schizophrenia as ideology

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In lieu of beginning this paper with a (necessarily) abstract discussion of a concept, *the public order,* I shall invite the reader to consider a *gedanken* experiment that will illustrate its meaning. Suppose in your next conversation with a stranger, instead of looking at his eyes or mouth, you scrutinize his ear. Although the deviation from ordinary behavior is slight (involving only a shifting of the direction of gaze a few degrees, from the eyes to an ear), its effects are explosive. The conversation is disrupted almost instantaneously. In some cases, the subject of this experiment will seek to save the situation by rotating to bring his eyes into your line of gaze; if you continue to gaze at his ear, he may rotate through a full 360 degrees. Most often, however, the conversation is irretrievably damaged. Shock, anger, and vertigo are experienced not only by the "victim" but, oddly enough, by the experimenter himself. It is virtually impossible for either party to sustain the conversation, or even to think coherently, as long as the experiment continues.

The point of this experiment is to suggest the presence of a public order that is all-pervasive, yet taken almost completely for granted. During the simplest kinds of public encounter, there are myriad understandings about comportment that govern the participants' behavior—understandings governing posture, facial expression, and gestures, as well as the content and form of the language used. In speech itself, the types of conformity are extremely diverse and include pronunciation; grammar and syntax; loudness, pitch, and phrasing; and aspiration. Almost all of these elements are so taken for granted that they "go without saying" and are more or less invisible, not only to the speakers but to society at large. These understandings constitute part of our society's assumptive world, the world that is thought of as normal, decent, and possible.

The probability that these understandings are, for the most part, arbitrary to a particular historical culture (is shaking hands or rubbing noses a better form of greeting?) is immaterial to the individual member of society whose attitude of everyday life is, *whatever is, is right*. There is a social, cultural, and interpersonal status quo whose existence is felt only when abrogated. Since violations occur infrequently, and since the culture provides no very adequate vocabulary for talking about either the presence or abuse of its invisible understandings, such deviations are considered disruptive and disturbing. The society member's loyalty to his culture's unstated conventions is unthinking but extremely intense.

The sociologist Mannheim referred to such intense and unconscious loyalty to the status quo as *ideological.* Ideology, in this sense, refers not only to the defense of explicit political or economic interests but, much more broadly, to a whole world view or perspective on what reality is. As a contrast to the ideological view, Mannheim cited the *utopian* outlook, which tends "to shatter, either partially or wholly, the order of things prevailing at the time" (*7*). The attitude of everyday life, which is ideological, is transfixed by the past and the present; the possibility of a radically different scheme of things, or revolutionary changes in custom and outlook, is thereby rejected. The utopian perspective, by contrast, is fixed on the future; it rejects the status quo with abrupt finality. *Social change* arises out of the clash of the ideological and utopian perspectives.

Residual Rule Violations

It is the thesis of this paper that the concepts of mental illness in general—and schizophrenia in particular—are not neutral, value-free, scientifically precise terms but, for the most part, the leading edge of an ideology embedded in the historical and cultural present of the white middle class of Western societies. The concept of illness and its associated vocabulary—symptoms, therapies, patients, and physicians—reify and legitimate the prevailing public order at the expense of other possible worlds. The medical model of disease refers to culture-free processes that are independent of the public order; a case of pneumonia or syphilis is pretty much the same in New

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York or New Caledonia. (For criticism of the medical model from psychiatric, psychological, and sociological perspectives, see *3, 4, 6, 8, 11,* and *13.*)

Most of the "symptoms" of mental illness, however, are of an entirely different nature. Far from being culture-free, such "symptoms" are themselves offenses against implicit understandings of particular cultures. Every society provides its members with a set of explicit norms—understandings governing conduct with regard to such central institutions as the state, the family, and private property. Offenses against these norms have conventional names; for example, an offense against property is called "theft," and an offense against sexual propriety is called "perversion." As we have seen above, however, the public order also is made up of countless unnamed understandings. "Everyone knows," for example, that during a conversation one looks at the other's eyes or mouth, but not at his ear. For the convenience of the society, offenses against these unnamed residual understandings are usually lumped together in a miscellaneous, catchall category. If people reacting to an offense exhaust the conventional categories that might define it (e.g., theft, prostitution, and drunkenness), yet are certain that an offense has been committed, they may resort to this residual category. In earlier societies, the residual category was witchcraft, spirit possession, or possession by the devil; today, it is mental illness. The symptoms of mental illness are, therefore, violations of residual rules.

To be sure, some residual-rule violations are expressions of underlying physiological processes: the hallucinations of the toxic psychoses and the delusions associated with general paresis, for example. Perhaps future research will identify further physiological processes that lead to violations of residual rules. For the present, however, the key attributes of the medical model have yet to be established and verified for the major mental illnesses. There has been no scientific verification of the cause, course, site of pathology, uniform and invariant signs and symptoms, and treatment of choice for almost all of the conventional, "functional" diagnostic categories. Psychiatric knowledge in these matters rests almost entirely on unsystematic clinical impressions and professional lore. It is quite possible, therefore, that many psychiatrists' and other mental-health workers' "absolute certainty" about the cause, site, course, symptoms, and treatment of mental illness represents an ideological reflex, a spirited defense of the present social order.

Residue of Residues

Viewed as offenses against the public order, the symptoms of schizophrenia are particularly interesting. Of all the major diagnostic categories, the concept of schizophrenia (although widely used by psychiatrists in the United States and in those countries influenced by American psychiatric nomenclature) is the vaguest and least clearly defined. Such categories as obsession, depression, and mania at least have a vernacular meaning. Schizophrenia, however, is a broad gloss; it involves, in no very clear relationship, ideas such as "inappropriateness of affect," "impoverishment of thought," "inability to be involved in meaningful human relationships," "bizarre behavior" (e.g., delusions and hallucinations), "disorder of speech and communication," and "withdrawal."

These very broadly-defined symptoms can be redefined as offenses against implicit social understandings. The appropriateness of emotional expression is, after all, a cultural judgment. Grief is deemed appropriate in our society at a funeral, but not at a party. In other cultures, however, such judgments of propriety may be reversed. With regard to thought disorder, cultural anthropologists have long been at pains to point out that ways of thought are fundamentally different in different societies. What constitutes a meaningful human relationship, anthropologists also report, is basically different in other times and places. Likewise, behavior that is bizarre in one culture is deemed tolerable or even necessary in another. Disorders of speech and communication, again, can be seen as offenses against culturally prescribed rules of language and expression. Finally, the notion of "withdrawal" assumes a cultural standard concerning the degree of involvement and the amount of distance between the individual and those around him.

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The broadness and vagueness of the concept of schizophrenia suggest that it may serve as the residue of residues. As diagnostic categories such as hysteria and depression have become conventionalized names for residual rule breaking, a need seems to have developed for a still more generalized, miscellaneous diagnostic category. If this is true, the schizophrenic explores not only "inner space" (Ronald Laing's phrase) but also the normative boundaries of his society.

These remarks should not be taken to suggest that there is no internal experience associated with "symptomatic" behavior; the individual with symptoms *does* experience distress and suffering, or under some conditions, exhilaration and freedom. The point is, however, that public, consensual "knowledge" of mental illness is based, by and large, on knowledge not of these internal states but of their overt manifestations. When a person goes running down the street naked and screaming, lay and professional diagnosticians alike assume the existence of mental illness within that person—even though they have not investigated his internal state. Mental-health procedure and the conceptual apparatus of the medical model posit internal states, but the events actually observed are external.

Labeling Theory

A point of view which is an alternative to the medical model, and which acknowledges the culture-bound nature of mental illness, is afforded by labeling theory in sociology. (For a general statement of this theory, see *2*.) Like the evidence supporting the medical model, which is uneven and in large measure unreliable, the body of knowledge in support of the labeling theory of mental illness is by no means weighty or complete enough to prove its correctness. (Useful supporting material can be found in *1, 5, 6, 9,* and *10*.) But even though labeling theory is hypothetical, its use may afford perspective—if only because it offers a viewpoint that, along a number of different dimensions, is diametrically opposed to the medical model.

The labeling theory of deviance, when applied to mental illness, may be presented as a series of nine hypotheses:

1. Residual rule breaking arises from fundamentally diverse sources (i.e., organic, psychological, situations of stress, volitional acts of innovation or defiance).
2. Relative to the rate of treated mental illness the rate of unrecorded residual rule breaking is extremely high.
3. Most residual rule breaking is "denied" and is of transitory significance.
4. Stereotyped imagery of mental disorder is learned in early childhood.
5. The stereotypes of insanity are continually reaffirmed, inadvertently, in ordinary social interaction.
6. Labeled deviants may be rewarded for playing the stereotyped deviant role.
7. Labeled deviants are punished when they attempt the return to conventional roles.
8. In the crisis occurring when a residual rule breaker is publicly labeled, the deviant is highly suggestible and may accept the label.
9. Among residual rule breakers, labeling is the single most important cause of careers of residual deviance.

The evidence relevant to these hypotheses is reviewed in the author's *Being Mentally Ill (8)*.

According to labeling theory, the societal reaction is the key process that determines outcome in most cases of residual rule breaking. That reaction may be either denial (the most frequent reaction) or labeling. Denial is to "normalize" the rule breaking by ignoring or rationalizing it ("boys will be boys"). The key hypothesis in labeling theory is that, when residual rule breaking is denied, the rule breaking will generally be transitory (as when the stress causing rule breaking is removed; e.g., the cessation of sleep deprivation), compensated for, or channeled into some socially acceptable form. If, however, labeling occurs (i.e., the rule breaker is segregated as a stigmatized deviant), the rule breaking which would otherwise have been terminated, compensated for, or channeled may be stabilized; thus, the offender, through the agency of labeling, is launched on a career of "chronic mental illness." Crucial to the production of chronicity, therefore, are the contingencies (often external to the deviants) that give rise to labeling rather than

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denial; e.g., the visibility of the rule breaking, the power of the rule breaker relative to persons reacting to his behavior, the tolerance level of the community, and the availability in the culture of alternative channels of response other than labeling (among Indian tribes, for example, involuntary trance states may be seen as a qualification for a desirable position in the society, such as that of shaman).

"Schizophrenia"—A Label

On the basis of the foregoing discussion, it would seem likely that labeling theory would prove particularly strategic for facilitating the investigation of schizophrenia. Schizophrenia is the single most widely used diagnosis for mental illness in the United States, yet the cause, site, course, and treatment of choice are unknown, or the subject of heated and voluminous controversy. Moreover, there is some evidence that the reliability of diagnosis of schizophrenia is quite low. Finally, there is little agreement on whether a disease entity of schizophrenia even exists, what constitutes schizophrenia's basic signs and symptoms if it *does* exist, and how these symptoms are to be reliably and positively identified in the diagnostic process. Because of the all but overwhelming uncertainties and ambiguities inherent in its definition, "schizophrenia" is an appellation, or "label," which may be easily applied to those residual rule breakers whose deviant behavior is difficult to classify.

In this connection, it is interesting to note the perfectly enormous anomaly of classification procedures in most schizophrenia research. The hypothetical cause of schizophrenia, the independent variable in the research design—whether it is a physiological, biochemical, or psychological attribute—is measured with considerable attention to reliability, validity, and precision. I have seen reports of biochemical research in which the independent variable is measured to two decimal places. Yet the measurement of the dependent variable, the diagnosis of schizophrenia, is virtually ignored. The precision of the measurement, obviously, is virtually nil, since it represents at best an ordinal scale, or, much more likely, a nominal scale. In most studies, the reliability and validity of the diagnosis receives no attention at all: An experimental group is assembled by virtue of hospital diagnoses—leaving the measurement of the dependent variable to the mercy of the obscure vagaries of the process of psychiatric screening and diagnosis. Labeling theory should serve at least to make this anomaly visible to researchers in the field of schizophrenia.

More broadly, the clash between labeling theory and the medical and psychological models of mental illness may serve to alert researchers to some of the fundamental assumptions that they may be making in setting up their research. Particular reference should be made to the question of whether they are unknowingly aligning themselves with the social status quo; for example, by accepting unexamined the diagnosis of schizophrenia, they may be inadvertently providing the legitimacy of science to what is basically a social value judgment. For the remainder of this paper, I wish to pursue this point—the part that medical science may be playing in legitimating the status quo.

As was earlier indicated, there is a public order which is continually reaffirmed in social interaction. Each time a member of the society conforms to the stated or unstated cultural expectations of that society, as when he gazes at the eyes of the person with whom he is in conversation, he is helping to maintain the social status quo. Any deviation from these expectations, however small and regardless of its motivation, may be a threat to the status quo, since most social change occurs through the gradual erosion of custom.

Since all social orders are, as far as we know, basically arbitrary, a threat to society's fundamental customs impels its conforming members to look to extrasocial sources of legitimacy for the status quo. In societies completely under the sway of a single, monolithic religion, the source of legitimacy is always supernatural. Thus, during the Middle Ages, the legitimacy of the social order was maintained by reference to God's commands, as found in the Bible and interpreted by the Catholic Church. The Pope was God's deputy, the kings ruled by divine right, the particular cultural form that the family happened to take at the time—the patrilocal, monogamous, nuclear fam-

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ily—was sanctified by the church, and so on.

In modern societies, however, it is increasingly difficult to base legitimacy upon appeals to supernatural sources. As complete, unquestioning religious faith has weakened, one very important new source of legitimacy has emerged: In the eyes of laymen, modern science offers the kind of absolute certainty once provided by the church. The institution of medicine is in a particularly strategic position in this regard, since the physician is the only representative of science with whom the average man associates. To the extent that medical science lends its name to the labeling of nonconformity as mental illness, it is giving legitimacy to the social status quo. The mental-health researcher may protest that he is interested not in the preservation of the status quo but in a scientific question: "What are the causes of mental illness?" According to the argument given here, however, his question is loaded —like, "When did you stop beating your wife?" or, more to the point, "What are the causes of witchcraft?" (For a comparison of the treatment of witches and the mentally ill, see *12*.) Thus, a question about causality may also be ideological, in Mannheim's sense, in that it reaffirms current social beliefs, if only inadvertently.

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