

Some Comments on Labelling

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Controversy continues about the nature, classification, and even the existence of mental illness, i.e., the appropriateness of a "medical" versus a psychological, social, or cultural model of mental disorder. This controversy, coupled with the complex issue of role performance and expectation among mentally ill persons (or any other persons whose behaviors are considered potentially deviant), finds expression in the present debate about "labelling." Several major arguments have been presented. Thomas Szasz, for example, maintains that "the phenomena called mental illness is a type of role and nothing but a role." He believes that we call people mentally ill when they behave in socially unacceptable, illegitimate ways. An overburdened housewife "escapes from her life of drudgery into the pretense that she is the Virgin Mary,—the role she has selected for herself," and she is then labelled mentally ill.¹ In Szasz's view, psychiatry, like law, is concerned mainly with defining which rules are socially legitimate and, in the case of institutional psychiatry, Szasz's *betè noire*, making deleterious dispositions on the basis of these definitions. Mental illness, in the traditional medical model, is largely a "myth."

Scheff makes similar and other points.² Those labelled mentally ill are "residual rule breakers"—those who violate certain of society's standards, not easily classified into other types of deviance, i.e., not crime, not bad manners, but something else. Though "residual rule breaking" is quite prevalent in society, nevertheless only a few are labelled (especially the poor), but in an unpredictable fashion, so as to reinforce or reward future and continued rule breaking. Deviant roles are reinforced by the medical model which often ignores the context under which the rule-breaking occurred. The medical model fails to consider whether the behavior was precipitated by a family constellation, is a consequence of family dynamics, and so on. Instances of "residual rule breaking" which might otherwise be of transient nature are in various manners perpetuated and reinforced into the lasting and more destructive role of mental illness. "Being mentally ill," in Scheff's view a sociological status, requiring a kind of systems analysis for its proper understanding, has been falsely transmuted into the presence or absence of a certain kind of mental state or "mental illness."

Sarbin provides some historical explanation of how the mental illness model arose, arguing that mental illness, if it can be considered such, is of a quite different logical status from any other sort of illness.³ His analysis is historical and linguistic, in the Ryle school of British philosophy. He rejects the concept of "internal states of mind" as unobservables and as a diversion from causal factors in the external world. Furthermore, the designation "mentally ill" is pejorative, a degradation. An emphasis on abnormal mental states implies a discontinuous, rather than the more correct, continuous model of mental disorder. Sarbin's own view is that disordered conduct or mental illness "follows from, or is concurrent with attempts to solve certain problems generated in social systems." The best metaphor for mental illness is a "transformation of social identity." The emphasis here is again on mental disorder as behavior that fulfills a par-

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ticular type of role, a "degraded" one, usually granted or assigned (ascribed) rather than chosen (achieved).

Other views relevant to the labelling perspective of disordered behavior are summarized by Newbrough⁴ and in two collections of essays,^{5,6} the work of Akers, Becker, DeLamater, Erikson, Kitsuse, Lemert, Simmons, Werthman, Wheeler and Cottrell. The work of two leading theorists will be mentioned. The position of Becker⁷ is theoretically perhaps the most extreme, albeit evincing a disingenuous moral neutrality. "[D]eviance is not a quality of the act a person commits, but rather a consequence of the application by others of rules and sanctions to an 'offender.' The deviant is one to whom that label has successfully been applied; deviant behavior is behavior that people so label." Becker directs the enquiry entirely away from the sources of the deviant behavior, the deviant person himself or his personality. The focus is to be entirely sociologic, a study of the process and decisions in the applications of labels. Probably more useful in thinking about mental disorder, however, is Lemert's distinction between primary and secondary deviance.⁸ Lemert distinguishes between the original behavior or act which violates some social norm, which may occur for many different reasons, but which behavior is not fixed, nor does it imply a deviant status. Such rule-breaking behavior is common. Society's response to the deviant behavior now becomes important. Public labelling, social penalties and rejection of potential deviant may, in reciprocal action with new instances of deviancy, reinforce and engender a state of secondary deviance. "When a person begins to employ his deviant behavior, or a role based upon it, as a means of defense, attack, or adjustment to the overt and covert problems created by the consequent societal reaction to him, his deviation is secondary." Now there is stigmatizing, stereotyping, and the deviant is locked into a deviant role, with an accordingly changed self-image.

The above examples and quotations give some idea of argumentation in this area. The writers deemphasize or reject the importance of "abnormal" mental states, or the presence or absence of symptoms in the conceptualization of mental disorder. They stress instead the context of behavior, interaction between participants, covert and overt, and especially *process*, the process whereby one person comes to acquire a role or status *vis-a-vis* another. Societal reaction to the deviant or mentally disordered person is stressed, rather than the person's psychological characteristics.⁹ The writers assume that deviant behavior, including mental disorder, is generally transient unless reinforced by stigmatizing labels. The escalating of norm-violating behavior into fixed roles is seen as secondary to self-fulfilling prophecies. Depending upon the writer, a substantial proportion, from all to a considerable proportion of the disorder is explained by societal reaction to the deviant or to his handling rather than by special characteristics or propensities of the individual himself.¹⁰

Without question many of these arguments have merit. Reading of the cited works is a stimulating venture. The reader is struck by the apparent plausibility of the dialogue and the therapeutic hope of less pernicious outcomes were initially offending behaviors to be handled in less stigmatizing manners. The emphasis on *process*, interaction, and a "continuous" model of mental disorder has definite appeal *vis-a-vis* legitimate psychiatric interest in families, groups, and the community. Moreover, especially in the case of one type of deviance, mental disorder, the disquieting thought occurs that the authors' positions are enhanced by the inability of the clinician, and even the psychiatric epidemiologist, to offer a fully acceptable or agreed-upon criterion for mental illness as counterweight to these arguments.^{11,12}

Nevertheless there must also be stated many reservations and difficulties with a labelling or "societal reaction" view of mental disorder. This paper will discuss some of these difficulties, intertwined with certain comments on the implications of labelling phenomena for research on the epidemiology of mental disorder. A final comment reinforces the need for those interested in law and psychiatry to become clear about the strengths and weaknesses of labelling theory.

1. *Labelling theory has little to say about the sources or causes of primary deviance, i.e., why does violation of group norms occur in the first place, and why for a given society or social class at a particular or a changing rate? Is this solely a function of the differential use and application of labels? Why do some people commit deviant acts, or first exhibit "symptoms," while others do not? Among various of the above-cited authors appears the assumption that these initial acts are either random occurrences or transient events. Neither of these assumptions may be so. To the extent that mental disorder has a genetic basis,¹³ certain individuals may more likely be expected to exhibit symptoms than others, especially considering the more severe disorders, i.e. psychosis. To the extent that social structure or social organization influences or engenders behavioral or mental disorders, rates of such disorders will vary independent of labelling concerns.^{14,15} Also, the investigation of Eaton and Weil of the Hutterite population, where the application of stigmatizing labels would appear to have been at a minimum, did not find an absence of stable or continuing mental disorder among these people.¹⁶ "Core" disorders were readily identified and characterized among Hutterite individuals. The relatively high rate of recovered to active cases among the Hutterites would, however, give support to labelling proponents about the perpetuation or exacerbation by societal reaction of the less severe cases of mental disorder. In summary, the first criticism of labelling theory is that the sources of primary deviancy are inadequately explained by this approach, and not enough attention is paid to factors other than labelling which might account for the frequency of these disorders among different populations. There is evidence that stable disorders occur even in the absence of pernicious labels.*

2. *Despite the attractiveness of labelling prose, there does not exist a body of empirical research clearly supporting these contentions. That this should be the case even in the field of crime and delinquency,¹⁷ where one would expect societal reaction to be a potent variable in the production of careers, probably even more so than in the case of mental disorders, is striking. Furthermore, in the area of mental disorders *per se*, Walter Gove has recently provided a critical discussion of the evidence for labelling theory.¹⁸ This author finds little to support empirically the position that mental hospitalization is mainly an example of secondary deviance. To the contrary, there is some evidence that the majority of persons who are hospitalized are indeed suffering from serious disturbances, and that considerable screening, other than the ritual application of stigmatizing labels, the above position of Scheff, does occur. Ritualization, when it occurs, occurs only at the end stages of the hospitalization process. Other sorts of evidence for labelling, the often quoted work of Rosenthal and Jacobson,¹⁹ fails to constitute empirical evidence for labelling theory as the main positions of this school are summarized above. The Oak School experiments do provide some data on self-fulfilling prophecies, namely, that higher teacher expectations can in covert ways lead to increased performance of the children, higher I.Q. performance, better grades. In this work, however, the children themselves were neither stigmatized nor encouraged by the public application of certain labels. There is nothing in the work to suggest that there was induced in these children altered role performance, or that self-image was changed, consequent to public expectation. Also, in the area where the effect of a *priori* labelling might have been expected to be the greatest, the assignment of teacher grades at the end of the year, a much smaller experimental effect was noted. There were higher grade point gains for the experimental children in only one of eleven areas, that of reading—and this probably correlated with the increased I.Q. performance. Furthermore, not every researcher has been able to duplicate the "Pygmalion" effect. By Rosenthal's own count only 84 of 242 studies have been able to demonstrate such a positive effect of expectations.²⁰*

Recent sociological research, that of Rosenhan,²¹ is now often cited as strong evidence that psychiatrists cannot distinguish the "sane" from the "insane" and, inferentially, that psychiatric diagnoses are meaningless labels which, rather than promoting under-

standing, are detrimental to patients. The attractiveness of this research to those critical of the "medical model" in psychiatry has been considerable, and, like Eysenck's well known but poorly researched and misleading 1952 article concerning the effectiveness of psychotherapy,²² the Rosenhan work is offered as "proof" for the labelling viewpoint. If anything, however, Rosenhan's article is evidence to the opposite, namely that psychiatrists were in time clearly able to distinguish the "sane" from the insane; furthermore, their initial mistakes were somewhat understandable given the social psychology of the admission situation and the design of the research. Extensive and telling criticisms of the Rosenhan research methodology continue to appear and should be consulted.^{23,24} By contrast, the more tempered psychiatric research of Mendel and Rapport does present empirical data of relevance to and in genuine support of labelling theory. These researchers found that "to hospitalize a patient is a major decision which forever after changes the attitude of both the patient and those who care for the patient." A past hospitalization makes a present one more likely. Physicians responsible for hospitalization seem, unwittingly, to take this history into account, independent of the number of symptoms and apparently even of the severity of the patient's present illness. This article does support a view of the "career" patient, repeated hospitalization being as much a function of a patient's previous patient status as it is the degree of present psychiatric disorder.²⁵

3. Labelling arguments have been most strongly advocated by writers whose position appears to be that of some "sympathy" for deviance, at least for the view that deviants are often the victims of society and its stereotyping. All of the writers seem to imply that labels promote and reinforce continuing careers of deviance. On the other hand there is empirical evidence that the application of labels, if judiciously timed, can have just the opposite effect, namely, acting as a deterrent to future deviance, as an inhibition towards the development of future roles.⁹ Thorsell and Klemke summarize six lines of evidence to support this position. For example, the application of a criminal label, "shoplifter," to the naive pilferer may deter such behavior in the future.⁹ Labels may result in both positive and negative outcomes depending upon the use and the implications of the label. In the Hutterite population benefits—more attention, extra trips—accrue to cases of mental disorder.¹⁶ There is also now some evidence for decreasing social distance between the general population and those who are mentally ill.²⁶ Increasing willingness by the public to view mental illness as "genuine" illness, rather than as deviance *per se*, may bring certain operational benefits rather than stigma to the mentally disordered. The effectiveness of the A.A. (disease) approach to alcoholism might be mentioned here. A Congressman of the United States recently absolved himself on the basis of an alcoholic label. "I know that I am a well man as long as I do not drink and—with competent medical advice, and the support of friends, I will remain well."²⁷ *Labels must be evaluated in terms of their operational meaning for those who are labelled.* A major feature of the medical model, ignored by labelling theorists, is the benefits conferred by the sick role: absolution from blame, temporary suspension from normal responsibilities.¹² In community settings proper "labelling" permits the delivery of services and allows a monetary flow to persons suffering from mental disorders. For the more severely ill the patient's evaluation of the benefits of hospitalization may outweigh any stigma attached.²⁸ It is premature to conclude that labelling is inherently stigmatizing or reinforcing of negative outcomes, as the labelling school often seems to imply, even in the case of mental disorder. This is an important point requiring more empirical work. The viability of a secondary prevention model for mental disorder requires that the arguments of the labelling school be addressed.

4. Some queries can also be raised about the "continuous" model of mental disorder that is one feature of the labelling position. This is a difficult area. The point is not to pit Menninger or Freud versus Kraepelin, or even milieu therapy and psychodynamics versus a deficiency of neurotransmitters. However, though the "character of danger"

confronts us all, not all succumb. It is difficult to discount both the high frequency and the character of symptoms in some of the more severe disorders as not implying something more than a "problem in living." Perhaps this is the view of the clinician rather than the behavioral scientist, the reification of an idea or one's own experience, but it may be unwise to dismiss prematurely that which is a "thing" about mental illness in favor of the "process" alone. The following dialogue is illustrative, a dialogue between Hannah Green, the author of *I Never Promised You a Rose Garden*, and her husband.²⁹ "What is your conception of mental health now?" H.G. "Wow! What a question. In this case too, I don't really have an answer. The differences to me between mental illness and mental health are matters of degree. The difference in degree is the difference between a glass of water and the Atlantic ocean. The difference between sickness and health cannot be conceived. From the most mundane things like having friends, the ability to hear and understand what people mean when they talk to you, to the most far out spiritual states. I think the differences are profound." Perhaps this statement amounts to no more than the declaration that "Some people are happier than others," but this simplification is moot. As an experimental statement, Mrs. Green's view may be contrasted with Szasz's above commentary on the psychotic housewife. Which is more true to the phenomena? To regard mental disorder, or being in a mental hospital, as mainly or no more than a "role" is to neglect the private pain of the mentally ill. Voluntary admissions to state hospitals continue to occur, even when policies about commitments change. *The labelling position, it can be argued, ignores the severity of illness, impairment, as one way of providing cut-off points between disorder and non-disorder.*

5. The labelling position implies a rather exclusive orientation towards individual or single role expectations. Labelers fail to enquire whether the multiple "roles" that a person may occupy may reflect some underlying unit, disunity, health or disorder. Consistency of behaviors in the spectrum of anti-social behavior, for example, does give a kind of convergent validity to the notion of an underlying anti-social personality disorder. Here the reference is to the early identification, alcoholism, histories of criminal arrest, poor automobile driving records, frequency of divorce, poor military histories, etc. of some persons.³⁰ Vaillant, *et al.*, in longitudinal follow-up studies of college men report evidence for a concept of good and less than good mental health over the life span, i.e., in physicians, problems of life adjustment occurring prior to medical school were found later to be associated with the so called "occupational hazards" of medicine: poor marriages, use of drugs and alcohol, histories of psychiatric care.³¹ Patients even when discharged to the community do not necessarily acquire new "roles," do not necessarily cease to manifest disturbed behavioral impairments of mental state which cause others to distance themselves from them.³² *To focus on single roles therefore is to fail to ask the question, is there a head to the octopus? Is there convergent validity to the concept of mental disorder either horizontally or along the life arc? To understand these consistencies of behavior under labelling theory we must assume that reinforcing of one role, stigmatization in one area, induces enduring role changes in multiple other areas; in other words, to be "mentally ill" is a "Master Status" which overrules all other of a person's attributes. Again this assumption may have some validity and certainly requires more empirical study. The above sorts of examples do need to be explained more convincingly if these consistencies of behavior are not to be regarded as evidence against the theory.*

6. From the perspective of psychiatric epidemiology, practical and theoretical, appears another particularly vexing criticism of the labelling arguments. Any investigation of the rates or sources of mental disorder with respect to individual stress, social disorganization, or cultural strain requires that psychiatric or mental disorders be open to detection, characterization, classification, and quantification independently of these last concerns. For example, editing of protocols (removal of social data) from information on the

individual symptom patterns was a part of the methodology of the best-known studies of mental disorder (Mid-Town, Stirling County) which tried to characterize both environment and setting. If psychiatric disorder is to be defined or recognized only insofar as it receives a label, then research on unrecognized or untreated disorder becomes a theoretical impossibility. There could, by definition, and to be consistent, be no existing cases of covert or unlabelled mental disorder. To introduce a study of the labelling process *as a part*, rather than *independently* of a thorough characterization of the disorder itself vitiates any attempts to statistically inter-relate these phenomena against some third backdrop. Additional discussion of this point is to be found in editorial comment in *Explorations in Social Psychiatry*.³⁴

There is furthermore some related theoretical argument about the conceptual adequacy of labelled disorder as a hypothetical construct in the area of mental disorder. Dohrenwend and Dohrenwend discuss the problem of the establishing of construct validity for the concept of mental disorder, and criticize to some extent the use of symptom patterns by the existing epidemiologic studies.³⁵ Their arguments have some merit and can be equally applied to a construct of mental disorder which relies heavily on the labelling framework. Is the labelling process itself, or the covert communication of role expectations, necessarily any more replicable, observable, consistent, or subject to rules of inference than is the more traditional concept of mental disorder, which includes symptoms, the expression of subjective distress, or even certain types of verbal behavior, i.e., references by patients to non-existent phenomena? From an operational perspective the labelling position seems to offer only one method to establish the presence or absence of the hypothetical construct (deviance): it exists if it is labelled. Either there is one method to study the "trait" mental disorder, this method tautological (deviance is whatever is labelled such), or else it must be argued that there are an infinity of methods, a different method for each and every instance of the application of the label. Neither of these positions is at all satisfactory. *It appears that it would be very difficult to establish construct validity for a labelling concept of mental disorder*, as these validity searches are recommended by Campbell and Fiske.³⁶ With only one method to assess the presence or absence of the disorder it would appear impossible to set up heteromethod-heterotrait triangles. Could there then be genuine discriminant validation? *What, besides the trivial, would be the conceptual differences among mental disorder, crime, bad manners, social undesirability, etc.?* Studying or validating a concept of mental disorder under the labelling rubric becomes essentially a quantification of method variance rather than a search for validity or reliability across various methods of trait ascertainment. Whether or not a label has been applied to a mental disorder is only one criterion by which to assess its presence or severity. Looking at symptoms, looking at distress, looking at role functioning or at biological variables (sleep, catecholamines) are other methods which can be correlated with the presence or absence of labels to better establish construct validity for the concept of mental disorder. Sole, or even major, reliance on the labelling perspective in the elucidation of mental disorder may not result in any sounder theoretical constructs than are now available. In fact the entire enquiry would be trivialized.

The above criticisms do not of course mean that the labelling perspective does not have some validity, nor that this point of view should be neglected in future research into the nature of mental disorder. In particular the labelling arguments have some of the following implications for future psychiatric work.

1. More detailed investigations of the type recently reported by Barbara Dohrenwend should be encouraged.³⁷ If, for example, transient stressful events occur more frequently in the lower social classes, we need to know whether these events provoke episodes of mental disorder or in fact become themselves "labelled" as events of mental disorder. Do the nature and frequency of such events vary by social class or as a function of some other variable, i.e., social organization? Are such events interpreted, handled or labelled

in differing ways depending upon the social setting—and if so, why? How does the subjective response accompanying stressful events vary from group to group, or does it? Is this response a function of the past or present use of labels or the structure of sentiments within the group?

2. The field of psychiatric epidemiology requires meticulous investigation of the natural history of mental disorders, as well as additional cross-sectional studies. Though incidence studies are more cumbersome than prevalence ones, and in some ways less useful, there remains the methodologic challenge to perform such studies. Better understanding of when and how mental disorders begin or end might give a better theoretical and practical understanding of these disorders, understanding which might counter certain labelling arguments. Construct validity would be strengthened by more predictive power, as this is available as a function of the knowledge of natural history. In particular such studies challenge our nosology. Is acute, short-duration schizophrenia, American type, equivalent to schizophreniform illness, European type? Studies of duration of illness may elucidate this type of question, as well as illustrate the effects, if any, of labels on the natural history of the disorder.

3. In future field or community studies of the prevalence of mental disorder in relation to social structure, the labelling arguments should be more clearly addressed. This might be accomplished, for example, by regarding the use of labels as one of the community sentiments. Administration of the Starr inventory or profile²⁶ to a probability sample of the community or to community leaders might be worth doing as a complementary investigation to participant observation anthropology. As a reliability check on protocols, rather than psychiatrist interviewing participants, participants might conversely rate protocols. Protocols of some experimental subjects might be blindly evaluated by other subjects in the study to get a better sense of the use of labels and the present understanding of, and attitudes towards, disorder in the experimental setting. The purpose of the label and the value orientation of the labellers are important factors of the variance in understanding the meaning of a label in a given setting. Researchers should themselves be more specific about these points in presenting their own methodology and definitions of mental disorder. This is part of the "new politics."

4. Until some of the above issues are better understood, there should be continuing suspicion of the use of "in-treatment" statistics within the field of psychiatric epidemiology. To the extent that labelling arguments are correct, these statistics may in fact reflect only method variance—and not the true frequency or severity of mental disorder within the community.

5. Ideally, of course, there should be fostered experimental studies, with randomized assignments, wherein labels given to various disorders at the time of their earliest manifestation vary by protocol. It has been noted above that there is an absence of experimental studies to justify the vigor of the labellist prose. Differential treatment regimens in fact include the use of a label for a given regimen. Experimentally some early disorders should be given no label at all, and the course of "treatment" or handling should be no treatment at all. The labelling arguments provide some of the strongest theoretical justification that the best "treatment" for certain statistically unlikely behaviors may be no treatment at all, rather a "benign neglect." Attempts to do this experimentally will of course never be precisely "no treatment." Other more "active" treatments will continue to be sought by some of those who receive the "no treatment" regimen. Nevertheless alternative labels—and conceptualizations—other than the "illness" metaphor deserve their chance in the future understanding of the nature and treatment of mental disorder.

Law, Psychiatry and "Labels"

It is beyond the intention of this article to document the specific impact of "labelling" arguments upon the area of law and psychiatry. Suffice it to say, partly based upon labelling prose, major critiques can be and have been levelled at the worthwhileness of

any form of involuntary psychiatric treatment, the extent of legal protections necessarily required to defend those "labelled" as mentally ill from the remainder of society, the admittedly deplorable stigmatization of the mentally ill via preemployment screening requirements, and the existence of the insanity defense or the incompetency to stand trial plea.³⁸ Psychiatry, in the words of one leading jurist a "baffling field"³⁹ rather than a medical discipline, at least from the standpoint of law, is argued to have as its subject matter not mental illness but "legal fiction."⁴⁰ Scholarly, influential law review articles argue that "[p]sychiatrists . . . employ the words 'mental illness' but do so not to describe a medical condition but rather to achieve social purposes."⁴⁰ Only physical abnormalities and diseases are to count as legitimate illnesses. The citations supporting these views are the usual ones to Szasz, Scheff, and similar thinkers. If psychiatric diagnoses are neither reliable nor valid, but are instead mere "labels," carelessly and inconsistently applied to socially deviant behavior, then of course courtroom prediction and courtroom diagnosis should cease immediately.⁴¹

Other recent examples from the legal and sociological literature concerning the intersection of labelling theory, law and psychiatry could be offered, but the above should suffice. Critical discussions of the worthwhileness of psychiatry for the law often present "labelling" arguments as established truth, and as devastating to traditional psychiatric theory concerning the existence and nature of mental illness, the utility of the "medical model," and the potential expertise that psychiatrists might bring to the legal process. Considering the qualifications regarding labelling theory presented above, continuing critique and analysis are necessary to place in perspective both the strengths and the weaknesses of this approach. An uncritical acceptance of labelling arguments might promote premature and misleading closure to current key dialogues in law and psychiatry.

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