OF OTHERS INSIDE

INSANITY, ADDICTION AND BELONGING IN AMERICA

DARIN WEINBERG

FOREWORD BY BRYAN S. TURNER

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The type of social science . . . we wish to put forth is an *empirical science* of concrete *reality*. We wish to understand the reality that surrounds our lives, in which we are placed, *in its characteristic uniqueness*. We wish to understand on the one hand its *context* and the cultural *significance* of its particular manifestations in their contemporary form, and on the other the causes of it becoming historically so and not otherwise.

—Max Weber, *The Methodology of the Social Sciences*, 1922

Foreword

Social science, and specifically sociological, approaches to health and illness have been typically bifurcated around a dichotomy between what, for convenience, we might call *naturalism* and *social constructionism.* Naturalistic explanations seek physical causes of health and illness on the assumption that disease can be effectively controlled or eliminated by targeted medical intervention. This approach historically involved treating the human body as a machine that could be manipulated by medical science without the distractions of such dubious entities as "mind" or "subjectivity." The spectacular treatment of the infectious diseases of childhood in the late nineteenth and early twentieth century provides the ideal model of medical science and its therapeutic potency. Of course, critics of this vision of medical history argue that these treatments were successful only after the social and physical environment had been improved by the introduction of sewerage, clean water, and an adequate food supply. Perhaps more importantly in the present context, while the physical etiology for example of measles has been successfully identified, there is far less scientific consensus as to the physical "substance" that produces alcohol addiction or mental illness. Similarly, the quest to discover genes that explain specific forms of social deviance is like a fable from Don Quixote in the sense that deviancy, because it is paradoxically a product of law or moral convention, does not lend itself to such explanations. The classic sociological argument is that the search for a genetic explanation of deviancy involves a category mistake. As Emile Durkheim argued, social facts can be explained only by social facts. Is homosexuality a genetic disorder, a socially constructed category, or a lifestyle choice? Is there a gene to explain the prevalence of divorce in modern society? Perhaps, but first we need to find the gene that will explain the prevalence of matrimony. We tend to assume that matrimony needs no explanation simply because it is a "normal" relationship between men and women that has the blessing of the Law. We tend to look for naturalistic explanations in the social sciences only when phenomena appear to be untoward.

The naturalistic research strategy looks particularly unpromising if our effort is to explain the link between mental disability and patterns of social exclusion such as homelessness. At least some aspects of homelessness will be a function of macrosocial and economic changes – including interest rates, property prices, the rental market, availability, local governmental policies, and so forth. The complex causal processes behind the housing market do not allow for simple biological explanations of aggregate homelessness. Moreover at the individual level, the social reality of alcoholism is profoundly shaped by local circumstances. The consumption of whisky among middle-class Scots may be addictive from some perspectives, but we know that middle-class resources (income, education, and connections) typically act as a buffer against negative labeling, permitting them to manage such dispositions or preferences without coming to the attention of the authorities. Homeless men consuming alcohol in public spaces in Britain are by contrast very likely to come to the attention of the police. In the everyday world, my consumption preferences may very well constitute someone else's addiction.

These arguments are well known, and possibly taken for granted by social scientists. In order to avoid these pitfalls of naïve naturalism, social constructionist sociologists have contested clinical labels, arguing, for example from the standpoint of symbolic interactionism, that pathology is in the eye of the beholder. Alcoholism exists if a professional person can deploy expert knowledge to secure the social efficacy of the label. I am mad if a label of insanity can be successfully attached to me or, in the famous words of W. I. Thomas, definitions are real if they are real in their consequences. Social constructionist critics of the naturalist position have drawn attention to the social processes by which "troubles" in some very broad sense get translated into recognizable medical "conditions" that professional groups can diagnose and if necessary treat. Constructionist epistemologies have many and diverse origins—including the pragmatism of Richard Rorty and the poststructuralism of Michel Foucault. These approaches at one level demonstrate that, insofar as conditions have a history, they can be shown to be context-dependent and hence determined by a welter of social and cultural variables. Foucault's classical accounts of the history of psychiatry, penology, and criminology in such influential studies as *Discipline and Punish* or *Madness and Civilization* have had an important general impact on the study of professional groups and institutions and their systems of knowledge. In his powerful and commanding study of mental illness, Foucault explored

the social history of folly in Shakespeare's *King Lear* to the interventions of Pinel and Tuke. Whereas in Tudor times folly was associated with a creative and superior imagination, the rise of the science of psychiatry ruled out any contamination of reason by folly, and the mentally unstable required restraint and seclusion. The effect of Foucault's social constructionist history of insanity was to show the arbitrary nature of the categories that are mobilized to describe and manage troublesome people or threatening social groups. The history of madness illustrates the ways in which scientific labels function to bring about an exclusion or seclusion of individuals and groups that do not fit easily or comfortably in regimes for the social and political administration of populations. In short, through the concept of "governmentality," Foucault was able to demonstrate the close relationship between a system of power and an order of knowledge.

Foucault's analysis of insanity has been deeply influential in shaping attitudes toward the development of psychiatry in Western societies and in molding historical inquiries into the role of the state in the general management of populations. This approach has more recently had a major impact on the study of physical disability and old age as well. Disability is often regarded as a consequence of social exclusion through the denial of social rights in a culture that promotes "able-ism" as a dominant ideology rather than as the consequence of a debilitating physical condition. Similarly, "old age" is seen to be a product of powerful social forces that have the effect of marginalizing the elderly and converting them, with the assistance of gerontology and geriatric medicine, into a tangible and recognizable social group of "old people." Despite Foucault's significant contribution to the critical history of insanity, sexual deviance, and crime, this approach is in many respects unsatisfactory.

Although the Foucauldian perspective has been productive in research terms, the approach has difficulty in accounting for the growth of social rights. In particular, the Foucauldian perspective on "power/knowledge" has problems accounting for the fact that new rights (or claims on the state) are often predicated on findings or proof of disability. Disability as a condition is plainly not just a matter of social rights denial, since being successfully defined as disabled can be necessary in acquiring rights to some forms of welfare entitlement. The analytical limits of a Foucauldian (or otherwise strict social constructionist) perspective are further illustrated when we consider the phenomenology of physical disability. Social constructionism has not fully succeeded

in explaining the very real performative impediments associated with disability status. We might contrast the Foucault-inspired sociology of mental illness as a system of governmentality with the rich ethnographical accounts of the performative peculiarities of Tourette's syndrome by Oliver Sacks in his essay "A Surgeon's Life" in *An Anthropologist on Mars*. The macrosociology of governmentality tells us nothing about the phenomenology of the everyday world of involuntary swearing, twitching, and mimicry of the Tourette's syndrome victim.

Attempts to deconstruct the hegemonic paradigms of social control typically ignore as irrelevant or reject as misleading the subjective experiences of the individuals who get labeled as mad or neurotic or incompetent. Critical theories of insanity, because they concentrate on the study of the conditions that produce interpretation or knowledge (such as the history of psychiatric labels), do not address the phenomenological character of madness—or addiction, or illness, or deviance. They ignore the question (which we might express in Heideggerian terms) "What is this *thing* called madness?" in favor of other questions—under what conditions can untoward behavior get successfully labeled as a case of insanity? Those who treat the social world as socially constructed, that is, as a text that can be read and critically interpreted by sociologists or cultural analysts, often miss the performative aspects of the human condition. We may without doubt agree that the disabled child suffers from a loss of rights, but what is the phenomenology of the thalidomide child's experience? And furthermore, how shall we promote the rights of those with disabilities or special needs if we are not prepared to acknowledge the obduracy of those disabilities or special needs? The strict constructionist argument sometimes seems to imply that if we can simply persuade ourselves and our significant others that our disabilities are unreal then so they will be. This is not a happy conclusion for those of us who know that overcoming affliction very often amounts to much more than changing our beliefs.

It has been a common theoretical strategy of medical sociology to support cultural relativism with respect to a variety of conditions that can be regarded as "disability." In many tribal societies, any condition that reduces one's chances in the marriage market (such as small stature or disfigurement) is a "disability." However, it is not enough to argue simply that because impairments vary between societies, we need not consider their materiality, only their social constitution and consequences. For example, it is unlikely that a "small person" could become a successful basketball star, but it is not merely social conventions that prevent small

people entering such sporting professions. They simply cannot perform the tasks that confront star players. A person of slight stature simply does not have the potentialities that are necessary for performance at that level. It may indeed be conceivable that a small but powerful monarch might influence the exchange value of people of small stature in elite marriage markets. But in the case of basketball, this kind of relativism is not so easily applied. Changing the rules of basketball so that stature did not count would in fact totally transform the game; it would no longer be basketball. There are certain social institutions—in this case, basketball—that, while being amenable to some reforms within a finite spectrum of possibilities, cannot be amenable to an infinite range of reforms without threatening their very abolition.

In the perspective of writers like Pierre Bourdieu and Richard Shusterman, we need as researchers to be attentive to the social practices of everyday life and what I would call the phenomenological conditions and circumstances of skill, performance, and action. Performing as a successful classical ballet dancer is not merely a function of social construction; it needs to be accomplished as a performance. There is of course a democratic politics behind social constructionism that encourages us to believe that, if only the social definition of the situation were to be changed, then I too could become a Nureyev, but such forms of idealism typically come up against the laws of gravity. We must as sociologists, again employing a language that could be derived from Heidegger, attend to what I want to call the "stuffness" of life or its quiddity. Often social constructionism appears to miss the thing-ness (quid) of a condition or what Heidegger might call the "throwness" of phenomena.

Darin Weinberg has addressed this traditional contradiction or tension between naturalism and social constructionism in an area that has been particularly prone to unhelpful arguments about the objective versus the constructed relationship between homelessness, addiction, and insanity. His arguments, which are systematically embedded in his ethnographic research, offer a way out of the conundrum by showing how these positions represent false alternatives. The arguments that he deploys, to use his own words, to advance a novel sociological understanding of the relationship between social exclusion and mental disability, should be carefully followed by the reader. It is not my intention here to produce a glib summary of his thesis; it provides its own compelling arguments, and the reader should be attentive to his text. It seems to me more useful in this short foreword to consider his

exploration of the multiple meanings of the phrase "others inside." It conveys a sense of the strangeness of addiction and insanity to those presumed to be afflicted, and the problems of explaining that strangeness from the outside. A disease can often be best described by metaphors of an invasion of our inner world. Cancer may be experienced as such an invasion and no strictly constructionist account can fully grasp the "thing-ness" of such an alien and disturbing occurrence. Addiction in these terms might be conceptualized as one way in which people sometimes experience alienation from their sense of control over their lives. It was Karl Marx who in his *Paris Manuscripts* first explored the possibility that the subjectivity of social life can be alienated in just this sense by the overwhelming pressures exerted upon us by the capitalist mode of production. People cease to experience society as a collection of fellow human beings and begin to experience it as an anonymous, objective, and unforgiving thing. This kind of alienation implies a phenomenological transference of the agency we once found in our selves and each other to nonsubjective forces like the market system or conditions like insanity or addiction. The alienation that attends a dis-ease is also fundamentally a profound dis-comfort. We need also to explore the objective social conditions that may produce an addiction or mental illness, of which homelessness may be a poignant feature. To be homeless is to be discomforted, and in need of fortification.

Sociology is at its best a critical discipline that produces its own type of discomfort, inviting us to see the world as an alien place by breaking down taken for granted assumptions. The social constructionist argument, which is clearly a powerful vision of the world, is also discomforting; it helps us to question what Bourdieu has called the "doxic," or unquestioned, qualities of our objective realities. It often as a result appears to place sociologists and clinicians in opposite and opposed camps, by calling our attention to the negative as well as the therapeutic consequences of medicalization. Medical interventions are often understood by sociologists to obfuscate the material circumstances of homelessness by focusing undue attention on the individual characteristics of the alcoholic and naturalizing their personal incapacity to deal with social life. Weinberg takes a refreshingly open approach to the professional competences of both clinicians and sociologists by taking us beyond the critique of medicalization to suggest a more just, fruitful, and compassionate deployment of the medical devices that are to hand. In the last analysis, doctors like sociologists are only practitioners attempting to make sense of contradictory and uncertain evidence; both require

hermeneutics. Clinicians, psychiatrists, and sociologists are not necessarily in opposite camps. As an illustration of this shared world, I often use a personal experience as a teaching device with my students to illustrate the notion of interpretative sociology and investigative medicine. During an investigation of a painful episode of pancreatitis, an attendant nurse tried to reassure me that my condition was not necessarily life-threatening or pathological—to which I exclaimed, "That's good news!" The clinician hovering over me thoughtfully responded, "There is no such thing as 'good news'; there is only interpretation." As an interpretative sociologist I could only agree, but I might also have said that a professional interpretation did not fully or effectively address the quiddity of my pain. Weinberg provides us with a method by which these two dimensions of human problems can be compassionately explored. In short, he shows how hermeneutics also needs phenomenology.

Of Others Inside is a study of social problems, but it contains a powerful philosophical and methodological conclusion, namely that the conventional analytical dichotomy between objectivism and subjectivism turns out to be a false opposition. Weinberg has transformed a debate that has become increasingly unproductive by showing that while we need to understand how mental disability is constructed, we also need to understand its clinical reality, not least from the victim's point of view. If the naturalistic paradigm has sought to demonstrate the physical determinacy of the world, the sociologist wants also to identify just how social and historical causality works, and interacts with those forces that are presumed to be natural. In sociology as in life, deeply divided camps often turn out to be not only highly compatible, but also mutually sustaining positions. In resolving this conundrum between objectivism and subjectivism in the sociology of mental health, *Of Others Inside* is a remarkable, original, and timely achievement.

BRYAN S. TURNER

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Contents

1 Introduction

Beyond Objectivism and Subjectivism in the Sociology of Mental Health

THE OBJECTIVE of this book is to advance a novel sociological understanding of the relationship between social exclusion, specifically homelessness, and mental disability. Current research leaves little doubt that homelessness, mental illness, and addiction are empirically linked, but the particular nature of this relationship is anything but settled. In fact, debate in this area has fallen into something of a theoretical stalemate. While clinically oriented studies argue that the rise of homelessness in the eighties was caused primarily by the deinstitutionalization of people with mental illnesses, alcoholism, and rising rates of drug addiction (cf. Baum and Burnes 1993), sociologically oriented studies argue that homelessness was caused by social structural processes like deindustrialization, racial and economic segregation, dwindling social services, and dwindling low-income housing stocks (cf. Rossi 1989; Snow and Anderson 1993; Wagner 1993; Wright 1989). Social scientists have generally argued that even if there is some truth to findings of mental disability among the homeless, these findings must be interpreted in light of their social structural contexts. While some suggest that homelessness (and severe poverty more generally) is less a result than a cause of mental disabilities, others argue that the epidemiology and clinical assessment of mental disorder are themselves social context sensitive and prone to produce false positives (cf. Horwitz 2002; Snow et al. 1986).

Moreover, in critical contrast to clinically oriented research, sociological research often suggests that findings of mental disabilities among dispossessed peoples reflect a pervasive tendency in Western societies to unjustly attribute personal pathology to the poor and other outsiders. Critical sociologists generally base their condemnation of what is often called the *medicalization* of poverty and marginality on four specific complaints. The medicalization of poverty and marginality (1) blames victims, (2) obfuscates social structural sources of misery and injustice, (3) wrongly exalts the medical profession, and (4) by casting problems

in individualistic terms, exonerates the better-off from the duties of citizenship. Several eminent members of this research tradition including Peter Conrad, Michel Foucault, Roy Porter, Nikolas Rose, David Rothman, and Andrew Scull have made absolutely indispensable contributions to our sociohistorical understanding of medicine and psychiatry as technologies of social control and of why culturally marginalized populations are so often held to suffer from mental disabilities. Nonetheless, this body of research suffers a rather profound limitation. One searches the critical literature in vain for analyses that in any way provide for the terrible reality that mental illnesses and addictions seem to possess for those who claim to suffer from them. Moreover, despite a broad historical validity, critical analyses of the medicalization of poverty and marginality simply fail to capture much of the complex micropolitics of actual clinical work involving homeless, impoverished, or otherwise culturally dispossessed people.

This can be demonstrated by counterposing the four critiques I've just mentioned to the work that I observed take place in my own ethnographic research settings. These settings were treatment programs state-mandated to serve homeless clients "dually diagnosed" with both serious mental illness and alcohol or drug addiction. As such, we should have every reason to suspect them to exhibit the problems suggested by critics of the medicalization of poverty. However, they did not do so. First, as to blaming victims: the diagnosis of mental disability was used in my programs to facilitate people's disowning of behaviors they found troubling or blameworthy. Hence the recipients of this label were not so much blamed as morally purified through the attribution of mental disability. Second, as to obfuscating social structural injustices: claiming mental disability and following a medicalized regimen of personal recovery did not discourage people from recognizing their victimization by economic, racial, or masculine oppression. Indeed, several counselors quite actively sought to politicize clients and in one of my programs successfully installed racial, gender, and sexual awareness segments into the program's clinical regimen. Third, as to exalting the medical profession: despite trading on the concepts of disease and recovery, these settings were not staffed by medical doctors but by self-described recovering addicts committed to a fairly nonauthoritarian image of their own roles as clinicians. Lastly, as to the duties of citizenship and social inclusion: far from reducing their entitlement to public benefits, diagnoses of mental disability were, sadly enough, the most promising access to entitlement that many of these people knew. A diagnosis could entail a move

from no shelter or short-term shelter to a long-term program bed. It usually entailed state-sponsored provision of more intensive casework and a reduction of the chores associated with accessing benefits, housing, meals, shower, laundry, transportation, legal assistance, etc. And if one doggedly persevered, it could also mean a fairly significant increase in income. One might jump from no benefits, or meager General Relief benefits, to the more generous Supplemental Security Income, or Social Security Disability Insurance. In these various ways, claiming mental disability entailed certain modest entitlements for the people I studied and hence modest reentries back into their communities rather than exclusion from them.

Stated very briefly, then, my effort in this book is to reconcile the macrohistorical insights of the medicalization literature to the micropolitics of mental illness and addiction as these took form in two contemporary treatment programs state-mandated to serve homeless clients. More specifically, I have sought to analyze the sociological dimensions of why, and specifically how, mental illnesses and addictions came to be socially constructed or, as I prefer, socially *activated,* as manifest causes of human behavior and experience in these programs. In undertaking this project I eventually ran up against some rather serious theoretical limitations in the social scientific literature on mental health. These limitations became apparent to me when I discovered the very basic fact that though members of my programs regarded mental illnesses and addictions as genuine causal agents that overtly interfered with their lives, they nonetheless very plainly exercised discretion over whether, when, and how they invoked mental illness and addiction to account for their own and each other's troubles. None of the extant approaches to theorizing the nature of mental illness and addiction can provide for this basic fact.

The Limits of Objectivism and Subjectivism in the Sociology of Mental Health

Since its inception, sociology has been caught between two seemingly antithetical analytic projects. The first, which may be called the objectivist project, is reflected in Durkheim's famous insistence that social facts be regarded as *things*—that is, as determinate objects with characteristic properties that exist as such beyond the consciousness of social actors (Durkheim 1982). This theoretical project has yielded research that attends to the social structures that ostensibly cause human