MENTAL ILLNESS SERVICE AS A DIVISION OF
THE SOCIAL CONTROL INDUSTRY: AN ANALYSIS
OF CONFLICTS AMONG PROFESSIONAL WORKERS.

BY

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A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF ARTS.

DEPARTMENT OF SOCIOLOGY

WINNIPEG MANITOBA

MAY, 1974
ABSTRACT

MENTAL ILLNESS SERVICE AS A DIVISION OF THE SOCIAL CONTROL INDUSTRY: AN ANALYSIS OF CONFLICTS AMONG PROFESSIONAL WORKERS.

An industrial model is utilized in an attempt to see how conflicts among different professional groups dealing with mental illness affect the forms of treatment administered. Mental illness is seen as a division of the social control industry. Producer/consumer concentration variables, market entry variables and product/service differentiation variables are used as market structure variables to account for variation in the forms of service delivered.

After investigating the initial entry of medicine in rendering the social control services, some of the functions served by medical ideology in administering control were identified. The evidence suggests that mental institutions are concerned primarily with social control rather than medical treatment.

Centred around the issue of the plea of insanity, competition between the legal profession and psychiatry was analysed. It was found that the suspension of capital punishment decreased the rate of insanity plea.
The medical model of mental illness was seen as a barrier of entry to other non-medical professionals. Some of the strategies employed by the non-medical professions in gaining entry to the mental illness service market were then identified. They included formal organization, coalition, ideological unmasking, compromise and mutual expedience. It was found that the greater the kinds of professionals involved in servicing mental illness, the wider the definition of mental illness, and the greater the number of people diagnosed as mentally ill.

Lastly, an argument is put forward to suggest that our society prefers 'illness-health' explanations for some deviant behaviors. Evidence seemed to support the notion that the development of the nosology of mental illness was more a reflection of changing social values than a refinement of existing medical knowledge.
ACKNOWLEDGEMENTS

The writer gratefully acknowledge the assistance of many people who directly or indirectly are responsible for the successful completion of this study. The following, however, deserve special mention.

First, I wish to express my gratitude to Dr. K.W. Taylor, my thesis advisor. His patience, encouragement, counsel and understanding were greatly appreciated in writing this thesis. The genuine interest he showed and the tremendous time he spent on this thesis were two indispensable factors in bringing of this study.

Second, a special thanks is also extended to Prof. E. Linden and Prof. D. Perlman, my committee members, who offered constructive criticisms and suggestions in the process of this study.

Lastly, an appreciation is also expressed to Dr. D. Rennie, my department head, who took the time edit
# Table of Contents

Chapter I Introduction........................................ 1
  Goals and purposes.
  Shortcomings of other approaches.
  Review of literature.
  Outline of succeeding chapters.

Chapter II Framework of Analysis............................. 9
  Market concentration.
  Conditions of entry.
  Product differentiation.

Chapter III Mental Illness and Social Control.............. 13
  Historical background.
  Functions of medical ideology.
  Mental institutions as agencies of social control.

Chapter IV Market Concentration.............................. 31
  Competition among producers: psychiatry vs the legal profession.
  The plea of insanity: the issue and the controversies.
  Capital punishment and the plea of insanity.
  Relative power: consumers vs producers.

Chapter V Conditions of Entry................................. 55
  Barrier of entry: the medical model of mental illness.
  Tactics to gain entry.
  Accommodation of the market: the 'hammer' effect.

Chapter VI Product Differentiation........................... 94
  Dual nature of mental illness.
  Choice of consumers: the 'illness-health' product.

Chapter VII Summary, Conclusion, and Discussion........... 109

Selected References.
List of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Results of moral treatment of patients admitted to Worcester State Hospital, Massachusetts, U.S.A., who were ill less than one year prior to admission, 1833-52</td>
<td>25</td>
</tr>
<tr>
<td>2. Relative percentage of commutations to executions for murderers convicted in Canada, 1930-54</td>
<td>41</td>
</tr>
<tr>
<td>3. Length of sentence for persons convicted of manslaughter and lesser offences upon reduction of charge from murder in Canada, 1966-70</td>
<td>42</td>
</tr>
<tr>
<td>4. Capital cases considered by Governor in Council for four periods since 1950</td>
<td>43</td>
</tr>
<tr>
<td>5. The relative rate of successful pleas of insanity to convictions of murder in capital cases sent to court for trial in Canada, 1930-54</td>
<td>47</td>
</tr>
<tr>
<td>6. The relative rate of successful pleas of insanity to convictions of murder in capital cases sent to court for trial in Canada, 1961-72</td>
<td>48</td>
</tr>
<tr>
<td>7. Distribution of the principal types of therapy by social class</td>
<td>51</td>
</tr>
<tr>
<td>8. Percentage of sources of referral for schizophrenics entering treatment for the first time by class</td>
<td>53</td>
</tr>
<tr>
<td>9. The effect of legal counsel upon the admission decision of a civil commitment process in a mental hospital</td>
<td>54</td>
</tr>
<tr>
<td>10. Estimated percentage of mental disorder as reported by major epidemiological studies by periods</td>
<td>80</td>
</tr>
<tr>
<td>11. Number and percentage of mental patients first admitted to all mental institutions in Canada by selected categories of diagnosis and population of Canada, 1932-40</td>
<td>87</td>
</tr>
<tr>
<td>12. The relative increase of medical doctors to other non-medical professionals employed in all mental institutions in Canada, 1932-40</td>
<td>88</td>
</tr>
<tr>
<td>Table</td>
<td>Page</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>13. Total number of first admission to mental institutions in Canada by diagnostic categories and population growth of Canada, 1960-70.</td>
<td>89</td>
</tr>
<tr>
<td>14. Relative increases of selected professionals in all mental institutions of Canada, 1960-70.</td>
<td>90</td>
</tr>
</tbody>
</table>
List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Theoretical abstraction of the social control industry</td>
<td>22.</td>
</tr>
<tr>
<td>3.</td>
<td>Number of residence patients, total admissions, net release and deaths, state and county mental hospitals, United States, 1950-68</td>
<td>29.</td>
</tr>
<tr>
<td>4.</td>
<td>The effect of the adoption of the doctrine of diminished responsibility on the pleas of insanity and insane on arraignment, United Kingdom, 1947-63</td>
<td>37.</td>
</tr>
<tr>
<td>5.</td>
<td>Comparison of selected epidemiological studies of mental disorder in chronological order</td>
<td>82.</td>
</tr>
<tr>
<td>6.</td>
<td>Expansion of nomenclature from DSM-I (1952) to DSM-II (1968)</td>
<td>84.</td>
</tr>
<tr>
<td>7.</td>
<td>The development of the nosology of psychiatry</td>
<td>106.</td>
</tr>
<tr>
<td>8.</td>
<td>The relationship between the historical development of industry and psychiatry</td>
<td>113.</td>
</tr>
</tbody>
</table>
Chapter I

Introduction

The goal of the present study is to apply an industrial model for the understanding of mental illness services. It emphasizes the conflicts among different professional workers in affecting the kinds of services delivered. This aspect of mental illness has largely been neglected by previous studies and approaching the problem of mental illness from this perspective may be helpful.\(^1\) Before going into my framework of analysis, a brief introduction on the usual approaches to the problem and their shortcomings is presented.

Mental illness has been declared a major health problem in Canada. It is estimated that one out of eight infants will be hospitalized in a psychiatric institution before death\(^2\) (Richman, 1964). In 1971, the total expenditure

\(^1\) The National Scientific Planning Council of the Canadian Mental Health Association has recognized the conflict problem among different interested groups in implementing the mental health programs as a major obstacle to any comprehensive national mental health programs (1961).

\(^2\) The figure is based on the Saskatchewan admission rate to its mortality. This index, or expectation, represents the probability of psychiatric hospitalization during the lifetime of a group of new-borns. For every 100,000 new-borns, the estimated number of admissions for all age groups is 12,415. However, over one-third (4,650) of the admission are estimated to occur after the age of 65.
on public mental institutions alone amounted to over $437 millions and over 50,000 new mental patients are added every year (Mental Health Statistics, 1971).

Despite the huge expenditure and resources spent to combat mental illness, the advance of medical science in this aspect doesn't appear to be very promising. It is openly declared that "the pursuit of cures in the mental health movement constitutes something of a cul de sac." (Joint Commission on Mental Health and Illness to the U.S. Senate, 1961, p.54). Today many authorities believe that to view mental illness as an illness has limited usefulness both for the understanding and solving the problem (Milton and Wahler, 1973). Some assert that mental illness is neither mental nor is it an illness (Plog and Edgerton, 1969), or that following a medical path will lead us further astray (Sarbin, 1972).

However, if we decide to approach from a new path, we first have to withdraw from the old path. To be able to withdraw from the old path, we have to discover the obstacles which may prevent us from withdrawing. To propose a new path while unwilling to withdraw from the old path may lead us further

3. Wootton (1958) asserted that as long as social workers employed psychiatric terminology such as social diagnosis and treatment, they tended to neglect social action and environmental factors in relieving their clients' problems.
astray.  

In the study of mental illness, sociologists have long proposed a new path other than the medical path. A review of sociological literature on the topic of mental illness, however, presents a gloomy picture. There are in general two main approaches. The first is known as the 'anomie' or 'social disorganization' approach. This approach is interested in finding the relationship of certain social characteristics such as mobility, social class etc., to mental illness. Presumably, this relationship, if found, implies a causal link, that is, epidemiology leads to etiology. In doing so, it presupposes an answer to an antecedent question: what is mental illness (Blum, 1970)? Sociologists who take this approach are interested not in whether the 'illness' path can lead us to the understanding of the phenomenon labeled as mental illness, but in enlarging the 'illness' path as to include 'social pathological factors'. They are trying to transform mental illness from an organic illness to a social illness. One does not have to go as far as the position of Szasz (1960) to see the futility of such an approach. To relate a socio-

4. Social psychiatry offers us a good illustration. A new path is proposed in terms of social, cultural and psychological causation in understanding mental illness, but basically, the old 'illness' path is still retained.
5. For a general review of the anomie approach, see Hunt (1959) and Weakland (1969).
6. If one believes, as Szasz does, that mental illness is a myth, then, sociologists who take this approach
logical variable to mental illness without transforming the latter into a sociological concept first is both a logical and a methodological inconsistency since the levels of analysis are different (Dunham, 1965). Most of the findings are thus contradictory, inconclusive, anti-theoretical, and cannot be compared over time and space (Weakland, 1969).

Recently, another approach, generally known as the 'labeling perspective' has reversed this trend (Becker, 1963, Lemert, 1967, Erikson, 1964, Schur, 1971). Here, the definitional problem of mental illness becomes the main theme to be studied (Scheff, 1966). However, the labeling perspective fails to offer us a comprehensive theoretical framework (Gibbs, 1966). While it is hard to deny the importance of labeling, to explain everything in term of labeling will lead us nowhere. Furthermore, the labeling perspective offers but again a conflict model (Akers, 1968), which concentrates on the conflicts between the controlling

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are guilty of perpetuating the myth. Fully aware of the social implications of the notion of illness, but still allowing themselves to be used, sociologists are, so to speak, acting 'in bad faith' in Peter Berger's terminology (1963).

7. The point was raised by Dunham (1965) in urging the initiation of a specialty in sociology called 'clinical sociology'. Just as stress, a psychological variable can be related to ulcers by transforming them in term of energy conversion, sociologists may be able to find a way to do it too.
authorities and the controlled as though both were homo-
genous groups. Little attention has been paid to the
analysis of conflicts among different controlling agencies and
professionals in their attempts to expand their agencies
and incomes.

Review of previous research

To view mental illness care as a kind of industry is
not without predecedent. Many writers have explored some of
the economic aspects of mental illness, though none have
attempted to construct a comprehensive model for analysis.
Szasz (1960) has attacked psychiatrists for having a vested
economic interest in maintaining a medical model of mental
illness and in one instance (1964) related the taxation
system to psychoanalysis to illustrate his point.

For income tax purposes, psychoanalysis is treated
depending on the patient's occupation; it is de-
ductible as a medical expense by the housewife; as
a business expense by the internist; it may or may
not be deductible as a medical expense by the psy-
chiatrist who is not officially in training; and it
is completely non-deductible by the analytic candidate.
(Szasz, 1964, pp. 639-640)

Mechanic (1966) has accused psychiatry of concentrating on
highly profitable private practice while leaving the ma-
jority of mental patients in mental institutions unattended.
Albee (1968) explored the nature of the shortage of
mental health professionals and concluded that the shortage
is largely due to an ideological barrier which serves no
purpose but economic self-protection. Henry, Sims and
Spray (1971) proposed a fifth profession, the psychotherapist,
to replace the existing four, namely, psychiatrist, psycho-
analyst, clinical psychologist, psychiatric social worker.
They argued that it is economically unsound to have four
types of training for essentially the same kind of work.
Goode (1960) outlined some of the conflicts and battles
between psychiatry and clinical psychologists and contended
that while the manifest differences are in ideology, the
real conflict is economic. Rome (1966) analysed some of the
barriers governments will encounter when they try to buy
most of the medical service from the professionals to
redistribute among the public. Strauss et al. (1964)
noticed that within any given mental health unit, there is
a secret battle among different professions for a bigger
share of the total allocation of resources and each maintains
a definite sphere of interest. Brenner (1973) tried to
correlate the rate of mental illness with the economic
situation and unemployment in the society. Graziano (1969)
found that existing professions can control innovation which
might affect their status by holding up the allocation of
resources. Kahn (1966) wanted specification of service
boundaries within community psychiatry centres which "should
involve many disciplines, [but] the centre should not, per se, be an integral part of a medical network." (p.173). Last but not least, the research on social classes and mental illness (Hollingshead and Redlich, 1958; Myers and Bean, 1966) consistently shows differences in the diagnostic labels attributed to different classes and the treatments they received. Presumably, different classes enjoy different consuming power for affecting the kinds and degree of services which they receive.

Outline of the succeeding chapters

In Chapter II, the main features of my theoretical framework will be outlined. They serve as guidelines of inquiry to the relationships I will be looking for in the succeeding chapters.

In Chapter III, the relationship between mental illness and social control is analysed. After a brief historical account of how medicine came into the social control business, some of the functions served by medical ideology in rendering the control service are identified. Lastly, some empirical evidence is presented showing that mental institutions are concerned primarily with social control rather than treatment.

In Chapter IV, competition between the legal profession and psychiatry is analysed. The conflict centres around
the issue of the insanity plea. Some empirical data are then presented to support the argument that the suspension of capital punishment has an effect on the rate of insanity plea. Lastly, the relationship between the mental health professions and their clients is analysed. It focuses on the relative power of the professions and their clients in shaping the kinds of services delivered and received.

In Chapter V, the relationship between the medical profession and other non-medical professions is analysed. The focus is on the attempt made by the medical profession to exclude non-medical professions from any role in the treatment of mental illness and how the latter professions respond. Lastly, an attempt is made to investigate the forms of treatment for mental illness resulting from the admission of other professions into the industry. Data are presented to test the 'hammer effect', that is, the more professions involved in servicing mental illness, the larger the percentage of people diagnosed as mentally ill.

Chapter VI tries to establish the notion that our society has a preference to label some deviant behaviors as 'sick', that is, they differentiate the 'illness-health' product over other products. Some evidence is presented to supported the notion that the consumers (our society as a whole) want control rather than treatment from psychiatry.

In Chapter VII, a conclusion and some of its implications are presented.
Chapter II

Framework of Analysis

The present study is an attempt to apply an industrial model to the analysis of the conflicts among different controlling agencies in affecting the form of control which will be administered. The treatment of mental illness is viewed as a division of the civil social control industry. Different professional workers are seen as producers of the social control services, competing in a market situation. Market structural variables are utilized as independent variables to account for exchanges of goods and services (dependent variables). The market structure is analysed in terms of (a) concentration variables (producer/consumers), (b) variables of entry to (and exit from) the market, and (c) product/service differentiation variables (Mueller, 1970; Burns, 1936).

Concentration variables deal essentially with the power to control exchanges in the market that comes from the degree of cooperation among producers against consumers or among consumers against producers. The greater the imbalance of concentration in either of the parties in the market, the greater the influence of the most concentrated in shaping the kinds of exchanges that take place. When a market has only one producer organization or one consumer
organization a monopoly is said to exist. In cases of oligopoly, that is, a market with a small number of either producers or consumers, several questions arise: how did the "partnership" originate? How is the market divided among the different producers or consumers? What kinds of cooperation and competition are there between different producers or consumers in the market?

Variables of entry to the market deal primarily with the relationship between the established producers in the market with potential new entrants. In every market, the established producers will set up barriers of entry to potential competitors in order to maintain their control. If the established producers fail to provide adequate products or services or adapt to changing demands; new competitors will be attracted into the market. The market, in turn, needs adjustment to accommodate the newly admitted competitors. The variables of entry are thus measured by the kinds of barriers to entry established producers employ to bar potential competitors, the tactics and strategies the potential competitors use in entering the market, and the expansion and marketing strategies required after more competitors have entered the market.

The product/service differentiation variables deal mainly with the preference of consumers for one product/
service over another. This is a major determinant of market control. Once the consumers regard a particular product/service of a certain producer as unique, other competitors find it extremely difficult to replace the product. Once a certain product/service's name has been established, it tends to extend to related products/services. Product differentiation variables are thus measured by the extent to which a certain product/service is recognized by the consumers as unique in the market, how the product/service can be modified in meeting changing demands, and how the names of certain products/services, after being recognized as unique, can be sold for other purposes.

In the succeeding chapters, mental illness will be analysed according to the aforementioned framework. The chapter on market concentration will ask questions such as how is the market divided between the legal profession and the medical profession? How do they compete? How does a change in consumer power affect the form of services?

The chapter on condition of entry will ask questions such as how does the medical profession attempt to exclude other professions from the market? How do other non-medical professions gain their entry? What tactics and strategies do they use? How does the the market accommodate to the admission of more professions into the mental illness industry?
The chapter on product differentiation will ask questions such as to what degree do consumers prefer 'health-illness' to other products? How is the concept of mental illness being expanded to cover new demands for social control? How is the name of mental illness sold for other than medical purposes?
Chapter III

Mental Illness and Social Control

The mental illness industry is here viewed as a division of the social control industry. Therefore, before going into the analysis of the mental illness market structure, it would appear helpful to discuss briefly (a) the historical background of the initial entry of the mental illness industry into the social control business, (b) the functions of medical ideology in social control, and then, (c) demonstrate that the primary goal of mental institutions is social control rather than treatment of the patients.

In Medieval times, the social control industry was monopolized practically by the Church.\(^8\) Behavior which now we label as mental illness was then called witchcraft (Szasz, 1970). The Church's monopoly depended on people believing that deviant behavior had theological causes.

\(---\)

8. By monopolized, I mean the final control and the ultimate decision was in the hand of the Church. The States were of course influential too. However, since the laws of the state were governed by the Divine Laws of God, the Church always maintained a superior position to the States (see J.N. Figgis, The Political Aspects of St. Augustine's "City of God", (Longman, 1921) for a discussion of the relationship between the Church and the States in Medieval times.).
By definition, the Church became the only legitimate institution to deal with it. Ideological barriers of entry were set up so that other institutions, such as the state and the university (where all professions came from), had to assume an ecclesiastical guise in order to gain a foothold in the market.  

In the days of the Church's monopoly, its uniqueness in providing the social control services had never been questioned. In fact, any one who doubted such uniqueness became ipso facto a heretic. A heretic was subject to severe social control; he might be burned at the stake, or he might be excommunicated. Either way, the supremacy of the Church was maintained.

With the coming of the Renaissance and the Reformation, the ideology of the Church began to fade, and its hold over the social control industry was thus weakened.

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9. In ruling their states, the rulers had to call themselves representatives of God governing on His behalf until the Kingdom of God comes.

10. Braginsky and Braginsky (1973) found in an experiment that the more politically deviant the patient was, the more the diagnosticians said he was mentally disturbed. Of more importance was the finding that independent of the patients' political attitude, the fact that they criticized the mental health professionals would increase their degree of 'madness'.
To account for the rise of psychiatry as a major social control institution after the decline of the Church, three major social changes during this transformation (Renaissance and Reformation) have to be considered. First, the transformation resulted in the emergence of the individual as a new social unit, more vulnerable to new rising social controls. Second, urbanization and industrialization had weakened the influence and control exerted by traditional institutions such as the clan, and the family at a time when more social control was needed. Third, the state began to assume most of the formal social control services, enforcing laws and standards of conduct. However, there were many behaviors which violated the ethics and morality of the society the control of which the state found problematic. The mental hospital and hence psychiatry developed in such a social context.

To begin with, the forerunners of the mental hospital were the almhouse, the asylum, the leprosarium, and the Hôpital General (A French establishment at the time of Louis XIV). These institutions made no pretence in declaring themselves agencies of the state for social control purposes. Their purposes were to "prevent mendicancy and idleness as the sources of all disorder" and "the punishment
of vagabonds and the relief of the poor" (Foucault, 1965). Although a physician was appointed to visit the Hôpital General twice a week, it was never intended to be a medical establishment.

With the French Revolution came the ideals of 'Liberty Equality and Fraternity' which inhibited open declarations of persecution of the poor and the alienated. However, the demand for social control services did not alter. In the light of this changing ideology, psychiatry and medical ideology began to develop.

"According to this rhetoric, involuntary confinement in a mental hospital was redefined as benefitting the inmates instead of society. He was defined as ill and unaware of his need for medical help, or unreasonably uncooperative in seeking it. He was therefore hospitalized against his will so that he could receive the neccessary psychiatric treatment. The same social function that was openly performed for a thousand years, namely the control and correction of deviant behavior by means of confinement was now covertly continued under a new medical rubric that satisfied the demands of the day for humane reform." (Leifer, 1969, p.98)

To be sure, the movement to transform the asylum into a mental hospital\(^\text{11}\) began after the French Revolution. There was a utopian flavour in pioneer psychiatrists' (Pinel in France, Tuke in England and Rush in U.S.) attempts to rehabilitate the inmates. However, their efforts were not kept up.

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\(^{11}\) It is interesting to observe that the word 'asylum' was first meant to suggest a haven of safety and security. When the place deteriorated, so did the term. 'Hospital' became the new euphemism. With the deterioration of the 'hospital', one may wonder what will be the new euphemism.
"In the end, the institution did not fulfil either the modest or grandiose hope of their founders. and yet, the penitentiary, the insane asylum and the almhouse continued to enjoy impressive longevity. The causes of both the failure and persistence of the program illuminate the function of these structures in the community, especially in the decades after 1850. Americans found reason to perpetuate them, long after their original promise had faded."

(Rothman, 1971, Introduction)

When medical technology had failed to fulfil its promises to rehabilitate the inmates, medical ideology proved to be extremely useful in serving the control purposes.

"But rather than lead to the dissolution of the asylum, these circumstances heightened the attractiveness of a custodial operation. From the perspective of the community's officials, the paupers and the immigrant insane, especially the troublesome and dangerous ones, were a convenient and practical group to incarcerate. The program had acquired a legitimacy in the Jacksonian period which did not quickly erode. The reform ideology not only sanctioned but encouraged isolation, so that later administrators could enforce with good conscience. And to the degree that overseers and judges used the asylum instead of a poorhouse or a jail for the insane, they could adopt a humanitarian pose."

(Rothman, 1971, p.285)

In the final analysis, the demand for social control services for a certain group of people manifesting deviant behavior or thought is present in every period of history. No matter which ideology is used to render the service, it doesn't change the basic demand, all that changes is the institution which will be legitimized to produce the service.
Functions of medical ideology in social control

The proceeding historical account has asserted that while medical technology had failed to fulfill its promises of rehabilitation, medical ideology proved to be extremely useful in serving the purposes of controlling inmates. Some of the functions that medical ideology serves in maintaining social control are the following:

(1) Moral vs. legal enforcement  Many western legal rules have little moral or symbolic significance. This variation is reflected in a traditional legal distinction between acts mala prohibita (wrong by prohibition) and acts mala in se (wrong in themselves). By definition, "a crime is any act or omission prohibited by public law for the protection of the public and made punishment by the state in a judicial proceeding in its own name" (Marshall and Clark, 1952, p.15). The foregoing definition requires the previous existence of a law to warrant public prosecution. It does not include transgressions against the moral or private orders. Legal enforcement is therefore far from being sufficient for providing social control services. Consider then the effectiveness of exerting control over those 'crime without victims' by applying a medical label and action instead of charging offenders with vague legal terms such as vagrancy, obscenity or public decency.

(2) Individual rights vs. collective control  The
assumption of innocence until proven guilty is a fundamental legal principle. Legal definition must be precise, absolute and without exception. Under the rigid interpretation of legality, preventive social control is almost impossible. On the other hand, the main theme in medicine is that prevention is better than cure and diagnosis is always in relative terms. Except in case of surgery, there is no risk involved in medical treatment. It either helps or is neutral, it can't hurt (Scheff, 1967). An analogy can be found in the type I error and type II error in Statistics. Whereas the legal concept emphasizes type I error at the expense of type II error, the reverse is true for the medical concept. Together, legal ideology and medical ideology make the net of social control ideology more comprehensive than ever.

(3) Free will vs. determinism The notion of Mens Rea is always problematic to the legal profession. With the exception of some offenses such as manslaughter, a wrongful act and a wrongful intent must concur in order to constitute a crime. The laws have their roots in history and are largely an expression of the realism and rationalism of Western thought (Hall, 1966), the notion of free will is most basic and essential to the whole foundation of legal concepts. As a rule, all persons are assumed to be of sound mind and responsible for their actions unless proven otherwise. However, since the notion of Mens Rea is also important, it
would be most helpful if some expert could be employed to assume the burden of proof in determining one's criminal responsibility for the legal profession and the psychiatrist is the one chosen. Although the notion of determinism as proposed by psychiatry has no place in legal concepts, it tends to make the legal practice more flexible in nature, by creating some excusing conditions.

(4) Punishment vs. rehabilitation Attitude toward social control apparently fluctuate between punishment and rehabilitation. Mr. Justice Kelly in an address at Queen's University (June 20, 1963) said law is "retributive, punitive, exemplary and corrective." (Grygier, 1965, p.15).

Sentencing therefore fulfills a multiplicity of aims. The place where these multiple aims are to be fulfilled is the prison. However, as many authors have asserted, the prison system fails at large to achieve all these conflicting goals (Kirkpatrick, 1965).

"The prisons are expected to punish; on the other hand, they are supposed to reform. They are expected to discipline rigorously; at the same time that they teach self-reliance. They are built to be operated like vast impersonal machines, yet, they are expected to fit men to live normal community lives. They operate in accordance with a fixed autocratic routine, yet, they are expected to develop individual initiative." (Bennet, 1948, p.3.)

On the other hand, hospitalization seems to be a much better alternative to the prison to serve the dual purposes of punishment and rehabilitation.
(5) **Blind justice vs. moral pluralism** The concept of justice is always somewhat arbitrary especially in a pluralistic society. The legal concepts are always normative and value-laden. Contrast with this the supposedly value-free medical ideology, the warm relationship between doctors and patients and the belief that health is always for good. By attributing a sick role to someone, his civil obligations and hence his civil rights can be removed without any legal and moral complexity.

(6) **Coercive control vs. information control** Legal control always involves force and publicity and is subject to greater scrutiny. Psychiatric control can utilize both coercive control and information control, with less publicity and scrutiny. Information control includes such techniques as psychotherapy, hypnosis, all kinds of conditioning, and all kinds of electronic tools such as computers and electronic testing devices. Coercive control includes such techniques as shock therapy, drug therapy, and surgery (London, 1969).

**Theoretical abstraction of the social control industry**

Figure 1 represents a theoretical abstraction of the social control industry. Two things are illustrated in Figure 1. First, notice the shortness and convenience of the civil commitment path through medical control as compared to the legal control path. In practice, two physicians' signa-
Figure 1

Theoretical Abstraction of the Social Control Industry

Solid arrows indicate the legal control path.

Broken arrows indicate the medical control path.
tures are sufficient to confine one to a mental institution with minimal publicity and legal complexity in most jurisdictions in North America (Allen, Ferster, And Wienhofen, 1968).

Second, the court has the option of confining its clients to either the prison or a mental institution, which creates a competitive situation between the legal and the medical professions.

Mental institutions as agencies of social control

If the mental institution is mainly an agency for social control, it follows that the services required from it are not primarily medically oriented. Statistics show that anywhere from 50% to 80% of the inmates in mental institutions receive only custodial care (Marshall, 1970). It also follows that in the case of a conflict between the ideal of control and the ideal of rehabilitation, the former will be given priority.

If the goal of mental institutions is treatment, then the adoption of new procedures should be based on a demonstration of higher rates of successful treatment by new procedures. On the other hand, if the primary goal of the mental institution is control, then the adoption of new kind of procedures would be based on the rationale that the new procedures can control more effectively.
A comparison between the results of moral treatment and drug therapy will make the above argument clear.

Moral treatment was a practice adopted in many mental institutions during the first half of the 19th century. This period was characterized by a new enthusiasm in psychiatry aroused by pioneers such as Pinel in France, Tuke in England and Rush in U.S. Genuine attempts were made to transform the asylum into a real hospital dedicated to the treatment of patients. The result for one hospital can be seen in Table 1.

During the twenty years, there were 2267 such admissions (ill less than one year prior to admission) in Worcester State Hospital, of whom 1618 (71%) were discharged as recovered or improved. This is regarded as amazingly high when a 15% remission rate would be considered very desirable by contemporary mental institutions (Joint Commission on Mental Health and Illness, 1961). The validity of the above figure was supported in a follow-up study between 1882-93 by Dr. J. Park who succeeded in getting information about 1157 former patients of Worcester State Hospital during the period 1833-53 and found that 54% remained well (Bockoven, 1972).

Moral treatment was being abandoned during the later half of the 19th century because of the dramatic increase of the patient population. Since the state controlled the
Table 1

Results of moral treatment of patients admitted to Worcester State Hospital, Massachusetts, U.S.A., who were ill less than one year prior to admission, 1833-1852.

<table>
<thead>
<tr>
<th>Five-year Period</th>
<th>Patients Admitted</th>
<th>Patients Recovered</th>
<th>Patients Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1833-37</td>
<td>300</td>
<td>211 (70%)</td>
<td>39 (8.3%)</td>
</tr>
<tr>
<td>1838-42</td>
<td>434</td>
<td>324 (74.6%)</td>
<td>14 (3.2%)</td>
</tr>
<tr>
<td>1843-47</td>
<td>742</td>
<td>474 (63.9%)</td>
<td>34 (4.6%)</td>
</tr>
<tr>
<td>1848-52</td>
<td>791</td>
<td>485 (61.3%)</td>
<td>37 (4.7%)</td>
</tr>
</tbody>
</table>

+ The figure, 39, does not agree with the percentage, (8.3%).

Source: Bockoven, J.S., Moral Treatment in Community Mental Health. (Springer Publishing Co., 1972). Table 1, p.15.
the inputs to mental institutions and was primarily concerned with social control, most of the inmates referred were hard-core criminals, immigrants and the very poor. Psychiatrists in mental hospital had no alternative but to retain these almost incurable inmates and a vicious cycle began. "The more incurables they kept, the more they received. Inevitably custody and not recovery preoccupied the asylum." (Rothman, 1971, p.274).

New kinds of treatment were introduced. It can be argued that these new treatment were adopted not because they showed better success in treatment, but because they could either control better, as in Electric Shock Treatment, or were more economical, such as the milieu therapy. This point can be best illustrated by examining the drug therapy widely practised now in all contemporary mental institutions.

Drug therapy became popular in the 1950's not because a new drug had been invented with proven therapeutic effect, but as a relief to the intolerable trend of rising patient populations and the increased demand for control and restraint within the institutional setting. This relationship is shown clearly in Figure 2.
Figure 2
The effect of drug therapy on the patient population and the restraint required in the mental hospitals of New York, 1955-1959

As the number of patients on drug increases, both the length of residence and the restraint required decrease. Furthermore, drug therapy brings a more rapid circulation of patients which hospital managements had never experienced before. More patients can be admitted without an increase in the total patient population. As a matter of fact, a decrease in total population is observed as in Figure 3. This is accomplished by a faster release rate coupled with a greater readmission rate.

Despite the manifest rationale that drugs heal mental illness, many studies have indicated drug therapy is not very effective as treatment, and at best, it merely relieve symptoms of the illness (Prien and Kleit, 1970). When drugs are withdrawn, the symptoms will come back more severly than before. Even more important is the finding that while patients released on drug therapy show comparatively low performance in normal life within the community, they cause less trouble (Rickels, 1968; Veteran Administration, 1970; Gurel, 1970.).

Therefore, we may conclude that the adoption of drug therapy over moral treatment was perhaps based on considerations of social control rather than treatment.

Another kind of evidence that the control goal is prior to the rehabilitation goal in mental institutions can be found if one compares the length of incarceration of civil commitment patients and legal commitment patients.
Figure 3

Number of resident patients, total admissions, net releases and deaths, state and county mental hospitals, United States, 1950-1968.

If it may be assumed that both kinds of patients are suffering from the same type of illness (after all, the same kind of diagnosis and label are applied to both cases by psychiatrists), then the required time to treat one should not be so much different from the other. However, since the legally committed inmates have committed a felony prior to their commitment which implies that they need more social control, their length of incarceration should be longer. Data from Morris (1970) again confirms the proposition. The median length of stay in Mattewan, a maximum security mental institution in New York State is six to seven years as compared with the median length of stay of four months for other civil commitment hospitals in the same State. (The use of median is to avoid many extreme cases.)

Summary. The chapter explored the social control nature of the treatment of mental illness. It first traced historically how the mental illness industry entered into the social control business. Then, it identified some of the functions medical ideology serves in rendering social control services. Lastly, evidence was examined to evaluate the proposition that the primary goal of mental institutions is social control rather than treatment.

12. Unfortunately, Morris made no attempt to control for the types of diagnosis applied to these two groups. Thus the differences he found may be attributable to different types of mental disorders as well as to differences in the criteria for release of these two types of patients.
Chapter IV

Market Concentration

The chapter focuses first on cooperation and competition between the legal and medical professions within the social control industry. The second focus is on the relationship between consumer power and psychiatric services. Competition between the legal profession and the medical profession centres around the issue of the insanity plea. The relationship between consumer power and psychiatric services is examined to show how consumer power will affect and determine both the types and the quality of the service received.

Cooperation and competition among producers

In the social control industry, when issues such as sexual offences, juvenile delinquency, drug addiction, alcoholism, divorce, sterilization, abortion, criminal responsibility, validation of will and contracts etc., are troublesome to the legal profession, these issues will be passed to psychiatry. However, the role of psychiatry is always supplementary and there are clear limits to psychiatric responsibility in the market. This is evidenced by the low degree of acceptance of
psychiatric criminology\textsuperscript{12} in legal practice. In psychiatric theories, especially the psychoanalytic theory, mental illness and crime are but different manifestations of the same underlying causes. No theory of mental medicine could develop without the working hypothesis of determinism (White-\textsuperscript{lock}, 1963), and from this perspective crime is but another form of mental illness (Alexander and Staub, 1962). The notion of determinism, while given full recognition and legitimacy in all other aspects of mental illness, is strongly rejected in legal practice (Hall, 1966).

From this viewpoint the ideological battle between psychiatric determinism and the legal free will notion is a struggle for a greater share of the social control market.\textsuperscript{13} This is evident if we trace the development of the plea of insanity.

The classic McNaughten Rule was established in 1843 when professional psychiatry was too young to have its voice heard. The rule states that insanity itself is not a

\textsuperscript{12} Psychiatric criminology includes Caldwell's phrenology, Lombroso's and later Hooton's and Sheldon's constitutional psychiatry. Goring's hereditary theories and the endocrinological theories of Berman and Podolski, Eysenck's theories of criminals as poor conditioners and Freudian theories of poor ego and defected superego (Halleck, 1968).

\textsuperscript{13} The assertion is not intended to be inclusive. There are of course many other considerations involved in the struggle between psychiatry and the legal profession. For the sake of my analysis, only the struggle for clients is considered.
defense. To establish a defense, an accused must "laboring under such a defective reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know the nature and quality of the act he was doing, he did not know he was doing what is wrong." (Robitscher, 1966). Under a strict interpretation of the rule, only the most severe psychotics labouring under hallucination would be qualified (Goldstein, 1967). Furthermore, psychiatry had to work under a strictly legal and moral test -- right from wrong and not healthy from ill which further limited their autonomy. The 1869 New Hampshire Rule under the influence of a very famous forensic psychiatrist by the name of Issac Ray expanded the legal role of psychiatry. It states that if the criminal action was the "offspring or product of mental disease", then the accused could plead insanity. Incidentally, attached to the New Hampshire Rule is a provision for compulsory hospitalization for defendants successfully pleading under the rule. The goal of control remained, but the administration of the control has changed. The Irresistible Impulse Test was stated in 1886 in Alabama. A category of behavior called irresistible impulses was recognized, acknowledging the psychiatric determinism. Finally, the 1954
Durham Rule states that a defendant must be held not guilty if the jury finds that his act was the product of mental disease or defect. This enables the testifying psychiatrist to present the whole psychiatric history of the defendant which under the McNaughten Rule would be irrelevant (for a detailed account of the development of the plea, see Goldstein, 1967; Whitelock, 1963 and Robitscher, 1966). It should be noted that the Durham Rule has much wider implications than the New Hampshire Rule though the wordings of the two are quite similar. The scope of mental disease diagnosis has expanded to such an extent that if the Durham Rule is interpreted liberally, it will give psychiatry priority over the legal profession in many decisions.15

This struggle for more influence in court by psychiatry naturally arouses reaction within the legal profession. Their counter-attack consists of three strategies.

(1) Bar off encroachment through legal means

It is noteworthy to observe that whenever another profession is charged with encroachment on the legal profession, the case is adjudicated by a member of the legal profession on the bench (Griswold, 1955). This ensures that their interests will be protected. Therefore, the

15. Apparently, the Durham Rule has never been interpreted liberally. Even in Washington, D.C. where Durham Rule was formulated, psychiatrists testing the application of the Rule, interpreted the Rule strictly, and psychiatrists who, under the McNaughten interpretation, might have been convicted of a crime, were acquitted (Arens, 1967).
forementioned rules on the plea of insanity have never become popular in most jurisdictions. Britain and Canada still observe the McNaughten Rule with only a few wordings modified. Even in the United States where the influence of psychiatry is supposed to be stronger, the Durham Rule is observed only in Washington, D.C., and Maine; only four states have abandoned the McNaughten Rule (Vermont, Illinois, New York, and New Hampshire), in all the remaining states, the McNaughten Rule still prevails.¹⁶

(2) Propose alternative rules  Immediately after the Durham Rule was coined, the American Law Institute proposed an alternative rule to define and restrict the definition of mental disease so as not to include "an abnormality manifested only by repeated criminal or otherwise antisocial conduct" (American Law Institute, Model Penal Code, 1962).

(3) Modify legal definitions of responsibility
A powerful selling feature of psychiatry is its emphasis on subjective liability as against rigid objective liability in law. Given identical offenses, some accused are definitely more excusable and arouse more sympathy from juries. The rigidity of law allow psychiatry to champion itself as

¹⁶. It should be noted that the three strategies of counter attack by the legal profession represent only one alternative point of view derived from my framework of analysis. There are several other possible alternative explanations for the reluctance of the legal profession to adopt the rules as proposed by psychiatry, e.g. they might be bad laws.
more flexible in nature. The adoption of the Doctrine of Diminished Responsibility by the legal profession may be regarded as a strategy to absorb and check the influence of psychiatry in court. Under the doctrine, the accused, who formerly had to plead insanity, can now plead diminished responsibility as an alternative. Here, the accused now chooses the legal service instead of the psychiatric service. The effect of the Doctrine of Diminished Responsibility as a maneuver over the plea of insanity and insanity on arraignment can be seen in Figure 4.

After the Homicide Act was passed in England in 1957, the number of insanity pleas and insanity on arraignment cases declined dramatically. The Homicide Act was a direct application of the Diminished Responsibility Doctrine in legal practice. It distinguishes capital from non-capital murder and manslaughter. Before the Act, all homicides were murderers and circumstantial factors were disregarded.

**Abolition of the insanity plea**

Out of these controversies about the insanity plea, there is at present a strong movement to abolish it all together (Katz and Goldstein 1964) The position of the legal profession on abolition of the insanity plea is summarized in a comment by Judge Burger of the United States
Figure 4

The effect of the adoption of the doctrine of diminished responsibility on the pleas of insanity and insane on arraignment, United Kingdom, 1947-1963.

Court of Appeals, D.C., that,

"the adversary system (insanity plea) with all its clash and partisan contention is simply not attuned to the nuance of psychiatry and we waste these talents when we try to use them in the pointless quest to resolve the issue of criminal responsibility in that atmosphere."

(Burger, 1964, p.3)

In other words, there are so many other useful products the mental health industry can produce, why bother to retain this particular product which will only lead to competition between partners within the social control industry?

Paradoxically, many psychiatrists want to abolish the insanity plea as well (McDonald, 1964). The reason is not difficult to understand if one draw an industrial analogy. The market manager (forensic psychiatrist in court) tries to expand his market as much as possible to secure more orders. However, the production manager (psychiatrist in mental institution) finds that these new clients are not profitable at all because criminals referred by courts are less easy to rehabilitate, so it is better not to accept them at all. This is evident at St. Elizabeth Hospital in Washington, D.C. where the Durham Rule is in effect. The superintendent, Dr. Cameron, ran into many legal troubles (Rouse v. Cameron, 1966; Dobson v. Cameron, 1967; Millard v. Cameron, 1967, etc.) because many hard-core criminals were being referred under the Durham Rule to the hospital where treatment facilities were inadequate to accommodate all of them
As we saw in Figure 1, the mental illness industry has two sources of clients, a referral system from the court and direct recruitment from the community. The real interest of psychiatry lies not in the expansion in the court referral system, but in the expansion of the community recruiting channel. It is the official position of the American Psychiatric Association that physicians should have unrestricted power of civil commitment (Szasz, 1963) and that provisions should be made for involuntary hospitalization without the necessity of court proceedings (Davidson, 1964). Thus, favoring the abolition of the insanity plea is perhaps not entirely contrary to psychiatry's interest.

**An Empirical Investigation**

The issue of capital punishment can be used to investigate the competition between the legal profession and psychiatry. Historically, the defence of insanity has been almost exclusively confined to cases where capital punishment could be imposed. Few accused persons have chosen to subject themselves to perpetual confinement in a security hospital where the alternative was a definite and potentially reducible term of imprisonment. Considering the pre-trial bargain, the probation deal, the parole deal, the good time earning deal etc., the legally
accused persons on charges other than capital punishment would naturally prefer the legal service to the psychiatric service.

However, in the case of murder before capital punishment was suspended, the choice of the legal service risks the consequence of being executed if convicted. As Table 2 shows, after being convicted of murder, the chance is $1 : 2.28$ in favor of being executed. This makes the attractiveness of the legal service low compared to the psychiatric service.

After capital punishment was suspended, however, the attractiveness of the legal service is greatly enhanced. Table 3 shows that of the 444 persons convicted of murder between the period 1966-72, only 118 serve ten years or more. Even if they are sentenced to death as in the case of killing a policeman or prison guard, the chance of being commuted is 100% (Table 4).

Meanwhile, the attractiveness of psychiatric service remains constant. Therefore, I would hypothesize that the rate of insanity pleas will decline dramatically after capital punishment has been suspended. However, two considerations have to be added. First, although capital punishment was suspended in 1967 in Canada, the Criminal Code was changed in 1961 to distinguish capital from non-
### Table 2

Relative percentage of commutations to executions for murderers convicted in Canada, 1930-54.

<table>
<thead>
<tr>
<th>Five-year Period of Convictions*</th>
<th>Total No. of Convictions</th>
<th>No. of Commutations</th>
<th>No. of Executions</th>
<th>Relative % of Commutations to Executions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1930-34</td>
<td>108</td>
<td>18</td>
<td>76</td>
<td>1 : 4.22</td>
</tr>
<tr>
<td>1935-39</td>
<td>86</td>
<td>24</td>
<td>51</td>
<td>1 : 2.13</td>
</tr>
<tr>
<td>1940-44</td>
<td>177</td>
<td>19</td>
<td>36</td>
<td>1 : 1.89</td>
</tr>
<tr>
<td>1945-49</td>
<td>273</td>
<td>25</td>
<td>55</td>
<td>1 : 2.20</td>
</tr>
<tr>
<td>1950-54</td>
<td>202</td>
<td>22</td>
<td>46</td>
<td>1 : 2.09</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>669</strong></td>
<td><strong>108</strong></td>
<td><strong>246</strong></td>
<td><strong>1 : 228</strong></td>
</tr>
</tbody>
</table>

* The number of commutation and the number of execution do not equal to the total number of convictions.

Source: Reports, Joint Committee On Capital And Corporal Punishment And Lotteries, (Queen's Printer, Ottawa, 1956).
Table 3

Length of sentence for persons convicted of manslaughter and lesser offences upon reduction of charge from murder in Canada, 1966-1970

<table>
<thead>
<tr>
<th>Sentence</th>
<th>Manslaughter</th>
<th>Lesser Offences</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspended Sentence,</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>probation and fine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1 year</td>
<td>11</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>1 and under 2 years</td>
<td>38</td>
<td>7</td>
<td>45</td>
</tr>
<tr>
<td>2 and under 5 years</td>
<td>102</td>
<td>3</td>
<td>105</td>
</tr>
<tr>
<td>5 and under 10 years</td>
<td>148</td>
<td></td>
<td>148</td>
</tr>
<tr>
<td>10 years and over</td>
<td>116</td>
<td></td>
<td>116</td>
</tr>
<tr>
<td>Life</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Indefinite (Juvenile)</td>
<td>6</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>420</strong></td>
<td><strong>24</strong></td>
<td><strong>444</strong></td>
</tr>
</tbody>
</table>

Capital cases considered by Governor in Council for four periods since 1950

<table>
<thead>
<tr>
<th>Period</th>
<th>Cases</th>
<th>Executed</th>
<th>Commuted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1, 1951 to June 30, 1957</td>
<td>90</td>
<td>55</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>61</td>
<td>39</td>
</tr>
<tr>
<td>July 1, 1957 to Apr. 15, 1963</td>
<td>66</td>
<td>14</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21</td>
<td>79</td>
</tr>
<tr>
<td>Apr. 16, 1963 to May 25, 1965</td>
<td>14</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>May 26, 1965 to Sept. 15, 1971</td>
<td>35</td>
<td>0</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

capital murder, that is, the doctrine of diminished responsibility was adopted. As argued above, the adoption of the doctrine of diminished responsibility is a response of the legal profession in reaction to psychiatric determination of legal responsibility. Statistics show that since 1962, no one in Canada has been executed (Murder Statistics, D.B.S., 1961-72). Therefore, the suspension of capital punishment is merely a formality. It would appear more meaningful to draw the dividing line in 1961 instead of 1967.

Second, pleading insanity as a defense means admitting the indictment. For those defendants who have good reason to believe that they can prove their innocence, pleading insanity is really not an alternative. Therefore, if we exclude the acquittal cases, and merely compare the insanity plea cases to the convicted cases, the relation-ship should be clearer.

Before presenting my data, a brief account of how the insanity issue is raised in court may be helpful. It is specified in Section 16, Clause 4 in the Criminal Code that "everyone shall, until the contrary is proved, be presumed to be and to have been sane." (The Criminal Code, 1969). Theoretically speaking, therefore, the plea can only be initiated by the defendant since he is totally responsible for the burden of proof. Any
doubt on the part of the prosecution on the mental state of the defendant should be raised before the trial is sent to court in the process known as 'fitness to stand trial'. Once a defendant has been found fit to stand trial, any subsequent attempt to plead insanity should be considered a free decision by the defendant on the consultation of his counsel. Although various alternatives have been proposed for providing expert testimony should the insanity plea be raised (such as the psychiatric clinic attached directly to the court, the psychiatrist sitting as assessor, and the psychiatrist drawn by the court from a panel nominate by the profession), most of the Canadian courts still operate under an adversary system where both the defence and the prosecutor bring forth their own psychiatrists to examine the defendant. This oftentimes results in a "battle of experts" on the issue, however, a lack of facilities and psychiatric personnel in court render other alternatives infeasible.

Data were obtained from two main sources. For the pre-1961 period, the Joint Committee on Capital and Corporal Punishment and Lotteries of 1956 provided a comprehensive break-down of all murder cases sent to court for disposition in Canada between 1930-54. Utilizing
these data, one can calculate the relative percentage of convictions, insanity pleas, and acquittals for each year and also the ratio of the conviction rate to the insanity plea rate. The result is presented in Table 5. For the post-1961 period, data in a Dominion Bureau of Statistics series called Murder Statistics, allows a break down of the disposition of murder cases into the required categories. The percentage of each disposition is again calculated and the ratio of conviction to insanity plea computed. The result is presented in Table 6. Two things have to be noted. First, the data as provided by the Joint Commission end in 1954 and the Murder Statistics appear only in 1961. For the period in between, similar rates cannot be computed because different categories were used. Second, grouping murder cases according to chronological order is quite arbitrary, so one might find a great fluctuation year by year, but on the average, these fluctuations will be levelled out.

A comparison between Table 5 and Table 6 firmly supports my proposition that there is a great drop in insanity pleas after 1961. As Table 5 shows, in the pre-1961 period, for every one hundred murder cases, 41 will be convicted and 13 will be found insane, on the average. In the post-1961 period, as Table 6 shows, for every one hundred murder cases, 70 will be convicted while only 6 will be found insane, on the average. In other words, in
The relative rate of successful pleas of insanity to convictions of murder in capital cases sent to court for trial in Canada, 1934-54.

<table>
<thead>
<tr>
<th>Year</th>
<th>Capital Cases</th>
<th>Convictions</th>
<th>Successful Insanity Pleas</th>
<th>Ratio (1):(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>1930</td>
<td>54</td>
<td>17</td>
<td>32</td>
<td>7</td>
</tr>
<tr>
<td>1931</td>
<td>49</td>
<td>25</td>
<td>51</td>
<td>10</td>
</tr>
<tr>
<td>1932</td>
<td>47</td>
<td>23</td>
<td>49</td>
<td>6</td>
</tr>
<tr>
<td>1933</td>
<td>43</td>
<td>24</td>
<td>56</td>
<td>8</td>
</tr>
<tr>
<td>1934</td>
<td>46</td>
<td>19</td>
<td>41</td>
<td>3</td>
</tr>
<tr>
<td>1935</td>
<td>46</td>
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<td>1936</td>
<td>48</td>
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<td>1937</td>
<td>35</td>
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<td>1938</td>
<td>45</td>
<td>22</td>
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<td>4</td>
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<tr>
<td>1939</td>
<td>37</td>
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<tr>
<td>1940</td>
<td>40</td>
<td>17</td>
<td>43</td>
<td>5</td>
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<tr>
<td>1941</td>
<td>40</td>
<td>13</td>
<td>33</td>
<td>8</td>
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<tr>
<td>1942</td>
<td>41</td>
<td>15</td>
<td>37</td>
<td>9</td>
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<tr>
<td>1943</td>
<td>23</td>
<td>9</td>
<td>39</td>
<td>4</td>
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<tr>
<td>1944</td>
<td>33</td>
<td>11</td>
<td>33</td>
<td>2</td>
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<tr>
<td>1945</td>
<td>35</td>
<td>17</td>
<td>48</td>
<td>8</td>
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<tr>
<td>1946</td>
<td>66</td>
<td>32</td>
<td>48</td>
<td>5</td>
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<td>1947</td>
<td>61</td>
<td>18</td>
<td>30</td>
<td>13</td>
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<td>1948</td>
<td>56</td>
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<td>1950</td>
<td>29</td>
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<td>1</td>
</tr>
<tr>
<td>1951</td>
<td>52</td>
<td>15</td>
<td>29</td>
<td>7</td>
</tr>
<tr>
<td>1952</td>
<td>50</td>
<td>18</td>
<td>36</td>
<td>0</td>
</tr>
<tr>
<td>1953</td>
<td>36</td>
<td>10</td>
<td>28</td>
<td>8</td>
</tr>
<tr>
<td>1954</td>
<td>35</td>
<td>15</td>
<td>43</td>
<td>4</td>
</tr>
</tbody>
</table>

| Total | 1102 | 448 | 144 |

| Average % | 41 | 13 | 4.17 |
| Median %  | 39 | 13 | 2.70 |

Source: Reports, Joint Committee on Capital and Corporal Punishment and Lotteries, (Queen's Printer, Ottawa, 1956).
Table 6

The relative rate of successful pleas of insanity to convictions of murder in capital cases sent to court for trial in Canada, 1961-1972.

<table>
<thead>
<tr>
<th>Year</th>
<th>Capital Cases</th>
<th>Convictions</th>
<th>Successful insanity pleas</th>
<th>Ratio (1):(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>1961</td>
<td>136</td>
<td>79</td>
<td>58</td>
<td>8</td>
</tr>
<tr>
<td>1962</td>
<td>127</td>
<td>89</td>
<td>70</td>
<td>10</td>
</tr>
<tr>
<td>1963</td>
<td>170</td>
<td>108</td>
<td>64</td>
<td>11</td>
</tr>
<tr>
<td>1964</td>
<td>153</td>
<td>110</td>
<td>72</td>
<td>8</td>
</tr>
<tr>
<td>1965</td>
<td>156</td>
<td>118</td>
<td>76</td>
<td>10</td>
</tr>
<tr>
<td>1966</td>
<td>157</td>
<td>115</td>
<td>73</td>
<td>3</td>
</tr>
<tr>
<td>1967</td>
<td>173</td>
<td>127</td>
<td>73</td>
<td>11</td>
</tr>
<tr>
<td>1968</td>
<td>221</td>
<td>152</td>
<td>69</td>
<td>22</td>
</tr>
<tr>
<td>1969</td>
<td>249</td>
<td>181</td>
<td>73</td>
<td>21</td>
</tr>
<tr>
<td>1970</td>
<td>274</td>
<td>196</td>
<td>72</td>
<td>19</td>
</tr>
<tr>
<td>1971</td>
<td>292</td>
<td>225</td>
<td>77</td>
<td>17</td>
</tr>
<tr>
<td>1972</td>
<td>186</td>
<td>125</td>
<td>67</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>2294</td>
<td>1625</td>
<td></td>
<td>144</td>
</tr>
<tr>
<td>Average %</td>
<td>70</td>
<td>6</td>
<td>14.78</td>
<td></td>
</tr>
<tr>
<td>Median %</td>
<td>72</td>
<td>6</td>
<td>11.41</td>
<td></td>
</tr>
</tbody>
</table>

the pre-1961 period, for every one found insane, only 4.17 person will be convicted; in the post-1961 period, however, for every one found insane, 14.78 person will be convicted. If median percentages rather than average percentages are used, the general picture does not change at all. The difference is so great that we can safely conclude that there is really a drop in insanity pleas after 1961.

**Consumer power and psychiatric services**

The second focus in this chapter is on the relative power of the consumer vis-a-vis the producer in determining the kind of service that will be delivered. The relationship has been discussed by Johnson (1972). He breaks down the power relationship between the producer of service and the consumer into three types: collegiate, patronage, and mediation. In the mental illness industry, the collegiate type is typified by private-practice psychiatry where the prestige and the autonomy of the profession are best guaranteed because the clients are individuals, heterogenous as a body. The patronage type is exemplified by institutional psychiatry working in a gigantic bureaucracy such as the hospital, the army, the university, the prison. The client now becomes a powerful organization which has certain goals psychiatry has to observe and which affect the kind of service psychiatry
will produce. The mediation type is best illustrated by community psychiatry centres where governments act as strong mediators to regulate the distribution of psychiatric services among the clients. It is not the intention of this paper to go into more detail on these three types of psychiatry which would require a separate paper in itself. Nonetheless, let me illustrate with two empirical studies the delicate relationship between the power structure of the clients and the professions.

The New Haven study by Hollingshead and Redlich (1958) and the follow-up study by Myers and Bean (1968) have become classics in the study of mental illness. In general, they found that lower class clients were more likely to be diagnosed as psychotics and receive organic treatments in hospitals, while higher class clients were more likely to be diagnosed as neurotics and receive psychotherapy without hospitalization. This finding is very consistent with the hypothesis that the power of the client will affect the types of service obtained (see Table 7). Of interest also is their finding that the upper class diagnosed schizophrenic patients were exclusively referred by private physicians, families and friends while lower class diagnosed

17. This is generally known as the 'double agent' dilemma in psychiatry (Halleck, 1971).
Table 7

Distribution of the principal types of therapy by social class

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Psychotherapy number</th>
<th>Psychotherapy per cent</th>
<th>Organic therapy number</th>
<th>Organic therapy per cent</th>
<th>No treatment number</th>
<th>No treatment per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>14</td>
<td>73.7</td>
<td>2</td>
<td>10.5</td>
<td>3</td>
<td>15.8</td>
</tr>
<tr>
<td>2</td>
<td>107</td>
<td>81.7</td>
<td>15</td>
<td>11.4</td>
<td>9</td>
<td>6.9</td>
</tr>
<tr>
<td>3</td>
<td>136</td>
<td>52.7</td>
<td>74</td>
<td>28.7</td>
<td>48</td>
<td>18.6</td>
</tr>
<tr>
<td>4</td>
<td>237</td>
<td>31.1</td>
<td>288</td>
<td>37.1</td>
<td>242</td>
<td>31.8</td>
</tr>
<tr>
<td>5</td>
<td>115</td>
<td>16.1</td>
<td>234</td>
<td>32.7</td>
<td>367</td>
<td>51.2</td>
</tr>
</tbody>
</table>

* Class 1 is the highest class, Class 5 is the lowest class

schizophrenic patients were referred largely by public agencies (Table 8).

Another empirical support comes from Wenger and Fletcher (1969). They tried to find out whether the presence of a legal counsel hired by the patient will change the likelihood of hospitalization. Presumably, the legal counsel will enhance the relative power of the patient vis-à-vis the psychiatrist. Their findings are presented in Table 9. Table 9 shows that the presence of a legal counsel does affect the outcome of the process of hospitalization. In the 66 cases where patients were not represented by any counsel, 61 of them were admitted to the hospital. On the other hand, of the 15 cases where legal counsels were present, only 4 were admitted. The implication is clear, the admission decision of a civil commitment process in a mental hospital is not purely a medical decision, but perhaps involves also power playing and negotiation.

Summary  This chapter focused on the competition between the legal profession and psychiatry over the issue of the insanity plea. A brief history of the plea was presented. Empirical data were analysed to discover how the rate of occurrence of the insanity plea was affected by the suspension of capital punishment in Canada. The movement to abolish the plea was discussed. Finally, the relative power of the producers and consumers of mental illness service was analysed.
Table 8

Percentage of sources of referral for schizophrenics entering treatment for the first time—by class

<table>
<thead>
<tr>
<th>Sources of referral</th>
<th>Class</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I-II</td>
<td>III</td>
<td>IV</td>
<td>V</td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private physicians</td>
<td>45.5</td>
<td>66.7</td>
<td>35.3</td>
<td>10.6</td>
</tr>
<tr>
<td>Clinic physicians</td>
<td>---</td>
<td>3.7</td>
<td>23.3</td>
<td>12.5</td>
</tr>
<tr>
<td>Nonmedical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police and court</td>
<td>---</td>
<td>7.4</td>
<td>24.8</td>
<td>52.3</td>
</tr>
<tr>
<td>Social agencies</td>
<td>---</td>
<td>---</td>
<td>3.8</td>
<td>17.6</td>
</tr>
<tr>
<td>other professions</td>
<td>---</td>
<td>3.7</td>
<td>1.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Family and friends</td>
<td>54.4</td>
<td>11.1</td>
<td>9.8</td>
<td>3.2</td>
</tr>
<tr>
<td>Self</td>
<td>---</td>
<td>7.4</td>
<td>1.5</td>
<td>---</td>
</tr>
<tr>
<td>N</td>
<td>11</td>
<td>27</td>
<td>133</td>
<td>216</td>
</tr>
</tbody>
</table>

* I-II indicates higher class

Table 9

The effect of legal counsel upon the admission decision of a civil commitment process in a mental hospital

<table>
<thead>
<tr>
<th></th>
<th>Not Admitted</th>
<th>Admitted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Counsel</td>
<td>4</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>No Legal Counsel</td>
<td>61</td>
<td>5</td>
<td>66</td>
</tr>
<tr>
<td>TOTAL</td>
<td>65</td>
<td>16</td>
<td>81</td>
</tr>
</tbody>
</table>

Chapter V

Conditions of Entry

This chapter will focus on the conflict among different professions within the mental illness service industry, that is, the relationships between the medical profession and the non-medical health professions in the mental illness service industry. It will first look at the medical model of mental illness which is seen as serving the function of upholding the monopoly of the medical profession in the industry. The strategies and tactics that some of the non-medical professions employ in forcing themselves into the market will be analysed. Lastly, an empirical enquiry will be conducted to investigate the change and accommodation within the mental illness service industry after more professions have come in.

There are in general two types of monopolistic situations. The first type is characterized by a single profession dominating the distribution of service completely. This occurs when the profession is able to meet demand adequately and when its uniqueness in providing the service is never questioned. A good example for this is the legal profession. The demand is controlled because what is legal or illegal is in the final analysis determined
by the legal profession and laws prohibit the practice of law to all except lawyers.

A second type of monopoly is characterized by a profession allowing other professions to practice in the market so long as it holds the controlling position. This kind of monopoly is quite common in other commodity industries and multi-national enterprises. Rather than killing off all the smaller competitors, a gigantic corporation will try to sell 49% of its shares, then attempt to buy 51% of competitors' shares. This type of "holding corporation" allows its "competitors" to survive and expand so long as it controls them. In the service industry, with some modifications, the basic mechanism still prevails. A profession will try to exclude other professions from sharing the market as much as possible. If for some reason the demand in the market is out of the control of the profession; so that it fails to meet the demand adequately, the uniqueness of that profession in providing the service alone will be questioned. Moreover, the inability of the established profession to provide service adequately creates a partial vacuum in the market, and more competitors will be attracted. One way for the established profession to maintain its monopoly is not to exclude newly attracted
competitors, which may put it in a vulnerable position, but to absorb them into the market; give them a share but maintain a hold on the controlling positions.

**Medical model of mental illness as a barrier of entry**

In the mental illness industry, defining mental illness in a rigid medical fashion is a strategy for excluding other professions from the market. The relaxation of the medical model is a strategy for absorbing its competitors and critics by buying them off. This relaxation of the medical model is due to the fact that psychiatry has failed to meet the demand adequately.

Mannheim (1936) talked about the concept of ideology in reflecting the fact that individuals or groups may become so intensely interest-bound to a situation that their thinking reflects facts that serve that interest and ignores facts that would undermine it. When the situation is a market and the interest is economic, the ideology serves the purpose of excluding other competitors from sharing the profit. In the mental illness industry, the ideology is the medical model.

However, the concept of the medical model of mental illness has to be understood with more sophistication. Although advertising statements such as "mental illness
is like any other illness" or "estimates indicate that one out of every ten babies born today will be hospitalized for mental illness at some time during his life" (Hilgard and Atkinson, 1967) appear quite casually in psychiatric propaganda, probably only a small minority of psychiatrists adheres to a rigid medical model and believes there is no difference between physical illness and mental illness.

However, that mental illness is different from other illnesses doesn't mean that the medical model is shaken; there are a few sophisticated rationales to foster the model. First is what I called 'physiological reductionism'. The fact that a small portion of mental illness does have a demonstrated organic base points to the assumption that eventually, as medical science advances, other organic and physiological causes for other types of mental illness will be found. After all, the functions of the human brain are still quite unknown. Clinical evidence is often cited to demonstrate that after mental patients have died, postmortem examinations reveal brain damage (Ross, 1959).

Second is the concept of conservation and conversion of energy. If, as seen by Freud (Jones, 1953), physiological energy and psychological energy are convertible, then, one might lead to another. Therefore, it is
hard to distinguish one from the other just by observing the overt manifestation. A paralysed leg might be due to some psychological defects while anxiety might have a physiological cause.

The third rationale is the concept of symptomology. Behavioral disorders are seen as only the symptoms of underlying organic causes. Eliminating the symptoms is always secondary to the discovery of the true causes. However, in the absence of any knowledge of the underlying causes, concentrating on the symptoms might be a method for eventually discovering the true causes (White, 1956).

The fourth rationale is the concept of inner causation. The disease notion is applied to any behavior to which an inner causation is attributed. Therefore, a weak ego or an imperfect superego is considered an equivalent to a weak heart or an imperfect kidney. In this way, every social maladaptation and behavior disorder can be attributed to some inner psychic conflict, which, ipso facto, becomes a disease (Menninger, 1963).

The fifth rationale is the concept of expertise. Something becomes a disease because a doctor said so (McAndrew, 1969). For who else has more expertise than a doctor to determine what is a disease and what is not?
Even at such a state of sophistication, psychiatry soon finds that the medical model is hardly satisfactory in meeting new demands. New services are required whether the medical model can cover them or not. These new demands include servicing rising social problems and hardships in interpersonal relations, such as juvenile delinquency, alcoholism, marital maladjustment and occupational dissatisfaction.

The rising demand for new services affects psychiatry in two ways. First, it aggravates the chronic manpower shortage in psychiatry. Unlike the other professions which can adjust their recruitments according to the demands, psychiatry is handicapped because its only source of recruitment is from the medical profession, which has a severe manpower shortage itself. Out of this scarcity, only a small percentage of physicians will be recruited as psychiatrists. In 1955, it was estimated that about 6.7% of all physicians were psychiatrists (Joint Commission on Mental Health and Illness, 1961). Furthermore, the majority of psychiatrists go in for private-practice, leaving the shortage in mental institutions more acute. It is estimated that in 1967, the average ratio was 200 patients to one psychiatrist in the U.S. public mental institutions (Davidson,
1967), and that two-thirds of the 2000 mental health clinics operated without a full time psychiatrist (Albee, 1968).

Second, the new demand for servicing of mental illness aggravates the credibility problem of medical ideology in providing the service alone. Having no demonstrated organic and physiological causes, these new problems have to be classified into the psychiatric nosology nevertheless. Due to lack of objective criteria, most psychiatric classifications are based on either etiological, descriptive or therapeutic response criteria, depending on the orientation of the individual psychiatrist. What begins as a descriptive label for an individual's behavior, for example, "paranoid", is transformed into an explanation of that behavior (Adams, 1964). Because different descriptions of behavior can be elicited from different psychiatrists, the reliability of diagnosis is extremely low. Ziegler and Philips (1961) found that identical symptoms can appear in cases placed in different diagnostic categories. Schmidt and Fonda (1956) found that although psychiatrists reached 85% agreement on major categories, when they came to subtypes, the agreement is about one half, no better than chance. This disagreement was especially noticed for the personality disorders and neurosis. Even more amazing were findings
by Lewis and Piotrowski (1954) that most patients who initially received less severe labels of diagnosis, but who failed to improve subsequently were re-diagnosed as schizophrenics. There has been an increasing rate of diagnosis of mania and hypomania ever since lithium compounds had been discovered as successful in relieving manic symptoms (Communication Research Machines Inc., 1972).

As a result, psychiatry soon finds that to defend the medical model rigidly in an attempt to monopolize the market completely will attract more and more assailants and criticisms of their theories and practices, which will eventually weaken their uniqueness in providing the service.

The outcome of this invasion of the province of psychiatry by so many non-psychiatric disciplines is of course quite impossible to anticipate. Not only were its traditional competitors (psychologists and social workers) active, but other social scientists (sociology, anthropology), physical scientists (ethology, zoology, and biochemistry), and other humanitarian disciplines (history, philosophy, law) joined in the chorus to claim some legitimacy in the mental illness service industry. To avoid the fate of being overthrown, psychiatry found it expedient to absorb them into the market as long as the controlling positions were maintained.
by psychiatry. If there were to be changes in the study of mental illness or the treatment of the mentally ill, these changes would take place within an appropriately enlightened psychiatry. Or, so it seemed. Thus while psychiatry expanded greatly, it did so largely by annexing competitors such as clinical psychologists, social workers, nurses, with the sometimes tacit, but usually explicit, understanding that both in development of theory and in treatment of patients medical suzerainty would prevail (Plog and Edgerton, 1969).

It should be noted that not all psychiatrists favor this annexation and expansion strategy to meet new demands in the market. The more organically orientated psychiatrists would prefer to cope with the problem by controlling the demand instead. They are not willing to allow the concept of mental illness to expand so dramatically as to go beyond the control of the medical model (Rimland, 1969). They accused their colleagues of overselling themselves and becoming "Dr. Fix-its", "modern supermen" (Davidson, 1963).

Strategies of Entering the Market

Entry to the mental illness service industry is not granted automatically. Every potential competitor has to demonstrate certain abilities and press hard in order to get in. Some of their strategies and techniques of gaining
entry to the market can be identified, and include (1) formal organization, (2) coalition, (3) ideological unmasking, (4) compromise, and (5) mutual expediency.

(1) **Formal organization** The strongest barrier to entry established professions can set against potential competitors is the claim of protecting public interest by barring charlatans and quacks. To gain public confidence, the potential competitors must get better organized so as to safeguard professional standards. Clinical psychology is probably the best organized group among the potential competitors in the mental illness industry.

As early as 1896, clinical psychology was established as a branch of psychology (Ellis, 1956). The development of I.Q. tests and personality tests further strengthened the claim of psychologists to the market since these tests proved to be extremely useful for controlling purposes (Braginsky and Braginsky, 1973). However, psychologists' ambitions include more than the role of technicians for psychiatry, and psychotherapy becomes the bone of contention.

Freud, the inventor of psychotherapy, was himself a physician. He nevertheless acknowledged that,
"Psychotherapy is a part of psychology....The possibility of its application to medical purposes must not lead us astray. Electricity and radiology also have their medical applications, but the science to which they belong is nevertheless physics." (Freud, 1927, p.207)

After finding a few converts among his European colleagues, Freud came to the United States where he was warmly received by psychiatry. The development of psychotherapy in North America thus took place within organized medicine whereas in Europe it did not. In 1937, the American Psychoanalytic Association broke away from the International Psychoanalytic Association because it claimed psychotherapy was solely a medical practice and could be practised by physicians only. In this claim, it was soon joined by the American Psychiatric Association and the American Medical Association (Leifer, 1969).

In 1957, the American Medical Council reaffirmed its earlier position that the application of psychotherapy to the treatment of illness is a medical function, although psychologists and others may properly be used by medical men in contributory roles when supervised by a physician (Goode, 1960). This is to say, the medical profession did not object to psychologists practising psychotherapy so long as they were working for the medical profession.
The medical objection is to the psychologists' private practice. After all, any profession is glad to give up the drudgery but keep the supervisory role. In other words, psychiatry wants psychology to assume the role of a 'technician'.

In response, psychology was the first among the social sciences to get professionalized. The American Psychological Association assumed the responsibility for establishing and certifying standards of professional competence. They have a code of ethics and maintain strict discipline. Besides academic degrees, psychologists receive diplomas issued by the Board of Examiners in Professional Psychology. Due to their organized efforts, their place in the mental illness service industry is firmly established. The public makes in general no distinction between psychiatrists and psychologists (Nummally and Kittross, 1958).

(2) Coalition It is stated in the report of the Committee on relations with other professions of the American Psychological Association that "psychology will

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18. M. Brody, "Unsupervised Lay Psychotherapy", Bulletin of the Medical Society of County Kings, 34, (Nov. 1954), p.178 stated that it is "to be hoped that the number and calibre of clinical psychologists will continue to advance, just like the rapid advances of technicians whose aid to physicians cannot be overestimated."
cooperate with any responsible professional organization in combating any unwarranted limitation on the professional functions of the members of that organization." As a matter of fact, it can be argued that the reason why psychiatry can subdue all the competitors under its banner is because the various competitors lack coordination. The old political doctrine of 'divide and rule' still is very useful in the mental illness service industry.

(3) Ideological unmasking Some disciplines, for some reasons, just can't get professionalized as such. Sociologists, for example, have long proposed a clinical sociology but with no apparent success (Wirth, 1931; Dunham, 1965). Their position is, of course, to regard mental illness as another form of social deviance to justify their service. However, in doing research on mental illness, sociologists often find themselves caught in definitional problems (Blum, 1970; Weakland, 1969; Dunham, 1965). Mental illness is not a social concept and to relate some sociological variables to it is both a logical and a methodological inconsistency because the levels of analysis are different. Since the operational definition of

19. Goode (1960) adopted a sour grapes attitude in this respect. "Let us give our energies to the creation of a science all can respect; this will protect both sociologists and the public better than the erection of a guild." p.914.
mental illness changes from one study to another depending on the criteria that have been used and since the concept of mental illness also changes from time to time, most studies on mental illness cannot be compared with one another and in many cases, seem to contradict on another. To avoid this definitional problem, many sociologists would simply leave the definition of mental illness to psychiatry in joining the so-called inter-disciplinary studies. This puts sociologists always in a subordinate role. Frustrated by this subordinate role, William Goode (1960) in his presidential address to the Eastern Sociological Society said,

"We sociologists have been increasingly drawn into one these embroglios, between antagonists of such magnitude, organized medicine and psychology, that our small voice is given little attention. Yet, if they need not take our political power seriously, we can nevertheless use our sociological tool...." p.902

The sociological tool Goode referred to is the sociology of professions. He went on to analyse some of the 'tricks' played in the mental illness industry by both psychiatry and psychology. The message is clear; if the established professions in the industry don't buy sociology off, they may face social, scientific and public exposure.

20. In comparison, criminologists are much better off. Fully realizing this definitional problem, they have constructed their own typologies of crime (Clinard and Quinney, 1967).

21. Some sociologists have tried to construct a socio-
The success of this sort of threat in bringing sociologists into the health industry is evident by examining the rapid growth in employment of sociologists in health institutions and the expansion of medical sociology as a specialty within sociology in the 1960s. Freeman et al. (1972) in an article called "Present status of Medical Sociology" have studied both of these trends. Prior to 1960, the number of sociologists who held a tenured position in health professional schools could be counted on the fingers of one hand, now, it has jumped to a figure that puzzles even the health professionals themselves. The only statistic available is the membership list of the Medical Sociology Section of the American Sociological Association which has around 700-800 persons who care to subscribe as compared to 26 in 1950 and 188 in 1959 (Riley, 1960). More and more independent journals have been found such as the Journal of Health and Human Behavior, Social Science and Medicine, Social Psychiatry, etc. Medical sociologists are perhaps moving towards separate professional status since

logical definition of mental illness but their concepts are too broad to have any meaningful application. Scheff (1966) saw mental illness as a residue of deviance our culture fails to label. Dunham (1965) tried to apply Merton's notion of 'retreatism' to mental illness; Sarbin (1967) attempted to see mental illness in term of social role deviation.
they are being employed outside the departments of sociology in the universities.

The analysis of professionalism is by no means the only tool sociologists can employ to gain entry to the mental illness service industry. The new labeling perspective is another common tool some sociologists choose to use. By attacking the controlling agency and institution directly and exposing many arbitrary characteristics of psychiatric practice, they can attract enough notice to warrant being bought off. A new kind of therapy in psychiatry called family therapy is being accepted as a legitimate practice in psychiatry (Laing and Esterson, 1967). In essence, family therapy embodies most of the main themes of the labeling perspective.

(4) Compromise Anthropology presents another picture. The mental illness service industry is prosperous only in western societies. Interest in other cultures by psychiatry is at best academically oriented. Therefore, very few anthropologists were employed in medical institutions. To force themselves into the market, anthropologists first exposed the cultural relativism

22. Benedict (1934) found that the entire tribe of Kwakiutl would be diagnosed as megalomanic paranoid. Since it is inconceivable that a whole society could be sick, it must be due to the cultural differences.
of mental illness (Benedict, 1934), the similarity between psychiatry and shamanism (Torrey, 1972), the fallacy of the universalism of some Freudian stages of development in other cultures (Whiting and Child, 1953). After they were accepted into the market, their antagonism takes on a more moderate tone. The absolute position of cultural relativism is abandoned; culture does make a difference in the manifestation and labeling of mental illness, but the ultimate defect in terms of pathology is acknowledged. This is also reflected in the change of terminology in anthropological studies. Before, the study of mental illness in other cultures was called "cultural and personality study". Now it is known as "social or cultural psychiatry; 'ethnic psychiatry' and the like (Opler, 1969). To enlarge their services beyond studying other cultures, they offer the observation techniques of linguistics for application to psychiatric diagnosis. This gives rise to a new psychiatric technique called psycholinguistics, which involves the recording, analysis and comparison of patients' verbal and even

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23. In abandoning absolute cultural relativism, Opler (1969, p.98) said, "My position is not one of absolute cultural relativism, but of a relativity limited by principles of cultural evolution."
nonverbal paratactic or emotional utterances, as well as analysis of patient-doctor communication in studies of the transference and counter-transference phenomena. In the final analysis, a knowledge of the limits of harassment and a willingness to compromise with the established profession are the two key elements for acceptance into the market.

(5) Mutual expedience Psychiatric social workers present us with another interesting picture of entry into the market. To begin with, the development of psychiatric social work as a specialty within social services is a rather late phenomenon. Although in 1874 at a meeting of the U.S. National Conference of Social Workers, a paper was read on "The Duty of the States toward Their Insane Poor", it was not until 1926 that the American Association of Psychiatric Social Workers began its existence as an independent national organization (French, 1940). In the United Kingdom, the development was even slower. The first class of professional psychiatric social workers, consisting of twenty persons, graduated in 1939 from the London School of Economics (Ashdown and Brown, 1953). Today, however, psychiatric social workers are the backbone of every mental health
unit. Some commentators have asserted that psychiatric social workers do more psychotherapy than psychiatrists and psychologists combined (Iscoe, 1957; Andriola, 1957).

To account for the entry of the psychiatric social workers into the market, a brief historical background of both psychiatry and social work up to the time they joined forces is essential.

In psychiatry, the coming of the 20th century marked a new stage. There was a shift from the old classical school to a new dynamic school of psychiatry. Emphasis was put on the personality of the patient in relationship to his environment. This is evident in 1894 when the American Neurological Association sent a circular to prominent psychiatrists and neurologists and received a majority response expressing their belief in the advantage of after care work (French, 1940). The theory of Freud further strengthened this movement. Psychiatrists found themselves often involved in duties outside the hospital setting. Since the Freudian theory emphasized the importance of childhood experience, child guidance and juvenile delinquency became a primary concern for psychiatry. Dr. William Healy operated a psychiatric
clinic at the Juvenile Court in Chicago in 1904, and in 1910, the Juvenile Psychopathic Institute was inaugurated (French, 1940). In the light of such new assignments, psychiatrists needed assistants to dig out the life history of the patients, and social workers appeared to be the most desirable choice.

On the other hand, the coming of the 20th century marked a new stage for social work too. Although social services in the forms of charity and alms giving had a long history, modern social work developed only in the 19th century as a result of the Industrial Revolution. The newly rising middle class was willing to finance a new group of professionals in the name of humanitarianism to relieve some of the social evils created by the very process which brought them to power (Queen, 1922). Since the prevailing ideology at that time was laissez-faire, social work should function to "distribute alms in such a way, and with such a safeguard as to encourage the virtues of thrift, self-help, and independence " (Wootton, 1959, p.268). Social workers made no pretence that they were dispensers of charity. At the turn of the century, the social values of our society had changed. Charity and alms-giving were no longer seen as mercy giving and benevolence, but as a
duty to protect every citizen. Social workers found themselves caught. While their basic functions had not changed much, they needed a new ideology to justify their functions. Psychiatric rhetoric provided social workers with just the right kind of ideology.

"As early as 1919, psychiatry swept the National Conference of Social Work.... By 1940, any deviation from Freudian psychology in the theory of social work was looked upon by some with the same horror as a true Stalinist appraising a Trotskyite." (Wooton, 1959, p.270)

It is therefore out of this mutual expedience that psychiatry and social workers joined hands. So long as psychiatric social workers were willing to take up psychiatric training and recognize the legitimacy of the medical ideology in this respect, they were given a considerable amount of professional autonomy. As

24. The development of the English Poor Law illustrated the point well. The Poor Law was first enacted in 1536 as a form of Royal charity. In 1834, the middle class under the influence of laissez-faire changed it to discourage idleness. The Work-house Test was designed to make welfare in the house almost the last resort for those needing assistance. The Poor Law Commissioners employed inspectors and overseers to enforce the rules and they became the forerunners of modern social workers. By 1909, the Royal Commission on the Poor Law discredited and discarded all the principles of 1834. The state has the responsibility to make sure all her citizens are well taken care of (Queen, 1922).

25. In 1950, as many as 41% of all social workers were said to be still employed in the administration of public assistance in U.S. (Wooton, 1959)
compared to other professions such as clinical psychologists, the working partnership between psychiatry and social worker has always been pleasant. A psychiatrist once described their relationship by comparing the psychiatrist to the father of the household and the social worker to the mother. The mother saw to it that the father thought himself to be the head of his own household, but both knew that it was she who, in not needing recognition, was really in charge of the situation (Ashdown and Brown, 1953).

An Empirical Investigation

It has been argued in the preceding paragraphs that the demand for new services in the mental illness industry which psychiatry was unable to meet, brought many competitors into the market under the suzerainty of psychiatry. The admission of more professions into the mental illness industry, however has a 'feed back' effect on the market. The fact that more professions are admitted into the market in turn demands a much wider market to accomodate the services of these professions. The fact that new technologies are available demands more consumers. This may be called the 'hammer
The remaining section of this chapter is designed to test the notion of 'hammer effect'. If the 'hammer effect' is working, one should expect three inter-related phenomena to develop concurrently. First, there should be a trend to widen the scope and definition of mental illness. Presumably, the wider the definition, the more people will be diagnosed as mentally ill, and the larger the market will be to accommodate the newly available services. Secondly, this widening of the definition of mental illness should be disproportional in nature. This is to say, the increase is largely due to the increase of the less severe and functional mental disorders at the expense of the more severe and organic mental disorders. Presumably, more non-medical professions find more non-organic disorder in order to render their services. Thirdly, there should be an increase in types of professionals corresponding to the increase of mental illness, but this increase in the types of professionals is again disproportional in nature: there should be a greater increase of

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26. The term 'hammer effect' is from Kaplan (1964, p.28). The effect goes like this: if you give a small boy a hammer, don't be surprised if everything he sees suddenly needs pounding. To be sure, Kaplan is talking about the 'hammer effect' in connection with the law of instrument.
non-medical professional types than medical professional types. Together, we have three inter-related propositions.

**Proposition 1** : There is a dramatic increase in the reported prevalence rate of mental illness after 1950.

**Proposition 2** : The rate of neurosis and personality disorders increases faster than the rate of psychosis.

**Proposition 3** : The number of non-medical professionals working in mental institution increases faster than the number of the medical professionals.

**Proposition 1** There is a dramatic increase in the reported prevalence rate of mental illness after 1950 and especially in the 1960. The rationale is that this was the time when social psychiatry began to become popular. Social psychiatry, as differentiated from traditional psychiatry, emphasizes social settings and social factors in influencing the etiology of mental illness. As a discipline, it utilizes all the concurrent knowledge of social sciences which means, in effect, admitting all other non-medical professions into the mental illness industry. Most social psychiatric research is inter-disciplinary in nature employing many other non-medical professions. Social psychiatry begins around the 1950s and becomes very popular in the
1960s. If the 'hammer effect' is working, we would expect an increase of the reported rate of mental illness simply because many other professions have participated in the research of social psychiatry.

Data were obtained from the major epidemiological studies of the prevalence of mental illness. The work of Goldhamar and Marshall (1953), Plunkett and Gordon (1960) and Dohrenwend and Dohrenwend (1969) were especially useful. After arranging the studies in chronological order with dividing lines at 1950 and 1960, the average and median rate of studies in each period are computed and compared.

Findings As presented in Table 10, the results are overwhelmingly in support of my hypothesis. The average prevalence rate in the pre-1950 period is 3.2 and the median is 2.1 per 100 persons; the average for the 1950s is 15.9 and the median is 13.6 per 100 persons; the average rate in the 1960s is 28.4 and the median is 23.4. There is only one study in the 1950s (Eaton and Weil, 1955) and one study in the 1960s (Manis et al., 1964) which are exceptional. The remainder found rates significantly higher than those in the pre-1950 period.

These data clearly demonstrate a dramatic increase of the reported rate of prevalence of mental
Table 10

Estimated percentage of mental disorder as reported by major epidemiological studies by periods.

<table>
<thead>
<tr>
<th>Year</th>
<th>Studies</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1917</td>
<td>Rosanoff</td>
<td>1.9</td>
</tr>
<tr>
<td>1931</td>
<td>Brugger</td>
<td>1.3</td>
</tr>
<tr>
<td>1933</td>
<td>Brugger</td>
<td>3.5</td>
</tr>
<tr>
<td>1937</td>
<td>Brugger</td>
<td>3.5</td>
</tr>
<tr>
<td>1939</td>
<td>Cohen et al.</td>
<td>2.3</td>
</tr>
<tr>
<td>1942</td>
<td>Lemkau</td>
<td>1.8</td>
</tr>
<tr>
<td>1942</td>
<td>Kaila</td>
<td>1.1</td>
</tr>
<tr>
<td>1942</td>
<td>Kaila, Study II</td>
<td>1.0</td>
</tr>
<tr>
<td>1943</td>
<td>Roth and Luton</td>
<td>6.9</td>
</tr>
<tr>
<td>1948</td>
<td>Mayer and Cross</td>
<td>9.0</td>
</tr>
<tr>
<td>1951</td>
<td>Fremming</td>
<td>11.9</td>
</tr>
<tr>
<td>1951</td>
<td>Bremer</td>
<td>23.2</td>
</tr>
<tr>
<td>1955</td>
<td>Eaton and Weil</td>
<td>1.7</td>
</tr>
<tr>
<td>1956</td>
<td>Trussel et al.</td>
<td>18.0</td>
</tr>
<tr>
<td>1956</td>
<td>Essen and Moller</td>
<td>13.6</td>
</tr>
<tr>
<td>1957</td>
<td>Cole et al.</td>
<td>32.0</td>
</tr>
<tr>
<td>1959</td>
<td>Pasamanick et al.</td>
<td>10.9</td>
</tr>
<tr>
<td>1960</td>
<td>Llewellyn-Thomas</td>
<td>64.0</td>
</tr>
<tr>
<td>1962</td>
<td>Srole et al.</td>
<td>23.4</td>
</tr>
<tr>
<td>1962</td>
<td>Premrose</td>
<td>13.2</td>
</tr>
<tr>
<td>1963</td>
<td>Leighton et al.</td>
<td>50.0</td>
</tr>
<tr>
<td>1964</td>
<td>Manis et al.</td>
<td>3.4</td>
</tr>
<tr>
<td>1964</td>
<td>Helgason</td>
<td>28.6</td>
</tr>
<tr>
<td>1964</td>
<td>Taylor-Chare</td>
<td>37.0</td>
</tr>
<tr>
<td>1965</td>
<td>Hare and Shaw</td>
<td>20.6</td>
</tr>
<tr>
<td>1966</td>
<td>Piotrowski et al.</td>
<td>15.5</td>
</tr>
</tbody>
</table>

Average: 3.2
Median: 2.1

Average: 15.9
Median: 13.6

Average: 28.4
Median: 23.4

illness during the past two decades. Despite its methodological defects, which include the inability to control the randomness and representativeness of the samples, the different criteria each sample study might be using, the different communities each study are oriented to etc., the general trend is obvious. To relieve some of the above methodological shortcomings, Figure 5 is presented. Figure 5 compares three studies in the pre-1950 period with three studies in the post-1950 period in terms of four criteria: (1) the general question each study was asking, (2) the personnel involved in conducting the study, (3) the method of collecting data, and (4) the diagnostic criteria each study was using in assessing the rate of mental illness.

There are three contrasts which can be made from Figure 5. In the post-1950 studies, the diagnostic criteria used were either symptomological or operational definitions of mental illness. Diagnoses were made from generalizations of the results of questionnaire. In the pre-1950 period, concrete criteria were employed, and diagnoses were made at the time of interview by psychiatrists.

In the post-1950 period, studies conducted were of much larger scale, sometimes the whole community was studied whereas in the pre-1950 period, the
Figure 5
Comparison of selected epidemiological studies of mental disorder in chronological order

<table>
<thead>
<tr>
<th>Studies</th>
<th>General Query</th>
<th>Personnel</th>
<th>Data Collection Method</th>
<th>Diagnostic criteria</th>
<th>Reported Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nassau County, N.Y.</td>
<td>Social mal-adjustment due to mental illness</td>
<td>5 physicians, 1 psychologist</td>
<td>Selected 4 districts from official data, intensive household interviews</td>
<td>4 major groups of psychosis: constitutional, exogenous origin, uncertain etiology, others</td>
<td>1.9</td>
</tr>
<tr>
<td>Rosanoff, 1917</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baltimore, MD.</td>
<td>Socially evident mental illness</td>
<td>1 psychiatrist, 1 medical statistician, 1 social worker</td>
<td>Official and institutional statistics</td>
<td>Statistical Manual for the Use of Hospitals for Mental Disease, 1934, 10 categories</td>
<td>1.8</td>
</tr>
<tr>
<td>Lemkau et al. 1942</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Williamson County, TENN.</td>
<td>Candidates for mental illness treatment</td>
<td>2 psychiatrists, 2 social workers, 1 psychiatric nurse.</td>
<td>After getting secondary data, survey entire rural area and some urban areas</td>
<td>3 main categories: personality problems, mental deficiency, organic causes</td>
<td>6.9</td>
</tr>
<tr>
<td>Roth &amp; Lutton 1943</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salt Lake City, Utah.</td>
<td>Diagnosable Mental Illness</td>
<td>2 psychiatrists, 1 social worker</td>
<td>8 separate blocks in city, 25 consecutive families each block, unstructured questions</td>
<td>Overt symptomology or admission of illness by respondents. No fixed criteria in diagnosis</td>
<td>32.0</td>
</tr>
<tr>
<td>Cole et al. 1957</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-town, Manhattan, N.Y.</td>
<td>Sociocultural factors and Mental Illness</td>
<td>Psychiatrists, Psychologists, Sociologists, Anthropologists,</td>
<td>Highly structured questionnaire, concentrate household interviews, random samples</td>
<td>Operational definition of mental illness, general questions to be rated later by psychiatrists from surface and overt disturbances</td>
<td>23.4</td>
</tr>
<tr>
<td>Scodie et al. 1962</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterling County, Nova Scotia, Canada</td>
<td>Social disintegration and mental illness</td>
<td>Psychiatrists, Psychologists, Sociologists, Anthropologists, etc.</td>
<td>Stratified samples, entire county, questionnaire plus interview, all relevant official data consulted, very intensive</td>
<td>Symptoms rating by psychiatrists from results of questionnaire, defined in Diagnostic and Statistical Manual of Mental Disorder 2nd. edition</td>
<td>50.0</td>
</tr>
<tr>
<td>Leighton et al. 1963</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

studies were less intensive in nature and often relied on official statistics.

In the post-1950 period, the studies are often-times inter-disciplinary in nature which involved many other professionals, whereas in the pre-1950 period, the personnel involved were mostly psychiatrists or included at most, psychiatric social workers.

To further check the notion that the increase of the reported rate of mental illness is a function of the changing diagnostic categories, Figure 6 is presented. Figure 6 compares the second edition (1968) of the Diagnostic and Statistical Manual of Mental Disorder to its first edition in 1952. The expansion of the nomenclature of mental illness is tremendous. This expansion is especially noticeable in the categories of neurosis and personality disorders. As listed in the second edition of the Diagnostic and Statistical Manual of Mental Disorder, there are eleven sub-categories of neurosis, five of which are new; there are thirty-three sub-categories of personality disorders, twenty-two of which are new (see appendix in Abnormal Psychology, Current Perspective, C.R.M., 1972). As compared to psychosis, both neurosis and personality disorders are believed to be less organically orientated and less severe. With this in mind, we now proceed to proposition
Figure 6
Expansion of nomenclature from DSM-I (1952) to DSM-II (1968)

<table>
<thead>
<tr>
<th>DSM-II Diagnostic Nomenclature*</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. MENTAL RETARDATION</td>
</tr>
<tr>
<td>Borderline</td>
</tr>
<tr>
<td>Mild</td>
</tr>
<tr>
<td>Moderate</td>
</tr>
<tr>
<td>Severe</td>
</tr>
<tr>
<td>Profound</td>
</tr>
<tr>
<td>Unspecified</td>
</tr>
<tr>
<td>With each: Following or associated with</td>
</tr>
<tr>
<td>Infection or intoxication</td>
</tr>
<tr>
<td>Trauma or physical agent</td>
</tr>
<tr>
<td>Disorders of metabolism, growth, or nutrition</td>
</tr>
<tr>
<td>Gross brain disease (postnatal)</td>
</tr>
<tr>
<td>Unknown prenatal influence</td>
</tr>
<tr>
<td>Cerebrovascular abnormality</td>
</tr>
<tr>
<td>Prematurity</td>
</tr>
<tr>
<td>+Major psychiatric disorder</td>
</tr>
<tr>
<td><em>Psychosocial (environmental)</em></td>
</tr>
<tr>
<td>deprivation</td>
</tr>
<tr>
<td>Other condition</td>
</tr>
<tr>
<td>II. ORGANIC BRAIN SYNDROMES (OBS)</td>
</tr>
<tr>
<td>A. Psychoses</td>
</tr>
<tr>
<td>Senile dementia</td>
</tr>
<tr>
<td>Presenile dementia</td>
</tr>
<tr>
<td>Senile dementia</td>
</tr>
<tr>
<td><em>Alcoholic hallucinosis</em></td>
</tr>
<tr>
<td>+Alcohol paranoid state</td>
</tr>
<tr>
<td>+Acute alcohol intoxication</td>
</tr>
<tr>
<td>+Alcoholic delirium</td>
</tr>
<tr>
<td>+Pathological intoxication</td>
</tr>
<tr>
<td>Other alcoholic psychoses</td>
</tr>
<tr>
<td>PSYCHOSES ASSOCIATED WITH INTRACRANIAL INFECTION</td>
</tr>
<tr>
<td>General paresis</td>
</tr>
<tr>
<td>Syphilis of CNS</td>
</tr>
<tr>
<td>Epidemic encephalitis</td>
</tr>
<tr>
<td>Other and unspecified encephalitis</td>
</tr>
<tr>
<td>Other intracranial infection</td>
</tr>
<tr>
<td>PSYCHOSES ASSOCIATED WITH OTHER GENERAL CONDITION</td>
</tr>
<tr>
<td>Cerebral arteriosclerosis</td>
</tr>
<tr>
<td>Other cerebrovascular disturbance</td>
</tr>
<tr>
<td>Epilepsy</td>
</tr>
<tr>
<td>Intracranial neoplasm</td>
</tr>
<tr>
<td>Degenerative disease of the CNS</td>
</tr>
<tr>
<td>Brain trauma</td>
</tr>
<tr>
<td>Other cerebral condition</td>
</tr>
</tbody>
</table>

*Many of the titles listed here are abbreviated form.
+These diagnoses are new and do not appear in DSM-I.

**IV. NEUROSES**

- Anxiety
- Hysterical
- *Hysterical, conversion type*
- *Hysterical, dissociative type*
- Phobic
- Obsessive-compulsive
- Depressive
- Neurotic
- Obsessional
- Hypochondriac
- Other neurosis

**V. PERSONALITY DISORDERS AND CERTAIN OTHER NONPSYCHOTIC MENTAL DISORDERS**

- Personality disorders
- Paranoid
- Cyclothymic
- Schizoid
- Explosive
- Obsessive-compulsive
- Hysterical
- *Artistic*
- Antisocial
- Passive-aggressive
- Inadequate
- Other specified types
- Sexual deviation
- Homosexuality
- Fetism
- Pedophilia
- Transvestism
- Exhibitionism
- Voyeurism
- Sadism
- Masochism
- Other sexual deviation
- Alcoholism
- *Epidemic excessive drinking* |
| Alcohol dependence | *Voluntary excessive drinking* |
| Other alcoholism | *Alcoholism* |
| Drug dependence | Other alcoholism |
| Alcoholism | Drug dependence |
| Opium, opium alkaloids and their derivatives | *Other hypnotics and sedatives or "tranquilizers"* |
| *Other psychiatric and sedatives or "tranquilizers"* | *Cocaine* |
| +Cannabis sativa (hashish, marihuana) | *Other psychostimulants* |
| +Hydrobromic | *Hallucinogens* |
| Other antipsychotic | Other drug dependence |

**VI. PSYCHOPHYSIOLOGICAL DISORDERS**

- Skin
- Musculoskeletal
- Respiratory
- Cardiovascular
- Hematologic and lymphatic
- Gastrointestinal
- Genitourinary
- Endocrine
- Organ of special sense

**VII. SPECIAL SYMPTOMS**

- Speech disturbance
- Specific learning disturbance
+Tic
+Other psychomotor disorder
+Disorders of sleep
+Feeding disturbance
+Emasculation
+Enuresis
+Encopresis
+Gynecomastia
+Other special symptoms

**VIII. TRANSCENDENTAL DISTURBANCES**

- Adjustment reaction of infancy
- Adjustment reaction of childhood
- Adjustment reaction of adolescence
- Adjustment reaction of adult life
- Adjustment reaction of late life
- Adaptation reaction

**IX. BEHAVIORAL DISORDERS OF CHILDHOOD AND ADOLESCENCE**

- Hyperkinetic reaction
- Withdrawal reaction
- Overreaction
- Runaway reaction
- Unsocialized aggressive reaction
- Group delinquent reaction
- Other reaction

**X. CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NONSPECIFIC CONDITIONS**

- Social maladjustment
- Occupational maladjustment
- Dysphoric behavior
- Social maladjustment
- Occupational maladjustment
- Dysphoric behavior

**XI. NONDIAGNOSTIC TERMS FOR ADMINISTRATIVE USE**

- Diagnosis deferred
- Boarderline
- Experiment only
- Other

The sign indicates that these diagnoses are new and do not appear in DSM-I.

2 and proposition 3.

Proposition 2  The rate of neurosis and personality disorders increases faster than the rate of psychosis.

Proposition 3  The number of non-medical professionals working in mental institutions increases faster than the number of medical professionals.

To test both these propositions and see their relationship, four types of data over two periods of time are required. The two periods chosen for comparison are the 1930s and the 1960s. The 1940s and the 1950s may be considered as transitional periods in the development of social psychiatry. A comparison between the 1930s and the 1960s then should show the desired contrasts most clearly. Two types of data are sought within each period. The first is the relative increase of the rate of neurosis and personality disorders to the rate of psychosis. This is done by breaking down figures on first admission patients to all mental institutions in Canada into these three main diagnostic categories. The second type of data is the relative increase of non-medical professionals employed by all mental institutions in Canada to the increase of medical professionals as employed by the same mental institutions.
Findings  The results are presented in Tables 11-14.

As Table 11 shows, in the 1932-40 period, the increase of the first admissions is very small—21% over nine years. The population growth meanwhile is 8%, making an average rate of increase of 1.44% a year. For the same period, only one out of five first admission patients are diagnosed as not being psychotic, and only three out of a hundred are diagnosed as neurotics. Meanwhile, as Table 12 shows, the increase of professionals is also very small, but with the medical professionals outgrowing the non-medical professionals. The medical professionals increased by 68% as compared to a -57% for psychologists, 50% for therapists and 28% for social workers.

However, in the period between 1960-1970, the picture changes dramatically. As Table 13 shows, the increase of first admissions jumps 102% over 11 years. With a 20% population growth rate, the average increase per year is 7.45%. For the same period, the composition of the diagnostic categories among first admission patients has also gone through a dramatic change. While 50% of patients are still diagnosed as psychotics in 1960, the figure drops regularly until in 1970, only 31% are so diagnosed. Neurosis accounts for 22% of
Table 11
Number and percentage of mental patients first admitted to all mental institutions in Canada by selected categories of diagnosis* and population of Canada**, 1932-1940

<table>
<thead>
<tr>
<th>Year</th>
<th>Total N</th>
<th>Total %</th>
<th>Neurosis N</th>
<th>Neurosis %</th>
<th>Without Psychosis*** N</th>
<th>Without Psychosis*** %</th>
<th>Population (in thousand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1932</td>
<td>5774</td>
<td>100</td>
<td>141</td>
<td>2.4</td>
<td>1105</td>
<td>19.1</td>
<td>10510</td>
</tr>
<tr>
<td>1933</td>
<td>5858</td>
<td>100</td>
<td>191</td>
<td>3.3</td>
<td>1185</td>
<td>20.2</td>
<td>10633</td>
</tr>
<tr>
<td>1934</td>
<td>6403</td>
<td>100</td>
<td>164</td>
<td>2.6</td>
<td>1299</td>
<td>20.3</td>
<td>10741</td>
</tr>
<tr>
<td>1935</td>
<td>***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10845</td>
</tr>
<tr>
<td>1936</td>
<td>7594</td>
<td>100</td>
<td>216</td>
<td>2.8</td>
<td>1733</td>
<td>22.8</td>
<td>10950</td>
</tr>
<tr>
<td>1937</td>
<td>7519</td>
<td>100</td>
<td>210</td>
<td>2.8</td>
<td>1728</td>
<td>23.0</td>
<td>11045</td>
</tr>
<tr>
<td>1938</td>
<td>7612</td>
<td>100</td>
<td>233</td>
<td>3.0</td>
<td>1731</td>
<td>22.7</td>
<td>11152</td>
</tr>
<tr>
<td>1939</td>
<td>7533</td>
<td>100</td>
<td>267</td>
<td>3.5</td>
<td>1401</td>
<td>18.6</td>
<td>11267</td>
</tr>
<tr>
<td>1940</td>
<td>6987</td>
<td>100</td>
<td>232</td>
<td>3.3</td>
<td>1271</td>
<td>18.1</td>
<td>11381</td>
</tr>
</tbody>
</table>

% increase 21.0 54.5 15.0 8.3 1932-40

*** Before 1949, all diagnostic categories were grouped under psychosis except this.
**** The information of 1935 is missing.
Table 12

The relative increase of medical doctors to other non-medical professionals employed in all mental institutions in Canada, 1932-40 *

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical Doctors</th>
<th>Psychologists</th>
<th>Therapists**</th>
<th>Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1932</td>
<td>185</td>
<td>23</td>
<td>61</td>
<td>20</td>
</tr>
<tr>
<td>1933</td>
<td>198</td>
<td>15</td>
<td>58</td>
<td>25</td>
</tr>
<tr>
<td>1934</td>
<td>277</td>
<td>18</td>
<td>60</td>
<td>25</td>
</tr>
<tr>
<td>1935</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>1936</td>
<td>276</td>
<td>***</td>
<td>64</td>
<td>29</td>
</tr>
<tr>
<td>1937</td>
<td>305</td>
<td>8</td>
<td>77</td>
<td>27</td>
</tr>
<tr>
<td>1938</td>
<td>328</td>
<td>14</td>
<td>75</td>
<td>29</td>
</tr>
<tr>
<td>1939</td>
<td>329</td>
<td>13</td>
<td>78</td>
<td>25</td>
</tr>
<tr>
<td>1940</td>
<td>317</td>
<td>10</td>
<td>78</td>
<td>30</td>
</tr>
</tbody>
</table>

% increase 67.7 -56.5 27.9 50.0


** Therapists include occupational therapists, physiotherapists, and all other therapists.

*** Information not available
Table 13

Total number of first admission to mental institutions in Canada by diagnostic categories * and population growth of Canada **, 1960-1970.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Admission</th>
<th>Psychosis</th>
<th>Neurosis</th>
<th>Personality Disorders</th>
<th>Population Growth (by thousand)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>1960</td>
<td>25546</td>
<td>100</td>
<td>12830</td>
<td>50</td>
<td>5624</td>
</tr>
<tr>
<td>1961</td>
<td>27821</td>
<td>100</td>
<td>13420</td>
<td>48</td>
<td>6324</td>
</tr>
<tr>
<td>1962</td>
<td>29905</td>
<td>100</td>
<td>14001</td>
<td>48</td>
<td>7238</td>
</tr>
<tr>
<td>1963</td>
<td>30239</td>
<td>100</td>
<td>13245</td>
<td>44</td>
<td>8117</td>
</tr>
<tr>
<td>1964</td>
<td>37413</td>
<td>100</td>
<td>14115</td>
<td>38</td>
<td>10285</td>
</tr>
<tr>
<td>1965</td>
<td>38910</td>
<td>100</td>
<td>13974</td>
<td>36</td>
<td>11143</td>
</tr>
<tr>
<td>1966</td>
<td>38880</td>
<td>100</td>
<td>14404</td>
<td>37</td>
<td>10816</td>
</tr>
<tr>
<td>1967</td>
<td>40775</td>
<td>100</td>
<td>14341</td>
<td>35</td>
<td>11409</td>
</tr>
<tr>
<td>1968</td>
<td>43600</td>
<td>100</td>
<td>15316</td>
<td>35</td>
<td>12519</td>
</tr>
<tr>
<td>1969</td>
<td>46408</td>
<td>100</td>
<td>14947</td>
<td>32</td>
<td>13707</td>
</tr>
<tr>
<td>1970</td>
<td>51527</td>
<td>100</td>
<td>15744</td>
<td>31</td>
<td>15358</td>
</tr>
</tbody>
</table>

% increase 101.7  22.7  173.1  193.2  19.5

1960-70


Table 14

Relative increases of selected professionals in all mental institutions of Canada, 1960-70*

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Medical staff **</th>
<th>Total Non-medical professions ***</th>
<th>Psychologists</th>
<th>Therapists ****</th>
<th>Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>1015</td>
<td>1494</td>
<td>140</td>
<td>465</td>
<td>213</td>
</tr>
<tr>
<td>1961</td>
<td>1083</td>
<td>1609</td>
<td>154</td>
<td>551</td>
<td>234</td>
</tr>
<tr>
<td>1962</td>
<td>1141</td>
<td>1846</td>
<td>177</td>
<td>637</td>
<td>271</td>
</tr>
<tr>
<td>1963</td>
<td>1203</td>
<td>2004</td>
<td>194</td>
<td>715</td>
<td>309</td>
</tr>
<tr>
<td>1964</td>
<td>1299</td>
<td>2414</td>
<td>212</td>
<td>835</td>
<td>389</td>
</tr>
<tr>
<td>1965</td>
<td>1361</td>
<td>2840</td>
<td>224</td>
<td>948</td>
<td>425</td>
</tr>
<tr>
<td>1966</td>
<td>1296</td>
<td>2899</td>
<td>243</td>
<td>1080</td>
<td>427</td>
</tr>
<tr>
<td>1967</td>
<td>1587</td>
<td>3534</td>
<td>308</td>
<td>1336</td>
<td>547</td>
</tr>
<tr>
<td>1968</td>
<td>1614</td>
<td>4431</td>
<td>416</td>
<td>1349</td>
<td>706</td>
</tr>
<tr>
<td>1969</td>
<td>1671</td>
<td>4591</td>
<td>421</td>
<td>1451</td>
<td>731</td>
</tr>
<tr>
<td>1970</td>
<td>1925</td>
<td>4850</td>
<td>443</td>
<td>1423</td>
<td>753</td>
</tr>
</tbody>
</table>

% Increase 1960-70 89.7

224.6 216.4 206.0 253.5


** Total medical staffs include all M.D., full time and part time.

*** Total non-medical professions include all affiliated professions and technicians except nursing staff.

**** Therapists include occupational therapists, physiotherapists and all other therapists.
diagnoses in 1960 and increases regularly until in 1970 it accounts for 30% of diagnoses. Personality disorders accounts for 25% of diagnoses in 1960, but jumps to 36% in 1970, the largest of all diagnostic classes.

Furthermore, although the total admission rate has increased by 102% in the 1960s, the increase for psychosis is only 23%. When the growth of population is taken into consideration (20%), the rate for psychosis remains practically constant. On the other hand, the increases for both neurosis and personality disorders are so large (at 173% and 93% respectively) that we can conclude that the increased number of total admissions almost entirely a reflection of the increase of neurosis and personality disorders at the expense of psychosis.

Moreover, Table 14 shows that for the same period, the increase of medical professionals lags behind the other non-medical professionals, with a 90% increase for the medical professionals but 216%, 206%, and 254% for psychologists, therapists and social workers respectively.

The above findings clearly support my two propositions. The differences are so massive that we can safely conclude that the increase in the rates of
neurosis and personality disorders is coupled with the increase of the non-medical professions in the mental illness industry.

The above procedure has established convincingly a relationship between an increase in rates of neurosis and personality disorder at the expense of psychosis and an increase of non-medical professions at the expense of the medical profession. However, the causal direction of the relationship is still unknown. That is, do increase in neurosis and personality disorder cause increases in the employment of non-medical professionals or vice versa? To establish causal direction would require longitudinal studies of hospitals to observe which comes first. However, if, as I have argued, there is actually a feedback effect in operation, then, a widened scope of mental illness would admit more non-medical professionals who in turn would further widen the scope of mental illness. It seems clear that it is in the non-medical professionals' interest to enlarge the scope of mental illness.

Summary

The chapter first analysed the medical model of mental illness, which was seen as a barrier to entry
to protect the monopoly of the medical profession in the mental illness industry. Then, different strategies and tactics were discussed in bringing other non-medical professions into the mental illness industry. They included formal organization, coalition, ideological unmasking, compromise, and mutual expedience. Lastly, an empirical investigation was conducted to test the notion of 'hammer effect', that is, the more professions admitted into the market, the wider the market has to be, and the more consumers are required.
Chapter VI

Product Differentiation

Product differentiation is a process by which the consumers come to prefer one product/service to another. It is the major factor in upholding an established producer's position in the market. In this chapter, an attempt will be made to show that the consumers (the general public or our society as a whole) prefer the 'illness-health' product over other products in accounting for many deviant behaviors, so, by implication, they also uphold the producer, which is psychiatry. First, the dual nature of mental illness, both as a medical concept and as a social concept will be explored. A number of studies will be cited in support of the notion that what the consumers want from psychiatric intervention is social control. Then, the community mental health movement is analysed in terms of the direct application of the Keynesian economic theory in the mental illness industry. Lastly, to demonstrate that mental illness is a social concept more than a medical concept, a few studies are cited to support the notion that the development of the nosology of mental illness is not a refinement of the existing medical knowledge, but rather a reflection of the changing value of our society.
Dual nature of mental illness

The term, mental illness, does not stand aloof. It denotes certain conceptual and explanatory models, which in turn determines the kind of institution society will legitimize to deal with the problem. The institution will again determine the kind of practice and workers required. The 'illness' concept denotes a medical model and the institution so legitimized is psychiatry. The practice is therefore called treatment and therapy and the workers, health professionals. From the logical point of view, the legitimacy of psychiatry rests on the medical model and the concept of "illness" seems meaningless apart from a medical model. However, psychiatry and mental illness in combination seem impervious to logical attacks. The medical model might be bitterly attacked and partially forsaken, if not altogether; 27 but the concept of mental illness and the institution emerge stronger than ever. This is evident if one compares the scope of mental illness now with, say, twenty years ago (see Figure 6 for a comparison),

27. Siegler and Osmond (1966) outlined five alternative models besides the medical model with equal degree of acceptance. They include the moral, the psychoanalytic, the family, the interactional, and the social models.
and the power as vested in community psychiatry with traditional psychiatry (Chaplan, 1964).

To account for this logical inconsistency, we have to distinguish first between mental illness as a social concept and mental illness as a medical concept. It was around 150 years ago that psychotic behavior, perhaps the only publicly or officially recognized form of deviancy at that time, was first thought of as a disease (Milton and Wahler, 1973). In the ensuing years, what might be called the disease concept of psychosis has been extended to other forms of disorders of emotions, thoughts, and deviant behavior.

As Szasz (1960) argued, the word disease or illness can be used for scientific purpose to convey information (that certain behavior is sick, leading to some diagnosis and treatment), or it can be used for social purposes to induce feelings and images so as to promote action (that the 'sick person is dangerous, helpless' and needs hospitalization). The scientific purpose might be poorly developed and useless for conveying the right information (that is, the medical model might not explain very much), but as long as the social purposes prove to be useful, mental illness as a social concept will continue to flourish. It is fashionable to talk about our 'sick'
society without realizing some of its implications. We are, so to speak, differentiating the product we want as consumers: we want an 'illness-health' product.28

To clarify my point, let us assume that society as a whole is a consumer. Society has always regarded certain conditions of man's psychological being (by which I mean that part of his being that is described in terms of his thoughts and feelings) as abnormal and needing control. The primary concern there is social control. The fact that medical ideology happens along does not change the nature of the concern for control, all it changes are the institutions legitimized to provide the service and the terminology. The merit and quality of the terminology is of secondary importance so long as it can serve the control purpose. Thus, in medieval times, whether burning a witch at the stake could really save her soul is secondary so long as the control purpose is achieved. Similarly, whether psychiatric treatments can really heal mental illness is of secondary importance so long as the control purpose is achieved.

28. The other alternative products are 'good-evil', 'good-bad', 'normal-abnormal' etc.
There are a number of studies demonstrating indirectly that what consumers want from psychiatric intervention is control rather than treatment. Nunnally and Osgood (1960) have found the public regards mental illness with fear, distrust and dislike. They differentiate physical illness from mental illness and regard the former with much higher appreciation. The higher regard for physical illness and lower regard for mental illness affect the esteems of the respective professionals as well. Any word containing 'psych' or 'psyche' to some extend stigmatizes the professionals as well as the patient. This could indicate that the mental health worker's emphatic preference for the word 'psychotic' as against 'insane' has availed little in improving attitudes toward the mentally ill. It also would indicate the futility of further attack on lay terms. Star (1960) asked 3500 interviewees about the bases of their reaction to descriptions of six common types of mental illness frequently diagnosed by psychiatrists. Only for the case of paranoid schizophrenia was a majority (75%) of the people interviewed willing to recognize the description as representing mental illness. For other minor types of mental illness, if respondents believed they could live with them without control from the authorities, they would not recognize them as mental illnesses. Clausen, Yarrow and their colleagues (1955) described five
stages of attempts by a wife to adapt and normalize her husband's abnormal behavior. Only when the behavior reached an intolerable and dangerous state did the wife refer him to psychiatric facilities. Philips (1967) undertook an experiment to test whether the symptoms per se or the kind of service one seeks determined mental illness. Subjects were given five case abstractions with which type of service was systematically varied. Case descriptions went from severely paranoid to completely "normal". Types of services were those of clergyman, ordinary physician, psychiatrist in private practice, psychiatrist in a mental institution. Philips found that, independently of the severity of the symptoms, the fact that someone had been treated in a mental institution was enough to cause his rejection.

In any given industry, the consumer's choice is an important determining factor in shaping the kind of product that will be produced. In many cases, however, the consumer's choice is conditioned; they tend to differentiate products. Once a certain brand is preferred, other brands find it extremely difficult to compete in the market and maintain complete autonomy. For example, in the soft drink industry, Coca-cola is so strongly differentiated by consumers that similar products are difficult to sell in the market unless they include the name "cola"
as well (even in reverse, such as the "uncola").

In the social control industry, once consumers have differentiated the product mental illness because it serves well in providing the control function, competitors find it extremely difficult to replace. They might be able to provide strong evidence and arguments that so-called mental illness is neither mental nor an illness (Plog and Edgerton, 1969); that mental illness is misnamed, a metaphor and a myth (Szasz, 1960); an interpersonal problem (Adams, 1964); a residue of social deviance (Scheff, 1966); a matter of who defines whom (Laing, 1967); a kind of game playing (Goffman, 1961); a social and political scapegoat (Szasz, 1970); however, they can not change the market situation so long as they can not provide the social functions that the medical ideology can provide in rendering the control. 29

The inability of other professions to change the consumers' service preference and substitute their services in place of mental illness safeguards psychiatry's

28. Merton's (1957) notion of manifest and latent function is applicable here. The manifest function of mental illness, which is to treat the problem and behavior through medical technology, might not be well served, but as long as the latent function, which is social control, is fulfilled, mental illness as a social concept will flourish.

29. Imagine a situation when the authority accepts the fact that mental illness is not an illness, and therefore mental hospitals should not be retained. The patients no longer have a patient's status, may have to be confined somewhere, but where?
suzerainty position within the mental illness industry. All competitors and critics have to be content with a place within the hierarchy and call themselves health professionals, although their services might be completely irrelevant to health in the medical sense. Dr. Brayfield, the executive officer of the American Psychological Association has commented on this situation,

"...Psychologists may reconceptualize the problem of mental health and make explicit their independent and unique role. ... Interestingly, however, this statement itself, when read in conjunction with the other recent APA "White Paper" on the Psychologist in Voluntary Health Insurance, illustrates our inconsistency with respect to our role as a health profession. The community mental health center paper espouses a nonmedical model and casts doubt on individual psychotherapy as a major approach; the insurance paper essentially accepts the medical model and utility of one-one psychotherapy." (Brayfield, 1966, p.1121)

In any given industry, once a certain brand of product has made its name differentiated, this brand's name may be useful in selling other types of related products. Kraft in the dairy industry, Johnson & Johnson in the light drug and sundry industry, and Sunkist in the fruit industry are a few of the examples. In the mental illness industry, once consumers prefer the "illness-health" product, the name of health can be sold and extended to other related areas. From this perspective, a community health program can be seen as a deal between psychiatry
and social-action orientated governments trying to buy the name of health from psychiatry. Implicit in the deal is the understanding that a psychiatrist will always head any mental health unit. Curiously enough, not too many psychiatrists are too enthusiastic about the whole arrangement. One of the biggest barriers to community psychiatry comes from the psychiatrists themselves who are very reluctant to give up their profitable and autonomous private-practice (Rome, 1966). The whole issue becomes clear if we try to see the community mental health movement as an application of Keynesian economic theory to the mental illness industry. According to the Keynesian theory, a consequence of the capitalistic economics is that serious imbalances develop in the distribution of goods and services. The government is therefore required to intervene to redistribute services and goods on behalf of the consumers. This is done through the manipulation of consumption and investment through taxation, welfare and subsidy policies which affect incomes. In the mental illness industry, the laissez-faire doctrine is represented by the

30. Dr. E. Howard, assistant executive vice-president of the AMA commented on this situation, "the issues that are confronting the American Medical Association is the question of social security expansion into the purchase of health benefit." (Rome, 1966).

31. Psychiatry is not alone. The whole medical profession is quite upset about it.
private practice of psychiatry. The serious imbalance is reflected by the following figures. A U.S. survey in 1963 showed that there were 400 long-stay mental hospitals with a population of more than half a million. Although 30% were non-governmental institutions, they cared for only 2% of all patients (presumably the rich ones). The rest were crowded into large governmental institutions (U.S. National Centre for Health Statistics, 1965). Although there were 3,000 psychiatrists in the U.S. in 1940, 5,500 in 1950 and 9,000 in 1956, the majority worked privately (Felix, 1967). In 1950, 15% worked inside the hospital. In 1956, the situation was not much better, only 1389 (about 15.4%) psychiatrists (including residents and interns) were full time employees in mental hospitals (Clausen, 1961). In 1966, only 35% of more than 14,000 psychiatrists interviewed indicated that they spent one or more hours per week in mental institution work (U.S. Public Health Service, 1966). Under such an imbalanced market situation, the coming of the government is but a natural consequence.

Some psychiatrists are realistic enough to

32. From this perspective, Sigmond Freud becomes the 'Adam Smith' in the mental illness industry. Traditional institutional psychiatry is "mercantilism" in the mental illness industry.
see the inevitability of the rising trend in government intervention in industry. The best strategy is to press for the best deal. Some psychiatrists favor community psychiatry as a mean to enlarge the market and enhance the social power of psychiatry. 33 Some psychiatrists see community psychiatry as the best means through which they can achieve social and political changes. 34 Some, more conservative in their approach, would like to limit their selling to some extent. They urge the government to assume more responsibility directly instead of buying the name of psychiatry. 35 To fully equip themselves for the new situation, medicine has developed a new kind of training known as Public Health Administration and established programs in various medical schools and universities.

33. Community psychiatry would now include programs for fostering social change, resolution of social problems, political involvement, community organization planning and traditional psychiatric clinical practice (Roberts et al., 1966). The object is to achieve these goals by influencing laws, statutes, regulations and customs (Chaplan, 1964).

34. Halleck (1971) claimed that all kinds of therapies are politically and morally bound. If a psychiatrist believes the root of mental illness lies in social environment, then community psychiatry offers him the best chance to combat social systems directly.

35. Bockoven (1972) warned his colleagues not to oversell themselves; community psychiatry will make more sense if the government and other community leadership assume more direct responsibility.
The Social Aspect of Mental Illness

The main theme in this section, product differentiation, is that the consumers prefer mental illness to other products. Implicit in this theme is the notion that mental illness is more a social concept than a medical concept. It follows that the development of the nosology of mental illness is a reflection of the changing social values rather than a refinement of existing medical knowledge. A corollary is that behaviors do not become mental illness until social values have changed to accept them as such.

The forementioned two assertions have been supported by several writers. Leifer (1969) presented his argument in Figure 7. He noticed that the development of psychiatry does not follow an advancement of medical knowledge. On the contrary, the further the development goes, the harder it seems to be for medical knowledge to encompass.

Szasz (1970) went even further by taking up the issue of masturbatory insanity. He noticed that contemporary psychiatric historians, in discussing the development of the nosology of mental illness, tended to conceal and minimize the issue of masturbatory insanity. Actually, masturbation has been regarded by psychiatrists as a very severe symptom in causing psychosis and neurosis. The concept spans all psychiatric history except the most recent
Figure 7

The development of the nosology of psychiatry

<table>
<thead>
<tr>
<th>SOCIAL FUNCTION</th>
<th>DISEASE</th>
<th>SIMILARITY TO A PRECEDING CATEGORY</th>
<th>DIFFERENCE FROM A PRECEDING CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Practice</td>
<td>Medical disease</td>
<td>Caused by bodily disorder</td>
<td>Psychological symptoms prominent</td>
</tr>
<tr>
<td>Hospital Psychiatry</td>
<td>Organic brain disease</td>
<td>Disabling psychological symptoms requiring hospitalization</td>
<td>No organic basis</td>
</tr>
<tr>
<td>Office Practice (Psychoanalysis and psychotherapy)</td>
<td>Psychosis</td>
<td>Resembles bodily disease</td>
<td>No actual bodily disease</td>
</tr>
<tr>
<td></td>
<td>Conversion hysteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Psychiatry</td>
<td>Other psychoneurosis</td>
<td>Discrete &quot;symptoms&quot;; psychological conflict; undesirable</td>
<td>No resemblance to physical disease</td>
</tr>
<tr>
<td></td>
<td>Character neurosis; behavioral maladjustments</td>
<td>Psychological conflict; undesirable</td>
<td>Patterned behavior rather than discrete symptoms</td>
</tr>
</tbody>
</table>

period when Western societies moved toward more sexual toleration.

"In short, the shifts from Witchcraft to masturbatory insanity to the modern concept of mental illness, may perhaps be understood as changes in Western man's imagery and concept of personal badness. This changing imagery and understanding of evil reflects in turn the changing cultural conditions .... Man's partner in crime thus shifts over a period of time from the devil, to his own penis, and hence to his self." (Szasz, 1970, p.205)

Perhaps of more importance are the findings by MacAndrew (1969) on how alcoholism became a disease. He showed that many psychiatrists have long tried to lead consumers to believe that alcoholism was a disease and thus include its treatment in the mental illness industry. This goes back to Rush in 1811, Trotter in 1810, and von Bruhl-Cramer in 1819. The message was revived by Edwards in 1896 in an article called "The Treatment of Inebriety as a Disease" and by Deeley in 1899 in another article called "Drunkenness a Curable Disease". However, while their message received some attention, it had never been supported. The public at that time still held the value of personal accountability for drinking. Recently, when alcoholism becomes a more severe social problem consumers decide that medical ideology might be useful in providing control. Then, alcoholism becomes a disease.
"In officially proclaiming that alcoholism is not a disease whatever else the proclaimers may be doing, they are not announcing a discovery of fact... The success of this latest venture in medical designation is a social-historical attainment and not a scientific achievement."

(MacAndrew, 1969, p.495-6)

Summary

The chapter tried to establish the argument that consumers prefer the 'illness-health' product in accounting for some deviant behavior. It first looked at the dual nature of mental illness, both as a medical concept and as a social concept. It was argued that as long as mental illness serves the social functions well, the question of whether or not medical techniques can solve the problem is less important. Then, the contemporary mental health movement was analysed in term of the Keynesian theory. Lastly, a few studies were cited to supported the notion that the development of the nosology of mental illness is a reflection of the changing social value rather than a refinement of existing medical knowledge.
Chapter VII

Summary, Conclusion and Discussion

Summary

In the study of mental illness, little attention has been paid to the analysis of the conflicts among different professionals. An industrial model is utilized as an attempt to see how conflicts among different professional groups dealing with mental illness affect the forms of treatment administered. Mental illness is seen as a division of the social control industry. Market structural variables such as the concentration (producer/consumer) variables, the entry to the market variables and the product/service differentiation variables are utilized as independent variables to account for the different forms of service given.

After defining the problem and the goal of this paper in Chapter I, my framework of analysis was presented in Chapter II. In Chapter III, the relationship between mental illness and social control was examined. After a brief historical account of how the mental illness service industry initially entered into the social control business, some of the functions medical ideology serves in rendering the control services are identified. Lastly, some evidence
was presented which seemed to suggest that the primary goal of mental institutions is social control rather than treatment.

In Chapter IV, competition between the legal profession and psychiatry was analysed. Centred around the issue of the insanity plea, empirical evidence was brought to show how the suspension of capital punishment affected the frequency of the insanity plea. It was found that less people would plead insanity after capital punishment was suspended. Lastly, the relationship between consumer power and the forms of service administered was examined. Empirical evidence tended to support that the higher the consumer power, the more consumers can shape the service they want.

Chapter V focused on competition between the medical profession and non-medical professions within the mental illness industry. The medical model of mental illness was viewed as a barrier of entry to other professions in entering the market. However, other professions managed to get in by employing some strategies. These strategies include formal organization, coalition, ideological unmasking, compromise and mutual expedience. The admission of more professions into the mental illness service industry created a demand for enlargement of the market
to accommodate the new professionals. Empirical data suggested that there was a trend toward widening the definition of mental illness. As a consequence, more people were diagnosed as mentally ill. The increase of mental illness seemed to be largely a function of the functional mental disorder at the expense of the organic mental disorders. Simultaneously, the increase of mental illness was coupled with an increase of the professionals. However, more non-medical professionals were employed at the expense of the medical profession. Therefore, it was concluded that it was in the interests of the non-medical professionals to see mental illness expanded.

In chapter VI, the argument that consumers have a preference for the 'illness-health' explanation over others to account for deviant behavior was presented. Mental illness was found to be more a social concept than a medical concept. Some studies were cited to support the notion that the development of nosology of mental illness is merely a reflection of the changing social value rather than a refinement of existing medical knowledge.
Conclusions

(1) The development of psychiatry and its practice can be re-interpreted with reference to the economic development of our society. Their relationship is presented in Figure 8. The three stages in the development of psychiatry as listed in Figure 8 (from asylum to hospital psychiatry, from hospital psychiatry to psychoanalysis, from psychoanalysis to community psychiatry) are hailed by psychiatrists as three great revolutions in the history of psychiatry (Bellak, 1964). Each development forward is regarded as a marked improvement over the preceding one. My analysis shows that they may be regarded as reflections of the changing economic practice in our society. This is evident if we compare the North American case with the development of psychiatry in Russia. In the U.S.S.R., where every industry was nationalized and the doctrine of laissez-faire has never been allowed to develop, we find that the mental illness service industry was also nationalized and psychoanalysis and private practice psychiatry do not exist, and the Hippocratic Oath is not observed.

"The Soviet doctor is bound to cooperate actively with the government, Party, Komsomol, and professional organizations in measures aimed at safeguarding the health of the population. This means that he can have no secrets from the State." (Fenwick, 1967, pp.1-2)

Since the Keynesian theory is in many ways similar to socialistic doctrine, we find that what the Soviet
### Figure 8

The Relationship between the Historical development of industry and psychiatry

<table>
<thead>
<tr>
<th>Development of industry</th>
<th>Features</th>
<th>Development of Psychiatry</th>
<th>Features</th>
<th>Producer-consumer relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercantilism</td>
<td>Direct state control on trade and industry; chartered monopoly to state controlled company aiming at more export and a surplus of gold.</td>
<td>Hospital Psychiatry</td>
<td>Hugh institution State-built psychiatrists as state employees control and segregation of patient</td>
<td>Patronage: the state as the only buyer who can shape the supply of service</td>
</tr>
<tr>
<td>Laissez-faire</td>
<td>Free trade; pursuit of self interest guide by 'invisible hand' for common good. Buying power of consumers determines the choice of product. Rise of middle class</td>
<td>Psychoanalysis Private practice Psychiatry</td>
<td>One to one on fee basic therapy. Psychiatrist as agent of patient who could afford.</td>
<td>Collegiate: contractual mutual expectation of what to produce</td>
</tr>
<tr>
<td>Keynesian theory</td>
<td>State as mediator to balance the distribution of goods. Progressive public enterprise to encourage investment and consumption; heavy state subsidy.</td>
<td>Community Psychiatry</td>
<td>State-subsidized mental health units; public health insurance to ensure services to the poor; Progressive health policy by government.</td>
<td>Mediation: state as strong mediator to regulate even distribution of goods/services</td>
</tr>
</tbody>
</table>
psychiatry is practicing is very similar to our community psychiatry (Szasz, 1970).

(2) The nature of the problem of mental illness appears not to lie in the objective happening of the phenomenon per se, but rather in the conflicts between different controlling professions. This problem has been recognized by the Scientific Planning Council of the Canadian Mental Health Association (1961) and again by the Royal Commission of Health Services (1964), however, little effort has been expended to solve it. According to my model, the process of product differentiation has made it extremely difficult for new competitors to change the product entirely. The best strategy for them seems to be to get into the market first and wait for their chances to win over the consumers. 36

Therefore, within every mental illness hierarchy, we find an uneasy coalition existing, each level defensive of its own spheres of interest and each waiting to expand at the expense of the others.

36. In Alberta, apparently the non-medical professions have gained considerable favor with the consumers; patients can now be taken off of physician's care and placed on non-medical therapies (Edmonton Journal, Sunday Dec. 22, 1973). In Manitoba, a recent government report favors a reduction of psychiatric power and influence (Clarkson and Associates, 1973).
(3) As seen in Chapter V, the expansion of the scope of mental illness functions as a strategy to buy off different competitors in non-medical professions. It is clearly in the interests of the non-medical professions to see that the mental illness definition be expanded because they are the ones who get employed. Once the non-medical professions gain entrance to the market, they tend to become more compromising. Any innovation which will affect the status quo affect adversely their interests as well.  

"The mental health power structure, committed primarily to its own preservation, is alertly opposed to any events that might change it. Thus when innovation intrudes, the structure responds with various strategies to deal with the threat; it might incorporate the new event, alter it to fit the preexisting structure so that, in effect, nothing is really changed. It might deal with it also by active rejection, calling upon all of its resources to starve out the innovator by insuring a lack of support."

(Graziorno, 1969, p.16)

(4) One of the reasons why psychiatry always maintains a dominant position is the principle of 'divide and rule'. Although there are many nonpsychiatric disciplines challenging the supremacy of psychiatry, seldom has any organized group formed which would permit a concerted attack on the problem. Even if

37. Ausubel (1961, p.70) in an article, "Personality Disorders is Disease." said, "Hence, even if psychologists were not currently managing to hold their own vis-a-vis psychiatrists, it would be far less dangerous and much more forthright to press for the necessary ameliorative legislation than to seek cover behind an outmoded and thoroughly discredited conception of the behavior disorders."
a small coalition exists, sooner or later, contesting views will separate into competing camps where differing orthodoxies become established. This problem is further exacerbated by an insufficient exchange of information among interested disciplines.

Further Research

My framework to view mental illness service as an industry is not intended to be inclusive. Still in its embryonic stage, it is intended rather to be suggestive and stimulative for further theoretical refinements. After all, the original model is designed in economics to analyse commodity industry. When the model is transplanted to the analysis of a service industry from a sociological point of view, some of its features are difficult to apply directly, though the analogy is clearly there. However, a model is not a miniature of truth, it is merely a convenient path which might lead to the understanding of truth. By utilizing an industrial model, one can get away from many ideological complications and minimize the commitment to a particular orientation. Furthermore, an industrial model offers us a much broader and comprehensive approach to the understanding of the problem; all the interested groups can be analysed within a single frame of reference.
The present study dealt primarily with the conflicts among different professionals in the mental illness service industry. There are many other conflicts among other professionals which deserve attention on. For example, many authors have expressed the idea that there are many conflicting goals within our judicial system (McGrath, 1965). These conflicts were often expressed in ideological terms. No attempt has ever been made to analyse the different judicial institutions such as the Police, the Court and the Prison as production units within the social control industry. Since these units are interrelated (one's outputs become another's inputs), a conflict of goal will automatically jam the product. Furthermore, the free legal aid system also deserves our attention. This may be interpreted again in term of the Keynesian theory in the judicial industry. It is hoped that further research will carried out in furthering my framework of analysis.
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