SOC 3290: Deviance:
Lecture 30: Mental Disorder II:

Today we will continue our look at mental disorder by looking at (1) social response to, and (2) theoretical explanations of mental disorder.

(1) Societal Responses to Mental Disorder:

In order to understand mental disorder, it isn't enough to focus on the problem itself. We must also consider how various aspects of society respond to mental problems because these can have a significant impact on the sufferer's life or illness. Let's begin by looking at how people in the past dealt with the mentally ill.

Historically, in ancient Greece mental disorder was viewed with awe. Socrates felt that madness was the greatest blessing, for which both states and individuals should be thankful. Epilepsy - then equated with mental illness - was considered sacred, a sign of divine favour. Later, in the middle ages, mental patients were sometimes portrayed as the only ones in touch with ultimate reality.

Yet, for most of human existence, those with mental problems have been badly treated. During the stone age it was attributed to evil spirits that had entered the body - and it has been discovered that early lobotomies were performed at this time by boring a hole in the skull to "allow the evil spirit to escape."

With the beginning of the Hebrew and Greek civilizations, evil spirits were still considered the cause of mental illness. In Leviticus it states: "A man or also a woman that hath a familiar spirit, or that is a wizard (witch) shall surely be put to death." This later provided the rationale for witch burning in medieval Europe - when the church defined the mentally ill as witches who had invited the devil to reside in their bodies.

By the middle 1700's, demonology and witch burning began to disappear, but the mentally ill were still treated badly. Those believed to be dangerous were kept in jails or poorhouses, while the rest were allowed to beg for food on the streets. There were also a few institutions for "treating" them, such as the "Bedlam" hospital in London, where patients were handcuffed and chained to the walls. It even put patients on display, selling tickets to this sideshow of the more seriously agitated patients. Similarly, in France at this time, the mentally ill were treated like animals, but their asylums were much worse than zoos (e.g. living in rags, caked with their own filth, chained up and abused with whips and chains).

In 1793 a revolutionary change in attitude occurred when French doctor Phillipe Pinel was placed in charge of a large asylum in Paris. Shocked by the conditions, he removed the chains from the inmates, and began administering "moral treatment" (i.e. treating them like human beings and encouraging them to have hope and confidence in themselves). As a result,

instead of behaving violently - as was the popular view - the patients became thankful and docile, and some were able to leave the asylum despite having been chained for years. Soon, this method was adopted in England and the U.S.

Many patients who had been confined to poorhouses and jails were moved to the new asylums to receive this new humane treatment. But gradually these asylums became overcrowded and served largely as warehouses for the mentally disordered. The conditions in many institutions became almost as dismal as before. But, by 1955, new alternatives began to emerge (e.g. the first successful antipsychotic drugs, outpatient clinics, private psychiatrists, and community mental health centres). This was coupled, by about 1970, with a move toward deinstitutionalization (advocated by both humanitarians and fiscal conservatives). All of this attempted to be more therapeutic than asylums had been in the past. Yet, even today, this therapeutic objective is still far from fulfilment for many mental patients.

The Public:

One major problem in trying to help the mentally disturbed lies in the public's negative attitude toward them. They are essentially stigmatized as moral lepers. Most people, irrespective of background, feel that the mentally ill are somehow dangerous, dirty, unpredictable or worthless. Yet, unlike the past, where people openly showed their intolerance, today's apparently civilized people try to conceal theirs by presenting a front of tolerance, publicly expressing sympathy for the mentally ill. Yet, their intolerance seeps through all the same (e.g. nurses avoiding "crazies, support groups criticizing those on medication as not "clean and sober," halfway houses not accepting the mentally ill, friends and family members being uncomfortable).

The public's negative attitude toward the mentally ill can also be seen in popular, stereotypical jokes (e.g. only murderers, psychos and schizos's can beat a lie detector; ads for marked down furniture and appliances suggesting that "our prices are so low, we've gone mad!"). This negative attitude even affects psychiatrists - who are supposed to be compassionate to do their job well (e.g. never touching their patients; being perceived by the public as "half crazy themselves). Moreover, it is very difficult for psychiatrists to approach the mentally ill as equals. Most believe that an "unbridgeable gulf" exists between psychotics and the rest of us. Indeed, those few psychiatrists who do befriend mental patients are often seen by their colleagues as the "lunatic fringe of the psychiatric profession."

The Court:

Since the general public doesn't appreciate having the mentally ill around, courts can oblige by putting them away in mental institutions or prisons. This can be done through (1) involuntary commitment proceedings; (2) denying their right to trial; or (3) allowing the defence of insanity.

Involuntary Commitment:

Courts can hospitalize the mentally ill against their will, either for a few days or for a lifetime. Such individuals can be released only if they convince the hospital authorities of their recovery. In order for people to be involuntarily committed, they need not commit a crime, be convicted of one, nor even be charged. They need only be judged by a court appointed psychiatrist to be dangerous to themselves or others.

Since this is a serious matter, careful safeguards have been put in place to protect the rights of the mentally ill. Yet these were widely sidestepped or ignored up until the 1960's - when judges, psychiatrists and lawyers were relatively careless in handling commitment proceedings (e.g. incompetent psychiatrists, the whole procedure taking 2-3 minutes). Thus, at that time, many people who were not really mentally ill were forcibly committed.

Since the early 1970's, many higher courts have clamped down on such abuses. Most laws today are much more concerned with protecting the civil liberty of the mentally ill than with committing them to psychiatric hospitals for treatment. Moreover, many lower court judges today will not commit patients to a mental hospital even when they are severely ill. While this approach has enhanced the rights of the mentally ill, it has created a new problem since many seriously ill patients are released into the community without treatment. They tend to end up homeless or in jail for vagrancy, disturbing the peace, or disorderly conduct.

Denying Rights:

Courts can also confine people to mental institutions by denying them the right to be tried. While it is a fundamental constitutional right to stand trial if we are charged with a crime, this can be taken away from the mentally ill. When charged, the court can determine that the accused is not "fit" or "competent" to stand trial." Thus, without the benefit of a trial and without having been found guilty, mentally ill accused can be committed to a mental institution for an indefinite period - often locked up longer than they would have if they had been tried, found guilty and sentenced. Back in the early 1960's, over half of non-convicted defendants - considerably more than convicted criminals - spent the rest of their lives in mental institutions. While no longer true, there are some legal moves back in this direction with, for example, enhancements to "dangerous offender" legislation.

Insanity Defence:

Courts can also put away a mentally ill person for a crime by allowing a defence of insanity. If judged "insane," the defendant can be sent to a mental institution; if judged "sane" (and convicted), the defendant is sent to prison. Yet this legal concept of insanity isn't necessarily the same as the popular or psychiatric notion of mental illness (e.g. serial killer Jeffrey Dahmer was ruled same by the courts and sent to prison).

There have been two major rules for establishing an insanity defence. The M'Naghten Rule asserts that an accused is to be considered insane if at the time of committing the crime they did not know what they did was wrong (i.e. the "right or wrong test"). This originally English rule was around since the mid-1800's, but was later broadened by a 1954 ruling of the U.S. Court of Appeals. This broadened the M'Naghten Rule by introducing what has come to be known as the Durham Rule. This states that the accused is not guilty if they are mentally ill, because their crime is considered the "product" of their mental illness (i.e. the "product test").

Up until the mid 1980's, defence lawyers successfully used the Durham Rule to win acquittal for their clients when their behaviour had been so bizarre that everybody agrees that the accused was insane. Moreover, even in cases where the accused is clearly not mentally ill, acquittal was also easily won because the law puts the burden of proof on the prosecution to prove "beyond a reasonable doubt" that the accused was sane. This is extremely difficult for prosecutors because defence psychiatrists, by presenting evidence on the accused's illness, can easily convince the jury that there is at least some possibility of insanity, which in effect will create some doubt in their minds that the accused was sane.

Legislators in the U.S. stepped in during the early 1980's to shift the burden of proof for proving insanity to the defence - effectively making it harder to win acquittal by reason of insanity. In Canada, however, the old rules largely still apply.

The Mental Hospital:

Mental hospitals are "total institutions" - places or residence and work where large numbers of people are cut off from the larger society, leading enclosed, regimented lives. Their needs and desires are subordinated to the smooth operation of the hospital, and consequently the hospital staff tend to treat patients as if they are objects rather than people (e.g. talking about people like they aren't there). Considering patients as objects, staff tend to show them little or no respect. They can enter patients rooms, take their belongings, and monitor their personal hygiene. In some institutions, the air is thick with foul odours, patients are lined up like cattle to be showered in succession, deliberate and systematic physical abuse of patients occurs, sexual abuse of female patients, overuse of drugs and medical neglect are common. Moreover, institutional psychiatrists are often less competent - despite being in charge of the most seriously ill patients. Those who are more skilled prefer the far easier and more lucrative practice of treating the "worried well," - mildly neurotic rich people. Thus, psychiatry is a specialty where the most skilled practitioners take care of the least impaired patients.

This combination of dehumanization and relative incompetence produces unexpected consequences. First, patients often exhibit symptoms that staff consider indicative of their mental illness, but actually result from the staff's actions (e.g. trashing their rooms in frustration in response to being put in the "hole," which is then interpreted as further evidence of illness). Second, some patients develop a deep sense of hopelessness, loss of initiative, deterioration of social skills, and inability to function outside ("hospitalitis"). Third, staff actually become less

capable than other patients in diagnosing mental illness (e.g. in the Rosenhan study, it was the patients, not the staff, that more quickly figured out that his "pseudopatients" were faking it).

Yet this negative view of the mental hospital hasn't emerged from every study on the subject. Ray Weinstein (1983, 1981) suggests that in-depth qualitative data tend to be overwhelmingly critical of mental hospitals, but about 3/4 of broader, quantitative studies show mental hospitals to be relatively nice places for the patients. This is because a majority of patients told interviewers that "hospital personnel understood their problems, helped them to get well, treated them with kindness and respect, took a personal interest in them, and were attentive to their needs." Weinstein's analysis has been criticized, however, for the detached, aloof methodology employed where patients may not reveal their true feelings. Indeed, patients' expressions of positive attitude towards the institution and its staff may be designed to impress staff with their progress and secure quicker release. Conversely, it may simply be out of fear of being punished for "biting the hand that feeds them."

Perhaps as a result of failing to cure their patients, mental hospitals today routinely use tranquillizing, antidepressant or antipsychotic drugs to alleviate patients' symptoms rather than eliminate the cause of mental disorder. Moreover, in the last few decades fiscal problems have forced many communities to cut back on services, causing mental hospitals to "deinstitutionalize" their patients sooner than before. Hence, many mental patients today are homeless on the streets or in jails. Nevertheless, the majority of deinstitutionalized individuals live in publicly financed group homes, apartments, or single-family homes, receiving care in general hospitals, Veterans' Hospitals or community outpatient clinics.

The Community Mental Health Centre:

The idea of community mental health was initiated in the 1950's and grew over time. Today, community mental health centres exist in many locales. Their objective is to offer professional and paraprofessional help to the emotionally disturbed. Resources such as hospitals, courts, police, welfare, schools, churches, employers, co-workers and neighbours are linked to provide support to anyone in time of stress. Patients can receive inpatient or outpatient care in their communities. This is an important option, for those already under stress don't need it added to by being put away in some distant, isolating institution, stigmatized further by incarceration. They have a better chance of recovery, moreover, because of the active participation of family members and others who are genuinely concerned who treat them with respect.

Interestingly, the nonprofessional method of treatment provided by a network of family and friends ("network therapy") has proven highly effective in bringing deinstitutionalized patients back to normal life. This involves offering a support system to former patients who otherwise would be lonely and isolated. Relatives, friends, neighbours and others get together to discuss what each can do for him or her (e.g. calling, driving to church, help finding a job). Added to this, a crisis team is available 24-7 to make house calls to resolve crises. Through network therapy even schizophrenics are rarely readmitted to mental hospitals. They have lower

rates of relapse, show far fewer symptoms, and are more satisfied with their lives - compared to those hospitalized or on drug therapy alone.

Why do lay-persons engaged in network therapy provide such better treatment for mental disorders than professional psychiatrists? Probably many psychiatrists, particularly the medically oriented ones, are so professional that they cannot relate to their patients on a social level. To such psychiatrists, being professional often means treating a mental illness as a medical doctor would a physical illness (i.e. through diagnosis and medication). Yet treating a mental disorder is something radically different - requiring not objective detachment but a great deal of genuine compassion and empathy like in network therapy.

Theoretical Perspectives on Mental Disorder:

There are essentially three ways of looking at mental disorder: the medical, psychosocial and labelling models. The medical model defines mental illness as a disease with a biological origin, and psychiatrists who take this approach treats this "illness" by using physical means like drugs, electric shock and surgery. The psychosocial model can be found in many psychological and sociological theories (e.g. behaviourism, social learning, cognitive, psychoanalytic, and social stress approaches). For example, psychoanalytic theory attributes mental disorder to emotional conflict emerging out of parent-child interactions, and attempts to talk it out. Stress theory, on the other hand, explains mental disorder as the result of stressful experiences rather than attempting to treat the disorder. Finally, the third, labelling approach, is neither explanatory or treatment-oriented. It has often been called antipsychiatric because it offers up a radical critique of what psychiatrists think and do about mental disorder. Each model will be discussed in turn.

The Medical Model:

Under this approach, mental illness is seen to be akin to physical disease in that its causes are biological. Thus, it should be treated as would a physical disease. This approach has been dominating psychiatry since the 1970's when drug treatment emerged as a promising alternatives to the earlier talk therapy. Advocates point to two kinds of evidence in support of their position.

First, there is genetic evidence that, for example, suggests that identical twins have a 78% chance of both developing major depression (but this is only 20% for fraternal twins). Similarly, schizophrenia is 3 and 1/2 times more common among schizophrenic adopted children's biological relatives than among their nonbiological relatives. This suggests that genetic factors are at least as involved in some types of mental illness as they are in physical conditions.

The second type of evidence comes from the numerous cases of successful treatment of mental patients with antipsychotic and antidepressant drugs. Since Thorazine was introduced in the 1950's to treat hospitalized schizophrenics, many new antipsychotic and antidepressant drugs have been synthesized enabling patients to leave institutions. Aside from their "relative

effectiveness" in treating mental disorders, the drugs are so convenient that most psychiatrists today routinely prescribe them for their patients. The success of such treatments is taken to suggest that mental illness originates from a chemical imbalance in the brain.

Actually, however, these drugs treat only the symptoms, not the causes of mental disorders. Since the causes remain, drug therapy must continue in order to avoid relapse. Logically, then, the chemical imbalance in the brain cannot be the cause of the mental disorder, but perhaps an intervening factor. If it were the sole cause, the drug treatment alone would have eliminated it. As for the genetic studies, they do not necessarily mean that mental disorder is genetically determined. If defective genes were the sole cause of mental illness, then the odds of identical twins becoming mentally ill with the same disorder would be 100%. We can't ignore this evidence of greater vulnerability, but this alone can't lead to mental disorder. It has to be triggered by psychosocial forces, such as emotional conflict or stress.

The Psychosocial Model:

The psychosocial model has many types, but we will today focus on psychoanalytic theory and social stress theory.

Psychoanalytic theory originated in the works of Sigmund Freud, tracing mental disorder to some unresolved psychic or emotional conflict in the patient. To Freud, conflict is inevitable within the personality, as the id (animal desires), ego (mediator/"reality principle") and superego (moral conscience) are always jockeying for control. In Freud's view, the superego is just as unreasonable as the id: one wants its desires satisfied with anybody - wherever and whenever - while the other prohibits any kind of pleasure. The ego has to try to mediate between these unreasonable positions, convincing each aspect of the self that compromise is necessary. Much of this conflict emerges in childhood. If the ego succeeds in resolving the conflicts, the child will grow up to be normal. If not, the unresolved conflict will develop into a neurosis or a psychosis.

Such conflict is usually so painful that the patient "represses" it, pushing it into the unconscious areas of the mind. This conflict is then manifested in the form of psychiatric symptoms such as anxiety, depression, or compulsion. To help cure the patient, the psychoanalyst must bring the conflict out into the open so that the patient can understand and solve the problem (e.g. a man who makes obscene phone calls to child care workers may eventually reveal that he was forced to have sex with his mother as a child. Once this repressed, unresolved conflict between the id and ego is brought to the surface, with the analyst's help, he can suddenly realize that he was "projecting" his sexual feelings toward his mother on child care workers, and resolve the conflict).

The problem with this whole perspective is that, while having a certain logic, psychoanalytic theory is not empirically testable. The concepts of id, ego, and superego are not measurable, so they have to be accepted on faith. Once the concepts are accepted as real, however, there is enough logical reasoning and "talking cures" to make it convincing to some.

The second psychosocial approach we will discuss is social stress theory. Since the 1980's there has been an avalanche of studies on social stress as a significant contributor to the development of mental illness. Various studies on the impact of life crises (e.g. divorce, unemployment, bereavement) on the victims, for example, show that a large minority (20-40%) fail to recover fully from depression or other psychiatric problems despite a long passage of time. Even less serious experiences can be stressful enough to develop mental problems (e.g. job stress).

While stress can certainly lead to mental disorder, most people exposed to stressful situations do not develop psychiatric symptoms. This is because they have the coping resources for dealing with stress (e.g. social support, personal skills, and high self-esteem).

In short, social stress can cause mental illness if the person's coping resources are inadequate. Since some people encounter more stress and have fewer coping resources than others, they are more likely to develop psychiatric symptoms. Society can be seen as promoting mental illness in two ways: (1) by putting some people in more stressful situations (e.g. the poor); and (2) by depriving them of the social and psychological resources required for dealing with the stress. Nevertheless, critics have observed that most of the studies in this vein have not clearly demonstrated stress as the cause of mental disorder, because it is often also the effect of the problem.

The Labelling Model:

Advocates of the medical or psychosocial models tend to assume that mental illness is real - otherwise they would not bother to look for the causes or cures. But a few psychiatrists and many sociologists question that very assumption. They believe that mental disorder is not a sickness but a label imposed on some disturbing behaviour. This argument comes in four forms.

First, psychiatrist Thomas Szasz has sharply criticized the medical approach for assuming that mental illness is just as real and objective as a bodily disease. He says that psychiatrists advocating this approach are merely spreading psychiatric propaganda: "Mental illness is a myth whose function it is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations." Szasz is not saying that the behaviour labelled mental illness doesn't exist. He merely objects to the use of the label because it masks as well as distorts the true nature of the behaviour by implying that it is similar to physical disease.

In Szasz's view, mental illness can be more accurately referred to as "a problem in living," a "moral conflict in human relations," or a "communication expressing some socially unacceptable idea." All of these imply that so-called mental illness is not a medical problem, but a social and moral one. It is not of internal origin, but external. It is, in his view, a conflict between the "mental patients" and those around them, such as family, neighbours, friends, or the whole society. But, in labelling them mentally ill as if they had a disease in them, psychiatrists use such means as drug therapy , shock treatment, or putting them away to control them alone - exempting their family or others involved in the moral conflict with them. To Szasz, these violate

the sufferer's civil rights to freedom and privacy. The treatments, in effect, are less good for the "patients" than for others around them - who end up enjoying the double benefit of freedom from being "treated" and from being disturbed by the "patients."

If mental illness is merely a label imposed on an interpersonal conflict, it shouldn't surprise us that today many normal people are treated as mental patients simply because they have problems with others. The 1952 DSM listed about 100 mental disorders; the 1994 DSM-IV now lists over 300. Now, many problems such as reacting angrily to criticism or losing one's temper are listed as mental disorders to be controlled. Moreover, psychiatrists are recruited by various agencies to control typical teenage rowdiness and acting out, or more serious behaviours that result from social causes like poverty, child abuse, and family misery - normal responses to an abnormal environment. Rather than deal with the root causes, psychiatrists label these normal children "emotionally disturbed," give them drugs or incarcerate them. In short, kids who stand out as different are labelled mentally ill and controlled accordingly.

The Impact of Labeling:

Sociologist Thomas Scheff also views mental illness as a myth - an ambiguous label he calls "residual rule breaking." This means it is sort of a catch-all category containing all kinds of rule violations that society doesn't clearly define as such (like it does crimes). The mentally ill often do not so often commit specific, punishable offences defined in law as they vaguely violate social norms. In other words, most people don't clearly regard the mentally ill as rule breakers who should be punished - so they can be said to belong in this residual, leftover category of deviance. This is ambiguously defined as a sort of rule violation after all of the other rule breaking acts have been clearly defined as such. The ambiguity of mental illness makes it easy to place people in such a category. Indeed, Scheff argues that such labelling can lead the person to develop a more stable, chronic mental disorder.

Scheff assumes that psychiatric symptoms arise from many diverse sources - genetic, psychological, social, or whatever. Many people, after being influenced by one of these factors, show psychiatric symptoms but are not labelled by families, friends, and others as mentally ill. This is because most symptoms appear in apparently normal people and last only for a short while. However, a small minority of these people do get labelled mentally ill - which will eventually cause them to become chronically mentally disturbed.

Scheff argues that, after being labelled mentally ill, people are encouraged to acknowledge their condition. If they refuse, they will be forced into treatment. If they accept, they will be complimented for "doing the right thing." After release, they may attempt to resume their normal lives, but are likely to remain stigmatized by others. Thus, they may become very confused, anxious and ashamed, and this simply feeds back into the prejudices and labelling dynamics all over again. Ultimately, then, Scheff concludes that labelling a person mentally ill is the single most important factor in making that person become a chronic mental patient. Indeed, some studies have demonstrated the power of such labelling in aggravating the mental patient's

condition (Link et. al., 1991).

Insanity as Supersanity:

Finally, British psychiatrist R.D. Laing also considers mental illness a myth, but his approach is different. He criticizes his colleagues for believing that patients' experiences are somehow unreal, perverse, or otherwise inferior. He notes that it is the so-called "normal" people who have killed millions since WWI, "statesmen" who boast about doomsday weapons, etc. Thus, Laing sees psychotics as more sane than "normals" - and their psychosis as a "sane response to an insane world" (e.g. like a single bird dropping from its flock to land, while the rest are heading for disaster).

Laing criticizes psychiatrists for thinking that patients are disoriented to space and time, while failing to understand the nature of space and time. In his view, there are two types of space and time: outer and inner. When a psychiatrist prejudicially considers a mental patient disoriented, the patient is actually oriented to inner space and time (e.g. imagination, dreams, fantasies, contemplation), while the psychiatrist is oriented to outer. If we simply experience God's presence, for example, that is an inner experience that cannot be rationally or objectively demonstrated. Thus, mentally ill people are inner-oriented, attuned to themselves, not concerned with what others think of them. By contrast, normal people are outer-oriented, attuned to others and sensitive to what they think of them. To Laing, inner-orientation is superior to outer-orientation. As a form of inner-orientation, insanity involves entering a state of more rather than less reality, or supersanity rather than subsanity, of mental breakthrough rather than breakdown.

But, if supersanity is so superior, why do so many mental patients appear so unhappy? Laing suggests that this is because of society's extremely negative attitude towards madness. We respect those with outer orientations for their achievements, but not the other kinds of travellers journeying in inner space and time (astronauts are heroes but recovered schizophrenics are "ex-mental patients"). Thus, highly competent individuals are encouraged and prepared for their into journeys in "outer" space, but most mental patients have been forced into their journeys into inner space and time by being placed in an untenable, unlivable position in the "normal" world. They thus lack knowledge and preparation for their inner journeys, and don't know how to deal with the terrors, voices and images to be encountered. This they get lost in the inner world - which is why they appear so spaced out and unhappy.

Yet, since Laing regards insanity as supersanity, he doesn't use drugs to dull his psychotic patients' sensitivity to the inner world. Instead, he lets them live freely with little psychiatric supervision, giving them time to engage in deep thinking and more effectively explore their inner worlds, come to terms with the demons, and eventually return. This unconventional program has "reportedly" cured most of the patients who stayed at Laing's unconventional hospital.

Criticisms of Labeling Theory:

A number of sociologists have criticized this labelling model, arguing that mental illness

is not a myth but real behaviour that exists all over the world. Clausen and Huffine (1975), for example, argue that if it is a myth, it is remarkable that it has been manifested in all societies, present and past. Yet, they may misunderstand what Szasz means by using the term myth. He is referring to the label "mental illness," not to the behaviour so labeled. Further, this criticism serves to divert attention for Szasz's reason for calling mental illness a myth, which is to show how the label "mental illness" unjustly victimizes individuals so labelled.

Scheff also assumes that the label unjustly victimizes the individual, increasing and stabilizing their psychiatric symptoms into chronic conditions. This labelling argument has been attacked by critics, most notably Walter Gove - who had a high profile debate with Scheff about this in the 1970's. According to Gove, the evidence shows that most patients hospitalized already have serious mental conditions, that there are screening processes in place, and that mental hospitalization does not necessarily or even typically lead to chronic mental illness. Thus, Gove concludes that the evidence supports his own medical model. Scheff disagrees, claiming that the studies he analyzes give more support to his labelling model. Gove replies that these studies Scheff relies on are methodologically flawed. And the controversy continues.