

Symbolic interaction has increasingly emphasized cultural domination and resistance, human agency, and the variety of ways power and inequality are reproduced. How subjects construct social meanings under oppressive conditions has become a major research focus. This study reconceptualizes deviance in light of the above. Descriptive data were collected during two periods of research (1980-85; 1989-1991) on the posthospital worlds of psychiatric patients by means of participant observation, informal interviewing, and semiformal interviewing with 410 nonchronic and chronic ex-psychiatric patients residing in Southern Ontario, Canada, and central counties of Michigan. Using the concepts of ritual and a culture of resistance, we portray deviants constructing meaning under structures of domination, renegotiating meaningful self-images, identities, and overall conceptions of self. Expressive and instrumental rituals that lead to a culture of resistance are examined.

RESISTANCE AMONG EX-PSYCHIATRIC PATIENTS

Expressive and Instrumental Rituals

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THIS ARTICLE FOCUSES ON how ex-psychiatric patients create and enshrine rituals to establish meaning and group identity and, in the process, resist mental health officials and nonsympathetic others. The meaning-making process of ex-psychiatric patients is observed through ethnographic research. Specifically, we observed rituals that attempt to save face and that provide evidence of a culture of resistance. This culture of resistance is an example of what Fine (1987) calls an "idioculture." Griswold (1994, 59) defines idioculture as "rich with implications, alive with symbols and expressions known only to insiders, and used to separate insiders from outsiders." To know how ex-psychiatric patients are "reading" their social world, we focus on their meaning-construction process, how they define situations.

AUTHORS' NOTE: We wish to thank Bernard N. Meltzer and Larry T. Reynolds for their constructive criticisms on earlier drafts of this article. Also, we appreciate the invaluable suggestions provided by the anonymous reviewers.

JOURNAL OF CONTEMPORARY ETHNOGRAPHY, Vol. 26 No. 4, January 1998 426-449
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Other ethnographies have focused on subcultural groups enacting a culture of resistance. For example, *Learning to Labor* (Willis 1981) analyzes how British working-class "lads" produce meanings through dress and demeanor, constructing a counterschool culture but, nevertheless, damn themselves through resisting the adult expectation to study. *Subculture: The Meaning of Style* (Hebdige 1979) is a semiotic study, or iconology, that decodes the sartorial display and bodily adornment of punk rockers who haunt the cavernous streets of London, a world ruptured, for many, from the attainment of employment and stability. An American comparative ethnographic study that has incorporated the theme of resistance, *"Getting Paid": Youth Crime and Work in the Inner City* (Sullivan 1989), illustrates how working-class African American, Hispanic, and White teenagers construct cultures of resistance by defining robbery and mugging as their work—getting paid—when no other employment is available. Wagner's (1993) *Checkerboard Square*, another American study, focuses on a culture of resistance in a homeless community. From Latin America, Salazar's (1990) *Born to Die in Medellín* is a journalistic account depicting the horrors that Colombian children face and choose in a world in which opportunities have vaporized and violence rules.

Such ethnographic research portrays actors making life meaningful through a culture of resistance. Similarly, we observed meaning in the making through social action that illustrated that the mentally ill are not just acted upon but resist rules of coercive social and psychiatric institutions; moreover, through resistance rituals, ex-psychiatric patients construct alternative forms of social organization, culture, and community. A narrative of resisting (what ex-psychiatric patients subjectively define as) oppression enables them to live in a social world in opposition to mainstream society.

RITUAL AND RESISTANCE

From a Goffmanian perspective, everyday life is saturated with ritual: "acts through whose symbolic component the actor

shows how worthy he is of respect or how worthy he feels others are of it" (Goffman 1967, 19). Keeping in mind strictures against reification, we must begin any definition of ritual by noting, as Kertzer (1988, 8) does, that "it is not an entity to be discovered" but that which emerges through interaction. In this study, we are not talking about ritual that is sacred, in the traditional sense, but that of everyday life, the profane. Though the sacred and profane refer to different dimensions of social life, the elements of ritual, *qua* ritual, are similar.

Bocock (1974, 37) argues that "ritual is the symbolic use of bodily movement and gesture in a social situation to express and articulate meaning." Even simpler, it is "bodily action in relation to symbols" (Bocock 1974, 36). But what is it symbolic of? Ritual is the symbolic enactment of "desires," "feelings," and "wishes" (Bocock 1974, 9). Ritual has both cultural, or expressive, and societal, or relational, aspects (Griswold 1994, 4). Thus, rituals are shared symbolic acts that bond us to values, norms, and beliefs. The verb *bond* implies that integration of participants emerges through ritual, so that some measure of we-feeling, or solidarity, is created (Bocock 1974, 56-64); but it also includes an awareness of social constraint (Collins 1989, 19). Both implications are, of course, derivative of Durkheim's ideas. Because ritual involves relations to others, a social situation, it is primarily collective, not private¹ (Bocock 1974, 36).

Goffman argues that ritual actions in everyday life center on protecting "face," or "territories of the self," expanding the ethologists' concept of territory to include "areas" of visual, verbal, and informational privacy (Roth 1995, 317). In Goffman's (1967, 19) words, "one's face is a sacred thing, and the expressive order required to sustain it is therefore a ritual one." The self is "a ritually delicate object" (p. 31). "When a face has been threatened, face-work must be done" (p. 27). "As sacred objects, men are subject to slights and profanation; hence as players of the ritual game they have had to lead themselves into duels" (p. 31).

When ex-psychiatric patients define their face as having been violated, ritualistic resistance was one response. Resistance rituals took, primarily, two forms: expressive and instrumental. The former are rituals in which ex-psychiatric patients expressed outrage at mental health personnel. The latter are rituals that attempt to bring about social change.

Resistance is defined as activities of those with less power who believe their activities are confronting the powerful who are oppressing them. From an outsider's perspective, actions defined as oppressive by ex-psychiatric clients may appear, instead, appropriate. The Thomas Axiom—things defined as real are real in their consequences—helps us understand the ex-psychiatric patients' definition of oppression and resistance. For example, scarification by punk rockers who put razor blades in their ears and rings through their noses, lips, eyebrows, tongues, nipples, and genitalia—which might be defined by conventional society as self-mutilation or disfigurement—is defined by rockers as action to horrify the public from which they feel alienated (Travers 1982). These actions epitomize Bock's (1974, 37) notion of the relationship between the body and ritual: "Rituals relate people to their bodies in ways which few other social actions do, for they involve using the body to express feelings, and even ideas, in a disciplined way." Body language speaks: displayed by punk rockers, its form and posture is to shock others as a form of resistance to mainstream society. Thus, we are concerned with a consciousness of resistance.

Resistance rituals are, in part, an attempt to alter identities and power. Ex-psychiatric clients can concoct disorder and debunk the human-made for what it is. The constructed aspect of reality, its rules and regulations, is what they can expose. Mystifying rituals reify what is humanly constructed so as to legitimate power arrangements. Demystifying rituals expose what is presented as real or natural as merely socially constructed in order to discredit representations.

THE EX-PSYCHIATRIC PATIENTS

In this analysis, we focus on the ritual actions of the subcultural group of ex-psychiatric patients. What this population possesses fits the definition of a deviant subculture: "shared ways of thinking, feeling, and acting that members of a deviant group have developed for engaging in deviant behavior, organizing relations among themselves, and defending themselves against social punishment" (Rubington 1982, 69-70). Deviant groups employ these strategies to adapt to situations, social settings, organizations, or institutions. As Cohen (1955) has pointed out, there are five stages in the development of a deviant subculture: (1) experiencing a problem or set of problems, (2) communicating about it with others who share the same social fate, (3) interacting over an extended period of time on the basis of these problems, (4) developing a solution(s), and (5) sustaining and passing on the tradition. The ex-mental patient subculture arose in response to their negative posthospital situations: the effects of negative labeling, the stigma of mental illness, oppressive psychiatric and postpsychiatric treatment, and the mental health system in general. Through participation in this deviant subculture, members came to internalize a deviant ideology—a set of perspectives about themselves against the larger perceived hostile society; moreover, they learned and transmitted to one another strategies on how to manage their spoiled identities and sets of justifications for engaging in deviant activities, and generally taught one another how to "make it on the outside."² This is not to say that diagnoses of mental illness are groundless or that the treatment of those so diagnosed is always mean-spirited. Similar to Buckholdt and Gubrium (1979, 230), we found caretakers with a sense of "duty" and "personal commitment" and that much interaction among caretakers and clients is illustrative not of "constant turmoil" and "chaos" but rather of "routine." We also realize that our population can be "mean and downright devious" (Buckholdt and Gubrium 1979, 233), so we are not out to make them heroes. Rather, we limit our focus to their reactions to perceived threats of face.

METHODS

This article is based on data that have been collected as part of an ongoing study on the posthospital worlds of discharged psychiatric patients. Specifically, in the period of 1981-85, Herman (1986, 1987, 1994a) conducted an ethnographic study on a stratified random sample of 285 chronic³ and nonchronic⁴ Canadian ex-psychiatric patients living in six geographical locations in Southern Ontario, Canada. From a community psychiatric facility and teaching hospital in South Ontario, Herman obtained a listing of all patients discharged over a ten-year period. To fully protect the rights and identities of those ex-patients who may not have desired to participate in the study, it was agreed that Herman not initially view the names on the discharge list. Each name on the list was assigned a number, and a stratified random sample was obtained. Upon drawing the sample, a letter was sent by the medical director of the hospital on behalf of Herman outlining the nature of the study and the identity and affiliation of the researcher, stressing the voluntary nature of the study, emphasizing confidentiality of the subjects, addressing potential benefits and risks, and so on. The letter asked for their permission to be contacted. If clients agreed to do so, their names were given to Herman. She was given a list of 300 names. Due to death and subsequent refusal to participate, only 285 were studied. Over 1,575 hours of participant observation and interviews were conducted. Initially, informal interviews were conducted with each of the ex-patients in such locations as shopping malls, drop-in centers, group homes, coffee shops, their family homes, and their places of employment. The interviews lasted from three to five and a half hours. These interviews provided Herman with a wealth of information about the social worlds of these persons. In addition, many subjects with whom she had developed rapport also invited the researcher to participate further in their lives. Herman was invited to "hang out" with them—to enter into and experience their world from their perspectives. In particular, she was invited to attend several self-help group meetings, activist group meetings, and protest marches; to interact with family,

friends, and neighbors; and to be present at many therapy sessions. Moreover, she was afforded the opportunity to observe subjects interacting with coworkers and their superiors. She ate countless lunches and dinners in their homes (as they did in hers). Every Wednesday, she met a group of ex-patients at a local donut shop, where they would discuss problems they were facing on the "outside" and for which they collectively sought solutions.

From 1988 to 1991, and presently, Herman has also been collecting qualitative data on discharged American psychiatric clients residing in three counties in central Michigan. She obtained a listing of 175 clients who frequented a community mental health center. Again, in compliance with ethical considerations and to protect confidentiality, she was given only a listing of their names if they desired to participate in the study. She subsequently conducted over 630 hours of participant observation and informal interviewing with 125 American chronics and nonchronics in such locations as community mental health centers, shopping malls, parks, adult foster care homes, and fast-food restaurants. As with the Canadian cohort, she attempted to immerse herself in the social worlds of her subjects, to understand, from their perspectives, what their posthospital worlds were like. Additional subjects were then recruited through sponsorship by others with whom she had already developed rapport.

FINDINGS—EXAMPLES OF RESISTANCE

Deviants are often portrayed as powerless victims, relatively passive in accepting deviant identities, negative social statuses, and corresponding roles. Our study indicates, to the contrary, that many deviants, similar to "normals," are active creatures who resist, although not always successfully, the labels and identities bestowed on them. In this sense, our sample engages in many activities we term here as *rituals of resistance*.

Why is it that discharged psychiatric patients have formed a subculture and engage in various rituals of resistance? To

answer this question, it is necessary to focus on the concepts of identity transformation, deviant identities, and stigma. Individuals institutionalized in psychiatric hospitals (referred to as "total" or "people-processing institutions") are stripped of their prior nondeviant conceptions of self and proffered a new definition of self as mental patient—a deviant identity that not only is incompatible with prior self-images and identities but also carries with it corresponding negative social statuses and roles. Prior studies (Goffman 1961; Herman 1981, 1986, 1987, 1994a, 1994b) suggest that although individuals may try to reject these deviant social labels, the social structure of the psychiatric hospital with its rules and regulations, rewards and punishments, make it virtually impossible for them to avoid coming to see themselves as the institution, staff, family, and fellow patients see them. In fact, in the context of in-patient socialization, individuals quickly learn that to get released, they must verbally and behaviorally "play the role of mental patient" (Rosenhan 1973). Unfortunately, such role-playing has profound negative implications for their social identities. In-patients gradually come to internalize the identity of mental patient. Individuals released from the institution attempt to return to lives of normalcy (Herman 1986, 1994a, 1994b). For the most part, they seek to shed their deviant identities as mental patients and resume old, normal identities, roles, and statuses. However, such persons find that this is not an easy task. They come to realize that they possess a stigma that threatens their participation in "normal" society and inhibits identity transformation. Herman's (1986) data indicate that discharged psychiatric patients learn that they possess a potentially stigmatizing attribute in one of three manners: (1) as a result of societal reaction, official labeling, and institutional processing; (2) through post-hospital negative reactions from normals who stigmatized them; and (3) through self-labeling. In certain cases, ex-psychiatric patients dealt with the stigma potential of their "failing" by employing "offensive" and "defensive" strategies of stigma management. Offensive strategies include selective concealment, therapeutic disclosure, preventive disclosure, and political activism—strategies having positive implications for identity

transformation and the resumption of normal identities. Defensive strategies include institutional retreatism, societal retreatism, capitulation, passing, and subcultural participation—strategies lessening stigma but having negative implications for identity transformation. The employment of both offensive and defensive strategies fosters a subculture of resistance.

In an effort to avoid further or potential stigma on their daily rounds, ex-patients, through social interaction with other ex-patients, began to create deviant subcultures. Herman, quite by accident, happened upon the emergence of three distinct subcultures, referred to elsewhere (Herman 1987, 1995) as the “mixed nutters,” “looney tuners,” and “daffy ducks.” They engaged in behaviors and developed social meanings to separate themselves from the outside world, and, concomitantly, a set of rituals as adaptive strategies for survival—that is, a culture of resistance. Such strategies served the multiple functions of repudiating the medical profession’s and society’s label of *mental patient*, avoiding social control, and enabling the creation of an oppositional subculture.

We now turn to a discussion of the various resistance rituals that ex-psychiatric patients have socially constructed. Examination of the data indicates that resistance rituals may be divided into two general types: expressive and instrumental, with expressive having the two subtypes of (1) antideferential rituals and (2) self-harm/self-mutilation rituals.

ANTIDEFERENTIAL RITUALS

The data indicate that many ex-psychiatric patients, through social interaction, have developed and employed two types of expressive rituals to retaliate against mental health agents and the community at large. Ex-psychiatric patients use one such type, termed here as *antideferential rituals*, against those who have negatively labeled them, attempted to control them, or stigmatized them.

For the most part, ex-patients define the police, neighbors, and mental health officials as the “enemy.” In retaliation, 21

percent of the ex-patients in this study have collectively decided to “moon” these individuals—that is, drop their pants, bend over, and expose their buttocks. As Jonathan, a forty-two-year-old chronic of Asian descent, put it,

We've gotten together and created this salute for people who are out to get us—those who don't like us or think that mentals are “garbage” who should be locked up. We moon the bastards. Joe and Mike usually begin by playing a little song on the kazoo or harmonica as sort of a prelim to the act. Then, in concert, we all turn about-face and simultaneously drop our drawers to them. As an additional bonus, we all muster up or make a farting noise directed at them!

In a similar vein, Audrey, a thirty-two-year-old ex-patient, speaking on the beliefs of the group and the ensuing ritual of mooning, states,

It's them against us, you know. The world is a cold, dark, ugly place for ex-mentals. We are viewed as the scum of the earth. After a whole lot of talking between us as to what we should or should not do, we've come to believe that we shouldn't give in to their view of us—we shouldn't give in to how they treat us. We should somehow fight back in any way that we know how. Society is wrong about us. They are more charitable to AIDS patients than crazies. So we decided that every neighbor that doesn't want us living next door to them, every cop who harasses us, every caseworker who gives us a hard time, will get a close-up view of our big, fat, hairy asses. We'll bend over and moon them!

In short, then, this ritual of mooning is a shared symbolic act that serves to bond ex-patients to values and norms of the subculture and solidifies their relations with one another.

A second type of antideferential ritual used by many ex-psychiatric patients is ritualistic spitting. Over 60 percent of the sample employed this action, largely against members of the mental health profession (psychiatrists, nurses, caseworkers, drop-in center workers), various agents of social control, and intolerant/hostile members of the community. Examination of the data indicate that spitting takes the ritualistic forms of either

in unison or in succession. Agnes, a twenty-seven-year-old ex-patient of Native American descent, speaking on the ritualistic nature of spitting, states,

When the caseworker or shrinkiatrist becomes "deaf" to our concerns, i.e., refusing to listen to our problems or take us seriously, and treats us like we are some retards, in utter frustration, we decide that there is only one way to respond—that is, to hock goobers [spit] on them. Ralph, John, and Jeremy and I count: one, two, three; then we all hurl these goobers right at their faces—nice juicy green ones if we can muster them up. . . . This signifies that we aren't accepting their crap, their view of us and the way society treats us.

A second chronic ex-psychiatric patient, Moses, adds,

Goobering is one way to strike back against those who are against us—people whose job it is to herd us like cattle, to force us to swallow drugs that make us sicker sometimes; people who treat us like we have the "Mark of Cain."

A third ritual of resistance developed and employed by over one-quarter of the ex-psychiatric patients against mental health officials and nonsympathetic others is to defecate and/or urinate on them or social objects with which they are associated. For example, many ex-patients in this study, in retaliation against these individuals, would urinate on the feet of caseworkers and psychiatrists, urinate or defecate on the doorsteps of mental health buildings, or engage in "painting activities"—that is, defecating and smearing fecal material on the office doors, cars, and briefcases of the "enemy." Speaking of his painting activities, Waldo, a twenty-nine-year-old ex-patient, states,

When the staff at community mental health—those damned doctors and therapists—piss us off and try to get us to eat more meds or shackle us into stupid make-work programs, we respond by dumping a big load on the front doorsteps, or if the shit is loose, pick up a handful and smear it all over their cars or on the front door of their office. We paint them an original masterpiece that they will never forget. That gives them the message that we are angry as hell!

A second chronic ex-psychiatric patient, Lucky, adds,

It's like this. We mentals have been disqualified. Even though we've been released from the crazy house, they [caretakers] still tries to make things difficult for us. We aren't free. They still try to put up barbed-wire fences around us—they come up with so many rules and regulations for us to follow—"do this, don't do that; take this medication or else; follow your program; go to the workshop every day and earn 20 cents an hour or else." Live in this group home with others like you; eat rotten food and get beaten up. What kind of freedom is that? When we decide that we don't want to follow this crap anymore, we just pull out our peckers and piss all over them—just like they been doing to us all along!

In short, then, the ritualistic actions of defecating and/or urinating are imbued with social meaning. As Goffman (1967, 89) reminds us, "Whatever is in the patient's mind, the throwing of feces at an attendant is a use of ceremonial idiom that is as exquisite in its way as is a bow from the waist done with grace and a flourish." Given the belief that they are stigmatized, victimized, and oppressed, the ex-patients stage these resistant actions with specific intentions, thereby calling attention to what they consider their wrongful, negative statuses.

Another ritual of resistance developed and employed by 16 percent of the ex-psychiatric patients is to write/draw graffiti on the various institutions of social control that dominate them. In particular, some ex-mental patients have decided to write profanity and draw pictures on the front facades of the building in reaction against the community mental health centers, their social policies, and staff who implement them. Alex, a twenty-eight-year-old chronic of African American descent, explaining the symbolic meaning underlying his activities, states,

Life for mentals is sheer hell. There is no doubt about it. We are treated as if we don't count in this world. Society has shunned us. The doctors and nurses are only in it for the money; they really don't give a damn about us. You can tell 'cause they are never really listening to what you have to say; they don't care that the programs stink or that we're being exploited in the

boarding homes; nobody has any backbone to stand up and help us out. They force us to go to work at the sheltered workshop even though we don't want to go. They threaten us all the time. We have to follow asinine rules that make no sense. Ex-mentals are being victimized left and right and no one cares. Finally, after much talking among the rest of us, we decided to try to get even and stand up for ourselves and for what we know is right by taking spray-paint cans and writing on cars, walls, buses, or anywhere—"Fuck you people who treat us like shit! We aren't taking it no more! Free the nuts!" Each time we write a statement like that, we draw a star beside it and a peace sign, which signifies that we have hope things will transform and we will have peace in our lives.

The actions of drawing mural graffiti and writing profanity are examples of ritual action expressing meaning that has emerged out of social interaction among discharged psychiatric clients. All of these antideferential rituals, the symbols and meanings associated with them that this population has developed and employ, emerge out of the subcultural ideology. Ex-patients have developed these rituals as attempts to protect aspects of their sacred faces. Actions such as these arose because the mental health profession sees no reason to offer accounts and/or apologies for their daily assaults on the patients' territories of the self. Similar to working-class youth who develop subcultures of resistance (cf. Corrigan 1979; Patrick 1973; Willis 1981), our sample has developed and internalized a perspective on themselves and on their relations with other societal members, a set of ideas repudiating conventional stereotypical conceptions of their deviant identities, roles, and statuses within society and ideas about how to resist their usual treatment.

Under what conditions did these antideferential rituals occur? Mooning and spitting frequently occurred in response to a specific incident in which the ex-patients had recently been involved such as the police taking an ex-patient's friend away, to stigmatizing treatment by a stranger or neighbor, to being chastised by a caseworker, to an involuntary change in housing facilities, or to exploitation in a group home. Over 38 percent of the sample turned to mooning or spitting when they had subjec-

tively experienced the stigma of their "failing." Such stigmatization by normals was very traumatic and difficult for ex-patients, leading to these negative, although unproductive, responses.

SELF-MUTILATION/SELF-HARM RITUALS

In a second type of expressive ritual, ex-patients turn their actions inward and engage in acts of self-mutilation or self-harm. Specifically, over one-quarter of the sample engaged in such acts as refusing to take psychotropic maintenance medications, burning their flesh with cigarettes, and scarring themselves with razor blades. These acts are analogous to resistance rituals found by Hebidge (1979) among punk rockers and Travers (1982) among punks.

Nancy, a twenty-nine-year-old Native American ex-patient, speaks about her active refusal to take her maintenance medications:

It is similar to being anorexic. That is the best way I can explain it. Sometimes, you just get so fed up with all the bullshit—the mean treatment, the negative attitudes that everyone is against us mentals, the stupid, negative make-work programs we have to go to, the caseworker's program we have to follow, the exploitation in the group homes—everyone is trying to control my life and every aspect of it. The only thing I have control over is to take or not take my meds. A bunch of us decided that they are designed to alter our brains and turn us into compliant robots—so we just decided not to take 'em. We put them under our tongue if the group home staff is watching and later flush them.

In a somewhat similar fashion, Bert, a sixty-nine-year-old chronic, speaking on his scarification with razor blades and his jack knife, says,

It gets to the point in life when we all just want to tell the government to fuck it. No more programs, drugs, this experiment, and that experiment. I'm tired of all this crap. The group home stinks, and they abuse us all the time; I'm always being

yelled at for something or kicked in the butt. I just go into my room, shut the door, and gradually carve things into my arms and leg. As I draw blood and go deeper and deeper, it gives me a sense that I have some control over me.

Sally, another ex-psychiatric patient, tells of her reasons for burning her flesh with cigarettes:

I have been burning marks into my arms and legs for over two years now. In fact, a few other patients do it as well. It is a symbol that we only know what it means. It's sort of a secret symbol that we share with each other that signifies that we are pissed at the way we mentals are treated by society—the more burns on us mean that we are more pissed off at society and that we ain't going to take it no more.

In short, then, these ritualistic acts of self-harm/self-mutilation bond ex-patients to their ideology, beliefs, norms, and values and to one another. Their symbols are known only to insiders and used to separate them from outsiders. The actions of burning oneself, cutting oneself, or refusing to take medications express a shared meaning among the subcultural group members and, hence, qualify as rituals. These ritualistic actions are defined by the ex-psychiatric patients as resistance and express their collective desires to undermine the status quo.

Under what structural conditions did these self-harm/self-mutilation rituals occur? Over 25 percent of the sample engaged in these ritualistic acts of resistance in response to a specific incident that had affected the individual. So, for example, ex-patients would often mutilate themselves after an altercation with a caseworker, following a negative session with a psychiatrist, if families or friends disappointed them, following emotional or sexual abuse inflicted by a boarding home staff member, or as a result of stigmatization on the part of a "normal other." So, for example, it was not uncommon for one-third of the ex-patients to burn themselves with cigarettes when caseworkers failed either to show up for appointments or to take seriously their problems. This lack of attention set the ex-patients on a downward spiral in which they would mutilate themselves repeatedly for several days, some for several weeks.

Ironically, all of the behaviors we have discussed above tend to confirm, in others' eyes, the ex-patients' deviance. This leads to a catch-22 situation in which the very expressive means available for resistance provide the grounds for the treatment that they are resisting. We will now turn to a third type of resistance used by ex-psychiatric patients that is not expressive but, rather, instrumental in nature and, arguably, more effective.

INSTRUMENTAL ACTION

Just as many of the discharged psychiatric patients in this study employed antideferential and self-harm/mutilation rituals, the data indicate that many also develop and engage in a number of more instrumental acts. Following Goffman (1967), our study indicates that ex-patients employed such acts of resistance as organized sit-downs during programs in community mental health centers, walk-outs from sheltered workshops, protest marches, the distribution of protest leaflets and newsletters, and the like.

Over 18 percent of the sample resisted mental health officials through organized refusal to work in sheltered workshop settings. Such programs as ARC, Handicapped, Inc., and Mid-Michigan Industries are vocational and rehabilitation organizations that attempt to teach clients marketable skills for which they are paid menial wages. While these deviance-processing institutions defend their social programs, the clients, by contrast, define the work as boring, meaningless, degrading, exploitative—programs providing them no marketable skills.

Aldo, a forty-two-year-old Canadian chronic ex-patient, speaking on the negative aspects of sheltered workshops and the ensuing ritual of resistance developed and employed, states,

Going to the ARC Industries everyday is just shitty! Those guys who are running the place are just in it for the bucks—all they do is exploit the mentals and the retards. They pay us only 20 cents an hour to put these nuts and bolts in a box; last year my job was to shove sanitary napkins in boxes. That was so damned em-

barrassing. I am capable of doing more than that. They don't even try to train us to do something worthwhile, like computers or something. Those bloody bureaucrats don't know what would be best for us, how to help us; they just have their heads up their asses! As long as they are lining their own pockets, they don't care about us. What we mentals decided to do was to revolt against this bullshit and stage sit-downs and walk-outs. We needed to do something to get their attention. So, last week, when we couldn't take it anymore, Joe organized us on the count of three to just sit down in the building and no one do anymore work. That lasted the rest of the afternoon, and even though they treated us badly, most of the people resisted giving in.

Sarah, a twenty-five-year-old, American nonchronic, speaking of how she organized a walk-out of a community mental health program, remarks,

We decided one afternoon during break in this aftercare program that community mental health runs that this was all bullshit. We come here twice a week from our group homes, and they have these shrink sessions in group. We know that they are just watching and recording everything we say and then they use it against us to reconfirm how crazy we are. The doctor uses this information to up [increase] our medications. So what they are is confirming our craziness or reconfirming it. They are doing nothing to help us on the outside. These people don't have one iota as to what our needs really are; they have us knitting and finger painting and cutting and pasting—tell me that these kindergarten activities are helping us in any way. It got to the point where one day, I organized all of us to just walk out in protest. The staff were freaked out; they didn't know how to handle it. We tried to explain our demands, but the sad part about all of it was that they interpreted this revolt as instances of mental illness and upped all our doses. They then put us on house arrest for one month, and all our privileges were denied.

A second type of instrumental resistance that 11 percent of the sample developed and employed was to join and participate in ex-mental patient activist groups (cf. Anspach 1979). These groups, with their ideological goal of self-affirmation, represent what Kitsuse (1980, 9) terms "tertiary deviation"—referring to the "deviant's confirmation, assessment, and rejection of the

negative identity embedded in the secondary deviation, and the transformation of that identity into a more positive and viable self-conception." As discussed elsewhere (Herman 1994b), political activism serves a threefold function for the ex-psychiatric patients: (1) it repudiates stereotypical standards of normalcy (standards to which they could not measure up) and the deviant labels placed on these individuals; (2) it provides them with a new, positive nondeviant identity, enhances their self-esteem, and affords them a new sense of purpose; and (3) it serves to propagate this new, more positive, image of ex-mental patient to other individuals, groups, and organizations. The payoff from political activism was, then, personal as well as social.

Like other activist groups such as the Disabled in Action, the Gray Panthers, and the Radical Feminist Movement, ex-psychiatric patients, through participation in similar groups, come to reject the prevailing societal values of normalcy. They repudiate the deviant identities bestowed on them as a result of institutionalization. They also reject the stigma associated with their social identities—the fact that society has disqualified them and treats them “differently.” Manfred, a thirty-five-year-old baker, sums it up for the majority of ex-patients when he says,

We've come to realize through this group that the way society views us is all wrong. They have set up these artificial standards of what is normal and what is abnormal. And we have been placed by others into the abnormal category. At first, in the hospital, we come to accept it and everything that it means to be a mental patient, but now we realize that this is all wrong. Not only is it wrong how they categorize us, but also how they then disqualify us—throw us out with the trash. Mentals are shunned, ostracized, or treated with a lack of respect. We are discriminated against, just like other minorities. But the sad thing is that no one stands up for us in the government and fights for our rights. That's why we got to do it ourselves—by becoming politically active.

Upon repudiating prevailing cultural values and deviant identities, these ex-patient activists collectively redefine themselves in a more positive, nondeviant image—according to their own

newly constructed standards. Ex-mental patient activists conceived of their problems not as personal failings or potentially stigmatizing attributes but, rather, as societal problems. To the extent that ex-patients viewed their situations in this manner, it allowed them to develop more positive self-images. Humphreys (1972, 142) conceives of this process as one of "stigma conversion."

Marissa, a novice activist, speaks about placing the "blame" on society for her negative, deviant self-image and identity:

At first, we all felt ashamed—that it was our faults that we became mentally sick. That's the way society wants us to think—to blame ourselves. But ever since I joined this [activist] group, they have got me to think differently about myself. I am no longer ashamed. It's not my fault. And I am now madder than hell [about] the way we are treated in society.

Just as political activism serves to repudiate the dominant value system, to provide its members with more positive, non-deviant self-conceptions, so, too, does it attempt to propagate this new positive, normal image of the ex-psychiatric patient to caretakers and the community in general. Thus, through various activities such as rallies, protest marches, demonstrations, attendance at conferences on human rights, lobbying activities, and the production of newsletters and pamphlets, ex-patient activists seek to counter or remove the stigma associated with their "failing" or deviant attribute; in its place, they offer a new image of former psychiatric patients as human beings, capable of self-determination and political action. Hector, a long-term activist, sums it up when he states,

If I had to tell it to you in a nutshell, activism means that we're no longer willing to be pushed around, exploited, treated like the scum of the earth; we're no longer going to be blamed for our illness. We cannot help it; it is not our fault; we reject the way society views and treats us; we are disqualified and discriminated against. We don't like the stereotype of "mental" that is all

over the media. It is wrong, distorted, and negative—we reject it. We are full-fledged humans with an illness like cancer or heart disease; we are to be treated with dignity and respect, to be helped and not hindered, to be saved and not stigmatized by society, to be reintegrated and not bound in prisons without walls.

Through participation in political activist groups, these ex-patients repudiated societal values and conventional standards of normalcy. They rejected their deviant identities and social statuses, adopted more “moral,” nondeviant identities, and cast the mental health personnel into moral disrepute. In so doing, they attempted to alter society’s stereotypical perceptions about mental patients and mental illness in general.

Of course, the instrumental resistance employed by these ex-psychiatric patients was unsuccessful in transforming the mental health care industry. Some of the activities were successful in bringing about some measure of social change. For example, discharged psychiatric patients in this study were successful in having legislation changed and stricter violations imposed regarding conditions in boarding homes and group homes. So, too, were they successful in having two ineffective community psychiatric programs abolished and bringing about new programs that better served their needs.

Under what structural conditions did ex-patients employ such instrumental actions? The data indicate that these actions were developed and employed not in response to an isolated incident affecting a particular individual but largely as a direct response to cuts in various community psychiatric programs, a reduction of services, or the implementation of new policies (subjectively perceived as negative). Clients conceived such changes in the community mental health care system as affecting all of them; hence, they bonded together to retaliate through the employment of the instrumental actions we have discussed above. Program cuts were defined as a profanation of self, or better, of a collective self, the community of ex-mental patients.

SUMMARY

It is important to make clear that not all of the same people in the sample engaged in all three types of resistance. Some individuals employed primarily one type, while others employed two; still others used all three. Moreover, some of these acts of resistance were employed repeatedly, while others were non-repetitive. However, employment of each type seemed to vary according to factors such as age, length of hospitalization, and frequency of hospitalization. That is, preliminary analysis indicates that older, chronic ex-patients—those who had been institutionalized in psychiatric hospitals for periods of one or more years and/or those institutionalized on five or more occasions—seemed to create and use primarily such rituals as self-mutilation and various antideferential rituals. By contrast, the data suggest that younger, nonchronic ex-psychiatric patients—those hospitalized on psychiatric wards of general hospitals for periods of months (not years) and/or those hospitalized on less than five occasions—enacted both expressive and instrumental rituals, ranging from self-harm/self-mutilation to antideferential rituals to various politically instrumental acts. In particular, nonchronics' use of such rituals of resistance as walk-outs, sit-downs, protest marches, and political activist activities served to repudiate stereotypical definitions of mental illness, provided ex-patients with new, more positive nondeviant self-conceptions, and served to propagate this new image of mental patient and mental illness in general to the society at large. Chronic ex-patients did not engage in instrumental acts of resistance. Such structural factors as their long-term institutionalization in total institutions, their frequency of institutionalization, the numbers and large dosages of psychotropic medications, their forced placement in group homes with other individuals labeled as mentally ill, and coercive attempts by caseworkers to force their attendance at various sheltered workshop programs for the mentally and physically disabled (cf. Herman 1986, 1994a, 1994b) militated against instrumental action and identity transformation. Consequently, they failed to develop an oppositional discourse.

CONCLUSION

Ex-psychiatric clients engage in demystifying rituals and construct a narrative that transforms a negative identity into a positive one. Rituals can promote social solidarity and mystify power relations; traditionally, they have been conceived as activities of power holders. Ex-psychiatric patients, like other deviants who are traditionally conceived (Wagner 1993, 6-7) as vulnerable, inept, irrational, and isolated to the extent of being incapable of collective action, are able, through rituals, to create a culture of resistance. This is a discourse of struggle, in which the mentally ill, from their perspective, negotiate a moral identity (resisting oppression) and cast disrepute on the moral identity of those who treat them (again, from their perspective) with scorn. Granted, the vast majority of these acts represent personal rather than political resistance; yet, the personal is political, maybe nowhere more so than in the struggle against negative and the struggle for positive representation.

Resistance took primarily two forms: expressive and instrumental. Both were strategies that the powerless deployed to confront the powerful. The ex-psychiatric patients were able to accomplish some social change, but their structural position of powerlessness and their conditions limited their horizons. False universalization has classified all mentally ill as vulnerable and in need of benign sheltering (Wagner 1993, 4). In contrast to popular tendentiousness and social science literature, some mentally ill who define themselves as having been slighted or profaned are defiant enough to play the ritual game, enacting expressive and instrumental duels. These spirited actors make their own lives, a culture of resistance, in the cracks and crannies of social constraint.

NOTES

1. As Bocock (1974, 45) wrote, "This type of distinction makes it possible to distinguish social ritual from ritual of individuals with particular obsessions. It is the former which are of interest to the sociologist, and the latter to the psychiatrist and psycho-therapist."

2. It is important to note that the various acts of resistance learned in the subculture may have provided temporary relief but in no sense provided material solutions.

3. For the purposes of this study, chronicity was not defined in medical diagnostic terms—that is, “chronic schizophrenic”; rather, it was defined in terms of duration, continuity, and frequency of hospitalizations. Thus, the term *chronic* is defined to refer to those institutionalized in psychiatric hospitals for periods of two years or more, those institutionalized on a continuing basis, or those hospitalized on five or more occasions.

4. The term *nonchronic* refers to those individuals hospitalized for periods of less than two years, those institutionalized on a repeated basis, those hospitalized on fewer than five occasions, or those treated on psychiatric wards in general hospitals.

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