Labeling theory of mental illness:
A critique illustrated by two case histories
Siri Gullestad and Finn Tschudi


Currently, the labeling approach to deviant behavior is quite popular. In this article Scheff's sociological theory of mental illness is singled out for critical discussion. Does labeling act as a causal factor in the development of mental illness as stated by this theory? The theory is found insufficient because it neglects the subjective experience of labeling. Rosenhan's well-known study of "pseudo patients" may support the "stickiness" of the label for the staff, but the crucial question is whether it "sticks" for the patient.

Scheff's operationalization of labeling makes it equivalent to Buber's "I-it" relations. This is found to be a rather one-sided view of diagnosis. Our case histories illustrate that diagnosis cannot be fruitfully described independently of the patient's reaction. The crucial question is how the diagnosis fits in with the patient's own standards. The case histories further show that a similar analysis holds for patients' reaction to the behavior of the staff, an area that is somewhat neglected in the labeling approach. ☐ Diagnosis, hospitalization, labeling, mental illness, schizophrenia.

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The labeling theory of mental illness has gained considerable influence. One reason for this popularity is probably the fact that it is regarded as a necessary antidote to traditional psychiatric theory. The labeling theory, by emphasizing how society's labeling (diagnosis, hospitalization) operates as an agent creating mental illness, has contributed to a general critical attitude towards hospitalization and influenced the ongoing discussion of deinstitutionalization (e.g. Goffman 1961). Although the labeling perspective, broadly considered, represents a sound awareness of the importance of social reaction, it is our contention that the labeling theory is insufficient in the understanding of mental illness and suffers from severe theoretical weaknesses. The sociological determinism implied in the theory neglects the individual as a psychological being, i.e., the fact that a person's reaction to being labeled mentally ill will depend upon the meaning he or she attributes to this experience (cf. Becker 1972), i.e., how the person construes the situation to use Kelly's (1955) phrase. This basic point has not received sufficient attention in the labeling theory.

A critical discussion of the labeling theory seems important, because the sociological determinism implied in the theory gives rise to simplistic solutions to complex problems (e.g. the position that psychiatric hospitals are superfluous because mental illness is just a result of labeling), and also because the labeling theory is uncritically accepted in widely used textbooks (Hilgard et al. 1979, Ullmann & Krasner 1975).

In this article we shall single out Scheff's (1966, 1975a, b) influential sociological theory of mental illness for special discussion, since it is the most systematic version of labeling theory. We shall outline the central tenets of the theory and discuss some of the controversy it has given rise to. The theoretical discussion is further elaborated through the presentation of two case histories from Reitgjerdet Hospital, a well-known Norwegian state hospital for "especially dangerous and difficult psychotic men". Our case studies illustrate that even though the labeling be massive, it is improbable that it acts as a causal factor in the way implied by labeling theory.

Scheff's theory
Scheff (1966) views psychiatric symptoms as violations of social norms. Crime, perver-
sion, treason, and bad manners are examples of labels of readily identified norm violations. Having exhausted such violations "there is always a residue of the most diverse kind of violations for which the culture provides no explicit label". Scheff singles out violations of "the norm governing decency and reality", and further states that "each culture tends to reify its definition of decency and reality" (pp. 33, 34). As an example of "norms of decency and reality" he quotes Goffmann's (1964) so-called "rule of involvement", e.g. the rule requiring that an adult be "involved" when in public. "Awayness", e.g. withdrawal or "inward emigration" from other people, is a violation of this rule. "Occult involvement" (hallucinations) is an example of "awayness", and is, apart from some highly specialized contexts, behavior likely to be regarded as severe deviation. In this way, psychiatric symptoms may be seen as residual rule-breaking.

Scheff views mental illness as a "career". This implies a process-oriented perspective. The central variable in this process is the dimension labeling vs denial. If residual rule-breaking occurs, the crucial event is whether, and the extent to which, the deviance is publicly recognized (labeled). This is stated in Scheff's most central hypothesis (No. 9): "Among residual rule-breakers, labeling is the single most important cause of careers of residual deviance" (p. 92). Conversely, nothing much happens if labeling does not occur (denial): "Most residual rule-breaking is 'denied' and is of transitory significance" (hypothesis 3, p. 51). Denial implies ignoring or rationalizing the rule-breaking behavior.

Hypothesis 9 may be seen as inverting the common sense and medical view that public recognition (e.g. hospitalization) is a necessary consequence of a pre-existing disorder. The attraction of the labeling theory may reside precisely in this sharp departure from common sense (cf. the similar perspective in criminology where the labeling theory emphasizes how "prisons create criminals" rather than "criminals create prisons"). In this theory, the disordered behavior of chronic patients is seen as the final stage in a deviant career, which has been shaped mainly by the public reaction. Scheff here draws on Lemert's (1951) distinction between primary and secondary deviation. Primary deviation is defined as original rule-breaking, and is judged to be relatively harmless (cf. hypothesis 3). Secondary deviation occurs when a person, after having been labeled a deviant, is led to behave according to others' expectations (self-fulfilling prophecy).

According to this conceptualization, we have different types of deviance, more or less characterized by secondary deviation. If the deviant career is (almost) exclusively determined by the social reaction, we have a pure labeling case. Lemert (1972) discusses stuttering as an example. At the other extreme, which may be called a pure dispositional case, the final state is exclusively determined by the initial state, the social reaction being irrelevant. The course of untreated paresis might be an example.

To what extent should mental illness be seen as a pure labeling case? Unfortunately Scheff does not discuss this question. However, it is probably fair to say, as Murphy does in her thorough review of labeling theory, that "labeling theorists have tended to use the 'pure case model'" (1976, p. 1020). Hypothesis 9 is clearly consistent with this view.

In discussing labeling theory a sharp conceptual distinction between individual behavior and social reaction is necessary. Becker's (1963, p. 20) 2x2 classification of types of deviant behavior may be useful in this regard, although it should be borne in mind that it is a simplification, and that the terminology may occasionally sound awkward. Table 1 introduces Becker's terminology, added features are explained later. The occurrence of pure deviant and conforming behavior is trivial; it appears con-
Table 1. Typology of deviant behavior and a representation of the central hypotheses of labeling theory vs dispositional theory.

<table>
<thead>
<tr>
<th>Indivdual behavior</th>
<th>Not perceived as deviant</th>
<th>Perceived as deviant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>denial (ignoring)</td>
<td>labeling (Scheff)</td>
</tr>
<tr>
<td></td>
<td>sane context</td>
<td>insane context (Rosenhan)</td>
</tr>
<tr>
<td>Rule-breaking behavior (e.g. &quot;insanity&quot;)</td>
<td>secret deviant</td>
<td>Dispositional theory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scheff Hyp. 3</td>
</tr>
<tr>
<td>Obedient behavior (e.g. &quot;sanity&quot;)</td>
<td>conforming</td>
<td>Dispositional theory</td>
</tr>
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founded, and it would not be possible to ask questions as to the relative importance of the two factors. Conversely one may argue that the subsequent fate of persons in such incongruous cases may throw crucial light on the relative importance of personal dispositions versus social reaction.

Consider first the case of secret deviance, where the rule-breaking behavior is not followed by labeling (denial). From a labeling perspective one would expect the person to slip back in line, that is a movement from secret deviant to conforming, and this is exactly what Scheff says in hypothesis 3. cf. the left vertical arrow in Table 1. A dispositional model, however, would see the rule-breaking as expressing some inner determinants; the rule-breaking would continue regardless of initial "denial" and eventually pull forth a labeling reaction (e.g. "chronic patient"), cf. the top horizontal arrow.

Consider next the falsely accused. A dispositional model would of course imply that the person’s nature would win out and he/she would slip back from falsely accused to conforming, cf. the bottom horizontal line in Table 1. From the labeling point of view one would expect the social reaction to win out, and we would end up with pure deviant, cf. the right vertical arrow.

One could, however, discuss whether Scheff can make any definite statement on the fate of the falsely accused, since hypothesis 9 seems to take it for granted that residual rule-breaking must have occurred if a deviant career is to take place. On the other hand, Scheff emphasizes that the prevalence of residual rule-breaking is "extremely high" (1966, p. 47), so perhaps most of us might in principle risk having some of our behavior singled out for labeling. Furthermore, Scheff emphasizes vicious circles in his process-oriented view: "the more the rule-breaker enters the role of mentally ill, the more he is defined by others as mentally ill, but the more he is defined mentally ill, the more fully he enters the role and so on" (pp. 97, 98). This, he notes, is what is often referred to as a "deviation amplifying system", and it is well known that in such systems the initial state may be of little importance for the final state, cf. Tschudi (1977). As Murphy (1976, p. 1020) states: "the primary deviation of mental illness is held to be for the most part insignificant and social reaction becomes the main etiological factor".

It may be helpful to think of obedience vs rule-breaking not as a dichotomy but as a dimension with many steps on the road to extreme rule-breaking (insanity). The basic point is not where the person starts but that being labeled as more deviant than is warranted will tend to escalate the rule-breaking. From the labeling point of view all persons characterized as pure deviant have in some sense earlier been falsely accused.

Note that the present causal interpretation of a dispositional model versus a labeling model closely follows the pattern of reasoning underlying the use of cross-lagged correlations in unravelling causal factors in non-experimental settings, see e.g. Neale
& Liebert (1980) for an introductory exposition. As already stated, the vertical arrows in Table 1 illustrate a pure labeling case. The horizontal ones a pure dispositional case. In practice one might expect both types of movement to occur; the relative preponderance of one or the other type of movement would then indicate the extent to which we have a mixed case.

Discussion of the theory

Previously, most of the critical discussion of the labeling theory has focused on the various contingencies leading to labeling that lie outside the patient and his/her behavior. The labeling theory logically requires that a variety of circumstances extrinsic to the behavior determines the labeling reaction, else labeling would simply be a logical consequence of deviant behavior and could not have its own causal influence. According to Scheff, the social status of the rule-breaker is an essential factor here, the low-status, powerless, people being more likely to be labeled. This part of the theory has been seriously challenged by Gove (1970, 1975, 1980). For instance, Gove & Tudor (1973) dispute that those with less power are more likely to be hospitalized, and contend that the available evidence shows that men are more likely than women to be hospitalized as psychotic, though generally men have more power than women. Generally, Gove finds labeling to be a natural reaction to deviant behavior (for further discussion of this, see Scheff 1975a).

Labeling theorists generally emphasize that it is arbitrary what is labeled mental illness. Both Scheff and Rosenhan draw on Benedict’s (1934) cultural relativism. Murphy (1976) strongly contests this view by drawing on painstaking anthropological work. She concludes that regardless of cultural context there are some states (e.g. hallucinations, delusions) which are always recognized as insane, and which are not confused with e.g. shamanism. Her position implies that Scheff’s “norm of decency and reality” is not just a cultural reification but reflects universal concerns shared by all peoples.

Neither Gove nor Murphy, however, directly treat the central issue of the relative importance of social reaction versus individual disposition for understanding the course of mental illness. In his by now classic study “On being sane in insane places” Rosenhan (1973) addresses himself to this issue. Since Scheff (1975a) can find no other study providing stronger support for labeling theory, we will consider this study in some detail.

Rosenhan’s main question is “do the salient characteristics that lead to diagnosis reside in the patients themselves or in the environments and contexts in which observers find them”? (p. 55). Emphasizing context, falsely accused should not be recognized as sane, but should be labeled “insane”. Rosenhan and seven of his coworkers falsely gained access to mental hospitals as “pseudopatients” and behaved as if they felt normal under the circumstances. After an average of 19 days they managed to get released and, except for one person, with the diagnosis “schizophrenia in remission”. Rosenhan’s conclusion, that these experiences “support the view that psychiatric diagnosis betrays little about the patient but much about environment”, has been severely criticized. Spitzer (1975, 1976) and Farber (1975) forcefully argue that it is inappropriate to generalize just about anything from Rosenhan’s pseudopatients to ordinary patients (see also Rosenhan, 1975 for a rejoinder).

The central question in the present context, however, is whether Rosenhan’s study can be said to support the main hypothesis of labeling theory, namely that “labeling is the single most important cause of careers of residual deviance”. This issue does not seem to have been raised in the discussion. Rosenhan claims that a psychiatric label has an influence of its own, and that “diagnosis acts on the patients as a self-fulfilling prophecy. Eventually, the patient accepts the diagnosis with all its surplus meaning and acts accordingly.” (1973, p. 62). Rosenhan, however, nowhere provides support for saying that the labeled person “fully entered the role” (Scheff), or that a self-fulfilling prophecy was taking place; e.g. that the pseudopatients actually turned insane. On the contrary, falsely accused pseudopatients all
stayed normal, got out of the hospital, and continued a normal life. Rosenhan himself gained wide acclaim by writing the article here under discussion! His results, then, are very much consistent with the dispositional interpretation, cf. the bottom horizontal arrow leading from falsely accused to conforming in Table 1. Rosenhan chooses not to emphasize this fact (is it regarded as too obvious?). We find it deplorable that Scheff refers to Rosenhan as a major support, whereas Rosenhan ends by referring to Scheff. What would be relevant evidence is nowhere supplied.

Rosenhan emphasizes the "stickiness" of the label; once applied it tends to persist, and this is seemingly supported by the diagnosis of "schizophrenia in remission" at release. Spitzer claims that this conclusion is unwarranted, since he finds that this diagnosis is very rarely used. It may rather be seen as a tacit recognition of "normality", he argues. While acknowledging Spitzer's arguments, Farber is more inclined to side with Rosenhan on this issue, and he points to a possible "overjustification of original judgement" (1975, p. 612). We might add that recent work in social psychology provides ample evidence of a variety of mechanisms which may sustain "theories" despite really confirming evidence (Nisbett & Ross 1980). Rosenhan's study thus alerts us to the possibility that self-fulfilling prophecies may be operative for staff, but not necessarily for the patients, as Scheff implies.

Consider now the second group of interest to our discussion, the group of secret deviant persons. What is the implication of a pure context model for secret deviance? Table 2, which has the same structure as Table 1, shows the contrasting implications of a pure context model and a pure dispositional model for how persons will be judged for incongruous cases.

Unfortunately Rosenhan does not discuss the secret deviant case (upper left cell in Table 2). Since, however, Rosenhan (1975) does not deny the possibility of valid individual diagnosis, his position does not imply a pure contextual model as in Table 2b. Such a model would provide no basis for distinguishing different individual dispositions.
His position is thus consistent with the (hypothetical) pattern in Table 2c. This might be called a conjunctive or mixed model of sanity, both disposition and environment are necessary for sanity.

On the other hand, Scheff’s theory has an explicit hypothesis concerning secret deviance. Labeling theory states that secret deviance is of transitory significance (cf. hypothesis 3) and suggests that the secret deviant will slip back in line and become conforming. Scheff does not, however, give convincing evidence to support this contention. Murphy, in her study, also considers the consequences of unlabeled mental illness. She finds for instance that Eskimos and Yorubas lack words to identify what in our society would be called psychoneurotic patterns. Her point is that even if “. . . these symptoms are unlabeled, ( . . . ) they do exist. People recognize them and try to do something about them” (1976, p. 1024). Some of them are transient; others are life-long characteristics. From our own society, we also know that a person can have a life-long career as a severely handicapped neurotic, without being labeled a mental patient. Thus, there seems to be little evidence supporting the hypothesis of the labeling theory that secret deviants usually become conforming.

Furthermore, Scheff’s preference for denial rather than labeling (cf. hypothesis 3 vs hypothesis 9) raises some puzzling problems. What does it mean that the rule-breaking should be ignored or rationalized? This amounts to the paradoxical recommendation of “active ignoring” (cf. Elster 1981) that is really a special form of attention. Passive ignoring, by contrast, simply involves not having any deliberate attitude towards the eccentric person, scolding the person if he or she is a nuisance and letting the person do his or her own thing when no one is bothered by the behavior. Active ignoring would tend to be a form of over-protection, i.e., the contrary of respecting the rule-breaker as a responsible person.

Another neglected question is what it means for an individual if he or she feels that the hold on reality seems to slip, and that the symptoms are ignored or rationalized. This may be as anxiety-provoking as any labeling, and may indeed create even more doubts in the person about his or her own grip on reality! Essentially the same point has been made by Valins & Nisbet (1971), who argue that diagnostic labels may give the person support against the darker fears which might otherwise lead the person into vicious circles of self-escalation.

Concluding this discussion, we note that Scheff (1966) argues that his own limited focus on social processes represents a necessary reaction to the standard psychiatric exaggeration of the importance of individual processes (pp. 25-27). The approach that Scheff reacts against may well be found guilty of “emptying the environment”. But this is not rectified by going to the opposite extreme of “emptying the organism”, as Scheff does. The thesis of the present paper is that we must struggle to conceptualize jointly the person and the environment, or rather person-in-situation. Scheff further states that “the intentional formulation of mutually incompatible models, each incomplete is one road of progress in science. . . .” (p. 27) and cites Whitehead who says that “a clash of doctrines is not a disaster—it is an opportunity”. Of course, a clash of doctrines can retrospectively be seen as an opportunity, but it is absurd to turn it into a purpose for a theory. Fruitful disagreement belongs to the class of phenomena—like self-respect—that are essentially by-products, i.e. that cannot be intentionally brought about (cf. Elster 1981).

Interpreting Scheff’s theory with goodwill, one could of course say that a theory has to isolate some causal mechanisms, holding others constant. This seems to be Scheff’s intention: “. . . The social system model ‘holds constant’ individual differences, in order to articulate the relationship between society and mental disorder” (1966, p. 25). Holding individual differences constant means, however, that one cannot say anything about the relative importance of societal reaction and individual disposition. But this is exactly what Scheff does later on. His self-critical attitude—limiting the pretensions of the theory—therefore gets the character of a ritual.
Case studies

It should be understood that commitment to Reitgjerdet Hospital is a very strong societal reaction. There is an aura of gruesomeness surrounding the institution, which has been described as the "backyard of Norwegian psychiatry". One is reminded of Foucault's (1961) analysis of asylums in the age of enlightenment, where he describes how irrationality was projected on the insane so that the "normals" could be relieved of being confronted with forces of darkness. In fact, psychiatric scandals connected with Reitgjerdet Hospital could be seen to support the view that there may be more madness in the labeling system than in the individual being labeled.

Several factors contribute to making commitment to Reitgjerdet a harrowing experience. Since it is a state institution a large proportion of the inmates will be highly isolated from their home place, completely deprived of daily points of reference. Furthermore, the institution is notorious for not respecting personal dignity. It has been a customary procedure to strap down newly arrived patients (cf. Goffmann's well-known description of mortification rituals). Complete seclusion with scarcely any possibilities for leaves of absence has been customary.

Thus, Reitgjerdet Hospital may be seen to represent an extreme labeling, as defined in the labeling theory. The variable "labeling" is regarded by Scheff (1975b) as a continuum, and is defined as "the degree of categorization—the degree to which a human being is reduced to a single category" (p. 77). Scheff relates the end-points of this dimension to a number of dichotomous conceptions and singles out Buber's "I—it" vs "I—thou" as most central. Extreme labeling epitomizes I—it; the other is treated as an object, as nothing but a deviant. Extreme denial corresponds to a complete I—thou relation. Encounters take place with no agenda; one is sensitive to the total experience of the other.

How is the label experienced?

Does labeling lead to self-fulfilling prophecies? Further, does labeling, especially diagnosis, necessarily imply I—it relations? Our two case histories serve to illuminate why such questions are not likely to be answered in accordance with the labeling theory. We want to suggest that other questions may prove more fruitful.

Consider first Y, a 30-year-old man who has always led a confused existence. From the age of twenty-two he developed paranoid ideas: he felt that people stared and laughed at him, felt persecuted, and believed that people wanted to kill him. He was hospitalized in a psychiatric institution at the age of twenty-five.

Y himself sought psychiatric help because he felt confused to the point of beginning to doubt his own sanity. He began to label himself "mad". According to the labeling theory the hypothesis would be that a self-fulfilling prophecy had already been created: Y's reaction would be seen as basically an internalization of previous societal reactions. This seems untenable, however, considering that the reaction of the environment was one of "denial". "Denial is to 'normalize' the rule-breaking by ignoring or rationalizing it" (Scheff 1975a, p. 10). Scheff's hypothesis is that denial will be followed by return to normality (cf. our previous discussion of secret deviance).

In Y's case, however, we have a person insisting that he was "turning mad", in spite of the fact that his family—the idea of having an insane member arousing strong resistance—tried to find more normal explanations of his behavior. This indicates that Y began to doubt his own sanity as a result of an internal evaluation: he no longer understood his own reactions, and as a consequence his self-image started to break down. He thus labeled himself before he was labeled by the environment. Note that this is a common complaint against the labeling theory, for instance Gove (1980) sharply argues that denial is a prevalent reaction to madness, but that this usually does not prevent the development of insanity. So far this illustrates how labeling may in many cases better be seen as a final consequence of residual rule-breaking and not as instigating self-fulfilling prophecies.
In answering whether an official diagnosis reflects an I-it relation, one should first consider how the person experiences the labeling. At the time of his first hospitalization Y found the diagnosis of mental illness quite understandable. Besides, this signified for him that he was finally to be helped, since he was now surrounded by professional people (a possible effect of diagnosis which Scheff completely ignores). It is difficult to see how a diagnosis that does nothing but confirm the person’s own self-conception can have any effect in producing a patient-career. The basic question is how the diagnosis fits in with one’s own standards.

A more complicated analysis of diagnosis than the one proposed by Scheff seems called for. Scheff’s position implies that there is an a priori incompatibility between diagnosis and an I-thou attitude. Conversely: “The attitude of I-thou encompasses, in part, the attitude of denial. The individual is accepted for what he is without judgment, comparison, evaluation, or criticism” (Scheff, 1975b, p. 79). We agree with Scheff that an I-thou attitude is one of understanding the other as he is, without criticism. But we do not think that such an attitude is incompatible with “comparison, evaluation...”. On the contrary, in some cases it may be necessary to compare and evaluate to be able to understand properly. Scheff’s theoretical position seems to be a rather naive version of the old hermeneutical Verstehen approach within the humanities and the social sciences (on the “Verstehen” approach, cf. Gadamer 1960, Habermas 1968). The crucial point is what should be understood by “diagnosis”. If diagnosis implies reducing the individual “...to an abstraction rather than seeing him in his full complexity” (Scheff 1975b, p. 79), it of course represents an I-it attitude. And Scheff is right that this is the case in much psychiatric practice. Diagnosis might, however, also be a way to understand the individual in his/her complexity, as we have in clinical evaluation with a view to psychotherapy. We should not forget that diagnosis literally means to discern, discriminate. Thus, diagnosis does not necessarily represent an I-it attitude. A more basic point is the difficulty of giving an objective defi-

nition of labeling. Y experienced the labeling implied in diagnosis as fitting in with his own standards, whereas another patient might have experienced the same labeling as alienating and objectifying.

The story of X will provide a different vantage point for emphasizing the importance of how the person experiences the diagnosis. X is a mentally retarded 60-year-old-man. After having been arrested for indecent exposure, he spent several years in various institutions, and was then transferred to Reitgjerdet where he was to spend the next 20 years.

The immediate event that led to his transfer to Reitgjerdet was that he showed seriously confused behavior, was violent, and had shown increasing autistic behavior. Furthermore, he had several times escaped. He was under preventive detention. This implied that his crime, indecent exposure, was judged to be caused by psychosis, and recidivism was judged likely. Thus, there are two noteworthy features of the diagnosis, his official status: the crime and the label “psychotic”. A crucial and to our knowledge ignored question is whether and in what way the person will register the diagnosis “psychotic”. For X it was clearly the case that it was incomprehensible; it did not carry any meaning for him. He had not understood the point of the forensic observation and the subsequent diagnosis. When directly questioned as to whether he had ever doubted his sanity, he answered “no”. How could he have internalized the label when he had not registered and understood it? This points to a general dilemma of the labeling theory: if a diagnosis does not make any sense to the person, how can it then have any effect? Scheff’s hypothesis that the labeling reaction will be a self-fulfilling prophecy rests on the assumption that it can be described as an unequivocal message. But the case of X illustrates that a one-dimensional conceptualization of the societal reaction may be misleading. In this case the question should not be: What is the effect of the label “psychotic”? but rather: How does the label, the official reaction, fit in with his own standards? For X it was a perfectly comprehensible and reasonable relation between his
action and his transferral to Reitgjerdet. He had committed a crime and as he himself said: "I should not have escaped".

This point may be stated in the language of attribution theory. When one sufficient cause of an outcome (for X incarceration at Reitgjerdet) is found, other possible causes are discounted (see for instance Kelley 1973). X may have followed the simple attribution rule: stop searching for causes when one sufficient cause is found. We think that X’s case may illustrate a rather general state in that the societal reaction rarely will be an unequivocal message “psychotic”. Rather hospitalization will be directly caused by socially offensive behavior (see e.g. Yarrow et al. 1955) which it has been found impossible to deal with in other ways. This behavior may or may not be related to psychosis, as for instance described by Murphy (1976).

Thus, X did not internalize the label insane, although for him the cards should be heavily stacked in favor of “accepting the proffered role”. Scheff’s theory implies that persons with few resources and with few alternatives are more vulnerable to “accept the role of the insane.” (cf. hyp. 8, pp. 88, 96). An attribution analysis suggests a more complicated picture than Scheff’s theory. With limited intellectual resources, as in the case of X, one sufficient cause provides a stable attributional scheme. Other persons may resort to more complex schemes—search for several causes. “Insanity” may then come to be entertained as one contributing factor.

The cases of X and Y illustrate that labeling may be experienced as reasonable, though on different premises. But what if the labeling is experienced as unreasonable?

The last ten years of X’s stay at Reitgjerdet provides a perspective on this question.

After five years’ stay it was decided that the preventive detention should be prolonged, partly because of another episode of indecent exposure. X then looked forward to the day he thought he should be released. However, for rather obscure reasons, this turned out to be the first day of another 10-year stay. “But I did not hear anything! The day I should be released came, and I did not hear anything.” X made every possible attempt to be set free. He tried to talk to the medical director, and was told that he had to stay because “he was ill”. He never got any further explanation. Several times he tried to reach the control commission, but “I never received any answer”, adding, “them people were just runnin’ around, shakin’ hands, but them did nothin’.” He commented on his further attempts to get out: “kept fussin’ but them people did not react”.

Note that during this last 10-year period we are justified in saying that X was “falsefully accused”. Even if the label “psychotic” may have had some validity, one should remember that he was retained in a hospital for “especially dangerous and difficult psychotics”. The Blom-Report states that it is beyond doubt that a large number of patients have been retained at Reitgjerdet without being especially dangerous or difficult. X was one of these patients.

The detention sentence having expired, X saw no reason why he should have to stay there any longer. Several times he returned to this theme of injustice: “I was there ten years too long. Ten years is a long time.” How did he then explain this prolonged internment to himself? Perhaps we might say that he never found a satisfactory answer to this question. In his own words: “What could you say?” His only choice turned out to be what could best be described as a realistic resignation, to make the best out of the position here and now.

We can now compare two different reactions to labeling: In the first period, labeling was experienced as comprehensible and just, not “falsefully accused”. It was readily assimilated, to use Piaget’s concept, except the diagnosis “insane”. In the last period, labeling was experienced as unreasonable and unjust, i.e. “falsefully accused”. Scheff seems to lack the distinction whether the labeling is seen as reasonable or unreasonable. One might, however, argue that it is the latter which is primarily implied, since his interpretation of labeling as I-it implies something meaningless and hard to understand. Our contention, however, is that in neither case will labeling in itself be likely
to lead to internalization; the basic question is how the labeling is experienced. Scheff comments on the psychological situation of the labeled person in hypothesis 8: "in the crisis occurring when a residual rule-breaker is publicly labeled, the deviant is highly suggestible and may accept the proffered role of the insane as the only alternative" (1975b, p. 88). "Highly suggestible" is a key phrase here. This is shallow psychology! The question should rather be: How does the labeling reaction fit in with the person's own standards? In the present context, Scheff's notion of "suggestibility"—something invading the person—seems quite irrelevant. "Unjust" is a perfectly viable construction of something which happens to you and which deeply goes against your moral standards. You fight it in every way at your disposal. You may then, like X, resign and adapt.

Other aspects of societal reaction

So far we have concentrated on the diagnosis, the official status of the patient. Much of the labeling literature centers around this aspect. An emphasis on this feature per se is found in Rosenhan's previously referred to discussion of the "stickiness" of the label. Exclusively focussing on this aspect would, however, make labeling theory rather absurd: something written on a piece of paper does not ipso facto change a person. For the further discussion we may single out at least four different aspects of the societal reaction:

a) diagnosis, official status of the patient
b) behavior of staff towards patient
c) behavior of other patients towards patient
      d) reaction from family
e) reaction from work environment

Having considered a) we shall now discuss how each of the remaining aspects may relate to I–thou. Consider first staff behavior. No less than for diagnosis it is important to conceptualize staff behavior as consisting of several different features. Perhaps one could think of it as a profile where each element could be characterized on a bipolar dimension ranging from extreme "it" to extreme "thou". One might then arrive at an overall assessment on the it–thou dimension either through impressionistic judgment or by some explicit scoring system. Rosenhan vividly describes depersonalization (contrasted with "concern and individuation") and how this leads to powerlessness. This would correspond to a high "fitness".

There are, however, several difficulties with such an approach. A basic problem is whether staff behavior can be evaluated on it–thouness independently of how the "recipient" will construe the behavior. We will argue that this will not generally be the case. What one person may experience as rather neutral, may for another signify a thou–relation. A case in point is one of the staff who made weekly car trips with X to a café downtown. Here they had a cup of coffee and some cakes, which for X was a very nice experience. From different points of view such staff behavior might not much epitomize "thouness": staff might also be seen as if behaving towards a pet dog.

The general point this illustrates may be stated in terms of individual optimal levels of complexity in interpersonal relations. Behavior with a low complexity may be seen as it-relations by a person with high requirements for variety and complexity. An over-riding feature of Rosenhan's description is how very boring he and his coworkers found hospital life to be. On the other hand, for a person with more limited resources, like X, hospital life may, as we shall see, provide adequate opportunities and challenges to foster well-being. For the person with few resources, it may be somewhat easier to make the best out of an unjust situation. There will be a long history of having experienced powerlessness against "the system".

A further problem with the notion of a profile of it–thou elements, is how the person will "weigh" the various elements. To what extent is the person set to emphasize thou versus it? X did, for instance, report one incident when a staff member made a deep incision under his arm with his bunch of keys. Punitiveness is a key feature in Scheff's description of it-relations. X, however, emphasized that this was a unique episode; it carried little weight in his overall evalua-
tion of the staff. Generally, X described quite differentiated reactions to the staff: he felt close to some of them, distant to others, and a few he downright disliked. Our impression is that X generally was inclined to single out positive features of staff behavior; his overall evaluation was quite favorable.

A further point is how the relation between the staff and the system is constructed. We have seen that X clearly differentiated between the hospital system (represented by the medical director and the control commission) to which he reacted negatively, and the staff, to which his reactions were mainly positive. This differentiation was facilitated by the fact that the staff had no power concerning administrative decisions, such as leaves of absence or other privileges. This is quite unlike the usual practice in psychiatric hospitals today where staff routinely participate in all decisions concerning the patients. There may, paradoxically, be beneficial effects of this lack of power for the staff, since they will thus not be likely to be held responsible for detention. They may come to be seen as not so much intrinsically part of the system, and this may provide better grounds for forming viable personal relations with them.

Turning now to relations to other patients, X could again report several positive experiences. He had several friends, "we stuck together". He recalls several names, and for instance well remembers those who gave him gifts or would provide him with cigarettes. X could clearly differentiate those among the patients who had been there too long or who should not have been there at all from those who were really dangerous and agitated and needed to be there. When asked whether he had ever feared becoming like the latter, he answered in the negative.

With regard to relations to his family, he had a sister two years older with whom he had regular contact. She visited him once a year and then stayed a couple of hours. These yearly visits meant much to him, and he looked forward to this visit long in advance. He also regularly corresponded with his sister.

There were several other positive features in X's everyday life. He talked with pleasure about parties for the staff and patients where he could dance with female staff. He very much enjoyed playing the piano and the accordion, which he did quite well. He also followed TV serials. When he talked about his daily life, one could hardly escape the impression that he prospered and felt quite well. When asked about "feeling sad", he answered "rarely". He emphasized the importance of doing the best one could in the situation, to enjoy the positive aspects rather than dwell on the negative ones.

The case of X illustrates that it does not make much sense to summarize the societal reactions on a total it-thou scale, as implied by Scheff. It-thouness cannot be evaluated without considering the person's experience of the social reaction. We should rather consider what possibilities there are for ferreting out "nuggets of meaning" under adverse circumstances.

Whereas X somehow managed to survive during his stay at Reitgjerdet, Y's experience was dramatically different and illustrates it-it relations in relation to staff. Some time after his first hospitalization Y impulsively nearly killed a nurse, believing that she had laughed at him. There may well have been some provocation, but according to quite idiosyncratic criteria. The institution considered it too dangerous to keep him, and he was therefore transferred to Reitgjerdet hospital. Most of his five years at Reitgjerdet were spent in the closed admission-ward. The journal reports that Y's self-destructive behavior, which previously had occurred only occasionally, increased dramatically after the hospitalization at Reitgjerdet. He knocked his head against the wall, he threw himself—head first—out of bed, and he tried to tear off his genitals. Aggression and self-destructiveness were seldom met with attempts at psychological understanding of the patient's situation, but were conventionally tackled by means of straps. For long periods he spent most of the day lying strapped to his bed. Y felt he was forced into passivity in the completely closed admission-ward, where patients were "aired" twice a day in a closed airing-yard.

For Y, being hospitalized at Reitgjerdet was a "horrific" experience. "... Got worse
at ReitGERD. Turned completely mad..." He persistently asked to be transferred back to the other psychiatric institution, and he often wrote letters to a psychiatrist there whom he very much liked, asking him to take him back. The idea of not coming out of Reitgerdet made him panic; in fact Reitgerdet symbolized a point of no return. He constantly asked himself: "What shall become of me?" At the same time he felt that he "... deserved to be there. Had committed a crime... What I did was gruesome... Deserved my punishment..." He also felt that he was "... very sick" during most of his stay.

In fact, Reitgerdet had no treatment-program to offer a person like Y. Correctly, he perceived Reitgerdet as a place where he was "kept". He felt reduced to being nothing but a "dangerous psychotic"—an individual that had to be shut up. The message that was conveyed to him was that nothing could be done to help him. This definition as a "hopeless case" made him exceedingly depressed and desperate. In short, he felt that he was a person without a future.

In Y's case we thus have a person that actually experienced being treated like an object. The treatment he experienced at Reitgerdet seems to correspond exactly to what Scheff specifies as an I–it attitude. As previously discussed, Scheff emphasizes the reduction of a human being to a single category. In our view, the crucial thing here is that defining and labeling someone once and for all, like a thing or an object, means depriving him of his humanity: being human means having the possibility of change, the possibility of "pour soi" (Sartre 1948. Cf. also Skjervheim 1976). In Y's case the fact of being treated like an object increased his profound feeling of not having any identity, of not having any real self. His massive self-destructiveness could be viewed in this context: in cases where the individual feels alienated from his own self, self-injury and pain can be the only way to feel that one is alive (cf. Becker 1968). Thus, the case of Y may be seen to illustrate Scheff's contention that I–it treatment escalates to vicious circles in the careers of mental patients.

Careers like Y's, of which there are many in psychiatric hospitals, may at first sight also seem to illustrate Scheff's hypothesis that labeling (1–it treatment) creates mental illness. We have argued, however, that the crucial point is how the I–it treatment is construed. In Y's case such treatment reinforced an already existing self-doubt that found increasingly pathological expression, but it did not create his lack of identity in the first place. Stated otherwise, Scheff seriously neglects the importance of the initial state.

Altogether, Scheff lacks any theory of why an it-environment should be conducive to "internalize the role of the mentally ill". It is not controversial that prolonged hospitalization has deleterious consequences from the point of adjusting to life outside hospital: "hospitalization syndrome" is well known (Braginsky et al. 1969). But this is different from internalization where reality orientation will be deficient. Being unfavorably defined may in some circumstances (violence to women (?), unemployment) initiate cycles of self-doubt leading the victim to adopt the negative view provided by the labeler. This could perhaps be seen as a direct way in which labeling may work. But it is very difficult to see any such direct way in which being treated harshly, as an object, should lead to insanity. We have hinted that an environment with very low complexity (subjectively) may make it difficult to uphold normal cognitive functioning, and effects of prolonged isolation may be seen to support such a view (e.g. arctic exploration). This might be seen to illustrate more indirect ways in which the environment could undermine sanity. Here, however, it is possible to sketch a theory of cognitive functioning to guide our understanding.

Conclusion

We think it may be useful to distinguish between two positions in labeling theory: First a radical position, with the ambition of explaining the etiology of mental illness (cf. Scheff 1966, hypothesis 9). Secondly, a moderate position, with the (much weaker) ambition of explaining vicious circles
involved in careers of chronic mental illness. In the moderate version, the labeling theory has of course been of some value. This position is no longer controversial; on the contrary, it is common sense in much of today's psychiatry. In our view, theoretically, the radical position is the interesting one. But in this respect, there is no evidence supporting labeling theory. Scheff's theory is barren from a psychological point of view, and should be replaced by theories considering how persons build, or fail to build, meaning under various circumstances.

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Notes
1) Our presentation of two case histories from Reitgjerder Hospital is based on interviews with the patients in question, on their journals, and on information given by staff and doctors knowing them well.
2) Recently, a commission appointed by the government has revealed that the psychiatric practice of Reitgjerder Hospital is in many respects most deplorable (the Blom-Report, 1980).
3) Generally, the oppressed can more easily come to terms with their situation if they believe that there are internal divisions among their oppressors. Thus they may side with the lower-level oppressors against the higher-level ones (as in the example cited), or with the higher-level ones against the lower-level ones, as in "Si le roi savait".
4) In cases of patients staying in hospital for a prolonged period of time, there are, as always in such cases, two possible interpretations: we can be dealing with a real after-effect or a mere sampling effect (cf. Feller 1950, p. 118ff). In the first case, the person is changed by the experience, in the second he is simply being revealed as what he is, since the less serious cases are constantly leaving the hospital, so that the ones who remain are the more serious ones with small prospects of improvement. In the case of social mobility it has also been found that the longer a person stays in a given class, the smaller the chances of his leaving it within a specified time period. Again two explanations have been proposed. On the "cumulative inertia" model the person is actually changed by the experience, whereas on the "mover-stayer" model what happens is only that the individuals who by disposition are stayers come to be distinguished from those who by disposition are movers (cf. Boudon 1973). Or again for unemploy-

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