ASYLUMS

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Essays on the Social Situation of Mental Patients and Other Inmates
and persistently that we have a right to suspect that there are good functional reasons for these features being present and that it will be possible to fit these features together and grasp them by means of a functional explanation. When we have done this, I feel we will give less praise and blame to particular superintendents, commandants, wardens, and abbots, and tend more to understand the social problems and issues in total institutions by appealing to the underlying structural design common to them all.
Traditionally the term *career* has been reserved for those who expect to enjoy the rises laid out within a respectable profession. The term is coming to be used, however, in a broadened sense to refer to any social strand of any person's course through life. The perspective of natural history is taken: unique outcomes are neglected in favor of such changes over time as are basic and common to the members of a social category, although occurring independently to each of them. Such a career is not a thing that can be brilliant or disappointing; it can no more be a success than a failure. In this light, I want to consider the mental patient.

One value of the concept of career is its two-sidedness. One side is linked to internal matters held dearly and closely, such as image of self and felt identity; the other side concerns official position, jural relations, and style of life, and is part of a publicly accessible institutional complex. The concept of career, then, allows one to move back and forth between the personal and the public, between the self and its significant society, without having to rely overly for data upon what the person says he thinks he imagines himself to be.

This paper, then, is an exercise in the institutional approach to the study of self. The main concern will be
with the moral aspects of career—that is, the regular sequence of changes that career entails in the person’s self and in his framework of imagery for judging himself and others.\textsuperscript{1}

The category “mental patient” itself will be understood in one strictly sociological sense. In this perspective, the psychiatric view of a person becomes significant only in so far as this view itself alters his social fate—an alteration which seems to become fundamental in our society when, and only when, the person is put through the process of hospitalization.\textsuperscript{2} I therefore exclude certain neighboring categories: the undiscovered candidates who would be judged “sick” by psychiatric standards but who never come to be viewed as such by themselves or others, although they may cause everyone a great deal of trouble;\textsuperscript{3} the office patient whom a psychiatrist feels

\textsuperscript{1} Material on moral career can be found in early social anthropological work on ceremonies of status transition, and in classic social psychological descriptions of those spectacular changes in one’s view of self that can accompany participation in social movements and sects. Recently new kinds of relevant data have been suggested by psychiatric interest in the problem of “identity” and sociological studies of work careers and “adult socialization.”

\textsuperscript{2} This point has recently been made by Elaine and John Cumming, Closed Ranks (Cambridge: Commonwealth Fund, Harvard University Press, 1957), pp. 101-2: “Clinical experience supports the impression that many people define mental illness as ‘that condition for which a person is treated in a mental hospital.’ . . . Mental illness, it seems, is a condition which afflicts people who must go to a mental institution, but until they go almost anything they do is normal.” Leila Deasy has pointed out to me the correspondence here with the situation in white-collar crime. Of those who are detected in this activity, only the ones who do not manage to avoid going to prison find themselves accorded the social role of the criminal.

\textsuperscript{3} Case records in mental hospitals are just now coming to be exploited to show the incredible amount of trouble a person may cause for himself and others before anyone begins to think about him psychiatrically, yet alone take psychiatric action against him. See John A. Clausen and Marian Radke

he can handle with drugs or shock on the outside; the mental client who engages in psychotherapeutic relationships. And I include anyone, however robust in temperament, who somehow gets caught up in the heavy machinery of mental-hospital servicing. In this way the effects of being treated as a mental patient can be kept quite distinct from the effects upon a person’s life of traits a clinician would view as psychopathological.\textsuperscript{4} Persons who become mental-hospital patients vary widely in the kind and degree of illness that a psychiatrist would impute to them, and in the attributes by which laymen would describe them. But once started on the way, they are confronted by some importantly similar circumstances and respond to these in some importantly similar ways. Since these similarities do not come from mental illness, they would seem to occur in spite of it. It is thus a tribute to the power of social forces that the uniform status of mental patient cannot only assure an aggregate of persons a common fate and eventually, because of this, a common character, but that this social reworking can be done upon what is perhaps the most obstinate diversity of human materials that can be brought together by society. Here there lacks only the frequent forming of a protective group life by ex-patients to illustrate in full the classic cycle of response by which deviant subgroupings are psychodynamically formed in society.

This general sociological perspective is heavily re-


\textsuperscript{4} An illustration of how this perspective may be taken to all forms of deviancy may be found in Edwin Lemert, Social Pathology (New York: McGraw-Hill, 1951), see especially pp. 74-76. A specific application to mental defectives may be found in Stewart E. Ferry, “Some Theoretic Problems of Mental Deficiency and Their Action Implications,” Psychiatry, XVII (1954), pp. 45-73, see especially pp. 67-68.
inforced by one key finding of sociologically oriented students in mental-hospital research. As has been repeatedly shown in the study of non-literate societies, the awesomeness, distastefulness, and barbarity of a foreign culture can decrease to the degree that the student becomes familiar with the point of view to life that is taken by his subjects. Similarly, the student of mental hospitals can discover that the craziness or “sick behavior” claimed for the mental patient is by and large a product of the claimant’s social distance from the situation that the patient is in, and is not primarily a product of mental illness. Whatever the refinements of the various patients’ psychiatric diagnoses, and whatever the special ways in which social life on the “inside” is unique, the researcher can find that he is participating in a community not significantly different from any other he has studied. Of course, while restricting himself to the off-ward grounds community of paroled patients, he may feel, as some patients do, that life in the locked wards is bizarre; and while on a locked admissions or convalescent ward, he may feel that chronic “back” wards are socially crazy places. But he need only move his sphere of sympathetic participation to the “worst” ward in the hospital, and this, too, can come into social focus as a place with a livable and continuously meaningful social world. This in no way denies that he will find a minority in any ward or patient group that continues to seem quite beyond the capacity to follow rules of social organization, or that the orderly fulfillment of normative expectations in patient society is partly made possible by strategic measures that have somehow come to be institutionalized in mental hospitals.

The career of the mental patient falls popularly and naturalistically into three main phases: the period prior to entering the hospital, which I shall call the prepatient phase; the period in the hospital, the inpatient phase; the period after discharge from the hospital, should this occur, namely, the ex-patient phase. This paper will deal only with the first two phases.

THE PREPATIENT PHASE

A relatively small group of prepatients come into the mental hospital willingly, because of their own idea of what will be good for them, or because of wholehearted agreement with the relevant members of their family. Presumably these recruits have found themselves acting in a way which is evidence to them that they are losing their minds or losing control of themselves. This view of oneself would seem to be one of the most pervasively threatening things that can happen to the self in our society, especially since it is likely to occur at a time when the person is in any case sufficiently troubled to exhibit the kind of symptom which he himself can see. As Sullivan described it,

What we discover in the self-system of a person undergoing schizophrenic change or schizophrenic processes, is then, in its simplest form, an extremely fear-marked puzzlement, consisting of the use of rather generalized and anything but exquisitely refined referential processes in an attempt to cope with what is essentially a failure at being human—a failure at being anything that one could respect as worth being.

Coupled with the person’s disintegrative re-evaluation of himself will be the new, almost equally pervasive circumstance of attempting to conceal from others what he

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8 This simple picture is complicated by the somewhat special experience of roughly a third of ex-patients—namely, readmission to the hospital, this being the recidivist or “repaient” phase.

takes to be the new fundamental facts about himself, and attempting to discover whether others, too, have discovered them. Here I want to stress that perception of losing one’s mind is based on culturally derived and socially engrained stereotypes as to the significance of symptoms such as hearing voices, losing temporal and spatial orientation, and sensing that one is being followed, and that many of the most spectacular and convincing of these symptoms in some instances psychiatrically signify merely a temporary emotional upset in a stressful situation, however terrifying to the person at the time. Similarly, the anxiety consequent upon this perception of oneself, and the strategies devised to reduce this anxiety, are not a product of abnormal psychology, but would be exhibited by any person socialized into our culture who came to conceive of himself as someone losing his mind. Interestingly, subcultures in American society apparently differ in the amount of ready imagery and encouragement they supply for such self-views, leading to differential rates of self-referral; the capacity to take this disintegrative view of oneself without psychiatric prompting seems to be one of the questionable cultural privileges of the upper classes.

For the person who has come to see himself—with whatever justification—as mentally unbalanced, entrance to the mental hospital can sometimes bring relief, perhaps in part because of the sudden transformation in the structure of his basic social situation; instead of being

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7 This moral experience can be contrasted with that of a person learning to become a marihuana addict, whose discovery that he can be “high” and still “op” effectively without being detected apparently leads to a new level of use. See Howard S. Becker, “Marihuana Use and Social Control,” Social Problems, III (1955), pp. 35-44; see especially pp. 40-41.

8 See Hollingshead and Redlich, op. cit., p. 187, Table 6, where relative frequency is given of self-referral by social-class grouping.

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to himself a questionable person trying to maintain a role as a full one, he can become an officially questioned person known to himself to be not so questionable as that. In other cases, hospitalization can make matters worse for the willing patient, confirming by the objective situation what has theretofore been a matter of the private experience of self.

Once the willing prepatient enters the hospital, he may go through the same routine of experiences as do those who enter unwillingly. In any case, it is the latter that I mainly want to consider, since in America at present these are by far the more numerous kind. Their approach to the institution takes one of three classic forms: they come because they have been implored by their family or threatened with the abrogation of family ties unless they go “willingly”; they come by force under police escort; they come under misapprehension purposely induced by others, this last restricted mainly to youthful prepatients.

The prepatient’s career may be seen in terms of an extrusory model; he starts out with relationships and rights, and ends up, at the beginning of his hospital stay, with hardly any of either. The moral aspects of this career, then, typically begin with the experience of abandonment, disloyalty, and embitterment. This is the case even though to others it may be obvious that he was in need of treatment, and even though in the hospital he may soon come to agree.

The case histories of most mental patients document offenses against some arrangement for face-to-face living—a domestic establishment, a work place, a semi-public

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9 The distinction employed here between willing and unwilling patients cuts across the legal one of voluntary and committed, since some persons who are glad to come to the mental hospital may be legally committed, and of those who come only because of strong familial pressure, some may sign themselves in as voluntary patients.
organization such as a church or store, a public region such as a street or park. Often there is also a record of some complainant, some figure who takes that action against the offender which eventually leads to his hospitalization. This may not be the person who makes the first move, but it is the person who makes what turns out to be the first effective move. Here is the social beginning of the patient's career, regardless of where one might locate the psychological beginning of his mental illness.

The kinds of offenses which lead to hospitalization are felt to differ in nature from those which lead to other extrasy consequences—to imprisonment, divorce, loss of job, disownment, regional exile, non-institutional psychiatric treatment, and so forth. But little seems known about these differentiating factors; and when one studies actual commitments, alternate outcomes frequently appear to have been possible. It seems true, moreover, that for every offense that leads to an effective complaint, there are many psychiatrically similar ones that never do. No action is taken; or action is taken which leads to other extrasy outcomes; or ineffective action is taken, leading to the mere pacifying or putting off of the person who complains. Thus, as Clausen and Yarrow have nicely shown, even offenders who are eventually hospitalized are likely to have had a long series of ineffective actions taken against them.  

Separating those offenses which could have been used as grounds for hospitalizing the offender from those that are so used, one finds a vast number of what students of occupation call career contingencies. Some of these contingencies in the mental patient's career have been suggested, if not explored, such as socio-economic status,

visibility of the offense, proximity to a mental hospital, amount of treatment facilities available, community regard for the type of treatment given in available hospitals, and so on. For information about other contingencies one must rely on atrocity tales: a psychotic man is tolerated by his wife until she finds herself a boy friend, or by his adult children until they move from a house to an apartment; an alcoholic is sent to a mental hospital because the jail is full, and a drug addict because he declines to avail himself of psychiatric treatment on the outside; a rebellious adolescent daughter can no longer be managed at home because she now threatens to have an open affair with an unsuitable companion; and so on. Correspondingly there is an equally important set of contingencies causing the person to by-pass this fate. And should the person enter the hospital, still another set of contingencies will help determine when he is to obtain a discharge—such as the desire of his family for his return, the availability of a "manageable" job, and so on. The society's official view is that inmates of mental hospitals are there primarily because they are suffering from mental illness. However, in the degree that the "mentally ill" outside hospitals numerically approach or surpass those inside hospitals, one could say that mental patients distinctively suffer not from mental illness, but from contingencies.

Career contingencies occur in conjunction with a second feature of the prepatient's career—the circuit of agents—and agencies—that participate fatefuly in his passage from civilian to patient status. Here is an in-
stance of that increasingly important class of social
system whose elements are agents and agencies which are
brought into systemic connection through having to take
up and send on the same persons. Some of these agent
roles will be cited now, with the understanding that in
any concrete circuit a role may be filled more than once,
and that the same person may fill more than one of them.

First is the next-of-relatiion—the person whom the pre-
patient sees as the most available of those upon whom he
should be able to depend most in times of trouble, in
this instance the last to doubt his sanity and the first to
have done everything to save him from the fate which,
it transpires, he has been approaching. The patient's
next-of-relatiion is usually his next of kin; the special
term is introduced because he need not be. Second is the com-
plainant, the person who retrospectively appears to have
started the person on his way to the hospital. Third are the
mediators—the sequence of agents and agencies to
which the prepatient is referred and through which he
is relayed and processed on his way to the hospital. Here
are included police, clergy, general medical practitioners,
office psychiatrists, personnel in public clinics, lawyers,
social service workers, schoolteachers, and so on. One of
these agents will have the legal mandate to sanction com-
mitment and will exercise it, and so those agents who
precede him in the process will be involved in something
whose outcome is not yet settled. When the mediators
retire from the scene, the prepatient has become an
inpatient, and the significant agent has become the hospital
administrator.

While the complainant usually takes action in a lay
capacity as a citizen, an employer, a neighbor, or a kins-
man, mediators tend to be specialists and differ from
those they serve in significant ways. They have experi-
ence in handling trouble, and some professional distance

\[^{14}\text{See Cumming and Cumming, op. cit., p. 92.}\]
\[^{15}\text{Hollingshead and Redlich, op. cit., p. 187.}\]
\[^{16}\text{For an analysis of some of these circuit implications for
the inpatient, see Leila Deasy and Olive W. Quinn, "The
illustration of this kind of analysis may also be found in Alan
G. Cowman, "Blindness and the Role of the Companion," Social
Problems, IV (1956), pp. 68-75. A general statement may
be found in Robert Merton, "The Role Set: Problems in Soci-
elogical Theory," British Journal of Sociology, VIII (1957),
pp. 108-20.}\]
patient. The prepatient often goes to the interview with the understanding that he is going as an equal of someone who is so bound together with him that a third person could not come between them in fundamental matters; this, after all, is one way in which close relationships are defined in our society. Upon arrival at the office the prepatient suddenly finds that he and his next-of-rela-
tion have not been accorded the same roles, and apparently that a prior understanding between the professional and the next-of-relation has been put in opera-
tion against him. In the extreme but common case, the professional first sees the prepatient alone, in the role of examiner and diagnostician, and then sees the next-of-relation alone, in the role of adviser, while carefully avoiding talking things over seriously with them both togeth-
er. And even in those non-consultative cases where public officials must forcibly extract a person from a family that wants to tolerate him, the next-of-relation is likely to be induced to “go along” with the official action, so that even here the prepatient may feel that an alien-
ating coalition has been formed against him.

The moral experience of being third man in such a coalition is likely to embitter the prepatient, especially since his troubles have already probably led to some estrangement from his next-of-rela-
tion. After he enters the hospital, continued visits by his next-of-rela-
tion can give the patient the “insight” that his own best interests were being served. But the initial visits may temporarily strengthen his feeling of abandonment; he is likely to beg his visitor to get him out or at least to get him more privi-
leges and to sympathize with the monstruousness of his plight—to which the visitor ordinarily can respond only by trying to maintain a hopeful note, by not “hearing” the requests, or by assuring the patient that the medical

17 I have one case record of a man who claims he thought he was taking his wife to see the psychiatrist, not realizing until too late that his wife had made the arrangements.

authorities know about these things and are doing what is medically best. The visitor then nonchalantly goes back into a world that the patient has learned is incredibly thick with freedom and privileges, causing the patient to feel that his next-of-relation is merely adding a pious gloss to a clear case of traitorous desertion.

The depth to which the patient may feel betrayed by his next-of-rela-
tion seems to be increased by the fact that another witnesses his betrayal—a factor which is apparently significant in many three-party situations. An offended person may well act forbearantly and accom-
modatively toward an offender when the two are alone, choosing peace ahead of justice. The presence of a wit-
ess, however, seems to add something to the implications of the offense. For then it is beyond the power of the offended and offender to forget about, erase, or suppress what has happened; the offense has become a pub-
lic social fact. When the witness is a mental health commission, as is sometimes the case, the witnessed betrayal can verge on a “degradation ceremony.” In such circumstances, the offended patient may feel that some kind of extensive reparative action is required before wit-
nesses, if his honor and social weight are to be restored.

Two other aspects of sensed betrayal should be men-
tioned. First, those who suggest the possibility of another’s entering a mental hospital are not likely to provide a realistic picture of how in fact it may strike him when he arrives. Often he is told that he will get required medical treatment and a rest, and may well be out in a few months or so. In some cases they may thus be concealing what they know, but I think, in general, they will be telling what they see as the truth. For here there is

quite relevant difference between patients and mediating professionals; mediators, more so than the public at large, may conceive of mental hospitals as short-term medical establishments where required rest and attention can be voluntarily obtained, and not as places of coerced exile. When the prepatient finally arrives he is likely to learn quite quickly, quite differently. He then finds that the information given him about life in the hospital has had the effect of his having put up less resistance to entering than he now sees he would have put up had he known the facts. Whatever the intentions of those who participated in his transition from person to patient, he may sense they have in effect "conned" him into his present predicament.

I am suggesting that the prepatient starts out with at least a portion of the rights, liberties, and satisfactions of the civilian and ends up on a psychiatric ward stripped of almost everything. The question here is how this stripping is managed. This is the second aspect of betrayal I want to consider.

As the prepatient may see it, the circuit of significant figures can function as a kind of betrayal funnel. Passage from person to patient may be effected through a series of linked stages, each managed by a different agent. While each stage tends to bring a sharp decrease in adult free status, each agent may try to maintain the fiction that no further decrease will occur. He may even manage to turn the prepatient over to the next agent while sustaining this fiction. Further, through words, cues, and gestures, the prepatient is implicitly asked by the current agent to join him in sustaining a running line of polite small talk that tacitly avoids the administrative facts of the situation, becoming, with each stage, progressively more at odds with these facts. The spouse would rather not have to cry to get the prepatient to visit a psychiatrist; psychiatrists would rather not have a scene when the prepatient learns that he and his spouse are being seen separately and in different ways; the police infrequently bring a prepatient to the hospital in a strait jacket, finding it much easier all around to give him a cigarette, some kindly words, and freedom to relax in the back seat of the patrol car; and finally, the admitting psychiatrist finds he can do his work better in the relative quiet and luxury of the "admission suite" where, as an incidental consequence, the notion can survive that a mental hospital is indeed a comforting place. If the prepatient heeds all of these implied requests and is reasonably decent about the whole thing, he can travel the whole circuit from home to hospital without forcing anyone to look directly at what is happening or to deal with the raw emotion that his situation might well cause him to express. His showing consideration for those who are moving him toward the hospital allows them to show consideration for him, with the joint result that these interactions can be sustained with some of the protective harmony characteristic of ordinary face-to-face dealings. But should the new patient cast his mind back over the sequence of steps leading to hospitalization, he may feel that everyone's current comfort was being busily sustained while his long-range welfare was being undermined. This realization may constitute a moral experience that further separates him for the time from the people on the outside.20

20 Concentration-camp practices provide a good example of the function of the betrayal funnel in inducing co-operation and reducing struggle and fuss, although here the mediators could not be said to be acting in the best interests of the inmates. Police picking up persons from their homes would sometimes joke good-naturedly and offer to wait while coffee was being served. Gas chambers were fitted out like delousing rooms, and victims taking off their clothes were told to note where they were leaving them. The sick, aged, weak, or insane who were selected for extermination were sometimes driven away in Red Cross ambulances to camps referred to by terms such as "observation hospital." See David Boder, I Did Not Interview the Dead (Urbana: University of Illinois Press,
I would now like to look at the circuit of career agents from the point of view of the agents themselves. Mediators in the person's transition from civil to patient status—as well as his keepers, once he is in the hospital—have an interest in establishing a responsible next-of-relations as the patient's deputy or guardian; should there be no obvious candidate for the role, someone may be sought out and pressed into it. Thus while a person is gradually being transformed into a patient, a next-of-relations is gradually being transformed into a guardian. With a guardian on the scene, the whole transition process can be kept tidy. He is likely to be familiar with the prepatient's civil involvements and business, and can tie up loose ends that might otherwise be left to entangle the hospital. Some of the prepatient's abrogated civil rights can be transferred to him, thus helping to sustain the legal fiction that while the prepatient does not actually have his rights he somehow actually has not lost them.

Inpatients commonly sense, at least for a time, that hospitalization is a massive unjust deprivation, and sometimes succeed in convincing a few persons on the outside that this is the case. It often turns out to be useful, then, for those identified with inflicting these deprivations, however justifiably, to be able to point to the co-operation and agreement of someone whose relationship to the patient places him above suspicion, firmly defining him as the person most likely to have the patient's personal interest at heart. If the guardian is satisfied with what is happening to the new inpatient, the world ought to be.


21 Interviews collected by the Clausen group at NIMH suggest that when a wife comes to be a guardian, the responsibility may disrupt previous distance from in-laws, leading either to a new supportive coalition with them or to a marked withdrawal from them.

Now it would seem that the greater the legitimate personal stake one party has in another, the better he can take the role of guardian to the other. But the structural arrangements in society which lead to the acknowledged merging of two persons' interests lead to additional consequences. For the person to whom the patient turns for help—for protection against such threats as involuntary commitment—is just the person to whom the mediators and hospital administrators logically turn for authorization. It is understandable, then, that some patients will come to sense, at least for a time, that the closeness of a relationship tells nothing of its trustworthiness.

There are still other functional effects emerging from this complement of roles. If and when the next-of-relations appeals to mediators for help in the trouble he is having with the prepatient, hospitalization may not, in fact, be in his mind. He may not even perceive the prepatient as mentally sick, or, if he does, he may not consistently hold to this view. It is the circuit of mediators, with their greater psychiatric sophistication and their belief in the medical character of mental hospitals, that will often define the situation for the next-of-relations, assuring him that hospitalization is a possible solution and a good one, that it involves no betrayal, but is rather a medical action taken in the best interests of the prepatient. Here the next-of-relations may learn that doing his duty to the prepatient may cause the prepatient to distrust and even hate him for the time. But the fact that this course of action may have had to be pointed out and prescribed by professionals, and be defined by them as a moral duty, relieves the next-of-relations of some of the

guilt he may feel. 23 It is a poignant fact that an adult son or daughter may be pressed into the role of mediator, so that the hostility that might otherwise be directed against the spouse is passed on to the child. 24

Once the prepatient is in the hospital, the same guilt-carrying function may become a significant part of the staff's job in regard to the next-of-relations. 25 These reasons for feeling that he himself has not betrayed the patient, even though the patient may then think so, can later provide the next-of-relation with a defensible line to take when visiting the patient in the hospital and a basis for hoping that the relationship can be re-established after its hospital moratorium. And of course this position, when sensed by the patient, can provide him with excuses for the next-of-relation, when and if he comes to look for them. 26

Thus while the next-of-relation can perform important functions for the mediators and hospital administrators,

23 This guilt-carrying function is found, of course, in other role complexes. Thus, when a middle-class couple engages in the process of legal separation or divorce, each of their lawyers usually takes the position that his job is to acquaint his client with all of the potential claims and rights, pressing his client into demanding these, in spite of any niceties of feelings about the rights and honorableness of the ex-partner. The client, in all good faith, can then say to self and to the ex-partner that the demands are being made only because the lawyer insists it is best to do so.

24 Recorded in the Clausen data.

25 This point is made by Cumming and Cumming, op. cit., p. 129.

26 There is an interesting contrast here with the moral career of the tuberculosis patient. I am told by Julius Roth that tuberculous patients are likely to come to the hospital willingly, agreeing with their next-of-relation about treatment. Later in their hospital career, when they learn how long they yet have to stay and how depriving and irrational some of the hospital rulings are, they may seek to leave, be advised against this by the staff and by relatives, and only then begin to feel betrayed.

they in turn can perform important functions for him. One finds, then, an emergent unintended exchange or reciprocation of functions, these functions themselves being often unintended.

The final point I want to consider about the prepatient's moral career is its peculiarly retroactive character. Until a person actually arrives at the hospital there usually seems no way of knowing for sure that he is destined to do so, given the determinative role of career contingencies. And until the point of hospitalization is reached, he or others may not conceive of him as a person who is becoming a mental patient. However, since he will be held against his will in the hospital, his next-of-relation and the hospital staff will be in great need of a rationale for the hardships they are sponsoring. The medical elements of the staff will also need evidence that they are still in the trade they were trained for. These problems are eased, no doubt unintentionally, by the case-history construction that is placed on the patient's past life, this having the effect of demonstrating that all along he had been becoming sick, that he finally became very sick, and that if he had not been hospitalized much worse things would have happened to him—all of which, of course, may be true. Incidentally, if the patient wants to make sense out of his stay in the hospital, and, as already suggested, keep alive the possibility of once again conceiving of his next-of-relation as a decent, well-meaning person, then he, too, will have reason to believe some of this psychiatric work-up of his past.

Here is a very ticklish point for the sociology of careers. An important aspect of every career is the view the person constructs when he looks backward over his progress; in a sense, however, the whole of the prepatient career derives from this reconstruction. The fact of having had a prepatient career, starting with an effective complaint, becomes an important part of the mental patient's orientation, but this part can begin to be played
only after hospitalization proves that what he had been having, but no longer has, is a career as a prepatient.

THE INPATIENT PHASE

The last stop in the prepatient’s career can involve his realization—justified or not—that he has been deserted by society and turned out of relationships by those closest to him. Interestingly enough, the patient, especially a first admission, may manage to keep himself from coming to the end of this trail, even though in fact he is now in a locked mental-hospital ward. On entering the hospital, he may very strongly feel the desire not to be known to anyone as a person who could possibly be reduced to these present circumstances, or as a person who conducted himself in the way he did prior to commitment. Consequently, he may avoid talking to anyone, may stay by himself when possible, and may even be “out of contact” or “manic” so as to avoid ratifying any interaction that presses a politely reciprocal role upon him and opens him up to what he has become in the eyes of others. When the next-of-relations makes an effort to visit, he may be rejected by mutism, or by the patient’s refusal to enter the visiting room, these strategies sometimes suggesting that the patient still clings to a remnant of relatedness to those who made up his past, and is protecting this remnant from the final destructiveness of dealing with the new people that they have become.27

27 The inmate’s initial strategy of holding himself aloof from ratifying contact may partly account for the relative lack of group formation among inmates in public mental hospitals, a connection that has been suggested to me by William R. Smith. The desire to avoid personal bonds that would give licence to the asking of biographical questions could also be a factor. In mental hospitals, of course, as in prison camps, the staff may consciously break up incipient group formation in order to avoid collective rebellious action and other ward disturbances.

28 A comparable coming out occurs in the homosexual world, when a person finally comes frankly to present himself to a “gay” gathering not as a tourist but as someone who is “available.” See Evelyn Hooker, “A Preliminary Analysis of Group Behavior of Homosexuals,” Journal of Psychology, XLII (1956), pp. 217-25; see especially p. 221. A good fictionalized treatment may be found in James Baldwin’s Giovanni’s Room (New York: Dial, 1956), pp. 41-57. A familiar instance of the coming-out process is no doubt to be found among prepubertal children at the moment one of these actors slides back into a room that had been left in an angered huff and injured amour propre. The phrase itself presumably derives from a rite-de-passage ceremony once arranged by upper-class mothers for their daughters. Interestingly enough, in large mental hospitals the patient sometimes symbolizes a complete coming out by his first active participation in the hospital-wide patient dance.
ate company of a group of persons of his own institutional status.

Like the neophyte in many of these total institutions, the new inpatient finds himself cleanly stripped of many of his accustomed affirmations, satisfactions, and defenses, and is subjected to a rather full set of mortifying experiences: restriction of free movement, communal living, diffuse authority of a whole echelon of people, and so on. Here one begins to learn about the limited extent to which a conception of oneself can be sustained when the usual setting of supports for it are suddenly removed.

While undergoing these humbling moral experiences, the inpatient learns to orient himself in terms of the "ward system." In public mental hospitals this usually consists of a series of graded living arrangements built around wards, administrative units called services, and parole statuses. The "worst" level often involves nothing but wooden benches to sit on, some quite indifferent food, and a small piece of room to sleep in. The "best" level may involve a room of one's own, ground and town privileges, contacts with staff that are relatively undamaging, and what is seen as good food and ample recreational facilities. For disobeying the pervasive house rules, the inmate will receive stringent punishments expressed in terms of loss of privileges; for obedience he will eventually be allowed to reacquire some of the minor satisfactions he took for granted on the outside.

The institutionalization of these radically different levels of living throws light on the implications for self of social settings. And this in turn affirms that the self arises not merely out of its possessor's interactions with significant others, but also out of the settings that are evolved in an organization for its members.

There are some settings that the person easily dis-

29 A good description of the ward system may be found in Ivan Belknap, Human Problems of a State Mental Hospital (New York: McGraw-Hill, 1956), ch. ix, especially p. 164.

counts as an expression or extension of him. When a tourist goes slumming, he may take pleasure in the situation not because it is a reflection of him but because it so assuredly is not. There are other settings, such as living rooms, which the person manages on his own and employs to influence in a favorable direction other persons' views of him. And there are still other settings, such as a work place, which express the employee's occupational status, but over which he has no final control, this being exerted, however tactfully, by his employer. Mental hospitals provide an extreme instance of this latter possibility. And this is due not merely to their uniquely degraded living levels, but also to the unique way in which significance for self is made explicit to the patient, piercingly, persistently, and thoroughly. Once lodged on a given ward, the patient is firmly instructed that the restrictions and deprivations he encounters are not due to such blind forces as tradition or economy—and hence dissociable from self—but are intentional parts of his treatment, part of his need at the time, and therefore an expression of the state that his self has fallen to. Having every reason to initiate requests for better conditions, he is told that when the staff feel he is "able to manage" or will be "comfortable with" a higher ward level, then appropriate action will be taken. In short, assignment to a given ward is presented not as a reward or punishment, but as an expression of his general level of social functioning, his status as a person. Given the fact that the worst ward levels provide a round of life that inpatients with organic brain damage can easily manage, and that these quite limited human beings are present to prove it, one can appreciate some of the mirroring effects of the hospital.30

30 Here is one way in which mental hospitals can be worse than concentration camps and prisons as places in which to "do" time; in the latter, self-insulation from the symbolic implications of the settings may be easier. In fact, self-insulation
The ward system, then, is an extreme instance of how the physical facts of an establishment can be explicitly employed to frame the conception a person takes of himself. In addition, the official psychiatric mandate of mental hospitals gives rise to even more direct, even more blatant, attacks upon the inmate's view of himself. The more "medical" and the more progressive a mental hospital is—the more it attempts to be therapeutic and not merely custodial—the more he may be confronted by high-ranking staff arguing that his past has been a failure, that the cause of this has been within himself, that his attitude to life is wrong, and that if he wants to be a person he will have to change his way of dealing with people and his conceptions of himself. Often the moral value of these verbal assaults will be brought home to him by requiring him to practice taking this psychiatric view of himself in arranged confessional periods, whether in private sessions or group psychotherapy.

Now a general point may be made about the moral career of inpatients which has bearing on many moral careers. Given the stage that any person has reached in a career, one typically finds that he constructs an image of his life course—past, present, and future—which selects, abstracts, and distort in such a way as to provide him with a view of himself that he can usefully expound in current situations. Quite generally, the person's line concerning self defensively brings him into appropriate alignment with the basic values of his society, and so may be called an apologia. If the person can manage to present a view of current situation which shows the operation of favorable personal qualities in the past and a favorable destiny awaiting him, it may be called a success story. If the facts of a person's past and present are extremely dismal, then about the best he can do is

from hospital settings may be so difficult that patients have to employ devices for this which staff interpret as psychotic symptoms.

...to show that he is not responsible for what has become of him, and the term sad tale is appropriate. Interestingly enough, the more the person's past forces him out of apparent alignment with central moral values, the more often he seems compelled to tell his sad tale in any company in which he finds himself. Perhaps he partly responds to the need he feels in others of not having their sense of proper life courses affronted. In any case, it is among convicts, "winos," and prostitutes that one seems to obtain sad tales the most readily. It is the vicissitudes of the mental patient's sad tale that I want to consider now.

In the mental hospital, the setting and the house rules press home to the patient that he is, after all, a mental case who has suffered some kind of social collapse on the


Apparantly one of the occupational hazards of prostitution is that clients and other professional contacts sometimes persist in expressing sympathy by asking for a defensible dramatic explanation for the fall from grace. In having to bother to have a sad tale ready, perhaps the prostitute is more to be pitied than damned. Good examples of prostitute sad tales may be found in Henry Mayhew, *London Labour and the London Poor, Vol. IV, Those That Will Not Work* (London: Charles Griffin and Co., 1862), pp. 210-72. For a contemporary source, see Women of the Streets, edited by C. H. Rolph (London: Secker and Warburg, 1955), especially p. 6: "Almost always, however, after a few comments on the police, the girl would begin to explain how it was that she was in the life, usually in terms of self-justification...." Lately, of course, the psychological expert has helped out the profession in the construction of wholly remarkable sad tales. See, for example, Harold Greenwald, *The Call Girl* (New York: Ballantine Books, 1958).
outside, having failed in some over-all way, and that here he is of little social weight, being hardly capable of acting like a full-fledged person at all. These humiliations are likely to be most keenly felt by middle-class patients, since their previous condition of life little immunizes them against such affronts, but all patients feel some downgrading. Just as any normal member of his outside subculture would do, the patient often responds to this situation by attempting to assert a sad tale proving that he is not "sick," that the "little trouble" he did get into was really somebody else's fault, that his past life course had some honor and rectitude, and that the hospital is therefore unjust in forcing the status of mental patient upon him. This self-respecting tendency is heavily institutionalized within the patient society where opening social contacts typically involve the participants' volunteering information about their current ward location and length of stay so far, but not the reasons for their stay—such interaction being conducted in the manner of small talk on the outside. With greater familiarity, each patient usually volunteers relatively acceptable reasons for his hospitalization, at the same time accepting without open immediate question the lines offered by other patients. Such stories as the following are given and overtly accepted.

I was going to night school to get a M.A. degree, and holding down a job in addition, and the load got too much for me.

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A similar self-protecting rule has been observed in prisons. Thus, Alfred Hassler, *Diary of a Self-Made Convict* (Chicago: Regnery, 1954), p. 76, in describing a conversation with a fellow prisoner: "He didn't say much about why he was sentenced, and I didn't ask him, that being the accepted behavior in prison." A novelistic version for the mental hospital may be found in J. Kerkhoff, *How Thin the Veil: A Newspaperman's Story of His Own Mental Crack-up and Recovery* (New York: Greenberg, 1952), p. 27.

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The others here are sick mentally but I'm suffering from a bad nervous system and that is what is giving me these phobias.

I got here by mistake because of a diabetes diagnosis, and I'll leave in a couple of days. [The patient had been in seven weeks.]

I failed as a child, and later with my wife I reached out for dependency.

My trouble is that I can't work. That's what I'm in for. I had two jobs with a good home and all the money I wanted.33

The patient sometimes reinforces these stories by an optimistic definition of his occupational status. A man who managed to obtain an audition as a radio announcer styles himself a radio announcer; another who worked for some months as a copy boy and was then given a job as a reporter on a large trade journal, but fired after three weeks, defines himself as a reporter.

A whole social role in the patient community may be constructed on the basis of these reciprocally sustained fictions. For these face-to-face niceties tend to be qualified by behind-the-back gossip that comes only a degree closer to the "objective" facts. Here, of course, one can see a classic social function of informal networks of equals: they serve as one another's audience for self-supporting tales—tales that are somewhat more solid than pure fantasy and somewhat thinner than the facts.

But the patient's apologia is called forth in a unique setting, for few settings could be so destructive of self-stories except, of course, those stories already constructed along psychiatric lines. And this destructiveness rests on more than the official sheet of paper which attests that the patient is of unsound mind, a danger to himself and

33 From the writer's field notes of informal interaction with patients, transcribed as nearly verbatim as he was able.
others—an attestation, incidentally, which seems to cut deeply into the patient’s pride, and into the possibility of his having any.

Certainly the degrading conditions of the hospital setting belie many of the self-stories that are presented by patients, and the very fact of being in the mental hospital is evidence against these tales. And of course there is not always sufficient patient solidarity to prevent patient discrediting patient, just as there is not always a sufficient number of “professionalized” attendants to prevent attendant discrediting patient. As one patient informant repeatedly suggested to a fellow patient:

If you’re so smart, how come you got your ass in here?

The mental-hospital setting, however, is more treacherous still. Staff have much to gain through discrediting of the patient’s story—whatever the felt reason for such discrediting. If the custodial faction in the hospital is to succeed in managing his daily round without complaint or trouble from him, then it will prove useful to be able to point out to him that the claims about himself upon which he rationalizes his demands are false, that he is not what he is claiming to be, and that in fact he is a failure as a person. If the psychiatric faction is to impress upon him its views about his personal make-up, then they must be able to show in detail how their version of his past and their version of his character hold up much better than his own.34 If both the custodial and psychiatric factions are to get him to co-operate in the various psychiatric treatments, then it will prove useful to disabuse him of his view of their purposes, and cause him to appreciate that they know what they are doing, and are doing what is best for him. In brief, the difficulties caused by a patient are closely tied to his version of what has been happening to him, and if co-operation is to be secured, it helps if this version is discredited. The patient must “insightfully” come to take, or affect to take, the hospital’s view of himself.

The staff also have ideal means—in addition to the mirroring effect of the setting—for denying the inmate’s rationalizations. Current psychiatric doctrine defines mental disorder as something that can have its roots in the patient’s earliest years, show its signs throughout the course of his life, and invade almost every sector of his current activity. No segment of his past or present need be defined, then, as beyond the jurisdiction and mandate of psychiatric assessment. Mental hospitals bureaucratically institutionalize this extremely wide mandate by formally basing their treatment of the patient upon his diagnosis and hence upon the psychiatric view of his past.

The case record is an important expression of this mandate. This dossier is apparently not regularly used, however, to record occasions when the patient showed capacity to cope honorably and effectively with difficult life situations. Nor is the case record typically used to provide a rough average or sampling of his past conduct. One of its purposes is to show the ways in which the patient is “sick” and the reasons why it was right to commit him and is right currently 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

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34 The process of examining a person psychiatrically and then altering or reducing his status in consequence is known in hospital and prison parlance as bugging, the assumption being that once you come to the attention of the testers you either will automatically be labeled crazy or the process of testing itself will make you crazy. Thus psychiatric staff are sometimes seen not as discovering whether you are sick, but as making you sick; and “Don’t bug me, man” can mean, “Don’t pester me to the point where I’ll get upset.” Sheldon Messinger has suggested to me that this meaning of bugging is related to the other colloquial meaning, of wiring a room with a secret microphone to collect information usable for discrediting the speaker.
“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. Misbehaviors which someone saw as the last straw, as cause for immediate action, are likely to be reported in detail. In addition, the record will describe his state on arrival at the hospital—and this is not likely to be a time of tranquility and ease for him. The record may also report the false line taken by the patient in answering embarrassing questions, showing him as someone who makes claims that are obviously contrary to the facts:

Claims she lives with oldest daughter or with sisters only when sick and in need of care; otherwise with husband, he himself says not for twelve years.

Contrary to the reports from the personnel, he says he no longer bangs on the floor or cries in the morning.

... conceals fact that she had her organs removed, claims she is still menstruating.

35 While many kinds of organization maintain records of their members, in almost all of these some socially significant attributes can only be included indirectly, being officially irrelevant. But since mental hospitals have a legitimate claim to deal with the “whole” person, they need officially recognize no limits to what they consider relevant, a sociologically interesting licence. It is an odd historical fact that persons concerned with promoting civil liberties in other areas of life tend to favor giving the psychiatrist complete discretionary power over the patient. Apparently it is felt that the more power possessed by medically qualified administrators and therapists, the better the interests of the patients will be served. Patients, to my knowledge, have not been polled on this matter.

At first she denied having had premarital sexual experience, but when asked about Jim she said she had forgotten about it ‘cause it had been unpleasant.36

Where contrary facts are not known by the recorder, their presence is often left scrupulously an open question:

The patient denied any heterosexual experiences nor could one trick her into admitting that she had ever been pregnant or into any kind of sexual indulgence, denying masturbation as well.

Even with considerable pressure she was unwilling to engage in any projection of paranoid mechanisms.

No psychotic content could be elicited at this time.37

And if in no more factual way, discrediting statements often appear in descriptions given of the patient’s general social manner in the hospital:

When interviewed, he was bland, apparently self-assured, and sprinkles high-sounding generalizations freely throughout his verbal productions.

Armed with a rather neat appearance and natty little Hitlerian mustache this 45 year old man who has spent the last five or more years of his life in the hospital, is making a very successful hospital adjustment living within the role of a rather gay liver and jim-dandy type of fellow who is not only quite superior to his fellow patients in intellectual respects but who is also quite a man with women. His speech is sprayed with many multi-syllabled words which he generally uses in good context, but if he talks long enough on any subject it soon becomes appar-

35 Verbatim transcriptions of hospital case-record material.
36 Verbatim transcriptions of hospital case-record material.
ent that he is so completely lost in this verbal diarrhea as to make what he says almost completely worthless.  

The events recorded in the case history are, then, just the sort that a layman would consider scandalous, defamatory, and discrediting. I think it is fair to say that all levels of mental-hospital staff fail, in general, to deal with this material with the moral neutrality claimed for medical statements and psychiatric diagnosis, but instead participate, by intonation and gesture if by no other means, in the lay reaction to these acts. This will occur in staff-patient encounters as well as in staff encounters at which no patient is present.

In some mental hospitals, access to the case record is technically restricted to medical and higher nursing levels, but even here informal access or relayed information is often available to lower staff levels. However, ward personnel are felt to have a right to know those aspects of the patient’s past conduct which, embedded in the reputation he develops, purportedly make it possible to manage him with greater benefit to himself and less risk to others. Further, all staff levels typically have access to the nursing notes kept on the ward, which chart the daily course of each patient’s disease, and hence his conduct, providing for the near present the sort of information the case record supplies for his past.

I think that most of the information gathered in case records is quite true, although it might seem also to be true that almost anyone’s life course could yield up enough denigrating facts to provide grounds for the record’s justification of commitment. In any case, I am not concerned here with questioning the desirability of maintaining case records, or the motives of staff in keeping them. The point is that, these facts about him being true, the patient is certainly not relieved from the normal cultural pressure to conceal them, and is perhaps all the more threatened by knowing that they are neatly available, and that he has no control over who gets to learn them. A manly looking youth who responds to military

Verbatim transcriptions of hospital case-record material.

However, some mental hospitals do have a “hot file” of selected records which can be taken out only by special permission. These may be records of patients who work as administration-office messengers and might otherwise snatch glances at their own files; or of inmates who had elite status in the environs of the hospital and hence have a special reason to maneuver access to their records. Some hospitals even have a “hot-hot file,” kept in the superintendent’s office. In addition, the patient’s professional title, especially if it is a medical one, is sometimes purposely omitted from his file card. All of these exceptions to the general rule for handling information, of course, the institution’s realization of some of the implications of keeping mental-hospital records. For a further example, see Harold Taxel, “Authority Structure in a Mental Hospital Ward” (Unpublished M.A. thesis, Department of Sociology, University of Chicago, 1953), pp. 11-12.

This is the problem of “information control” that many groups suffer from in varying degrees. See Goffman, “Discriminating Roles,” in The Presentation of Self in Everyday Life (New York: Anchor Books, 1959), ch. iv, pp. 141-166. A suggestion of this problem in relation to case records in prisons is given by James Peck in his story, “The Ship That Never Hit Port,” in Prison Etiquette, edited by Holley Cantini and Dachnix Rainer (Bearsville, N.Y.: Retort Press, 1950), p. 66; "The hacks of course hold all the aces in dealing with any prisoner because they can always write him up for inevitable punishment. Every infraction of the rules is noted in the prisoner’s jacket, a folder which records all the details of the man’s life before and during imprisonment. There are general reports written by the work detail crew, the cell block crew, or some other crew who may have overheard a conversation. Tales pumped from stoolpigeons are also included. "Any letter which interests the authorities goes into the jacket. The mail censor may make a photostatic copy of a prisoner’s entire letter, or merely copy a passage. Or he may pass the letter on to the warden. Often an inmate called out by the warden or parole officer is confronted with something he wrote so long ago he had forgot all about it. It might be about his personal life or his political views—a fragment of
induction by running away from the barracks and hiding himself in a hotel-room clothes closet, to be found there, crying, by his mother; a woman who travels from Utah to Washington to warn the President of impending doom; a man who disrobes before three young girls; a boy who locks his sister out of the house, striking out two of her teeth when she tries to come back in through the window—each of these persons has done something he will have very obvious reason to conceal from others, and very good reason to tell lies about.

The formal and informal patterns of communication linking staff members tend to amplify the disclosive work done by the case record. A discreditable act that the patient performs during one part of the day’s routine in one part of the hospital community is likely to be reported back to those who supervise other areas of his life where he implicitly takes the stand that he is not the sort of person who could act that way.

Of significance here, as in some other social establishments, is the increasingly common practice of all-level staff conferences, where staff air their views of patients and develop collective agreement concerning the line that the patient is trying to take and the line that should be taken to him. A patient who develops a “personal” relation with an attendant, or manages to make an attendant anxious by eloquent and persistent accusations of malpractice, can be put back into his place by means of the staff meeting, where the attendant is given warning or assurance that the patient is “sick.” Since the differential image of himself that a person usually meets from those of various levels around him comes here to be unified behind the scenes into a common approach, the patient may find himself faced with a kind of collusion against himself—albeit one sincerely thought to be for his own ultimate welfare.

thought that the prison authorities felt was dangerous and filed for later use.”

In addition, the formal transfer of the patient from one ward or service to another is likely to be accompanied by an informal description of his characteristics, this being felt to facilitate the work of the employee who is newly responsible for him.

Finally, at the most informal of levels, the lunchtime and coffee-break small talk of staff often turns upon the latest doings of the patient, the gossip level of any social establishment being here intensified by the assumption that everything about him is in some way the proper business of the hospital employee. Theoretically there seems to be no reason why such gossip should not build up the subject instead of tear him down, unless one claims that talk about those not present will always tend to be critical in order to maintain the integrity and prestige of the circle in which the talking occurs. And so, even when the impulse of the speakers seems kindly and generous, the implication of their talk is typically that the patient is not a complete person. For example, a conscientious group therapist, sympathetic with patients, once admitted to his coffee companions:

I’ve had about three group disrupters, one man in particular—a lawyer [sotto voce] James Wilson—very bright—who just made things miserable for me, but I would always tell him to get on the stage and do something. Well, I was getting desperate and then I bumped into his therapist, who said that right now behind the man’s bluff and front he needed the group very much and that it probably meant more to him than anything else he was getting out of the hospital—he just needed the support. Well, that made me feel altogether different about him. He’s out now.

In general, then, mental hospitals systematically provide for circulation about each patient the kind of information that the patient is likely to try to hide. And in
various degrees of detail this information is used daily to puncture his claims. At the admission and diagnostic conferences, he will be asked questions to which he must give wrong answers in order to maintain his self-respect, and then the true answer may be shot back at him. An attendant whom he tells a version of his past and his reason for being in the hospital may smile disbelievingly, or say, “That’s not the way I heard it,” in line with the practical psychiatry of bringing the patient down to reality. When he accosts a physician or nurse on the ward and presents his claims for more privileges or for discharge, this may be countered by a question which he cannot answer truthfully without calling up a time in his past when he acted disgracefully. When he gives his view of his situation during group psychotherapy, the therapist, taking the role of interrogator, may attempt to disabuse him of his face-saving interpretations and encourage an interpretation suggesting that it is he himself who is to blame and who must change. When he claims to staff or fellow patients that he is well and has never been really sick, someone may give him graphic details of how, only one month ago, he was prancing around like a girl, or claiming that he was God, or declining to talk or eat, or putting gum in his hair.

Each time the staff deflates the patient’s claims, his sense of what a person ought to be and the rules of peer-group social intercourse press him to reconstruct his stories; and each time he does this, the custodial and psychiatric interests of the staff may lead them to discredit these tales again.

Behind these verbally instigated ups and downs of the self is an institutional base that rocks just as precariously. Contrary to popular opinion, the “ward system” insures a great amount of internal social mobility in mental hospitals, especially during the inmate’s first year. During that time he is likely to have altered his service once, his ward three or four times, and his parole status several times; and he is likely to have experienced moves in bad as well as good directions. Each of these moves involves a very drastic alteration in level of living and in available materials out of which to build a self-confirming round of activities, an alteration equivalent in scope, say, to a move up or down a class in the wider class system. Moreover, fellow inmates with whom he has partially identified himself will similarly be moving, but in different directions and at different rates, thus reflecting feelings of social change to the person even when he does not experience them directly.

As previously implied, the doctrines of psychiatry can reinforce the social fluctuations of the ward system. Thus there is a current psychiatric view that the ward system is a kind of social hothouse in which patients start as social infants and end up, within the year, on convalescent wards as resocialized adults. This view adds considerably to the weight and pride that staff can attach to their work, and necessitates a certain amount of blindness, especially at higher staff levels, to other ways of viewing the ward system, such as a method for disciplining unruly persons through punishment and reward. In any case, this resocialization perspective tends to overstate the extent to which those on the worst wards are incapable of socialized conduct and the extent to which those on the best wards are ready and willing to play the social game. Because the ward system is something more than a resocialization chamber, inmates find many reasons for “messing up” or getting into trouble, and many occasions, then, for demotion to less privileged ward positions. These demotions may be officially interpreted as psychiatric relapses or moral backsliding, thus protecting the resocialization view of the hospital; these interpretations, by implication, translate a mere infractions of rules and consequent demotion into a fundamental expression of the status of the culprit’s self. Correspondingly, promotions, which may come about because of ward population pressure, the
need for a "working patient," or for other psychiatrically irrelevant reasons, may be built up into something claimed to be profoundly expressive of the patient's whole self. The patient himself may be expected by staff to make a personal effort to "get well," in something less than a year, and hence may be constantly reminded to think in terms of the self's success and failure.\(^{41}\)

In such contexts inmates can discover that deflations in moral status are not so bad as they had imagined. After all, infractions which lead to these demotions cannot be accompanied by legal sanctions or by reduction to the status of mental patient, since these conditions already prevail. Further, no past or current delict seems to be horrendous enough in itself to excommunicate a patient from the patient community, and hence failures at right living lose some of their stigmatizing meaning.\(^{42}\)

And finally, in accepting the hospital's version of his fall from grace, the patient can set himself up in the business of "straightening up," and make claims of sympathy, privileges, and indifference from the staff in order to foster this.

Learning to live under conditions of imminent exposure and wide fluctuation in regard, with little control over the granting or withholding of this regard, is an important step in the socialization of the patient, a step that tells something important about what it is like to be an inmate in a mental hospital. Having one's past mistakes and present progress under constant moral review seems to make for a special adaptation consisting of a less than moral attitude to ego ideals. One's shortcomings and successes become too central and fluctuating an issue in life to allow the usual commitment of concern for other persons' views of them. It is not very practicable to try to sustain solid claims about oneself. The inmate tends to learn that degradations and reconstructions of the self need not be given too much weight, at the same time learning that staff and inmates are ready to view an inflation or deflation of a self with some indifference. He learns that a defensible picture of self can be seen as something outside oneself that can be constructed, lost, and rebuilt, all with great speed and some equanimity. He learns about the viability of taking up a standpoint—and hence a self—that is outside the one which the hospital can give and take away from him.

The setting, then, seems to engender a kind of cosmopolitan sophistication, a kind of civic apathy. In this unserious yet oddly exaggerated moral context, building up a self or having it destroyed becomes something of a shameless game, and learning to view this process as a game seems to make for some demoralization, the game being such a fundamental one. In the hospital, then, the inmate can learn that the self is not a fortress, but rather a small open city; he can become weary of having to show pleasure when held by troops of his own, and weary of having to show displeasure when held by the enemy. Once he learns what it is like to be defined by society as not having a viable self, this threatening definition—the threat that helps attach people to the self society accords them—is weakened. The patient seems to gain a new plateau when he learns that he can survive while acting in a way that society sees as destructive of him.

A few illustrations of this moral loosening and moral fatigue might be given. In state mental hospitals currently a kind of "marriage moratorium" appears to be accepted by patients and more or less condoned by staff. Some informal peer-group pressure may be brought against a patient who "plays around" with more than one hospital partner at a time, but little negative sanction seems to be attached to taking up, in a temporarily steady

\(^{41}\) For this and other suggestions, I am indebted to Charlotte Green Schwartz.

\(^{42}\) See "The Underlife of a Public Institution," this book, fn. 167.
way, with a member of the opposite sex, even though both partners are known to be married, to have children, and even to be regularly visited by these outsiders. In short, there is licence in mental hospitals to begin courting all over again, with the understanding, however, that nothing very permanent or serious can come of this. Like shipboard or vacation romances, these entanglements attest to the way in which the hospital is cut off from the outside community, becoming a world of its own, operated for the benefit of its own citizens. And certainly this moratorium is an expression of the alienation and hostility that patients feel for those on the outside to whom they were closely related. But, in addition, one has evidence of the loosening effects of living in a world within a world, under conditions which make it difficult to give full seriousness to either of them.

The second illustration concerns the ward system. On the worst ward level, discrediting seem to occur the most frequently, in part because of lack of facilities, in part through the mockery and sarcasm that seem to be the occupational norm of social control for the attendants and nurses who administer these places. At the same time, the paucity of equipment and rights means that not much self can be built up. The patient finds himself constantly toppled, therefore, but with very little distance to fall. A kind of jaunty gallows humor seems to develop in some of these wards, with considerable freedom to stand up to the staff and return insult for insult. While these patients can be punished, they cannot, for example, be easily slighted, for they are accorded as a matter of course few of the niceties that people must enjoy before they can suffer subtle abuse. Like prostitutes in connection with sex, inmates on these wards have very little reputation or rights to lose and can therefore take certain liberties. As the person moves up the ward system, he can manage more and more to avoid incidents which discredit his claim to be a human being, and acquire more and more of the varied ingredients of self-respect; yet when eventually he does get toppled—and he does—there is a much farther distance to fall. For instance, the privileged patient lives in a world wider than the ward, containing recreation workers who, on request, can dole out cake, cards, table-tennis balls, tickets to the movies, and writing materials. But in the absence of the social control of payment which is typically exerted by a recipient on the outside, the patient runs the risk that even a warmhearted functionary may, on occasion, tell him to wait until she has finished an informal chat, or teasingly ask why he wants what he has asked for, or respond with a dead pause and a cold look of appraisal.

Moving up and down the ward system means, then, not only a shift in self-constructive equipment, a shift in reflected status, but also a change in the calculus of risks. Appreciation of risks to his self-conception is part of everyone's moral experience, but an appreciation that a given risk level is itself merely a social arrangement is a rarer kind of experience, and one that seems to help to disenchant the person who undergoes it.

A third instance of moral loosening has to do with the conditions that are often associated with the release of the inpatient. Often he leaves under the supervision and jurisdiction of his next-of-relations or of a specially selected and specially watchful employer. If he misbehaves while under their auspices, they can quickly obtain his readmission. He therefore finds himself under the special power of persons who ordinarily would not have this kind of power over him, and about whom, moreover, he may have had prior cause to feel quite bitter. In order to get out of the hospital, however, he may conceal his displeasure in this arrangement, and, at least until safely off the hospital rolls, act out a willingness to accept this kind of custody. These discharge procedures, then, provide a built-in lesson in overtly taking a role without the
usual covert commitments, and seem further to separate the person from the worlds that others take seriously.

The moral career of a person of a given social category involves a standard sequence of changes in his way of conceiving of selves, including, importantly, his own. These half-buried lines of development can be followed by studying his moral experiences—that is, happenings which mark a turning point in the way in which the person views the world—although the particularities of this view may be difficult to establish. And note can be taken of overt tacks or strategies—that is, stands that he effectively takes before specifiable others, whatever the hidden and variable nature of his inward attachment to these presentations. By taking note of moral experiences and overt personal stands, one can obtain a relatively objective tracing of relatively subjective matters.

Each moral career, and behind this, each self, occurs within the confines of an institutional system, whether a social establishment such as a mental hospital or a complex of personal and professional relationships. The self, then, can be seen as something that resides in the arrangements prevailing in a social system for its members. The self in this sense is not a property of the person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connection with the person by himself and those around him. This special kind of institutional arrangement does not so much support the self as constitute it.

In this paper, two of these institutional arrangements have been considered, by pointing to what happens to the person when these rulings are weakened. The first concerns the felt loyalty of his next-of-relations. The patient's self is described as a function of the way in which these roles are related, arising and declining in the kinds of affiliation that occur between the next-of-relations and the mediators. The second concerns the protec-