CHAPTER 4

Psychopathology or Deviance: Treatment or Intervention?

RUTH BENNETT and ELIZABETH SANCHEZ

Currently, the following concepts are used virtually interchangeably in the mental health profession: psychopathology, mental illness, maladjustment, behavior disorder, emotional disorder, and deviance. Several other related terms turn up in common parlance, for example, crazy, insane, nonconforming, and unsocialized. Often these labels are applied to individuals or groups of individuals with whom we do not share a set of values. Recently student demonstrators have been referred to as “crazies.” It has also been easy to dismiss women’s liberationists, Black Panthers, Young Lords, and hippies as deranged, while the “silent majority” or middle Americans are regarded, by implication, as mentally sound. It is apparent that terms which refer to mental illness are sufficiently fuzzy to allow professionals and nonprofessionals alike to take liberties in their usage. This practice is, at best, unscientific. At worst, it seems dangerous, particularly in times like ours in which technological change is accelerated, bringing with it changes in values, norms, and practices. Needless to say, the various labels referring to mental illness, when applied to groups or persons with whom we disagree, allow us to ignore, ridicule, or even incarcerate them.

Not only are deviance and psychopathology often equated, but also deviant sectors of society and nonlegitimated group and crowd deviant actions are often thought to result from individual psychopathology. Unfamiliar or new systems are seen not merely as repositories for individual pathology but as resultants of individual pathology as well. For example, in a recent study by Hendin (1971) of campus militants, it was found that their relationships with their families were disturbed. Although campus militants may well have poor relationships with their parents, no control groups of campus nonmilitants were studied to determine what their relationships at home were like. Given a generation gap, all college students
may have difficulty communicating with their parents. Disturbances in individuals may possibly explain why they gravitate to militant groups, but the phenomenon of campus rebellion is a sociocultural pattern, the causes of which may be far more complex than individual psychopathology.

Not 10 years ago, a very different view of the relation between deviance and psychopathology was being taken, largely among social scientists, but also in other sectors of society. In a number of studies conducted roughly a decade ago, conformity was found to be related to factors indicative of mental illness. DiVesta and Cox (1960) found a relationship between conformity and anxiety. Breger (1963) reported a relationship between conformity and inability to express hostility overtly. Hoffman (1953) observed a relationship between conformity and lack of ego strength. On the other hand, in our own research on residents of a home for the aged (Nahemow & Bennett, 1967) a positive relationship was obtained between conformity and mental health.

Undoubtedly, the truth lies somewhere between the two extreme positions: some mentally ill people deviate from social norms, and others conform to them; also, the ill may deviate from some social norms but conform to others. Observed rates and correlations of deviance and conformity probably depend on the norms to which individuals are expected to conform and the degree of commitment that individuals have to these norms. The definitions and measures of conformity and deviance used in research may also determine the rates obtained. As far as can be determined, there seems to be no more conceptual clarity today in the study of conformity and deviance and their relationship to mental illness than existed 10 years ago.

This chapter is addressed to classifying acts of conformity and deviance according to who enacts them and the extent of group legitimation, examining current theories concerning the relationship between conformity and deviance and psychopathology, discussing the points of view of socially oriented theorists regarding the treatment of psychopathology, and making suggestions for rendering this field more amenable to research in the future.

There is, as yet, no consensus on the definitions of the concepts of norm, conformity, deviance, and mental illness, and no reliable, valid, or good methods for directly observing and measuring these concepts.

The concept of social norm is a key one in these fields. Each field has its own definition of norm, as well as its own definitions of the derivative concepts of conformity, deviance, and abnormality. Sociologists define norms as expectations for behavior to which positive or negative sanctions are assigned. Conformity is behavior enacted in accordance with norms; deviance is behavior that violates norms. It is this set of definitions that has been described.

However, psychopathology is another story. A specific person can have an illness prescribed by a physician, and yet be deviant in a particular way. Thus, there is the discrepancy between the ill and the deviant. This has been discussed by Calhoun (1951), who stresses that the major source of this disparity is the difference between the mental illness that is present and the deviant actions that may result.

CLASSIFICATION

Both classification and deviation are necessary if the field is to progress. Two ways of classifying deviance are (a) by the degree of illegitimacy and (b) by the nature of the deviation. The former includes the acts of persons who are criminals, whether or not they are commission of crimes. The latter includes those acts of individuals who are not engaged in the commission of crimes but who are engaged in acts of violation of norms.

Both the term "deviant" and "criminal" are sometimes applied to the same person. This is because many people believe that deviance is synonymous with crime. This is not the case. Deviance includes a much wider range of behavior than does crime. For example, a person who is deviant may be defined as a person who breaks the rules of society, while a criminal is defined as a person who commits a crime. The two concepts are not synonymous.

Two examples of the application of the term "deviant" would be a person who does not conform to a certain social norm, and a person who engages in behavior that is not considered normal by society. In both cases, the person is considered deviant. However, the term "criminal" is only applied to the person who engages in behavior that is considered illegal by society. In this case, the person would be considered criminal.

As the field of psychopathology continues to develop, it is likely that more and more will be learned about the nature of deviance and its relationship to mental illness. The more we know about these concepts, the better we will be able to understand and treat those who suffer from them.
has been used in our research, as well as in the work of some other authors described in the rest of the chapter.

However, it should be noted that there are also anthropological, social psychological, and psychiatric definitions of norms, conformity, and deviance. Anthropologists, much like sociologists, see norms as culturally specific patterns of behavior. For social psychologists, most of whom work with ad hoc groups, norms represent behaviors of a majority of a group; deviance or nonconformity is taking a stand against a majority view, often when the majority is wrong and there is much group pressure to conform; conformity usually means supporting an erroneous judgment of a group majority. The psychiatric view of norms seems to alternate between accepting as a norm a statistical standard of behavior of average individuals or, conversely, defining as a norm that which is right for any individual at any given time. Little or no effort has been made to try to develop definitions of these concepts that are acceptable to members of all of the professions mentioned above.

CLASSIFYING DEVIANCE AND CONFORMITY

Both deviance and conformity may be cross classified in a number of ways. Two crucial dimensions for classifying acts of conformity and deviance are whether they are enacted by an individual, a group, or a crowd and whether they are nonlegitimated acts and nonlegitimated rituals or legitimated acts and legitimated rituals.

Using the words legitimated and nonlegitimated raises the sticky question of legitimated by whom. Usually, we think in terms of society as a whole and assume more rationality, homogeneity, and cohesion in society than is warranted. For example, we assume social agreement on the definition of a crime because such agreement is reflected in codified laws. However, it is probably true that consensus on the definition of a crime varies from state to state, subculture to subculture, and subgroup to subgroup. Whereas acts of vigilante groups toward Blacks may have been applauded in the South, they were often punished in the North. However, it should be noted that even this situation is changing, and vigilant acts toward Blacks may be coming to be regarded as criminal behavior throughout the United States.

Two other questions are raised by this conceptualization of deviance and conformity: (1) conformity to what and deviance from what and (2) who does the legitimating and nonlegitimating of behavior? As noted above, these questions may be answered tentatively by the statement that codes of
behavior and legitimators of behavior vary from region to region, subculture to subculture, and subgroup to subgroup. This makes especially problematic decisions determining what is deviant, who is deviant and what should be done with a deviant. Therefore any classification of conformity or deviance must be regarded as highly tentative, culture bound, and time bound.

However, if there is concern with intervening in deviance-producing and deviance-maintaining systems, as is suggested by Scheff (1964) and those involved in community psychiatry programs such as Gruenberg (1969) and Sainsbury (1969), an effort should be made to locate such systems. It is our view that psychopathology may be generated in many nondeviant sectors of society. By cross-classifying acts of deviance and conformity according to who performs them and whether or not they are legitimated, this point may be illustrated.

Examples of nonlegitimated acts of deviance performed by groups are gang wars, revolutionary activities, and police brutality; nonlegitimated acts of deviance performed by crowds are rioting, ritual persecutions, pogroms, and witch hunts; nonlegitimated acts of deviance performed by individuals are crimes and other forms of rule breaking. Legitimated acts of deviance performed by groups are vandalism by some groups of children and adolescents, most acts of warfare, convention behavior, and hazing. Legitimated acts of deviance performed by crowds are participation in vigilant raids and behavior during carnivals. Some examples of legitimated acts of deviance performed by individuals are mystical experiences and religious visions and acts of mischief by children and adolescents.

Examples of nonlegitimated acts of conformity engaged in by groups are superpatriotic activities; crowds may engage in nonlegitimated conformity demonstrations such as those recently conducted by "hard-hats." Individuals who exhibit blind obedience to authority exemplify a high degree of nonlegitimated conformity. Legitimated conformity on the part of groups is behavior exhibited at meetings of organizations, behavior during rites of passage, some patriotic behavior, and behavior exhibited on feast days and holiday celebrations. Examples of legitimated conforming behavior on the part of crowds are subway behavior, behavior at athletic meets, and other behaviors of large groups of spectators. Legitimated conformity on the part of individuals consists of most daily, role enactment behavior.

The problem of fitting mental illness into the tentative classification system outlined above is difficult. It is clear that most forms of deviance or rule breaking occur in groups and/or are legitimated either at specified

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* The terms legitimated and nonlegitimated are only approximately accurate; for example, group activities such as revolution obviously have some intragroup legitimation.
periods during the life cycle or under specific conditions. This is probably true for most societies. The only category of deviance that seems to have concerned those interested in its relation to psychopathology is that of nonlegitimated rule breaking by individuals.

However, it is possible for mental illness to be expressed in the acts listed in all cells of this classification system. For example, the superpatriot or “hard-hat” may be as paranoid in his extreme conformity as the criminal is in his individual rule-breaking activity. In other words, nondeviant sectors of society may also produce and sustain psychopathology. To resolve this problem, mental health studies of superpatriots are needed along with studies of prison or hospital inmates.

ETIOLOGY OF PSYCHOPATHOLOGY AND ORIENTATION OF TREATMENT

In regard to nonlegitimated acts of deviance performed by individuals, there is virtually no agreement about causes. In general, the various authors whose work is discussed below seem to view deviance and psychopathology as indistinguishable. They differ, though, in their views of etiology. At one extreme are social scientists who virtually ignore the medical framework in relation to psychopathology and regard as deviance all behavior disorders that have an etiological basis in society. At another extreme are those postulating a medical model in which deviance and psychopathology are equated but are thought of in organic terms. Treatment, if and when suggested, may or may not correspond to the definition of or presumed etiological basis for psychopathology. With the exception of Erikson (1962) none of the environmentalists considered here proposes to treat the deviant’s environment. Yates (1970) is intermediate in his views between an environmentalist and an individualist. There is some agreement that one or another aspect of environment generates deviance and/or psychopathology; however, most therapies proposed are directed at the “victim” of environment and not at the causal agents.

According to some, psychopathology resides in the eyes of the beholder and not in those whose behavior may violate social norms. If social norms change, the deviant may in time be thought of as normal. According to sociologist Erikson (1962), deviance is conventionally defined as a symptom of internal breakdown in society and as an accidental result of disorder and anomie. However, in his view this framework is too narrow because deviant activities “develop forms of organization, persist over time, and sometimes remain intact after the strains which originally produced them have disappeared [p. 307].” Erikson believes that the study of deviant be-
havior is as much a study of social organization as it is of disorganization and anomie. No form of behavior is inherently deviant but rather is deemed deviant by a social audience. Therefore he thinks the audience is the critical variable in the study of deviance. Society is the screening device that isolates the deviant details in otherwise conforming behavior. He considers a number of factors important to society which are "not directly related to the deviant act itself: it is concerned with the actor's social class, his past record as an offender, the amount of remorse he manages to convey and many similar concerns which take hold in the shifting moods of the community... [p. 308]."

Erikson notes that Durkheim theorized that deviant acts are not necessarily harmful to a society and that deviance helps keep social order intact. He suggests, therefore, that deviant behavior, by its extreme nature and subsequent interaction with social control agencies, marks the behavioral boundaries of a social system, thereby defining how much variability and diversity a system can cope with before losing its distinct structure. Erikson's research interests are to determine how persons are selected to play deviant roles and to study comparatively the societies that allow individuals to engage in deviant behavior at specific ages or during special seasons. He notes that such societies allow deviants, upon termination of "the period of services on society's boundaries," to relinquish the deviant role without stigma.

A significant impetus to study the society that designates people as deviant or mentally ill came from the work of Scheff (1964). He studied some of the variations in the procedures for hospitalizing and committing persons alleged to be mentally ill in metropolitan and nonmetropolitan jurisdictions in a midwestern state. He interviewed judges, psychiatrists, and officials of 20 counties and observed proceedings in four jurisdictions. He found that in jurisdictions characterized by a small volume of cases there were only moderate public pressures against erroneously releasing patients from hospitals. Personal acquaintance with the patient or his family, little psychiatric sophistication, and, where the patient has them, resources for defending himself against allegations about him bring about "substantial rationality" in commitment procedures. On the other hand, jurisdictions with large numbers of cases, strong public pressures against erroneous releases, and lack of personal acquaintance with the persons alleged to be mentally ill, as well as limited resources whereby persons can defend themselves against such allegations, have many hospitalizations. In fact, hospitalization and treatment were found to be virtually automatic once the complaint had been brought to court. These findings suggest that in urban areas where there are large numbers of cases the relationship between urbanism and the high incidence of mental illness may simply be...
due to the absence of broad, rational screening processes. Scheff also suggested that the decision about diagnosis, hospitalization, and treatment is made basically by relatives or others who bring the individual to court. He concludes that to understand the incidence of mental illness one must study the operation of social control in the community.

In a later work, Scheff (1966) formulated a theory of mental illness which contains two basic components: "social role and social reaction. Its key assumptions are that most chronic mental illness is at least in part a social role and that the societal reaction is usually the most important determinant of entry into that role [p. 28]." Rule-breaking acts, responses of others, and rulebreakers' responses to others' responses constitute a social system with definite boundaries and self-maintaining properties. To treat illness means, therefore, to disrupt a chain of relationships in a bounded, self-maintaining system. Scheff points out that, in spite of large numbers of studies done on functional mental disorders, there is no substantial verified body of knowledge about them. Most methods of diagnosis are clinical and have not been verified by scientific measures. He criticizes psychiatric, genetic, biochemical, and psychological investigations on the grounds that they focus attention on individual differences rather than on the social system in which the individual is found.

Blum (N. D.) lends support to Scheff's assertion that screening processes are largely unscientific, as well as particularistic. He discusses the verdict of not guilty because of insanity (NGI), usually based on the amount of biographical data available and known to jurors. He cites a case involving a man who had regular incestuous relations with his daughter and whose wife knew of these acts. Four alternate "rules" were used to reach the NGI verdict: (1) the unfreedom rule, (2) the cultural alien rule, (3) the search procedure rule, and (4) the disposition rule. The unfreedom rule says, "Given a member's description of an act as a rule violation, any description of the actor which posits him as being chained by impulse or bound by stimuli in such a way as to be unfree to alter his action at the time of the event warrants a judgment of him as excusable [p. 28]." The cultural rule says, "Given a member's description of the act as a rule violation, any description of the actor which posits him as not knowing the meaning of his actions and hence as not being a normal, competent member of the collectivity, warrants a judgment of him as excusable [p. 29]." The search procedure rule says that jurors should search a defendant's biography on the supposition that if he is sick some biographical component, such as work history, will show this. The disposition rule allows jurors to equate mental illness with disposition, that is, to decide on a verdict on the basis of whether a hospital or a prison is more suitable for the type of person in question. When all was said and done, no positive criteria indicating mental
illness were used to reach an NGI decision. The decision to hospitalize rather than imprison a deviant was not based on clear-cut signs and symptoms of mental illness.

By and large, none of the sociological theorists cited above give concrete suggestions for reducing the societal bases for deviance. At best it may be inferred that they would suggest intervention at some point in a deviance-producing or deviance-maintaining system. Erikson's allusion to societies which set aside periods for ritual deviance suggests that perhaps some sort of prolonged Mardi Gras season would eliminate some forms of what passes for mental illness in our society.

Yates (1970), whose point of view is based on learning theory and is, we consider, intermediate between the environmentalist and the individualist point of view, has experimentally altered institutional environments to approximate community environments. Through reinforcement and other learning principles, the institutionalized individuals' "wrong" behavior, which was learned somewhere along the line at critical development periods and which may be a symptom of a pathology syndrome, can be corrected. Once the symptom is "extinguished," secondary symptoms may well disappear. Behavior, not personality, is treated. The milieu of the individual deviant is revised in order to change his behavior but not to make the behavior seem less deviant.

The theorists to be discussed below view the etiology of psychopathology, or at least some forms of it, in societal terms. Those who propose treatment, however, offer suggestions for the treatment of individuals, not systems.

Szasz, a psychiatrist, wrote (1960) that the conventional notion of mental illness is derived from the idea that a discoverable defect exists in physicochemical processes and hence that mental disorders are not due to differences in individual needs, opinions, aspirations, and experiences. His criticisms of the conventional point of view imply that the converse is true, namely, that a defect or disease of a physicochemical process manifests itself in an individual other than by delusions and "belief in things." According to Szasz, mental symptoms are bound to the social context because they refer to an individual's communications about himself, others, and the world, when the observer believes them to be otherwise. This involves making judgments by comparing the "sick" individual's beliefs with those of the observer and society. While symptoms arise in the context of the stresses and strains inherent in social intercourse, conventional notions of mental illness use them to identify or describe a feature of an individual's personality. Mental illness as a defect in the personality is often considered a cause of human conflict; the cause of conflict is not viewed as the social situation that produces stresses and strains, but rather as the personality that does not adapt to these stresses. Mental illness implies deviation from social and ethical norms. Social measures, an idea that psychiatrist's socioethical

Therefore, he thinks that the most part communicated in an unusual idiom [p. 118]. Szasz is the proper heir to the theory of "social tranquil:" a certain specific problems may be recognition [p. 118].

In a later and longer experience with the social background of the phenomena of mental illness, to diminish or disappear (as conceptualized mental illness to behavior, playing (character personal controls, and strategies) is used because there is a recognition it is especially useful. A of human action determined by rules in behavior labeled as megalomania the helplessness of one role as the Judaeo-Christian of helping the weak, ill, and poor, as to those helped. When measured in terms of goals (ends) disease with mental illness, Szasz sees as basically survival, of nature of metagames concern.

Socially deviant or obnoxious in many different ways. Placing other people may be justified cannot be supported by scientific evidence of suffering as illness. Szasz, p. 118). Non-A's (which look like the cut-off A) is illness-imitating we lump together an imitation; illness should be concerned sympotms of something more
psychosocial and ethical norms, and yet the remedy is sought in terms of medical measures, an idea that Szasz finds logically absurd. He notes that the psychiatrist's socioethical orientations influence his diagnosis and therapy. Therefore, he thinks that "what people now call mental illness are for the most part communications expressing unacceptable ideas, often framed in an unusual idiom [p. 116]." Belief in mental illness, according to Szasz, is the proper heir to belief in witchcraft and demonology. This belief acts as a "social tranquilizer thus encouraging the hope that mastery of certain specific problems may be achieved by means of a substitute . . . operation [p. 118]."

In a later and longer exposition of his theory, Szasz (1961) wrote, "When the social background of behavioral phenomena is treated as a variable, the phenomena of mental illness can be seen to appear, become intensified, diminish or disappear [p. 10]." Using hysteria as a paradigm, Szasz conceptualized mental illness in terms of (1) sign usage (hysteria-protolanguage); (2) rule following (helplessness, illness, and coercion); and (3) game playing (characterized by end goals of domination, interpersonal controls, and strategies of deceit). Hysteria, the "language of illness," is used because there is inadequate facility with another language or because it is especially useful. As rule following, illness is seen as a pattern of human action determined by roles and rules. There are two sources of rules in behavior labeled as mental illness. One is "paired activity," involving the helplessness of one role partner and the helpfulness of another. The other is the Judeo-Christian cultural tradition, which places emphasis on helping the weak, ill, and poor, behavior that is rewarding to the helpers as well as to those helped. When viewed as game playing, illness is conceptualized in terms of goals (ends) and strategies (means). Contrasting body illness with mental illness, Szasz noted that the object of the body-illness game is bodily survival, whereas mental illness involves a heterogeneous mixture of metagames concerning how men should live. He noted:

"Socially deviant or obnoxious behavior may, in principle, be classified in many different ways. Placing some individuals or groups in the class of sick people may be justified by considerations of social expediency but cannot be supported by scientific observations or logical arguments [p. 43]."

By defining the behavioral disorder of hysteria as an illness, or any kind of suffering as illness, Szasz noted that we have lumped together A's (ill people), non-A's (which look like A's), and counterfeit A's. Hysteria (a counterfeit A) is illness-imitation behavior and to classify it as illness is to lump together an imitation and an actual item. Szasz concluded that psychiatry should be concerned with signs qua signs and not with signs as symptoms of something more real than themselves. He believed that psy-
chopathy should be conceived of in terms of object relationships, using, rule following, social roles, and game playing and that psychopathology should be conceived of as “a theory of human relationships involving special social arrangements and fostering certain values and types of learning [p. 297].”

The theorists whose points of view will now be briefly discussed were along more or less similar lines. Clausen (1968) advocated a positive approach to defining mental health, one dealing with performance, capacities, and utilization, as well as situational and contextual influence. He rejected the medical model of disease for dealing with mental health and disorder and believed that the nomenclature and practices of psychiatry were inadequate for defining and measuring mental health. Clausen located the etiology of psychopathology in the individual, though viewed in terms of his context. He noted that the problem seems to be lodged not in the organism so much as in the person and that it is the functions of the socialized person (thought processes, beliefs, motivations, feelings, interpersonal skills) that are disordered, not those of the organism.

Presumably, if one accepts Szasz’s as well as Clausen’s conceptualizations, treatment for mental illness would consist of resocialization, re-education, behavior therapy, and/or persuasion techniques directed at the “sick” individual, more specifically at his personality, rather than at others in his social milieu.

For Gruenberg (1969) the secondary symptoms of mental disease may be as debilitating as the disease itself. Gruenberg referred to these secondary symptoms as social breakdown syndrome (SBS), for which there is no cure. He suggested that SBS may be prevented by reorienting both the individual and his immediate environment. Thus, although the major illness is treated medically, the secondary symptoms should be handled through social intervention techniques.

Pasamanick (1968) viewed mental illness as disease but cautioned not to confuse it with deviance. Diseases can be treated by a variety of therapies; not so deviance, which requires social change.

**RESEARCH UTILIZING INDEPENDENT DEFINITIONS OF MENTAL ILLNESS AND DEVIANCE**

In order to bring about some conceptual clarity, as well as to foster research, the following suggestion is tentatively offered: define mental illness and deviance independently and hold to these definitions. If we agree to label a behavior as pathological, treatment should be aimed at the individual, his personality, his behavior, or his nervous system. However,
if a behavior is viewed as deviant—and if that is deemed undesirable—then the social system may have to become the target of effort to eliminate the causes of deviance. In order to approach this goal, illness and deviance should be observed independently. The following examples from our research on the institutionalized aged (Bennett & Nahemow, 1965b; Walton, Bennett, & Nahemow, 1964) will illustrate how this can be done.

After extensive participant observation and interviews with residents of a home for the aged (selected for study because it was a clearly bounded community for the normal aged), norms were located on which there were varying degrees of consensus and which were adhered to with varying degrees of conformity. Norms were defined as expectations for behavior, on which there were varying degrees of consensus, but which were arbitrarily defined as norms because more than 50% of respondents agreed on them. Four norms were studied; three concerned interaction among residents and one concerned interaction between staff and residents, namely, tipping the help.

These norms formed the basis for constructing indices of socialization (knowledge of norms and customary practices) and conformity (behavior enacted in accordance with norms). Patterns of conformity were studied in 100 residents of a home for aged over a two-year period. One hundred consecutive new residents were interviewed on admission and after one month, two months, and two years in the home. Findings showed that conforming behavior was exhibited early. For example, at one month, 72% of the residents reported no overt conflict with their roommates, 88% reported no conflict with tablemates, 58% said they would not ask staff members for a change of room, and 74% said they tipped the help.

With time, conformity to each norm showed a distinct pattern of change. Conformity decreased on the two norms pertaining to interpersonal relations with other residents. At the end of two years, fewer residents reported that they liked or tolerated all roommates or all tablemates. Apparently, even if they intended to conform to the norm of avoiding conflict at all costs, the exigencies of group living eventually brought residents into conflict. What is interesting is that, despite increased conflict, a greater proportion of residents adhered to the norm that prevented them from asking staff members for a change of room. Adherence to this norm increased progressively, with 58% obeying it at one month, 62% at two months, and 71% at two years. Apparently, residents felt the need to avoid making any conflict public and therefore kept themselves from complaining to staff members.

Responses to the tipping norm, a subgroup norm found among residents, were also intriguing, since the conforming response was in conflict with administrative policy and with the norms of the higher-level staff.
At one month, about three-fourths of the residents gave tips; by two years, nearly everyone did. Although administrative and professional staff members tried to enforce a "no tipping" policy, they appeared to be unsuccessful in discouraging both residents and staff members from giving and accepting tips. One of the first things learned by the new resident was that he was expected to pay for many of the services he received, and numerous myths were circulated among residents about the lack of care given to individuals who had not tipped. The fact that the tipping norm was clearly operative despite the existence of an administrative policy prohibiting it indicated that residents did not blindly conform to staff rules, but were prepared to do so only when they approved of these rules or when the rules met their needs.

Mental illness was studied independently by a psychiatrist who, as far as possible, tried to eliminate questions about current social behavior from the standard clinical examination he constructed. His work was conducted two years after residents were admitted. Residents were diagnosed according to whether they had senile dementia or functional mental disorders or were normal; the majority were diagnosed as normal. Estimates of conformity taken independently were based on self-reports of behavior enacted in accordance with norms; integration was measured on the basis of self-reports and on reports by others of involvement in activities and friendships; and evaluations were based on reports of feelings about the home. Early conformity, integration and evaluation measures did not correlate significantly with mental disorder. After two years, all mentally disordered subjects were characterized by low participation in home activities, such as clubs, games, concerts, and friendship groups. Those with senile dementia were most like the normal aged. They evaluated the home positively and were positively identified with it. Those with functional disorder, on the other hand, evaluated the home negatively. They were the residents who had no positive affective bonds with their present environment. Failure to participate was also associated with functional psychiatric disorder. Residents with functional psychiatric disorder were uniformly maladjusted according to measures of social adjustment. There is some question, of course, about whether or not the psychiatric examination really omitted social data. On the assumption that it did, it is possible to assert that a relationship exists between functional pathology and social deviance, when both sets of measures are obtained in the same period.

The concepts of socialization and conformity refer to social processes found in any social system. However, the specific items in scales constructed to measure these processes will vary, depending on the cultural patterns of the system. Thus in one setting it may be a sign of conformity to give tips to hired help; in another, it may be deviant to do so. Although all social
systems require the processes of socialization, integration, evaluation, and conformity, the emphasis placed on these processes will vary considerably. In some types of settings, therefore, integration may be thought of as central; in others, conformity to rules may be stressed.

To describe the adjustment of any one individual at each adjustment phase in a given social setting, the pattern of the group should be understood. If the normative pattern is to grow more discriminating with time in one's evaluation of a setting, then an individual who complains at a later date is not deviant even if he was a well-known "eager beaver" on entry. Group standards also should be considered in evaluating the mental state of an individual. If it is normative to be a nonparticipant in activities, then nonparticipation is not indicative of mental illness. The patterns, phases, and criteria of adjustment look entirely different in different types of residential settings. It is a credit to the adaptive capacity of most inmates of institutions that they can figure out the normative expectations of the group very quickly and, for the most part, behave in terms of them.

In a review of literature on residential settings for the aged, Bennett and Nahemow (1965a) found systematic differences in criteria of adjustment. In homes for the aged, adjustment criteria were fairly explicit and participation in formal and informal activities emerged as a major adjustment criterion. In retirement housing, participation in informal social relationships seemed an important adjustment criterion. In mental hospitals, nursing homes, and Veterans' Administration centers, on the contrary, there were virtually no social adjustment criteria. For the most part, people were expected to receive medical and nursing care passively. Our own data collected in the course of participant observation indicated similar trends. Needless to say, if the criteria of adjustment vary from setting to setting, so do the modes of adjustment found among residents. Probably it is more difficult to adjust to a setting with no explicit criteria than to one in which criteria are clearly set. Hence the apparently contradictory nature of many research findings on adjustment rates in institutions may possibly be explained in terms of institutional requirements that are rarely investigated directly, rather than in terms of individual pathology. Lack of clarity of expectations or, even, absence of any expectations for adjustment may account for the deviance or apathy found in many, if not most, mental institutions or homes for the aged.

The aspect of an institution (or of any social group) which apparently determines whether there will be complex normative expectations is the degree to which the group recognizes that it is functioning as a permanent-membership body. For example, when an institution, like a home for the aged, is explicitly structured as a terminal one, adjustment is considered critical. In fact, staff members probably evaluate themselves in terms of
how well they help people to adjust. This was recognized by Geld (1964) and labeled the "principle of permanency." The way in which this principle works is illustrated in a comparison we made of an admission ward and continued-treatment wards of a large mental hospital. Our findings showed that adjustment criteria were fewer in an admission building, from which patients were sent to other parts of the hospital, than in a continued-treatment building housing patients who were chronically ill, but not violent. In the latter, some patient and staff norms were found and were explained. Also, patients were aware of them and communicated them to the interviewers. This finding was not anticipated initially; it was thought that people who had been in a "back ward" of a hospital for many years would be much more uncommunicative than new arrivals. What was interesting was that a social system did not develop in the admission building despite the fact that many geriatric patients had lived there for as long as five years. One of the reasons that staff members kept geriatric patients in the admission building for several years was that they considered it more therapeutic. However, the knowledge that this was a temporary residence for incoming patients was powerful enough to prevent any sort of socialization from developing. On the temporary ward, more random acting-out behavior was observed than occurred on the permanent ward. Clearly, this temporary environment needed altering or treatment.

SUMMARY AND CONCLUSION

In this chapter, it was noted that accepted cross-disciplinary definitions of the concepts of deviance and mental illness are lacking and that currently the terms are used interchangeably. We attempted to classify deviance and conformity according to whether they are enacted by groups, crowds, or individuals and whether they are legitimate or nonlegitimated. It seemed possible for mental illness to manifest itself in each cell of such a classification system. However, it was noted that traditionally the only area that has been of concern to those interested in psychopathology is nonlegitimated, individual rule breaking.

Literature on psychopathology representing a predominantly environmental approach to the relations between deviance and psychopathology was reviewed in relation to proposed treatment. By and large, proposed treatment was aimed at changing the deviant and/or sick individual, rather than his environment. Even community psychiatry or mental health programs with stated aims of intervening in deviance-producing systems in the community direct their treatments at sick individuals.

One possible solution was suggested for dealing with the dilemma of
deciding what is deviance and what is illness. This was to define and measure the two concepts independently and to study their interrelationships in a variety of contexts and over time. We illustrated how this was done in some of our research conducted in a home for the aged in which psychiatric examinations and measures of social adjustment were taken independently. The findings showed that only functionally disordered residents, as opposed to those with mild organic disorders, were involved in deviant behavior. Other research was described in which it was found that residential settings for the aged vary in the emphasis placed on conformity. In some settings, social interaction of any sort is valued more than conformity. Engaging in conflicts with other inmates may not be seen as deviance in such interaction-valuing residential settings.

An interesting question is whether deviants (with or without a label of mental illness) in one system, who are placed in another system in which their behavior is valued, become deviant there as well. There seems to be some controversy about this issue but no research. For example, recently we heard a psychiatrist say that a schizophrenic adolescent who had visual hallucinations remained clearly schizophrenic even in a drug-taking hippie commune. More research is needed on this problem and similar ones.

It may be concluded that, until there is some consensus and more research on the interrelationship between deviance and illness, the sophisticated practitioner as well as the enlightened layman probably will continue to label as sick any behavior which challenges their values.

REFERENCES


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