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The Moral Career of the Mental Patient

ERVING GOFFMAN

Textbooks on psychiatry distinguish neurosis from psychosis. Generally, neurotics make much trouble for themselves but little or none for others, are not dangerous to others, and can function in daily life. Generally, psychotics make as much trouble for others as they do for themselves, are often a danger to themselves as well as to others, and are less able to take care of themselves. Public opinion concurs with professional judgment but adds to it the important dimensions of fear, anxiety, and ambivalence. Lay and expert judgment concur that the most severely impaired are rightly confined to mental hospitals.

Erving Goffman counters this view with his own conception of three stages a person goes through as a "mental patient"—prepatient, patient, and ex-patient. Some degree of impairment in everyday life may be a condition for becoming a mental patient. But the sufficient condition according to him is the marshalling together of a team of laypersons as well as professional agents of social control who in concert facilitate the person's entry into the mental hospital. Hence, severity of impairment is of considerably less importance than the social organization of what he calls an *alienative coalition*. Once again, the social reaction to a pattern of behavior assumes considerably more importance than the pattern of behavior in its own right when a person becomes socially constructed as a deviant.

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, drawing mainly upon data collected during a year's participant observation of patient social life in a public mental hospital,[1] wherein an attempt was made to take the patient's point of view.

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 overly to rely 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.[2]

Reprinted from "The Moral Career of the Mental Patient," *Psychiatry: Journal for the Study of Interpersonal Processes*, Vol. 22 (May 1959), pp. 123–135, by special permission of the author and The William Alanson White Psychiatric Foundation, Inc.

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 insofar 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.[3] 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;[4] the office patient whom a psychiatrist feels 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.[5] 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....[6]

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.*[7] This paper will deal only with the first...[phase].

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 changes 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.*[8]

Coupled with the person's disintegrative reevaluation of himself will be the new, almost equally pervasive circumstance of attempting to conceal from others what he takes to be the new fundamental facts about himself, and attempting to discover whether others too have discovered them.[9] 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.[10]

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 situations; instead of being 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.[11] 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 offense against some arrangement for face-to-face living—a domestic establishment, a work place, a semipublic 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 extrusory consequences—to imprisonment, divorce, loss of job, disownment, regional exile, noninstitutional 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 extrusory 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.[12]

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.[13] Some of these contingencies in the mental patient's career have been suggested, if not explored, such as socioeconomic 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.[14] For information about other contingencies one must rely on atrocity tales: a psychotic man is tolerated by his wife until she finds herself a boyfriend, 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 bypass 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 fatefully in his passage from civilian to patient status.[15] Here is an instance 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 a single person may fill more than one of them.

First is the *next-of-relation*—the person whom the prepatient sees as the most available of those upon whom he should be able to most depend 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-relation is usually his next of kin; the special term is introduced because he need not be. Second is the *complainant*—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, school teachers, and so on. One of these agents will have the legal mandate to sanction commitment 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 kinsman, mediators tend to be specialists and differ from those they serve in significant ways. They have experience in handling trouble, and some professional distance from what they handle. Except in the case of policemen, and perhaps some clergy, they tend to be more psychiatrically oriented than the lay public, and will see the need for treatment at times when the public does not.[16]

An interesting feature of these roles is the functional effects of their interdigitation. For example, the feelings of the patient will be influenced by whether or not the person who fills the role of complainant also has the role of next-of-relation—an embarrassing combination more prevalent, apparently, in the higher classes than in the lower.[17] Some of these emergent effects will be considered now.[18]

In the prepatient's progress from home to the hospital he may participate as a third person in

what he may come to experience as a kind of *alienative coalition.* His next-of-relation presses him into coming to "talk things over" with a medical practitioner, an office psychiatrist, or some other counselor. Disinclination on his part may be met by threatening him with desertion, disownment, or other legal action, or by stressing the joint and explorative nature of the interview. But typically the next-of-relation will have set the interview up, in the sense of selecting the professional, arranging for time, telling the professional something about the case, and so on. This move effectively tends to establish the next-of-relation as the responsible person to whom pertinent findings can be divulged, while effectively establishing the other as the 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-relation 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 operation against him. In the extreme but common case the professional first sees the prepatient alone, in the role of advisor, while carefully avoiding talking things over seriously with them both together.[19] And even in those nonconsultative 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 alienative 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-relation. After he enters the hospital, continued visits by his next-of-relation 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 privileges and to sympathize with the monstrousness 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 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-relation 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 accommodatively toward an offender when the two are alone, choosing peace ahead of justice. The presence of a witness, 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 public social fact.[20] When the witness is a mental health commission as is sometimes the case, the witnessed betrayal can verge on a "degradation ceremony."[21] In such circumstances, the offended patient may feel that some kind of extensive reparative action is required before witnesses, if his honor and social weight are to be restored.

Two other aspects of sensed betrayal should be mentioned. 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 a

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 note. Further, through words, cues, and gestures, the prepatient is implicitly asked by the current agent to join with him in sustaining a running line of polite small talk that tactfully 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.[22]

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-relation 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-relation 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 cooperation 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.[23]

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-relation 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.[24] It is the circuit of mediators, with their great psychiatric sophistication and their belief in the medical character of mental hospitals, that will often define the situation for the next-of-relation, 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-relation 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-relation of some of the guilt he may feel.[25] 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.[26]

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-relation.[27] 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 reestablished 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.[28]

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

NOTES

1. The study was conducted during 1955–56 under the auspices of the Laboratory of Socio-environmental Studies of the National Institute of Mental Health. I am grateful to the Laboratory Chief, John A. Clausen, and to Dr. Winfred Overholser, Superintendent, and the late Dr. Jay Hoffman, then First Assistant Physician of Saint Elizabeth's Hospital, Washington, D.C., for the ideal cooperation they freely provided. A preliminary report is contained in Goffman, "Interpersonal Persuasion," pp. 117–193; in *Group Processes: Transactions of the Third Conference,* edited by Bertram Schaffner; New York, Josiah Macy, Jr. Foundation, 1957. A shorter version of this paper was presented at the Annual Meeting of the American Sociological Society, Washington, D.C., August, 1957.

2. 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."

3. This point has recently been made by Elaine and John Cumming, *Closed Ranks;* Cambridge, Commonwealth Fund, Harvard Univ. Press, 1957; pp. 101–102. "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 do 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.

4. 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, let alone take psychiatric action against him. See John A. Clausen and Marian Radke Yarrow, "Paths to the Mental Hospital," *J. Social Issues* (1955) 11:25–32; August B. Hollingshead and Frederick C. Redlich, *Social Class and Mental Illness;* New York, Wiley, 1958; pp. 173–174.

5. 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. Perry, "Some Theoretic Problems of Mental Deficiency and Their Action Implications," *Psychiatry* (1954) 17:45–73; see especially p. 68.

6. [Goffman developed this point more fully as follows.] Whatever...the various patient's 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. Conscientious objectors who voluntarily went to jail sometimes arrived at the same conclusion regarding criminal inmates. See, for example, Alfred Hassler, *Diary of a Self-made Convict;* Chicago, Regnery, 1954; p. 74.

7. 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 "repatient" phase.

8. Harry Stack Sullivan, *Clinical Studies in Psychiatry,* edited by Helen Swick Perry, Mary Ladd Gavel, and Martha Gibbon; New York, Norton, 1956; pp. 184–185.

9. This moral experience can be contrasted with that of a person learning to become a marihuana...[user], 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* (1955) 3:35–44; see especially pp. 40–41.

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

11. 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.

12. Clausen and Yarrow, *op. cit.*

13. An explicit application of this notion to the field of mental health may be found in Edwin M. Lemert, "Legal Commitment and Social Control," *Sociology and Social Research* (1946) 30:370–378.

14. For example, Jerome K. Meyers and Leslie Schaffer, "Social Stratification and Psychiatric Practice: A Study of an Outpatient Clinic," *Amer. Sociological Rev.* (1954) 19:307–310. Lemert, see footnote 5; pp. 402–403. *Patients in Mental Institutions, 1941;* Washington, D.C., Department of Commerce, Bureau of the Census, 1941; p. 2.

15. For one circuit of agents and its bearing on career contingencies, see Oswald Hall, "The Stages of a Medical Career," *Amer. J. Sociology* (1948) 53:327–336.

16. See Cumming and Cumming, *op. cit.;* p. 92.

17. Hollingshead and Redlich, *op. cit.;* p. 187.

18. For an analysis of some of these circuit implications for the inpatient, see Leila C. Deasy and Olive W. Quinn, "The Wife of the Mental Patient and the Hospital Psychiatrist," *J. Social Issues* (1955) 11:49–60. An interesting illustration of this kind of analysis may also be found in Alan G. Gowman, "Blindness and the Role of Companion," *Social Problems* (1956) 4:68–75. A general statement may be found in Robert Merton, "The Role Set: Problems in Sociological Theory," *British J. Sociology* (1957) 8:106–120.

19. 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.

20. A paraphrase from Kurt Riezler, "The Social Psychology of Shame," *Amer. J. Sociology* (1943) 48:458.

21. See Harold Garfinkel, "Conditions of Successful Degradation Ceremonies," *Amer. J. Sociology* (1956) 61:420–424.

22. Concentration camp practices provide a good example of the function of the betrayal funnel in inducing cooperation 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, Univ. of Illinois Press, 1949; p. 81; and Elie A. Cohen, *Human Behavior in the Concentration Camp;* London, Cape, 1954; pp. 32, 37, 107.

23. 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.

24. For an analysis of these nonpsychiatric kinds of perception, see Marian Radke Yarrow, Charlotte Green Schwartz, Harriet S. Murphy, and Leila Calhoun Deasy, "The Psychological Meaning of Mental Illness in the Family," *J. Social Issues* (1955) 11:12–24; Charlotte Green Schwartz, "Perspectives on Deviance—Wives' Definitions of Their Husbands' Mental Illness," *Psychiatry* (1957) 20:275–291.

25. 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 nicety 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.

26. Recorded in the Clausen data.

27. This point is made by Cumming and Cumming, see *op. cit.;* p. 129.

28. 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.