An Examination of Some Factors Involved in Lay Definitions of Mental Illness

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AN EXAMINATION OF SOME FACTORS INVOLVED IN LAY DEFINITIONS OF MENTAL ILLNESS

by

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Abstract

The study of mental illness has recently become a focus for sociological attention. Despite this focus, the tenets of the dominant theoretical orientation in the area, the societal reaction or labeling approach, require both theoretical clarification and empirical grounding. Therefore, there is a need for research directed towards these ends. The present study examines one ambiguous aspect of the societal reaction perspective.

According to this approach, mental illness is the product of a series of social contingencies, the most important of which is people's definition of (and subsequent reaction to) an individual as mentally ill. This definition is supposedly predicated upon deviant behavior in the form of a residual rule violation by the individual, and is facilitated by a number of social and situational factors, the most notable of which is labeling by a mental health professional. This research attempts to examine systematically the relative effects of individual behavior and expert labeling on people's definitions of an individual as mentally ill.

The research design took the form of a survey experiment in which participants (208 summer school students at the University of Manitoba) completed one of nine possible questionnaire versions. The nine versions represented the cells of a 3x3 factorial design in which behavior and labeling were varied. Specifically, the conditions of the behavior variable consisted of a rule violation which was non-residual, ambiguous or residual, while the label conditions comprised weak, conflicting or strong expert labeling. Participants reached a definition of a hypothetical individual presented to them in the version they received as mentally ill or not mentally ill.

Crosstabulations of the research results indicated that the number of participants reaching definitions of mental illness increased as the behavior presented varied from non-residual (33.8%) to ambiguous (70.4%) to residual (76.8%). Labeling had an enhancing effect: the number of definitions of mental illness within each of the three behavior categories increased as labeling changed from weak to conflicting to strong. A multiple regression analysis indicated that the behavior variable explained 8% of the total variance, with 'label' accounting for 5%. None of the demographic variables analyzed (age, sex, student status/occupation) were significant.

The results indicate that lay people define others as mentally ill on the basis of the others' behavior (i.e., whether or not it constitutes a residual rule violation) with expert labeling serving to facilitate these definitions. The extent to which these conclusions can be generalized to other situations and other types of behavior is a question for future research, but this exploratory study suggests the relative importance of behavior and labeling in the process of societal reaction.

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I. Theoretical Approaches to Mental Illness

A. Introduction

The study of mental illness, which was traditionally within the exclusive domain of medicine/psychiatry, has become a sociological concern over the last several decades. In the quest for an understanding of mental illness, sociologists have focused their attention on the social factors involved in its genesis, its treatment and its distribution in the population. There have emerged two basic theoretical approaches to the phenomenon within the discipline -- the medical model and the societal reaction or labeling perspective -- and there is a growing corpus of literature comprising the sociology of mental illness. However, many of the central theoretical propositions have not been empirically validated or clarified and hence there is a need for research directed toward this end.

The present study deals with one such ambiguous issue in the societal reaction approach. According to this perspective, mental illness is the product of a series of social contingencies, the most important of which are people's definition of, and subsequent reaction to, an individual as mentally ill (Scheff, 1966; Lemert, 1951; Goffman, 1961). This social definition is supposedly predicated upon deviant behavior on the part of the individual and facilitated by a number of social and situational factors, the most notable of which is labeling by others (i.e., of the individual as mentally ill). However, despite the posited importance of this contingency in the genesis of mental illness, the specific conditions under which social members define a person as mentally ill have not been empirically established. The existing studies of the definitional process have concentrated upon

factors involved in professional definitions of mental illness, and so research aimed at clarifying the factors which figure in lay definitions is necessary.

Thus, societal reaction theory and research will be reviewed and hypotheses regarding the conditions under which lay social members come to 'label' others mentally ill will be derived. Specifically, the following questions will be considered:

1. To what extent does an individual's behavior affect lay others' definitions of him/her as mentally ill?;
2. To what extent does expert labeling of an individual as mentally ill affect lay others' definitions of him/her?;
3. How do the foregoing two factors (i.e., individual behavior and expert labeling) interact to affect lay others' definitions of an individual?.

A research design will be formulated to supply answers to these crucial questions, thereby illuminating the conditions for lay labeling and providing the societal reaction perspective with a measure of the empirical grounding which it clearly requires.

Before turning to this task, however, it is necessary to situate the theoretical framework for this study within the context of the sociology of mental illness. As noted, the societal reaction approach is one of two general orientations; the other is the medical model. The two may be dichotomized on the basis of the level of analysis at which they attempt to explain mental illness: the former focuses upon the interactional matrix, while the latter posits the individual, psychological nature of the 'disease'. Because societal theory developed largely in response to the traditional medical orientation, a review of

its basic concepts is warranted. To this end, a description of the medical model and an evaluation of its sociological relevance will be provided prior to turning to an exegesis of societal reaction.

B. The Medical Model

The several schools of thought comprising the medical model are united by a shared focus on the mentally ill individual as the locus of the disease and, hence, of treatment. Implicit in this approach is the assumption that mental illness exists as a disease entity, either literally (i.e., physiologically) or figuratively (psychologically) and thus the way to learn about it is to study the individual afflicted with it (Szasz, 1961; 1970). Such individuals are located for investigation on the basis of expert diagnosis in the same way that a physical pathology such as diabetes is studied by locating physician-diagnosed diabetics.

Proponents of this orientation therefore employ the elements of the medical model of disease in constructing their conceptions of mental illness. These elements, which include pathology, etiology, nosology, therapy and epidemiology, have been scientifically proven to be invaluable in the study of illnesses afflicting the body and so it is assumed that they are equally appropriate in dealing with those which afflict the mind. The validity of this assumption is, according to critics, highly questionable inasmuch as mind and body have little in common and hence no matter how efficacious concepts prove in explicating the latter, they cannot be relevant to the study of the former (Leifer, 1969; Scheff, 1967). In order to understand the basis of this criticism, the five aforementioned elements will be defined and briefly discussed

as they apply to mental illness, followed by an evaluation of the correspondence between physiological and mental disease.

The first element of the medical model, pathology, concerns the nature and process of disease. As it is applied to mental illness, it carries with it the assumption that there is within the individual a state of illness which persists and/or develops over time (Taber, et al., 1968). The study of pathology focuses upon this posited disease process, attempting to isolate the accompanying signs and symptoms in order to improve diagnostic accuracy by refining the classification system. In physiological pathology, this involves the specification of the patient's symptoms -- his/her subjectively perceived bodily state (e.g., pain) -- and, more importantly, the objectively verifiable physiological signs such as fever or the presence of certain micro-organisms, which document the existence of a particular type of pathology. In mental illness, however, the deviant behavior which constitutes the symptomatology by which the disease is recognized is tautologically explained only by the pathology it documents. In other words, mental illness lacks the objective signs by which other forms of disease are diagnosed and classified. While there are many behavioral indicators that are taken to be symptomatic of mental illness, the absence of signs is a feature unique to this type of pathology.

An important corollary of the premise of pathology is that the individual is not responsible for his/her behavior or condition because he/she has lost control to the imputed pathogen (Wootton, 1959:207; Taber, et al., 1968).

Related to the concept of an extant disease process within the (mentally) ill individual, is the notion of etiology or causation.

Advocates of the medical model conform to the belief that there is "a pernicious agent and a causal sequence" in the case of mental illness as in other forms of disease (Taber, et al., 1968). Given the aforementioned assumptions of pathology, it follows that the etiology of mental illness is sought within afflicted individuals. Thus, the physiological and/or psychological attributes of people presumed to be mentally ill are examined for commonalities from which causal elements are posited.

The concept of nosology in medicine involves the classification of diseases according to specific and unique patterns of symptoms, signs and causes. In the realm of mental illness, classification presumes that the causes, signs and symptoms of diseases of the mind, like diseases of the body, exist objectively[1] (i.e., independent of culture and values) and hence, that each instance of illness can be accurately and objectively diagnosed and classified on the basis of the pre-defined symptomatology specified by the nosological scheme (Wootton, 1959:207). In other words, mental pathology can be placed in distinct diagnostic categories (the most common of which are contained in the Kraepelinean classification system) because it is assumed that "qualitatively different states of disorder in the personality do exist and may be

[1] The failure of research to isolate objective disease signs is generally explained by mental health professionals (when acknowledged at all) as the result of insufficient research rather than the non-existence of these signs. This is not considered a major issue, however; psychiatrists, like other medical specialists, place far more emphasis on clinical evidence than on research findings. As practitioners, their aim is action and not esoteric knowledge (Freidson, 1970b:98) and thus the experience they acquire in dealing with patients "provides a basis for therapeutic choice that is believed to be superior not only to the abstract considerations posed in textbooks but even to general, scientifically verified knowledge." (Freidson, 1970b:86).

identified." (Taber, et al., 1968).

The fourth element in the disease model is therapy -- the treatment necessary to produce rehabilitation or cure (Scheff, 1967:2). The underlying assumption is that the diseased individual requires therapy to get well and this therapy must be of the appropriate type to produce the desired return to health (Taber, et al., 1968). The applicability of the concept of treatment to mental illness is predicated on the additional assumptions that mental illness is amenable to treatment and cure, that the appropriate therapeutic techniques exist, and that without it the condition of those afflicted will deteriorate rapidly (Scheff, 1967:110-111).

Finally, the medical model assumes that disease is neither uniform nor random; rather, it occurs in identifiable and meaningful patterns among different human groups (Coe, 1970). Unlike the previous components, epidemiology moves beyond the examination of discrete individuals to the macro-social level of collectivities. For those working within the medical model, epidemiological research supplies additional information about the nature and causes of disease. In the case of mental illness, studies of this type generally locate socio-culturally and geographically the diagnosed mentally ill. By specifying the age, sex, socio-economic status, place of residence and other demographic attributes of those afflicted, the configurations of the disease in the population can be established and possible elements in its etiology are suggested (Freidson, 1970b:8).

Having defined the terms of the medical model, it is now possible to assess the validity of applying these concepts to mental illness[1].

[1] This is not to imply that these concepts are perfectly applicable to physical illness. They represent an ideal-typical model to which diseases of the body correspond to a greater or lesser extent.

It was previously noted that the major criticism regarding their application stems from the fact that the elements of the model were developed around physiological illness, from which mental illness differs radically. The most obvious difference lies in the dissimilarity of the focus of attention for investigators of the two phenomena -- medical scientists who study the former are concerned with the body as a 'physio-chemical machine', whereas mental health professionals are concerned with the mind as manifested in behavior. Physiological disease is an objectively (i.e., scientifically) verifiable disruption of the structure and/or function of the body machine (Leifer, 1969:19), whereas mental disease is rooted in the social entity of mind, which can only be inferred from the subjective evaluation of individuals' behavior (Szasz, 1961).

To return to the point made previously, mental illness is without the bodily signs by which other types of pathology can be independently established as definite and distinct disease entities. It is due to this fundamental difference that the presence or absence of physical disease in the body can be scientifically proven, since

> "what health is can be stated in physiological and anatomical terms" (Szasz, 1966:24)

(i.e., in terms of signs). However, the existence of mental illness remains largely a matter of value judgment about the appropriateness of any given action (i.e., whether or not it is interpreted as symptomatic). Hence, mental health professionals are involved in a qualitatively different type of decision-making (i.e., social as opposed to physiological) than medical professionals because their data (behavioral acts)

are qualitatively different from the bodily signs and conditions on which medical diagnoses are ultimately based (Leifer, 1969:31)[1].

It may be further argued that the concepts of medicine are not appropriate to define mental health or illness. While physiological health may be understood in terms of homeostasis, adaptation and conformity to population norms, the efficacy of these terms in the assessment of mental health is questionable, due to the socio-political connotations of such terms in the behavioral arena (i.e., only acceptance of and conformity to a status quo which may be antithetical to one's own best interests, constitutes health) (Wootton, 1959:217). Leifer concludes:

> "The use of the medical model to conceptualize psychiatric patients and practitioners may be challenged by a critique of the fit of medical and biological concepts to human social behavior. While these concepts may be useful for understanding biological survival and adaptability, their utility for understanding the rules, games, meanings and values of social action are highly dubious."
>
> (Leifer, 1969:21)

[1] This does not mean that there is no agreement among psychiatrists and/or psychologists regarding indicators of mental illness. For example, an individual who expresses the belief that everybody is plotting against him or her would likely be diagnosed as paranoid with a high degree of reliability. However, the fact that he/she is reliably diagnosed does not establish the validity of the diagnosis; to do so, it would be necessary to prove the (independent) existence of the disease via signs, which, as aforementioned, have not been determined for any kind of 'mental' illness (excluding, of course, pathologies of the brain such as tumors, lesions, etc., which remain within the province of other medical specialists such as neurologists).

Thus, the attempt to understand the phenomenon of mental illness which is established on the basis of some perceived behavioral deviation from 'certain psychosocial, ethical or legal norms' (Szasz, 1966:25) in terms of a model formulated to deal with the dissimilar phenomenon of illness of the body cannot succeed. Empirical research supports this contention: when the concepts of the medical model which have proved so illuminating in the investigation of physiological illness are employed to study mental illness, they have not proved nearly so illuminating. It remains impossible to state unequivocally in medical (scientific) terms, what mental illness is, what causes it, how the different types can be classified, and how it can be effectively treated. The lack of success[1] of psychiatric diagnosis and treatment based on this model is summarized by one critic who states on the basis of a review of research:

> "The assumption that psychiatric disorders usually get worse without treatment rests on very little other than evidence of an anecdotal character. There is just as much evidence that most acute psychological and emotional upsets are self-terminating. ... (I)t is still not clear, according to systematic studies evaluating psychotherapy, drugs, etc., that most psychiatric interventions are any more effective, on the average, than no treatment at all."
>
> (Scheff, 1967:111)

[1] It should be noted that this failure refers only to the inability of medical concepts to specify the nature of mental illness. Certainly the discipline of psychiatry has been very successful in obtaining popular acceptance of its claims that mental illness is a disease which can be understood and treated within the medical model by specialists who are medical doctors.

(Kittrie, 1971; Leifer, 1969)

Another concludes:

> "The premises of nosology (diagnostic categories) and etiology (necessary and sufficient causes) have not withstood rigorous examination, and the large body of scientific work based on these premises is not cumulative. The premises of pathology (disease process within) and treatment (directed intervention) are largely unexamined."
> (Taber, et al., 1968)

It is apparent from the foregoing discussion that mental illness differs from physiological illness in several crucial ways. Studies of the latter focus on the physiological structure and function of the body, whereas those dealing with the former focus on the social entity of mind as inferred from behavior. Pathology of the body is determined by both symptoms and objective signs, while the existence of mental pathology cannot be validated by any scientifically verifiable signs, because none have been determined. Finally, the criteria by which physical health is assessed have very different connotations when applied to human social behavior. For these reasons, then, the application of the terms of the medical model to mental illness does not appear to be warranted and cannot further understanding of this qualitatively different phenomenon.

Despite the invalidity of conceiving of mental illness in medical terms, the fact remains that a substantial amount of sociological work has employed this model. Therefore, a comment on the nature of this work is in order before turning to the other major paradigm in the sociology of mental illness.

Not surprisingly, the concerns of pathology, etiology, nosology and therapy are the domain of mental health 'professionals' -- doctors, psychiatrists and clinical psychologists. The activity of sociologists within this paradigm is confined primarily to epidemiological studies

designed to situate and describe those designated by the above professionals as mentally ill (cf., Dunham, Hollingshead and Redlich, Kaplan, et al., and Roberts and Myers in Spitzer and Denzin, 1968)[1]. Despite the large corpus of literature, the contribution of this type of work to the development of a sociological understanding of mental illness cannot be assumed.

Perhaps the most serious criticism of epidemiological investigations is that they are not based upon the concerns and definitions of sociology. Rather,

> "(b)y and large, epidemiological studies are conducted within the medical or psychiatric framework, accepting, without reservations, the various assumptions that are implicit in a medical model of mental illness."
> (Scheff, 1967:2)

To use Straus's (1957) dichotomy, such studies constitute sociology in medicine as opposed to sociology of medicine inasmuch as the terms of, and issues for, investigation are medical and the goals are medically pragmatic. It is apparent, then, that the information provided by them cannot be directly relevant to a sociological theory aimed at developing an understanding of the social factors involved in the genesis and recognition of the phenomenon of mental illness because this is not their aim. Such studies are intended to serve the ends of mental

[1] For example, Roberts and Myers surveyed people receiving psychiatric treatment in New Haven to determine their religion, national origin and immigrational status. These characteristics then were correlated with respondents' type of mental illness (as diagnosed by their psychiatrists). The results indicated that psychoneuroses were more frequent among Jews, alcoholism was higher among Irish Catholics, and schizophrenia was not related to the variables analyzed.
(Roberts and Myers, 1968)

health professionals and any specifically sociological import which they may have is serendipitous (Freidson, 1970b:46-47). For this reason, research dealing with the epidemiology of mental illness is allotted a position of secondary significance within the disciplines of both sociology and medicine (i.e., it is not strictly sociological because the medical model is employed, but neither is it medical research because the methods employed and the focus of attention are social).

In light of the marginal relevance of the sociological work conducted on the basis of the medical model coupled with the previously noted inapplicability of the terms and assumptions of this model to the phenomenon of mental illness, it is not surprising that an alternative theoretical approach based upon explicitly sociological principles and goals should emerge. It is towards this other major approach that attention will now be directed.

C. Societal Reaction Theory

The societal reaction or labeling perspective of mental illness which supplies the theoretical framework for this thesis was developed, in part, in response to the perceived deficiencies of the medical model. Based primarily on the work of Lemert (1951), Erikson (1957), Goffman (1961), Becker (1963) and Scheff (1966), it employs the conceptual tools of a more general sociological theory of deviance to "construct a theory of mental disorder in which psychiatric symptoms are considered to be labeled violations of social norms, and stable 'mental illness' to be a social role" (Scheff, 1966:25). The application by these theorists of the tenets of labeling theory to mental

illness marked a major shift from the long dominant medical conceptualization of the phenomenon. Proponents argue that mental illness is not an individual pathology, but rather a socially constructed product which emerges over time from the processes of interpersonal interaction. It is these processes (most notably the definitions and reactions of others) which are regarded as instrumental in producing extant or recurrent mental illness and stable populations of the mentally ill, and therefore the medical model's focus on isolated cases of professionally diagnosed pathology is deemed inappropriate. Instead, it is contended, attention must be directed towards the social matrix, for, in the words of one labeling spokesperson,

> "at the present time the variables that afford the best understanding and prediction in the course of 'mental illness' are not the refined etiological and nosological features of the illness, but gross features of the community and legal and psychiatric procedures."
>
> (Scheff, 1966:29)

Thus, labeling theorists shift the emphasis from internal 'causes' of the deviant behavior which is supposedly symptomatic of mental illness, to the social factors and processes involved in the recognition and definition by other individuals of behavior as an exemplification of this type of deviance. They are concerned with the way in which social members come to ascribe mentally ill identities and the subsequent effects of these ascriptions on the careers of the labeled individuals. Proponents claim that without these crucial contingencies of social definition and the consequent reaction, stable cases of mental illness would not arise. In positing the social nature of deviance, then, they eschew the naively asocial etiological position assumed by

other theoretical schools in the area[1] and focus their attention on the processes of interpersonal interaction. It is this expanded focus (which includes not only deviant actions and actors, but also social members' definitions and reactions) which has been dubbed the 'hallmark' of the labeling perspective (Schur, 1971:8), and which serves to render the factors involved in the genesis of mental illness amenable to sociological investigation.

It is necessary to elaborate upon the foregoing with a systematic discussion of the central themes of the perspective. The ensuing exegesis will examine the nature and causes of mental illness, the contingencies involved in its development and the methodology appropriate in its study, according to the societal reaction approach. Because theorists of this school have not yet supplied a definitive description of the labeling theory of mental illness (D'Arcy, 1976), the delineation will draw not only upon the statements dealing explicitly with mental illness, but also upon those addressing the more general phenomenon of deviance.

1. The Nature of Mental Illness

As noted, labeling theory regards deviance as the product of social ascription rather than individual achievement: deviants of any type are seen as initially not qualitatively different from their 'normal' counterparts; that which sets them apart is others' recognition and treatment of them as outsiders. In short, it is social definition which gives rise to social differentiation (Rubington and Weinberg, 1977:197). In the case of mental illness, this contention

[1] The most obvious example is, of course, the individually-oriented medical model of mental illness.

is supported by the fact that the medical/psychiatric symptoms of mental illness are vaguely defined and, like any definition of behavior, involve a high degree of subjectivity and value judgment. It is not surprising, then, that the diagnostic reliability of 'mental health professionals' (psychiatrists, psychologists, doctors) is low (Scheff, 1966:46; Mechanic, 1968:100-107; Temerlin, 1975), since mental illness is regarded as more a matter of extra-individual considerations than the individual's objective, diseased nature. In other words, it is not what he/she is or does that makes an individual mentally ill, but what others make of and do to him/her. Scheff summarizes:

> "the status of the mental patient is more often an ascribed status, with conditions for status entry and exit external to the patient, than an achieved status with conditions for status entry dependent on the patient's own behavior. According to this argument, the societal reaction is a fundamentally important variable in all stages of a deviant career."
>
> (1966:129)

The importance placed upon other people's decisions that an individual is mentally ill and their subsequent treatment of him/her as such is readily apparent. These definitional processes which are manifested in the interaction between the (potentially) mentally ill individual and other social members, comprise the sine qua non of this, like other forms of 'sociopathic individuation' (Lemert, 1951). The advantages of taking this position on the nature of mental illness are two-fold. First, it enables advocates of the societal reaction approach to remove mental illness from the inaccessible realm of individual psychological defects and locate it squarely within the observable social world. Illustrating this point, Lemert's comments on paranoia are equally germane to mental illness in general:

> "By thus shifting the clinical spotlight away from the individual to a relationship and a process, we make an explicit break with the conception of paranoia as a disease, a state, a condition or a syndrome of symptoms. Furthermore, we find it unnecessary to postulate trauma of early childhood or arrested psychosexual development to account for the main features of paranoia ...".
>
> (Lemert, 1962)

Second, the relativity and subjectivity of the concept of deviance is acknowledged, enabling investigators to take into account not only the definitional processes involved in the ascription of deviant identities, but also the effects of the values of the group(s) doing the defining and the situational influences involved. Becker summarizes the logic of this position:

> "It is easily observable that the different groups judge different thing to be deviant. This should alert us to the possibility that the person making the judgment of deviance, the process by which that judgment is arrived at, and the situation in which it is made may all be intimately involved in the phenomenon of deviance."
>
> (Becker, 1963:4)

It follows that the proponents of the labeling approach regard the behavior and character of deviating individuals as merely one element (ranging along a continuum of importance) involved in the creation of deviance. Because the crucial variable is social definition, how an act is defined socially transcends the primacy accorded to the act <u>per se</u> in other theories of deviance. Hence, labeling theory assigns priority to the reactions of others in its explanation of mental illness and, as such, it is a theory of recognition and

definition wherein the nature of this, like other types of deviance, is both social and relative[1]. Erikson summarizes:

> "'Deviance is not a property inherent in certain forms of behavior; it is a property conferred upon these forms by the audiences which directly or indirectly witness them. Sociologically, then the critical variable is the social audience ... since it is the audience which eventually decides whether or not any given action or actions will become a case of deviation.'"
>
> (Schur, 1971:12)

This emphasis on other people's definitions in determining what constitutes an instance of deviation does not mean that labeling theory suggests that social rules do not exist or that actions which technically violate these rules do not occur. Rather, the theory draws a distinction between rule violations which do not come to social attention and those which do. Of these two types of deviance (which are designated as primary and secondary, respectively), the former is regarded as less sociologically important[2].

[1] As a result of this attention to reaction (i.e., the audience's role), labeling theory has been faulted for a lack of concern with the role of individuals' actions in the development of their own (deviant) identities. Critics contend that proponents of the perspective have gone too far in their attempt to 'round out' the one-sided approach presented in the medical model by stressing social reaction to the exclusion of any other factors. As a result, labeling theory is equally one-sided. This accusation will be discussed subsequently in the section examining the perspective's problems.

[2] This is not to suggest that undetected rule-breaking is completely irrelevant; rather, since these perpetrators do not come to be recognized and treated as deviants, labeling theorists choose to study the more obvious and accessible group of detected rule-breakers. This choice has led to accusations of political naiveté and status quo bias (Liazos, 1972), since the focus on how people become deviant removes attention from the more general question of why some people become (socially sanctioned) deviants and others do not. Suffice it to say that the decision to focus on one set of problems necessarily involves the exclusion of other problems, but this does not mean that these other problems do not also warrant investigation.

It is necessary to elaborate upon the nature of this dichotomy, since it is central to the approach at hand. Other theories of deviance fail to make a distinction between these two types of deviance due to their lack of concern with social reactions (i.e., anything beyond the commission of a deviant act). Labeling theory, however, because of its wider focus, recognizes the difference between instances of simple rule-breaking on the one hand, and actions (and actors) which are socially recognized and treated as deviant, on the other. The majority of simple rule-breaking behavior is either unnoticed, normalized, rationalized, denied or ignored by the social audience (Hawkins and Tiedeman, 1975:112)[1]. In other words, it is not singled out for consideration and defined as a key feature of the rule-breaker's identity. Since it does not become the basis for further interaction, labeling theorists regard such primary deviations as of minor importance. As one proponent states:

> "deviations are not significant until they are organized subjectively and transformed into active social roles and become the social criteria for the assigning status."
> (Lemert, 1951:75)

Hence, deviant acts achieve sociological import only when they are recognized and defined by others as such and the rule-breaker is treated as deviant (i.e., when they become the basis for the ascription of a deviant social identity.

[1] For example, a study by Yarrow, et al.,(1955) examined the wives of mental patients to determine their initial interpretations of their husbands' deviant behavior. The results indicated that the husbands' rule-breaking was frequently attributed to physical problems, character weaknesses (e.g., laziness, meanness) or environmental conditions.

If, as a result of this differential treatment, the rule-breaker redefines himself/herself and adopts a deviant self-identity (as he/she may be forced to do if societal reaction is strong and/or widespread), he/she moves from the realm of primary to that of secondary deviance. The latter is defined by Lemert as

> "'deviant behavior or social roles based upon it (i.e., deviant behavior), which becomes a means of defense, attack or adaptation to the overt and covert problems created by the societal reaction to primary deviation.'" (Gove, 1975:4)

An individual becomes a secondary deviant when he/she accepts the role ascribed to him/her by others and employs it in his/her interaction with them. It is this acceptance of a deviant identity which constitutes labeling theory's self-fulfilling prophecy -- he/she has become that which he/she is purported to be (i.e., the type of person whose deviant actions are neither random nor incidental to his/her identity).

In terms of mental illness, the foregoing discussion indicates that, while many people technically violate the kind of rules which might earn them a mentally ill social identity, the majority of this behavior remains primary deviation (Goffman, 1961). Those who come to be publicly designated and treated as mentally ill constitute the secondary deviants for whom mental illness has been socially stabilized into a principal social role or 'master status' (Becker, 1963)[1].

[1] While Becker was the first to apply this term to deviance, the concept was developed by Everett Hughes, who employed it in regard to the effects of color or race: "Membership in the Negro race, as defined in American mores and/or law may be called a master status-determining trait. It tends to overpower, in most crucial situations, any other characteristics which might run counter to it." (Hughes, 1958:111) (Emphasis added)

It is this latter group with which the labeling theory of mental illness is concerned inasmuch as they are, in social terms, the 'real' mentally ill (i.e., they are defined and treated as such).

The transition from primary to secondary deviance on the basis of others' definitions/reactions essentially comprises the labeling theory of the creation of stable populations of deviants. The particulars involved in the stages of this transition will be examined subsequently; at this point, however, it is sufficient to note that, according to this theory, mental illness is more than simple rule violation. An understanding of the nature of the phenomenon requires investigation of the social variables which, over time, render certain of the numerous social members who engage in transitory episodes of deviance, qualitatively different from others (i.e., secondarily deviant).

2. The Nature of Social Life

The model of social life posited (or assumed) by the labeling perspective underpins the conception of deviance and reflects the theory's roots in symbolic interactionism. Because the attribution of deviance to actors is regarded not as the discovery of a pre-existing objective state, but rather as the culmination of negotiation on the part of members of the audience, and between them and the individual upon whom they have focused their attention, a processual, as opposed to a static, conception of social reality emerges. Hence, deviant actions and actors are products of the process of social interaction. This view of social life takes into account the active, creative role played by members in the construction of their reality, thereby avoiding the psychological or social determinism which would result from the presumption of a static social world.

The notion of social life as produced, maintained and changed through the processes of interaction (primarily of a symbolic nature) among members is a basic tenet of symbolic interactionism (Mead, 1934). Labeling theory, as an extension of the basic concepts of this approach to the substantive area of deviant behavior (Davis, 1975; Rubington and Weinberg, 1971:195), clearly adopts this tenet, and posits deviance as one aspect of social life which is so generated. As members' identities continually emerge from the processes of interaction, so deviant identities emerge in the same sequential fashion, subject to the myriad contingencies of social life (Becker, 1963).

This theme of process is reflected by labeling theory's use of the concept of 'career' which is usually employed to denote movement through a series of positions in an organization, but which also may be used to describe the more general phenomenon of individuals' social progress throughout the course of their lives. The concept is comprised of two dimensions:

> "Objectively, a career consists of the passage through various statuses, roles, and positions. Subjectively, a career is made up of people's perceptions of themselves as they move through different groups, organizations, and institutions."
>
> (Haas and Shaffir, 1978:19)

Becker (1963) applies the term specifically to the stages involved in the development of deviance. Thus, becoming mentally ill, like becoming a doctor or lawyer, involves a series of promotions or status passages, each of which is dependent in part on the individual, but more on others (both lay and professional), whose validation is essential if he/she is to become (i.e., be recognized and treated as) a bona fide physician, barrister or lunatic. While the particulars of

these stages will be examined in greater detail subsequently, it is sufficient at this point to note that they are based on a processual model of social life wherein neither identities nor the order of which they are a part are fixed, but are rather always in the throes of becoming. The status quo at any given time for both is seen as the product of a number of varying interacting 'causes' (i.e., contingencies).

3. Causes and Contingencies

Given the importance attached by labeling theorists to social recognition of and reaction to deviant behavior in the creation of deviant identities, it is not surprising that the initial sources of such behavior are not regarded as theoretically relevant. It is proposed that deviance is polymorphous, potentially arising from any of a number of diverse psychological and social origins such as naïveté, defiance, culture conflict, anomie (Lemert, 1951:35-42), role conflict, and desire for personal gain (Gove, 1975:5). Initial deviant behavior (i.e., primary deviation) is "attributed to inconsistencies in the social structure, to hedonistic variables, or to ignorance, while psychological characteristics such as personality or psychiatric disorders are ignored." (Gove, 1975:5). Because the inherent ambiguity of human behavior is recognized in labeling theory, an understanding of the role of social definition in making people's actions understandable (and thereby supplying the grounds for appropriate reaction) is deemed the keystone in constructing an adequate account of the phenomenon of deviance. Thus, the search for specific individual etiological factors is eschewed, and labeling theory, consistent with its social, processual conception of the nature of deviance, searches

for 'causes' in the contingencies of social recognition and reaction, inasmuch as they serve to stabilize random deviant behavior into secondary deviation or established social roles (Schur, 1971:11). The imputation of a deviant identity or labeling by others figures so importantly in this stabilization process because we only come to know where we stand or who we are through people's reactions to us which they, in turn, base on who they think we are (i.e., imputed identity). In this way, our identities emerge and crystallize out of the flux of social interaction:

> "(A)ll individuals continually orient themselves by means of responses that are perceived in social interaction: the individual's identity and continuity of experience are dependent on these cues."
>
> (Scheff, 1966:63)

It is now necessary to examine the causal contingencies comprising the stages in deviant careers whereby, according to the labeling perspective, an individual's amorphous deviation is transformed into a mentally ill role. Goffman emphasizes the importance of these contingencies in the careers of the most obvious incumbents of this role -- the institutionalized mentally ill:

> "The society's official view is that inmates of mental hospitals are there primarily because they are suffering from mental illness. However, in the degree that the 'mentally ill' outside hospitals numerically approach or surpass those inside hospitals, one could say that mental patients distinctively suffer not from mental illness, but from <u>contingencies</u>."
>
> (1961:135)
> (emphasis added)

i) Rule Violation

There is general consensus among labeling theorists that the development of a deviant identity requires an initial violation of

some type of norm by an actor. Becker states:

> "The first step in most deviant careers is the commission of a nonconforming act, an act that breaks some particular set of rules."
>
> (1963:25)

The specification of this as a contingency may seem to be a restatement of the obvious, since virtually all theories of deviance begin with such a contention. However, the crucial difference between labeling theory and the others is that most of the latter also end there, while the former does not. Simple rule infraction or primary deviation may be a necessary prerequisite, but it is regarded as far from sufficient in the process of development of any kind of deviant identity. Indeed, some proponents do not even see this condition as necessary. Becker (1963), in his discussion of types of deviance includes the category of falsely accused deviants who, despite behavioral conformity, are nonetheless perceived as deviating and are treated as such. Under certain circumstances, then, social definition (i.e., labeling) alone is deemed sufficient to muster the societal reaction upon which the potential deviant's career is contingent. These circumstances will be examined subsequently, along with the intervening factors affecting the development of a deviant career.

At this point, it should be noted that the <u>type</u> of rule broken by an actor has important implications for both the type of label which may be invoked by others and the strength of their reaction. Perhaps the most obvious type of rule is the formally encoded regulations which constitute the law. Violators of legal rules are typically labeled criminal and they are liable to official (as well as informal) sanctions by way of social reaction. These sanctions, of course, vary according to the

seriousness of the transgression (e.g., sentences for shoplifting are lighter than those for grand larceny) (Hawkins and Tiedeman, 1975:33).

Less obvious are the rules for which violators may be labeled mentally ill. Unlike the preceding type, the nature of this category of rules is much more ambiguous and the potential sanctions for violators much less clearly defined. Different theorists have proposed different names for this class of rules. Hawkins and Tiedeman refer to them as constitutive rules, and define them as those norms which

> "are not codified or documented in writing, nor are they readily verbalizable or recognized in the sense of informal norms. These rules are the taken-for-granted conditions or background expectancies which are tacitly understood but routinely ignored in everyday life; these rules are recognized only in their breach."
> (Hawkins and Tiedeman, 1975:34)

Examples include norms governing personal space and involvement; people simply assume that others will maintain the proper interpersonal distance from them and present an adequately involved demeanor when engaged in interaction.

Scheff designates these assumed or 'common sense' norms as residual rules. They form (part of)

> "the assumptive world of the group, the world that is construed to be the only one that is natural, decent and possible"
> (1966:32)

and it is violations of the diverse and often seemingly trivial canons comprising the category which provide the basis for the attribution of mental illness (Scheff, 1966:34). Under the rubric of residual rule-breaking may be subsumed all deviations which cannot be otherwise categorized (i.e., as crime, rudeness, immorality, etc.): as such, it

is a default category which 'explains' seemingly inexplicable behaviors by attributing them to mental illness. Scheff concludes: "we can categorize most psychiatric symptoms as instances of residual rule-breaking or residual deviance." (1966:33)

Expressing the same idea in somewhat different terms, Goffman notes that the biographies of mental patients usually "document offence against some arrangement for face-to-face living" (1961:133). Similarly, Lemert (1962) believes that it is "playing fast and loose with the primary group values by the individual" such that his/her behavior appears ambiguous and unpredictable, which constitutes the kind of rule-breaking upon which imputations of mental illness are based.

The above attempts to specify the nature of the rules comprising the primary deviance of mental illness may be criticized for being vague, but according to proponents, this ambiguity stems from the rules themselves. Because they are so implicit and ubiquitous in the fabric of social life, these rules are nowhere explicitly listed nor are they actively taught. Members do not consciously or actively weave them into interaction -- they are an integral part of the whole cloth. Thus, although they are difficult to codify or even verbalize, social members nevertheless know a violation of these rules when they see one.

This is not to suggest, however, that no attempts have been made to specify the generic characteristics of residual rules. On the contrary, several authors have posited formal requirements of residual rule violations, but these requirements, not surprisingly, are not objective attributes of the rules <u>per se</u>. Rather, consonant with labeling theory's relativistic, interactional stance, they pertain to others' reactions.

It is suggested that it is the ability of others to role-take with the rule-breaker and supply him with a 'vocabulary of motives' (Mills, 1970) or an 'account' (Scott and Lyman, 1975)[1] which renders the violation understandable as some particular, well-defined type of deviance and hence, not an instance of residual rule-breaking (Wilkinson, 1974; Mechanic, 1962). Thus,

> "the evaluator attempts to understand the motivation of the actor. In the language of Mead, he assumes the role of the other and attempts to empathize. If the empathy process is successful, the evaluator is likely to feel that he has some basis for labeling the deviant act as 'delinquency', 'undependability' or whatever. It is primarily in those cases where the evaluator feels at a loss in adequately empathizing with the actor and where he finds it difficult to understand what attributed to the response that the behavior is more likely to be labeled 'queer', 'strange', 'odd' or 'sick'."
>
> (Mechanic, 1962)

While this conceptualization leaves unclear the content of the rules whose violation may produce attributions of mental illness, it does suggest one of their formal characteristics.

In response to questions regarding the specific etiology of residual rule-breaking, labeling theorists suggest that these potential precursors of mental illness, like any primary deviations, arise from such diverse sources as physiology (e.g., stigma), psychology (e.g.,

[1] Motive vocabularies are defined as social ascriptions which serve to facilitate understanding (and hence interaction) in situations where an individual behaves in an unanticipated fashion, by providing a reason for the problematic conduct (Mills, 1970). Similarly, accounts are described as normative justifications and excuses which prevent interactional breakdowns by bridging the gap between an individual's behavior and others' expectations (Scott and Lyman, 1975). These concepts are elaborated upon subsequently.

faulty socialization), situational factors (e.g., stress, ignorance) and intentional innovation or rebellion (Scheff, 1966:39-45). However, given the ambiguity and cultural relativity of the rules involved, transgressions are frequent and, coupled with the fact that the population of people recognized as mentally ill is relatively small and stable, attempts to specify the causes of individual motives underlying initial residual rule-breaking are deemed unimportant. It is clear from the above that most of the transgressors do not come to occupy mentally ill roles, so insight into specific etiologies does little to account for the phenomenon of mental illness -- the majority of this deviance remains primary:

> "Most residual rule-breaking is 'denied' and is of transitory significance. The enormously high rates of total prevalence suggest that most residual rule-breaking is unrecognized or rationalized away."
>
> (Scheff, 1966:51)

ii) Discovery

This position serves to direct attention to the additional social contingencies which figure in the stabilization of such deviation into a social role. The second contingency in the societal reaction model of the creation of deviance involves the discovery by others, either directly or indirectly, of an individual's rule violation. The development of mental illness therefore is contingent upon others' perception of an instance of residual rule-breaking, for without this, there would be no basis for them to define the individual and/or his/her actions as deviant, which, as noted, is central to the theory. The factors affecting the likelihood of this contingency being met will be subsequently examined.

iii) Definition

The next step in the development of deviance involves the definition of the perceived violation as an instance of some type of deviance and the subsequent ascription of a deviant identity to the actor. This contingency constitutes the crux of labeling theory, for without this designation of the act/actor by others, deviation, for all social intents and purposes, did not occur. Analagously, actions which others recognize as deviant, are deviant in that they (potentially) become the basis for future treatment of the actor as a deviant individual. The primacy of this social definition is reflected by Erikson:

> "'the critical variable in the study of deviance is the social audience rather than the individual person, since it is the audience which eventually decides whether or not any given action or actions will become a visible case of deviation.'" (Hawkins and Tiedeman, 1975:46)

In the case of mental illness, this contingency consists of others' decision that an individual has broken a residual rule (i.e., that his/her behavior was irrational or uninterpretable) and further, that he/she, and not just his/her behavior, is mentally ill. In order to explicate the process whereby people recognize residual rule-breaking and define it as symptomatic of mental illness, it is germane to return to the preceding discussion of the nature of residual rules. It was suggested that others attribute mental illness to an individual when they are unable to role-take with him/her (i.e., put themselves in his/her place and see his/her behavior as sensible or understandable). Put another way, they cannot supply him/her with a (socially accepted) reason or motive for his/her actions which makes 'good sense' to them.

At this point, it is necessary to clarify this contention with a statement of the sociological meaning of motivation. Unlike traditional

formulations which represent the concept as consisting of internal traits and states of individuals which cause behavior, the interactionist approach treats motives as the imputations and ascriptions of others which transform observed acts into socially intelligible building blocks of interaction (Blum and McHugh, 1971). Motives are imputed or ascribed to an individual when his/her behavior departs from the expected[1]-- in such a situation, motive provides an answer to the question 'why did the individual do what he/she did?'. In this way, they serve to link the problematic behavior with either understandable anticipated consequences (i.e., 'he/she did it in order to ...') or with situations and norms ('he/she did it because ...') (Mills, 1970). Thus, people attribute motives to render others' past actions and events meaningful to them, and an imputation which accomplishes this is, for all intents and purposes, the actor's reason(s) for doing what he/she did. This variation on W.I. Thomas's dictum[2] may be summarized as:

> "Any motive that is accepted (acted upon) by the audience is socially 'real' in the sense that it becomes the basis for future action."
>
> (Brissett and Edgley, 1975:153)

[1] According to symbolic interactionist orthodoxy (from which labeling theory stems), when an individual's behavior conforms to others' expectations, motives will not be imputed because reflexivity only arises when a situation becomes problematic. As long as interaction proceeds smoothly, no one's actions will be singled out for scrutiny; rather, people will simply continue on with the business of social life. This proposition is anecdotally illustrated in the social psychology maxim, 'whoever discovered water, you may be sure was not a fish'.

[2] Namely, that situations defined as real are real in their consequences. (Thomas, 1970)

Not only do socially supplied vocabularies of motive provide definitions of behavior, they also supply information about the nature of the actor. Implicit in the establishment of the type of act under scrutiny is the identification of the (type of) individual who did/would do it. An adequate motive thus formulates types of people by linking the problematic behavioral event to the biography of its author:

> "It is through motive as a culturally available designation that the observer recovers alter's membership out of observed temporal phenomena, because motives delineate the biographical auspices of acts in situations."
> (Blum and McHugh, 1971)

In other words, when others ascribe motives to an actor, on the basis of a situated performance, they imply a course of social action and suggest a (type of) person.

Given the important role played by socially ascribed motives, it is necessary to discuss their sources. Mills (1970) states that vocabularies of motive, like rules and norms of behavior, are socially learned and situationally specific (i.e., particular motives accompany particular situations and account for acts therein). Thus, being an adequately socialized member involves sharing in the group's knowledge of what types of factors motivate what types of people to what types of action. Members' knowledge of motive vocabularies enables them to construct an intersubjectively shared image of a practical actor in any typical or recurrent social situation (i.e., they know what 'anyone' would do under the circumstances).

Garfinkel emphasizes the social nature of motives by explicitly designating them as a component of the common culture or background expectations and underlying rules which supply the bases for members' inferences and actions:

> "Socially-sanctioned-facts-of-life-in-society-that-any-bona-fide-member-of-the-society-knows depict such matters as conduct of family life; market organization; distribution of honor, competence, responsibility, goodwill, income, motives among members; frequency, causes of and remedies for trouble; and the presence of good and evil purposes behind the apparent workings of things."
>
> (1967:76)

Blum and McHugh (1971) similarly posit the normative character of motive content by locating the source in language and culture. Hence, social members acquire shared vocabularies of motive which provide accepted explanations for unexpected actions. The motives they impute to a deviating individual define, for them, the meaning of both his/her acts and nature (i.e., his/her identity).

Finally, the motives which members acquire to link up behavior with situations and people vary over time, like other rules and norms, according to prevailing ideologies and social orders:

> "Individualistic, sexual, hedonistic and pecuniary vocabularies of motives are apparently now dominant in many sectors of twentieth century urban America. Under such an ethos, verbalization of alternative conduct in these terms is least likely to be challenged among dominant groups. In this milieu, individuals are skeptical of Rockefeller's avowed religious motives for his business conduct because such motives are not now terms of the vocabulary conventionally and prominently accompanying situations of business enterprise."
>
> (Mills, 1970)

Hence, we are likely to see conduct as reasonable, rational and understandable when we can take the role of the other and see his/her behavior as the means to some culturally sanctioned end such as individual betterment, sexual gratification or financial gain.

To return to the topic of mental illness, it is apparent from the foregoing that the lack of a culturally sensible motive for an individual's behavior will render it incomprehensible and irrational. If we cannot

imagine why someone acted as he/she did (i.e., what reason or end he/she had in mind), we cannot formulate his/her motives or identity in typical ways. Put differently, the imputation of socially recognized and accepted motives results in the construction (i.e., definition) of a rational actor; conversely, the inability to supply motives for unexpected behavior means that such an actor cannot be constructed by those grappling with the meaning of his/her actions.

Residual rule-breaking is, by definition, precisely the kind of unexpected behavior for which no specific vocabularies of motive exist because the rules are so taken-for-granted. Such violations, therefore, cannot be accounted for as something a social member would do 'in order to accomplish X' or 'because of Y'[1]. When others are confronted with an instance of unaccountable rule-breaking, they invoke the residual category comprising behavior which cannot be otherwise categorized (i.e., the diverse deviations which appear unmotivated in common-sense terms and, as a result, inexplicable): mental illness. It should be noted that this is a qualitatively different type of explanation than that provided by other vocabularies of motive, in that the latter only <u>implicate</u> the nature or identity of the actor in their explanation of his behavior, while in the former case, the explanation <u>consists</u> of the actor's (imputed) identity. To illustrate, in response to the question of motivation of an individual who cheated on an examination, an adequate (i.e., understandable) answer would be that she wanted to improve her grade. Implicit in this account is the allegation that the individual is a cheater. For a residual rule violation, however, the only

[1] This distinction is Schutz's (1962).

explanation available for the question'why did she do that?' is the answer 'she is crazy'. Thus, the explanation for problematic behavior provided by ascribing a mentally ill identity to the actor is tautological: the imputed mental illness which accounts for the behavioral deviance is proved to exist only by the behavior it 'explains'. That is, to continue the above example, if the question 'how do you know she is crazy?' should arise, the typical answer refers back to the unaccountable violation: 'just look at what she did!'.

The distinction is important given the emphasis placed upon the ascription of a mentally ill identity by labeling theorists. To summarize the foregoing, the identity of a residual rule-breaker is established on the basis of the others' inability to role-take with him/her and come up with an account. The imputation of mental illness, then, is a default option, accomplished almost automatically when a culturally meaningful vocabulary of motives is unavailable.

This contingency in the creation of deviance is met if people begin to use an actor's deviance (as imputed from his/her apprehended deviant actions) as the central aspect of his/her identity. It becomes his/her master status, in light of which all of his/her behavior (both future and past) will be interpreted. Given the previously noted ambiguity or lack of essential, objective meaning of human conduct, the profound implications for the labeled deviant's career emerge. Others employ the mechanisms of selective perception to support their interpretations of the actor's deviant nature which serves to justify their treatment of him/her as more and more of a deviant. This, in turn, results in increasing exclusion of the actor from normal channels of interaction (i.e., those in which he/she is not defined and treated as a deviant)

and the actor is pushed further and further into a deviant identity. The ultimate result of this spiralling reaction process is that he/she becomes that which he/she is claimed to be. Hence, for labeling theorists, "(t)reating a person as though he were generally rather than specifically deviant produces a self-fulfilling prophecy." (Becker, 1963:34)

iv) Escalation

Given the importance of this contingency in the creation of deviance, a closer consideration of the spiralling or escalation in interaction which occurs as a result of the previous contingencies, is warranted. The process is initiated by others' perception of an individual's transgression of a rule on the basis of which they are led to question their conception of the nature or identity of the rule-breaker. Heretofore, they have taken for granted his/her normalcy in constructing their actions toward him/her, but this definition of his/her identity has been made problematic by his/her behavior. They see their previous responses as no longer adequate and the intensity of their reactions is increased.

Because people structure their actions towards others at least partially on the basis of their identification of those others, it follows that the questioning of another's identity spurs attempts to arrive at a more accurate definition of him/her. Thus, when confronted with behavior that is construed as deviant, they will posit tentative redefinitions which are tested in subsequent interaction. If a definition of deviance appears to be confirmed, it becomes less and less tentative and the rule-breaker is treated as more and more of a deviant until this new identity comes to be as taken-for-granted as the old one was. In other words, escalation continues until others feel confident

in the accuracy of their new definition of the individual. Lofland states:

> "During escalation, Others experience both increasing doubts that Actor can reasonably be imputed a normal pivotal identity and increasing faith in the imputation of his pivotal deviance . ... Even though the imputation as deviant may be tentative, the very fact that suspicion has been aroused is likely to conduce action which takes account of that suspicion and attempts to protect Others against the worst that Actor might do."
>
> (Lofland, 1969:148)

One of the factors facilitating the spiralling of interaction leading to secondary deviance is retrospective interpretation of the suspected individual's past. Once a rule-breaker's identity as normal is questioned, and the hypothesis of his/her deviance is being tested, those dealing with him/her will employ not only the evidence gleaned in interaction (primarily the rule-breaking incident) but also any information pertinent to his/her identity from the past.

These others examine both his/her current behavior and biography in light of a deviant definition to see if support is provided for the application of the proposed label. While it might appear that this attempt to cross-validate two aspects of the individual's identity (i.e., his/her present and past) would lead to much less ascription of deviance, according to the labeling theory, the opposite is true. Closer analysis of the process of reinterpretation supports this contention.

First, it is not difficult for others to construe behavior which they previously had ignored, normalized, rationalized or otherwise not labeled, as deviant since, as aforementioned, the meaning of behavior is not inherent but rather is socially conferred. In other words, the reinterpretation of an individual's actions is easily accomplished

because behavioral data are ambiguous (Lofland, 1969:149). The re-interpretation of his/her biography is even less problematic, inasmuch as the data comprising biographies impose fewer strictures on reanalysis since they are necessarily highly selective and abbreviated. The formulation of a new biography for an individual merely involves shifting emphasis to other data or events, such that his/her rule-breaking (which gave rise to initial imputations of deviance) can be seen as the logical outcome of his/her reinterpreted past. Such retrospective interpretation provides further 'proof' of the validity of the deviant label, as well as making the rule violation understandable, since it can now be attributed to his/her essentially deviant nature (i.e., he/she is, was and always has been 'that way' all along) (Schur, 1971:55; Lofland, 1969:150).

To return to the earlier contention that the examination of an individual's past by others in light of a tentative deviant definition makes the imputation of deviance more instead of less likely, it appears from the foregoing that the process of retrospective interpretation is so selective that biographical 'support' for virtually any current behavior can be mustered. Further, interpretations of present and past tend to reinforce one another and contribute to the escalation to secondary deviance by increasing others' confidence in the accuracy of the imputed deviant identity. Thus, the deviant nature of an individual's present behavior is given credence by his/her deviant character as manifested in the past, and the latter is supported by the deviant behavior which he/she is still emitting. Both of these phenomena, which, when taken independently, are ambiguous and tentative, serve to validate each other when scrutinized in conjunction. For example, if

others begin to question a man's heterosexuality because he associates with a known homosexual, they will review his past for evidence to document a tentatively imputed homosexual identity. Isolated incidents of 'effeminate' behavior (e.g., certain mannerisms, style of dress, sensitivity, lack of interest in contact sports) are recalled to support the allegations. His association with a homosexual is thereby rendered understandable -- it is simply one more manifestation of the individual's homosexual nature which would have been apparent all along, had they only known what to look for.

At this point, it is germane to consider a final concept proposed by labeling theorists which facilitates the escalation from primary to secondary deviation -- stereotypes or typifications. It is suggested that social members' reliance on stereotypic definitions of deviant acts and conceptualizations of the essential nature of deviating individuals contributes to the processes of recognition of, and reaction to them as both specifically and generally deviant. As previously mentioned, both these contingencies must be met if stabilized deviance is to result, so a closer scrutiny of the typified basis for them is necessary.

> "Typifications are descriptions drawn from a common stock of knowledge which serve as short-hand notations for various phenomena. Typifications are thus simplified, standardized categories or labels, used to place other people or things."
> (Hawkins and Tiedeman, 1975:82)

These stereotypes or typifications are necessary devices for managing interaction in complex social orders, inasmuch as we need some basis on which to organize rationally our actions towards others who are unknown or only slightly known to us, and stereotypes provide such a basis for establishing identities. They enable people to get on with the business of interaction without having to negotiate one another's identities at

length. Such stereotypic definitions are generally subject to pragmatic validation -- they are not permanent, but are retained only as long as they work (i.e., they are not contradicted or disproved in interaction). However, despite the advantages of employing stereotypes, there is also the danger that they will foster inaccurate selective perception. That expectations affect perceptions is a basic tenet of social psychology, and as people employ stereotyped expectations they run the risk of perceiving only those things which are consistent with these expectations. Clearly, in routine interaction this tendency is offset by the aforementioned pragmatic test, but in the case of deviant stereotypes, the basis for their application is so ambiguous that they are not nearly so subject to this 'built-in' correction mechanism.

In other words, according to labeling theory, it is much less likely that an individual who is ascribed a deviant identity on stereotypic grounds will be able to disprove its validity and negotiate a new one because such deviant identities escalate almost independently of the individual's actions. Hence, people relying on deviant stereotypes tend to

> "jump from a single cue or small number of cues in actual, suspected, or alleged behavior to a more general picture of 'the kind of person' with whom one is dealing."
> (Schur, 1971:52)

An instance of rule-breaking behavior serves as the primary cue or status-determining characteristic in identifying someone as a deviant type, with all the auxiliary characteristics and expectations appertaining thereto[1].

[1] This distinction was initially advanced by Hughes, who suggested that "(t)here tends to grow up about a status, in addition to its specifically determining traits, a complex of auxiliary characteristics which come to be expected of its incumbents. ... (P)eople carry in their minds a set of expectations concerning the auxiliary traits properly associated with many of the specific positions available in our society ... The expected or 'natural' combinations of auxiliary characteristics become embodied in the stereotypes of ordinary talk, cartoons, fiction, the radio, and the motion picture."
(1958:103,106)

As others employ this stereotyped 'knowledge' of the individual in their interaction with him/her, they feed the process of escalation to secondary deviance. To reiterate an earlier contention, the individual thus becomes that which he/she is held to be.

Given the relatively trivial basis on which a stereotypic deviant identity is imputed (i.e., a rule-violation) it is necessary to consider the accuracy of deviant stereotypes. Like other stereotypes, they do provide a wealth of information upon which others can structure their responses, and, to the extent that this information is valid, they are invaluable time-savers in structuring interaction with deviants. However, to the extent that deviant stereotypes are inaccurate, while they still do away with the necessity of negotiating the rule-breaker's identity at length, they nonetheless have very negative consequences for the individual(s) so identified. Simmons summarizes:

> "Stereotypes of deviants probably do contain some fraction of truth; certainly the population does better than chance in recognizing deviants and predicting their behavior. However, as Merton and others have pointed out, even those aspects of the stereotype which have some descriptive validity may be the self-fulfilling result of the stereotype in the first place. ... (T)he negative stereotype results in a virtual a priori rejection and social isolation of those who are labelled, wrongly or rightly, deviant. In this sense, the person so labelled is literally prejudged and is largely helpless to alter the evaluations or the treatment of himself. The force of such negative stereotypes is not necessarily attenuated even when the individual is aware that his image is a stereotypic one."
>
> (1975)

An examination of some deviant stereotypes at least suggests their inaccuracy. For example, in one study subjects described marijuana smokers as escapist (52%), insecure (49%), lacking self-control (41%), nervous (26%), lonely (22%), weakminded (17%), mentally ill (13%) and dangerous (11%) (Simmons, 1975). In light of the fact that the use of

marijuana is now so prevalent that legalization of the drug appears imminent, the highly negative stereotype of the user would seem unfounded. The stereotypes of the mentally ill will be examined subsequently; it is sufficient to note at this point that deviant stereotypes present a negative characterization of many diverse facets of a rule-breaker's identity on the basis of his/her transgression. Given the aforementioned prevalence of primary deviation, the contention that all rule-breakers conform to a stereotyped identity (in other words, that stereotypes of deviants are valid) appears unfounded.

The inaccuracy of the characteristics and expectations constituting typifications of deviants (as compared to typifications of other social roles) is related to the difficulty in correcting them on the basis of pragmatic tests in interaction. Because contact with devaints tends to be limited, even if people carefully considered the accuracy of the stereotype in regard to each potential deviant with whom they dealt, the scant subjective evidence they obtained would not be sufficient to produce a revision of their deeply entrenched 'common-sense' knowledge of deviants:

> "Since conventional roles are more explicitly taught and because people have greater contact with others in these roles, the stereotypes of conventional occupations may be revised. Deviant roles, on the other hand, are usually not formally taught during socialization. Rather, these roles are learned indirectly; and since the folk-knowledge about deviance is seldom revised by first-hand experience, these views remain highly stereotyped."
> (Hawkins and Tiedeman, 1975:81)

The foregoing emphasis on the role of others' definitions of and reactions to an individual's rule-breaking should not be taken as evidence of the latter's lack of participation in the escalation process; rather, it underscores his/her lack of power or ability to stop this process once it has been initiated. During escalation, the individual becomes aware of others' responses to him/her -- they are treating him/her differently,

whether this treatment is merely covert suspicion as to his/her 'normalcy', or overt rejection of him/her as deviant, or something in between these two extremes. Whatever the strength of others' reactions, however, the individual in this situation has a limited number of lines of response open to him/her, none of which appear particularly efficacious in halting or reversing the spiralling interaction:

> "He can act as if nothing is amiss; that is, he can strive to act normally. But by doing so, since he then takes no overt action explicitly to deny what is suspected, his behavior may be taken as indicating insensitivity, evasiveness or even assent to what is suspected. He can seek to counter the suspicions through denials and counterdefinitions of himself, but such a response is easily read as protesting too much or being too defensive and as confirmation of Others' doubts about his normalcy. Or, he can act in compliance with the identity imputed to him. The irony is, of course, once begun, the practices of Others toward Actor operate to confirm what is suspected, almost irrespective of what Actor does. This is especially true if the imputations arouse in Actor a new level of anxiety and concern over what seems to be believed about him thereby altering his orientation to the situation."
>
> (Lofland, 1969:153)

Thus, in the movement from primary to secondary deviation, it is apparent that while the individual designated as deviant plays a central (i.e., focal) role, he/she is decidedly subordinate in the genesis of his/her own deviant career. Others' reliance on deviant stereotypes and their reinterpretations of his/her past feed the escalation process which culminates in the final contingency in the creation of deviance -- his/her adoption of the deviant status. The process of escalation is complete when not only others, but also the individual himself/herself comes to accept the deviant identity imputed to him/her and employ it in interaction (i.e., he/she has both a deviant social, and self-identity).

Equilibrium is attained at secondary deviance, wherein the individual is both a socially- and self-proclaimed outsider. A possible corollary

involves movement into an organized deviant group (Becker, 1963:37). At this point, his/her patterns of behavior and his/her identity as deviant have been established and a return to 'normalcy' is deemed unlikely. His/her initially random primary rule-breaking has been transformed via the processes of escalating interaction, into the central feature of his/her social role.

v) Escalation in Mental Illness

The foregoing discussion of escalation has been couched in terms of general deviance, and it is therefore necessary to extrapolate these concepts to the specific case of mental illness. Thus, the above social reaction contingency wherein the individual whose behavior has been defined as specifically deviant comes to be regarded and treated as generally deviant (i.e., as having a deviant identity) involves the decision by others that a residual rule-violator is not only acting 'crazy': he/she <u>is</u> mentally ill. The subsequent reaction to the labeled deviant is well documented in studies of social members' exclusion of the mentally ill from normal channels of interaction (Lemert, 1962; Phillips, 1968; Cumming and Cumming, 1957; Goffman, 1961). The widespread rejection of those defined as this type of deviant ensures that they cannot maintain their normal roles or identity, which, in the eyes of the social audience, justifies treating them as increasingly mentally ill. As the interaction between the labelers and the labeled spirals or escalates, the latter are forced out of touch with shared social reality by the former's growing repudiation, ultimately producing a self-fulfilling prophecy (i.e., people occupying stable mentally ill roles). The impact of exclusion on the labeled individual is magnified in the case of mental illness by the fact that such reaction occurs not only on an informal,

interactional level, but also on a formal institutional one[1]. Those designated as mentally ill can be physically removed from the community which, needless to say, ensures that they will not be able to retain their orientation in the 'real' world.

Escalation to a mentally ill identity is further facilitated by the fact that not only are labeled individuals cut off from the roles and communication channels by which 'sanity' is retained, they may actually be rewarded for accepting the mentally ill identity ascribed to them (Scheff, 1966:84-87). Denial of mental illness is regarded by mental health professionals as a manifestation of pathology; the afflicted individual cannot 'recover' until he/she admits he/she is sick. Hence, this admission is regarded as progress.

It is apparent from the above that the spiralling of interaction which was previously discussed in terms of the creation of deviance in general is also operative in the transition from simple residual rule-breaker to the status of mentally ill. In the words of Scheff, the parties to the labeling of mental illness participate in a 'vicious circle' of interaction or a 'deviation-amplifying system' wherein primary residual rule-violation is stabilized or exacerbated (1966:97-101). Lemert's (1962) analysis of the dynamics involved in the genesis of paranoia illustrates the escalation that occurs between an individual and a social audience which suspects him of being paranoid. The rule violations of the former call forth increasingly hostile responses from the latter, which in turn spur the individual on to more intense reactions. The more he/she insists on knowing 'what is going on behind his/her back', the

[1] The impact of formal or official labeling is discussed subsequently.

more insistently others deny collusion on their part, while, ironically, conspiring to exclude him/her on the basis of his/her 'unfounded' insistence and hostility.

The two additional concepts of stereotyping and retrospective interpretation relevant to the escalation process will now be discussed as they pertain specifically to mental illness. The former has received particular attention from theorists in the substantive area of mental illness. Given the contention that mental illness does not exist 'objectively' (i.e., as an internal condition or state of discrete individuals), but rather only socially (i.e., it is created and maintained through the processes of social interaction), it follows that mental illness is, in our culture, a social institution[1], the imagery of which is culturally transmitted (Scheff, 1966:64). Thus, in the course of socialization, members learn what mental illness is and what a mentally ill person is like. These typifications and stereotypes are part of the common-sense knowledge in which members of a social order share (Garfinkel, 1967). In light of the foregoing discussion of the important implications they hold in the labeling theory model of the creation of deviance, the stereotypes of mental illness deserve consideration. To this end, their sources, contents and effects will be examined.

Perhaps the most obvious source of typifications is language -- the myriad of metaphors, phrases and colloquialisms which characterize mental illness. Expressions such as 'have you flipped?' or 'are you crazy?' are so much a part of our universe of discourse that we rarely consider the assumptions about the nature of mental illness implicit in them (Hawkins and Tiedeman, 1975:83). Second, the mass media contribute

[1] That is, in the broad sense of being a shared or institutionalized body of knowledge.

to people's stereotypic knowledge in their standardized portrayal of what the mentally ill are like (Scheff, 1966:68-74; Nunnally, 1961). Third, mental health experts' conceptions and the public education campaigns based on them are a more formal source of popular knowledge of mental illness (Hawkins and Tiedeman, 1975:83-84).

More important than the sources of these images is their content. Stated succinctly, all of the above present the mentally ill as people who look, act and <u>are</u> qualitatively different from normals, and mental illness as a serious and/or hopeless condition (Scheff, 1966:64-80); Hawkins and Tiedeman, 1975:82-86; Nunnally, 1961).

On the basis of these stereotypes, people come to define the mentally ill in negative ways. For example, the results of Nunnally's (1961) semantic differential indicate that:

> "Although there were some differences between average ratings given to 'neurotic man' and 'neurotic woman' on the one hand, and 'insane man' and 'insane woman' on the other hand (the latter concepts particularly getting higher ratings for 'unpredictability', 'dangerousness', and 'dirtyness') <u>all</u> the abnormal concepts received higher average ratings for 'tense', 'sick', 'sad', 'passive', 'weak', 'delicate', 'cold', and also for 'foolish', 'ignorant' and 'insincere'. In general, ratings given to these concepts appeared to reflect an unfavourable overall evaluation and a low rating on 'understandability'."
>
> (Orford, 1976:151)

As people employ these definitions based on the culturally pervasive negative stereotypes in their dealings with those designated as mentally ill, the characteristic responses are, not surprisingly, rejection and fear (Nunnally, 1961; Phillips, 1968; Cumming and Cumming, 1957; Scheff, 1966:74). In terms of the contingencies involved in the creation of mental illness, it is clear that such popular rejection figures significantly in limiting or curtailing labeled individuals' access to the normal roles and channels of communication that everyone requires to

retain his/her identity and hold on reality. Simmons summarizes:

> "The negative stereotype may imprison or freeze the individual so labelled into willy-nilly adopting and continuing in a deviant role. This 'role imprisonment' occurs because the stereotype leads to social reactions which may considerably alter the individual's opportunity structure notably, impeding his continuation or re-adoption of conventional roles. The reaction of others, based on stereotypes, is thus a major aspect of the link between performing deviant acts and systematically adopting deviant roles."
> (1975:207)

In a similar vein, Scheff (1966:82) argues that in ambiguous situations or crises, stereotypes of mental illness provide a well-defined role for both the audience and the primary deviant. Thus, stereotypes figure not only in <u>others</u>' definitions and reactions, but also in the final contingency in the creation of deviance -- <u>self</u>-labeling or the acceptance by the individual of a mentally ill identity. Goffman's account of their role in the subjective aspect of labeling is edifying:

> "Here I want to stress that perception of losing one's mind is based on culturally derived and socially ingrained stereotypes as to the significance of symptoms such as hearing voices, losing temporal and spatial orientation, and sensing that one is being followed, and that many of the most spectacular and convincing of these symptoms in some instances psychiatrically signify merely a temporary emotional upset in a stressful situation, however terrifying to the person at the time. Similarly, the anxiety consequent upon this perception of oneself, and the strategies devised to reduce this anxiety, are not a product of abnormal psychology, but would be exhibited by any person socialized into our culture who came to conceive of himself as someone losing his mind."
> (1961:132)

The second concept relevant to escalation in interaction is the reinterpretation of the suspected individual's past to bring it into line with the new (or 'newly discovered') stereotypic mentally ill identity imputed to him.

The previously-noted ease with which this is accomplished for

deviance in general is even greater in the case of mental illness due to the ambiguity of residual rules, the high degree of situational relativity involved in defining a violation and the pervasiveness of this form of primary deviation. Hence, biographical support is more readily mustered for allegations of mental illness than, say, criminality, in which violations of the better-defined legal rules are required for documentation. One obvious instance of reinterpretation occurs in the construction by mental health professionals of case histories of mental patients:

> "The case record is an important expression of this mandate (i.e., the wide jurisdiction of psychiatry). This dossier is apparently not regularly used, however, to record occasions when the patient showed capacity to cope honorably and effectively with difficult life situations. Nor is the case record typically used to provide a rough average or sampling of his past conduct. One of its purposes is to show the ways in which the patient is 'sick' and the reasons why it was right to commit him and is right currently to keep him committed; and this is done by extracting from his whole life course a list of those incidents that have or might have had 'symptomatic' significance."
>
> (Goffman, 1961:155-156)

Thus, once others begin to doubt an individual's sanity and pose tentative redefinitions of his identity (i.e., as mentally ill), both their stereotyped conceptions of mental illness and the facility with which they find 'evidence' of the suspected pathology in his past contribute to the escalation in interaction leading from primary to secondary deviance. To reiterate, if the labeled individual comes to accept and employ the mentally ill identity ascribed to him, the final contingency is met. A stable incumbent of the mentally ill role has been socially created.

vi) Facilitating Factors

The foregoing presentation of the steps in the development of deviance represents an ideal-typical model; labeling theorists recognize the fact that the process does not occur in a vacuum. They therefore posit a number of social variables or factors which affect the probability of the above contingencies being met. These variables are important in that they specify the conditions under which individuals will and will not (likely) emerge as full-fledged deviants. By taking into account the social conditions which facilitate the recognition and definition of an act and its author as deviant by others, labeling theory moves away from the simple causal models characteristic of the other approaches to deviance which fail to attend to the factors intervening between primary and secondary mental illness. Labeling advocates have directed considerable attention to these facilitating factors at both theoretical and empirical levels.

It is proposed that whether or not a rule-violation receives the requisite social definition depends upon the time, frequency, perceived seriousness and consequences of the act and the social positions of the actor and audience. The likelihood of the labeled individual accepting the status ascribed to him/her is a function of the nature and strength of the societal reaction coupled with the degree of his/her exposure to it. The effects of these variables on the contingencies of labeling will be considered in turn.

The time at which a rule infraction occurs is important, inasmuch as social values change over time and actions which at one time were popularly regarded as deviant and called for a negative reaction, come to be seen as acceptable. Examples supporting this contention of the temporal

relativity of rules include responses to the consumption of liquor and the practice of birth control, all of which have become (or are becoming) accepted actions.

In the case of residual rules, the point in time at which the violation occurs is particularly important, given the ambiguous and variable character of the rules. Behavior previously seen as strange or inexplicable is rendered understandable by the advent of a socially accepted vocabulary of motives. Caetano illustrates this point in his research on psychiatrists' interpretation of the mental status of a nonconforming young man. The findings indicate that

> "more than a few psychiatrists did not perceive drug abuse, belief in the supernatural and the rest of the behavioral features that defined the hippie as symptoms of mental illness. ... In contrast, the vast majority (of psychiatrists) defined 'being a hippie' as mental illness."
> (1974)

The former group accepted the individual as normal because they accepted the 'hippie' identity as valid, whereas the latter viewed him as mentally ill because they did not acknowledge the legitimacy of wearing long hair and smoking marijuana. Clearly, rules change over time and actions which at one point are regarded as symptomatic of mental illness (i.e., as violations of residual rules) come to be seen as normal or as transgressions of other types of rules.

The frequency, visibility and perceived seriousness of rule-breaking bear even more obviously on the contingencies involved in the creation of deviance. As these three increase, so do the chances of others witnessing, recognizing and defining the behavior as something towards which action should be taken (e.g., informal measures such as social exclusion or formal ones such as incarceration in prison or a

mental hospital). Thus, according to labeling theory, the more often and the more open an individual's violations of residual rules, the more likely it is that they will come to public attention, which constitutes a necessary stage in the sequence whereby deviance is created. Similarly, the more serious the violations, the smaller the probability that others will be able to ignore or normalize them. In this way, an individual who does not often make eye contact in conversation with another is breaking a residual rule, but the violation is not frequent, highly visible or serious and hence the chances of others designating him/her and/or his/her behavior as mentally ill are slim. However, if he/she consistently refuses to acknowledge the presence of anyone (an obvious and more serious violation), he/she is far more likely to be labeled as mentally ill.

The consequences of an individual's rule violation are primarily important as they affect whether or not the deviation comes to be noticed by others. Thus, rule violations which might have remained hidden are brought to public attention by the results which may stem from them (Becker, 1963:13). For example, pregnancy is an obvious indicator that an unmarried girl has been sexually active; people know she is a rule-breaker by her physical condition. Such consequences are further important if they are not invariably the result of rule violation, since in these cases the social audience will tend to attribute greater frequency of violation to those who do suffer the result, which further justifies the attribution of a deviant identity. To extend the above example, young unwed mothers suffer the sanctions, not only for the infraction of a sexual norm, but also for general moral laxity, inasmuch as it is assumed that they probably indulge in the violation frequently

in order to become pregnant.

Further, the perceived seriousness of these consequences for other people is relevant in these others' decision as to whether or not they will define and treat the rule-breaker as a deviant. If the consequences of his/her violations affect others in negative ways, they are more likely to take action (either formally or informally) against him/her.

In the case of mental illness, the influence of the above variable is apparent in research focusing on the factors precipitating redefinition of a person as mentally ill. Results indicate that the residual rule-breaker may not be labeled by his/her family until (the consequences of) his/her behavior threaten(s) them or jeopardize(s) their security (Yarrow, et al., 1955; Jackson, 1973). Hawkins and Tiedeman summarize one example of this phenomenon:

> "In general, due to the 'male breadwinner' base of the majority of American families and the economic necessities of survival, the husband-father occupies a position of highest centrality (i.e., importance) on a strictly instrumental scale. That is, the family will be in deep financial trouble if he loses his job and adequate paychecks stop flowing in. Because of this centrality, abnormal behavior will be met with early and long-lasting defense systems, particularly those of normalization and attenuation. Only when the behavior becomes severely disruptive will it eventuate in labeling as mental illness by family members. And this decision point, more than coincidentally, may come only after an employer has terminated the husband's job ..."
>
> (1975:125)
> (emphasis added)

Less obvious than the effects of the preceding variables are those of the social positions of the actors and audience involved in the labeling process. These variables are nonetheless important, as they influence the probability of the latter imputing the deviance to the former's behavior (and identity) which is a necessary contingency in launching rule-breakers on deviant careers. Becker contends:

> "The degree to which an act will be treated as deviant depends also on who commits the act and who feels he has been harmed by it. Rules tend to be applied more to some persons than others."
>
> (1963:12)

Specifically, labeling theory posits an inverse relationship between the power of the rule-breaker and the likelihood of the audience defining him/her as deviant and a direct relationship between the power of the definers and the likelihood of their label 'sticking'. The reasons for this are twofold: first, on a macro level, the more powerful one is, the greater input he/she has into the content of social rules (Becker, 1963:17-18; Akers, 1968) and hence the more likely these rules are to reflect (or at least not be antithetical to) one's vested interests.

Second, the enforcement and public acceptance of these rules also reflect the influence of social position. While this is more apparent in the case of formal rules as manifested in police and court treatment of law-breakers (Chambliss, 1969 and 1973) and public rejection of those identified as criminals (Schwartz and Skolnick, 1962), it is also true for informal rules, as indicated by the greater ability of the powerful to define situations for subordinate others (Waller, 1970; Scheff, 1975) and the concomitant popular acceptance of these definitions and rejection of the informal rule-breaker (Lemert, 1951).

Relevant to the consideration of the effects of social position and power in labeling, is the role played by the expert. Labeling theory accords a high degree of importance to the designation of an individual as deviant by an official or expert labeler (i.e., one who supposedly has special knowledge about a given type of deviance) (Becker, 1963:31; Hawkins and Tiedeman, 1975:48; Schur, 1971:12). He/she has been granted, by virtue of his/her position, the socially recognized and legitimated

power to define what and who is deviant and hence his/her decisions influence lay others as they formulate their definitions of and reactions to the people he/she labels. In this way, expert labeling contributes to the formation of agreement among social members that an individual 'really' is deviant and should be treated as such. Lofland summarizes this process:

> "It ... seems possible to forge a kind of consensus under conditions in which those who initiate the imputation are seen as having special expertise or power in discerning deviants. Imputational specialists are among those so viewed, and the work they do seems highly facilitative in forging unanimity in Actor's world. Their command over resources endows their work with a gravity and bathes it with a degree of publicity far beyond anything the mere layman can achieve. ... Attention accorded them by the mass media serves not only to publicize their work but continually to reinforce its legitimacy. Actors and Others can hardly be expected to disregard or take lightly the kind of imputational dramas which such specialists can produce."
>
> (1969:156)

Thus, the importance of official labeling is recognized by proponents of the perspective -- an individual pronounced criminal by a judge or defined as mentally ill by a psychiatrist is much more likely to be recognized (and treated) by others as that type of deviant than one not so officially labeled (Hawkins and Tiedeman, 1975:48). This factor is especially relevant in the case of the previously mentioned 'falsely accused deviant', who does not satisfy the first contingency of breaking some type of social rule, but nevertheless is launched on a deviant career by the strength of the societal reaction to him/her. Since the requisite reaction cannot be a function of others' observation of the violation, it is apparent that the source of definitional consensus must be sought elsewhere. The suggested effects of expert labeling therefore become important in mustering support for a deviant label, for which (potential) ascribers lack the behavioral basis or 'evidence'. Expertise, by definition is socially sanctioned credibility

in a particular area and so the opinions of such experts carry weight in lay people's formulations of the nature of an individual and his/her actions.

To turn to the topic of mental illness, this status variable has received considerable attention. Labeling theorists posit that imputations of mental illness by such mental health experts as psychiatrists, psychologists and doctors increases the likelihood that both others and the individual himself/herself will accept the validity of the proferred label (Scheff, 1966:128). The reasons for the importance of expert definition in this area are twofold. First, the ambiguity of psychiatric 'symptoms' coupled with the lay person's lack of knowledge about what (clinically) constitutes mental illness makes questioning of diagnoses unlikely (Hawkins and Tiedeman, 1975:156). Second, on a more general level, is the credibility of medical science to which mental health professionals are heir in our culture. Psychiatrists and doctors, as representatives of the profession par excellence command an autonomy unmatched by any other group (Freidson, 1970a). The subjectivity of their definitions is obscured by the objective, scientific mantle of medicine and lay social members accept on faith their value-laden judgments as fact (Leifer, 1969; Kittrie, 1971). Hawkins and Tiedeman summarize:

> "(N)o other professional commands the unquestioning respect and acceptance that the physician does. Patients may argue with their doctors, but the arguments are usually over billing procedures, scheduling arrangements and other such incidentals -- not over diagnosis. ... If the doctor says it's an ulcer, it is an ulcer. If he says it's rheumatoid arthritis, it is rheumatoid arthritis. And if he says it's schizophrenia, or obsessive-compulsive neurosis, or involutional melancholia, it must be. But whereas the ulcer and the arthritis are probably there and can be substantiated by others, the psychiatric syndrome has inherently fewer strict guidelines for consensual identification. In this way,

> ambiguity and the authority image combine to facilitate psychiatric definitions free from restriction of challenge."
>
> (1975:156-157)

These factors, then, contribute to the formation of consensus regarding the validity of a psychiatric label, which strengthens the societal reaction to the allegedly mentally ill individual and thereby facilitates the creation of deviance. Goffman illustrates the importance of expert definition in convincing an individual's significant other(s) that he/she should be committed:

> "He may not even perceive the prepatient as mentally sick or if he does, he may not consistently hold to this view. It is the circuit of mediators, with their greater psychiatric sophistication and their belief in the medical character of mental hospitals, that will often define the situation for the next-of-relation ...".
>
> (1961:143)

To the extent that 'official' definitions carry this kind of weight in mustering social support for imputations of mental illness, they contribute to the probability that the labeled individual will adopt the proferred identity, since his/her knowledge of who and what he/she is, is based on the cues and feedback of others (Hawkins and Tiedeman, 1975: 49).

An additional factor which bears upon the contingencies involved in producing deviance outcomes is the rule breaker's exposure to others' definitions of him/her as deviant. Clearly he/she must experience their reactions if he/she is to become a secondary deviant in terms of labeling theory (i.e., adopt the identity imputed to him/her and employ it in interaction and/or enter a deviant group) (Becker, 1963:37). The more he/she is exposed to definitions of himself/herself as deviant, the greater the probability of his/her adopting a deviant identity. This

occurrence is further affected by the amount of consensus the individual perceives among others' definitions of him/her. Chances of adoption are increased if it appears to him/her that people are in agreement regarding his/her deviance. Finally, the more powerful and/or significant the others promoting a deviant definition of him/her, the more likely he/she is to accept it (Lofland, 1969:204-205).

Hence, individuals who consistently face definitions of themselves as mentally ill cannot maintain 'normal' or sane self-concepts, inasmuch as they require at least some measure of validation by others. If others do not provide this validation, but rather define them either overtly or covertly as crazy, they will be forced to question and ultimately abandon their belief in their own sanity. The effects of the former (i.e., overt) definitions may be more obvious -- being pronounced mentally ill is clearly important -- but implicit definitions also figure in the creation of deviance. Lemert discusses these in terms of the type of reaction they may produce: once others come to see an individual as mentally ill, their interaction with him/her becomes spurious. They patronize and humor him/her, evade his/her questions and generally guide the conversation in order to 'protect' the group (be it family, co-workers, friends, etc.) from him/her. As a result, the individual is cut off from the flow of information which he/she requires to orient himself/herself and he/she is rendered unable to deal rationally and purposively with these others (Lemert, 1962). Thus, the consequences stemming from the other's designation of an individual as mentally ill are just as real whether or not the deviant is actually confronted with the allegations. Either way, their suspicions are reflected in interaction and, the greater amount of contact he/she has with such suspicious others, the more likely he/she is to accept the

mentally ill identity imputed to him/her.

Finally, the appearance of consensus among others which facilitates adoption also figures in this final stage of the creation of mental illness. When confronted with a seemingly solid wall of agreement about his/her identity as mentally ill, the individual cannot help but doubt his/her sanity. The effects of this apparent agreement are perhaps most obvious among mental patients: as inmates of 'total' institutions, they are forced to accept the official definitions of their status because no other definitions are available to them (i.e., the staff is in complete agreement) (Goffman, 1961).

According to labeling theorists, it is the foregoing facilitating factors which account for why some rule-breakers become full-fledged deviants while the majority do not. Specifically, the likelihood that a person will become (labeled) mentally ill is at least partially a function of the nature of his/her residual rule-violation (i.e., when it occurs, how often it occurs, how serious it is perceived to be and what the consequences are), his/her social position relative to that of the labelers, and the nature and strength of the societal reaction as perceived by him/her. However, the precise combinations of these factors which are necessary and sufficient to create a stable incumbent of the mentally ill role are not specified. The reasons for this are twofold. First and foremost, the societal reaction model is probabilistic -- the complex and variable nature of social life is recognized and so the specification of a deterministic, quantified formula of the conditions which produce mental illness is neither desirable nor possible. Second, the empirical development of the theory is far from complete and while the relative importance of each of the facilitating variables is

suggested by research results, it cannot be definitively stated at this time. Thus, the ambiguity surrounding the issue of who will and who will not become mentally ill can be partially resolved by continued research, but perfect prediction is not a goal which is consistent with the terms of labeling theory.

* * * * *

The foregoing discussion of the contingencies involved in the process of creating deviance and the factors bearing upon them is not definitive, but it does establish the emphasis in labeling theory upon the many social factors intervening between an instance of nonconforming action and the existence of a career deviant. To reiterate, this marks a movement away from oversimplified models of causation wherein the latter is equated with the former and the social evaluation of and reaction to behavior is deemed irrelevant. From the labeling perspective,

> "(a) social problem or social deviant is defined by social reactions to an alleged violation of rules or expectations. This perspective focuses on the conditions under which behavior or situations come to be defined as problematic or deviant."
>
> (Rubington and Weinberg, 1971:197)

Given the central role of these conditions or contingencies in labeling, it is useful at this point to recapitulate the major points made above. The creation of a deviant (i.e., one who is recognized by others and himself/herself as occupying a stable deviant role) is contingent upon:

1. the violation of some type of social norm or rule by an individual (i.e., primary deviation);
2. the observation or discovery of this violation by others, either directly or indirectly;
3. the definition by these others of the act as an instance of some type of deviance;
4. the definition by others of the rule violator as some type of deviant (i.e., he/she is seen as generally rather than specifically deviant on the basis of retrospective reinterpretation);
5. reactions by others towards the rule-breaking individual on the basis of their definitions in (3) and (4), cutting off his/her access to normal roles and channels of communication;
6. the acceptance by the individual of the deviant identity proferred him/her (i.e., secondary deviation).

According to the societal reaction or labeling approach, this sequence of events must take place if a career deviant of any type is to result. Labeling theorists

> "feel that regardless of the form of norm violation -- 'cheating, unfairness, crime, sneakiness, malingering, cutting corners, immorality, dishonesty, betrayal, graft, corruption, wickedness and sin' (Cohen, 1961:1) -- the same process of recognition of norm violations (i.e., negative sanctions) are involved for each type."
>
> (Hawkins and Tiedeman, 1975:64)

Thus, mental illness, as presented above, is the product of the sequential contingencies of labeling theory. Variables which bear upon the likelihood of these contingencies being met include the time, visibility, frequency, perceived seriousness and consequences of the rule violation, the social positions (power) of those doing the labeling and reacting and those at whom labels and reactions are directed, and the latter's exposure to, and evaluation of, the former (Lemert in Schur, 1971:10; Becker, 1963:22-24; Hawkins and Tiedeman, 1975:111-112).

It is these variables or conditions for labeling which have been the primary focus of empirical investigations within the paradigm. Because they are also the concern of this thesis, they require closer scrutiny. To this end, the research aimed at specifying the variables facilitating the meeting of the contingencies of social definition and reaction whereby mental illness is created will be examined and the results assessed. From this and the preceding theoretical exegesis, some variables requiring clarification will be selected, and a research design will be formulated to test the hypothesized relationships.

* * * * *

4. Critical Comments

Before turning to this task, however, some critical comments on labeling theory are in order. The preceding discussion has outlined its tenets in non-judgmental terms, but this is not because the perspective has spawned no criticism. Therefore, by way of presenting a more accurate picture, the major criticisms of the theory will be briefly detailed.

Perhaps the most basic shortcoming involves the general status of the perspective: critics contend that labeling is not a cohesive formal theory (Gove, 1975:7; Schur, 1969). It lacks a systematic statement of propositions and operational definitions, making empirical work hard to conduct and harder to assess. Indeed, what is or is not deviant remains largely unspecified (Schur, 1969), as does the quality and quantity of social reaction which is necessary and sufficient to render an individual an outsider (Mankoff, 1971). Due to these theoretical gaps, labeling is presented by critics as, at best, more of a general orientation comprised of sensitizing concepts and hypotheses in need of data, or, at worst, a loose aggregation of intuitively pleasing platitudes and paradoxes grounded only in 'common sense'. Because of the frequency with which this allegation is cited, an assessment of its validity is warranted.

First, if a formal, systematic statement of theoretical tenets was a prerequisite for sociological investigation, it is unlikely that the discipline would exist at all in its own right, since few extant perspectives meet this qualification. Second, the desirability of rigidly codified theory is questionable, inasmuch as valid explanations of social phenomena must involve a dialogue between the theoretical and the empirical, whereby the former is successively refined by the latter. Failure to do so results in the kind of grand theory which, although well-articulated and logically consistent, is removed from the issues and problems of everyday social reality .

Thus, while the accusation that the elements of labeling are not adequately delineated is true, it does not constitute a mortal flaw in

[1] The most obvious, although by no means only, example of this is Parsons's social action theory.

the theory. The perspective's deficiencies in this regard stem more from omissions and questions which can only be empirically answered. Certainly the societal reaction approach to deviance requires clarification, but to reject it on the grounds by which a mature theory is judged when it is still in its empirical infancy is unjustified.

Another criticism which is often levelled at labeling theory is that it does not account for initial rule-breaking (Mankoff, 1971). This, like the foregoing allegation, is accurate but, as previously explained, the explicitly sociological focus of the perspective (i.e., the emphasis on the observable processes of social interaction in the development of deviance) renders concerns of individual motivation for rule-breaking of lesser importance[1]. Given the large number of theories which attempt to explain deviance in psychological terms, the alternative emphasis of labeling appears to be one of its strengths.

The primacy accorded the reactions of others gives rise to the further charge that labeling theory presents an overly passive view of the deviant actor. One author summarizes:

> "One sometimes gets the impression from reading this literature that people go about minding their own business, and then - 'wham' - bad society comes along and slaps them with a stigmatized label. Forced into the role of deviant, the individual has little choice but to be deviant."
>
> (Akers, 1968)

Critics contend that the overemphasis on the social audience and successful labeling has resulted in a theory of social determinism which fails to take into account the individual's role in the creation of his/her own deviance (Quadagno and Antonio, 1975). Hence, the ways in which

[1] This does not mean that people's reasons for their actions are irrelevant in the attempt to explain human social behavior. These, too, are certainly amenable to sociological understanding. However, they are of secondary importance in the creation of deviants through societal reaction.

labeled individuals reject and/or eventually come to accept the identity ascribed to them are neglected[1]. In so doing, labeling theorists move away from the symbolic interactionist roots of the approach, wherein individuals are regarded as rational, purposive actors who have the capacity to negotiate with others in the construction of their identity and their social reality (Mead, 1934).

Once again, however, while this criticism may be accurate, it is a problem which requires an empirical solution to determine the relative power of the labelled individual in 'fighting' the deviant identity imputed to him/her. Even the foremost critic of the perspective concurs that this is essentially a problem of omission:

> "(T)he degree to which the individual shapes and modifies the societal reaction towards him or her needs further investigation."
>
> (Gove, 1975:14)

It should also be noted that the lack of attention to the individual's role in the negotiation of his/her identity is partially justified by the relative lack of power he/she actually possesses. Goffman's (1961) analysis of the dilemmas of mental patients and Lemert's (1962) investigation of people defined as paranoid both indicate the helplessness of individuals whose sanity comes to be suspect. While none of the

[1] Erikson made this criticism over twenty years ago in his discussion of the role of mental patients. He draws a distinction between role-validation (i.e., the role expectations a community profers) and role-commitment (i.e., the acceptance by the individual of the proferred role(s).) He concludes that sociologists, by focusing on the former, "have largely overlooked the extent to which a person can engineer a change in the role expectations held in his behalf, rather than passively waiting for others to 'allocate' or assign roles to him."
(Erikson, 1957)

individuals studied appeared to automatically or willingly accept the mentally ill identity ascribed by others, the strength of the societal reaction rendered attempts to reject the label unsuccessful. Thus, while it is true that labeling theorists do need to present a more balanced model (i.e., one that attends not only to reaction but also to interaction), their emphasis on the importance of social labeling appears warranted.

Labeling theory is also faulted for being overly relativistic, since deviance is whatever is defined as such and hence the crucial variable is located outside the deviant act/actor. Such normative criticisms assume that deviance exists objectively (i.e., apart from social definition) and ignore the interpretive nature of social life. This is not to suggest that deviance is purely a matter of definition without any behavioral referents or that, without reaction, no rule-breaking would occur. Rather, labeling theory draws a distinction between "mere physical acts and the meaningful constructions that constitute social reality" (Schur, 1969), such that behavior which is currently defined as rule-breaking would still occur in the absence of societal reaction, but stable populations of career deviants for whom life is organized around a deviant master status, would not.

Other problems relate to the specific effects of labeling -- critics claim that labeling may not be exclusionary (or at least not intentionally so) (Gove, 1975:15) and that it may even deter further deviance. In regard to the former, the intent of the audience would appear to be unimportant if the practical consequences of defining an individual as some type of outsider are exclusionary. In other words, it matters little if a social audience wants to help or punish someone

whom they regard as mentally ill if in both cases the individual ends up in a mental institution. Similarly, labeling may indeed deter further deviation in some instances, but if others have come to accept and act toward the individual on the basis of the label, his/her subsequent behavioral conformity may not be sufficient to dispel the deviant identity and he/she, for all social intents and purposes, would not be regarded as having been deterred by the societal reaction. An example of this phenomenon is provided by Smith (1978) in her analysis of a case history of a woman who is labeled mentally ill by her friends. As these friends began to question her sanity, they construed trivial and common behavior such as failing to wash the dishes well or clean the bathtub and indulging in certain foods (e.g., canned fruit, honey) as symptomatic of her mental illness. Thus, whether or not their implicit labeling and subsequent differential treatment of her 'really' served as a deterrent is irrelevant -- they regarded her as mentally ill and therefore saw her behavior as a manifestation of the pathology. Her apparent conformity did not dispel the deviant label.

It would appear, then, that the specific effects of labeling are once again less theoretical flaws than unanswered empirical questions.

While the foregoing list is by no means exhaustive, it does reflect the most frequently mentioned criticisms of labeling theory. A review of the evaluative literature reveals a host of additional criticisms, but these will not be detailed due to their peripheral relevance to the issues at hand. In addition, few of the evaluators present an accurate picture of the perspective. In the words of one author, the critiques

> "rarely render a faithful likeness of the original. The perspective has typically been caricatured, made to affirm principles that no labeling theorist has ever written or believed."
>
> (Goode, 1975)

Thus, it is sufficient to note that the labeling approach is not without deficiencies, but to reject it at this early stage of its development (primarily because it is not yet developed) is unwarranted. What is necessary at this point is empirical research aimed at refining the orientation into an explicit and well-grounded theory.

It is now possible to examine the empirical work which has already been completed.

* * * * *

II. Empirical Research from the Societal Reaction Perspective

A. Review of the Research

Before turning to the particulars of the empirical work dealing with the conditions conducive to the creation of mental illness, it is necessary to examine the levels of analysis from which these variables stem. Schur contends that labeling (i.e., the creation of deviance) occurs on three levels -- collective rule-making, organizational processing and interpersonal reactions (1971:11) -- which range along a continuum from macro- to microscopic. The first of these is operative at a socio-cultural level and deals with the nature and genesis of formal and informal norms and institutions. The second focuses on social structural concerns, while the third, micro level pertains to the dynamics of face-to-face interaction. These levels of analysis are applicable to mental illness as a type of deviance.

At the macro level, concern is with the origins and content of the cultural rules governing mental illness (i.e., what it is, how to recognize it, how to treat it, etc.). It is within this general social context that the institution of mental illness is maintained or changed. Both of the other two levels of labeling (i.e., lay and professional definitions of, and reactions to, mental illness and strategies of organizational processing) are ultimately grounded at this institutional level. D'Arcy states:

> "At the macro-sociological level of analysis, the institutional and social contexts in which mental health care agencies and agents operate can be seen to affect, via a long and perhaps complex chain of causality: (a) the amount of mental illness that can be recognized; (b) the recognition of mental illness; (c) the types of mental illness and its typification; and (d) the types of persons who become labeled and treated as mentally ill. In turn, they affect the saliency of other structural and interpersonal contingencies in producing mental illness."
>
> (1976:83)

Thus, the recognition, categorization and treatment of mental illness has

been institutionalized for lay and professional populationsalike:

> "When jurors, psychiatrists, kinsmen, and all ordinary members decide the sanity of another, their decisions are ultimately based on a socially accredited body of knowledge that they methodically use. This knowledge constitutes their common culture."
>
> (Blum, 1970:38)

Because of this shared knowledge, the entity of mental illness is (socially) maintained.

Labeling theorists concerned with meso-level factors focus upon the impact of structural conditions on the development of mental illness. Attributes of individuals (including such demographic characteristics as age, sex, socio-economic status, religion, ethnicity, etc.) which may affect official social definition and reaction processes are included here, as well as the structure of agencies involved in the processing and treatment of the mentally ill. The latter is regarded as important in that these social agencies share the requirements of all formal organizations (i.e., efficiency, maintenance or growth and accountability for decisions) which contribute to the evolution of the professional ideologies and processing stereotypes which, in turn, are central to the official labeling process (Hawkins and Tiedeman, 1975:179-206).

At the micro-social level, concern is centred on the inter- and intra-personal processes by which specific individuals become mentally ill. Both macro and meso levels are reflected here in social members' definitions of and reactions to residual rule-breakers as mentally ill.

Thus, the contingencies comprising the societal reaction model of mental illness are affected by variables operative at the above three levels. It should be noted, however, that while these levels involved in the labeling process may be discussed separately for the sake of clarity,

they are by no means independent of one another. Factors at the institutional, structural and interactional levels all operate to determine whether or not mental illness outcomes will obtain in any given case.

It is now possible to turn to the empirical tests of the labeling model of the development of mental illness which attempt to specify the conditions under which the hypothesized necessary contingencies will be met. These will be classified in terms of the foregoing three levels of analysis. Before examining their specifics, however, it is germane to consider the relative importance of each of three levels of labeling. As mentioned above, micro-, meso- and macroscopic factors operate in conjunction with one another, but the priority of each in the theory at hand can nonetheless be ranked.

It is the position of the author that the considerations at the micro level of interpersonal interaction are foremost inasmuch as it is the recognition/definition and ensuing reaction to mental illness by lay social members which constitutes the cornerstone in the creation of mental illness. According to the theory, without the popular validation of mentally ill labels, stable mental illness would not develop. While the meso-level concerns of professional definition and organizational processing of the mentally ill are certainly important, they typically come into play only after some form of lay labeling has occurred and the pre-patient has thereby been brought to official attention. In addition, given the well-documented medical presumption of illness (Scheff, 1966; Temerlin, 1975), it is clear that little screening-out of potential patients occurs in psychiatric diagnosis, leading one author to conclude that

> "the basic decision about mental illness usually occurs prior to the patient's admission to the hospital and this decision is more or less made by nonprofessional members of the community."
>
> (Mechanic, 1962)
> (emphasis added)

Since appearance for treatment at either a psychiatrist's office or a mental hospital is typically regarded as 'proof' of mental illness, it is obvious that an understanding of the processes of lay labeling which precede official diagnosis is crucial.

It will be recalled that concern here is with these very factors influencing the unofficial definition of and reaction to, individuals as mentally ill. Thus, in reviewing the empirical work on mental illness from the labeling perspective, attention will be directed to research conducted at the micro level of analysis. As aforementioned, this interpersonal level reflects institutional and professional, organizational factors but, in terms of the emphasis of societal reaction theory, supersedes them in importance.

The empirical literature, however, does not reflect this priority; rather, research is concentrated upon the latter dimension -- attention is focused almost exclusively upon the phenomena of professional diagnosis and organizational processing[1] (Larkin and Loman, 1978; Neff and Orcutt, 1978). The principal reason for this concentration is perhaps pragmatic. Researchers have tended to conduct their investigations where

[1] The emphasis on the official aspects involved in the creation of mental illness is reflected in Scheff's (1975) summary of tests of the perspective. Of the eighteen studies he was able to find which employed systematic methods to examine labeling theory, every one focuses on official processes.

populations of the labeled mentally ill have already been assembled (i.e., in treatment settings) because data collection is far easier among a 'captive audience'[1]. However, convenience is not an adequate justification for the choice of a research site and therefore an evaluation of the applicability of the information provided by studies focusing on official diagnosis/treatment is warranted. It will be recalled from the discussion of the tenets of labeling theory that labeling by a mental health professional is designated as a facilitating factor which is principally important in mustering popular support for an imputed mentally ill identity. It is not a central contingency in the creation of mental illness, and hence studies specifying the factors involved in expert diagnosis and processing are not direct tests of the perspective. Their results are only peripherally relevant to the articulation of the mechanisms of the labeling model. Neff and Orcutt's critical comments in this regard are germane:

> "Early theoretical statements in the labeling tradition (Lemert, 1951; Kitsuse, 1962) stress the need for research on the processes by which informal social audiences define certain behaviors or persons as deviant. Later work has placed paramount importance on the labeling and treatment of deviants by formal agents of social control. The term 'labeling theory' has increasingly become identified with the rather deterministic argument that stable careers of secondary deviance are produced by official reactions and public

[1] This is not to suggest that the propensity to study official diagnosis and treatment as opposed to informal definitions and reactions is solely a function of researchers' laziness. It reflects at least partially the difficulty of operationalizing aspects of labeling theory (most notably the processes of definition and reaction as they occur in lay interaction).

> labels (Lemert, 1972; Taylor, Walton and Young, 1973). Thus most research in the labeling tradition deals only with deviance which has come to the attention of social control agencies. ... Both critics and advocates of the labeling perspective have reached agreement that the current literature presents a narrow and oversimplified view of the issues in this area, and that a special need exists for empirical work on informal reaction processes (Gove, 1975; Scheff, 1975)."
>
> (Neff and Orcutt, 1978)
> (emphasis added)

For these reasons, then, the extensive empirical research conducted at the middle (i.e., formal, official) level of analysis will not be reviewed[1]. Similarly, macro-level studies dealing with the aspects of the social institution of mental illness (e.g., general attitudes toward, and stereotypes of, the mentally ill)[2] will not be detailed because these do not employ a labeling theory framework, nor do they constitute tests of the labeling perspective. In addition, the nature of the social institution of mental illness was previously discussed in regard to the phenomenon of escalation. Instead, attention will be directed toward the micro-level studies exploring the factors involved in lay labeling inasmuch as this relatively neglected phenomenon is the concern of this thesis.

[1] Examples of this type of work include studies specifying the demographic and situational factors affecting psychiatric diagnosis/commitment by Haney and Michielutte (1968), Haney and Miller (1970), Rushing (1971), Wenger and Fletcher (1969), Wilde (1968) and Wilkinson (1974). These analyses typically attempt to determine the 'biasing factors' involved in official dispositions and rates of deviance (Neff and Orcutt, 1978).

[2] The classic studies of this type are Cumming and Cumming (1957) and Nunnally (1961).

The central issue in the existing empirical studies of lay labeling is the extent to which people's definitions of an individual as mentally ill are the result of the individual's behavior, versus the extent to which they reflect <u>others</u>' definitions (i.e., labeling). It will be recalled that, in theory, both of these factors figure in the 'recognition' of mental illness: some residual rule-violating behavior on the part of the individual which comes to the attention of others generally constitutes the initial career contingency, with their definition of his actions/him as mentally ill being facilitated by labeling, especially if the label is applied by mental health professionals. However, theorists suggest that the former factor may be rendered less important or even unnecessary by the latter: in the case of the 'falsely accused deviant' (Becker, 1963), others' definitions of mental illness alone (i.e., in the absence of behavioral deviance) may be sufficient to promote popular acceptance of the label and thereby dispatch the individual on the road to a mentally ill identity.

The relative significance of these two factors has been a bone of <u>theoretical</u> contention, but the resolution of this controversy can only be determined empirically. Therefore, attention will now be directed toward the research which has attempted to specify the behavioral and labeling conditions under which people come to define individuals as mentally ill.

As noted, there is a paucity of such research: only six empirical investigations have attempted to clarify this central issue, and their results supply no definitive answers. Two studies (Phillips, 1968; Larkin and Loman, 1978) indicate that both behavior and label figure in others' evaluations, with the former assuming priority. Another (Loman

and Larkin, 1976) supports the general conclusion, but finds labeling the more important factor. Two studies show that behavior alone is important (Kirk, 1974; Kidd and Sieveking, 1974), while a final investigation (Caetano, 1974) suggests that label is the only significant variable. These studies will be reviewed in detail in an effort to account for the lack of consensus.

Phillips (1968) assessed the relative effects of individual behavior and labeling on people's reactions in a survey-experiment in which subjects were presented with vignettes containing information about a hypothetical individual's behavior and the type of professional help he was supposedly receiving. Five types of behavior (normal, phobic-compulsive, depressed-neurotic, simple schizophrenic and paranoid schizophrenic) were examined in conjunction with five help-sources (none, clergyman, physician, psychiatrist and mental hospital). The study design consisted of a Græco-Latin square, the cells of which were varied by the above five types of both behavior and help source, as well as the order of presentation of the vignettes. The subjects (300 married, white females) each received five cards comprising five different behavior/help-source combinations and after reading each, they completed a five-item social distance scale designed to measure their rejection of the hypothetical individual presented in the vignette[1].

[1] Thus, the extent to which subjects defined him as mentally ill was assessed via the extent to which they rejected him.

The results of an analysis of variance performed on these data indicated that the kind of help an individual was described as seeking had a statistically significant effect (at the .001 level) on subjects' rejection of him. Rejection increased as he was described as seeking no help; and as seeking help from, respectively, a clergyman; a physician; a psychiatrist; and finally a mental hospital. The greatest increment in rejection rates occurred when the individual had sought psychiatric help. The author concludes that contact with mental health agents and/or agencies serves to define individuals as mentally ill in the eyes of others. These results thus indicate that the definitions of mental health professionals (i.e., expert labeling) are important in lay members' evaluations of another's sanity. While it may be argued that Phillips's study was not an explicit test of the effects of expert labeling, it nonetheless implicitly examines the phenomenon, inasmuch as acceptance of an individual for treatment by a psychiatrist or mental hospital is tantamount to official diagnosis as mentally ill.

The effect of the hypothetical individual's behavior on subjects' rejection was also found to be significant at the .001 level, and this relationship was of a greater magnitude:

> "(W)hen a respondent was confronted with a case abstract containing both a description of their individual's behavior and information about what help source he was utilizing, the description of behavior played a greater part (i.e., accounted for more variance) than the help-source in determining how strongly she rejected the individual described."
>
> (Phillips, 1968)

In other words, the extent to which people rejected deviating individuals (i.e., defined them as mentally ill) reflected first, the degree of behavioral deviance and second, the implicit definition of the conduct supplied by the type of help received.

A study by Larkin and Loman (1978) examining lay labeling in a family context supports Phillips's conclusions. The authors conducted a survey experiment to assess the effects of individual behavior, psychiatric label, type of expert labeler and the nature of the individual's account of his behavior. The design was a 2x2x2x2 factorial (i.e., there was a weak and a strong condition of each of the above four independent variables) in which subjects (240 parents) were provided with written vignettes, the contents of which varied by experimental condition. The vignettes consisted of a description of the behavior of a hypothetical adolescent son having 'dating problems'. In the mild behavior condition, the boy was described as somewhat depressed; in the severe condition, he was presented as violent and dissociated[1]. The boy was then labeled either 'normal' or 'mentally ill' by either a school counsellor (who was defined as a 'weak' labeler) or a psychiatrist (strong labeler). The boy's own account of his behavior attributed his actions to 'being under too much stress' or problems for which he needed psychiatric help.

After reading the vignette for the experimental condition to which they had been assigned, subjects completed a scale consisting of seven items assessing the amount of parental control they would want to exercise in the situation described and three items measuring the amount of emotional strain they would feel under those circumstances. The results of an analysis of variance performed on the scale scores indicated that

[1] The authors claim that this operationalization of normal/mentally ill behavior was done on probabilistic grounds (i.e., the behavior was varied by how likely others would be to define it as normal).

behavior, label and account all had significant effects on the parental control variable, while behavior and label were significant in the strain variable. The individual's behavior was the most important consideration: the cell means for the two behavior conditions differed significantly under all conditions of the other variables. The mentally ill label had a significant main effect only in the mild behavior condition with the 'under stress' account. Thus, consistent with labeling theory, the ascription of mental illness to an individual by an expert facilitates lay definitions in specific (behavioral) circumstances.

Another empirical examination of the effects of behavior and labeling conducted by the same authors (Loman and Larkin, 1976) produced slightly different results. A 2x2x3 factorial design was employed in which subjects (204 sociology students) viewed videotaped behavioral sequences. The factors varied were behavior, label and actor's account. The taped sequence consisted of an academic counselling session in which a female student discussed the reasons for her failure in college. Her explanations of this problem constituted the (two) behavioral conditions -- mild and severe. In the former, the individual attributed her poor academic performance to the anomic atmosphere of the university and the indifference of her professors and even the counsellor to whom she was speaking. In the severe condition, she accused both her professors and the counsellor of actively persecuting her. The behavior thus varied in the likelihood of others defining it as mentally ill.

The label variable, which was presented by the person showing the videotape, also consisted of two conditions -- normal and paranoid. In the first, the student was described as having past academic problems,

but as being otherwise normal. In the second condition, she had supposedly been diagnosed in previous counselling as having psychiatric problems (namely, paranoid tendencies).

There were three conditions of the account variable -- no account, situational stress and mental illness. The student in the tape, respectively, did not explain her behavior in the counselling session, claimed it was the result of problems in her interpersonal relationships, or claimed she was losing control of herself and expressed a desire for psychiatric help.

After viewing a videotape, subjects completed questionnaires comprised of a six-item social rejection scale and a six-item social competence scale on which they rated the hypothetical individual presented to them. An analysis of variance performed on the results indicated that the effects of the label variable were statistically significant ($p < .01$) on both scale dimensions. The behavior variable had significant effects ($p < .01$) on social rejection only, and these were much smaller than those produced by 'label'. The account variable had no significant effects on either subjects' evaluation of the individual's competence or their rejection of her. In addition, there were no significant interaction effects between/among any of the variables.

These findings lead the authors to conclude that:

> "it was obviously the type of label attached to the actor which served as the central element of information in the audience's definition of the actor's condition. ... (i)t was the conscious acquiescence of the subjects to the characterization (and stereotypes) implicit in the label that produced the differences in the experiment."
> (Loman and Larkin, 1976)

These results suggest the relative primacy of the ascription of mental illness over an individual's actual behavior in others' definitions

of and reactions to him or her. The decision that he or she is socially incompetent and the concomitant rejection of the individual appear to depend much more on labeling since, in this study, it was less what an individual said or did that led others to conclude she was mentally ill (as manifested in their rejection/perceived incompetence of her) than what was said of her.

In apparent contradiction to these findings are the results of a study by Kirk (1974), which examined the influence of individual behavior, label, and role of the labeler. Subjects (864 community college students) read a short vignette containing information on these three variables. The design was a 3x3x4 factorial. The conditions of the behavioral variable consisted of three brief descriptions of a man who was either paranoid, a depressed/anxious neurotic or normal. The label variable was contained in a sentence following the description which defined the individual in question as 'mentally ill', 'basically wicked' or 'normal: just under stress'. Under the conditions of the third variable, the label was attributed to one of four sources: the individual himself; his family; 'some people'; or 'a psychiatrist who knows him'.

Subjects rated the individual described to them on a nine-item social rejection index, and the scores were subjected to an analysis of variance, the results of which showed a significant effect ($p < .001$) for behavior alone on rejection. The influence of label and labeler lacked statistical significance, as did the interaction effects between/among the variables. Similarly, the mean rejection score from a control group ($N = 87$) receiving no information on labels or labelers was not significantly different from the mean scores of groups which received labels.

From this, the author concludes:

> "Labeling rule-breaking behavior was found to have an influence on rejection independently of the behavior engaged in. This suggests that key elements in the labeling theory of mental illness may need to be modified, if not abandoned."
>
> (Kirk, 1974)

The validity of this conclusion will be considered subsequently in the critique of the empirical results. At this point, it is sufficient to note that the foregoing study appears to indicate that imputations of mental illness by lay or expert others have no effect upon people's reactions to deviants; these reactions are based solely upon behavior.

Support for this contention is provided by another study (Kidd and Sieveking, 1974), in which expert labeling of an individual as mentally ill did not significantly affect others' definitions of him. The investigation, which was conducted as a mail-out survey-experiment, was formulated to assess the impact of psychiatric testimony in criminal trials. Subjects (N = 76), who served as 'jurors', each received two case vignettes in which a hypothetical defendant had entered a plea of 'not guilty by reason of insanity'. They were asked to reach a verdict in each and to rate each defendant on a scale of fourteen bipolar adjective pairs representing three factors (i.e., an 'Insane-Nonaccountable' factor in which the defendant does not know right from wrong and is untrustworthy; a 'Not Trustable-Accountable' factor in which he is dishonest, responsible and in need of punishment; and a 'Chronic Physical Ailment' factor in which the defendant is physically ill).

The design of the study was a 2x2x2 factorial, varied by type of criminal case, model of psychiatric testimony and application of a mentally ill label. The conditions of the first variable consisted of

the hypothetical defendant committing a crime either against property (arson) or against the person (manslaughter). The theoretical model of the psychiatric testimony provided was based on either a medical or a social-psychological framework. The label was varied by whether or not the words 'mentally ill' were mentioned in the psychiatrist's testimony: in one condition they were mentioned three times, while in the other they did not occur at all.

An analysis of variance of the data obtained from the scales showed a significant effect ($p < .001$) for the type of case on the 'Insane-Nonaccountable' factor:

> "Jurors judged the defendant who committed a crime against property to be more insane and nonresponsible than the defendant who committed manslaughter."
>
> (Kidd and Sieveking, 1974)

There were no significant effects of any of the variables on the other two factors. The subjects' verdicts showed that 53% found the defendant guilty, 23% believed he was not guilty by reason of insanity, and 24% of them were undecided. Again, the variables did not produce significant effects either here or in regard to the subsequent punishment recommended by the subjects. Thus, behavior (i.e., case) appeared to be the only relevant variable in lay definitions of mental illness.

A final study which partially attempts to specify the influences of behavior and label on lay evaluations of others was conducted by Caetano (1974). While his principal aim was to examine the effects of labeling in conjunction with clinical experience, the results obtained from the former variable are relevant to the issues under consideration here. Subjects (36 psychiatrists and 77 students) viewed two videotaped diagnostic interviews conducted by a psychiatrist, one of which

featured a student who was paid to participate, and the other a hospitalized mental patient. Half of the subjects were told that both individuals were paid participants, the other half were told that they were both mental patients. After viewing each tape, they completed a questionnaire requesting three types of reaction: diagnosis (according to the traditional categories); justification for this definition (via a short 'pen sketch' of the relevant behavioral symptoms); and assessment of degree of illness impairment on a seven-point scale.

The results of an analysis of variance performed on the latter scores indicated that 'suggestion effects' derived from labeling individuals as mental patients had significant effects ($p < .01$) on subjects' evaluations of their degree of mental illness when the influence of clinical experience was controlled. Thus, while the mental patient received higher scores within categories (i.e., paid participant versus student), lay subjects rated the normal individual who was presented as a mental patient as sicker than the mental patient presented as normal, indicating the facilitative role played by labeling in lay imputations of mental illness.

An examination of the above studies indicates that, while all investigators purported to specify the behavioral and labeling conditions under which lay social members ascribe mental illness, their results are not consistent. Kirk (1974) and Kidd and Sieveking (1974) contend that expert definitions of an individual as mentally ill are irrelevant in others' formulations; that which counts is the individual's behavior. In contrast, Phillips (1968), Loman and Larkin (1976); Larkin and Loman (1978), and Caetano (1974) claim, on the basis of their results, that, while behavior is an important factor, people's definitions of another

as mentally ill are significantly influenced by expert labeling. Given this apparent contradiction, it is now necessary to evaluate critically the above studies to determine possible sources of variation. From these a general hypothesis about the conditions under which lay labeling occurs will be posited. Also, some general criticisms of the studies will be noted and a research design aimed at determining the effects of varying conditions will then be outlined.

The most important difference among the foregoing studies lies in the operationalization of the concepts being tested. Therefore, it is in this variation that an explanation for the inconsistencies in the results will be sought. It will be argued that, as per labeling theory, expert definition of an individual as mentally ill is a facilitating factor, the effects of which, therefore, are strongest in situations where an individual's behavior is ambiguous. Where his actions are perceived as either clearly understandable or rational (i.e., normal) or clearly irrational/incomprehensible[1] (i.e., mentally ill), social members need no such expert advice to enable them to reach a decision about the nature of his identity. To state the obvious, in the absence of obvious behavioral indicators, expert labeling operates to influence people's definitions in the direction of findings of mental illness.

To return to the empirical studies under review, it is apparent that the research conducted by Kirk (1974), which failed to find significant effects from psychiatric labeling, contains such obvious descriptions of paranoid, neurotic and normal behavior that evaluators needed no additional information to identify the individual presented to them.

[1] In terms of a socially accepted vocabulary of motives.

Thus, the attempt to specify the effects of psychiatric labeling versus behavior using such blatant synopses of symptomatology is invalid, since the former's influence is confounded by the labels implicit in the latter (Loman and Larkin, 1976). Similarly, both Phillips (1968) and Larkin and Loman (1978) who also employed short, written vignettes describing different types of mental illness, found labeling of secondary importance. By contrast, both Loman and Larkin (1976) and Caetano (1974), who employed videotaped sequences of ambiguous behavior found that expert definition significantly affected lay labeling.

Finally, it is necessary to account for the lack of influence of psychiatric definition found by Kidd and Sieveking (1974), who did not employ the same implicit behavioral definitions as Kirk. The absence of significant differences in their results under different conditions is attributable not to the way in which the behavior variable was operationalized, but rather to the operationalization of 'label'. The only difference between the two conditions of this variable was the mention of the words 'mentally ill', which clearly did not constitute adequate variation inasmuch as psychiatric definitions carry with them implicit labels, whether or not the term mental illness is explicitly invoked. Thus, the operationalization was such that the label variable was not actually varied and so the authors' results are not surprising.

Before proposing specific hypotheses regarding the relative effects of individual behavior and expert labeling, some more general critical comments on the existing investigations are in order. Perhaps the most obvious shortcoming of the foregoing studies is the way in which the concept of mental illness behavior was operationalized. It will be recalled

from the preceding discussion of labeling theory that the individual behavior upon which allegations of mental illness are based involves the violation of some residual rule(s) (Scheff, 1966; Goffman, 1961; Lemert, 1967). If others cannot role-take with an individual and see his/her behavior as an understandable means to some end or as a rational response to some circumstances (i.e., if they cannot supply him/her with a socially accepted vocabulary of motives), then they may resort to 'explaining' his/her actions by defining him/her as mentally ill (Mechanic, 1962). However, none of the empirical tests attempt to operationalize mentally ill behavior in these terms. Rather, two studies employ short, obvious descriptions of symptomatology which are not situated in any social context (Phillips, 1968; Kirk, 1974). Two others operationalize behavior in 'probabilistic' terms: they present behavior which is described as 'likely' to be construed as, respectively, paranoid and unusual or abnormal (Loman and Larkin, 1976; Larkin and Loman, 1978). In fact, these authors have simply located blatant symptom descriptions in specific situations[1]. One author attempts to sidestep the problem of operationalizing normal and mentally ill behavior by utilizing a 'known groups' technique (Caetano, 1974) -- in the normal behavior condition, a student was presented to subjects, whereas in the mentally ill condition, a mental patient was shown on the assumption that the two individuals were different. In the final study, there was no attempt to operationalize behavior as mentally ill/not mentally ill (Kidd and Sieveking, 1974). Subjects were presented with hypothetical individuals who had engaged in one or two types of crime (arson or manslaughter).

[1] For example, Loman and Larkin (1976) present subjects with a student who claims that 'everyone is out to get her for no reason'.

Thus, it would appear that none of the empirical investigations adequately test the relative effects of individual behavior which may be defined as mentally ill and psychiatric labeling, since none operationalizes the former in terms consistent with labeling theory (i.e., as a residual rule violation). An adequate investigation of the perspective clearly requires such an operationalization.

Another general criticism of the foregoing studies is that while all six purported to assess the effects of individual behavior and expert labeling on subjects' definitions (i.e., of the individual as mentally ill/not mentally ill), four of them did not obtain direct information on these definitions. Rather, three measure subjects' rejection of the individual (Phillips, 1968; Loman and Larkin, 1976; Kirk, 1974), while the fourth evaluates the amount of control subjects would want to exercise over the individual and the amount of emotional stress he would create in them (Larkin and Loman, 1978). The rationale for the former measurement is that definitions of mental illness generally prompt rejection of individuals so defined (Cumming and Cumming, 1957; Nunnally, 1961). However, on the basis of some evidence which suggests that rejection may be an extreme reaction which is manifested only after the failure of attempts to bring the individual perceived as mentally ill 'back into the fold' (Orcutt, 1973), Larkin and Loman endeavoured to measure inclusionary reactions as an indicator of definitions of mental illness[1]. To state the obvious, research aimed

[1] It should be noted that even if the intent behind people's reactions is not exclusionary, the consequences nonetheless may be so. For example, if the definition of an individual as mentally ill results in others' actively monitoring his/her behavior, insisting that he/she get psychiatric help to 'get better', attempting to isolate him/her from social situations which might exacerbate his/her condition and so on, it would seem that the implications for the individual's career would not be that different from those resulting from outright rejection.

at assessing the circumstances under which people define others as mentally ill should first determine whether or not the former actually do define the latter as mentally ill before assessing the reactions which presumably stem from such definitions.

B. Hypotheses to be Tested

With these general criticisms in mind, it is possible to turn to the formulation of some specific hypotheses regarding the relative effects of individual behavior and expert labeling on lay definitions. It appears from both labeling theory and research that when an individual's behavior is easily recognized by others, psychiatric definitions do not exert significant influences; but where there is behavioral ambiguity, the effects of this variable become important in structuring others' formulations of the identity of the individual in question. It is to this seemingly obvious but yet uninvestigated proposition that attention will be directed. Specifically, the following hypotheses are proposed:

1. There is an inverse relationship between the ease with which people can supply an individual with a socially available vocabulary of motives for his/her rule-breaking and the likelihood that they will define him/her as mentally ill.
    i) When the individual's behavior is understandable in terms of a vocabulary of motives, others will not define him/her as mentally ill regardless of psychiatric labeling.
    ii) When the individual's behavior <u>cannot</u> be understood in terms of any socially accepted vocabulary of motives, others will define him/her as mentally ill regardless of psychiatric labeling.

2. When an individual's behavior appears ambiguous (i.e., cannot be construed as completely understandable or completely non-understandable in terms of a vocabulary of motives) people will be influenced by psychiatric labeling in their definitions of the individual in the following ways:

   i) when no psychiatric labeling occurs, they will not define the individual as mentally ill;

   ii) when psychiatric labeling occurs, they will define the individual as mentally ill;

   iii) when conflicting psychiatric labeling occurs (i.e., the individual is defined by one expert as mentally ill and by another as mentally healthy), they will define the individual as mentally ill due to the introduction of the mentally ill label and the ease with which biographical support can be found.

III. Research Design

A. Methodological Approaches

Before proposing a research design to determine the effects of behavior and labeling on lay people's definitions of mental illness, it is necessary to consider the various possible methodological approaches by which the problem might be investigated.

Denzin (1970a:448) states that there are five basic types of research methods by which sociologists may glean knowledge about social reality: the experiment, the survey, participant observation, unobtrusive measures, and the life history. Each method has its strengths and weaknesses and each supplies information about the 'real world' from a slightly different perspective. Because the advantages inherent in each approach counterbalance to some extent the disadvantages of the others, the author argues that there is no single method which can provide definitive answers to sociological problems. Rather, researchers must attempt to validate findings obtained via one approach with those discovered by another. Thus, for example, if the results of a large-scale social survey suggest that feelings of alienation among workers are inversely related to the amount of control they are able to exercise over their work, the investigator could then employ participant observation and unobtrusive measures to cross-check his/her hypotheses. If he/she found via the former approach that skilled craftspeople who were able to regulate their work-flow derived satisfaction from their work whereas assembly-line workers did not; and, via the latter, that craftspeople had lower rates of absenteeism and changed jobs less frequently than their assembly-line counterparts and that highly automated industries had high rates of employee turnover, then he/she could have greater confidence

in the validity of all of his/her findings. By using such a 'triangulated' strategy (i.e., "the combination of methodologies in the study of the same phenomena ..." (Denzin, 1970b:297)), it becomes increasingly unlikely that the picture obtained of the social world is a methodological artifact.

From this perspective, then, the researcher is well-advised to conceive of any given method of data collection as one way (as opposed to the way) of obtaining knowledge. While certain approaches may be deemed more or less appropriate to particular sociological problems, none should be summarily dismissed from the sociological arsenal. This is not to suggest that results should not be assessed critically or that every method is equally capable of generating relevant data on all research questions. Rather, the point is that findings should not be rejected outright because 'participant observation is reactive' or 'experiments are subject to demand characteristics' or 'the survey fosters a response set' and so on.

To return to the problem upon which this thesis focuses, it is apparent that the selection of a methodology with which to clarify the phenomenon of lay ascription of mental illness must be made with the foregoing qualifications in mind. It is now possible to consider the five aforementioned methods in regard to the problem at hand. The aim of the ensuing discussion is to assess the relative merit of each of the five possible strategies in providing information pertinent to this problem, so exhaustive critiques will not be undertaken. Instead, the possibility of testing the previously proposed hypotheses by each method will be briefly examined.

1. The Life History

The life history method involves the in-depth study of a single case through documents such as diaries, letters and case histories which

> "throw light on the subjective behavior of individuals. Its basic theme is a record of experiences from the subject's point of view."
>
> (Denzin, 1970a:462)

In the study of the creation of mental illness, this approach is capable of supplying invaluable insight into the subjective effects of labeling (e.g., whether or not self-redefinition occurs, the consequences resulting from this redefinition or those stemming from attempts to reject a mentally ill identity, etc.). Subjective accounts of individuals who come to be recognized and treated as mentally ill (e.g., Krim, 1970) supply the kind of rich information which the sociologist as an observer could not otherwise obtain.

However, despite its utility in this regard, the life history method is incapable of shedding much light on the relative effects of individual behavior and expert labeling on lay people's definitions of mental illness. This lack of efficacy stems principally from the specificity of the focal concern -- it is unlikely that much information on lay labeling could be derived from the sources on which the method depends. Hence, this would not appear to be a particularly fruitful approach to follow in seeking data regarding our hypotheses.

2. Unobtrusive Measures

There are four basic types of unobtrusive measures: depository or erosion traces left by participants in social situations; archival records describing the behavior of individuals or organizations;

passive observations of behavior in situations where the observer has no control; and audio and video recordings of behavior in natural settings (Denzin, 1970a). In the study of mental illness, the latter three strategies are potentially germane. For example, Nunnally's (1961) content analysis of mass media presentations of mental illness provide a wealth of information about the nature of the social institution of insanity. Analyses of documents describing the movement of patients in and out of mental hospitals similarly illuminate aspects of the creation of mental illness (e.g., who gets committed, for how long, etc.). Films and tapes of, for example, life in a mental hospital[1] provide permanent records of actual interactional dramas which are amenable to coding and analysis. Like the life history method, however, unobtrusive measures are not well-suited to illuminating the phenomenon of lay definition of mental illness. The kind of information necessary to clarify this issue is not found in archives or documents. Neither is it apt to be obtained via passive observation or recordings since instances of lay labeling occur infrequently and unpredictably in natural settings. Thus, it would appear that, while unobtrusive techniques are eminently appropriate in obtaining data on some official, formal aspects of the creation of mental illness, they are of marginal value in examining the unofficial, informal aspects with which this thesis is concerned.

[1] An example of this is Frederick Wiseman's powerful documentary on life in a state mental institution, entitled "Titticutt Follies".

3. Participant Observation

The objective of participant observation is to "record the ongoing experiences of those observed, through their symbolic world ..." (Denzin, 1970b:185). The researcher participates in/observes social phenomena as they happen in an effort to understand the social reality of a particular person or group. Because the objective is more the generation of insight than the testing of specific hypotheses, research designs based on this approach are largely unstructured. The researcher proceeds into the field with some general questions and some sensitizing concepts (Blumer, 1969) and endeavors to share in the symbolic world of those observed. To the extent that he/she is successful, his/her results provide rich and convincing data on the nature of social reality from the perspective of participants.

Despite the potential advantages of this method, it would be difficult to generate data on the problem under scrutiny via participant observation since, as noted, the number of naturally occurring instances of lay labeling of an individual as mentally ill is bound to be small and unpredictably distributed. Thus, the likelihood of apprehending even one such instance in vivo is minimal. In addition, the participant observer's lack of control over the factors of individual behavior and the absence, presence and/or nature of expert labeling would render general conclusions about the relative importance of each of these variables problematic.

This is not to suggest that this strategy is inappropriate to study other aspects of the creation of mental illness. For example, because experts and groups of experts routinely reach decisions about whether or not individuals are mentally ill, participant observation is very appropriate to an examination of the factors involved in official labeling in

psychiatric diagnosis and commitment (cf. Scheff, 1966:130-155). Also, it is invaluable in forging an understanding of the situation of those officially designated mentally ill. This is most readily accomplished for patients in mental institutions (e.g., Goffman, 1961; Rosenhan, 1974).

Participant observation, therefore, is a powerful methodological tool but it is unlikely that sufficient data on the phenomenon of lay labeling could be provided via this approach to test the hypotheses with which this thesis is concerned.

4. The Survey

In social surveys, data are gathered by interview or questionnaire. Denzin states:

> "Observations are typically collected at one point in time -- no before observations are made, no control is exercised over experimental variables, and no control groups are explicitly constructed; a group of persons are observed at one point in time and questioned about their behaviors, attitudes and beliefs with respect to a series of issues." (1970b:165)

This approach enables the collection of information on specific topics, since the investigator controls the subject matter (i.e., he/she gets to determine the questions to which subjects will respond). It also allows comparisons to be made among the results because the same information (to a greater or lesser extent depending on the degree of standardization of the instrument[1]) is obtained from each subject. In addition, surveys are useful in describing general population parameters and trends.

The relevance of the survey to the study of mental illness lies principally in assessing attitudes toward mental illness, upon which

[1] Clearly, the results of fixed-choice questionnaires are much more standardized than those of open-ended interviews, but both are directed toward some topic(s) proposed by the investigator.

reactions to the mentally ill are presumably predicated (cf. Cumming and Cumming, 1957; Nunnally, 1961). In terms of the present interests, this method is capable of reflecting people's recollections of how they came to 'realize' that others were mentally ill (e.g., Smith, 1978; Yarrow, et al., 1955; Jackson, 1973). The major problem with using interviews or questionnaires to evaluate lay labeling stems from the investigator's lack of control over any of the variables: there is no way of assessing the relative influence of individual behavior, expert labeling or any other contributing factors since these will vary widely in each case. Also, the investigator must rely on subject's memories, the pitfalls of which are suggested by Larkin and Loman, whose comments regarding studies of labeling within the context of the family (i.e., Yarrow, et al., 1955; Jackson, 1973; Sampson, et al., 1964)are equally applicable to any survey focusing on the way in which people came to 'recognize' mental illness in others. They note that such studies are necessarily "based upon family members' recollections after medical diagnosis had occurred, making retrospective interpretation likely." (Larkin and Loman, 1978) (emphasis added).

Hence, it appears that the social survey can provide valuable information for the sociology of mental illness but its lack of control over the variables involved in lay labeling renders the approach problematic for the purposes of this thesis.

5. The Experiment

Experimental research is the archetypal form of scientific inquiry because it allows the investigator the greatest amount of control

over the phenomena he/she is studying[1] (Denzin, 1970b:147).

Ideally, the experiment consists of

> "a situation in which the investigator controls some and manipulates other variables, thus enabling him to observe and analyze the effects of the manipulated variable(s) in a situation in which the operation of other relevant factors is believed to have been held constant."

Data may be collected in either laboratory or field settings (Steffensmeier and Terry, 1975). This method is well-suited to the analysis of face-to-face interaction and of behavior under different conditions. Because the experimenter is able to control these conditions, he/she does not have to wait for an event relevant to his/her problem to occur naturally (as in the case with participant observation); nor need he/she attempt to locate people who have experienced a situation similar to the one in which he/she is interested, and rely upon their recollections (as in the social survey). He/She therefore is able to obtain data on very specific topics and problems. It is these advantages (i.e., control and the ability to focus on small-group processes) that render the approach invaluable in the study of micro-level aspects of the phenomenon of mental illness. Given labeling theory's emphasis on the role of interpersonal interaction in the creation of deviance, it is apparent that this method has the potential to supply information on these crucial processes. For example, the nature of the societal reaction to people designated as mentally ill could be systematically studied, and, by using psychiatrists as subjects, the factors involved in psychiatric

[1] This does not mean that experimental methods are 'best', for control is not the only concern of the social scientist (unlike his/her physical science counterpart). The shortcomings of the approach are discussed subsequently.

diagnosis could be more accurately determined (cf. Caetano, 1974; Braginsky and Braginsky, 1975). More specifically,

> "experimental research in either natural or laboratory settings may be a promising technique for investigating informal reactions to deviance ..."
> (Neff and Orcutt, 1978).

In light of the concerns of this thesis, then, this strategy appears capable of generating data relevant to the testing of the proposed hypothesis[1].

B. Evaluation of the Methodological Approaches

The foregoing discussion of the five sociological methodologies is far from comprehensive, but, as mentioned at the outset, its purpose was not to provide a thorough exegesis of the merits and deficiencies of each approach. The aim was to examine their potential to provide information regarding the hypotheses under investigation. It would appear from the discussion that the life history, unobtrusive measures and participant observation, while by no means irrelevant, are unlikely to produce sufficient information bearing upon the selected aspects of lay labeling. Similarly, a standard survey which does not permit manipulation of variables is incapable of soliciting data from which conclusions about the relative influences of these variables may be drawn. Therefore, the ensuing research design will take the form of a survey-experiment.

Some general comments on the method per se will be offered before the specifics of the design are detailed. One issue which warrants

[1] Again, it is necessary to note that this contention is not meant to imply that the data so generated would be free from flaws or provide definitive answers to all questions about lay labeling. Rather, the point is that the experiment is one apparently promising way by which the phenomenon under scrutiny can be investigated.

consideration here is the relative lack of any type of experimentation in investigations of labeling theory (Steffensmeier and Terry, 1975). Despite the fact that the experimental approach has the potential to illuminate important questions arising out of the labeling theory, it has not been employed by researchers with the frequency that might be expected. The paucity of experimental research on labeling may be attributable not to any intrinsic properties of the method which render it inappropriate, but rather to the methodological biases of the symbolic interactionist tradition from which labeling theory stems. It is the position of the dominant branch of the former (i.e., the Chicago school) that qualitative methods (life histories, open-ended interviews and especially participant observation) are the methods of sociological (interactionist) inquiry. According to the principal spokesperson of the Chicago school, Herbert Blumer, the aim of investigation is to see the actor's world as he/she sees it:

> "Through some form of sympathetic introspection, the student must take the standpoint of the acting unit (person or group) whose behavior he/she is studying and must attempt to use each actor's world of meaning. This intuitive verstehende approach emphasizes intimate understanding more than inter-subjective agreement among investigators."
> (Meltzer, et al., 1975:58).

Clearly, labeling theorists who accept this position as symbolic interactionist orthodoxy would be deterred from employing experimental methods in their empirical research. However, the Chicago school is far from synonymous with symbolic interaction. The other major interactionist orientation -- known as the Iowa school -- takes strong exception to the Chicago school's narrow interpretation of methods for inquiry. Students of the Iowa school contend that it is both possible and necessary to operationalize and test sociological concepts via more

rigorous scientific methods such as surveys and experiments. Because this position is not as widely accepted in symbolic interactionism or, concomitantly, in labeling theory (as manifested in both the type of methods most frequently advocated and actually employed), it is necessary to evaluate the basis for the greater credibility of the Chicago school.

Perhaps the primary reason for the greater support of the Chicago school by interactionist theorists is that it is presumed to reflect more closely the position of the founder of symbolic interaction, George Herbert Mead. Blumer is generally credited with extrapolating from Mead's work the methods by which research should be undertaken and, as a result, Blumer's methodological position is accepted as the position of Meadian symbolic interaction. An examination of Mead's writings, however, indicates that this is not the case: Mead's position differs radically from that of Blumer, and is far more accurately reflected in the approach of the Iowa school (Kohout, 1975; McPhail and Rexroat, 1979). Critics conclude that "Mead's emphasis on systematic observation and experimental investigation is quite different from Blumer's naturalistic methodology." (McPhail and Rexroat, 1979). Mead advocated scientific inquiry and called for the formulation and testing of hypotheses by both experimental and non-experimental means.

> "For Mead, modern science emphasizes the controlled perception of observed fact and the controlled reconstruction of an observed world. ... Mead, unlike Blumer, requires and discusses procedures for the controlled perception of observed facts and for establishing scientific problems as social objects."
>
> (McPhail and Rexroat, 1979).

Thus, it would appear that the use of experimentation is in no way inconsistent with the symbolic interactionist approach inasmuch as the

founder of the school of thought explicitly calls for the use of this strategy. The Chicago school's rejection of 'non-phenomenological' tactics of inquiry on the grounds that they are inappropriate to interactionist concerns is belied by the writings of Mead.

To return to labeling theory, the rejection of experimental tactics because they are regarded as inappropriate in symbolic interactionism (and hence, by association, labeling theory) is similarly invalid. An examination of the position of both Mead and the proponents of the Iowa school indicates that there is no theoretical reason why experimentation should not be employed as one method by which to test the tenets of labeling theory. Consistent with the strategy of triangulation presented previously (Denzin, 1970a; 1970b), investigators should use any and all strategies potentially capable of illuminating their research problems.

Prior to examining the specifics of the survey-experiment method to be employed in the ensuing research, some additional general comments on the experimental approach are germane. It was previously noted that, in experimental research, the researcher exercises a high degree of control over the phenomena he/she is studying and control figures importantly in the assessment of causality. Since the aim of much sociological inquiry is the determination of causal factors (Steffensmeier and Terry, 1975:38; Denzin, 1970b:147), this is the primary advantage of experimentation. The way in which this method deals with the issue of causality will be detailed.

Three criteria must be met in order to establish causality: covariance or association between independent and dependent variables; causal direction or the time order between the variables (i.e., the

independent variable must precede the dependent); and non-spuriousness or the exclusion of rival causal factors (Denzin, 1970b:147; Steffensmeier and Terry, 1975:38-40). The classical experiment is able to deal explicitly with these criteria because of the unique nature of its formulation. Specifically, it has three components: independent and dependent variables; experimental and control groups; and pre- and post-tests (Babbie, 1975:240). Via the experimental model, covariation is determined by the examination of the experimental group as compared to the control group. Differences in the former may be attributed to exposure to the independent variable since that is (ideally) the only factor not common to both groups. Goode and Hatt summarize the logic underlying this contention:

> "If there are two or more cases, and in one of them observation Z can be made, while in the other it cannot; and if factor C occurs when observation Z is made; and does not occur when observation Z is not made; then it can be asserted that there is a causal relationship between C and Z."
>
> (Goode and Hatt, 1952:76)

Causal direction is established in the experiment by comparing the pre- and post-test measures. Because the former is temporally prior to the latter, the independent variable can be proven to precede (and hence influence rather than be influenced by) the dependent variable. Finally, the standard method by which rival causal factors are excluded in the experimentation is the formulation of experimental and control groups which are as similar as possible.

> "In order to insure that no differences exist between the experimental and control groups before the experimental treatment, the typical strategy is to randomly assign subjects to one or another of the two groups. ... (R)andomization serves to distribute any differences between subjects normally, so that valid comparisons can be made. Randomization is an essential feature of experimental design simply because the investigator can neither know nor adequately control all the relevant factors that could influence his causal analysis ..."
>
> (Denzin, 1970b:150)

It should be noted that randomization cannot eliminate rival causal factors; it can only control for (some of) them and hence non-spuriousness of the causal relationship cannot be established but only inferred. This is because the procedure can deal with the problem of differences among subjects (i.e., extrinsic test factors) but random assignment can do nothing about controlling the effects of the observation process per se (i.e., intrinsic test factors) (Denzin, 1970b:150). These include factors such as maturation of subjects and changes in the measurement instrument(s), but the one which has received perhaps the most attention is the nature of the relationship between subject and researcher within the context of the experiment. Specifically, critics of the experimental method contend that subjects respond not only to the experimental variables but also to a host of other situational cuse which have come to be known as demand characteristics (Orne, 1970). These cues influence performance because, it is argued, participants in an experiment typically have a conception of what is involved in being a 'good subject' and they behave in a manner consistent with this conception. Orne summarizes:

> "The subject's performance in an experiment might also be conceptualized as problem-solving behavior; that is, at some level he sees it as his task to ascertain the true purpose of the experiment and respond in a manner which will support the hypotheses being tested. Viewed in this light, the totality of cues which convey an experimental hypothesis to the subject become significant determinants of subjects' behavior."
>
> (Orne, 1970).

However, co-operation may not be the only attitude embraced by subjects -- they may have a negative view of the subject role and therefore behave in an unco-operative fashion (i.e., actively attempt to disprove that which they believe to be the experimenter's hypothesis) (Adair, 1973).

Clearly, the extent to which the purpose of an experiment appears obvious to subjects is an important determinant of the extent to which the experimental results will be biased by demand characteristics. The primary source of cues regarding purpose is the experimental manipulations: the way in which the desired data is obtained from the subjects will indicate to a greater or lesser extent the researcher's aims. A second source of cues is the experimenter. In his/her interaction with subjects, he/she may transmit via linguistic, para-linguistic and kinesic cues, his/her expectations and thus produce a self-fulfilling prophecy in subject's responses. Second, by virtue of his/her physiological or social attributes, he/she may call out a particular type of response (Adair, 1973).

It is apparent from the foregoing that demand characteristics are a potential threat to the determination of a non-spurious relationship between independent and dependent variables and hence, to the establishment of causality. While this type of rival causal factor cannot be eliminated, the biasing effects of demand characteristics nonetheless may be reduced. Subject bias is controlled by obscuring the purpose of the experiment. The extent to which this may be accomplished depends on the nature of the research problem, but it is one safeguard which can be built into the experimental design (Adair, 1973). In addition, pre- and post-experimental inquiries are useful in determining subjects' perceptions of demand characteristics (Orne, 1970). Finally, supplementing experimental results with data obtained via other methods (i.e., triangulation) is invaluable in the assessment of demand biases. The effects of cues stemming from the experimenter may be reduced by minimizing the interaction between him/her and the experimental subjects, by using experimenters

unfamiliar with the experiment's purposes and by increasing the number of experimenters (Adair, 1973). Thus, by employing any or all of the above strategies, it is possible to reduce one of the major intrinsic threats to the establishment of a non-spurious relationship between the variables under study by the experimental method.

The foregoing discussion has outlined the way in which the classical experiment deals with the three components of causality. While it is superior to other methods by virtue of the amount of control it exerts over factors which enable causal relationships to be determined, it is still limited by factors intrinsic to the experimental design. Thus, the problem of causality is never completely solved, for, regardless of the degree of the researcher's control, the infinite complexity of social reality prohibits more than probabilistic conclusions about what 'causes' what in the 'real world'. In conclusion,

> "It is clear, then, that by whatever design the hypothesis is tested the results are never certain but <u>are approximations stated in terms of probability</u>."
>
> (Goode and Hatt, 1952:87).

Before proceeding to the description of the variation on the experimental method to be employed in the empirical testing of the previously proposed hypotheses, it is necessary to consider the cost at which the experiment obtains its high degree of control. In general, increasing control means increasing artificiality and hence the validity of experimental results (i.e., the extent to which findings can be generalized beyond the research setting) is jeopardized in 'artificial' experimental settings (Denzin, 1970b:161; Babbie, 1975:254). This is perhaps the most serious disadvantage of experimental methods and it plagues to varying degrees all experimentally obtained data. However, to reiterate the logic of triangulation, it is unwarranted to dismiss this(or any) method because

of its shortcomings. Rather, the researcher should make every attempt to alleviate the problem in the construction of his/her design, he/she should remain fully aware of the possible effects of artificiality when reaching conclusions about the generalizability of his/her results, and finally he/she should employ whatever other methods he/she can to obtain data on his/her problem with which to validate (or invalidate) the experimental results.

It is now necessary to undertake a more thorough examination of the nature of the method to be employed herein -- the survey experiment. This type of experiment

> "involves the intervention of the experimenter in the manipulation of the independent variables by a randomization procedure wherein some subjects are presented with one set of stimuli and other subjects receive a second set of stimuli."
>
> (Steffensmeier and Terry, 1975:46).

This is a departure from the classical experiment in that no control group is explicitly formulated. Rather, the various experimental conditions (i.e., 'sets of stimuli') represent varying degrees of values of the independent variable(s) under consideration[1], and these constitute the 'control' group(s).

The survey-experiment also differs from traditional experimental designs in that the data consist of subjects' self-reports rather than measurements or observations of their actual behavior (Steffensmeier and Terry, 1975:48). While reliance on the former is problematic in terms of predicting behavior (since what people <u>say</u> is not necessarily what

[1] For example, since our concern is with the influence of individual behavior and expert labeling on subjects' definitions of an individual as mentally ill, the control groups (or perhaps more accurately, comparison groups) are constructed by the combinations of the strength of labeling in conjunction with the type of behavior.

they do[1]), it may nonetheless be defensible on the following grounds. First, it may not be possible to create a convincing experimental setting capable of eliciting the specific behavior in which the researcher is interested. For example, behavior in a situation of crisis or natural disaster would be difficult to obtain experimentally, since the replication of such a situation would be extremely difficult. Thus, the researcher might obtain pertinent data by presenting his/her subjects with descriptions of disasters and asking them how they would behave under these circumstances[2]. Second, the reliance on self-reports is acceptable if the precise nature of behavioral responses is not the primary concern of the researcher. The most obvious example of this type of situation is the issue on which this thesis focuses -- lay definitions of mental illness. It is apparent that self-reports supply the most direct assessment of subjects' definitions, although conclusions about their subsequent reactions would require validation from measurements of overt behavioral responses to the individual(s) they have defined.

Finally, the survey-experiment differs from its classical counterpart in that the former does not employ a pre-test. Therefore, the time

[1] For an excellent discussion of this problem, see Deutscher (1973).

[2] Certainly information obtained this way would have to be supplemented with data collected in actual crises/disasters, but it would nonetheless provide some insight into the phenomenon. This is true even if people behave in radically different ways than they say they will, since this discrepancy would indicate that people's ability to predict their own actions in situations of type is poor. Thus, the power of the situational forces would be suggested.

order of the variables must be inferred or assumed and confidence in the causal assessment is diminished (Steffensmeier and Terry, 1975:48). While the failure to pre-test subjects is an unfortunate feature of this type of design, it is unavoidable inasmuch as the object of study in a survey-experiment is generally subjects' responses to the specific variables and/or situations with which they are presented and these obviously cannot be assessed without first presenting the relevant stimuli. Consequently, the researcher must be more critical of his/her results and couch his/her conclusions in more cautious terms than someone conducting a classical experiment.

There are also several advantages stemming from the departure of the survey-experiment from true experimental design. First, since data are collected via self-report rather than by an experimenter, the interaction between subjects and experimenter is reduced, thereby reducing the potential for experimenter-related demand characteristics to bias the results. Second, because subjects are presented with the experimental variables in written form, it is possible to control far more closely the nature of the stimuli received by the subjects (i.e., identical independent variables can be presented to all subjects in each experimental condition since the variation resulting from experimenters' differing presentations has been eliminated). Finally, the artificiality inherent in the traditional laboratory experiment is not as pronounced in survey experiments[1].

1 This is not to suggest that artificiality is not an issue in the latter. It is certainly a concern, but responding to an experimental survey is not as narrowly situated as acting within the physical confines of the laboratory.

C. The Proposed Method

1. Requirements of the Design

It is now possible to turn to the formulation of a research design by which the proposed hypotheses may be evaluated. The requirements for an investigation geared toward this end must first be made explicit. Because concern is with the relative effects of an individual's behavior versus expert labeling (i.e., of the individual as mentally ill) on lay people's definitions of the individual as mentally ill, it is necessary that the design allow the former two factors to be systematically varied. By doing so, the effects of conditions of each variable in conjunction with conditions of the other can be established. In addition, it is necessary that the variables under investigation be operationalized in a manner consistent with labeling theory[1], for if they are not, the ensuing results are of questionable value in supplying empirical grounding for the perspective. Similarly, subjects' definitions of the individuals whom they are assessing must be obtained[2].

A third criterion for an adequate design is that the behavior of the individual(s) presented to subjects must be situated in some social context. Failure to do so results in the presentation of brief summaries

[1] While this requirement seems blatantly obvious, it will be recalled that none of the existing investigations of the problem under consideration operationalized the concept of 'mentally ill behavior' in such a manner (i.e., as residual rule violation).

[2] Again, this seems apparent, but the majority of existing studies infer these definitions from other measures (most notably, rejection indices).

of symptomatology which implicitly label the individual(s) mentally ill[1]. Also, the situationally specific nature of human conduct is a central proposition of the symbolic interactionist tradition upon which labeling theory is based. Therefore, the behavior variable should consist of a presentation/description of behavior in a particular setting.

Another requirement concerns the variation of other factors in addition to those being evaluated. It is apparent that the less other factors vary, the more accurately the relative effects of behavior and expert labeling can be determined. Thus, for example, factors such as the biography of the individual whom subjects are asked to define and the circumstances surrounding his/her rule violation should be held constant across the different behavioral and labeling conditions.

Finally, it is desirable to situate the task assigned the subjects in some situation in which they might logically be asked to engage in the definition process which is required of them. By doing so, it is possible that subjects will have more of an incentive to participate honestly in the experiment, since they will have been provided with some

[1] An example of this phenomenon is provided by Kirk, who presented his subjects with the following description of behavior which is abstracted from any social context (i.e., unsituated):

> "Here is a description of a man. ... For a while now he has been very suspicious; he hasn't trusted anybody and is sure that everyone is against him. Sometimes he thinks that people he sees on the street are talking about him or following him."
>
> (Kirk, 1974)

The emphasis is clearly not on the individual's behavior (i.e., what he does/has done) but rather on his essential nature or identity (what he <u>is</u>, namely suspicious, untrusting, etc.). There is an implicit identification of the individual as mentally ill contained in the above vignette and it is therefore not surprising that the inclusion of explicit expert labels did not significantly alter subjects' definitions of him.

reason why they should define the individual(s) presented to them as mentally ill or not mentally ill. Some of the artificiality may thus be removed from their decision-making task. Also, in supplying such a context, the true purposes of the investigation can be obscured, thereby reducing the biases stemming from demand characteristics (i.e., the desire on the part of the subject to actively confirm or disconfirm what he/she believes to be the experimenter's hypotheses) (Rosenthal, 1976; Orne, 1970).

While all of the foregoing criteria would seem to be obvious requirements for any investigation of the factors under consideration here, none of the existing empirical studies meets all of them. To rectify this situation, a research design which incorporates these requirements will now be detailed.

2. Study Design

In order to determine the effects of different types of behavior and labeling in conjunction with one another, a factorial design will be employed. This type of design enables the concurrent manipulation of two or more (independent) variables, so that every combination of the different levels of each variable can be studied. Factorial designs have the additional advantages of economy and generality (Keppel, 1973:170). The former advantage refers to the number of subjects required to obtain information on the variables in question: a factorial design needs fewer subjects to obtain the same information as the requisite number of single-factor experiments would require. The greater generality of factorial experiments (compared to single-factor designs) stems from the fact that, in the latter, all variables except the one being manipulated are controlled and hence,

> "the particular pattern of results may be unique to the specific values of the other relevant stimulus variables maintained at a constant level throughout the course of the experiment. The factorial experiment provides one solution to this limitation by allowing the effect of an independent variable to be averaged over several different levels of another relevant variable."
>
> (Keppel, 1973:173)

Thus, these main effects[1] of the variables studied in a factorial design are more general because they reflect more than one condition of one or more potentially important variable(s). To illustrate, if only the effects of labeling an individual mentally ill on people's definitions of him/her were studied, his/her behavior would have to be held constant across the labeling conditions. The researcher's conclusions regarding the influence of the independent variable would therefore be limited to a single behavioral condition.

In addition, factorial experiments are capable of supplying information about the particular ways in which the independent variables under study may combine with one another to produce unique results. These interaction effects, as they are called, cannot be uncovered in single factor experiments.

For the foregoing reasons, then, a factorial design featuring three types of individual behavior and three expert labeling conditions will be employed in this study. Subjects in each cell of the factorial matrix will be presented with information on the behavior of a hypothetical individual and on the label applied to him/his conduct by psychiatric experts. The effects of these two variables will be assessed via the definitions made by subjects of the individual presented to them (i.e., mentally ill or not mentally ill).

[1] 'Main effect' is the term used to describe the average of the scores for one variable over the conditions of the other.

Before discussing the operationalization of these factors, however, it is necessary to specify the context in which the survey-experiment will be presented. As aforementioned, it is desirable that subjects be presented with a hypothetical situation in which it is logical that they be asked for a definition of an individual (i.e., as mentally ill/not mentally ill). For example, Larkin and Loman (1978) were interested in the ways in which family members were influenced by behavior and labeling variables, so they asked subjects to take the role of the parent of the individual presented to them and specify their feelings in the situation. Because interest here is in lay people's definitions beyond the immediate context of the family, a situation must be presented in which subjects could conceivably be asked to define an individual unknown to them on the basis of information describing his behavior and experts' definitions of him.

Perhaps the most obvious example of such a situation is a jury trial -- jurors are lay social members who must formulate this kind of definition. Thus,

> "the jury trial ... functions as a dramaturgical arena par excellence and, as such, highlights in bold relief those features of everyday life that are requisite for the imputation of deviance in members' day-to-day activities. By calling attention to the structural and social psychological components adhering in the trial court, one should be able to answer the question, "How, given conflicting evidence, does a jury decide on the 'right verdict'? The conceptualisations dictating this answer should constitute a description of the more general process of how an ascription of deviance is accomplished."
>
> (Hadden, 1973)
> (emphasis added)

Similarly, Hawkins and Tiedeman contend that in procedures such as trials and commitment hearings, the recognition of and reaction to deviance

is rendered overt, and hence amenable to analysis (1975:65). Therefore, definitions of mental illness (as a type of deviance) may be profitably investigated in this context and so the proposed experimental-survey will be presented in a trial setting.

Subjects will be told that jury decision-making in different types of trials is being studied and that they will assume the role of jurors in reaching a verdict in a criminal trial. In order to obtain information regarding definitions of mental illness, the plea in all of the hypothetical trials will be 'not guilty by reason of insanity'. Thus, subjects' verdicts will supply a direct reflection of whether or not they define the individual presented to them as mentally ill. Participants will be randomly assigned to one of the nine experimental conditions comprising the factorial matrix in which they will receive a booklet containing information described as the summary of an actual trial (the contents of which varies by condition). The verdicts obtained therefrom will then be analyzed to discover the factorial conditions under which subjects defined the hypothetical defendant as mentally ill (i.e., not guilty by reason of insanity). In this way, the relative effects of the manipulated factors will be specified and the nature of lay definitions of mental illness will be illuminated.

The particulars of the proposed procedure require further elaboration, but it is first necessary to examine more closely the strengths and weaknesses of employing a trial setting. On the positive side, psychiatric labeling may be convincingly introduced here, since some form of expert testimony is expected in the situation presented. This is an improvement over studies in which expert labeling consists of a single statement attributed to a psychiatrist which is affixed to a

brief behavioral description (cf. Phillips, 1968; Kirk, 1974; Larkin and Loman, 1978). The obviousness of the latter approach makes the purposes of the study readily discernible to questioning subjects and hence creates demand characteristics (Rosenthal, 19 ; Orne, 1970), which are reflected in their responses. Clearly, subjects presented with information about a psychiatrist's opinion of an individual for no apparent reason would suspect that this was 'supposed' to have some influence on their answers. Their suspicions might result in over-co-operation (since they want to fulfill the 'good subject role' and tell the researcher what he wants to hear) or in deliberate attempts to disprove the researcher's theory. The latter tactic, aptly called the 'screw-you effect' by one theorist (Adair, 1973), will produce findings opposite to those resulting from the former orientation, but equally inaccurate. While it is true that all experiments are subject to demand characteristics to some extent, their potential biases are reduced if the purpose of an experiment is obscured. In the proposed experiment, the trial context serves to disguise the focus of the inquiry and hence reduce these demand biases.

From the foregoing, the several advantages of a trial setting for research on the factors figuring in lay labeling of mental illness are apparent, but it is neccessary to account for why a criminal trial was selected over its civil equivalent of a commitment hearing. Certainly definitions of mental illness are made far more frequently in the latter setting, so it would seem the more logical choice. However, these definitions are invariably made by professionals (both mental health and judicial) and so it would not be plausible to request lay people to reach verdicts regarding individuals' sanity in a hypothetical commitment

hearing since they would never be expected to do so in reality. By contrast, lay people in the 'real world' regularly serve on juries in criminal trials in which they may be required to reach the kind of verdict for which they are being asked in this experiment.

In addition, the latter is free from the medical-therapeutic orientation which pervades commitment procedures. The medical rubric encourages the presumption of illness (or Type II errors) and might bias subjects in favor of definitions of mental illness. Hence, by employing a criminal trial context in which sanity is presumed rather than the converse, this potential bias inherent in commitment hearings is avoided.

Finally, a criminal trial has the advantage of allowing for a manipulation of the behavior variable along a continuum of understandability in terms of the availability of a socially accepted vocabulary of motives. In this context, the behavior presented to subjects may be ranged from a rule-violation for which a vocabulary of motives is readily available (i.e., a criminal violation) to a rule violation for which one is not (i.e., a residual rule-violation) while holding other factors constant. The details of the operationalization of these concepts is forthcoming; at this point suffice to say that the trial setting provides an appropriate vehicle for the variation of the behavioral dimension.

The disadvantages of the proposed trial setting also warrant consideration. The most obvious of these is the extent to which the results can be generalized to the issue of lay labeling in any social setting - because subjects are asked to define a particular type of individual (i.e., one who has been charged with a criminal offence), it may be contended

that only conclusions regarding serious rule-breakers can be drawn. While it may be true that lay social members may regard an individual who comes into contact with the law as different from other people, it is also true that people who have come into contact with psychiatric agents/agencies are similarly regarded as different (Nunnally, 1961; Phillips, 1968). Thus, for example, Loman and Larkin's (1976) conclusions regarding the effects of individual behavior and expert labeling would be restricted to individuals who must seek help from university counsellors (which was the context the authors employed), since such individuals are a special group. By the same logic, Caetano's (1974) results would be limited to individuals undergoing a psychiatric screening interview, since that was the context within which his subjects' decision-making task was framed. The alternative strategy of failing to provide a context may eliminate this specific disadvantage plaguing any study which does provide one, but as previously noted, it has its own serious disadvantages.

Therefore, while it is recognized that the results obtained using the proposed trial context must be generalized with care, to dismiss them as completely unique is unwarranted for this would require, on grounds of logical consistency, the dismissal of the results of all experiments situated within a particular context. It should also be noted that the limitations imposed by presenting subjects with a law-breaker are diminished by the fact that the individual on trial in this research is presented as having committed a non-serious, non-violent crime and hence it is unlikely that subjects would regard him as the type of criminal who is qualitatively different from the non-criminal population.

3. Sample

The subjects to whom the survey-experiment will be administered will be drawn from undergraduate summer school courses at the University of Manitoba. It is an availability sample and, as such, it is heir to the shortcomings of all non-probability samples. The most important of these concerns the issue of representativeness: samples must represent the population from which they are selected if the results obtained from them are to be generalized to the population as a whole, and representativeness is far more likely to be achieved via probability sampling (Babbie, 1975:140). Clearly, undergraduate students could not be regarded as representative of any particular population and hence data obtained from them must be treated as suggestive rather than definitive. However, the sampling procedure to be employed herein can nonetheless be defended on several grounds.

First, the population towards which interest is directed in this study is vast, since concern is with the population of lay social members (i.e., all those who are not mental health professionals). The task of drawing a probability sample would be momentous and the logistics of conducting an investigation on such a scale, formidable. Thus, a sample of students, though far from representative, is capable of providing information about one subset (albeit a very small one) of the lay population. This procedure is further justified by the paucity of research examining the phenomenon of lay labeling of others as mentally ill. Because there is so little empirical information available, there is a need for exploratory studies to suggest hypotheses for further more rigorous testing. The study at hand may be regarded as one such attempt at exploration.

In addition, by employing student subjects a number of extraneous and potentially influential demographic variables (e.g., age, occupation, education and, to a lesser extent, socio-economic status) are held relatively constant[1]. Finally, because it is possible to have student-subjects complete the survey-experiment during class time, the circumstances under which they respond are also held constant. Thus, the effects of variables such as time or the presence of unique distractions or the receiving of help from others are controlled.

For the foregoing reasons (and with the foregoing limitations firmly in mind), an availability sample of students will be obtained to participate in the proposed investigation.

4. Data Collection

The specifics of the data collection will now be presented followed by a description of the way in which the labeling theory concepts under investigation will be operationalized. All participants will receive a booklet[2], the first page of which explains the study as an inquiry into the decision-making processes of jurors in criminal trials. They will be asked to read carefully the information presented to them in the booklet, which represents a summary of the facts and testimony of an actual trial, and to reach a verdict on the basis of what they have read, as would regular jurors taking part in a trial.

[1] Specifically, almost all participants can be expected to be in the 17 to 25 year old age group, be full-time students, have a high-school education and come from a middle-class background. The actual homogeneity of the sample will be assessed on the basis of demographic information to be obtained from each subject.

[2] See Appendix.

There will be nine different booklets (i.e., nine versions of the 'trial') corresponding to the nine cells of the previously described factorial matrix. Subjects will be randomly assigned to the different versions. Each booklet contains information about the behavior of the hypothetical defendant in the trial (i.e., the nature of his rule-violation), summaries of testimony from witnesses to the rule-violation and from psychiatric experts, and a biography of the defendant. In every case the plea entered by the defendant's lawyer on his behalf is 'not guilty by reason of insanity'. All of the information presented will be held as constant as possible in the nine conditions, with the exception of the defendant's behavior and the expert labeling. These two factors will be systematically varied so that the subjects' verdicts will reflect the influence of these variables on their definitions of the defendant as mentally ill or not mentally ill (i.e., not guilty by reason of insanity or guilty).

After they have recorded their verdict in the space provided in the booklet, they will be asked to supply a short statement explaining the reasons for their decision. This request will be justified by stating that jurors in regular trials have the opportunity to debate extensively among themselves regarding the bases for their verdicts, and since such debate is not possible in this study, their written rationales are the next best thing. In reality, these statements will provide relevant qualitative data on the way in which subjects arrive at their definitions under the different experimental conditions.

Finally, subjects will be asked some basic demographic questions and requested to complete a short semantic differential scale regarding their feelings towards people who are mentally ill. The latter

will elicit supplementary information on the stereotypes of mental illness which subjects presumably employed in assessing the mental condition of the hypothetical defendant.

At this point, it should be noted that the defendant will be presented as having been 'caught in the act' of breaking and entering. This is necessary because the focus of this research is on the ascription of mental illness rather than the evaluation of guilt or innocence per se. Thus, subjects will be presented with information clearly indicating that the defendant did commit the violation with which he is charged, but they will also be told that no individual can be convicted of a crime if he/she is mentally ill at the time he/she commits it. Therefore, if they believe that the defendant was mentally ill when he committed the violation for which he is being tried, then they must find him 'not guilty by reason of insanity'. Conversely, if they do not believe he was mentally ill at that time, they must find him guilty, since he was apprehended in the act. In this way, their definitions of him as either guilty or not guilty by reason of insanity will not be confounded by questions of his guilt or innocence in the commission of the act with which he is charged.

It is now necessary to discuss the operationalization of the variables under scrutiny to create the nine experimental conditions. With regard to the effects of an individual's behavior upon others' definitions of him, it will be recalled that labeling theory posits residual rule-breaking as a pre-condition for the ascription of mental illness[1]. In order to evaluate this central theoretical contention,

[1] Of the studies previously reviewed, none operationalized mental illness in terms of residual rule-breaking. Three employed descriptions of psychiatric symptoms (Phillips, 1968; Kirk, 1974; Loman and Larkin, 1976), one relied on 'known groups' (Caetano, 1974), while the final study (Kidd and Sieveking, 1974) made no attempt to operationally define the concept.

this concept must be translated into empirically testable terms. However, it was also noted that labeling theorists' specifications of the types of behavior which constitute the primary deviation of mental illness, were ambiguous. Proponents have suggested that a generic characteristic of such deviations is that they lack a socially acceptable or sensible vocabulary of motives and, for this reason, audiences are unable to role-take with the perpetrators and thereby establish their identities. The operationalization of residual rules must reflect this characteristic, and therefore the behavioral conditions in this study will be varied along a continuum of 'understandability' -- an interpretable rule violation at one end (i.e., one for which a socially accepted vocabulary of motives is readily available), an ambiguous one in the middle, and finally a violation for which the audience cannot impute a socially sensible motivation to the actor at the other.

The content of these conditions is formulated on the basis of Mills's (1970) suggestion of the primacy of economic vocabularies of motive -- within our culture, rule violations for which there is the potential for economic gain are easily understood. The profit motive constitutes an adequate explanation of why people embezzle or traffic in drugs. However, when members risk rule violations without this potential, their motivation becomes problematic to observers, and it is in such cases that explanations of the action(s) in question are couched in terms of mental illness. To illustrate, the reasons why poor people steal are seen as obvious to members of our culture (i.e., they need/want the money), and such people readily are defined as thieves. In contrast, rich people who steal could not logically be regarded as motivated by

the same factors, and hence their violation remains uninterpretable except in reference to imputed mental illness; these thieves are defined as kleptomaniacs. Similarly, burning buildings to collect fire insurance is recognized as arson, whereas the same act without the potential for economic gain becomes pyromania.

To return to the issues at hand, concern is with the extent to which people's definitions of an individual are a function of his/her behavior. In other words, the question under consideration is 'to what extent are people's definitions of mental illness the result of mentally ill behavior (i.e., residual rule-breaking) on the part of an individual?' To answer this question, it is necessary to provide subjects with descriptions of individuals who have broken residual and non-residual rules, while holding other factors constant. Therefore, in light of the preceding discussion, the research design proposed herein will evaluate the effects of individual behavior upon subjects' definitions by varying the nature of the rule the individual has supposedly transgressed from more ambiguous (i.e., residual) to ambiguous to less ambiguous (i.e., non-residual) as determined by economic rationality. Specifically, the defendant presented in each condition will be charged with break, enter and theft and his <u>modus operandi</u> will be held constant. The variation among the conditions will consist of the kind of objects which the defendant is caught stealing. Thus, in the residual rule-breaking condition (i.e., at the opposite end of the understandability continuum), he is apprehended attempting to take worthless objects (old newspapers and rags) from a house into which he has broken. In contrast, in the condition at the other end of the continuum, he is caught in the same circumstances

stealing valuable objects (jewellery); in other words, committing a 'normal' crime. Between these two extremes is an ambiguous condition in which imputed economic motives cannot completely account for the defendant's rule-breaking -- he is apprehended in possession of some clothing which may be construed as having some value (i.e., more than the former, less than the latter).

It is necessary to make explicit the logic underlying these variations. In the first condition, the individual's behavior constitutes a residual rule-violation since no vocabulary of motives is readily available to account for his actions. He obviously could not be construed to have been motivated by the desire for economic gain, since he did not attempt to take anything valuable. Thus, subjects could not role-take with him and see his behavior as a rational means to some understandable (in this case economic) end and so his behavior may be regarded as a residual rule-violation.

In the non-residual rule-breaking condition, an economic vocabulary of motives is clearly available to explain the individual's actions (i.e., he was motivated by the desire for economic gain since he was attempting to take something valuable). It is easy to role-take with him and see his behavior as a rational (albeit illegal) means to the goal of improving his financial position -- a goal most members of our culture recognize if not share. Finally, in the ambiguous condition, the nature of the objects taken by the individual renders problematic the imputation of a motive vocabulary. In this case his actions could not be construed to be entirely unmotivated or irrational (since items of clothing have some value and people frequently steal them from stores), but neither do they appear entirely motivated or rational

In order to reduce imputations of bias to the psychiatrists on the part of the participants, the experts will be presented as court-appointed. Their testimony will thus appear to be based not upon vested interest (e.g., they have been hired by the defense to 'get the client off'), but rather on the 'real' mental condition of the defendant. In this way, the experts' definitions are presented as objective medical (psychiatric) diagnoses and the potential discreditation of sources is controlled.

To clarify the design described above, it is useful to present a graphic illustration of the proposed research. Each cell in the following table represents a different version of the mock trial to be presented to study subjects, with the particular variations indicated by the row and column labels.

Figure 1. The Research Design

NATURE OF RULE VIOLATION	Psychiatric Definition → / Individual Behavior ↓	No 'Mentally Ill' Label	Conflicting Labels Applied	'Mentally Ill' Label Applied
	Non-residual violation (economically intelligible motive)			
	Ambiguous rule violation (ambiguous motives)			
	Residual rule violation (unintelligible motive)			

NATURE OF EXPERT TESTIMONY

The contents of the testimony presented in the above conditions will now be detailed. Because the effects of individuals' demographic attributes on the ascription of mental illness are not at issue here, the hypothetical defendant will not testify. The possible influence of his personal characteristics, such as style of presentation, tone of presentation and so on is thereby controlled. This procedure is justifiable inasmuch as social members routinely define others on the basis of second-hand information about the latter's activities and identities. The fact they do not hear an individual's account of his/her behavior or motives does not prevent people from imputing a particular identity to him/her. In addition, by excluding the defendant's testimony from the trial, it is possible to omit his explanation of his behavior, which could not be held constant and hence might confound participants' verdicts under the different conditions.

The witnesses providing the facts of the case will be held as constant as possible. Testimony from one police officer and one witness will supply information on the defendant's modus operandi, the circumstances surrounding the commission of the crime and the apprehension (which will be essentially the same for each of the nine conditions) and the type of article stolen (which will vary by row).

With regard to psychiatrists' testimony, the content must vary according to the type of identity they ascribe. Because of the ambituous nature of psychiatric pathology, such experts generally support their definitions of an individual's mental illness/health with evidence from his/her past. Hence, in the research at hand, the psychiatrists' testimony will be based upon biographical information, but this information must be held constant if the effects of only

individual behavior and expert labeling (and not those of unique features of defendants' biographies) are to be examined. In order to do this, a standardized biography of the defendant will be provided upon which the psychiatric testimony will be formulated[1]. Depending on the condition, different interpretations and emphases will be placed upon selected events in the defendant's past. All participants will receive a copy of this biography along with the summaries of the other testimony.

Finally, the contents of the instructions to the participants regarding the way in which they are to reach their verdicts will remain the same in all conditions. They will be told that no person can be convicted of a criminal offense if he/she is mentally ill. Therefore, if they decide, on the basis of the evidence, that the defendant in the case was mentally ill at the time he committed the offense for which he is being tried, they must find him not guilty by reason of insanity. If, however, they believe that he was not mentally ill, they must find him guilty.

Included in these instructions to the 'jurors' will be the dispositions possible under either verdict. Participants will be told that if they find the defendant guilty, he will be sentenced by the trial judge, and if they pronounce him not guilty by reason of insanity, he he will be placed in a provincial mental hospital for assessment. This information will be supplied in light of the fact that

[1] In this biography, an attempt is made to present a very ordinary individual whose past is comprised of events that can and do happen frequently in people's lives. Hence, he emerges as an unexceptional individual.

> "(r)ule or category application may depend on perceptions of fair play or distributive justice held by the appliers ... Rules or categories may be applied based on preferable predicted outcomes of such applications."
>
> (Hawkins and Tiedeman, 1975:28,29)

Thus, if participants were influenced by these considerations and believed that the defendant would get off 'scot-free' if found not guilty by reason of insanity, their verdicts would be influenced by factors other than those being evaluated.

The verdicts obtained from the foregoing study will be subjected to multivariate analysis to determine the influence of both the nature of an individual's behavior and various types of expert labeling on the audience's definition of that individual. In so doing, the conditions under which this crucial contingency in the creation of mental illness is met, will be clarified and societal reaction theory will receive a measure of the empirical grounding which it so obviously requires in this area.

* * * * *

5. Specific Predictions

It is now necessary to return to the hypotheses regarding the effects of behavior and labeling derived from the theoretical and empirical literature and formulate these in terms of specific predictions about the results of the experimental design. Given the primacy of individuals' behavior in others' formulations of their identities, it is hypothesized that:

1. subjects in the three 'Non-Residual Rule Violation' conditions will find the defendant presented to them 'guilty' (i.e., not mentally ill), irrespective of psychiatric labeling;

2. subjects in the three 'Residual Rule Violation' conditions will find the defendant 'not guilty by reason of insanity' (i.e., mentally ill), irrespective of psychiatric labeling.

Since the influence of other's definitions ostensibly comes into play when individuals' behavior is ambiguous and may or may not be construed as a residual rule violation, it is hypothesized that:

3. subjects in the three 'Ambiguous Rule Violation' conditions will be influenced by psychiatric labeling in the following ways:

    i) in the condition in which there is no labeling by a psychiatrist, subjects will find the defendant 'guilty';

    ii) in the condition in which a psychiatrist labels the defendant mentally ill, subjects will find him 'not guilty by reason of insanity';

    iii) in the condition in which one psychiatrist labels the defendant mentally ill and another pronounces him mentally healthy, subjects will find him 'not guilty by reason of insanity'.

These hypotheses may be summarized diagramatically:

Figure 2. Summary of the Hypotheses

NATURE OF EXPERT TESTIMONY

NATURE OF RULE: PSYCHIATRIC DEFINITION → / INDIVIDUAL BEHAVIOR ↓	No Psychiatric Label	Conflicting Psychiatric Labels	Psychiatric Label
Non-Residual Violation	GUILTY 1	GUILTY 2	GUILTY 3
Ambiguous Violation	GUILTY 4	NOT GUILTY BY REASON OF INSANITY 5	NOT GUILTY BY REASON OF INSANITY 6
Residual Violation	NOT GUILTY BY REASON OF INSANITY 7	NOT GUILTY BY REASON OF INSANITY 8	NOT GUILTY BY REASON OF INSANITY 9

V. Findings and Conclusions

A. Aspects of the Data Analysis

1. Characteristics of the Sample

The sample to which the survey-experiment was administered consisted of 208 students enrolled in undergraduate courses offered in the University of Manitoba summer school programme. The students completed the questionnaires in approximately one-half hour of class time[1].

[1] In several instances, participants began during class time and stayed after class to complete the questionnaire. Some took up to 45 minutes, writing extensively in the open-ended 'Discussion' section.

Participation was voluntary, but there were no refusals to participate in any but one class in which the instructor would not allow class time for the survey. In that class, only approximately 20 of the 50 students remained in the room after class to hear the author's presentation and instructions and about half of these (N = 9) completed questionnaires. The various versions were distributed randomly to the participants and 22 to 24 questionnaires were completed for each of the nine versions[1].

The demographic information provided by the respondents indicates that the sample was predominantly femals (60.4%; N = 125) and younr -- 47.6% (N = 99) were 20 to 24 years old, with 14.9% (N = 31) under 20 years, 20.2% (N = 42) between 25 and 30 years and 17.3% (N = 36) over 30 years old. The majority of participants were full-time students (65.4%, N = 136) and over half of those who were part-time were teachers (59.7%, N = 40).

With few exceptions, participants answered all questions and indicated both on the questionnaires and to the author that they found participation interesting and enjoyable.

2. Crosstabulations of the Questionnaire Data

Before proceeding to more sophisticated methods of analysis, it is useful to describe the results obtained via crosstabulations of the various independent variables with the dependent variable (i.e., the definition of the hypothetical individual as mentally ill or not mentally ill as manifested in the verdict chosen -- 'not guilty by reason of insanity' or 'guilty', respectively). The 'guilty verdict was chosen by 39.4% (N = 82) of the respondents, and 'not guilty by reason of insanity' was selected by 60.6% (N = 126). The following table summarizes the verdicts chosen for each of the nine versions of the questionnaire.

[1] Versions 1 and 9: 22 questionnaires;
Versions 2,3,5 and 8: 23 questionnaires;
Versions 4,6 and 7: 24 questionnaires.

Figure 3. Verdict Chosen by Questionnaire Version

VERDICT	VERSION								
	Non-Residual Rule Violation			Ambiguous Rule Violation			Residual Rule Violation		
	#1	#2	#3	#4	#5	#6	#7	#8	#9
	Weak Label	Conflicting Labels	Strong Label	Weak Label	Conflicting Labels	Strong Label	Weak Label	Conflicting	Strong Label
Guilty	77.3% (17)*	69.6 (16)	52.2 (12)	41.7 (10)	34.8 (8)	12.5 (3)	33.3 (8)	26.1 (6)	9.1 (2)
Not Guilty by Reason of Insanity	22.7% (5)	30.4 (7)	47.8 (11)	58.3 (14)	65.2 (15)	87.5 (21)	66.7 (16)	73.9 (17)	90.9 (20)
TOTAL	(22)	(23)	(23)	(24)	(23)	(24)	(24)	(23)	(22)

* numbers in brackets are absolute frequencies

χ^2 (Chi square) = 41.62 (8 degrees of freedom), $p < .001$

Pearson's $r = .41$, $p. < .001$

The above data indicate that there is a significant relationship between verdict and version variables and that the general direction of the relationship is consistent with that hypothesized[1]. Specifically, increasingly fewer participants judged the hypothetical individual presented to them as 'guilty' (i.e., sane) with each subsequent version

[1] It should be noted at this point that labeling has an enhancing effect within each of the three behavior categories; increasingly fewer participants reached verdicts of 'guilty' (i.e., sanity) as labeling became stronger. The implications of these results are considered subsequently.

of the questionnaire, with one exception. In version number six (see Figure 3), more people reached a verdict of insanity than in any version but the ninth and strongest one. This finding suggests that strong labeling in conjunction with ambiguous behavior is more likely to result in lay definitions of mental illness than is behavior which clearly constitutes a residual rule violation in conjunction with weak or conflicting labels[1]. The relative importance of strong labeling is further suggested by the fact that the percentage differences for each of the three behavior types are greatest between the conflicting and strong labeling conditions (i.e., between versions two and three, five and six, and eight and nine as illustrated in Figure 3.

In order to examine more closely the effects of behavior and label, two new variables representing these constructs were created by collapsing the categories of the version variable. The behavior variable thus created consisted of three categories: non-residual rule violation, ambiguous rule violation, and residual rule violation.

[1] This unexpected finding in the sixth version may perhaps be explained by its similarity to the ninth version; that is, both versions involved behavior which was not clearly understandable in terms of an accepted vocabulary of motives in conjunction with strong labeling. This would suggest that, in situations in which behavior does not constitute a non-residual rule violation, the extent to which it constitutes a residual rule violation is of minimal importance (where expert labeling is strong). In other words, the important distinction here is between behavior that is readily applicable and that which is not, and the gradations between these two types appear insignificant.

Similarly, the three categories comprising the label variable were weak, conflicting and strong labels. An examination of Figure 3 indicates that the three behavior conditions were comprised of versions 1, 2 and 3; versions 4, 5 and 6; and versions 7, 8 and 9, respectively, while the categories of the label variable consisted of versions 1, 4 and 7; versions 2, 5 and 8; and versions 3, 6 and 9. The following two tables summarize the distribution of verdicts among these categories.

Figure 4. Verdict Chosen by Behavior

	BEHAVIOR		
VERDICT	Non-Residual Rule Violation	Ambiguous Rule Violation	Residual Rule Violation
Guilty	66.2% (45)*	29.6 (21)	23.2 (16)
Not Guilty - Insanity	33.8% (23)	70.4 (50)	76.8 (53)
TOTAL	(68)	(71)	(69)

* numbers in brackets are actual frequencies
χ^2 (Chi square) = 30.88 (2 df.), p. <.001
Pearson's r = .36, p. <.0001

Figure 5. Verdict Chosen by Label

	LABEL		
VERDICT	Weak Label	Conflicting Labels	Strong Label
Guilty	50.0% (35)	43.5 (30)	24.6 (17)
Not Guilty - Insanity	50.0% (35)	56.5 (39)	75.4 (52)
TOTAL	(70)	(69)	(69)

* numbers in brackets are actual frequencies
χ^2 (Chi square) = 10.07 (2 df.), p. <
Pearson's r = .21, p. <.001

Once again, the direction of the results is consistent with that predicted: guilty verdicts decrease as behavior moves from non-residual to residual rule violations and as labeling moves from weak to strong. In other words, participants were increasingly likely to reach a definition of mental illness as the behavior presented was increasingly difficult to understand and as the label supplied was increasingly strong. With regard to the behavior and label variables, the former had a stronger relationship with the verdict variable as indicated by both the Chi square and Pearson's r, and the overall percentage difference (i.e., there is a 43% difference among the behavior columns, whereas the difference among the three label categories is only 25.4%[1].

Additional information regarding participants' decisions was provided by the 'confidence in verdict' question which consisted of a four item Likert-type scale on which people indicated their certainty in the verdict they chose[2]. A frequency breakdown shows that 44.9% (N = 92) felt very certain of their choice; 41.0% (N = 82) felt somewhat certain; 12.2% (N = 25) felt somewhat uncertain; and 2.0% (N = 4) felt very uncertain. Due to the small frequencies of the latter two categories, they were combined with the 'somewhat certain' choice to create a 'not certain' category comprising 55.1% (N = 113) of the responses. These two categories were then combined with the categories of the dependent variable, verdict, to create a composite index with four categories: guilty/certain; guilty/not certain; not guilty by reason of insanity/not certain; and not guilty by reason of insanity/certain. Theee categories represent a continuum of increasing belief in the accuracy of a definition of mental illness (or, conversely,

[1] See Figures 4 and 5.

[2] See the sample questionnaires in Appendix 1.

decreasing belief in the accuracy of a definition of sanity).

A crosstabulation of the foregoing composite variable by questionnaire version produces cell frequencies too small for analysis (inasmuch as the table contains 36 cells), but an examination of verdict in conjunction with the collapsed behavior and label variables is instructive.

Figure 6. Verdict/Certainty by Behavior

	BEHAVIOR		
VERDICT/CERTAINTY	Non-Residual Rule Violation	Ambiguous Rule Violation	Residual Rule Violation
Guilty/ Certain	23.5% (16)*	7.0% (5)	13.0% (9)
Guilty/ Not Certain	42.6% (29)	22.5 (16)	10.1 (7)
Not Guilty-Insanity/ Not Certain	16.2% (11)	35.2 (25)	40.6 (28)
Not Guilty-Insanity/ Certain	17.6% (12)	35.2 (25)	36.2 (25)
TOTAL	(68)	(71)	(69)

* numbers in brackets are actual frequencies.
χ^2 (Chi square) = 33.76 (6 degrees of freedom), p. <.0001
Pearson's r = .28, p. <.0001

Figure 7. Verdict/Certainty by Label

	LABEL		
VERDICT/CERTAINTY	Weak	Conflicting	Strong
Guilty/ Certain	18.6% (13)	17.4 (12)	7.2 (5)
Guilty/ Not Certain	31.4% (22)	26.1 (18)	17.4 (12)
Not Guilty-Insanity/ Not Certain	24.3 (17)	39.1 (27)	29.0 (20)
Not Guilty-Insanity/ Certain	25.7 (18)	17.4 (12)	46.4 (32)
TOTAL	(69)	(69)	(69)

* numbers in brackets are actual frequencies.
χ^2 (Chi square) = 19.42 (6 degrees of freedom), p. <.01
Pearson's r = .23, p. <.001

A comparison of the row frequencies for each category of the dependent variable (i.e., guilty/certain, guilty/not certain, not guilty-insanity/not certain and not guilty-insanity/certain) indicates that the modal frequencies are consistent with the hypotheses presented. An examination of Figure 6 indicates that the majority of those who chose a verdict of guilty (both with and without certainty) were in the 'non-residual rule violation' behavior condition. The modal behavior category for those choosing verdicts of insanity (both with and without

certainty) was 'residual rule violation'. With regard to the label variable, a small majority of those choosing a guilty verdict (in both the 'guilty/certain' and 'guilty/not certain' rows) were in the weak labeling condition, while the majority selecting a verdict of 'insanity/not certain' were in the conflicting labels category. Participants who chose the 'insanity/certain' verdict were most frequently in the strong labeling category[1].

An examination of the distribution within each column does not reveal results exactly consistent with those expected. First, in the normal behavior column, it would be expected that 'guilty/certain' would be the largest cell, followed in order by 'guilty/uncertain', 'insanity/uncertain' and 'insanity/certain'. In fact, the order within the two 'guilty' categories was reversed and the two 'insanity' categories were virtually tied. In the ambiguous behavior column, the 'insanity' categories both have the same frequency (35.2%, N = 25)[2]. Theoretically, the categories which would have been expected to be most similar would be the uncertain ones (i.e., 'guilty/not certain' and 'not guilty by reason of insanity/not certain'). Finally, in the 'residual role violation' behavior column, the most frequently chosen verdict (by a small majority) was 'insanity/not certain' (40.6%, N = 28) rather than the 'insanity/certain' category (36.2%, N = 25) that would have been expected.

Within the columns of the label variable there are fewer anomalies. The distributions within the 'conflicting' and 'strong' labeling columns are consistent with expectation, but in the 'weak' condition, the 'guilty/

[1] See Figure 7.
[2] See Figure 6.

not certain' frequency was highest (31.4%, N= 22), followed by the almost-tied insanity verdicts ('certain' 25.7%, N = 18; 'not certain' 24.3%, N = 17) and the 'guilty/certain' category (18.6%, N = 13)[1].

In attempting to account for the discrepancies noted above, it should first be reiterated that the results obtained are generally consistent with the proposed hypotheses (i.e., that guilty verdicts are associated with normal behavior and weak labeling, while insanity verdicts are associated with mentally ill behavior and strong labels). Support for this contention is provided by the modal categories for each of the rows of the verdict variable. The fact that the frequency breakdowns within columns are not completely consistent with expectations may be explained by several factors. Perhaps the most important of these is the fact that all of the situations presented were to some extent ambiguous and therefore participants did not feel confident enough about their choice of verdict to describe themselves as 'certain' in all of the situations in which such a description was expected. The nature of the design may also have contributed to this lack of certainty, inasmuch as only a single behavioral incident was presented. According to labeling theory, as previously discussed, people come to define someone as mentally ill over a period of time, beginning with doubts as to his/her sanity through tentative redefinitions which are tested in subsequent interaction, to confidence in a definition of him/her as mentally ill. This process of escalation to a deviant identity is not reflected in the design and so it follows that participants did not express certainty regarding their redefinitions of the individual with whom they were presented.

[1] See Figure 7.

It should also be noted that the absolute and percentage differences are generally small where the reversals occur[1]. Finally, in light of the small sample size N = 208), the importance of these reversals is further minimized.

It would therefore appear that the information obtained from the crosstabulations of the verdict/certainty variable with the behavior and label variables provides supplementary support for the conclusions drawn from the verdict by behavior and label crosstabulations presented previously.

3. The Semantic Differential

The results of the seven-item semantic differential are summarized in the following table:

Figure 8. Summary of Semantic Differential Results

Word Pair	Mean Score on 5-point Scale	Standard Deviation
Foolish-Wise	2.6	.64
Unpredictable-Predictable	1.88	.90
Bad-Good	3.0	.61
Ignorant-Intelligent	2.7	.78
Sick-Healthy	1.9	.88
Dangerous-Safe	2.5	.84
Passive-Active	2.6	.87

[1] Thus, for example, in the 'residual rule violation' behavior column, the 'guilty/certain' and 'guilty/not certain' cells were reversed, but the difference between them was only 2.9% (N = 2). Similarly, the 'insanity' cells were reversed, but with a percentage difference of 4.4% (N = 3). (See Figure 6).

Consistent with the discussion of negative stereotypes of the mentally ill, none of the mean scores of any of the word pairs indicates a positive rating of a typical mentally ill person. The most unfavourable ratings occurred on the 'sick' and 'unpredictable' items. In addition, these were the only two items for which the modal category choice was not neutral[1]. The low ratings obtained on the predictability continuum are consistent with the foregoing theoretical discussion of mental illness as residual rule-breaking behavior (i.e., behavior for which others cannot supply a socially accepted vocabulary of motives and which, therefore, they cannot understand, or analagously, predict). The lot ratings on the 'sick-healthy' variable may indicate the extent to which lay people accept the medical model of deviant behavior. While none of the other word pairs had as strongly negative ratings as the preceding two, it should be emphasized that all of the mean scores indicated negative or, at best, neutral attitudes toward the mentally ill.

4. Multiple Regression Analysis

The results from the crosstabulations are instructive, but they do not provide information regarding the overall importance of the independent variables examined or the amount of variance they explain. To obtain this information, the questionnaire data were subjected to a multiple regression analysis to determine the relative effects of the independent variables studied on the composite verdict/certainty dependent variable. The independent variables consisted of the

[1] For both items, the mode occurred in the first category; i.e., 'very sick' and 'very unpredictable'. In the former, 40.0% (N = 80) of participants chose 'very sick', while in the latter, 47.5% (N = 95) rated a typical mentally ill person as 'very unpredictable'.

previously described behavior and label variables, as well as age, occupation[1] and sex[2]. The results of the regression are summarized in the following table.

Figure 9. Multiple Regression Summary Table

Independent Variables	Unstandardized Beta	Standardized Beta	R^2	R^2 Change	F
Behavior	0.3742	0.2939	0.0797	0.0797	19.86*
Label	0.3006	0.2379	0.1338	0.0541	13.29*
Sex	- 0.1043	- 0.0494	0.1373	0.0035	0.54
Age	- 0.1034	- 0.0941	0.141	0.0038	1.55
Occupation	0.0736	0.0663	0.1442	0.0031	0.73
R^2 = .14; F = 6.81; df. = 5 and 202; p. <.01					

* p. <.01

The above independent variables explain 14% of the variation in the dependent verdict/certainty variable. Of the former, 'behavior' has the greatest explanatory power (8%), with 'label' second (5%). Age, sex and occupation were not significant.

[1] Since the way in which 'occupation' was coded provided information regarding student status (i.e., full- or part-time), the 'student status' variable was not included in the regression.

[2] Sex was set up as dummy variable in order to run it in the regression.

These results support the hypothesis that an individual's behavior is the most important factor in others' definitions of him as mentally ill or not mentally ill. Expert labeling is of secondary importance[1]. The implications of these findings will be dealt with in greater detail subsequently.

B. The Hypotheses Reconsidered

The preceding discussion focused upon a general description of the results; it is now necessary to return to the specific hypotheses and consider each in light of the data. The first hypothesis predicted that participants in the three 'non-residual' rule violation categories (see Figure 3) would not define as mentally ill the hypothetical individual presented to them, regardless of the expert labeling which they received. The results support this hypothesis: the majority reached a verdict of 'guilty' in these categories. Specifically, 77.3% (N = 17) pronounced guilty verdicts in the first version, 69.6% (N = 16) did so in the second, and 52.2% (N = 12) so held in the third. The mean number of guilty verdicts for the three versions was substantially higher than the average for the other two behavior conditions; i.e., 66.2% (N = 45) as compared to 29.6% (N = 21) in the ambiguous conditions and 23.2% (N = 16) in the residual rule violation conditions. It is noteworthy that there is a direct relationship between definitions of mental illness and strength of labeling within

[1] An analysis of variance performed upon the data revealed no significant interaction effects between these (or any of the other) variables.

the non-residual rule-violation categories. This suggests that expert labeling has an effect on people's definitions even where the behavior of the individual under scrutiny is not 'mentally ill' (i.e., a non-residual rule-violation).

The second hypothesis predicted that participants in the three residual rule-violation categories (see Figure 3) would define as mentally ill the hypothetical individual presented to them, irrespective of psychiatric labeling. Again, the results confirm this hypothesis, since the majority reached verdicts of 'not guilty by reason of insanity': 66.7% (N = 16) in version seven; 73.9% (N = 17) in version eight; and 90.9% (N = 20) in the ninth version. The mean number of insanity verdicts for this behavior condition was 76.8% (N = 53), as compared to 33.8% (N = 23) in the non-residual rule violation category and 70.4% (N = 50) in the ambiguous rule-violation category. In the behavior condition under consideration the results also indicate that psychiatric labeling had an effect, in that the number of insanity verdicts increased with the strength of the labeling.

It was hypothesized that the labeling variable would determine the verdict in the ambiguous rule-violation categories (see Figure 3). Specifically, where there was no psychiatric label, the verdict would be guilty; and where there was conflicting and strong labeling, the verdict would be not guilty by reason of insanity. The results support the latter two predictions, but not the former. In version four, a slim majority of participants (58.3%; N = 14) reached not guilty by reason of insanity verdicts, with 65.2% (N = 15) in version five and 87.5% (N = 21) in version six reaching the same result. Once again, the number of insanity verdicts increases with the strength of the expert labeling.

The failure of the data to support the predicted outcome in the weak labeling condition (i.e., version four) requires consideration. While fewer people receiving this version reached verdicts of insanity than did those receiving the same labeling information in conjunction with residual rule-violating behavior (i.e., version seven), the majority in both versions pronounced insanity verdicts. These results suggest a more general lack of differentiation between ambiguous and residual rule-violating behavior. An examination of the results presented in Figure 3 support this suggestion: the percentage differences between 'ambiguous' and 'residual' conditions for each of the three label categories are small[1], while those between 'ambiguous and 'non-residual' categories are large[2]. Thus, it would appear that participants saw the ambiguous behavior as much more similar to a residual rule violation than to a non-residual rule violation. This interpretation is further supported by the fact that more people reached insanity verdicts when ambiguous behavior was coupled with strong labeling (i.e., version six) than when residual rule violating behavior was presented with weak or conflicting labels (i.e., versions seven and eight)[3].

In light of the foregoing interpretation, the fact that a small majority of participants in the 'ambiguous rule violation/weak label' version reached insanity verdicts as opposed to the 'guilty' verdicts predicted, is rendered understandable.

[1] Specifically, the difference in the numbers reaching insanity verdicts between versions four and seven is 8.4%; between versions five and eight is 8.7%; and between versions six and nine is 7.4%.

[2] The difference in the numbers reaching insanity verdicts between versions four and one is 35.6%; between versions five and two is 34.8%; and between versions six and three is 39.9%.

[3] See Figure 3.

* * * * *

The empirical findings presented above provide general support for the model of lay definition of mental illness which was set out in the theoretical section of this thesis; i.e., that people's definitions of others as mentally ill are based primarily upon the others' behavior, with expert labeling serving as an important facilitating factor. The results of the cross-tabulations, while far from definitive, are consistent with this interpretation. The regression analysis offers further support in that the results indicate that the behavior variable explains more of the variance in the dependent variable, verdict, than does the label variable (although it should be noted that neither variable explained a large amount of the total variation).

Finally, support is provided by an examination of participants' responses to the open-ended question which asked for a discussion of the reasons for their verdict. The results indicate that almost all of those answering the question concentrated on a discussion of behavior, using psychiatric labeling and the individual's (reinterpreted) biography as further support for the ascription of definitions of mental illness[1]. It should also be noted that these results provide a measure of validation for the operationalization of the behavior variable in terms of the availability of a vocabulary of (economic) motives. Many of those who offered comments focused upon the understandability (or lack thereof) of the hypothetical individual's actions. They reached their verdicts of not guilty by reason of insanity on the basis of their inability to understand 'why anyone would do that'.

[1] These results were not coded and analyzed because of their unstandardized nature. They were merely intended to provide additional, qualitative information to indicate whether participants were indeed reaching decisions on the basis of the information with which they were presented. The general tenor of their answers indicates that they were.

C. The Variance Unexplained

It is now necessary to speculate on the amount of the variance not explained by this research. As aforementioned, the variables examined account for 14% of the variance. While this percentage does not appear substantial, in an exploratory study such as this it serves to at least suggest the potential importance of the variables examined. Perhaps the best place to seek additional variables involved in the ascription of mental illness is the theoretical model advanced previously. It will be recalled that labeling theory propounds a model of mental illness which emphasizes the processual nature of its genesis and maintenance. People come to define others as mentally ill over a period of time and as a result of a series of contingencies which render labeling more or less likely. The research design here does not reflect the negotiation among labelers and between them and the individual under scrutiny, which contributes to the spiralling labeling process. Future research should therefore attempt to incorporate the processual dimension. It should be noted that while such incorporations are rendered difficult by labeling theory's low level of empirical development, they will become increasingly easier as exploratory studies such as the one at hand generate empirically grounded propositions and sensitizing concepts.

Another potential source of unexplained variance is the causes and contingencies in the development of mental illness which were <u>not</u> examined in this study. In particular, such facilitating factors as the time, frequency, perceived seriousness and consequences of residual rule violation and the social positions of the individual and the audience defining him/her are theoretically important, but a complete investigation of their effects was beyond the scope of the research undertaken here. Once again, such an investigation is a task for

future research.

In addition to incorporating the foregoing factors, subsequent studies should examine the effects of particular situations in order to determine the extent to which the results obtained from this (and other) situated studies are generalizable. In the absence of such information, it is necessary to interpret results narrowly. Thus, in the study at hand, the situation involved a rule violation which had ostensibly come to official attention and so participants were asked to define someone already embarked upon a deviant career. While their definitions reflected the kind of deviant they believed the individual in question to be (i.e., criminal or mentally ill), it is possible that people did/do not distinguish adequately or systematically between the different types of deviance. In addition, the results could have been confounded by the extent to which participants accepted a medical model of deviance; first, to the extent to which they regarded deviants (including criminals) as mentally ill and second, insofar as they had a propensity for medical type II errors[1].

Hence, the degree to which the results of this study may be generalized remains unknown. The focus was not upon the broad, general process by which mental illness is supposedly generated, but rather, upon several specific issues comprising part of this process. The narrow scope of the investigation is at least partially justified by the paucity of empirical information and the concomitant need for exploratory research.

[1] That is, when in doubt, treat.

The reasons for the choice of the context within which the study was situated will not be reiterated. Suffice it to say that the limitations imposed thereby must be kept firmly in mind until future research establishes the extent to which the results obtained are (or are not) situationally specific.

In conclusion, the results of this exploratory study serve to suggest the relative importance of behavior and, to a lesser extent, psychiatric labeling in people's definitions of an individual as mentally ill. The limitations on generalization of these findings imposed by the nature of the research method and the number and type of participants involved must be considered, but the results do appear to warrant further investigation via different methods and with different participants. The data generated by this investigation suggest that sociologists working within the labeling perspective have made a start in explaining the complex social phenomenon of mental illness.

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* * * *

Appendix 1

The following questionnaire is a composite of all the nine possible combinations of behavior and label. The pages marked with an asterisk (*) were common to all versions (with minor modifications), while the rest represent the three conditions of each of these two independent variables.

*

INSTRUCTIONS TO PARTICIPANTS

We are interested in studying the way in which jurors in different types of criminal trials reach their verdicts. Attached you will find a summary of a trial which contains the important facts of an actual case. After reading this, you will be asked to reach a verdict. We want you to consider carefully all information regarding the case before reaching a decision about the defendant presented to you, just as jurors in a real trial would. All necessary information regarding the law is provided for you. Also, we are interested in your personal judgment, so please give your own opinion, and not how you think others might judge the case or how you think you are supposed to judge it. There are no right or wrong answers, and your responses will be completely anonymous.

Please complete all questions. Thank you for your co-operation.

*

Regina versus David Matthews

I. The Charge

The defendant, David Matthews, is charged under Section 306 of the Criminal Code of Canada with breaking and entering.

II. The Plea

Following a preliminary hearing, the defendant's lawyer entered a plea of 'not guilty by reason of insanity' on behalf of the accused.

III. The Facts of the Case

At approximately 8:15 p.m. on the evening of April 11th, 1980, local police received a call from one Muriel Hammer who reported noticing a disturbance at a house across the street from hers. A squad car proceeded to the address provided by Mrs. Hammer. The door stood open and there were several lights on. The officers entered and, in the course of their search, discovered the defendant, later identified as David Matthews, in one of the upstairs bedrooms. Matthews, upon noticing the police, knelt in the corner of the room and held his T-shirt over his face with one hand. With the other hand, he clutched a paper bag. He offered no resistance to arrest.

The officers took Matthews to district police headquarters, where he was searched. He was unarmed and his pockets contained nothing but a few personal effects. The paper bag which was in Matthews's possession at the time of the arrest contained

several pieces of jewellery valued at approximately $450.00. These were positively identified by the owner of the house, Mrs. Charlotte Rousseau, as her property.

Matthews was then charged and released on his honor. Matthews's lawyer entered a plea of 'not guilty by reason of insanity' on behalf of his client, but Matthews refused to submit to a psychiatric examination. A psychiatrist was appointed by the court to comment on the case.

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IV. Defendant's Biography *

(The following description is based on information provided by the defendant's mother and several people who knew him.)

The defendant, David Matthews, is a 36-year old Caucasian male. He was married at 18, but separated from his wife eight months later. He has held a number of unskilled jobs (factory worker, cab driver) since he dropped out of school at 16 years of age, but is currently unemployed, having been dismissed several weeks ago from his most recent position as a night watchman for sleeping on the job.

He is described as quiet and withdrawn by his neighbors and co-workers. His landlady reports that she has had no trouble with him -- he always pays his rent on time and never disturbs the other tenants. She rarely sees him go out and cannot recall the last time he had visitors.

His mother supports this description, stating that David was always a 'loner' and was never close to others even as a child. He has had no contact with his father since his parents divorced, when he was six. His step-father, whom Mrs. Matthews married when David was thirteen, had little interest in the boy. It was about this time, she believes, that David began to run away from home, sometimes for days at a time. This continued until he quit school and left home permanently at sixteen. From then on, he rarely saw his mother.

The defendant's physical health is good and he was only hospitalized once when he was twelve for a head injury sustained when he was knocked from his bicycle by a car. He suffered from dizziness and blackouts for several months following the accident but there was no apparent permanent damage.

The defendant has no prior criminal record.

V. The Witnesses *

1. Muriel Hammer

Mrs. Hammer testified that she had been looking out her front window at about 8:00 p.m. on the night in question. She noticed a figure standing on the doorstep of the house directly across the street. She saw the individual open the screen door and, after several moments, open the inner door. He then entered the house, leaving both doors standing open. Mrs. Hammer then observed several lights go on in the house and at this point telephoned the police.

2. Officer Roy Valetti

Officer Valetti stated that he and his partner were dispatched to 319 - 23rd Street N.W. at 8:15 p.m. on Wednesday, April 11th. They arrived and approached the house. The officer testified that both outer and inner doors stood open. There was no sign of forcible entry and he concluded that the doors must have been left unlocked.

The two officers searched the main floor of the house and proceeded upstairs where Valetti found the defendant. When Valetti entered the room, the defendant cowered in the corner beside the bureau and pulled his T-shirt up over his face. He did not resist arrest.

Valetti described Matthews as co-operative but withdrawn, and stated that the defendant barely spoke from the time he was discovered until he was deposited at police headquarters, where Valetti left him.

3. Dr. Howard Lowe

Dr. Lowe, a court-appointed psychiatrist, was called in to comment on the case. The doctor stated that Matthews's refusal to submit to a psychiatric examination made it very difficult for him to reach any diagnosis. He said that while the defendant's lack of co-operation might indicate hostility or distrust, he could not form a professional opinion about his mental condition on this basis. Dr. Lowe concluded that the jurors had as much information as he did and, since he could not provide an accurate diagnosis, he declined comment. The jurors, he felt, would simply have to decide for themselves on the basis of the law and the facts of the case.

3. Dr. Howard Lowe

Dr. Lowe, a court-appointed psychiatrist, diagnosed the defendant as suffering from reactive psychoneurosis, emotional immaturity and a psychopathic personality. He stated that Matthews exhibited the standard symptoms associated with this personality disorder -- irrational thinking, a lack of concern for the consequences of his actions, an inability to cope with everyday living and the tendency to lie compulsively. The doctor said that psychoneurotics, while usually intelligent enough, act impulsively and irrationally to achieve their own ends. They are completely self-centred and are unable to relate to others.

Dr. Lowe stated that Matthews was a clear and typical case of this type of mental illness, and he traced the roots of the disorder back to the defendant;s isolated and unstable childhood. He concluded that the nature of Matthews's actions in breaking into the Rousseau house on April 11th provided further proof for his diagnosis -- Matthews's conduct could hardly be regarded as the product of a rational mind.

The following excerpt is taken directly from the trial transcript:

Defense Counsel: "Dr. Lowe, can you give us your opinion about how David Matthews became mentally ill?"

Dr. Lowe: "Certainly. Matthews's present condition -- his psychoneurosis with psychopathic tendencies -- is the result of circumstances dating as far back as his early childhood. Because he was a shy and quiet child, he had a hard time making friends and he therefore relied very heavily on his family for support. The first major upheaval in his life came when his parents

separated when he was six. You have to understand what a blow this was to the child. I mean, divorce is bound to be a traumatic event for any child, particularly at an age when he has just entered school and is trying to adjust to that as well. But for David, who depended upon his parents for what little security he had, the breakup of their marriage was bound to leave permanent emotional scars. The situation was made even worse by the fact that the boy's father made no attempt to stay in touch with him. David never got over his initial feelings that he was responsible for the divorce and that he had been betrayed by someone he loved.

Now this seemed to mark the beginning of a pattern of withdrawal and distrust of others. His mother's remarriage simply contributed to his growing mental problems. Here he was at another period of transition in his life -- adolescence -- and the one person on whom he thought he could depend rejected him, he believed, for another man.

From this point on, we see him drifting farther and farther from the conventional ties by which sanity is maintained, such as family, friends, school, work and so on. His one attempt to make contact with another human being -- I'm referring here to his brief marriage -- predictably ended in failure. What we see now is a man who has lost his hold on reality. He has no friends, he cannot hold down a job .. in short, he is a sick man."

Defense Counsel: "Thank you, Doctor. One final question. What about Matthews's behavior on the night of April 11th when he entered the Rousseau's house? How does that relate to his mental condition?"

Dr. Lowe: "Oh well, quite obviously the patient's -- I mean Matthews's -- actions are a reflection of his psychopathic personality. That's how it is with psychopaths. They are really out of touch, they feel no guilt or shame because they have lost the capacity to think and act rationally like normal members of society. Clearly Matthews did not act like a regular, rational criminal. Regular criminals do not just wander into an open house and leave the door open and the lights on.

No; the kind of irrational thinking that prompted David Matthews's behavior is typical of psychoneurotic-psychopathic personalities. It is my professional opinion that the man is mentally ill and in need of psychiatric treatment."

Defense Counsel: "Thank you, Doctor. No more questions."

Dr. Lowe: "Oh well, quite obviously the patient's -- I mean Matthews's -- actions are a reflection of his psychopathic personality. That's how it is with psychopaths. They are really out of touch, they feel no guilt or shame because they have lost the capacity to think and act rationally like normal members of society. Clearly Matthews did not act like a regular, rational criminal. Regular criminals do not just wander into an open house and leave the door open and the lights on.

Also, look at what he took -- several pieces of clothing that were of no apparent use to him. I suppose he could have worn them or sold them to a thrift shop or something, but that hardly seems worth the trouble of breaking and entering. The kind of irrational thinking that prompted David Matthews to take dry cleaning from someone's house is characteristic of psychoneurotic-psychopathic personalities. It is my professional opinion that the man is mentally ill and in need of psychiatric treatment."

Defense Counsel: "Thank you, Doctor. No more questions."

Dr. Lowe: "Oh well, quite obviously the patient's -- I mean Matthews's -- actions are a reflection of his psychopathic personality. That's how it is with psychopaths. They are really out of touch, they feel no guilt or shame because they have lost the capacity to think and act rationally like normal members of society. Clearly Matthews did not act like a regular, rational criminal. Regular criminals do not just wander into an open house and leave the door open and the lights on.

Also, look at what he took -- old rags and newspapers that could not possibly be of any value to anyone. The kind of irrational thinking that led David Matthews to take garbage from someone's house is characteristic of psychoneurotic-psychopathic personalities. It is my professional opinion that the man is mentally ill and in need of psychiatric treatment."

Defense Counsel: "Thank you, Doctor. No more questions."

4. Dr. John Eberhardt

Dr. Eberhardt, the second psychiatrist appointed by the Court, testified that he had examined the defendant at length and it was his professional opinion that David Matthews was not now mentally ill, nor had he been in the recent past. The doctor agreed with Dr. Lowe that Matthews was emotionally immature and had great difficulty relating to others, but denied that these problems were symptoms of an underlying psychosis or psychopathic personality. He believed that Matthews was a shy and highly insecure man whose lack of success in other ventures simply carried over into his attempt to break the law.

The following section is taken from the trial transcript of Dr. Eberhardt's testimony:

Crown Prosecutor: "Doctor, you have heard your colleague, Dr. Lowe, testify that David Matthews is presently suffering from mental illness and that he has been for some time. Could you explain to us the basis for your diagnosis that he is not?"

Dr. Eberhardt: "Certainly. It is very difficult to diagnose reactive neuroses and psychoneuroses because the behaviors which might be symptoms of these kinds of mental illness are pretty widespread in the general population. For instance, most people have trouble coping with others from time to time, and tell lies and think in irrational ways, but this does not mean that they are psychoneurotics. I think this is the case with Matthews -- he's not very good at getting along in social situations, so chooses to keep to himself.

As far as his childhood goes, I'm not denying that he had to face some problems as a child, but if we honestly believed that divorce and remarriage produced mental illness, psychiatrists would be treating close to half the population. David Matthews may be withdrawn and emotionally immature, but he is not mentally ill."

Crown Prosecutor: "Dr. Eberhardt; could you comment on Matthews's actions on the night of April 11th?"

Dr. Eberhardt: "Well, it seems clear to me that this is just one more example of the problems he has in coping with everyday life. He was not particularly successful at any of the other occupations he chose, so he could hardly be expected to be a master criminal.

The fact that Matthews was caught taking valuable items would indicate that he entered the house for reasons that we can all understand -- he saw an opportunity to 'get something for nothing' and he took advantage of it. Just because he was not very careful in doing so does not mean, in my opinion, that he is or was mentally ill. I don't think many psychiatrists would claim that carelessness is a symptom of mental illness."

Crown Prosecutor: "I have no other questions. Thank you, Doctor."

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Crown Prosecutor: "Dr. Eberhardt, could you comment on Matthews's actions on the night of April 11th?"

Dr. Eberhardt: "Well, it seems clear to me that this is just one more example of the problems he has in coping with everyday life. He was not particularly successful at any of the other occupations he chose, so he could hardly be expected to be a master criminal.

The fact that Matthews was caught taking items of questionable value may make it more difficult to understand his actions, but the fact remains that he saw an opportunity to 'get something for nothing', and he took advantage of it. Just because he was not very careful in doing so does not mean, in my opinion, that he is or was mentally ill. I don't think many psychiatrists would claim that carelessness is a symptom of mental illness.

Crown Prosecutor: "I have no other questions. Thank you, Doctor."

As far as his childhood goes, I'm not denying that he had to face some problems as a child, but if we honestly believed that divorce and remarriage produced mental illness, psychiatrists would be treating close to half the population. David Matthews may be withdrawn and emotionally immature, but he is not mentally ill."

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The fact that Matthews was caught taking items of no value makes it more difficult to understand his actions, but the fact remains that he saw an opportunity to possibly 'get something for nothing' and he took advantage of it. Just because he was not very careful in doing so does not, in my opinion, mean that he is or was mentally ill. I don't think many psychiatrists would claim that carelessness is a symptom of mental illness."

Crown Prosecutor: "I have no other questions. Thank you, Doctor."

VI. Judge's Instructions

Here are the Judge's instructions to the jury in full. "You have heard the facts of the case. It has been established that the defendant, David Matthews, on Wednesday, April 11th, did break and enter the dwelling-house at 319 - 23rd Street North-West. He was apprehended in possession of several articles of clothing. The defense has entered a plea of 'not guilty by reason of insanity' and you have heard the testimony from a psychiatrist appointed by this Court regarding the mental condition of the defendant. In reaching your verdict, you should consider carefully the qualifications of the expert witness, his experience, his opportunity to observe the defendant and all of the other factors presented by him. You are not bound to accept the testimony of the expert -- you are to give his testimony such weight as, in your judgment, it is fairly entitled to receive, with full recognition of the fact that, while you should not arbitrarily disregard the testimony of any witness, you need not accept any testimony about which you are not satisfied.

I will now discuss the law. Under Section 306 of the Criminal Code of Canada, anyone who breaks and enters a place and commits or attempts to commit a crime therein, is guilty of an offence. However, under Section 16 of the Criminal Code, no person may be convicted of an offence if he was mentally ill at the time he committed the act with which he is charged. Therefore, you, as jurors, must use your own good judgment to consider all the facts of the case and to reach a verdict about the defendant. If, on the basis of all the evidence, you decide that David Matthews was not mentally ill at the time he committed the act of which he is accused, you must find him guilty as charged. He will then be sentenced by the Court. But if you believe that the

VI. Judge's Instructions

Here are the Judge's instructions to the jury in full. "You have heard the facts of the case. It has been established that the defendant, David Matthews, on Wednesday, April 11th, did break and enter the dwelling-house at 319 - 23rd Street North-West. He was apprehended in possession of several dusting cloths and a newspaper. The defense has entered a plea of 'not guilty by reason of insanity' and you have heard the testimony from a psychiatrist appointed by the Court regarding the mental condition of the defendant. In reaching your verdict, you should consider carefully the qualifications of the expert witness, his experience, his opportunity to observe the defendant and all of the other factors presented by him. You are not bound to accept the testimony of the expert -- you are to give his testimony such weight as, in your judgment, it is fairly entitled to receive, with full recognition of the fact that, while you should not arbitrarily disregard the testimony of any witness, you need not accept any testimony about which you are not satisfied.

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that the defendant was mentally ill at the time he committed the act of which he is accused, you must find him not guilty by reason of insanity. Under Section 542 of the Criminal Code of Canada he will then be committed to one of the provincial institutions for the mentally ill until such time as he is pronounced sane.

I should also like to remind you that the defendant was not caught committing a serious violation of the law. He did not use violence or employ weapons. However, it is the duty of this Court to enforce the law and to protect society. Therefore, it is important that you determine to the best of your ability the proper disposition for this case.

The decision is now in your hands. Review the testimony, the rules of law and my instructions to you and reach a verdict about David Matthews."

VI. Verdict

Please lift the flap, mark your verdict clearly with an "X" and seal the flap. Mark only one verdict.

After due consideration, I find the defendant, David Matthews to be

GUILTY

NOT GUILTY BY REASON OF INSANITY

of the offence with which he is charged.

Confidence in Verdict.

People usually have varying degrees of confidence in the verdicts they reach. Therefore, we are interested in knowing how confident you are in the verdict you chose. If, for example, you are very sure of your choice, make an "X" in the space beside the words 'very certain' on the list provided below, and so on.

I am very certain ____ about the verdict I chose.

somewhat certain ____

somewhat uncertain ____

very uncertain ____

*

VII. Discussion

Jurors in regular criminal trials usually discuss the case and the reasons for their verdicts at some length in their deliberations. Because that is not possible here, we would like you to supply a short written account of the factors involved in your decision. In the space provided below, please give the major reasons for the verdict you chose. Anything which influenced your decision is important.

*

VIII. Background Information

Now we would like some general information about you. All your answers are confidential and you will remain anonymous.

1. Sex: Male ____
   Female ____

2. Age: Under 20 ____
   20-24 ____
   25-30 ____
   Over 30 ____

3. Student Status
   Full-time ____
   Part-time ____
   If part-time, what is your occupation?

   _____

4. We are interested in what people think about the mentally ill, so we would like to know how you would describe a typical mentally ill person. Below is a list of pairs of words. Look at each pair and decide which one of the two words best describes your idea of someone who is mentally ill. If you feel that either word describes a typical mentally ill person very well, put an 'X' in the space right beside the wrod. If you feel that either of the words describes a typical mentally ill person fairly well, put an 'X' in the space second from the wrod. Finally, if you feel that neither of the two words describes your idea of a mentally ill person, put an'X' in the middle space.

   For example, if you think of a typical mentally ill person as very tense, you would put an 'X' right beside "tense", like this:

   tense X ____ ____ ____ ____ relaxed

   I think of a typical mentally ill person as:

foolish	____	____	____	____	____	wise
bad	____	____	____	____	____	good
unpredictable	____	____	____	____	____	predictable
ignorant	____	____	____	____	____	intelligent
sick	____	____	____	____	____	healthy
dangerous	____	____	____	____	____	safe
passive	____	____	____	____	____	active

Thank you for participating in this study. If you would like to make any comments, please do so on the back of the page.