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**ESSAYS ON THE
SOCIAL SITUATION OF
MENTAL PATIENTS
AND OTHER INMATES**

IN each society there are favoured ways in which two individuals can approach and have dealings with each other, for example, as kindred to kindred, or high caste to low. Each of these frameworks for contact can be at once a source of identity, a guide for ideal conduct, and a basis of both solidarity and divisiveness. Each framework involves a set of interdependent assumptions that fit together to form a kind of model. In every case we find that characteristic pressures prevent persons from fully realizing the ideal and that the resulting deviations have characteristic reverberations. The student of society can therefore use for his purposes the same models that members of society use for theirs.

In our Western society, an important way in which two individuals may deal with each other is as server and served. By exploring the assumptions and ideals behind this occupational relationship, I think we can understand some of the problems of mental hospitalization.

I

Specialized occupational tasks can be divided into two categories, one where the practitioner 'meets the public' through his work, a second where he does not, performing it only for the established members of his work organization. I assume that the problem of facing the public and of controlling it is sufficiently central to merit treating together all who experience it. This means that a hardware-store clerk and a factory tool-bin man are to be separated for purposes of study, in spite of similarities in what they do.

Among tasks requiring the performer to meet the public, two kinds may be distinguished, one where the public consists of a sequence of individuals, and another where it consists of a sequence of audiences. A dentist performs the first kind of task, a comedian the second.

Tasks which require the practitioner to meet the public (in either of its forms) vary in the degree to which they are presented to this public as a personal service, that is, as an assistance desired by the recipient. A *personal-service occupation* may be defined, ideally, as one whose practitioner performs a specialized personal service for a set of individuals where the service requires him to engage in direct personal communication with each of them and where he is not otherwise bound to the persons he serves.¹ By this definition the process of being served a summons, for example, is not a personal service for the person served. A psychologist who sells vocational testing to persons who want to learn about their aptitudes is performing a personal service, but if he tests the same persons for the employment office of an organization they are merely the subjects of his work and not his clients. So also, in spite of the language of census takers, I exclude domestic servants from the category of servers, since a maid has a mistress, not a public, and I exclude charwomen, since they do not routinely engage in direct communication with those who walk on their clean floors.

In this paper I want to consider personal-service occupations as here defined, but I shall include some practitioners who do not entirely fit my definition, since the ideal on which it is based draws people who are not in a position to conform to it. Deviations from an ideal imposed by self or others create problems of identity that the student must understand in terms of the ideal – and understand differently depending on the relation of the deviation to the ideal: a high-pressure car salesman and an insurance-company doctor both provide something less than a personal service, but for a different framework of reasons.

A traditional means of classifying personal-service occupations is by the honour accorded them, with the liberal professions falling at one extreme and the humble trades and crafts at the other. This can be an obscuring distinction, separating by rank those

1. Sociological interest in service occupations stems largely from Everett C. Hughes and is documented in the work of his students at the University of Chicago, especially Oswald Hall and Howard S. Becker. See especially the latter's 'The Professional Dance Musician and His Audience', *American Journal of Sociology*, LVII (1951), pp. 136–44.

who are similar in spirit. The division I want to employ places at one extreme those, such as ticket-takers or telephone operators, who perform a perfunctory technical service, and at the other those with an expertness that involves a rational, demonstrable competence that can be exercised as an end in itself and cannot reasonably be acquired by the person who is served. Perfunctory servers tend to have customers, 'parties', or applicants; expert servers tend to have clients. Both types of servers are likely to have some independence from the persons they serve, but only experts are in a position to build that independence into a solemn and dignified role. It is the social and moral assumptions underlying the practice of expert, rather than perfunctory, servicing that I want to consider in this paper.

I suggest that the ideals underlying expert servicing in our society are rooted in the case where the server has a complex physical system to repair, construct, or tinker with – the system here being the client's personal object or possession. Hereafter in this paper when I use the term service relation (or occupation) this pure case will be implied unless the context necessitates a more careful reference.

We deal with a triangle – practitioner, object, owner – and one that has played an important historical role in Western society. Every large society has expert servers, but no society has given such service more weight than has ours. Ours is a service society, so much so that even such institutions as stores come to follow this style in word if not in fact, responding to the need of both clerks and customers to feel that expert personal service is being provided even while they despair of realizing it.

The type of social relationship I will consider in this paper is one where some persons (clients) place themselves in the hands of other persons (servers). Ideally, the client brings to this relationship respect for the server's technical competence and trust that he will use it ethically; he also brings gratitude and a fee. On the other side, the server brings: an esoteric and empirically effective competence, and a willingness to place it at the client's disposal; professional discretion; a voluntary circumspection, leading him to exhibit a disciplined unconcern with the client's other affairs or even (in the last analysis) with why the client should want the

service in the first place; and, finally, an unservile civility.² This, then, is the tinkering service.

We can begin to understand the service relation by examining the concept of the fee. There is a double sense in which a fee is not a price.³ Traditionally a fee is anything other than what the service is worth. When services are performed whose worth to the client at the time is very great, the server is ideally supposed to restrict himself to a fee determined by tradition – presumably what the server needs to keep himself in decent circumstances while he devotes his life to his calling. On the other hand, when very minor services are performed, the server feels obliged either to forgo charging altogether or to charge a relatively large flat fee, thus preventing his time from being trifled with or his contribution (and ultimately himself) from being measured by a scale that can approach zero.⁴ When he performs major services for very poor clients, the server may feel that charging no fee is more dignified (and safer) than a reduced fee.⁵ The server thus avoids dancing to the client's tune, or even bargaining, and is able to show that he is motivated by a disinterested involvement in his work. And since his work is the tinkering kind, which has to do with nicely closed and nicely real physical systems, it is precisely the kind of work in which disinterested involvement is possible: a repair or construction job that is good is also one that the server can identify with; this adds a basis of autonomous interest to the job itself. Pre-

2. This description of the service relationship draws heavily on Parson's paper, 'The Professions and the Social Structure', which I feel is still the leading statement in this area. See also Talcott Parsons and Neil Smelser, *Economy and Society* (Glencoe, Ill.: The Free Press, 1956), pp. 152-3.

3. See, for example, A. M. Carr-Saunders and P. A. Wilson, *The Professions* (Oxford: The Clarendon Press, 1933), section 'Fees and Salaries' pp. 451-60.

4. The more lowly the tinkering trade, the more need the server may have to forgo charging for certain minor but skilled services. Among shoemakers these acts of *noblesse oblige* can become lordly indeed, just at a time in history when lords can no longer afford the original version.

5. Carr-Saunders and Wilson, op. cit., p. 452: 'In most other professions [other than accountancy] the associations attempt to induce their members not to undercut, though objection is never raised to the remission of fees when the client is poor.'

sumably the server's remaining motivation is to help mankind as such.

The server's attachment to his conception of himself as a disinterested expert, and his readiness to relate to persons on the basis of it, is a kind of secular vow of chastity and is at the root of the wonderful use that clients make of him. In him they find someone who does not have the usual personal, ideological, or contractual reasons for helping them; yet he is someone who will take an intense temporary interest in them, from their own point of view, and in terms of their own best interests. As one student of human affairs suggests:

As defined in this culture, the expert is one who derives his income and status, one or both, from the use of unusually exact or adequate information about his particular field, in the service of others. This 'use in the service of' is fixed in our industrial-commercial social order. The expert does not trade in the implements or impedimenta of his field; he is not a 'merchant,' a 'collector,' a 'connoisseur,' or a 'fancier,' for these use their skill primarily in their own interest.⁶

It therefore pays the client to trust in those for whom he does not have the usual guarantees of trust.

This trustworthiness available on request would of itself provide a unique basis of relationship in our society, but there is still another factor: the server's work has to do with a rational competence, and behind this a belief in rationalism, empiricism, and mechanism, in contrast to the more self-referential processes that plague people.

The interaction that occurs when client and server are together ideally takes a relatively structured form. The server can engage in mechanical, handwork operations on the client's possession, especially work of a diagnostic kind; he can also engage in verbal exchanges with the client. The verbal part itself contains three components: a *technical* part, namely the giving and getting of relevant repair (or construction) information; a *contractual* part, being a statement, often discreetly brief, regarding approximate costs, approximate time for the job, and the like; and finally, a *sociable* part, consisting of a few minor courtesies, civilities, and

6. Harry Stack Sullivan, 'The Psychiatric Interview', *Psychiatry*, XIV (1951), p. 365.

signs of deference. It is important to see that everything that goes on between server and client can be assimilated to these components of activity, and that any divergences can be understood in terms of these normative expectations. The full assimilation of the interaction between server and client to this framework is often for the server one of the tests of a 'good' service relation.

The technically relevant information that the server needs, in order to repair or construct effectively, comes to him from two sources: from the client's verbal statements, and from the object itself, through the direct impression it makes on the server. Following the practice sometimes employed in medicine, we can call the client's reported difficulties *symptoms*, and the data directly obtained by the server *signs*, although there is no particular warrant for this usage in semiotics. The dignity of the service relation is partly based on the capacity of the client to contribute usable information, albeit filtered through lay language and lay sensibility. The servicing can then take on something of the spirit of a joint undertaking, with the server showing some respect for the client's unschooled appraisal of the trouble.

The server has contact with two basic entities: a client and the client's malfunctioning object. Clients are presumably self-determining beings, entities in the social world, that must be treated with appropriate regard and ritual. The possessed object is part of another world, to be construed within a technical, not a ritual, perspective. The success of the servicing depends on the server keeping these two different kinds of entities separate while giving each its due.

II

Let us now turn to the object that the server repairs or constructs. I have described this object (or possession) as a physical system in need of expert attention, and I shall focus on repairs, as more usual than construction. Linked with the notion of repairs is a conception of the repair cycle, the phases of which I would like to describe briefly.

We can begin by considering our everyday conception of etiology. The common nail can serve us as a starting point, for it is an object that commonly begins a repair cycle. A nail on the

server. We now have a triad – client, server, community – and this can strike at the heart of serving even more than the triadic feature that occurs when the server joins an establishment of some kind and divides his loyalty between the firm's clients and the firm's management.

v

We now turn to the medical version of the tinkering-services model.¹² Our giving our bodies up to the medical server, and his rational-empirical treatment of them, is surely one of the high points of the service complex. Interestingly enough, the gradual establishment of the body as a serviceable possession – a kind of physicochemical machine – is often cited as a triumph of the secular scientific spirit, when in fact this triumph seems in part to have been both cause and effect of the rising regard for all types of expert servicing.

The signs that medical men currently employ, especially signs involving refined laboratory work, are increasingly sophisticated, yet medical men still claim to rely on the patient for reporting symptoms; the client is still a participant to be respected in the service relationship. But, as with other competencies, there are special points of strain in fitting the treatment of the body into the service framework. I would like to mention some of these, with the understanding that the same problems also arise to some degree in other kinds of servicing.

The first issue is that the body is, as psychoanalysts say, highly cathected in our society; persons place great value on its appearance and functioning and tend to identify themselves with it. Individuals are uneasy about giving their bodies up to the rational-empirical ministrations of others, and hence need their 'confidence' in the server continuously shored up by bedside assurances. This problem must not be overstressed, however, not because persons are ceasing to identify with their bodies but because of what we are slowly learning about how much they

12. Compare T. S. Szasz, 'Scientific Method and Social Role in Medicine and Psychiatry', *A.M.A. Archives of Internal Medicine*, CI (1958), pp. 232-3, and his 'Men and Machines', *British Journal for the Philosophy of Science*, VIII (1958), pp. 310-17.

identify with quite non-corporal things, such as wrist watches and cars, seeing in a threat to these 'good objects' a threat to self.

The very willingness of clients to put their bodies' fate in the hands of their physicians carries its own problem for medical men: they may find that sympathy with the patient subjects them to emotional stress when they are uncertain of what is wrong or what can be done for the patient, or when they are certain that little can be done and must impart this information to the person (or his guardian) whose fate will be sealed by it.¹³ But here, perhaps, we have a problem not for medical servicing as such but for the individuals who perform it.

Another problem is that the body is one possession that cannot be left under the care of the server while the client goes about his other business. Admittedly physicians show a remarkable capacity to carry on the verbal part of the server role while engaging in the mechanical part, without this segregation breaking down, but there are inevitable difficulties here, since the client is very interested in what is happening to his body and is in a good position to see what is being done. (Barbers, hairdressers, and prostitutes know of these troubles, too, of course, since poor mechanical activity on their part may be instantly perceived by the ever-present client.) One solution is anaesthesia; another is the wonderful brand of 'non-person treatment' found in the medical world, whereby the patient is greeted with what passes as civility, and said farewell to in the same fashion, with everything in between going on as if the patient weren't there as a social person at all, but only as a possession someone has left behind.¹⁴

13. An analysis of the pressures upon a physician to evade communicating a known bad prognosis and to offer an opinion when in fact he feels uncertain is provided in Fred Davis, 'Uncertainty in Medical Prognosis, Clinical and Functional', *American Journal of Sociology*, LXVI (1960), pp. 41-7.

14. The non-person solution seems especially effective when the examining physician is accompanied by colleagues and subordinates, as when making rounds, for then he will have participants available for a technical conversation about the case. So effective is this way of suppressing the social presence of the patient that his fate can be openly discussed around his bed without the discussants having to feel undue concern; a technical vocabulary presumably unknown to the patient helps in this regard.

Another issue in medicine has to do with the appreciable margin of merely palliative action, of 'elective procedures', and of unsuccessful treatment. With many mechanical objects, every possible disorder can be fixed, depending only on how much of the original object is replaced with new parts, and this may require no great skill. A radio mechanic of average ability can fix absolutely any broken radio by the simple expedient of checking out sections of the circuit and replacing the parts where the trouble seems to lie. It is the realistic boast of a well-supplied automotive-parts distributor that he can build a complete car in his supply rooms from the parts on hand. Not so in medicine. Some parts of the body cannot be replaced, and not all physical disorders can be corrected. Further, due to medical ethics, a physician cannot advise a patient to junk the badly damaged or very worn object his body may have become (as can those who service other types of objects), although the physician may tacitly give such advice to other interested parties.

Although this lowered probability of repair is characteristic of medicine, there are effective techniques for the management of doubt. Even in the case of a brain surgeon, who may expect to lose half his cases, clients can be made to see that this is merely a chancy, last-resort department of medicine, made tolerable by the probability of effectiveness achieved in many of the other departments. Further, there are expert services, albeit of a non-tinkering kind, such as those a lawyer or broker provides, where the probability of success may well be lower than in general medicine and a sense of ethical professional service can still survive. In all these cases the server can take the stand that, whether he succeeds or fails this time, he is applying the best techniques to the best of his abilities, and that in general it is better to rely on these techniques and abilities than to rely on pure chance. Respectful and continued relations between many brokers and their clients attest to the fact that, once a service definition of the situation is accepted, clients are willing to accept a probability very little greater than chance as justification for remaining within the relationship. The client finds that he must consider not how well he has done with the server, but rather how much worse he might have done without him, and with this

understanding he is led to accord the ultimate tribute to esoteric skill: cheerful payment of the fee in spite of the loss of the object that the server was hired to save.

Another interesting difficulty in applying the tinkering-service model to medical practice is that the injurious agent is recognized in some cases to be not a randomly disposed improbable event in the environment, but the environment itself. Instead of there being one nail on the road, the road is covered with them. Thus, for certain physical disorders, a given climate or given type of work is exacerbating. If the patient can afford a complete change of scenery, the pathogenic environment can be looked upon as merely one of the many possible environments, and hence the improbable member of a generally healthy class. For many patients, however, change in life situation is not practical, and the service model cannot be satisfactorily applied.

Associated with the fact that the environment itself may be the pathogenic agent is the possibility of pursuing medicine at the community level, treating not a single individual but a large social unit, and reducing the probability of a specific illness within a whole set of persons rather than curing a specific patient. The whole emerging field of epidemiology is of this order, constituting not so much a threat to medical practice on individuals as a supplement to it.

While many individuals can be relied upon to act as responsible, self-willing agents in regard to their bodies, it is apparent that the very young, the very old, and the mentally ill may have to be brought to medical attention 'for their own good' by someone else, thus radically changing the usual relation between client, possession, and server. Often an attempt is made to assimilate such situations to the free-agent model by having the patient brought in by someone with whom he is socially identified, typically a kinsman who can stand in for him and as a guardian be trusted to represent his ward's best interests. Perhaps a factor here is that the seeking of medical service by free agents is often itself not so free, but a product of consensus, if not pressure, on the part of the patient's close kin group. It may be added that when dire news must be given a patient he may suddenly find that his capacities as object and as client are split apart. He retains his

status as an object but his role as client is subtly transferred to someone close to him. Sometimes the issue is not that he is no longer competent as a social person but that the physician is disinclined to become embroiled as a participant-witness of someone's immediate response to a destruction of life chances.

The guardian problem can illustrate the conflict that may arise between what a server and his discipline feel is in the best interests of the client and what the client himself desires. This potential conflict is sharpened by a further factor, the tension between client interests and community interests. An obvious example is the case of communicable diseases, where the physician has the legal obligation to protect the community as well as his client. Other examples of this conflict are abortion and the treatment of unreported gunshot wounds, although in both cases there is an out, an abortion often being defined as not in the 'best' interests of the person seeking it, and gunshot wounds being treated, provided police authorities are informed at the same time. A third instance is the early restriction on the use of plastic surgery for purely cosmetic reasons, although what was at stake here was not so much the welfare of the community as the dignity and disinterestedness of the medical profession itself. And of course there are other instances, such as the Soviet physician's interesting problem of whether to grant to a worker what will be his only holiday although he doesn't have very much wrong with him,¹⁵ or the American physician's problem of whether to 'write scrip' for drugs to confirmed addicts.

Another problem in managing medicine within the service framework is that patients often feel they can seek advice from their physician on non-medical matters, and the physician sometimes feels he has a special competence that justifies his accepting this diffusion of his role.¹⁶ More important, and increasingly important, is another problem: in spite of the efforts of medical professional associations, in some countries medical practice as a whole is tending away from the ideal of the free practitioner with an unorganized clientele to one where a bureaucratic agency of

15. M. G. Field, 'Structured Strain in the Role of the Soviet Physician', *American Journal of Sociology*, LVIII (1953), pp. 493-502.

16. Szasz, 'Scientific Method . . .' op. cit., p. 233 fn.

some kind provides service to clients who have little choice over which of the available physicians they get to see. This is a serious threat to the classic service relation, but I do not think we yet know about its long-range consequence for the service ideal.

From the point of view of this paper, the most relevant strain in the application of the service model to medicine resides in the workshop complex, in spite of the fact that on some occasions, as in certain surgical undertakings, a roomful of people may be intimately regulated by a multitude of detailed rules, almost all of which are rationally grounded in technical considerations. While typically presenting themselves as public service institutions run for the benefit of mankind, some hospitals have frankly operated for the profit of their owners, and all have shown concern about the social characteristics of their staff and patients. So, too, many hospitals are involved in training programmes that lead some treatment decisions to be influenced not merely by the needs of the patient in question but also by the techniques and medications in which the hospital specializes. Similarly, many hospitals are involved in research programmes that sometimes lead to treatment dictated not so much by the needs of the patient as by the requirements of the research design.

There are other difficulties, too. As already suggested, the client will find it difficult to treat his body, and have it treated, impersonally, and to overlook the fact that he cannot use it in the usual fashion while it is being repaired. Further, it is increasingly appreciated that even a brief sojourn in the hospital can create 'separation anxiety' in the very young; the implication is that the workshop in such cases is not a benign neutral environment, but a hurtful one. Furthermore, since the client must reside in the workshop during the active treatment phase of the repair cycle, he is well situated to see the difficulties of assimilating everything that occurs around and to him to the service model. The success of the patient in making this assimilation necessarily resides in his being deceived about certain procedures, because always some of the hospital routine will be dictated not by medical considerations but by other factors, notably rules for patient management that have emerged in the institution for the convenience and comfort of staff. (The same divergence from service-determined

rules is true, of course, of every workshop, but in these other workshops the client is not usually present to see what happens.) The longer the required stay in the hospital, and the more chronic and lingering the disorder, the greater the difficulty the patient will have in seeing the hospital as a thoroughly rational service institution.

In spite of these and other difficulties in housing medical services within a hospital establishment, there are factors which are effective in allowing the patient to assimilate all his hospital experience to the service model - providing his stay is not too long. Obviously the hospital can provide the patient with the benefit of heavy capital equipment and specialized instruments that no doctor's office could provide. Further, to rest immobile in bed is, after all, defined as what one does in our society when one is sick, and in some cases the patient may feel physically incapable of doing anything else. Some technical aspects of medical attention add additional support: bone fractures and many post-operative states patently necessitate immobility, as do, occasionally, such post-operative procedures as draining; some therapies require a highly regulated diet; charting and lab work often require constant availability of the patient. All of this provides rational justification for the posture the patient must assume in the hospital.

An additional factor strengthens this assimilation of hospital experience to the service model. Often during hospitalization and post-hospital care there is a split introduced into the patient's environment: within a bandage or cast or otherwise bounded part of the body, a medically adjusted environment is intensively maintained; the condition in which everything outside this boundary is maintained can then be rationalized not on the direct grounds of its salubriousness, but as a basis for ensuring the maintenance of the inner environment. In this way the area over which patently useful medical actions are maintained can be greatly reduced without jeopardizing the possibility that the patient will be able to assimilate everything that is occurring to him to the medical model.

These bases of validity to the service claims made by hospitals make more secure the service stance assumed by the physician,

line the patient must follow if the psychiatrist is to be affirmed as a medical server.

The likelihood of an unschooled patient following the psychiatric line is not great. He may never in his life have had so many reasons obvious to him for seeing that he is not a voluntary client and for being disgruntled at his condition. He sees the psychiatrist as the person in power. In contact with the psychiatrist the patient is likely to make those kinds of demands and requests and take those stands that pull the relationship out of the service schema to, for example, that of a charge pleading with his master for more privileges, a prisoner remonstrating with an unlawful jailer, or a prideful man declining to exchange communications with someone who thinks he is crazy.

If the psychiatrist takes these complaints seriously, the relationship ceases to be the one for which he was trained. To defend his own professional role and the institution that hires him, the psychiatrist is under pressure to respond by treating these outpourings not as directly usable statements of information but rather as signs of the illness itself, to be discounted as direct information.³² But to treat the statements of the patient as signs, not valid symptom reporting, is of course to deny that the patient is a participant as well as an object in a service relation.

The psychiatrist and patient tend to be doomed by the institutional context to a false and difficult relationship and are constantly funnelled into the contact that will express it: the psychiatrist must extend service civility from the stance of a server but can no more continue in that stance than the patient can accept it. Each party to the relationship is destined to seek out the other to offer what the other cannot accept, and each is destined to reject what the other offers. In many psychiatric settings, one can witness what seems to be the same central encounter between a patient and a psychiatrist: the psychiatrist begins the exchange by proffering the patient the civil regard that is owed a client, receives a response that cannot be integrated into a continuation of the conventional service interaction, and then, even while attempting to sustain some of the outward forms of

32. On the problem of discounted statements, see Stanton and Schwartz, *op. cit.*, p. 200 ff.

server-client relations, must twist and squirm his way out of the predicament. All day long the psychiatric staff seems to be engaged in withdrawing from its own implicit overtures.

VIII

In discussing the application of the expert service model to various trades, I suggested some standard discrepancies or strains and argued that institutional psychiatric servicing faced a very extensive set of these problems. This situation is in itself not very noteworthy; many 'expert' services are sold that satisfy even less well than psychiatry the requirements of the model in whose guise they are presented, albeit few involving so many clients so sorely tried. What is analytically interesting about the mental-hospital case is that doctors are involved, and so are involuntary inmates. Medical doctors in our society are exemplars of the rational, tinkering approach and ordinarily are allowed to invest their performances with great dignity and weight. Having committed much time and expense to acquiring the medical role, and expecting their daily activity to support them in the role their training has vouchsafed them, they understandably feel compelled to maintain a medical approach and the medical version of the service model. Society at large seems to back them up in this, for it is a satisfaction to us all to feel that those we exile to madhouses are receiving treatment, not punishment, under a doctor's care. At the same time, involuntary mental commitment (and often even voluntary commitment) ordinarily entails for the individual a condition of life that is impoverished and desolate indeed, often generating a sustained hostility to his captors. The limited applicability of the medical model to mental hospitals brings together a doctor who cannot easily afford to construe his activity in other than medical terms and a patient who may well feel he must fight and hate his keepers if any sense is to be made of the hardship he is undergoing. Mental hospitals institutionalize a kind of grotesque of the service relationship.

While both doctors and inmates find themselves in a difficult institutional setting, the doctors, being in control of the institution, have the greater opportunity to evolve some mechanisms

for coping with their problem. Their response to the situation provides us not only with an important aspect of hospital life but also with a case history of the interplay between social models of being – in this case the expert server – and the social establishments in which there is an attempt to institutionalize these role identities.

There are some features of the hospital situation that help the psychiatrist in the difficulties of his role. The physician's legal mandate over the fate of the patient and his institutional power over some elements of staff automatically provide the authority that other servers must in part win through actual interaction with the client. Further, while psychiatric knowledge often cannot place the psychiatrist in a position to predict the patient's conduct correctly, the same nescience provides the psychiatrist with interpretive leeway: by adding *post hoc* qualifications and adumbrations of his analyses, the psychiatrist can provide a picture of what has been happening with the patient that can no more be disproved than proved, as when an unanticipated psychotic break gives rise to the interpretation that the patient now feels secure enough or strong enough to express his psychosis. To this authority that cannot be discredited, the psychiatrist can add a force derived from medical tradition, 'clinical experience'. Through this magical quality, the formally qualified person of longest experience with the type of case in question is accorded the final word when there is doubt or ambiguity, this person also being apt to be the ranking practitioner present.

The psychiatrist, being medically trained, can provide minor medical services to patients and can refer more difficult medical cases to the hospital's hospital. This normative function (characteristic, as suggested, of what must be done in the Army, on a ship, in a factory, or wherever large numbers are gathered to contribute to an administrative end), instead of being seen as an ancillary housekeeping service, tends to be assimilated to the central functioning of the establishment, thereby strengthening the basis in reality of the notion that mental patients receive medical-like treatment in mental hospitals. Interestingly enough, state mental hospitals sometimes are so understaffed that medically qualified personnel could spend all their time making minor

medical repairs on patients and must practise psychiatry – to the extent they do – at the expense of needed medical treatment.

An obvious way for the psychiatrist to solve his role problem is to leave the state mental hospital as soon as he can afford to, often with the claim that he is leaving in order to go where 'it will really be possible to practise psychiatry'. He may go, especially for the last year or two of his obligatory residency, to a private hospital, perhaps of the psychoanalytically oriented kind, where there is a patient load approaching that of private practice, and where a higher ratio of patients are voluntary and 'suitable' for psychotherapy. From such a hospital (or directly from the state hospital), he may go into private practice, an arrangement that may not bring his skill to many patients but will guarantee that activity is conducted in accordance with the service complex: an office, a secretary, hour-long appointments, voluntary appearance of the patient, sole control over diagnosis and treatment, and so forth.³³ For whatever reasons, this two- or three-stage job cycle is sufficiently common to constitute a standard career pattern in psychiatry.

Where the psychiatrist cannot, or does not want, to leave the state mental hospital, some other paths appear to have been established for him. He may redefine his role from that of a server to that of a wise governor, embrace the custodial aspects of the institution, and devote himself to enlightened administration. He can admit some of the weaknesses of individual therapy in the situation and move in the direction of the newer social therapies,

33. It is remarkable that the self-discipline required of the mental client if he is to allow his psychiatrist to act like any other professional man receives full and detailed justification in the psychoanalytical literature on the basis of technical therapeutic considerations. A wonderful pre-arranged harmony exists between what is good for the patient and what in fact the psychiatrist requires if an office profession is to be maintained. To paraphrase Mr Wilson, what is good for the profession is good for the patient. I have found especially refreshing the discussion of the psychological importance of the patient's appreciating that the therapist has a life of his own and that it would not be good for the patient if the therapist postponed his vacation, or saw the patient in response to midnight telephone calls, or allowed himself to be physically endangered by the patient. See, for example, C. A. Witaker and T. P. Malone, *The Roots of Psychotherapy* (New York: Blakiston Co., 1953), pp. 201–202.

attempting to involve the patient's kin in psychotherapy (on the assumption that the disorder resides in a family system),³⁴ or attempting to locate therapy in the full round of daily contacts that the patient has with all levels of staff.³⁵ He can turn to psychiatric research. He can withdraw from patient contact as much as possible, retreating into paper work, or into psychotherapy with the lower levels of staff or with a small number of 'promising' patients. He can make a serious effort to warn the patients whom he treats that his knowledge is small, but this kind of candour seems destined to fail because the medical role is defined otherwise in our society, and because the power the psychiatrist has over the patient is not readily understood as something that would be given to anyone who knew little.³⁶ Occasionally the psychiatrist becomes a 'patients' man', agreeing with their claims as to what the institution is doing to them and voicing open criticism of the establishment to them. If he takes none of these tacks, the psychiatrist can at least become cynical about his role in the hospital, thereby protecting himself, if not his patients.³⁷

In addition to these modes of adaptation involving career alignments, we find adaptations of a more diffuse and more ideological kind, in which staff levels participate. It is as if the service dilemma constituted a sore spot in the hospital social system, and that around this spot intellectual energies are expen-

34. Faced with the doctrine that the patient may merely be the 'symptom carrier' for his intimate circle, some research psychiatrists have made an effort to import whole families on to experimental residential wards. The side problems consequent upon such novel living arrangements, especially as regards the structure of family authority, are very great, and their masking effect has perhaps been underestimated.

35. Here the psychiatrist may explicitly admit that he must be therapist not to the individual but to the hospital social system. Psychiatric and medical training seem to equip doctors to accept the responsibility of governing a ward or hospital, freeing them from the trepidation an individual might have who had relevant training or experience for the task.

36. For a comment on the fate of verbal modesty in the context of high hospital office, see A. H. Stanton, 'Problems in Analysis of Therapeutic Implications of the Institutional Milieu', in *Symposium on Preventive and Social Psychiatry*, Walter Reed Army Institute of Research, Washington, D.C. (15-17 April 1957), p. 499.

37. Bellman *op. cit.* p. 200.

ded to build up a protective skin of words, beliefs, and sentiments. Whatever its source, the resulting system of belief serves to bolster and stabilize the medical-service definition of the situation. We are thus provided with an illustration in miniature of the relation between thought and social position.

Perhaps the most obvious instance of institutional ideology is found in the public relations work that is currently fairly characteristic of mental hospitals. Hallway displays, orientation booklets, institutional magazines, displayable equipment, and newer therapies - these sources of definitions of the situation await patients, relatives, and visitors, establishing the obvious claims of the medical-service line.

Further, we have in mental hospitals a collection of traditional tales whose recounting illustrates the validity of the perspective employed by staff. These stories tell of times a patient was given privileges too early, or released against advice of physicians, and went on to commit suicide or murder. Attendants have jokes to tell illustrating the animal-like nature of patients. Those staff members who attend diagnostic conferences have humorous anecdotes about patients - for example, an inmate who made a dignified claim to sanity but finally allowed that he was an agent of the FBI. There are stories of patients who begged to be kept on a locked ward, or who engaged in obvious delinquencies in order to prevent their own discharge. There are other tales of 'pre-patients' who displayed increasingly florid and dangerous psychotic symptoms until others were finally convinced of the illness and provided hospitalization, at which point the patients were able to relax their symptomatology, having succeeded in communicating their need for help. Finally, there are heart-warming stories of impossible patients who finally came to form a good relationship with an understanding doctor and thereafter dramatically improved. As with the other of exemplary tales, these relationship stories seem to centre on proof of the rightness of the position taken by staff.³⁸

The ideological or interpretative implications of management's activity seem to focus on two issues, the nature of patients and

38. Patients, of course, have their own set of exemplary tales almost equally discrediting of staff.

the nature of the hospital's activity, in both cases bolstering up the medical-service definition of the situation.

The key view of the patient is: were he 'himself' he would voluntarily seek psychiatric treatment and voluntarily submit to it, and, when ready for discharge, he will avow that his real self was all along being treated as it really wanted to be treated. A variation of the guardian principle is involved. The interesting notion that the psychotic patient has a sick self and, subordinated to this, a relatively 'adult', 'intact', or 'unimpaired' self carries guardianship one step further, finding in the very structure of the ego the split between object and client required to complete the service triad.

The case record plays a role here. It provides a means of systematically building up a picture of the patient's past that demonstrates that a disease process had been slowly infiltrating his conduct until this conduct, as a system, was entirely pathological. Seemingly normal conduct is seen to be merely a mask or shield for the essential sickness behind it. An over-all title is given to the pathology, such as schizophrenia, psychopathic personality, etc., and this provides a new view of the patient's 'essential' character.³⁹ When pressed, of course, some staff will allow that these syndrome titles are vague and doubtful, employed only to comply with hospital census regulations. But in practice these categories become magical ways of making a single unity out of the nature of the patient – an entity that is subject to psychiatric servicing. Through all of this, of course, the areas of 'normal functioning' in the patient can be discounted and disattended, except in so far as they lead the patient willingly to accept his treatment.

The response of the patient to hospitalization can itself be nicely handled by translating it into a technical frame of reference, whereby the contribution of the hospital to the patient's trouble becomes incidental, the important thing being the internally generated mode of disturbance characteristic of the patient's conduct. Interpersonal happenings are transferred into the patient, establishing him as a relatively closed system that can be

39. The social psychology of perceived 'essential' character has recently been developed by Harold Garfinkel in a series of unpublished papers, to which I am much indebted.

thought of as pathological and correctable. Thus an action that the patient engages in with an official of the institution that may, to the official, have an aggressive cast is translated into a substantive term like 'aggressivity' that can be located well within the patient.⁴⁰ Similarly, a ward situation in which nurses do not bother to initiate contact with long-term patients (who in fact would respond to overtures) may be transferred into the patient by referring to him as 'mute'.⁴¹ As Szasz has suggested, this view has similarities to the earlier view that the mental patient has a devil or evil spirit within him that must be and need only be exorcized.⁴²

This translation process can be clearly seen in the process of group psychotherapy. In general this therapy – the principal verbal therapy patients in state hospitals receive – begins as a gripe session during which patients express demands and complaints in a relatively permissive atmosphere, with relatively direct access to a staff member. The only action on the part of the therapist that seems consistent with his obligation to the institution and his profession is to turn these demands aside by convincing the patient that the problems he feels he is having with the institution – or with kin, society, and so forth – are really *his* problems; the therapist suggests that he attack these problems by rearranging his own internal world, not by attempting to alter the action of these other agents. What we have here is a direct,

40. See John Money, 'Linguistic Resources and Psycho-dynamic Theory', *British Journal of Medical Psychology*, XXVIII (1955), pp. 264–6. Useful examples of this translation process are found in Edwin Weinstein and Robert Kahn, *Denial of Illness* (Springfield, Ill.: Charles Thomas, 1955). The authors cite such terms as 'akinetism', 'Anton's syndrome', 'reduplicative paramnesia', 'anosognosia', which have been used traditionally to refer to a patient's failure to admit his injured condition; they then describe under categories such as 'displacement', 'misnaming', 'paraphasia' the various ways in which patients decline to respond to their situation in a civil and cooperative way, the intransigence being described as a psycho-physiological by-product of brain injury, not as a social response to involuntary threatening treatment. See also Belknap, *op. cit.*, p. 170.

41. Robert Sommer, 'Patients who grow old in a mental hospital' *Geriatrics*, XIV (1959), p. 584.

42. T. S. Szasz, W. F. Knoff, and M. H. Hollender, 'The Doctor-Patient Relationship and Its Historical Context', *American Journal of Psychiatry*, CXV (1958), p. 526.

although no doubt not intentional, effort to transform the patient in his own eyes into a closed system in need of servicing. Thus, to cite a relatively extreme example, I have seen a therapist deal with a Negro patient's complaints about race relations in a partially segregated hospital by telling the patient that he must ask himself why he, among all the other Negroes present, chose this particular moment to express this feeling, and what this expression could mean about him as a person, apart from the state of race relations in the hospital at the time.⁴³

One of the most intimate service redefinitions of the patient's nature is to be found in the idea of the 'danger mandate' characteristic of many of the tinkering services. It has been said that a medical student becomes a doctor when he finds himself in a position to make a crucial mistake.⁴⁴ Underlying this attitude is a belief that a serviceable system has organizational danger points and can therefore be greatly damaged if unskilled action is taken in these crucial, precarious matters. As already suggested, this tends to provide rational grounds for a technical hierarchy of skill and a social hierarchy of servers within any one servicing establishment.

There is a version of the danger mandate in mental hospitals. This is the view that a wrong action can greatly endanger the patient, and that the psychiatrist is in a position, due to training and skill, to take potentially dangerous actions regarding patients, actions that lesser persons in the medical hierarchy ought not to be allowed to take. Of course, in questions of prescribing drug dosage and weighing possible contra-indicating side effects of physical treatment, the model here holds well enough, but the

43. The techniques employed by group psychotherapists can be studied as part of small-group indoctrination methods. For example, one commonly finds that a few patients will be well versed in the psychiatric line and reliably willing to take it. A gripe raised by a patient may then be picked up by the therapist and referred back to these patients for their opinion. They translate for the complainer, showing that his own fellows see his complaint as part of his own personality, leaving the therapist to come in with the authoritative translation, but now with some of the group polarized against the complainer. A recent discussion of these issues may be found in Jerome D. Frank, 'The Dynamics of the Psychotherapeutic Relationship', *Psychiatry*, XXII (1959), pp. 17-39.

44. Personal communication from Howard S. Becker.

carry-over into the psychotherapeutic realm is more precarious, although often no less insisted on. It is sometimes suggested that lesser personnel, such as social workers, nurses, and attendants, ought not to engage in 'amateur therapy', and certainly not in amateur 'psychoanalysis'. A staff psychiatrist who takes on an inmate for special sessions of psychotherapy ought not to have his work tampered with by others, especially lesser others. The wrong move during psychotherapy, it is said, can 'precipitate' a psychosis, or cast the patient back into a regression from which he may never return, and exemplary tales provide evidence for this. Now while it is perfectly clear that this view fits in well with the traditional notion of a danger mandate, and while it is clear that the possession of this mandate confirms one's view of self as an expert server, it is much less clear that a purely verbal act can in fact have this effect. In any case, as previously suggested, any hospital inmate in personal therapy is likely to be undergoing, during the other twenty-three hours of each day, a barrage of potentially traumatic experiences, relatively uncontrolled in barbarity, that surely cloud any issue of a verbal probe going in the right or wrong direction. Moreover, given the state of psychiatric knowledge and skill, if a wrongly placed verbal shaft could cause this kind of damage, patients would be in danger indeed during the twenty-fourth hour.

Two further imputations about the patient's nature may be described, both of which again function to support the service model. When a patient is offered a discharge and declines to take it, sometimes engaging in activity calculated to assure his retention, it is commonly said that this proves he is still ill, that he is, in fact, too ill to leave. In this way a link is made between two massive aspects of the situation: being defined as ill or well, and being in or out of the hospital. There are of course many good reasons unconnected with the service model for a patient's diffidence about leaving. For example, he has already suffered the stigma of being a mental patient and in this reduced status has even poorer prospects on the outside than he did before he came in; furthermore, by the time he is ready to be discharged he is likely to have learned the ropes in the hospital and have worked himself up to a desirable position in the 'ward system'.

The other patient action that is rationalized in terms of the medical model is that of sudden alteration in propriety of conduct. Since the current conduct of the patient is supposed to be a profound reflection or sign of his personality organization – his psychic system – any sudden, apparently unprovoked, alteration in either a 'healthy' or a 'sick' direction must somehow be accounted for. Sudden changes for the worse are sometimes called relapses or regressions. Sudden changes for the better are sometimes called spontaneous remissions. Through the power of these words the staff can claim that, although they may not know what caused the change, the change can be handled within the medical perspective. Of course, this interpretation of the situation precludes one's employing a social perspective. In what is called sudden regression, the new conduct may involve no more or less illness or health than any other alignment to life; and what is accepted as spontaneous remission may be a result of the patient's not having been sick in the first place.

I am suggesting that the nature of the patient's nature is redefined so that, in effect if not by intention, the patient becomes the kind of object upon which a psychiatric service can be performed. To be made a patient is to be remade into a serviceable object, the irony being that so little service is available once this is done. And the great shortage of psychiatric staff can be seen as created not by the number of ill persons but by the institutional machinery that brings to this area the service definition of the situation.

I want now, finally, to consider the definitions that the staff maintain regarding the nature, not of the patient, but of the hospital's action upon the patient. Since the staff possess the voice of the institution, it is through these definitions that the administrative and disciplinary machinery of the hospital is presented to the patient and to the public. In brief, we find that the facts of ward management and the dynamics of the ward system are expressed in the language of psychiatric medical service.

The patient's presence in the hospital is taken as *prima facie* evidence that he is mentally ill, since the hospitalization of these persons is what the institution is for. A very common answer to a patient who claims he is sane is the statement: 'If you aren't sick, you wouldn't be in the hospital.' The hospital itself, apart from

the therapeutic services administered by its trained staff, is said to provide a sense of security for the patient (sometimes only to be obtained by knowing that the door is locked)⁴⁵ and a release from daily responsibilities. Both of these provisions are said to be therapeutic. (Whether therapeutic or not, it is difficult to find environments which introduce more profound insecurities; and what responsibilities are lifted are removed at a very considerable and very permanent price.)

Other translations can be mentioned. Regimentation may be defined as a framework of therapeutic regularity designed to allay insecurity; forced social mixing with a multitude of heterogeneous, displeased fellow inmates may be described as an opportunity to learn that there are others who are worse off. Sleeping dormitories are called wards, this being affirmed by some of the physical equipment, notably the beds, which are purchased through hospital suppliers. The punishment of being sent to a worse ward is described as transferring a patient to a ward whose arrangements he can cope with, and the isolation cell or 'hole' is described as a place where the patient will be able to feel comfortable with his inability to handle his acting-out impulses.⁴⁶ Making a ward quiet at night through the forced taking of drugs, which permits reduced night staffing, is called medication or sedative treatment. Women long since unable to perform such routine medical tasks as taking bloods are called nurses and wear nursing uniforms; men trained as general practitioners are called psychiatrists. Work assignments are defined as industrial therapy or as a means through which the patient can express his reawakened capacity for assuming civil duties. Reward for good behaviour by progressively increasing rights to attend socials may be described as psychiatric control over the dosage and timing of social exposure. Patients housed where treatment is first given are said to be in the 'acute' service; those who fail to leave after the initial cycle of medical action are moved to what is called the 'chronic service'

45. Of the more than hundred patients I knew in the hospital I studied, one did allow that he felt too anxious to go more than a block or so from his ward. I knew, or knew of, no patient who preferred a locked ward, except patients described by staff.

46. See, for example, Belknap, *op. cit.*, p. 191.

or, more recently, 'continued-treatment wards'; those ready to leave are housed in a 'convalescent ward'. Finally, discharge itself, which at the end of a year tends to be granted to most first-admission, averagely cooperative patients or to any other patient for whom kinfolk exert pressure, is often taken as evidence that 'improvement' has occurred, and this improvement is tacitly imputed to the workings of the institution. (Among the reasons for discharge of a particular patient may be ward population pressure, spontaneous remission, or the social conformity instilled in him by the disciplinary power of the ward system.) Even the concise phrases, 'discharged as cured' or 'discharged as improved', imply that the hospital had a hand in the curing or improving. (At the same time, failure to be discharged tends to be attributed to the difficulty of treating mental disorder and to the stubbornness and profundity of this kind of illness, thus affirming the medical model even in the face of not being able to do anything for the patient.) In fact, of course, a high rate of discharge might just as well be taken as evidence of the improper functioning of the hospital, for since little actual treatment is available, the improvement of the patient occurs in spite of hospitalization, and presumably might occur more frequently in circumstances other than the deprived ones within the institution.

Some of the verbal translations found in mental hospitals represent not so much medical terms for disciplinary practices as a disciplinary use of medical practices. Here the lore of state mental hospitals contains some exemplary tales for sociologists. In some mental hospitals, it has been said, one way of dealing with female patients who became pregnant on the hospital grounds was to perform hysterectomies. Less common, perhaps, was the way of dealing with those patients, sometimes called 'biters', who continued to bite persons around them: total extraction of teeth. The first of these medical acts was sometimes called 'treatment for sexual promiscuity', the second, 'treatment for biting'. Another example is the fashion, now sharply declining in American hospitals, of using lobotomy for a hospital's most incorrigible and troublesome patients.⁴⁷ The use of electro-shock, on the

47. I have been told of manic mental patients who were tubercular and for whom lobotomy was prescribed lest their hyperactivity kill them. This is

attendant's recommendation, as a means of threatening inmates into discipline and quietening those that won't be threatened, provides a somewhat milder but more widespread example of the same process.⁴⁸ In all of these cases, the medical action is presented to the patient and his relatives as an individual service, but what is being serviced here is the institution, the specification of the action fitting in to what will reduce the administrator's management problems. In brief, under the guise of the medical-service model the practice of maintenance medicine is sometimes to be found.

CONCLUSION

IX

In citing some senses in which mental hospitalization does not fit the medical-service model, I have not mentioned the difficulties in applying the model to outpatient private psychiatric practice, although these of course exist (such as: the length of time required for treatment, with consequent strain on the concept of the fee; the low probability of effective treatment; and the very great difficulty of knowing to what to attribute change in the patient's condition).

Further, in focusing on the difficulties of the application to the mental hospital of the medical-service model, I do not mean to imply that the application of the model has not sometimes proved useful to those institutionalized as patients. The presence of medical personnel in asylums has no doubt served to stay somewhat the hand of the attendant. There seems little doubt that doctors are willing to work in these unsalubrious, isolating environments because the medical perspective provides a way of looking at people that cuts across standard social perspectives and therefore provides a way of being somewhat blind to ordinary tastes and distastes. The availability of the medical version of one's situation has no doubt provided some patients with a claim on

a decision that does involve the personal service, not the maintenance, function of medicine. It may be repeated that the act itself is not the determining issue but rather the organizational context in which it is recommended.

48. See Belknap, *op. cit.*, p. 192.