosages of medication that he happens to be taking at a particular time. Certainly, the condition, as reminded by his mother, affects his degree of self-esteem.

Even time is determined by his medication. Mike doesn't like to be kept waiting. It's almost as if the amount of time which is under his personal control is so limited that he wants to accomplish all he possibly can. He knows how he is going to feel before actually experiencing it, and thus, determines a course of action in accordance with these perceptions.

Such is the case when it comes to employment. Mike knows what is involved with pursuing active employment, furthermore, he knows that nothing would please his mental health worker more than earning an income. But Mike also realizes the limitations of his abilities. He knows that its unlikely that anyone one would hire him under these conditions. And what about self-esteem? Mike's practical knowledge all revolves around his experience as a recipient in Manitoba's mental health system. He knows exactly what a recipient should and shouldn't

do in order to survive, but beyond this social terrain he feels that he has little to give. Mike has been trained to take, he's been conditioned to lead a life of dependence. Employment, however, would mean a drastic change in this scheme. How could Mike possibly feel good about himself if his only mechanism for esteem is denied?

Lastly, Mike's life is surrounded by an ongong barrage of prejudice and discrimination. His mother's actions continually remind him that he cannot be totally trusted on his own, that he may, for example, forget to take his medications, that he may neglect to bathe frequently and that it's necessary to set-up appointments as they are needed. His neighbours tolerate his presence. His mother commented "often they're (friends) too busy to talk when they see Mike tagging along side me."

And what about employers? Their actions speak louder than words. Mike's been told that he could get a job at Doray Industries. He could work with other mentally handicapped individuals and earn upward of $.75 an hour. Most employers don't want people like Mike. Their prejudice has curtailed the desire to leave the vocation of mental patient and try another.

Landlords often discriminate against patrons of the mental health system. Their applications for rental accommodation are either rejected or for those establishments which do accept post-psychiatric patients applications are handled with those parties who are "responsible" for such individuals, i.e., welfare workers. Even the media perpetuates a discriminatory perspective of such individuals. Often, the most horrendous of human spectacles are selectively linked to people suffering form some form of social pathology.

These concerns are seldom raised by Mike, although he is aware of them. Rather than placing himself into situations where he is forced to confront these degradations (perhaps with the exception of living with his mother, to shich end, he has been repeatedly advised against by his mental health worker), he chooses, voluntarily, to live in a closed community. His life is in a predicament, but he views it as a life vocation, and no one can run down their own vocation.

2.4 Deinstitutionalization and Community Mental Health

To understand the nature of Mike's interaction with those around him it is necessary to situate his experience in a particular social context. This section will deal with those processes and structures which directly affect, impinge, or set limits on the behavior engaged in by all of Manitoba's post-psychiatric patients.

Since the early 1950's in the United States and the 1960's in Canada, the locus of mental health care has changed from institutional to community care. (In Manitoba, the New Democratic Party actively pursued a "community mental health program" in 1968). Bachrach (1977:1) refers to deinstitutionalization as the process of:

> 1. preventing inappropriate mental hospital admission through the provision of community alternatives for treatment,
>
> 2. releasing to the community all institutional patients who have been given adequate preparation for such a change, and
>
> 3. establishing and maintaining community support systems for non-institutionalized persons receiving mental health services in the community.

This represents the ideal which this "bold new approach" in mental

health care was to achieve.

The institution provided a number of services to the patient. For example, Okin (1978:1355) states:

> The institution was for many persons an integrated human services system that provided medical, nutritional, vocational, residential, legal and economic services, albeit in many instances, very inadequately.

Ideally, these services were to follow the patient to the community. In reality, the institutional populations did drop and patients were released to the community, but the services did not follow.

The policy to deinstitutionalize the mental hospital was not adequately planned. Bassuk and Gesson (1978:51) note,

> Development of community mental health was not based upon data collected by systematic research; rather, it was assumed that each mental health centre would be shaped by the particular needs of its area as they were perceived by the community itself.

This leads us to wonder, as did Bassuk and Gerson, if deinstitutionalization represents an abdication of responsibility? Adequate preparations were simply not made. Neither patients nor the community were adequately prepared for their return to the community. This has resulted in what various writers have termed the "myths" of deinstitutionalization.

Kirk and Therrien (1975) refer to the myth of <u>rehabilitation</u>. It was assumed by health care planners that the use of drugs combined with mental health programs, along with physical removal from the debilitating effects of the institution, would lead to rehabilitation. It was assumed that community living would be a therapeutic enterprise. This, however, is a simplistic notion of rehabilitation. Practitioners

still lack definitive treatment knowledge and therefore still rely primarily on symptom management. Secondly, the patients themselves, were never asked individually or collectively what they thought was in their best interest.

When we observe the mechanisms involved in structuring Mike's daily existence, although it is not totally synonymous with other deinstitutionalized patients, the location in which he receives his "therapy" has changed but the mode of treatment has not. Mike's life in the community is not therapeutic. His symptoms are still treated with chemotherapy and his autonomous activity is subject to the approval of his care-givers in the community mental health system.

A second myth, related to this, is the myth of reintegration. It was assumed that keeping these clients out of the hospitals meant they would become re-integrated in their home communities. In reality, those returning to the community found themselves "in" the community, but not "part" of it. Kirk and Therrien (1975) and Segal and Aviram (1978) note that integration constitutes more than mere presence in the community. Integration implies consuming goods and services and participating in social life. But, those who are considered mentally disordered are often ghettoized in the poorest areas, subjected to social rejection and isolated within the community.

Mike's involvement in social life revolves around his interaction with friends in the community mental health system. His friends, mostly recipients of this system, most often come together at established facilities such as drop in centres for post-psychiatric patients. Outside of this closed network Mike's participation at the community

level is virtually non-existent.

A third myth is that of comprehensive, continuity of case (Kirk & Therrien, 1975; Segal & Aviram, 1978; Brown, 1985). The ideal system was to provide a full range of services designed to meet all of the patient's needs. These were to be provided with continuity, so that the person experienced smooth transitions in services and could move with ease between services. In reality, services are fragmented and limited in range. The problem is a growing complexity of bureaucratic fragmentation. Bassuk and Gerson (1978) indicate that mental health departments often undercut each other's objectives, secondly, they often compete for limited funds, and lastly, they fail to focus on the priority of goals. Frequently compounding these issues is the problem of maintaining a two-system program. In Manitoba, for example, the same government bureaucracy that handles community mental health is also responsible for the functioning of provincial mental institutions. How adequately can the same group that promotes institutionalization also deal effectively with the necessary concepts of community mental health?

There is no smooth transition between mental health services in Mike's life. It is up to him to facilitate such transitions. The services which are available are each governed by separate bodies of authority and likewise are processed in accordance with a particular set of goals, but beyond this, there is no unifying feature in the system which brings comprehensive care to the "whole" person.

Finally, a number of people mention the myth of monetary savings (Kirk & Therrien, 1975; Segal & Aviram, 1978; Greenblatt & Norman, 1983). It was believed that deinstitutionalization would lead to a

significant decline in the costs of services. However, for a number of reasons, costs either remained the same, or simply shifted to other sectors, for example, the welfare system.

In general it was felt that the quality of life experienced by patients would be enhanced in the community. The reality is that institutional life provided more of a sense of community, or gemeinschaft relationships, and at least met the patients' basic needs (Okin, 1978). This reflects a simplistic view of community. Community is more than just a geographic unit (a catchment area); it is a part of social structure which helps bring meaning and coherence to a person's life.

Tonnies (1957) distinguishes between two fundamental forms of social life: gemeinschaft and gesellschaft, which respectively mean community and society. Gemeinschaft represents a more primary and personal level of relationships, where there is commitment to and identifiction with the members of the social unit. Gesellschaft is a less tightly knit social arrangement based on a contractual division of labour and bargaining. The ties in society, therefore, are based more on rational thought than the emotional ties of community. Deinstitutionalization has proceeded as if the community these people are being placed in is a gemeinschaft, when in reality, it is a gesellschaft. The community in which these individuals are placed often features weak bonds and fragmentary associations, and not the closeness that was naively assumed.

One would have to stretch the imagination to discover quality in Mike's life. Even if there was a monetary savings to be gained by

decarcerating individuals like him the result is one of providing a framework for a pathetic existence.

2.5 Praxis: Motivated Behavior

There is an urgency to answering the question, how can individuals like Mike, given the constraints of their situation, function adequately in a highly complex urban environment? How can they adapt to an everchanging social milieu in which even those of us who have developed a strong sense of personal identity become frustrated with our own dilemmas? This section will deal with a special case of praxis. It may be defined as,

> ...action which can be traced to definite decisions undertaken out of definite motives by definite people....That is, social events can be rendered intelligible by showing that they are the outcome of decisions taken in a social field by motivated actors (Laing, 1974:15).

Although Mike's lived experiences are constrained by such factors as: the effects of medication; accountability, both financially and emotionally, to a fragmented assortment of social service employees; and a facilitated dependence on a diminishing number of Manitoba's psychiatrists, he does, nevertheless, seek to establish some measure of control over his own welfare. In the example cited, Mike knew with precision just what it was that he had to do in order to obtain clothing. He knew the mechanics of the system well enough to manipulate the situation in his own favor. The key issue in this dilemma, at both a personal and a social level of cognition, was not that Mike desperately required the clothing (for employment or otherwise), but rather, since he knew someone else had managed to receive a suit, he too

wanted to accomplish the same task.

Mike is very good at what he does. He knew that asking his welfare worker for clothing money to purchase a suit would get him no where. In accordance with their mandate, the welfare department had given Mike all that he had been alotted. His mental health worker, however, operates under a different set of rules. Their concern was not Mike's financial security, but rather, his emotional and social state of being. Mike's statement that he was seeking employment may have been received with skepticism, but the fact of the matter is that such a venture is in keeping with the policies of this department, furthermore, not only was Mr. Lone aware of this but so was Mike.

There is a pathos to Mike's situation. Why, in view of his ability to understand the operation of his own reality, is he compelled to structure his experience with in the confines of a debilitating social milieu? Why must he rely on drop-in centres as the primary context for meeting and interacting with others? Mike's whole reality, everything he knows, feels or remembers is entwined with his experience as a psychiatric patient.

Acting in accordance with the ways in which a patient is expected to behave is what Mike knows best. His most accomplished source of self-esteem is derived from the very nature of his interactions with the various members of the mental health community. Such knowledge, is one of the few things that Mike can offer with some degree of accuracy. As witnessed in his relationship with his girlfriend, Mike understands not only the feelings of helplessness that she is experiencing, but further, the turmoil in which loved ones go through when family membes are

expected to succumb to the demands of care-givers. Perhaps this is the most pathetic situation; he feels like a patient, he's treated like a yet the powers that have sanctioned his release to the community no longer regard him as a formal patient although they continue to treat him as one.

CHAPTER THREE

This chapter is designed to illustrate the various methods used by post-psychiatric patients to achieve a degree of personal autonomy within the structure of Manitoba's community mental health system. Such behavior will be situated in the reality of social interaction between mental health care recipients and the generalized other.

3.1 A Meeting of the Minds

Harold Garfinkel's (1967) research on social order has shown that much of social interaction is governed by tacit rules of conduct. His breaching exercises have revealed that actors involved in social interaction behave in such and such a way, never fully realizing how they have constructed a situation. If, on a theoretical level, these exercises have revealed the underlying rules of social conduct between participants, then it may be safe to assume that such taken-for-grantedness exists in all interactions. Therefore, the way in which we behave and the manner in which we convey our assumptions will directly affect the means by which others will respond, and thus, create meaning within the situation.

Breaches create an emotional response. Since a person doesn't understand what is expected when we think they should, we get upset, angry, frustrated. The "mentally ill" regularly and inadvertently breach social situations because they have ideosyncratic rather than cultural modalities of thought and action.

Psychiatric caregivers often tend to operate under the assumption that a mental disorder implies an irreconcilable disability, that the

victim is "sick" all the time. Providers assume, in essence, that these individuals are different or special, to the extent that they must be helped, protected and guarded from the uncertainties of social life. If the warrant for this paternal guardianship, is in fact, based upon a solid foundation, then it would stand to reason that the actions of these recipients would, without assistance, be doomed to utter futility. Human meaning, in other words, would be paralyzed.

3.2 Survival in the Community Mental Health System

The structure of Manitoba's mental health programs leave very little latitude to free will and decision making on the part of the psychiatric patient. It is designed in such a manner that the victim becomes entangled in a web of social programs designed to structure their existence, while at the same time, destroy the validity of any personally autonomous action.

During the course of this research several instances were provided which indicated the means by which psychiatric and post-psychiatric patients were able to obtain a particular end while at the same time maintaining an acceptable standard of decorum. One post-psychiatric patient referred these interchanges as "head games." They represent the type of activities which are conducted by psychiatric patients in pursuit of a goal. The process not only leads to the possible self-satisfaction of obtaining the desired outcome, but further, is manifest in a way which satisfies the norms of acceptable conduct as determined by care-givers.

One such activity is getting yourself confined to a hospital psychiatric unit. It was referred to as the "Poor Man's Holiday Inn."

As one individual commented,

> We all need a retreat now and then. You can go away for the weekend, go fishing, even take the family to a hotel, but I don't have that luxury. When life gets me down I go to see my doctor. If I can convince him that I need attention then I can spend some time at the hospital.

He went on to describe the hospital as a place of rest.

> After all, every thing is provided. I don't have to worry about rent or food, in fact, if I behave myself I can usually get day passes. That way, I can come and go while at the same time everyone's happy with my progress.

The interesting part of this situation is getting yourself committed.

Another individual went on to say,

> The doctor may or may not know you wish to be committed. The secret is saying the right words and having a history of several committals to back you up. The word 'suicide' seems to ring some bells. Even though I know, that he may know, that I'm not being totally honest, the onus is on him. I can even get some friends to convince him if I have to. I know the psychology text books call this 'malingering,' but I prefer to think of it as working out a problem.

Regardless of what it is considered, the end result is the same. If the individual succeeds, then (s)he gets his/her wish, if not however, there is another recourse. It was suggested that,

> If you can't get your way with one doctor, or for that matter, nurse, then you need to get someone else to fight for you. Get someone, preferably a professional, to convince them you mean business.

It was later discovered that such methods were also used on mental health workers and welfare workers. When the alotted "special funds" of each welfare recipient are used up it is very difficult, if not impossible, to collect more money. This funding is provided for those items not normally included in the monthly budget. Items such as winter

clothing and furniture are examples of those articles which may be purchased for special needs. To get beyond this problem, an individual pointed out,

> You need to argue your case to a worker from a different department. If you can show your mental health worker that you desperately need clothes, for example, and make it clear to them that your welfare worker will not give you any more funds, then there's a good chance she'll go to bat for you.

Similar circumstances prevail with respect to one's rent budget.

> If you want to change your location and the welfare department refuses to allocate more funds, whether its more rent or for a security deposit, just convince your mental health worker its in your best interest. I moved three times last year. I got fed up with the landlords telling me how to live, so I just explained the circumstances to my worker. After she looked into the situation she helped me with the necessary arrangements.

These games, however devious or underhanded they may appear, do represent an assumed reality for those that enact them. It represents a meaning structure that obviously requires insight and a consideration of the ramifications of potential action. These actions are not conducted aimlessly by simple desire; they are motivated and guided by the necessity of achieving a particular end utilizing a particular method. In essence, these games are no different to those played by the assumed "normal" population. Although the actors of various social agencies may differ from individual to individual, the desire to look out for oneself is a very healthy approach to life in our complex environment.

3.3 The Underground Network

The sharing of head games enables many individuals to survive in the psychiatric community. These head games, where do they come from

and how do they develop? They are practical methods of manipulating situations which are seemingly hopeless to any form of reconciliation. These methods are developed out of trial and error by a population which has little more to loose. By sharing those ideas that have worked in the past, and those that haven't, many post-psychiatric patients are able to express some degree of autonomy. There appears to be an open willingness to share this information: What to do and what not to do. Which workers are more open minded than others. Where and where not to go for help. And even when is a good time to seek help.

Such advice and strategy was provided by post-psychiatric patients in order to overcome one of the structural problems experienced in conducting this research. Permission for access to privately organized drop-in facilities was easily obtained, gaining access to a particular government sponsored centre, however, was highly problematic.

This centre is held in the building which houses the provincial department of Community Services. At this centre, post-psychiatric patients have the opportunity to participate in both informal and formal activities. Informally, individuals can come and go on their own accord, and may interact with each other and with mental health workers who may be present. Formally, this centre provides weekly structured activities such as: weaving classes, group reviews of current events, cooking classes and religious meetings. Each of these structured activities are conducted by mental health workers and volunteers from the surrounding community.

Unlike other groups which are privately organized, this government sponsored centre is closed to outsiders. Outsiders, in this instance

refers to those individuals who have not been invited to attend. Once post-psychiatric patients have been referred to this organization, they may, assuming their behavior is not disruptive to others, attend the activities. Lacking this referral, however, prohibits entry.

After receiving informal consent from the drop-in centre's workers to attend the gatherings, this author was later notified, after three 1-hour visits, that formal approval would have to be granted in order to continue attending. Ironically, during the process of my escorted departure, the visitors at this centre verbally expressed their feelings of discontent. One individual shouted,

"This is Canada, not Nazi Germany. Leave him alone."

After going through the procedure of stating my intentions both verbally and in writing, I was then requested to provide documentation from my thesis committee. To this author's dismay, this was still not enough. Although the department of Community Services had accepted the legitimacy of my proposal, I was only granted limited access to this facility. First, I could only attend designated structured activities on a limited number of occasions. And lastly, I had to obtain written consent from those individuals I wished to interview. This last stipulation, however, was two-sided. Once written consent was obtained from these individuals, I was then requested to meet with them at locations outside of this government office.

This paternally reactive situation did not go without question. One employee suggested that,

> The more they (supervisory officials) attempt to block your access, the more it appears they have something to hide.

Furthermore, this same individual indicated that perhaps because of the orientation of this research, this department is more defensive of their own domain. It was stated that,

> This is a sociology thesis. If it was more in line with a psychological review of how to make the existing situation better, then I'm fairly sure you wouldn't have had this problem. I'm certain that the powers that be, are apprehensive of being placed in an awkward situation.

Shortly after this confrontation, several visitors at this centre stated that I should still attend the gatherings. It was even suggested that I obtain a doctor's letter stating I suffer from some form of an emotional problem. As one visitor pointed out,

> Hell, everybody's got some sort of problem. Why don't you take advantage of the situation?

He went on to mention,

> There's more than one way to skin a cat. If you can get a doctor to agree that you need to interact more frequently with others, how can this place keep you away? After all, isn't that what this place is all about?

Although this research continued outside of this facility, it did benefit from the wisdom of its visitors. After numerous meetings with many of these individuals at locations, such as, McDonald's restaurants, the Winnipeg Centennial library, psychiatric units and self-help drop-in centres, it became apparent that their lives, although restrained by particular structural impediments, did reveal a sense of integrity. These particular impediments which revolve around the confines of life in the mental health community are additional to those structural realities which exist for all participants in society. In this respect, the actions of these individuals must not only satisfy the demands of

mental health officials, but also, those requirements of social discourse in an urban environment.

3.4 What I See is What You Are

How can a physician determine if their patient is playing a head game? The fact is, they can't. In the absence of objective tests to determine the presence of mental disorder, doctors must rely upon their own perception of the situation which is presented to them. Whether or not a head game is occurring is not at issue. What is significant, is the fact that something is happening and its happening now.

The ramifications of this situation are endless. The consequences of displaying a particular behavior may be realized in many ways, i.e., incarceration in a psychiatric facility, incarceration in a penal facility, invasive physical therapy, such as E.C.T. (elctro-convulsive therapy) and a host of "talking cure" and chemotherapy techniques. If the physician determines that the individual is a threat to him or herself and/or to society in general they are at liberty to discharge their authority. How they implement this authority, however, and the rationale behind the exercise, is open to personal preference.

Although physicians are the providers of primary acute care in the case of mental breakdown, there appears to be differences of opinion in how to handle disordered behavior. Hospital emergency room physicians most often confront patients suffering from mental breakdown in situations which are highly emotional in character. As one physician noted,

> By the time they come here (the hospital) there has already been an emotional challenge established most often by family, friends and even the police

> department. What we see is the end product of a very frustrated individual. In such unsettling situations my role is to diffuse the tension and get something done.

The pleas of the victim don't always appear to be taken very seriously by the hospital staff. As another emergency room physician commented,

> Our facility is often very busy and we don't have a lot of time to spend on 'family disputes.' We have a lot of other sick patients that need our attention and so our priorities must be governed accordingly.

The victim in this situation is often shuffled and maintained within the hospital emergency facility until further psychiatric assessments are made. Often awaiting a psychiatric consultation, the individual is kept in protective custody indefinitely. As one patient mentioned,

> They keep you locked up and guarded until a psychiatrist decides to come. No one wants to hear what you have to say. They all figure the reason you're there in the first place is because you're crazy. If you yell and scream it only encourages what they already believe. On the other hand, if you behave in a docile manner, it also supports their conviction that something is definitely wrong with you.

Like Bateson's "double bind," it appears that the presumption of illness on the part of hospital staff places the victim in a situation (s)he can't win.[2] (S)he is dammed, regardless of how (s)he behaves.

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[2]This situation assumes that the victims do not actively create the dilemma for their own purposes, i.e., to get themselves committed in a psychiatric facility.

The circumstances leading up to a hospital visit tends to initiate a particular capacity for interpreting disordered behavior. It is an assumption on the part of care-givers that determines whether or not pathology exists.

Individuals requesting consultation at walk-in clinics are faced with a drastically different reception than those encountered at hospital emergency facilities. As one walk-in clinic physician put it,

> The atmosphere at walk-in clinics is notably different to emergency facilities. I talk to 'patients' who want to talk to me. I didn't pressure them to come here. They're here of their own free will. Most often, 'patients' who come to see me with emotional problems usually need someone to listen to them. Frequently they have difficulty coping with daily pressures, and thus, seek advice and guidance.

This doctor went on to comment that,

> Problems do occur on occasion. You have to be careful. Some of 'these patients,' especially those who don't normally come here, will try to justify their need for medication. Once it becomes apparent that they won't get it from me they try elsewhere until eventually someone will give it to them.

When asked, "what type of help he did provide to these patients,' he stated,

> "The best I can do is to give 'hands on' advice."

He felt positive reassurance accompanied by the occasional prescription of tranquilizers was a normal response.

"Very few of my patients are blatantly psychotic" he mentioned.

> "For those that are, I strongly suggest a psychiatric assessment. I can only try to facilitate the process by setting up a consult. Whether or not they take my advice is up to them."

The issue of free-will appears to encompass more than what is seemingly obvious in this situation. If a potential client of a walk-in

clinic is assumed to be there of his or her own free-will then it should also be safe to assume that his/her health, or lack of, has been taken into consideration prior to seeing the physician. If any individual feels, whether from past experience or advice from others that certain medications will help, then such individuals have the right to make their feelings known. It is apparent, however, that this particular physician assumes that patients with emotional disorders are a source of potential problem. Apparently, 'these patients' are assumed to possess attributes that others don't, since they were singled out as that group of individuals who would attempt to dupe the physician into prescribing medication. This is not an attempt to downplay the fact that people will try to obtain medication under false pretenses, for such is obviously the case. What this does reveal, however, are the particular beliefs of one physician. If 'these patients' require him to be careful, then in what other ways will his presumptions have an impact on clients who claim to have an emotional problem?

When individuals are consulted by psychiatrists their course of treatment and rehabilitation develop more as a consequence of the particular practitioner rather than the manifestation of a particular disorder. One psychiatrist stated,

> We each have different backgrounds in training. Although I work from a predominantly psycho-analytic approach many of my colleagues adopt behavioral therapy and chemotherapy techniques. I don't feel that the utilization of one technique over the other is necessarily the major problem in mental health care, rather, redundancy occurs when clinicians address each patient's complaint with the same technique. Patients are individuals. Because a prescribed dosage of medication alleviated the symptoms of one person doesn't mean that such a dosage, of for that matter, such a medication, will work in the same way on another.

Another psychiatrist thought that the problem in psychiatric care is one of assessment.

> Certainly, we have methods of bringing episodes of emotional disorders under control which are proven more effective than others, but that to me, is not the main problem. The issue is how, when and under what circumstances assessments are made. If one of my patients comes into the hospital emergency suffering from an acute psychotic breakdown and I'm not available for consultation, then someone else must assess the situation. My colleagues are all competent, but still, their assessment must rely upon the symptoms presented and their interpretation of my written history of this patient.

This situation becomes further aggrevated if the patient is brought to a health care facility in which his/her psychiatrist does not have bed granting privileges. In other words, assuming beds are available, the patient must be transferred from the care of an attending physician to that of another at his or her psychiatrist's hospital. The patient, by this time, has been assessed and treated by several physicians. If the severity of the symptoms demanded immediate attention, then its quite conceivable that treatment would be given without consultation to past history.

A third psychiatrist felt the major problem in mental health rehabilitation is continuity of care. There are a number of reasons why an individual may fail to continue on a particular therapeutic format. One reason, as pointed out by a post-psychiatric patient is that,

> Its awful easy to forget to take your medication, especially when you know in advance its going to make you nauseous or sleeply.

Secondly, individuals may get advice from others which may, in fact, either discount or oppose the advice of the psychiatrist. And lastly,

individuals may take substances which have adverse side effects when taken in conjunction with prescribed medications. The psychiatrist commented,

> There's no way of knowing exactly how the patient will act once (s)he leaves the psychiatric facility. The only thing you can count on, is that you will see the patient back in hospital sooner than otherwise planned if they neglect to take their medication.

Although the opinions of these physicians cannot be considered indicative of all other physicians in Manitoba, it does reflect a broad spectrum of responses to the problem of provision of psychiatric care. Like each of the patients these physicians treat, physicians are individuals. Each of them has a different outlook on their profession. Their background training in psychiatry is only one aspect of their capacity to deal with patients. The other aspect is their belief structure of individuals who manifest symptoms of functional pathology. Adherence to the D.S.M. (Diagnostic and Statistical Manual) manual only enables them to articulate in a scientifically appropriate manner, what they as individuals feel to be the problem. As one patient stated,

> My doctor is continually asking other staff how I behave. It's almost as if he's never quite sure if his own feelings are accurate. He likes to have his own thoughts confirmed by others before he lays the law down to me.

It became increasingly apparent through these interviews that the context of psychiatric assessment has a profound affect on the manner in which symptoms are perceived. When patients willingly accept the advice and course of treatment handed down by their physician, there is a stronger possibility that patient-physician dialogue will progress smoothly. When emotions are flaring, however, the societal demand for

control takes precedence. The physician, in this circumstance, takes command, by imposing his or her ideals over those of the patient, thus achieving an orderly situation.

3.5 Images of Successful Living: Yours or Mine?

The seasoned psychiatric patient knows quite clearly those hurdles which must be overcome in order to express any degree of autonomy. They must play the game as it is layed out for them, and they must play it well. To do so, even given the lack of opportunity to get beyond their own situation, they utilize a reflective evaluation (both individual and collective property) of past experience. For those that have adapted to life by the rules of this game, survival becomes just a little easier. Others less fortunate, who are either just learning the ropes or who are lost in the outreaches of their own imagination must totally depend on the will of others. Some may survive with help from their friends, others may never get beyond their own private reality.

The context of this situation which is created to help these individuals is pathetic. In our establishment of social order, the legitimized keepers of the peace in the psychiatric community have structured a fragmented and individualized wall of controlled conformity disguised as a system of therapy. In an attempt to devalue or remove ideosyncratic thoughts and behavior from the recipient, the authorities in the mental health profession utilize their own personalized methods.

The situation portrays a meeting of the minds. Victims who must confront these specialists are required to subordinate their own thoughts and internalize the reality of their superordinates. Success, in accordance to these superordinates is the degree to which individuals

manifest their newly adopted reality. Success, for the individual, however, is the degree to which they can maintain their own peace of mind while at the same time convince authorities of this ability.

CHAPTER FOUR

CONCLUSION

This chapter will summarize the findings of this thesis. It will reveal the significance of taken-for-granted assumptions in the social response to madness.

4.1 Personal Agency

This research has revealed, both theoretically and empirically, that the commonly assumed beliefs of mentally disordered individuals not having any direct control over the outcome of their lives is not only fictitious, but further, is debilitating to any future progress in our understanding of unexplainable behavior. It has shown that bizarre behavior is not pathological in and of itself, but rather, is a reflection of others inability to get beyond their own taken-for-granted assumptions of what such behavior represents.

At a theoretical level, psychotic or delusional behavior arouses a response of frustration and anger on the part of those who confront it. Similar to the responses of Garfinkel's breaching exercises, this behavior foils the progression of sustained meaning in the dialogue of interaction and signals the breakdown of a taken-for-granted reality. It indicates the inadequacy of attempting to gain an understanding of one's meaning structure which is governed through a particular set of assumptions by utilizing methods which manifest a different set of assumptions. Becker, Laing and Szasz have shown that this supra-human behavior is not sick behavior, nor is it wrong; it is one's own method of coping with or managing a reality that is in itself very confusing.

Although attempting to understand manifestations of dream-like behavior are not suggested to reflect game-like exercises of one group over another, it does in fact, reveal the artificiality of those structures of social dialogue which society takes for granted. It makes evident the commonly held assumptions from which we, as an integrated collectivity, derive our sense of reality.

Empirically, this research has shown that although social structural impediments have left limited room for creative solutions to a problem that would appear insurmountable in magnitude, these individuals are still able to cope. Contrary to the belief that the mentally disordered are not personally capable of securing a sustainable means of existance, this study has revealed that these individuals not only have a sense of what is in their best interest, but further, have developed reliable methods for achieving these ends within the limits of their biographical situation. The context in which these individuals must survive has left them very little to work with, yet, given these constraints, they rely upon their own ability to manipulate and master their activities.

The means by which personal agency is manifest in their situation may not be perceived as the best of human potential, but it does nevertheless, reflect a unique and creative response to a particular set of circumstances. The manner in which the so-called "normal" portion of society conducts their daily activities are all taken-for-granted; we seek suitable accommodations for our families, we eat regularly, we dine on occasion and we socialize in terms of what makes us feel comfortable. A degree of choice is certainly at the heart of our activity. This is

not to ignore the fact that structural impediments confine everyone's activity to some extent, for such is obviously the case. The point, however, is that our activity is not governed by the master status of mental patient. Why must these individuals adhere to such uniquely created systems of control? Are their circumstances so different that society must contract particular agencies to govern their activities? It would appear that they are not so unlike the rest of us attempting to cope with our own lives. For those individuals who are capable of governing their own activities these agencies become the brokers of their existence. Their activity accounts for the fact that they are active participants in the construction of their own reality.

If these individuals are actively constructing their course of action then distinguishing the leadership of care-givers from that of one's own autonomy becomes highly problematic. Is their behavior preformulated or was it assembled as it went along? The care-giving agencies provide particular services as governed by their mandate. The recipients, however, become the facilitators of reducing the fragmentation between agencies. They achieve their ends by cross-fertilizing the demands of one agency with those of another. Success, in other words, depends upon the recipients' ability to manipulate their superordinates into giving them what they want. Furthermore, such success becomes enhanced when those who have been manipulated congratulate the individual for achieving a level of competency.

4.2 Toward a Better Understanding of Craziness

The problem with individuals who exhibit strange, uncomprehensible behavior is not in them; its about them. The issue, in other words, is not personal in character; its social. Our current method of interpreting such behavior, however, revolves around an objective justification of personal attributes. It is the individual who must be treated in order to maintain compliance with an assumed rational order. Therapeutically, we medicalize the problem, and thus, mask the symptoms of what would otherwise portray the insecurity of our own taken-for-granted reality. Through our exclusive preoccupation with changing the person to fit into society we neglect to challenge those concerns which stultify the development of human potential. Factors, such as, pathological family interaction become secondary, if not peripheral concerns, in our overly zealous attempt to normalize the victim.

Because society does not perceive these individuals as victims of circumstances beyond their control it also follows the belief that their actions are not based upon any meaningful logic. That is, the legitimacy of their own sense of personal agency is called into question. The result is an invalidation of these people as active and creative beings. We have up until the present denied their right to vote; we have denied them opportunity to refuse treatment that they have considered detrimental to their own health; we have denied their say in whether or not they should be hospitalized; we have stigmatized them as undesirables to which end physical mobility becomes problematic; we have put stipulations on their right to own property and to make a

will of their estate. And further to these denials, a medical history of mental illness produces easier access to future incarceration for behavior which is perceived by others as not in keeping with a particular social order.

Through this removal of personal agency, society had adopted the idiom "crazy" to represent an assumed population of people that have been selectively designated by the medical community as incompetent to handle their own life. The whole notion of personhood is attacked and scrutinized, and has left these individuals with titles, such as, mental patient, madmen and abnormal. Their master status, in other words, becomes what they are and how they are to be treated. The fact that they are people who think and do things like any other person is not taken into consideration, or more appropriately, taken for granted.

4.3 Implications of Utilizing a Human Agency Perspective

The human agency perspective has de-mysticized "disordered" behavior as either sick behavior in accordance to any organic diagnoses or as a label applied to describe victims of a social category. What is has revealed is that all individuals are constructive beings, each attempting to forge their way through life with a skewed perception of reality. These perceptions have left some of us more visibly handicapped than others to present a sustainable self, and thus, many social actors are left with an inept ability to cope with the demands of social interaction in a cultural milieu.

But then the implications of this perspective creates a problem of human rights and the delivery of service to post-psychiatric patients. If they are sick, the experts can act in accordance to the justification

of their own assumption of what a behavior represents. Currently, Manitoba's legislation of the Mental Health Act dictates that psychiatric commitment only requires the signature of two physicians. Beyond this, there is no formal procedure by which to objectively discern the presence or absence of pathology or the circumstances which led up to such behavior.

If these social actors are not unlike others who deviate from norms of society then why are they not given the same rights as these individuals? In the criminal justice system those who stand accused of violating rules of the cultural order are given the opportunity to present their situation through several channels of authority, i.e., the police, a defense council and the courts. Furthermore, there is a structure of procedures which must be complied with in order to process any form of conviction. For example, in the United States a Miranda warning must be read to the accused. Individuals can only be detained for set periods of time before having their cases heard before the court. Even when the accused is sentenced to a period of incarceration, the length of the confinement is pre-established. Psychiatric incarceration, however, covers an indeterminate period of time.

By putting this perspective into practice it would immediately make the psychiatric profession accountable to the legal justice system. Psychiatrists would no longer be able to personally justify a course of action without defining their judgement before a court of law. Past research on situations in which the prestige of the psychiatric profession was called into question has revealed a marked tendency to reverse the designation of sane people as insane (Rosenhan, 1973:252).

That is, rather than focusing on the concern of producing a Type I error, clinicians were more apt to pay attention to their own diagnostic acumen.

The implementation of this perspective would also have a profound impact on the recipients of this care. No longer would they be expected to passively comply with the dictates of a psychiatrist. Rather than perceiving their situation as hopeless and above the law, they would be given the opportunity to either plead their case or have an advocate represent them. Wenger and Fletcher (1969:69) found in their study of representation in mental hospital commitment hearings that of eighty-one cases observed, 91 percent (61 of 66) of those without legal council present at the hearing were committed to the state hospital. Of the 15 subjects with an attorney, only 4 (26 percent) were admitted.

These figures can in no way reflect any future trends if this perspective was put into action but what they do indicate is a possible change in the actualization of psychiatric patients' rights. Furthermore, recipients of psychiatric care would have the right by law to actively question their prescribed rehabilitation format. Thus, the delivery of psychiatric service like other forms of medical intervention would be conducted with the consent of the individual in question.

While it maybe possible to deny a "sick" person their rights, it is infinitely more difficult, in a democratic state, to deny a person (an autonomous agent) of his or her rights simply because they are experiencing dis-ease in their personal lives. The reliance on the legal system to resolve these issues entails the adoption of a new set of problems, i.e., on already over-worked system, the use of legal rather

than medical definitions of social behavior, but within our given cultural reality, such a process, would protect the civil liberties of all norm violators. That is, the decision to intrude into anyone's life should be scrutinized to assess its validity. While this course of action may be a more just system than relying solely on the judgement of psychiatry, it cannot be considered an encompassing solution to alleviating the plight of psychiatric patients, many will still be detained because they're viewed as dangerous to themselves and others.

The question then arises, what does need to be changed in order to provide the possibility of expanding horizons for competence and self-esteem. We could change the system as indicated by the move toward a dependency on the legal justice system, but the fact is, psychiatric intervention did not create the problem. The problem must be stopped at its source. If we want change, its necessary to get at the family, the double binds, incest and abuse that are the fountain head.

Psychiatry has facilitated many individuals to exist in a simplified environment. The point, however, is that the casualties of this process are carrying the burden of an inadequate socialization; such people are often frail, brittle and would collapse without the constraints laid on them. They can manipulate a simplified set of social circumstances but many would be overwhelmed if they had to negotiate daily life without some shielding. What is required is a means to enable these individuals to become fully functional autonomous agents. In addition to providing some greater hope of a better future with rehabilitative techniques such as, long term and costly psychotherapy, we need to prevent the underlying causes of personal

ineptitude.

Prevention would often require intrusion into the family of origin. Such a solution, however, is outside of our cultural and political reality. It would require, for example, the de-medicalization of psychiatry and possibly moving it to an educational faculty whereby at least some degree of pathological family interaction could be halted. Furthermore, this solution would also require a change in the social perception of what "disordered behavior" really involves. Families are not receptive to outside intrusion. Before they can be expected to "open their doors" it's necessary that families be educated as a means of "opening their minds."

4.4 Future Research

This thesis, utilizing a human agency approach to the study of madness has helped to uncover not only the phenomenological reality of strange or uncomprehensible behavior, but further, the purposefulness and intentionality around which it is organized. The prevailing perspectives do not appear to be able to account for all the facts. The human agency perspective appears much better able to account for the means by which individuals defined as mentally disordered, do in fact, exhibit various degrees of residual agency in the construction of their own reality.

There are certain areas of investigation which future research could focus on. Theoretically, the human agency perspective could be utilized in uncovering the motivational structure of other socially defined collectivities. It could be used to examine the reality of individuals involved with the criminal justice system. Another

investigation could look at the ways in which institutionalized individuals make sense of their particular situation.

Methodologically speaking, one future project would be to repeat this study on madness utilizing a better data base. A cross examination of more clearly defined information could be obtained if the population under study was selected according to specific variables, i.e., age, degree and type of involvement with mental health system, family support network. There have been studies conducted by the Canadian Mental Health Association (1987) on supportive housing programs for the mentally ill, but they have focussed primarily on the integrative mechanisms of the program, rather than activities conducted by recipients to integrate their own lives with the broader community context.

Finally, it is increasingly clear to this author that madness must be viewed as a personal response to a constrictive debilitating environment. Our present system of community rehabilitation fails to recognize mad behavior as part of an overall aspect of all human behavior, and thus, perpetuates a prohibitive milieu which only prolongs human dependence. Rather than facilitating the process in which these individuals can learn to want to overcome their own situation the community mental health system fosters paternalism; the same structure which created ineptitude in the first place.

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