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

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

actions but which usually ignores the understandings human actors themselves have of their lives. Likewise, the objectivist project has encouraged biological and psychological researchers to postulate the very same ontological status for mental illnesses and addictions (cf. American Psychiatric Association 1994). Mental illnesses and addictions are thus regarded as biological or psychological things—determinate biological or psychological objects with characteristic properties, which exist as such independently of the actions and perceptions of the human actors who are said to be influenced by them.[1]

Medical research concerning the genetic origins of mental disability, its neurological characteristics, or the biochemistry of mental disorder may consider issues of subjective meaning and practice to the extent they are regarded as symptomatic of underlying biological problems. But the idea that subjective processes must figure in the very conceptual linkage of behavior with biology is generally ignored. This is equally true of psychological researchers who claim to have discovered objective intrapsychic processes underlying certain constellations of experiential and behavioral symptoms (Chodorow 1999). Though these processes may be variously interpreted, their characteristic properties are construed as objective and largely independent of people's interpretations of them. Sociologists interested in mental health issues often predicate their research on objectivist biological and psychological theories of mental disorder as well. Many seek to theoretically link *social factors* like race, class, gender, age, or sexuality, and particular categories of mental disorder (cf. Dohrenwend and Dohrenwend 1975; Eaton and Muntaner 1999; Faris and Dunham 1939; Hollingshead and Redlich 1958; Mirowsky and Ross 1999; Rosenfield 1999; Williams and Harris-Reid 1999). Though primarily interested in stress processes and psychiatric epidemiology, such theorists usually allow that mental disorders are not "mere social constructions," but they are genuine entities with objective intrapsychic, anatomical, or physiological components.

While the objectivist approach allows us to abstractly model mental disorders as discrete objects capable of causing human behavior, it does nothing to illuminate the temporal processes through which their meaning and practical relevance emerge and evolve for people over the course of history or situated social interaction. To put this more precisely, objectivist models of mental disorder do not themselves describe,

1. This includes the various "imbalances." Dysfunctional chemical or intrapsychic imbalances are uniformly cast as objectively embodied causal agents lying behind the experiential and behavioral problems that constitute their putative symptoms.

nor do they explain, how people come to subjectively perceive mental disorders as influential causal agents in the course of their daily lives. While a small amount of important research has been done with respect to how different objectivist models of disorder arise in history or are actually applied in clinical practice (cf. Barrett 1996; Hacking 1995; Lynch 1984; Peyrot 1995; Sass 1992; Young 1995), we must be careful not to assume that these models are necessarily operative in all cases of putative mental disorder. Indeed, the vast majority of cases wherein people infer the causal influence of mental disorders do not entail the methodical application of formal scientific models at all.

The second theoretical enterprise, which may be called the subjectivist project, is captured by Weber's injunction to treat the topical objects of the social sciences (i.e., people) as ontologically different in kind from the topical objects of the natural sciences. Whereas the objects of the natural sciences are regarded as relatively immutable, inanimate, and responsive only to ahistorical or fixed laws of nature, Weber (1978) proposed that social objects be regarded as eminently mutable, self-animating agents actively and meaningfully engaged in the world (see also Blumer 1969; Collins 1994; Giddens 1993). This theoretical project has yielded research that attends to the ways in which human *subjects*, through their own creative actions and interpretations, constitute themselves and the locally meaningful characteristics of the worlds in which they live.

Psychosocial theorists of mental disorder like Gregory Bateson (1972), R. D. Laing (1969), and Theodore Lidz (1958) boldly followed this analytic project to its logical conclusion by theorizing even the severest mental disorders exclusively in terms of people's dysfunctional social relationships with each other. They thereby reduced the entire spectrum of human behavior, no matter how self-destructive or seemingly unintelligible, to self-governed and intrinsically meaningful adaptations to the troubling social conditions under which people believe they must live. In brief, the universe of these psychosocial theorists is populated only by better and worse functioning human subjects. The main difficulty with this approach is this. Given that the inference of severe mental disorder tends to arise in response to just those problems that obstinately defy understanding in straightforwardly subjectivist terms (cf. Barrett 1996; Jaspers 1963), the project of deciphering the distinctive personal logic presumed to underlie symptoms of severe mental disorder has been a singularly elusive one. Hence, radically subjectivist theories have largely remained articles of ideological faith rather than

clinically valuable or empirically grounded scientific analyses. Most subjectivist theorists have not been so strident in their efforts to reduce *all* human behavior to quasi-rational, adaptive coping techniques. In other words, they have allowed that in some instances human behavior is properly understood to reflect the causal influence of nonhuman (or nonsubjective) forces (Horwitz 2002). However, where they have endeavored to theoretically provide for these forces, subjectivist social scientists have so far been unwilling or unable to resist uncritically objectivist references to historically and culturally invariant psychic or biological structures or processes.[2]

Such theories suffer from the same analytic limitations that I raised with respect to the more strictly objectivist approaches. They invoke biological processes as causes of human action and experience at an abstract level but tell us absolutely nothing about when, why, or how the people we study might be inclined to do so themselves. Furthermore, if our effort is to understand how or why people infer the influence of mental illness or addiction we must recognize that the bases of their inferences almost never include scientific evidence of biological and/or psychodynamic dysfunction. Much more commonly, the empirical evidence held to support these inferences is composed of manifest difficulties in attributing certain distressing and disruptive behavior to the movements of human subjectivity. Finally, this kind of theorizing can also be criticized for what Woolgar and Pawluch (1985) once called "ontological gerrymandering," or arbitrarily moving back and forth between objectivism and constructionism without sound analytic grounds for doing so.

In short, then, virtually all theorizing in the sociology of mental health and illness is predicated on an *a priori* analytic distinction between the *objective* causes and characteristics of the human condition, on the one hand, and the *subjective* interpretation and enactment of the

2. Subjectivist social scientists have contrived ingenious theoretical models in efforts to combine an analytic appreciation for the sociocultural determinants of insanities and addictions with a respect for their putative power to influence human experience and conduct. Since Lindesmith's pioneering work on opiate addiction (Lindesmith 1938), this has invariably been accomplished by insisting on a social *component* to the experience of insanities and addictions but nonetheless invoking objectivist versions of biological or psychic processes and conceptually positioning these processes, as it were, beneath human action and interpretation in order to invest them with a capacity to influence peoples' experiences and conduct (for classic restatements of this model, see Becker 1953, 1967; Lindesmith 1968; Schacter and Singer 1962; Thoits 1985, 1990). For critiques of this manner of theorizing, see Weinberg (1997a, 1997b, 1998, 2002).

human condition, on the other. Ultimately, as I have said, such distinctions are epistemologically limiting (Bourdieu 1990; Hacking 1999; Hazelrigg 1986; Pollner 1987; Woolgar and Pawluch 1985). Objectivist researchers must acknowledge that actual empirical instances of mental health and illness are inextricable from the locally meaningful activities in and through which social actors perceive them (cf. Barrett 1996; Coulter 1973; Gubrium 1992; Holstein 1993; Lynch 1984). However, subjectivists must themselves acknowledge that to the extent they are understood to influence human behavior and experience in any way at all, mental disorders must be understood to exist beyond the boundaries of human subjectivity. That is, those segments of behavior and experience we regard as symptomatic of mental disorder must be traced to causal agents distinct from both the human subjects who ostensibly suffer from them and those human subjects who endeavor to categorize, control, or cure them (Weinberg 1997a).

Hence, an interesting analytic problem arises as to how we might sociologically provide for the fact that mental disorders are at once realized only through the temporally emergent and situationally embedded practices of human subjects *and* often experienced by those human subjects as nonhuman objects that obdurately resist the efforts of both sufferers and health care providers to understand or control them. In the next section I describe how one avenue of research in the sociology of scientific practice may hold advantages for social scientists who would hope to overcome this analytic problem.

On the Status of Objective Forces in the Sociology of Scientific Practice

Over the last couple of decades, a number of sociologists, anthropologists, and historians of science have been working to develop the idea that science and technology are dynamic zones of encounter between human and nonhuman agencies (cf. Ashmore, Wooffitt, and Harding 1994; Callon and Latour 1992; Haraway 1991; Pickering 1995). These researchers have radically respecified the relationships that obtain between subjective and objective forces in ways that may be appropriated to overcome the limitations I have shown to afflict mental health research.

Social studies of science have shown time and again that scientific discoveries are temporally situated social constructions rather than revelations of a timeless and uniform natural order (cf. Ashmore, Wooffitt,

and Harding 1994; Bloor 1991; Callon and Latour 1992; Garfinkel, Lynch, and Livingston 1981; Haraway 1991; Latour and Woolgar 1979; Lynch 1993; Pickering 1995; Shapin 1994). However, despite their rejection of orthodox realism, or what Hilary Putnam (1987) calls "seventeenth century objectivism," many of the intellectual leaders in this field have nonetheless found it necessary to acknowledge that scientists are not wholly uninfluenced by the ostensive phenomena they seek to understand. These researchers have concluded that some form of agency must be conceptually ceded to the objects realized in the course of scientific practice as well as to the human subjects who experience and endeavor to cope with those objects.

The best-known version of this theoretical position is the actor-network theory proposed by Bruno Latour and his colleagues (cf. Callon and Latour 1992). Latour recommends a semiotic approach wherein agency is ascribed to nonhuman "actants" when they are categorically represented by one's research subjects as doing things in the world. Pickering (1995) argues, I think rightly, that while actor-network theory invaluably brings the "natural" world back into sociological theorizing regarding scientific practice, it sometimes seems to overemphasize intellectual processes and underemphasize the logic of embodied practical action. Furthermore, by positing a symmetry between human and nonhuman agents, actor-network theory de-emphasizes the fact that only human agents seem to behave intentionally—or with respect to their own goals. As an alternative, Pickering suggests we conceptualize the objects realized by scientists as not only semiotically, but also practically emergent and influential (see also Hacking 1983). That is, he suggests they be understood as material as well as semiotic products that in turn influence both human thought and embodied human practice in empirically identifiable kinds of ways. He also recommends foregoing the symmetry actor-network theory postulates between human and nonhuman agents. While there are at times good sociological reasons for attributing causal agency to nonhuman objects, there are apparently no good reasons for attributing intentions to them in the sense that we attribute intentions to human subjects.

Pickering's ideas may be usefully appropriated to theorize the effects and identities of mental illnesses and addictions. In opposition to orthodox objectivism, Pickering's approach confers no properties on the phenomenal world that need be regarded as occurring independently of human action and experience. Instead he suggests the phenomenal world influences us only in the sense that it often *resists* our efforts to

formulate its character, to predict what it will do, or to cope with the practical challenges it places before us. Our formulations, predictions, and efforts to cope are in every respect socially constructed but they are socially constructed in part to accommodate the *resistances* the world has presented toward former formulations, predictions, and coping strategies. Formulating the processes through which people perceive and engage their own or other people's mental disabilities in this way appears to overcome the limitations of extant theoretical approaches in the sociology of mental health.

Under a wide spectrum of social conditions, particular features of particular people's personal behavior and experience may be observed to *resist* recognition as the effects of the distinctive human subjects they take themselves, or are taken by others, to be. The empirical form taken by this resistance is not socially invariant but intimately related to the social contexts within which it is observed. It would therefore appear that an exciting, and as yet underdeveloped, research program for social scientists might be to investigate exactly how such episodes emerge and are managed in the variety of circumstances under which they occur. This research program would be predicated on an acknowledgment that social actors do in fact install nonhuman agents as surrogates for human selves for a wide variety of reasons. But in contrast to biomedical models of disorder, it would remain vigilantly agnostic as to the objective characteristics those surrogates are said to possess. Rather than positing such characteristics from outside the social worlds under investigation, we would seek to understand how and why members of those worlds attribute characteristics to these surrogates themselves. It is precisely such a project that I have undertaken in this book.

A Note on the Concept *Others Inside*

In what follows I use the concept *others inside* in place of the variety of concepts now used to construe insanities and addictions. Let me begin to explain my partiality to this concept by noting that it possesses a double entendre. On the one hand, it may be read to connote intrapersonal agents other than one's self. Writing of *others inside* preserves the idea that people diagnosed with serious mental health problems often feel profoundly alienated from the thoughts, behaviors, and experiences they and others diagnose as symptomatic of those mental health problems. By using this terminology I also hope to periodically remind the reader that my focus in this study is not scientific models

of insanity and addiction per se. Instead I am concerned with how putative mental health problems have been *experienced* and *managed* when they have been found to afflict homeless, impoverished, and/or otherwise culturally marginalized members of the community. While there can be absolutely no doubt that clinicians and researchers trained in the medical sciences have played core roles in shaping how Americans orient to putative mental health problems, they have never possessed a monopoly of influence over either caregiving itself or how insanities and addictions are understood. This is particularly true of settings mandated to treat poor and culturally marginalized Americans. By using the concept *others inside* I hope to give credence to the idea that people genuinely suffer from manifestly intrapersonal afflictions without thereby having to adopt any particular theory regarding the nature of those afflictions.

The concept "other" has already been used in similar ways by important scholars concerned with the phenomenology of disability. Arthur Frank (1997) has come to write of people's disabilities as "others within" in his analyses of illness narratives (see also Desjarlais 1997; Hacking 1999; Klienman 1988). Robert Barrett (1996) effectively draws upon the anthropological legacy of the concept "other" to highlight both the fact that people often experience schizophrenia as a distinct entity quite separate from themselves and the rich affinities between contemporary scientific theorizing regarding the nature of schizophrenia and the more general history of Western thinking about the nature of peoples different from ourselves. But the concept *others inside* also possesses a second connotation. It may also be read to connote the difficult relationship felt by homeless people seeking recovery from mental disabilities to those of us who share their communities but who are not homeless and diagnosed as mentally disabled. To what extent does recovery for them amount to a project of forging and fortifying a place for themselves *among* others inside—we who are housed, employed, and ostensibly free of the mental disabilities by which they are presumed afflicted?

As I have indicated, my fundamental objective in this book is to advance a novel sociological understanding of the relationship between social exclusion and mental disability. More specifically, I am concerned to closely scrutinize both the relationship between symptomology and alterity, on the one hand, and the relationship between clinical recovery from insanities and addictions and the assimilation of sufferers into their communities, on the other hand. My central argument is that throughout American history considerations of community solidarity and exclusion

have consistently figured centrally in assessments of whether, and how, the diagnosis and treatment of mental illness or addiction should be undertaken. The concept *others inside* allows me to more effectively emphasize the conceptual proximity of my discussion of mental disability and recovery to debates about social exclusion and community solidarity than is afforded by received biological and psychological concepts like disease or disorder. In sum, by writing of insanities and addictions as others inside those who are presumed to suffer from them I simultaneously emphasize both my agnosticism with respect to their basic nature and the enduring conceptual and institutional relationships that continue to exist in the United States (and elsewhere) between insanity, addiction, and cultural otherness more generally.

So how does this book improve upon the existing critiques of the medicalization of poverty and marginality? It does so by incorporating the following insight: even when it is construed as drenched in social structure, culture, and meaning, there is overwhelming evidence to suggest there is a depth to what Heidegger called human being-in-the-world of which we as selves, subjects, or egos are at best only dimly aware, and at best only partially able to control. My research suggests that the extreme material and emotional hardships of homelessness quite seriously intensify the tendencies we all sometimes have to find the *other*, the "not-us" and "not-me," in our very own personal actions and experiences. Though we may sometimes wish to relish such mysteries, we may sometimes also find them profoundly disturbing and yearn for therapeutic assistance to secure for ourselves a more intelligible and socially integrated personal being. In this sense, the work of recovery from insanity or addiction may be seen as a simultaneously collective and personal project of *self* (or social being) empowerment—one among many types of struggle for redemption from the jointly psychic and social spaces of otherness with which we cannot or do not want to identify. We should not, then, merely oppose the medicalization of poverty and marginality so much as strive to make more just, more sensible, and more compassionate use of the medical devices that history has bequeathed.

The Substantive Chapters in Brief

The study is divided into two parts, the first of which attends to the broader genealogy of my ethnographic research settings, and the second, to their immediate local histories, administrative structures, and

distinctive modes of therapeutic practice. Chapters 2 and 3 make up Part I. Chapters 4 and 5 make up Part II. Chapter 6 is my concluding chapter.

In Chapter 2 I describe the rise of the American mental health, alcohol, and "narcotic" drug addiction fields. I show that modern concepts of insanity and addiction were first forged to preserve the moral integrity of certain kinds of otherwise respectable troublemakers, and to serve as resources for their redemption. However, concepts of insanity and addiction (and techniques for their control) evolved in considerably more punitive directions as they came to be more routinely applied to troubles involving poorer and culturally marginalized Americans. I tell how these processes variously unfolded in the fields of mental health, alcohol, and "narcotic" drugs. Particular emphasis is given to how these events shaped the types of clinical services available to homeless Americans today.

In Chapter 3 I follow the continuing evolution of the state-sponsored mental health, alcoholism, and drug abuse treatment industries into the late twentieth century. Though certainly separate in many respects, these fields have developed parallel to one another, often competing for public funding, and for the authority to name, explain, and manage the *others inside* to which they consensually, and with widespread popular support, insist human beings are heir. I describe how these fields grew into more or less discrete national systems, each of which was focally organized around the understanding and management of human troubles as products of distinct types of *others inside* their clients. Due primarily to the proliferation of what Gusfield (1989) calls "troubled person professionals" concerned with such matters (and increased pressures on these professionals to recognize each other's efforts), I show that there has been a vast expansion of the professionally acknowledged antecedents, identities, and consequences of insanities and addictions among the American poor. However, despite increasing professional appreciation for their profound variety and complexity, the management of insanities and addictions in state-sponsored settings is becoming ever more strictly formulated in terms of tenably integrating sufferers into their respective communities. Hence, as I will show, more than merely rendering poor and marginalized Americans more vulnerable to insanities and addictions, or less capable of securing adequate treatments, it is precisely their putative social, economic, and cultural deficits that increasingly constitute the *empirical evidence* of their respective disorders themselves.

Chapter 4 is divided into three sections. In the first section I describe the origins of Canyon House,[3] nesting the particulars of the program's emergence in the wider processes discussed in Part I. In the second section I describe the structural specifics of Canyon House administration. I begin this section by very briefly discussing the referral sources and economic parameters of residents' admission into the program. I then touch upon the backgrounds from which most residents and staff were drawn. The bulk of this section, however, is devoted to delineating the regimen of activities in which residents were required to participate, and the stages through which they were required to pass in order to graduate from the program. In the third section I specify the dynamics of therapeutic practice at Canyon House. Most fundamentally, therapeutic practice at Canyon House consisted in efforts to empower residents as agents of their own recoveries. I first demonstrate that this work consisted fundamentally in fostering and exhibiting what I am calling *right living* among program residents and outline the basic characteristics of *right living* as it was understood at Canyon House. Next I indicate how insanities and addictions were invoked primarily as resources for a retrospective assessment of troubles residents had either caused or experienced in the past. Finally, I demonstrate how insanities and addictions were made to figure not only as accounts for past troubles but as tangible entities in their own right, or, to put it more precisely—consensually present nonhuman contributors to the ongoing organization of Canyon House affairs.

Chapter 5 contrasts the emergence, organization, and operation of Twilights with that of Canyon House. It, too, is divided into three basic sections. In the first section I discuss the origins of Twilights, once again nesting the particulars of the program's emergence within the wider processes discussed in Part I. In the second section I discuss the specific trials that were encountered over the course of implementing the program in the image of Canyon House.[4] In the third section I address the dynamics of therapeutic practice at Twilights, specifically contrasting these dynamics with those at Canyon House. As at Canyon House, therapeutic practice at Twilights consisted fundamentally in efforts to empower clients as agents of their own recoveries. However, in contrast

3. The names of the programs and all research subjects are pseudonyms.

4. Twilights was a nonresidential program expressly modeled on the design in place at Canyon House (an established residential program serving dually diagnosed clients). This was to facilitate rigorous comparisons of the outcomes achieved through residential and nonresidential interventions with dually diagnosed homeless clients.

to Canyon House, I show how this work was carried out primarily in fostering *tenable community living* among program clients rather than *right living*. When insanities and addictions were invoked at Twilights, it was generally in the course of realistic planning for the immediate future rather than as resources for retrospectively assessing past troubles. Finally, I describe how the contrasting dynamics of therapeutic practice at Twilights systematically altered the patterns according to which insanities and addictions were made to figure as consequential worldly agents.

Taken together, these chapters trace the sociohistorical emergence, evolution, and contemporary deployment of various concepts of insanity and addiction to understand and manage homeless and other marginalized Americans. They empirically demonstrate the folly in regarding insanities and addictions as sociohistorically invariant natural pathogens that exist beyond the scope of social history and socially situated human activity. They show, in both historical and ethnographic detail, just how insanities and addictions are genuinely *social* products. But beyond this, these chapters show how despite being thoroughly products of human manufacture, insanities and addictions remain eminently real, and causally influential, for those invested in their discovery and management. In Chapter 6 I summarize and discuss the theoretical conclusions of the analysis offered in the substantive chapters.