Loading the Dice in Favor of Madness'

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The gloomy biographies of mental patients most often represent psychiatric artifacts produced through a "loaded" process of sampling only the bleak events of the patients' lives. If a social identity were constructed for any person based on a biased sample of his life events, he could easily be portrayed as a villain or as a man of character, as a criminal or as a men of low and order, as a sinner or as a saint, and as an insane or as a sane person. In the present study, a group of college students were asked to compile their biographies highlighted by the bleak experiences of their past. These biographies were then rated and classified by a panel of judges into four categories of psychosis, neurosis, personality disorders, and normal. Over 90 percent of the biographies fell into one of the three categories of psychiatric disturbances. This finding tends to support the argument that, following the current psychiatric ideology and practice of loading the dice in favor of madness, a pathological case could be constructed for almost anyone regardless of the individual's psychological well-being.

In the process of initiation into the status of a mental patient, a crucial social-psychological event is the construction of a biography - in the form of a dossier - for the individual in "trouble". This biography, similar to an irrevocable criminal record, furnishes grounds for official discreditation of the individual and
provides a justification for any special treatment he may receive. A past is constructed for the may containing a standard set of"unde-sirable" events and experiences, which then are held *ex post facto* symptomatic or responsible for his officially labeled and certified trouble.

Not infrequently, such a biography is presented to laymen, as well as to some methodologically unsophisticated colleagues, as "scientific" evidence in support of a dubious theory of "abnormal" behavior, or as a vindication of some irreversible radical psychiatric or neurological intervention. Consequently, the question of the methodological meaningfulness of psychiatric dossiers as a form of evidence in scientific reasoning should he given serious consideration.

In addition, as we begin to feel the shadow of 1984 - being already a witness to the advances in social control technology that have made it increasingly possible for individuals' computerized social, political, and psychiatric profiles to be stored and made easily accessible in various regional or national information centers - entrapment in such fabricated pasts would continue to be an even greater source of human frustration and despair for those who have experienced more than their fair share of sufferings and problems of living.

The theme of this paper is to argue that the gloomy biographies of mental patients most often are artifacts produced by a process of biased sampling of the patients' life events according to professional ideologies and folklores of psychiatric practitioners. In principle, by selecting primarily "bleak" events of life, a portrait as gloomy could be painted for most ordinary people.

Abraham Maslow (1962) once asked his students to think about their "peak experiences," that is, their most wonderful experiences: happiest moments, ecstatic moments, moments of rapture from being in love, and so forth. They were then asked to describe their feelings at such acute moments. Maslow then argued that a person in peak experience would take on temporarily, many of the characteristics of self-actualizing individuals.

Undoubtedly, we have all had peak experiences and hence moments of self-actualization. But frequent peak experiences

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do not qualify us as permanently self-actualized, while a few "bleak experiences" are capable of bestowing upon us the lasting identity of "deviant," "criminal," or "insane."

I asked some of my students to think about their "bleak experiences," that is, their strangest, most devious, and most depressing experiences. In other words, they were to recall the experiences they would at the moment consider irrational, unintelligible, alien, or simply overreactions to environmental stress; experiences that, from a psychiatric standpoint, would be considered symptomatic of personality disorders, neurosis, or psychosis. They were then asked to write up their own biographies highlighted by these bleak experiences.

These students were senior psychology and sociology majors who were not unfamiliar with psychiatric conceptualization and language. Some were psychiatric nurses or working in psychiatric settings; some were involved in community mental health work. (Two of the anonymous students later admitted to the author that one was in psychotherapy and the other had been hospitalized for psychiatric problems.) In addition, they had been exposed to a series of lectures on the symptomatology of mental illness.

The biographies were anonymous and had to be compiled in the form of dossiers as if the respondents were going for a general mental health check-up to a psychiatrist. The students were repeatedly asked to be honest in reporting their experiences and feelings - they were allowed to withhold information if they so desired, but not to fabricate stories about themselves. (The two students with psychiatric histories admitted in private that they had failed to report or write about their bleak experiences or feelings.)

Based on their similarities to descriptions in the American Psychiatric Association's *Diagnostic and Statistical Manual,* the dossiers were classified into four categories: psychosis, neurosis, personality disorders and normal. Diagnostic evaluations were first made independently by three judges (a psychologist, a graduate student in psychology, and the writer). Pooling the results of the independent judgments and a reevaluation of those cases which had received different diagnostic labels, the judges came up with the results reported in Table 1.

TABLE 1. PERCENTAGE OF DIFFERENT DIAGNOSTIC LABELINGS OF DOSSIERS COMPILED BY MALE AND FEMALE RESPONDENTS

	Respondent's Sex		
	Male	Female	Both Sexes
Psychosis	27.3	29.2	28.6
	(6)*	(14)	(20)
Neurosis	18.2	60.4	47.2
	(4)	(29)	(33)
Personality Disorder	45.5	4.2	17.1
	(10)	(2)	(I2)
Normal	9.0	6.2	7.1
	(21	(31	(51)
Total	100.0	100.0	100.0
	(22)	(48)	(70)

* Numbers in parentheses indicate base for percentage.

The results are presented separately for sexes in order to reveal any possible differences between males and females in reporting their "abnormal," bleak experiences and feelings, as well as any possible tendency on the part of the judges to classify males and females differently.

As the summary of the data in Table 1 indicates, of the 70 dossiers compiled, 29 percent showed various psychotic symptoms, including auditory and visual hallucinations, systematized and unsystematized delusions, inappropriate emotional responses, disturbances of mood, disturbances of psychomotor activity, and so forth; 47 percent show "pathological" neurotic symptoms, that is, anxiety reactions, occasionally incapacitating phobias and obsessions, conversion reactions, frequent episodes of depressive reactions and some cases of automatic behavior; 17 percent of the dossiers fell into the category of personality disorder, that is, they exhibited symptoms of personality pattern disturbance, inadequacy, immaturity, compulsiveness, dependency, aggressiveness and involvement in anti-social

behavior, and psychosexual disturbance. Only 5 of the dossiers or 7 percent were classified as normal.

This study was not intended to be a small-scale epidemiological survey of prevalence of psychiatric symptoms. Consequently, the above results cannot be meaningfully compared to those of Srole et al. (1962), Leighton, et al. (1963), Manis, et al. (1964), and Phillips (1966).

But it may be interesting to point briefly to some apparent trends along the male-female dimension. While there seems to be no overall association between the sex of the respondents and diagnostic labeling of dossiers (Goodman and Kruskel's λ r = .16), some association would appear between the above attributes when one considers only the two categories of neurosis and personality disorders (λ r= .50). A considerably higher percentage of females' dossiers (60 percent) than males' (18 percent) were labeled as neurotic, while males' dossiers fell mostly in the category of personality disorders (46 percent) as compared to only two female dossiers (2 percent) that received this label. This pattern is consistent with the findings of a number of epidemiological studies reported by Dohrenwend and Dohrenwend (1967).

This interesting trend recurring in different studies seems to reflect the differences in the culturally defined roles of male and female in American society. The female role is more likely than the male role to promote or encourage a disposition or a life style that, in terms of the masculine model of mental health, could be considered neurotic. At the same time, elements of "sociopathic personality" an old name for the current official psychiatric category of personality disorders - are inextricably tied to the traditional masculine role model.

An important point to keep in mind throughout this discussion is that the biographical sketches, consisting of biased samples of the respondents' life events, were being "diagnosed," rather than the respondents themselves. The intention was to simulate, informally, one aspect of the madness-manufacturing process involved in the construction of psychiatric case histories. Ironically, the latter process, succintly articulated by Goffman (1961: 155-156), appears to be a little less loaded than ours.

> One of the purposes of psychiatric dossiers is to show the ways in which the patient is "sick" and the reasons why it was right to commit him and is right to keep him committed; and this is done by extracting from his whole life course a list of those incidents that have or might have had "symptomatic" significance. The misadventures of his parents or siblings that might suggest a "taint" may be cited. Early acts in which the patient appeared to have shown bad judgment or emotional disturbance will be recorded. Occasions when he acted in a way, which the layman would consider immoral, sexually perverted, weak-willed, childish, ill-considered, impulsive, and crazy may be described.

Questions may be raised, on the one hand, as to whether the students' biographical sketches were shaped by the "demand characteristics" (Orne, 1969) inherent in a study of this kind. This bias, introduced by the subjects' inadvertent attempt to behave in a manner favorable to what the study is designed to show, of course, cannot be ruled out. However, a functional simulation of the madness-manufacturing process should contain**,** as part of its relevant variables, strong demand characteristics. For the transaction between the patient and the healer in psychiatric settings is characterized by a strong demand for the patient to "put his best foot forward," that is, to come forward with the evidence and display the symptoms of the illness he is thought to have (Balinet, 195'7; Scheff, 1966, 1968). Some readers may, on the other hand, question the validity of our reported findings, criticizing the writer for "unprofessionally" forcing the normal-like experiences of the students into the psychiatric classification of symptoms and "illnesses."

Such a criticism displays some naiveté about the psychiatric nosology and the rituals of the diagnostic enterprise, and it really misses the gist of our argument. For it assumes that the current psychiatric classification is based on a "theory of

disease" analogous to that of medicine, and that the "abnormal" behavior, experiences, or personalities of mental patients are accordingly classified or described by "objective" clinicians.

The epistemological and theoretical problems of the psychiatric nosology have been discussed by Szasz (1961) and the present writer will not attempt to add anything to his brilliant analysis. However, the question of "clinical objectivity" is probably the most controversial and dubious aspect of the psychiatric profession and merits a brief comment.

Much is already known about the clinicians' tendency to reconstruct the normal and ordinary experiences of a "patient" in terms of the professional stereotypes and psychiatric folklores. A recent study by Rosenhan (1973) strongly suggests that when psychiatrists and nurses are not provided with "deviant" or "tragic" life episodes of a patient, such episodes are manufactured for him through an inadvertent fabrication or a redefinition of his normal personal history. Indeed, when Rosenhan and his associates obtained admission into a number of mental hospitals under false pretenses, dossiers were prepared for them in some of which their normal personal histories were modified to fit the existing psychiatric folklore of the personal history of a patient with schizophrenic reaction. According to Rosenhan:(1973: 252, italics added):

> . . . diagnoses were in no way affected by the relative health of the circumstances of a pseudopatient's life. Rather, the reverse occurred: *the perception of his circumstances was shaped entirely by the diagnoses* . . . . *The* facts of the case were unintentially distorted by the staff to achieve consistency with a popular theory of the dynamics of a schizophrenic reaction.

This is a rather compelling case study of how, in social and behavioral sciences, ideologies or so-called "theories" determine and change the empirical observations, and not the reverse. For example, the recent decision of the American Psychiatric Association to modify the official psychiatric "theory" of homosexuality through a vote and a subsequent referendum of the membership is an excellent case in point. Many professionally faithful psychiatrists and clinical psychologists will now have to modify their perceptual apparatus as far as homosexuals are concerned. Ironically, had APA failed to get a majority vote or win the following referendum, today those professionally oriented members would probably have continued to diagnose homosexuals as inadequate, immature, maladjusted, emotionally disturbed, neurotic, paranoid, psychopath, genetically abnormal, biochemically unbalanced, and finally suffering from an anomaly in the brain's electrical circuitry.

The game, "I'm sane, you're insane," is surely not a fair game. The dice are loaded on all sides for the parties who play against the house. Presumption of illness inherent in the medical model declares most people mad unless proven otherwise (Scheff, 1966); and a psychiatrist is hardly an impartial judge rendering a verdict of sanity. In the same way that a garbage collector may perceive many things as garbage, to a psychiatrist many behaviors and experiences tend to be taken as abnormal or symptomatic of mental illness. To Menninger (1930), even being "normal" is somewhat pathological. To him, "to be normal seems shockingly repellent." He sees "neither hope nor comfort in sinking to that low level" (in Kisker, 1964:1).

Nonetheless, in this game, the odds are not the same for all the players. Only the most naive behavioral scientist would deny the fact that the judgment of the normality or abnormality of any behavior or experience is, in part, a function of the social contingencies of the actor. For instance, streaking, which was in vogue a few months ago among some middle -class college students, making many primetime national television programs, received very little, if any, negative moral or clinical judgment. There was no standard diagnosis of exhibitionism due to castration complex, some exotic form of psychosexual disorder, or a simple character disorder. Rather, it was looked upon with enthusiasm and excitement as an adventuresome

an adventuresome, courageous, and healthy act. Would the same moral or clinical reaction have been entertained if lowerclass blacks - instead of white middleclass college students - had streaked%

Carried to extreme, one only has to turn the table to see that even the dealer may come out a loser playing with a set of fair dice. Anthropologists have long recognized that in many "primitive" societies the line between the madman and the shaman is not at all clear. Madness is often a prerequisite for becoming a successful shaman able to cure others (Krober, 1940). Ironically, in "modern" societies, the line between the insane and the healer is also not unproblematic (Farber, 1971). For instance, an eminent neurologist and psychosurgeon recently appeared on NBC's "Tomorrow" show to repeat his old line that paranoid schizophrenia is simply an anomoly in the electrical circuitry of the brain. He then offered psychosurgical rewiring as a humane panacea for "violent" prisoners who are, according to him, *prima-facia* paranoid schizophrenic. When reminded of the rejection of his position by the Senate Subcommittee of Labor, NIMH, and many prominent behavioral scientists, our eminent psychosurgeon went on to claim that this rejection was part of a conspiracy in Washington to perpeturate violence in America for unknown reasons. He then added the SDS of UCLA, the Communist Labor Party of Harvard, and the Weathermen of Texas to the list of conspirators.

Of course, the Senate Subcommittee of Labor, NIMH, and marry behavioral scientists, neurologists, and concerned citizens who question the "bad-connection" theory of schizophrenia and violence may all very well be involved, along with the SDS and Weathermen, in a communist plot to perpetuate violence in America. But, by the same token, a man may be even literally right in his claims of being persecuted, followed, poisoned, and his mind being controlled or tampered with. Now if this man is diagnosed as paranoid schizophrenic suffering from delusions of persecution, then our eminent psychosurgeon could hardly escape the same diagnosis.

Thus it should not come as a surprise to find many insane, emotionally disturbed, or maladjusted people in a game in which the dice are loaded in favor of madness. Self-reported delinquency studies reveal that most of us have committed frequent misdemeanors or even felonies for which we could easily have received the official credentials of criminality, if we were from the wrong side of the tracks. In the post-Watergate era, it should not be difficult to see how a man of law and order can become a criminal with a different set of dice.

In summary, our lives consist of an infinite series of events whose experiential meanings and figure-ground configurations are in a state of constant flux. Any given life history is one among an unlimited number of constructions and reconstructions of an ever evolving phenomenological reality. Any social-psychological biography, that which defines one's identity, one's character, one's past, and one's being or existence, is only a selective construction of events from a given time-bound ideological standpoint. If a social identity were to be constructed for a person through a loaded process of sampling his life events, he could easily be portrayed as a villain or as a man of character, as a criminal or as a man of law and order, as a sinner or as a saint, as insane or as sane. In other words, if the dice of people's life events were to be loaded, then anyone could become almost anything.

REFERENCES

Balint, Michael.
1957 The Doctor, His Patient, and the Illness. New York: International University Press.

Dohrenwend, Barbara S. and Bruce P. Dohrenwend.
1967 "Field studies of social factors in relation to three types of psychological disorders." Journal of Abnormal Psychology 72 (August): 369-78.

Farber, Leslie H.
1971 "Schizophrenia and the mad psychotherapist." Pp. 89-118 in Robert Boyers and Robert Orill (eds.), R.D. Laing and AntiPsychiatry. New York: Harper and Raw.

Goffman, Erving.
1961 Asylums. New York: Doubleday.

Kisker, George W.
1964 The Disorganized Personality. New York: McGraw-Hill.
Krober, Alfred L.
1940 Character and Personality. Vol. 8. Durham: Duke University Press.
Leighton, D.C., J.S. Harding, D.B. Macklin, A.M. Macmillan and A.H. Leighton.
1963 The Character of Danger. New York: Basic Books.
Manis, Jerome G., Milton J. Brawer, Chester L. Hunt and Leonard Krecher.
1964 "Estimating the Prevalence of Mental Ill ness." American Sociological Review 29 (February): 84-89.
Maslow, Abraham H.
1962 Toward a Psychology of Being. New York: Srole, Van Nostrand.
Menninger, Karl.
1930 The Human Mind. New York: Alfred A. 1962 Knopf.
Orne, Martin T.
1969 "Demand characteristics and the concept of quasi-controls." Pp. 280-348 in Robert Rosenthal and Ralph L. Rosnow (eds.), Artifact in Behavioral Research. New York: Academic Press.
Phillips, Derek L.
1966 "The'true prevalence' of mental illness in a New England state." Community Mental Health Journal 2 (Spring): 35-40.
Rosenhan, David L.
1973 "On being sane in insane places." Science 179 (January): 250-58.
Scheff, Thomas J.
1966 Being Mentally III: A Sociological Theory. Chicago: Aldine.
1968 "Negotiating reality: Notes on power in the assessment of responsibility." Social Problems 16 (Summer): 3-17.
Srole, Leo, Thomas S. Langer, Stanley T. Michael, Marvin K. Opler and Thomas A.C. Rennie.
1962 Mental Health in the Metropolis. New York: McGraw-Hill.
Szasz, Thomas S.
1961 The Myth of Mental Illness. New York: Harper and Row.