MEDICALIZING DEVIANCE IN THE COMMUNITY OF ELDERS: A NEW PSYCHIATRIC ENTREPRISE

by

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ABSTRACT

This study is about the process by which deviance is transformed into the medical category of medical illness in the elderly living in the community. Mental illness is considered here as a form of deviance in the sociological sense of term as it involves departure from socially expected rational behavior. More specifically, the study demonstrates by using a participant observation approach how psychiatric professionals in a community mental healthy team have created a new market for the distribution of their specialized geriatric services by establishing a network of both lay people and professionals who are trained to refer to the team elderly people whom they identify as mentally ill.

However, much of the illness in the study's sample of referred elderly related more to the 'problems of living' they experienced in struggling with the generally poor social conditions they were faced with, including forced retirement, inadequate income and housing, and physical illness. In some instances, such problems also stemmed from their differences in lifestyle, personal needs, and beliefs with the staff in the institutions caring for them.

By acknowledging the elderly's 'problems of living' as psychiatric disorders, the community mental health team effectively isolated them from their social and political context by making them into individual problems. This approach become a move towards 'blaming the victim', hence
ignoring the political (rather than therapeutic) interventions needed to improve the conditions contributing to the presence of such problems.

Finally, the study shows that community psychiatric professionals within the team tend to medicalize deviance as a response to the constraints imposed on them by their agency, which functions within a bio-medical framework in delivering mental health services to the community.
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To my advisors, Nancy Waxler-Morrison and Kathryn McCannell, and to the elderly who have made this thesis possible by sharing with me their fight for freedom and dignity.
INTRODUCTION

Deviance is as part of society as is conformity. Every human group throughout history regardless of its cohesiveness had to respond to such problems as violence, riots, sexual misconduct, or bizarre behavior. Understanding how a given society deals with its deviant members involves the study of norms. They provide the baseline against which deviation is defined, sanctioned, and corrected.

Historically, deviant behaviours which were once defined as immoral, sinful, or criminal have now been given medical meanings. Thus was created mental illness.

This medicalization of deviance has not occurred by itself through the natural evolution of society. Rather it is the result of the working of specific people operating under certain political and economic constraints who sought to explain and treat deviance as departure from normal brain function. Thus came about psychiatry.

Psychiatry's stronghold has traditionally been the asylum and the hospital. However, in the 1960's in the United States Community Mental Health Centres were developed in an attempt to turn psychiatric knowledge and techniques to community problems. Gerald Caplan's (1964) Principles of Preventive Psychiatry became the bible of the movement which advocated the prevention of mental illness through early identification and treatment of psychiatric disorders Caplan
recommended that psychiatrists and other mental health professionals should anticipate crisis and intervene to help people cope with stressful events in a variety of settings such as schools, pre-natal clinics, divorce courts, in an attempt to create a mentally healthy social environment.

However, in breaking away from the hospital, community psychiatry never relinquished the medical model of mental illness. Patients were still considered to be suffering from diseases of the mind. In fact, community psychiatry expanded the medical model of human problems by widening its definition of mental illness in its efforts to strengthen its jurisdiction over deviance.

The elderly have become a prime target for community psychiatry's ongoing search for those in need of psychiatric services. Their generally powerless status within society makes them more likely to experience the problems of living redefined as illness by psychiatric entrepreneurs.

This study is about the process of medicalizing deviance in the elderly. It demonstrates how psychiatric professionals in a community mental health team have opened new markets for the delivery of specialized geriatric services by creating a network of community agents in various institutions who are trained to refer elderly they identify as mentally disturbed. However, the illness these agents refer has more to do with human problems and conflicts than with brain pathology. Therefore, in the course of treating those problems, the community mental
health team acts as an agent of social control for those institutions.

More importantly, this study illustrates the struggle of the elderly as a new social class arising from the requirements of a capitalist economy which has made necessary the need for mandatory retirement. The individualization of the problems faced by this class into medical entities only serves to blame the victim and divert attention from the real political issues responsible for deviance in the first place.

Finally, this study also raises questions about the role of the social work profession as a contributor to the control of deviance within society. Social changes can be made more likely if social workers as a group involve themselves in the political struggle of the working class rather than in the medicalization of its demands.
CHAPTER ONE

DEVIANE AND ITS CHARACTERISTICS

In reviewing the literature on deviance, I have retained a number of definitions and characteristics which all point to a central concept: that deviance although a universal phenomenon, is socially relative in its definition and sanctioning. More specifically, deviance is usually identified and controlled as such in less powerful members of a given society by its dominant class to preserve an economic and social order they benefit from.

This chapter will also illustrate the concept of deviance through examples taken from the sociological literature on mental illness. More specifically, I will show how deviance has benefited psychiatrists in their efforts to define and sanction it as a biological disease;

DEFINING DEVIANCE

The study of deviance has attracted the attention of sociologists since the turn of the century. This interest has generated numerous attempts at defining and understanding deviance and explaining its causes. The definitions offered by several scholars have much in common in the sense that deviance is usually seen as doing or being that which is socially disapproved, although they differ in their emphasis on the behaviors which elicit such
disapproval. More specifically, they describe deviance as norm or rule violations which are negatively perceived by the society in which they take place. For example, Dinitz, Dynes and Clark (1969) affirm that:

Regardless of the specific content of behavior, the essential nature of deviance lies in the departure of certain types of behavior from the norms of a particular society at a particular time. (p. 4)

Along the same lines, Clinard (1968) describe deviant behavior as:

Essentially a violation of certain types of group norms; a deviant act is behavior which is proscribed in a certain way... Only those deviations in which behavior is in a disapproved direction and of sufficient degree to exceed the tolerance limit of the community constitute deviant behavior (p. 28).

Matza (1969) relying on a dictionary definition, writes in a concise and simple manner that "to deviate is to stray as from a path or standard" (p. 10).

Some authors have chosen to study deviance by putting the emphasis on how such deviance is so defined by society. These definitions shift attention from deviance as a specific pattern of behavior to deviance as social definition or label that individuals use to explain the behavior of others. Becker (1963), for example, describes the deviant as "one to whom that label has successfully been applied; deviant behavior is behavior that people so label" (p. 9). Becker here seems to refer to the fact that within a given society there are some people or groups who have or
take the authority to label others deviant. This suggests that deviance is a relative status that can be redefined under changing societal conditions by significant members of a society as opposed to an inherent quality of the person who carries the label. This concept is also echoed by Erickson (1966) who declares that:

Deviance is not a property inherent in any particular kind of behavior; it is a property conferred upon that behavior by the people who come into direct or indirect contact with it. (p. 6)

So in short, it is not the act but the definition that makes someone deviant and hence one could surmise that there are no universal forms of deviance but only socially constructed ones.

This concept of deviance is further refined by Schur (1971) who created a definition that includes social reaction to individuals who are suffering from a disability or illness, even though the latter may have violated no explicit rule or norm. He suggests that:

Human behavior is deviant to the extent that it comes to be viewed as involving a personally discreditable departure from a group's normative expectations, and it elicits interpersonal or collective reactions that serve to isolate, treat, correct, or punish individuals engaged in such behavior. (p. 74)

The definition accounts for an important aspect of deviance: that of abnormality and pathology as deviance.

Within this framework, mental illness is viewed as a form of deviant behavior like crime, juvenile delinquency,
and drug addiction. Unlike psychologists or psychiatrists, who are primarily dealing with the study and the treatment of individual cases of mental illness, sociologists tend to approach psychiatric disorders in terms of group or larger societal processes that influence the conduct of individual behavior. Mental illness is perceived as significant deviation from that which is considered or expected to be normal conduct in a given group or society.

CHARACTERISTICS OF DEVIANCE

For the purpose of this study I have retained three characteristics of deviance as identified by Conrad (1980). These are: deviance is socially defined; social groups make rules and enforce their definitions of deviance on their members through judgement and social sanctions; and defining and sanctioning deviance is for the purpose of one group establishing dominance over another through social control.

(1) Deviance is Socially Defined

Every society regardless of time or place has defined some of its members as mentally ill. Yet different societies consider different activities as mental illness. There are few acts, if any, that are seen as deviant in all societies and dealt with in the same manner. For example, certain forms of homosexuality involving male adults and younger boys were acceptable among the cultural elite in
classical Greece, but in America today such behavior is reported in the DSM III-R (Diagnostical Statistical Manual, Revised, 1987) as a psychiatric disorder under the name pedophylia. Suicide is another example of a behavior considered deviant and ungodly in most Christian cultures and yet in Japan, such behavior is considered an honorable act (Conrad, 1980).

These examples serve to illustrate the notion of what Ruth Benedict (1934) calls cultural relativity, meaning that each society should be viewed by its own conceptions and standards of behaviors when looking at how it defines deviance. This notion of relativity can also be applied to groups or subcultures within a given society. What is tolerated by one group of people (e.g., street people) may not be acceptable to another group (e.g., upper class) and hence judged to be deviant by the later. This implies the notion that deviance does not exist by itself objectively regardless of the act, behavior or status. As Conrad (1980) points out, "deviance is a socially attributed condition, and 'deviant' is an ascribed status" (p. 6). Therefore, within this framework, mental illness is not the characteristic of specific sets of behaviors but rather exists as a category of behaviors that have been defined as such by significant actors within our society. Scheff (1975) illustrates this point by saying that:

The concepts of mental illness in general - and schizophrenia in particular - are not neutral, value-free, scientifically precise terms but are, for the
most part the leading edge of an ideology embedded in the historical and cultural present of the white middle class of western societies. (p. 7)

By considering mental illness as a socially defined phenomenon, it can be argued that such definition can change according to which individuals, groups or society evaluates and defines deviance and for what purpose. Rosenhan (1973) demonstrated how relative and inaccurate the process of identifying mental illness can be in a study where eight eminently sane people gained access to various psychiatric hospitals across the nation as pseudopatients. They were three psychologists, one psychology graduate student, a pediatrician, a psychiatrist, a painter, and a housewife. The pseudopatients gained admittance to the hospitals by complaining that they had been hearing voices of unclear content, except that they appeared to say "empty," "hollow," and "thud." Beyond alleging the symptoms and falsifying name, vocation, and employment, no further alterations of person, history, or circumstances were made. Upon their admission to the various hospitals, the pseudo patients resumed their normal self and stopped simulating any symptoms of mental illness.

The object of the study was to see if the sanity of the pseudopatients could be detected amid the insanity of the institutional setting. It was not. Although they behaved on the wards as they did ordinarily, often publicly taking notes for the study, none of them was discovered. In fact, the pseudo patients were hospitalized between 7 to 52 days,
with an average of 19 days and each got discharged with a diagnosis of schizophrenia in remission.

Interestingly enough, Rosenhan (ibid) conducted another experiment to see if the tendency of diagnosing the sane insane could be reversed. It occurred in a research and teaching hospital whose staff was informed that in a three month period, one or more pseudopatients would attempt to gain admission into their facility. Each staff person was asked to rate each patient according to the possibility of him or her being a "sane" person. Ratings on 193 patients were obtained and forty-one of them were allegedly rated as pseudopatients by at least one staff member and twenty-three of those forty were rated as such by psychiatrists. The reality of the experiment was that no pseudopatient attempted to gain access to the hospital. These two experiments lead the author to conclude that "it is clear that we cannot distinguish the sane from the insane in psychiatric hospitals" (p. 71) and therefore psychiatric diagnoses may tell us more about the diagnosticians defining the illness than about the patients and their problems.

(2) Social groups make rules and enforce their definitions of deviance through judgements and social sanctions

This statement refers to the mechanism by which deviance is created. Becker (1964) declares that "social groups create deviance by making the rules whose infraction constituted deviance, and applying those rules to particular
people and labeling them as [deviants]" (p. 4). In terms of mental illness, one can consider the Diagnostic Statistical Manual III-R of the American Psychiatric Association (1987) as a set rules which defines what is abnormal behavior and which psychiatrists, who are sanctioned by society to apply these rules, use to guide their judgement in determining who is or is not deviant.

(3) **Defining and Sanctioning Deviance Involves Power**

Historically, the more powerful members within a society have been establishing standards of conduct for the less powerful ones. Power is usually determined in the sociological literature in terms of key socio-demographic characteristics such as social class, race, sex, and marital status. Most studies on power have used epidemiological methods in determining the prevalence or incidence of mental illness in social aggregates or large groups of people.

One of the most consistent findings in this area has been that the presence of mental symptoms is inversely proportional to the level of the social class (Horwitz, 1980). In other words, the lowest social class invariably displays a greater amount of mental illness than the highest social classes.

One of the most important studies in this area was undertaken by Hollinghead and Redlich (1958) in New Haven, Connecticut. The authors then attempted to collect data on all treated cases of mental illness in New Haven,
Connecticut. They surveyed all the clinics, hospitals, and private practitioners in the northeastern United States that might have been used by New Haven residents. Each patient was classified according to their membership in one of five social classes: class I being the upper class; class II, the upper middle class; class III, the middle class; class IV, the working class; and finally, class V, the lower class. The authors found that the lower the class, the greater the tendency is toward psychotic problems such as schizophrenia; and the higher the class, the more prevalent the tendency was toward mental illness of lesser gravity such as neurosis. Interestingly enough, they also found that individuals from the lowest social class, the one with the highest prevalence of mental illness, were in contrast much less inclined to attribute personal problems to mental disorder or to label someone as mentally ill. And yet, they were most often identified as needing psychiatric care and consequently referred to the appropriate agencies (e.g., hospitals, asylums) by 'social control' professionals such as the police or workers from the social welfare agencies.

One flaw of this study however is the severely limited generalizability of its findings to the general population not receiving psychiatric treatment. Its sample included only those individuals who were already identified as mental patients and receiving psychiatric services. It fails to account for a 'true' prevalence of mental illness by not including many people who are 'mentally ill' at large in the
community but not receiving psychiatric care. Nevertheless, it clearly showed that the poor were more likely to be institutionalized as mental patients than wealthier members of society, and that such a process was most likely to be initiated by a third party such as the police or social workers.

Srole et al. (1962) in their Midtown Manhattan study addressed this problem of true prevalence of mental disorder which Hollingshead and Redlich failed to look at. Because the latter study looked strictly at treated cases of mental illness, the authors decided to look only at cases of untreated mental illness in the general population. Some 1,660 individuals were interviewed by a team of psychiatrists to assess their psychiatric condition. The results hence obtained bore great similarities with Hollingshead and Redlich's (1958) study as they corroborated previous findings that more mental illness was located in the lower social class.

Similarly, another epidemiological study by Leighton and his associates (1968) indicated an extremely high level of true prevalence of mental disorder in a random sample of 1,303 respondents in a rural county in Nova Scotia. The respondents were rated as to their probability of being diagnosed as mentally ill by a team of psychiatrists applying the standards found in the DSM-II (APA, 1968). Predictably, the results of the study indicated that mental
disorder was most prevalent among individuals of the lowest socio-economic group.

A number of explanations have been advanced to account for the relationship between lower social class and mental illness. From the medical perspective comes the genetic theory which says that members of lower socio-economic groups are more predisposed toward mental disorder. This theory remains inconclusive however as numerous studies have demonstrated that genetic factors alone are insufficient to account for the fact that disorders such as schizophrenia are most prevalent in lowest socio-economic groups (Shield, Heston, and Gottesman, 1975).

Another explanation brought forward by Harkey et al (1976) is that of social selection which proposes that mentally ill and unstable individuals tend to pool or drift toward lesser social classes whereas healthier individual on the other hand tend to be upwardly mobile and congregate in the upper class. In other words, mental disorder here is considered a contributor to social class position.

However, in reviewing the weight of the evidence for studies using a social selection model, Melvin Kohn (1976) concludes that at least in the case of schizophrenia:

Individuals have been no more downwardly mobile (in fact, no less upwardly mobile) than other people from the same social backgrounds, or at a minimum, that the degree of downward mobility is insufficient to explain the high concentration of schizophrenia in the lowest socio-economic strata.
So, the social selection perspective appears to be no more adequate than the genetic predisposition model in accounting for the greater presence of mental illness in lower social classes. Therefore there is a need for an alternative model to explain why the poor, the helpless, the marginals (and the elderly certainly can be included amongst these categories) invariably are diagnosed more frequently with insanity.

In reviewing the literature on social class and mental illness, Horwitz (1980) notes that:

The recognition of mental illness varies directly with the social class of the labeler. The higher the social class status of the labeler, the more likely they are to recognize and label mental illness. Conversely, as social class declines, so does the likelihood that observers will apply labels of mental illness (p.64).

The author adds however that these studies do not necessarily indicate that there is in actuality more "true" mental illness in the community but that more lower class individuals are defined as mentally ill by others. It becomes then crucial to look at who labels mental illness and for what purpose. Since the studies on incidences and prevalence of psychiatric disorders in the general population exclusively rely upon psychiatrists' subjective judgements in identifying either the presence or absence of mental illness one has to look at a case of a powerful social group, psychiatrists, defining and sanctioning deviance in a less powerful group, the lower social class.
Let us explore how this power relationship developed itself historically.

SOCIAL CLASS, MEDICALIZATION & THE GROWTH OF PSYCHIATRY

Although mental illness as a form of deviance has always been recognized in one way or another by society, it was not until the 19th century that medical theories were advanced to explain insanity. Previously, the insane were treated similarly to criminals or sometimes tolerated as village idiots, or believed to be possessed by the devil. The destitute, the physically disabled, the mentally retarded and the insane were essentially considered to be part of the same category of deviance, and housed in prisons or poor houses. However, the rise of the biological sciences led a number of people to theorize that mental disorder was primarily a disease brought on by organic causes. Benjamin Rush (1745-1813) who is widely credited to be the father of American psychiatry, maintained that abnormal behavior was derived from brain disease that had its locus in the brain's blood vessels (Cockerham, 1981). Gradually psychiatrists started to emphasize similar ideas as part of their claim to professional legitimacy in medicine and proposed the use of medical techniques in treating mental illness.

In the next century, psychiatry continued to grow as a profession very much along the same lines. Eventually, the
biochemical approaches started to supersede the theories of organic brain disease in explaining mental disorder. In the 1950's, the discovery of psychoactive drugs finally gave psychiatry an effective medical means of treating mental illness. Concomitantly along with advances in scientific discoveries, the profession of psychiatry started to gain status and power as a medical specialty. From 1950 (when psychotropic drugs were discovered) to 1980, the number of psychiatrists in the United States increased from 1,000 to 25,000. Along with their increase in number came a diversification in their power base. Psychiatrists came to play important roles in the criminal justice systems, schools, the military and in community based services, and last but not least, in the health care system. To support their task, they have required various subordinate professional and para-professional positions such as psychiatric nurses, and psychiatric social workers to name just a few.

Since power rarely comes without money, at least within capitalist society, doctor's income in Canada (including that of specialists such as psychiatrists) increased by 136 percent between 1962 and 1972 which was 6.5 times that of the average industrial wage for that period of time (Swartz, 1977). Evans (1983) reports that one of the means by which doctors make their business more lucrative is by increasing their status from general practitioner to that of specialist, e.g., psychiatrist, so that they can claim
higher fees for the services rendered. Therefore, treating mental illness became a profitable venture for the medical profession.

Profits were also generated for health care related industries. Psychiatry became a market outlet for large pharmaceutical companies who began the production of psychothropic medications. Tranquilizers alone became part of a 100 million dollar a year industry (Lexchin, 1984). And because it is the doctors who choose the drug rather than the consumer, drug companies started to promote their products almost exclusively to them to the tune of over $150 million a year (Lexchin, 1984). The goal of the advertising campaign was to transform physicians into high prescribers of drugs through marketing strategies that included advertising, direct mailing, distribution of free samples, gifts, and sales representatives. Drug companies also had a large investment in encouraging the creation of deviance, especially if it could be bio-chemically treated.

Historically then, psychiatry and its allied medical entrepreneurs gradually cornered a profitable market on deviance by transforming it into mental illness. This process here will be referred to as the medicalization of deviance.

As Friedson (1970) reports, the medical profession medicalizes deviance by discovering new illnesses and devising appropriate medical treatment. He adds that:
One of the greatest ambitions of the physician is to discover and describe a "new" disease or syndrome and to be immortalized by having his name used to identify the disease. Medicine, then, is oriented to seeking out and finding illness, which is to say that it seeks to create social meanings of illness where that meaning or interpretation was lacking before. (p.152)

This trend of seeking out illness is most pronounced in the field of psychiatry where defining what is mental illness and what is 'healthy' and 'normal' behavior remains an even more contentious issue than in the field of physiological medicine. Conrad (1981) reports the case of attention-deficit hyperactivity disorder (ADHD) as an example of a psychiatric diagnosis in the making. This diagnosis includes such behaviors as excess motor activity, short attention span, restlessness, changing mood swings, impulsivity, inability to sit still in school and comply with rules, and sleeping problems. Yet prior to the "discover" of ADHD by the psychiatric professional, these behaviors received minimal attention from the medical profession. Conrad (Ibid) mentions that in fact the disorder...

...still remained unnamed or at least went by a variety of names (usually simply "Childhood behavior disorder") and did not exist as a specific diagnostic category until Maurice W. Laufer and his associates described it as the "hyperkinetic impulse disorder" in 1957. (p.156)

This event opened the door to the fabrication of a new diagnosis. A task force sponsored by the U.S. Public Health Service and the National Association for Crippled Children
and Adults agreed on the official diagnosis of "Minimal brain dysfunction" (Clements, 1966). Concurrent to this task force was the creation of the synthetic drug methylphenidate (Ritalin) which became increasingly the most popular medication for treating the newly labeled disorder. A large number of medical papers were published on ADH (Cole, Sherwood, 1976; Delong, 1972). Interestingly enough, seventy-five percent of these papers were concerned with drug treatment of the disorder (Conrad, 1981). As a result, ADHD became the most common child psychiatric problem in less than a decade (Gross and Wilson, 1974).

Along with the increase in the popularity of the disorder came an increase in profits for the drug company producing the "treatment of choice" for the disorder. The company CIBA which produces Ritalin realized a $13 million profit from that product alone which accounted for 15% of its total gross profits in 1971 (Charles, 1971). These facts lead Conrad (1981) to question "whether the development of new medical mechanism of social control in the form of psychotropic drugs leads to the emergence of new categories or designations of deviance and the expansion of medical jurisdiction" (p.161).

The example of attention-deficit disorder serves to illustrate that the growing power of psychiatrists has been partly as a result of their ability to redefine deviant behaviors in medical terms and identify their signs and symptoms which can be grouped in diagnostic categories for
which then bio-chemical treatments can be developed. Szasz (1961) argues that such redefinition is in fact the process by which psychiatry creates what he calls "the myth of mental illness". Although "mental illnessess" are regarded as basically no different than all other diseases of the body by psychiatrists, he believes such illnesses of mind are more 'problems of living' stemming from differences in personal needs, opinions, social aspirations, values and so on which, within the medical perspective, are attributed to physiological processes which in due time will be discovered by medical research and treated with medical technology.

To achieve this goal, psychiatry has grouped mental illness' various signs and symptoms into diagnostic categories which are contained most recently in the third revised edition of the American's Psychiatric Association's (1987) Diagnostic and Statistical Manual of Mental Disorders. The aim of the manual is to guide the psychiatrists in classifying disturbed individuals in particular diagnostic categories for which then a specific treatment can be developed and applied. Cockerham (1981) describes the hidden agenda behind this approach as "one of making psychiatry one of the most scientifically precise of all medical specialties and ending its dependency on subjective judgements of and insights into the human mind" (p. 79-80).

Yet the DSM III-R (Ibid), defines mental disorders very broadly as being practically any significant deviation from
some ideal standard of positive mental health. Therefore, the concepts of mental disorder often change to accommodate the changing values and professionals' judgements.

Potentially, the largest numbers of problems of living for psychiatry to diagnose as illness are to be found in the lower social classes and that for a number of reasons. First, there are much larger numbers of people in the lower class than in the middle and upper classes and hence their sheer numbers makes them more likely for higher incidences of deviant behavior. Secondly, higher status persons are more able to resist being identified as mentally ill because of their greater resources of wealth, power, and status where as in contrast, lower class persons are less able to resist being labeled because of their powerless condition (Scheff, 1966). Also, higher social classes defines normative behavior through rules and sanctions. Therefore, the lower social class is more likely to exhibit deviance unless it conforms to these rules and sanctions. Since many of the deviant behaviors tend to be defined along moral lines although they are presented as medical problems (homosexuality is a good example of that), the lower classes are more likely to deviate as their norms and values differ from that of the upper classes. Within this framework then, psychiatrists can be seen as moral entrepreneurs whose task is to enforce the norms and values of the upper class onto the lower class (Szasz, 1983).
Finally, social stressors such as poverty, unemployment and generally deprived living conditions which can be sources of deviance tend to be more prevalent in the lower social class than in the middle and upper classes (Kessler, 1979). The rate of mental hospitalizations has been shown to increase dramatically during economic downturns, and to decrease equally during upturns (Brenner, 1973). Since the lower social class is most affected by economic downturns those persons with the lowest socio-economic status existing largely on public welfare are most likely to be labeled mentally ill and have rates of mental hospital admissions twice as high as those of other more affluent socioeconomic groups (Ibid).

Furthermore, lower class patients tend to receive custodial care or somatic treatments, where as higher class patients are more likely to receive rehabilitative forms of care such as psychotherapy (Hollingshead and Redlich, 1958). As a result, patients from the lowest social class tend to have by far the longest period of hospitalization, and remain mentally ill for longer periods of time (Ibid).

Overall then, the lower social class is likely to display higher rates of mental illness because of its propensity to exhibit more deviant behavior defined as such by the higher social classes. This is a result of the disadvantaged social conditions they live in which can lead to impaired emotional health for which they receive
inadequate care, and because of their differing norms and values contravening those which are enforced by dominant social groups. Within this framework then, psychiatrists act as agents of the dominant class to control deviance in the lower social class.

MEDICALIZATION, THE ELDERLY AND PSYCHIATRY

Because of their lower socio-economic status the elderly tend to be members of the lower social class and therefore are more likely to be labeled mentally ill as psychiatry seeks to expand its jurisdiction over deviance. According to Myles (1984), in Canada, the lower socio-economic status of the elderly is a direct result of the policy of mandatory retirement and the ensuing implementation of the pension system which reduces an individual's average income by half after age 65. According to Olsen (1982), the demand for mandatory retirement rose from the exigencies of the capitalist economy with its episodic unemployment, and its need for a means of transferring skills generationally in industries owned by the dominant class which experienced surplus labour. Such economic imperatives and government policies around retirement have essentially created a new social class made of individuals who because of their age have become powerless and impoverished since the capitalist economy is organized around differential rewards for productive labour,
from which they are in large part excluded. In 1981, the National Council on Welfare (1982) reported that 57 percent of the elderly had yearly incomes under $2,000. The poverty line for a single person's income for that year was set at $6,521.00.

The elderly's low socio-economic status can result in a significant increase in the stress they face while struggling for their survival. This in turn can negatively impact their mental well-being. Many of the ailments affecting older people can be traced back to poverty throughout their lifetimes and even greater poverty upon attaining age sixty-five. One's standard of living may be the main determinant of health and decease. Studies of the effects of social class membership on health show consistently that lower class status predicts shorter life expectancy, and higher death and morbidity rates from all diseases (Harris et al., 1976; Tesh, 1981). More specifically, Harris' (1976) survey on the aged indicated that of the 50 percent of those surveyed who considered poor health as a serious problem in their lives, 36 percent of them had yearly incomes under $3,000. Butler (1975) notes that wealth provides greater opportunity for rest, sound nutrition, adequate housing, emotional security, reduced stress, and the capacity to have illness treated. Since wealth even in moderate amounts is not available to many elderly, it's reasonable to venture that they will suffer from poor nutrition, live in inadequate housing, experience
more stress and emotional instability, and consequently be at increased risk from developing 'problems of living' which will be labeled as mental illness by the psychiatric profession.

In fact this trend is already apparent when reviewing the epidemiological studies on the rates of mental illness in the elderly as defined by psychiatric standards. In these studies, the elderly are generally considered more likely than younger age groups to suffer from psychiatric impairments. Blazer (1980) summarizes a variety of epidemiological studies which report significantly higher rates of psychiatric disorders among those 65 and over. The author notes that ranges of 10 to 40 percent of the community's elderly have been reported as psychiatrically impaired in a variety of studies. Butler (1975) also reports high estimates of incidence of psychiatric impairments in the elderly population as compared to younger populations. They are: 2.3 per 100,000 in the under 14 age group; 76.3 in the 25 to 34 age group; 93.0 in the 35 to 64 age group; and 235.1 in the over 65 age group.

These increased rates of mental illness diagnosed by psychiatrists can be considered as indicative of their ability to redefine within the bio-medical framework many conditions which were previously seen as stemming from a life of hardship, or simply from the process of growing older. These problems were usually taken care of within the traditional networks of the family and of the community.
For example, if an elderly was found to be lonely, isolated, and sad, family members, and community members would visit, and or arrange outings to improve his or her condition. Today however, psychiatry has dictated a new approach to this problem by redefining it as depressive disorder (which is the most common disorder diagnosed in the elderly), and prescribing a treatment course of anti-depressant medication to cure the individual suffering from it. This process of transforming 'problems living' in elderly into mental illness will be referred here as medicalizing deviance.

The purpose of this study then is to demonstrate how the process of medicalizing deviance operates within a community mental health team offering specialized geriatric services to the elderly in its catchment area.
CHAPTER 2

METHODOLOGY

The quintessential task facing the researcher is choosing the best suited method(s) to investigate the problem(s) at hand.

This chapter introduces the methodological themes for this study by outlining its theoretical framework and listing the research hypotheses which guided this researcher in his investigation. Included here are also a description of the field strategy and methods of data collection, and discussion of the threats to reliability and validity of the findings and how those were dealt with in the course of the study.

THEORETICAL FRAMEWORK

The theoretical framework for this investigation is one which advances that mental illness can be viewed as deviance which is identified and sanctioned in the lower social classes by the dominant class through its psychiatric apparatus.

Although all societies throughout history have in one way or another attempted to control their deviant members, it is only in the last century or so that psychiatry has emerged as a mechanism through which deviant behavior is being defined, identified and treated. The growth of psychiatry as a social control agent can be attributed to the desire by the medical profession to increase its power and profitability. As a branch of medicine, psychiatry sought to adopt a scientific
explanatory model to explain behaviors in individuals which deviated from socially acceptable norms. Deviant behavior then became the expression of underlying dysfunctional organic processes. Psychiatry also increased the range of deviant behaviors which could be diagnosed as psychiatric disorders. This was in response to the economic constraints of the capitalist economy to which psychiatry was subjected in its expansion. Increased profitability came from expanding the range of problems diagnosed as psychiatric disorders and by increasing the price asked for their treatment through specialization. In Canada, these profits came mainly from state payments through medical insurance schemes.

Furthermore, the need for the creation and delivery of specialized treatment also led to the formation of a large medical industrial complex responsible for researching and fabricating increasingly more complex and costly treatments. The profit-making imperatives of this complex have also impacted on psychiatrists who often act as distributing agents of these treatments. The elderly because of their disadvantaged socio-economic position are more likely to be labelled as mentally ill as the dominant class seek to control a new form of deviance, that of aging, and also as psychiatry seeks to expand their market for new diagnosis.

Finally, psychiatrists also act as agents of social control for the dominant class by putting the responsibility of social problems on individual causes, and the solution to these problems on individual treatment, hence taking away the
focus from the inequalities within larger social systems. Ryan (1971) has identified this process as "blaming the victim": seeing the causes of the problem in individuals (who are usually of lower status) rather than endemic to the society. Hence, by labeling confused, isolated, and distressed elderly as demented or depressed, we ignore the meaning of these behaviors in the context of the social system.

Putting the focus on the system on the other hand might reveal the inadequate social conditions many elderly live in because of forced retirement, including below poverty level incomes, inadequate housing, and exclusion from active social roles. All these factors can have a negative impact on their emotional well being. These conditions exist as a result of the exigencies of a capitalist economy which requires a state policy of mandatory retirement as a means of transferring skills generationally in industries with surplus labour (Olson, 1982). Hence, by medicalizing deviant behavior in the elderly, psychiatry precludes us from recognizing it as possible reactions to the exploitative political arrangements that serve the benefits of the dominant class to the detriment of the working class.

HYPOTHESES

From this framework, I developed a number of general hypotheses to guide my investigation of the process of
medicalization in a community mental health team. The hypotheses are:

(a) If deviance is a socially attributed condition, then mental illness as such in the elderly is behavior which violates the expected norms and/or rules of conduct of the social group which the deviant individual belongs to. For example, the institutions serving the elderly would have a tendency to define deviant behavior in their clientele as symptomatic of mental illness if such behavior interfered with the proper and efficient running of that institution.

(b) The definition and sanctioning of deviance implies a relationship of power in which the deviant elderly is significantly less powerful than the group doing the labeling. Power here is understood in terms of gender, age, socio-economic status (education, income, social class), but also in terms of dependency issues, e.g., dependent on pension for income, dependent on nursing home for personal care.

(c) Psychiatry (and related professionals) tend to label and control an increasingly wider range of deviance as mental illness in the elderly in an effort to expand their power and profitability. This tendency increases the likelihood that problems of living faced by the elderly due to their low socio-economic status are transformed within the bio-medical framework into psychiatric disorder.

Confirmation of the above mentioned hypotheses would also indicate that the Community Mental Health Team functions an agent of social control for the dominant class and its institutions.

RESEARCH SETTINGS

In order to verify these hypotheses, I decided to investigate the delivery of psychiatric services to the elderly in a community mental health team in the urban core of
a large city. The team is described in detail in Chapter Three. Elderly here refers to anyone over the age of sixty-five. The delivery of such services is done on a voluntary basis where people or institutions in the community who decide they require the team's services make a referral either in person or by phone. To gain a better understanding of which type of institutions utilized community mental health services, I identified the main institutions which referred elderly clients to the team by interviewing the team's staff and gathering their opinion on this issue. Five categories of referring institutions were selected, and these were:

(a) Psychiatric wards - general hospital
(b) Nursing homes
(c) Social service agencies
(d) Community organizations
(e) Apartment buildings

The following is a brief description of these categories of institutions and of their role in relationship to the delivery of community mental health services.

**Psychiatric Wards-General Hospital**

Distributed throughout the province in general hospitals, these psychiatric wards are usually small, 20 beds or so, and are responsible for the management of local psycho-pathology for short periods of time, usually from a few days to up to several months. Regional psychiatric wards are not equipped to handle long term severe mental illness and therefore
individuals requiring longer term treatment are transferred to the provincial facility.

**Nursing Homes**

Nursing homes do not usually offer services to the psychiatric population but rather to elderly individuals who are incapable of caring for themselves independently. However, individuals with stabilized psychiatric disorders who are over the age of 65 are often referred to nursing homes from both the provincial and regional facilities. Furthermore, individuals who enter a nursing home may later develop a psychiatric disorder not sufficiently severe to justify a transfer to hospital but nevertheless requiring treatment. Nursing homes vary in size, but most typically have a 30 bed capacity although some can accommodate over one hundred residents.

**Social Service Agencies**

There are a large number of social service agencies providing direct and indirect services to the elderly. Some of these are very large and government run. The welfare offices are good examples of that as they operate under the Ministry of Social Services and Housing throughout the province. Other agencies are smaller and privately run, and usually localized to one urban area.
Community Organizations

This category refers to organizations which are not social service agencies but nevertheless provide some form of service to the elderly. These can include banks, senior's groups, and so on.

Apartment Buildings

Apartment buildings are the single largest type of housing for the elderly living in the team's catchment area. All buildings are usually 3 storeys or more and have a resident manager or caretaker. Included in this category are government subsidized housing projects purposely built for low income seniors.

METHODS OF DATA COLLECTION

I selected participant observation as the main methodological approach for this investigation. Denzin (1978) describes participant observation as an omnibus field strategy in that it simultaneously combines document analysis, interview of respondents and informants, direct participation and observation and introspection.

This study simultaneously combined referral forms analysis, case studies involving interviews with five elderly clients referred to the team, their referring agents, and other key informants and direct observation of the referral process.
Case Study

Subjects for the case study sample were selected by choosing the first referral of an elderly client by an institution belonging to one of the categories identified in the research setting section. Each referred subject had to meet two criteria to be included in the case study group:

(a) The referred subject had to be assessed by the Mental Health Team as requiring psychiatric care as some clients who are referred to the team are assessed as being inappropriate for various reasons, e.g., drug and alcohol problems. Although the turning down of a referral is an interesting process in itself, it does not allow for the investigation to go on if the client is not followed by the team.

(b) The client had to be 65 years of age or older at the time of referral.

Through this method then, a sample of five referred clients was gathered to investigate the process of their referral to the Mental Health Team through unstructured interviews and participant observation.

A case study approach was selected because of the exploratory nature of the investigation. The use of this approach allowed the investigator to formulate more precise concepts and hypotheses relevant to further research on the social control of mental illness. The case histories of all five subjects will be described in Chapter Three.

Referral Forms Analysis

An inclusive sample of referral forms from elderly clients referred to the team between 1986 and 1987 was
selected and tabulated by age, gender, reason of referral and referring agents. This document review provided a more "qualitative" analysis to the study of the referral process and served to identify with more precision who refers the elderly to the team and for what purpose. Data obtained from this analysis will be outlined in Chapter Three.

**Unstructured Interview**

The other strategy of data collection was unstructured interviews of key informants identified during direct observation of the various events related to the referral of elderly clients in the case study sample. These informants were identified by the importance of their role in identifying, assessing and referring the subjects. Some key informants were staff from the team or staff from the referring agencies and/or institutions. Finally, each of the five elderly persons in the case study sample were also interviewed in this way.

The interviews remained unstandardized because each of the respondents differed on their values, beliefs and knowledge around mental illness and the elderly. It was important that I be sensitive to those differences to explore each respondent's field of experience. It is difficult to ask a confused elderly person the same questions that I would ask his or her psychiatrist. It was a more flexible form of data collection tailored to the needs of the subjects in the study.
All interviews were taped and their content transcribed in full to maximize the accuracy of the data. Furthermore, during the interview, I also took notes to highlight the key points made by the informants. The content of the interviews was analyzed following transcription in an inductive fashion to allow patterns, themes, and categories of analysis to emerge around the global theme of the social control of mental illness.

Participant Observation

Participant observation here refers to a method in which the researcher is part of and participates in the activities of the people, group or situation that is being studied. The major issue in the use of this method is how much of a participant should the researcher be in a particular situation. The emphasis in this study was on the researcher participating in the situation needing observation. This participation occurred at two levels. Firstly, I took on an "active" participation by actually performing numerous staff functions such as assessments or counselling. Secondly, in the specific case studies selected for this investigation, I took on a "passive" participation role where I observed what was happening without directly involving myself in the ongoing process, e.g., I would sit through an assessment interview or a counselling session.

Field notes were the favored method of data collection during the observation periods. They provided me with a
detailed and descriptive account of the observations I made during any given period of time. This method included five elements of description as outlined by Lofland (1971):

(1) A running description to record accurately the concrete events that are observed.
(2) Previously forgotten happenings that may be recalled while still in the field.
(3) Analytical ideas and inferences.
(4) Personal impressions and feelings.
(5) Notes for further information.

All of the above elements were gathered in the field either by handwritten notes or they were recorded on audiotape and transcribed later on.

FIELD STRATEGY

As a participant-observer, I was fully engaged in experiencing the setting under study through both observations and direct contact with the various individuals being observed. This immersion in the field was made possible because of my position as a field work student at the community mental health team. This position entailed that twice weekly, I participated in all of the team's normal staff activities for a period of nine months between October, 1988 and June, 1989. These activities included intake interviews of referred clients, assessment of clients' "psychiatric" problems along with team psychiatrists, counselling of a small
caseload of clients and outreach visits to community facilities.

This position also allowed me to observe the team's staff in the performance of their various functions. My continuous presence at the team over a nine month period also allowed the staff to familiarize themselves with my presence to the point where I felt integrated to the team somewhat like a part-time employee. A trusting relationship developed between myself and the staff, which was small in number (ten full time therapists and six sessional psychiatrists). As a field student I was assigned to one of the therapists to be supervised by him. I was able to develop a trustworthy working relationship with him. There was a mutual respect for each other's work as therapists that developed within the first few months of my start at the team.

Secondly, a similar trust albeit not as intense, was built with the other workers whom I made an effort to get to know on a personal basis through various team activities, e.g., intake conference, but also through various extracurricular activities, e.g., staff parties, luncheons.

This intimate involvement of the researcher with team activities raises questions regarding the validity of the data. Support for this approach can be gathered by reviewing the debate in the field of ethnography between proponents of the naturalistic approach and proponents of the reflexive approach. Naturalism proposes that as far as possible, the social world should be studied in its natural state
undisturbed by the researcher. This approach poses a number of requirements. First, the researcher must remain true to the phenomenon under study rather than to any particular set of methodological principles. Secondly, naturalism advances that it is possible to construct an account of the culture under investigation that captures it as external to, and independent of the researcher. Under this requirement then, the description of a culture becomes the primary goal. What is favored then are detailed descriptions of the concrete experiences of life within that culture and what is discouraged are attempts to go beyond descriptions to extrapolate meanings which could be generalized across cultures.

Although the naturalistic way of doing research points to the danger of making sweeping inferences and assumptions about the culture being observed, it fails to recognize that all research by virtue of using a method, involves selection and interpretation. In some way, there is an empirical positivistic notion embedded in naturalism that the world can be studied objectively by replacing the microscope with field notes. Both positivism and naturalism seemed to be obsessed with eliminating the effects of the researcher on the data by turning him/her into "an automation and a neutral vessel of cultural experience" (Hammersley and Atkinson, 1983, p.14). A naturalistic approach also ignores the fact that the researcher is part of the social world he/she studies and
therefore, cannot avoid making some impact on it by studying it.

A reflexive approach on the other hand proposes that the researcher's impact on the culture and his/her reaction to it are valuable sources of data which should be exploited rather than eliminated. In other words, social research is not just observation. It is also participant-observation which means the researcher being part of the world observed, and reflecting on that participation. This phenomenon is referred to by Hammersley and Atkinson (Ibid) as reflexivity. If the researcher has an impact on the world he/she is investigating, not to document such impact would undermine the completeness of the study.

This paradigm was important for the way ethnographic research was used in this study. The naturalistic model of investigation proved to be an inadequate approach to best answer my research questions while accounting for my position as a field work student within the Mental Health Team. It neglected the fundamental notion of reflexivity, the fact that the researcher is part of the world she/he studies. As Hammersley and Atkinson (1983) put it,

"... All social research is founded on the human capacity for participant observation. We act in the social world and yet are able to reflect upon ourselves and our actions as objects in that world. By including our own role within the research focus and systematically exploiting our participation in the world under study as researchers we can develop and test theory without placing reliance on futile appeals to tenets of either positivist or naturalist varieties." (p. 25)
This statement was most relevant to my dual position within the team as both a researcher and a fieldwork student. Within the positivistic/naturalistic framework, my position as a researcher would have irrevocably compromised my data because of my involvement as a student needing to do well in his placement to pass his course. No longer was I a neutral observer of the phenomenon I was studying. My observations would have been so biased that my findings would be invalidated.

My argument is however, like Hammersley and Atkinson, that being a student at the team and performing many of the duties done by the staff and also getting to know them on a personal basis allowed me to gain insight and an understanding of their social world which would have been unavailable to me as a neutral researcher looking in from the outside. I exploited this position to make more complete observations of the processes I participated in while teasing out delicate information from the individuals I interviewed. Furthermore, acting somewhat like a staff member, I was able to put myself through similar situations that they experienced and note my own reactions to them. How did it feel to interview an elderly person; what is expected of me when I assessed that person; how do I deal with the nursing home staff who want this person committed to a mental institution; what kind of pressure do they put on me and how do I react as a mental health professional; are the kind of situations I encounter and the kind of reactions I have similar or different from my
colleagues; etc . . .? Overall, then, the opportunity I had of integrating myself as a researcher within the Team allowed me to increase the depth and richness of my data. This is illustrated by the following anecdote: a psychiatrist was discussing with me his radical anti-psychiatrist views, and said if what he had told me was to become common knowledge, he would be in deep trouble.

METHODOLOGICAL CONSIDERATIONS

In this section I will discuss how I addressed the threats to reliability and validity of my findings in relationship to the methodology I selected for this study.

Issues of Reliability

Assessing the internal reliability of observational research is a difficult issue for this study. Because I was the only researcher observing the individuals and groups studied, there are minimal ways in which to assess the internal reliability of my field notes. However, throughout the research I did get "feedback" from key informants to verify personal observations on certain events, e.g., an assessment in which they were involved. Furthermore, I compared data obtained from participant observation with data obtained from my interviews and chart review. Hence, according to Denzin (1978) the strength of this approach is based on the premise that:
no single method ever adequately solves the problem of rival causal factors . . . Because each method reveals different aspects of empirical reality, multiple methods of observations must be employed. (p. 28)

Therefore, comprising data served to increase the internal reliability of my findings.

Threats to external reliability were also addressed in designing this study. An ethnographic study unlike an experiment cannot be replicated with exactitude. Ethnography is a study of the process of change within a given culture, and therefore does not lend itself to exact replication because "natural" reality cannot be controlled in an experimental way (LeComte and Goetz, 1982). However, this replication problem was partly addressed by clearly indicating the methods used and describing with specificity the design of the study. Furthermore, the researcher's status position within the Mental Health Team, the choice of key informants, the social and interpersonal contexts in which the data was collected were clearly described. Essentially, then, other researchers wanting to replicate this study could use this report as an operating manual.

Issues of Validity

The concept of validity relates to whether researchers actually observe what they think they are observing or in the case of this study, how accurately am I looking at the control of mental illness within a given culture.
Content Validity

Content or face validity involves assessing whether there is a logical relationship between the variable and the measure used. Ethnographic research has a number of methodological limitations in regards to content validity. As Monette (1986) points out, observation rests on human sense organs and human perceptions both of which can be strong sources of bias. However, observational techniques such as participant-observation demonstrate a greater content validity as measures of behaviors and events than do many other techniques relying on second hand accounts. For example, surveys and questionnaires depend on someone else's perception and recollection, that of the respondent or the person completing the instrument in his or her place. This process is affected by many factors beyond the control of the researcher. On the other hand, observation techniques provide a first hand account of events and/or behaviors as they occur. Therefore, if the researcher is in a position to least influence these events by his or her presence, then what is observed is closest to reality. Another way of addressing the question of validity is by looking at it in terms of internal and external validity.

Internal Validity

Possibly the greatest strength of ethnography is its claim to high internal validity. The researcher's practice to become part of the culture studied as it happens and his or
her ability to collect data from its key informants ensures that the data collected and the constructs extracted from it actually reflect the reality of its participants' experience. As discussed earlier my position as a student doing a clinical practicum within the team allowed me to fully integrate myself as a staff member over the nine month period I was there, and participate in their reality to collect valid data. A number of threats to internal validity as identified by Campbell and Stanley (1963) were also addressed in this study to further strengthen its claim to high internal validity which I will discuss next.

**History and Maturation**

The study spanned a period of nine months. Therefore, the range of events and behaviors observed over that period of time can be assumed to be reasonably representative of the team's functioning over longer periods of time, and most likely cannot be attributed to a specific situation occurring during the observational period.

**Observer's Effect**

The observer's effect relates to how the subjects in a study react to the presence of the researcher. In other words, people being observed may behave differently than normally because they react to the presence of the observer.

The observer's effect in this study was judged to be minimal mainly because of my status as a member of the Mental
Health Team and because of the good relationship I entertained with the team's staff. It was my impression that the staff did not perform their functions any differently in my presence during observational periods. When dealing with subjects outside of the team, I felt that introducing myself as a practicum student with the Mental Health Team was a distinct advantage in accessing key informants for the study. All interviewed or observed informants were most cooperative in participating in the study.

Another form of observer's effect can be found in the way the respondents in the study are affected by the interviewer's characteristics and inversely, how the interviewer is affected by the respondents' characteristics. Sex, age, race, and social class are factors that may subtly shape the way in which the interviewer asks questions and interprets the words of respondents, and how respondents will answer these questions. In the case of this study, age was an obvious factor as many of the respondents were elderly. These socio-demographic characteristics are obviously not controllable. However, as a researcher I did tend to a host of "interviewer bias" factors such as my tone of voice, manner, gestures and dress. My approach towards elderly respondents was to use a polite manner and I took care to dress in a relatively conservative way. I doubt if the elderly I interviewed would have responded as well as they did would I have walked in dressed "Miami Vice style", wearing old faded jeans and a T-shirt. I also facilitated the interview process by engaging
in small talk to put the interviewee at ease; not answering immediately after a reply, thus encouraging the interviewee to comment at greater length; not showing shock or surprise at replies; looking for examples when the replies were too vague or abstract; and then using appropriate probing to elicit information which the respondent held close to his/her chest. Probing here was used carefully and with tact as too much probing may be unethical and make the respondent suspicious.

Selection

This threat relates to the fact that the data collected may be weakened by the improper selection of participants to observe and informants to interview. For this study, key participants and informants were carefully selected to be as representative as possible of the staff and the institutions involved in the control of mental illness within the elderly population. For example, a referred client from a nursing home was selected as a case study because nursing homes make up a large portion of the referrals to the team. All informants were selected on the basis of the importance of their participation within the case referred. For the above example, the team psychiatrist and primary therapist were interviewed and observed, as well as the nurse from the nursing home who made the referral and the nursing home operator who sanctioned it, as well as the family who was consulted in this case.
External Validity

The problem of external validity relates to how the research findings can be generalized to the larger population. Ethnographic research cannot rely on the strictures of statistical generalization to make a claim to external validity as rarely are the participants observed or interviewed randomly assigned. In fact, such a procedure would be irrelevant for most cases. Le Compte and Goetz (1982) talk of strengthening the external validity of ethnographic findings by defining the threats that reduce a study's comparability.

The problem of comparability is addressed mainly by multisite ethnographic designs. Although the community Mental Health Team was the centre of the study, many other sites were observed, such as nursing homes, a senior housing project, a psychiatric ward, etc. Hence, this multisite design served to strengthen the generalizability of the findings by increasing its comparability.
CHAPTER 3
RESEARCH SETTINGS AND DESCRIPTION OF SAMPLES

This chapter provides a description of the community institutions involved in the referral to the mental health team of elderly people from the case study sample. Each of these subjects were observed interacting within these institutions as well as within the community mental health team. A description of the team is also included. Interviews with the subjects and key informants within these institutions were also conducted. Findings from these observations and interviews are discussed in chapters four and five.

Statistics from the 1986 Census of the population over 65 residing in the team's general catchment area are given as the sampling frame for both the case study sample and for the referral forms sample. Demographic information obtained from the referral forms for the latter sample was compared with data from the Census.

Finally, a description of individual case studies is included at the end of the chapter.

RESEARCH SETTING

The following section includes a brief description of the institutions which either referred the five elderly people or were closely involved in the referral process. A description of the mental health team is also included. The institutions
were identified by type only so as to preserve the anonymity of the subjects and of other individuals interviewed and/or observed during the study.

Psychiatric Ward - General Hospital

The ward which referred Mr. L. is a 25 bed acute care facility located within a large general hospital. Normally a short stay unit, the length of treatment ranges from a few days to up to three months. It is an open ward facility and therefore caters to patients who are willing to stay for treatment and who do not display violent behavior. Violent and seriously disturbed individuals are sent to the provincial facility for treatment.

Nursing Homes

These are the facilities which have referred Mr. M. and Miss S. Two case study subjects were selected from two nursing homes because of the importance of this source of referral to the mental health team. Nursing home nurses are representatives of the single largest source of referring agents, that of professionals working in services other than mental health.

The nursing homes also possessed quite varied characteristics. The home which referred Mr. M. was a large over 100 bed facility funded through a private non profit organization. The other one was a smaller 40 bed facility administered and staffed by a religious nursing order.
Social Service Agency

The agency which referred Miss D. is a small four staff agency administered conjointly by Ministry of Health and Ministry of Justice representatives. The purpose of the agency is to provide follow-up care to patients who are resistive to treatment and/or reluctant to follow mandated rehabilitation programs, e.g. probation orders from both ministries.

Community Organization

The organization which referred Mr. W. is the constituency office of one of the major federal political parties. Although it does not offer services exclusively to the elderly, it nevertheless deals with them by hearing their complaints, helping them fill in forms, and so on.

Apartment Buildings

No specific referral from apartment buildings was selected as three out of five case studies already resided in apartment buildings. In two of those cases, the apartment managers were extensively involved with both clients and the mental health team, allowing me to make observations and conduct interviews with representatives of that group of important referring agents.
Other Institutions

Other institutions were also observed although not as extensively as the above mentioned institutions. These include a probation office, a provincial court, and a geriatric short stay hospital unit.

Community Mental Health Team

The main research setting of this study was the Community Mental Health Team responsible for delivering services to the psychiatrically disabled individuals in the urban core. In the next few paragraphs, I will give a brief historical description of the team, and discuss its function as outlined in its policy and procedures manual.

Each mental health team was created for the purpose of offering mentally ill individuals with psychiatric follow-up care while living in the community either independently or in a residential care facility. Mental health teams are scattered throughout the province and distribute their services to specific administrative regions usually located around large urban centres. Some mental health teams are operated under government jurisdiction while others are run by a non-profit organization receiving funds from both municipal and provincial sources.

The Mental Health Team described in this study comes under the administration of the non-profit organization. This organization has a total of six teams responsible for distributing services in various catchment areas. According
to its policy and procedure manual (reference withheld for confidentiality purposes) each team offers the following services:

(a) prompt psychiatric assessment and diagnosis including visits in the community in emergency circumstances.

(b) comprehensive treatment may include psychiatric, medications, individual, group and family therapy, occupational and recreational therapy programs (section 10.1).

All services are provided with a framework which specifies the following principle:

recognizes that the seriously mentally ill adult . . requires a broad range of services and is committed to using multi-disciplinary teams to meet patient needs. (Section 2.1)

Hence, each mental health team employs a variety of professionals to provide multi-disciplinary services to the mentally ill. These include nurses, psychologists, social workers, occupational therapists, and psychiatrists.

Services within the team are provided within a given organizational framework in which the above professionals occupy a given role. Each patient coming to the team for treatment is assigned to a primary therapist which can be either a nurse, psychologist, social worker, or occupational therapist. The therapist's role then is to assess the patient's problems and initiate a therapeutic treatment program that can include assessment by a psychiatrist,
medications, access to other community based services, as well as referral to a hospital. Within that framework, the primary therapist directs the treatment program and the psychiatrist acts as a consultant.

Each mental health team accepts referrals from any source including self-referrals provided there is an indication of mental illness in the referred person. Furthermore, people are accepted for referral only if they are treatable in a community setting. Hence, individuals who are hospitalized in a psychiatric ward cannot receive team services.

The referral of a person to a mental health team is a twofold process. First, an intake worker (primary therapists are assigned to intake duties on a rotational basis) takes the referral by filling out a standardized form which outlines the needed information regarding a patient's demographics and psychopathology. The worker determines whether the referral is at a first glance one which requires the team's involvement. Accepted referrals then go through a second selection process where all referrals from a given day are reviewed in intake rounds which occur every morning where all team staff determine the appropriateness of each referral. Once the referrals are deemed appropriate, they are assigned to an individual primary therapist's caseload. Once a patient is assigned to a therapist's caseload, it is then that therapist's responsibility to contact the patient, initiate treatment, and also terminate it.
Finally, particular to the mental health team investigated in this study was the assignment of a primary therapist to the position of geriatric specialist. This assignment came about due to the large number of elderly persons referred to the team and the specific treatment modalities they presented which were deemed to be quite different from that of a younger adult population and hence requiring a certain expertise from the therapist's part. Typically, most referrals of individuals over the age of 65 were assigned to this specialist, and some were dealt with by another therapist who although not a geriatrician took a special interest in the elderly.

SAMPLING FRAME

The information regarding the sampling frame was obtained from the 1986 Census (Statistics Canada, 1986). The Census tracts for the Vancouver area were selected because they were used by the mental health society to determine the catchment area serviced by team investigated in this study. Therefore the population characteristics outlined below are representative of the elderly population accessed by the team. The following population characteristics were selected: number of males & females between ages 65-74; number of males & females ages 75 and above; type of dwellings; and number of family vs. non-family persons. The population data is summarized in Table 1.
### Table I
1986 Census Tract Data

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Male</th>
<th>Female</th>
<th>Male &amp; Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Total population (all age categories):</td>
<td>42,964</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Total population, 65 years and over:</td>
<td>6,900</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

#### Population Characteristics by Age and Sex

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Male &amp; Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74 years</td>
<td>1870 (27)</td>
<td>1940 (28)</td>
<td>3810 (55)</td>
</tr>
<tr>
<td>75 years and over</td>
<td>880 (13)</td>
<td>2210 (32)</td>
<td>3090 (45)</td>
</tr>
<tr>
<td>Total Population: (Both age categories)</td>
<td>2750 (40)</td>
<td>4150 (60)</td>
<td>6900 (100)</td>
</tr>
</tbody>
</table>

#### Dwellings Characteristics and Types - All Age Groups

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owned</td>
<td>2,425</td>
<td>8</td>
</tr>
<tr>
<td>Rented</td>
<td>27,115</td>
<td>92</td>
</tr>
<tr>
<td>Total</td>
<td>29,540</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single detached house</td>
<td>145</td>
<td>11</td>
</tr>
<tr>
<td>Apartment, 5 storeys or more</td>
<td>21,385</td>
<td>72</td>
</tr>
<tr>
<td>Other dwelling type (includes semi-detached houses,...</td>
<td>7,975</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>29,540</td>
<td>100</td>
</tr>
</tbody>
</table>

#### Family Status - 65 Years and Over

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living in a family situation</td>
<td>2,120</td>
<td>31</td>
</tr>
<tr>
<td>Living with relatives</td>
<td>265</td>
<td>4</td>
</tr>
<tr>
<td>Living with non-relatives</td>
<td>125</td>
<td>2</td>
</tr>
<tr>
<td>Living alone</td>
<td>4,390</td>
<td>63</td>
</tr>
<tr>
<td>Total</td>
<td>6,900</td>
<td>100</td>
</tr>
</tbody>
</table>
The Census data reveals that the population over 65 years of age makes for 16 percent of the total population for that area. Overall, there are more women than men over the age 65 (60% vs 40%). This is especially prevalent in the older age group over 75 years (32% vs 13%). Sixty-three percent of all elderly live alone. There are no specific data available from the Census in regards to the dwellings elderly people reside in. However, data for the general population indicates that most residents rent their dwelling in a proportion of 92 percent, which is in 72 percent of the cases, an apartment in a building over five storeys.

Because of their lower socio-economic status, the elderly generally belong to the less affluent classes and therefore are in a more vulnerable position to be labelled as mentally ill. From the Census data, one could speculate that the elderly population of the sampling frame appears to belong to the lesser socio-economic groups. They are in a large proportion women over the ages of 75 who most likely rely on their old age pension as the sole source of income as many of them during their working years probably relied on their husband's income while raising a family, or if working, most likely did not contribute to an advantageous pension plan, if any at all. The lower status is also indicated by the fact that they are more likely to rent their dwelling as opposed to owning one and therefore a large portion of their income goes towards paying the rent. This situation is further aggravated by the fact that many of these women live alone (probably many
are widowed) and therefore cannot share the costs of living and rent with a partner. Overall, the most likely victim of labeling would be an elderly woman over the age of 75 on a fixed income who lives alone in an apartment building.

SAMPLING PROCEDURE

Two types of samples were selected for the study. First, five individuals over the age of 65 were selected to form a small case study sample for the purpose of gathering in-depth qualitative data on their case history through participant observation and interviewing. These individuals were purposely selected according to the source of their referrals in an effort to include in this sample the institutions which most typically refer the elderly to the Community Mental Health Team.

A second more inclusive sample was selected using the referral forms of all people over 65 referred to the mental health team between January and December 1987. Sixty-five forms were reviewed to obtain basic descriptive statistics on demographics, residence, source of referral and reason for referral. The purpose of this sample was also to verify the representativeness of the small case study sample on the above mentioned variables although this comparison is at best tenuous due to the large N difference between the two samples. Furthermore, the purpose of the small sample was to gather
exploratory in-depth information rather than trying to compile statistically meaningful data.

**Referral Forms Sample**

The following demographic information was obtained from the referral form sample. A total of 65 charts were reviewed of people referred to the Community Mental Health Team between January and December, 1987 who were 65 years of age or more at the date of their referral. This number represents approximately 72 percent of the total number of referrals of elderly people to the team for that year (N = 90 referrals). Twenty five charts were unavailable for review at the time because they were either located at another team subsequent to the transfer of the client, or were inadvertently misplaced or discarded by team staff. Of the 65 charts reviewed, 31 percent (N = 20) were male with the youngest subject being 65 and the oldest, 84. The average age for the sample was 72 years. The majority of the subjects were females, making up 69 percent of the sample, with the youngest female subject being 65 years of age and the oldest, 89, with an average age for that sample of 76. The average sample age for both sexes was 74.

The vast majority of individuals referred to the team in that sample resided in apartments (N = 59 or 90 percent of the sample). Two types of apartment residence were identified with 72 percent (N = 47) living in regular non-subsidized apartment buildings, and 18 percent (N = 12) residing in large
government subsidized seniors' apartment complexes. The latter is distinguished from regular apartment buildings because the rent is less than the equivalent apartment rent because it is subsidized, and they offer a number of in-house services to their residents which are unavailable to other dwellers such as a full-time nurse assigned to the building and various organized recreational activities such as bings and outings. The remainder of the sample consisted of one single individual (2% ) residing in a single unit home and five elderly (8% ) residing in nursing homes.

The Census tract data also compares favorably with the referral form sample on the various population characteristics (see Tables II and III). One could venture to say that the sample taken from the referral forms for 1987 is relatively representative of the population in the catchment area of the Community Mental Health Team in regards to age, sex, and dwelling type based on its comparison with the 1986 Census sample. Although there is a one year difference between the two sets of data, it is unlikely that the Census data for the elderly would change that much over a one year period as the elderly are a fairly stable segment of the population.

Case Study Sample

In regards to the case study sample, five subjects were selected from referrals made to the team between September 1987 and May 1988. All five subjects were over age 65 with the youngest being 69 and the oldest 77. There were three
## Table II

**Population Characteristics - Referral Form Sample**

(N=65)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Male &amp; Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>65-74 years</td>
<td>14</td>
<td>(22)</td>
<td>26</td>
</tr>
<tr>
<td>75 years and over</td>
<td>6</td>
<td>(9)</td>
<td>19</td>
</tr>
<tr>
<td>Total Population:</td>
<td>20</td>
<td>(31)</td>
<td>45</td>
</tr>
<tr>
<td>(Both age groups)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Dwellings

<table>
<thead>
<tr>
<th>Type</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single detached home</td>
<td>1</td>
<td>(2)</td>
</tr>
<tr>
<td>Apartments</td>
<td>59</td>
<td>(90)</td>
</tr>
<tr>
<td>Others (Nursing Home)</td>
<td>5</td>
<td>(8)</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
<td>100</td>
</tr>
</tbody>
</table>
### Table III

**Comparison of Population Characteristics —**

**Census Tract and Referral form Sample**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male Census</th>
<th>Male Sample</th>
<th>Female Census</th>
<th>Female Sample</th>
<th>Male &amp; Female Census</th>
<th>Male &amp; Female Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>65-74 years</td>
<td>27</td>
<td>22</td>
<td>28</td>
<td>40</td>
<td>55</td>
<td>62</td>
</tr>
<tr>
<td>75 years and over</td>
<td>13</td>
<td>9</td>
<td>32</td>
<td>29</td>
<td>45</td>
<td>38</td>
</tr>
<tr>
<td>Total Population:</td>
<td>40</td>
<td>31</td>
<td>60</td>
<td>69</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

*(Both age groups)*

#### Dwellings

<table>
<thead>
<tr>
<th>Types</th>
<th>% Census</th>
<th>% Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single detached home</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Apartments</td>
<td>72</td>
<td>90</td>
</tr>
<tr>
<td>Others</td>
<td>27</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
males (60%) and two females (30%) in the sample which is a reversal of the male/female ratio obtained for the chart sample (31% male and 69% female). The average age for both sexes was 72, with the ages for the males being in decreasing order, 77, 70 and 69; and for the females, 73 and 71. The average age for this sample is therefore lower than the chart sample for females which was 74, and the same for the male referral form sample.

The small case study sample did not correspond to the referral form sample in regards to residency. The number of individuals from Nursing homes were overpresented in the case study sample with 40 percent of the individuals (N = 2 out of 5) being referred from homes as compared to only 8 percent for the other sample (N = 5 out of 65). Two elderly lived in either regular or government subsidized apartment buildings which is underrepresentative of that type of living situation compared to the form sample (40 percent vs. 90 percent). Finally, only one individual was living in his own home prior to being admitted to a psychiatric ward of a general hospital and subsequent referral to the mental health team. It should be noted that comparison between the samples is at best tentative due to sample size difference.

Thus, if the smaller size case study sample is not necessarily statistically representative of the elderly population referred to the team, it nevertheless provides a richness of in-depth information that could not be achieved in the larger sample, given the time constraints of this thesis.
DESCRIPTION OF CASES

Since the case studies account for the bulk of my data, I will briefly describe their case histories to give the reader more familiarity with the events, people, and institutions that shaped these individuals' lives. The cases will only be identified by gender and a letter so as to preserve their anonymity.

Mr. W.

This sixty-nine year old single Caucasian man was referred to the mental health team by the manager of a constituency office. The man had been frequenting the office for approximately the last year or so for various services regarding mainly his finances and filling out various government forms. He was then described by the manager of the office as a gentle, soft spoken man who was invariably well dressed. However, approximately four months prior to the referral, she started to notice what she called "a gradual deterioration in this man's condition". He appeared confused about where he lived, at times thinking he was in Ontario, his birthplace; or that he was working for a school for mentally disabled children, which he did but about forty years ago. He started showing up to the office at least once a week in a state of confusion and often emotionally distressed.
The office manager called the Community Mental Health Team as a last resort after attempting to obtain help from other services including the Provincial Housing Corporation (which supervised the apartment building in which Mr. W. resided), long term care, and the Police Department. This man was then assessed by the geriatric specialist at the team and one psychiatrist and they suspected he suffered from "a form of primary degenerative dementia". They referred him to a geriatric assessment unit in a general hospital for assessment and the diagnosis hence obtained confirmed their suspicion. He was subsequently referred by the geriatric specialist to a nursing home.

Miss D.

This 73 year old single Caucasian female was referred by a social service agency who inherited this case following her arrest by the police on charges of theft under one thousand dollars. The events leading to her arrest are as follows: she was spotted by two policemen going from car to car trying to open their doors in a parking lot behind the police station. Alerted by her suspicious behavior, one of the policemen walked toward her as she was entering a BMW of which its owner had inadvertently left the doors unlocked. She subsequently was charged and summoned to appear in court for sentencing.

This was not Miss D.'s first offense. She was previously arrested eleven times and charged seven times for the same
offense between 1982 and 1988. The worker from the social services agency who referred her started to suspect that her behavior could be attributed to "some form of dementia which pushed her to break into cars and steal things". As a result, he sought the psychiatric expertise of the Mental Health Team to verify his suspicions.

Miss D. received her trial after numerous attempts where she did not show up at scheduled court appearances. The judge suspended the charges but ordered her to attend regular meetings with her probation officer and to receive treatment from the Mental Health Team. She agreed to the terms of her probation order but only attended the team on a few occasions and then vanished. The geriatric specialist at the team tentatively established that she was suffering from depression and had a low self-esteem related to the loss of her parents approximately one year before her first arrest, and therefore was seeking confirmation of worthlessness by committing anti-social acts such as breaking into cars and stealing. At the time of writing this report, I heard from her probation officer that she recently has been charged again with breaking into cars.

Mrs. S.

Mrs. S. is a 73 year old widowed resident of a nursing home. She is of Polish descent and immigrated to Canada after the war, after having survived the NAZI decimation of her village where she lost family and friends to the concentration
camps. She was admitted to the nursing home approximately two years ago following a major depressive episode following the death of her husband where she was hospitalized on the psychiatric ward of a general hospital.

She was referred to the Mental Health Team by the charge nurse of the nursing home because of concerns regarding her "depressed and paranoid behavior". The nurse said that Mrs. S. contracted a urinary tract infection about one month prior to her referral which was successfully treated with antibiotics. However, she feared that her mental state had been affected because she insisted on staying in her room, did not participate in the home's activities and did not communicate with the staff and at times was uncooperative to their demands.

She was seen at the team by one of the staff and a psychiatrist. Both were familiar with her case having had her as a client for approximately one year following her discharge from a psychiatric ward and her arrival at the nursing home. In their assessment they both felt that Mrs. S. did not evidence signs of depression or paranoid behavior but rather attributed her suspicious and withdrawn behavior to her natural untrusting self, a personality trait that stemmed from having to survive the NAZI persecution in her native country and to her feelings of embarrassment around her infection which frequently made her lose control of her bladder. They also felt that she appeared uncommunicative because of her shyness and her poor command of the English language.
Therefore, their decision was that Mrs. S. was not in need of psychiatric treatment and did not require medication as requested by the nurse in-charge at the home. However, three weeks later after much insistence from the home's head nurse that medication would improve Mrs. S.'s mental state, and because there did not seem to be a change in her behavior, the psychiatrist changed his mind and prescribed her an anti-depressant.

Mr. L.

Mr. L. is a 77 year old Caucasian gentleman who was admitted to the psychiatric ward of a general hospital because of a suicide attempt at his home following a particularly bad argument with his wife. He was first sent to a medical ward for treatment and was later transferred to the psychiatric ward where he stayed for one and a half months before being referred to the Mental Health Team for follow-up care upon his discharge from hospital. Mr. L. was ill informed about what the mental health team was all about and was somewhat annoyed that he would also have to see a psychiatrist when out of hospital for what he called "a moment of temporary insanity". He denied having further intentions to harm himself although he also added that death would be a welcomed relief. The root of his problems he claimed was partly the marital discord between him and his wife, which was resolved through separation, but most importantly the ill state of his health. He nevertheless agreed to attend the Team. Mr. L. was
assessed as suffering from depression by the psychiatrist at the team and was put on a trial of anti-depressant medication.

Mr. M

Mr. M. is a 70 year old retired engineer who contracted Huntington's disease one year after retirement. His condition gradually deteriorated to the point where he was unable to care for himself independently. He was transferred to a nursing home where he was residing at the time of his referral to the Mental Health Team.

Mr. M. was referred to the mental health team because the director of the home found him to be aggressive with a propensity to hit staff in an unpredictable manner, especially nursing staff who helped him with his meals. The director felt that the man should be certified and removed from the home into a psychiatric facility.

The team did assess Mr. M. on two occasions but found him to be not certifiable due to his rational thinking and non-threatening behavior. His primary therapist at the Team conjectured that his striking out attempts were involuntary and caused by chorea-form movements related to his disability which left him with poor coordination and control of his muscles. The fact that he "hit" at staff was probably not a premeditated act but an accident arising from the fact that a staff member would be standing near him, e.g., feeding him, as his arms would be moving in an uncontrollable fashion.
The director of the home was quite upset that the Team was not willing to certify the man and as a result requested his physician to increase the dosage of the tranquilizer he was on to control his "aggressive" behavior. Mr. M. was subsequently transferred to another nursing home.
CHAPTER 4
IDENTIFYING DEVIANCE IN THE COMMUNITY:
THE ROLE OF REFERRING AGENTS

If deviance is a socially attributed condition then the status of deviant is an ascribed one (Conrad, 1980). Deviance in the elderly referred to the Mental Health Team is defined as such by key referring agents in the community who evaluate, define, and ascribe such status in the people they refer. Hence, referrals to the team are a function of the process of attributing deviance by community agents.

The purpose of this section is describe the referring agents of deviance and the reasons behind their referrals.

THE REFERRING AGENTS: WHO ARE THEY AND WHY DO THEY REFER TO THE COMMUNITY MENTAL HEALTH TEAM?

Mental illness in the elderly is rarely first detected by mental health services. Rather it is brought to their attention by a variety of sources including friends or relatives, but mainly by the other services which cater to the needs of that population, e.g., nursing homes, police force.

In the referral form sample, 68 percent (N = 44) of the primary identifiers of illness who referred to the team were professionals although out of that number, only 14 percent (N = 9) were mental health professionals. The remaining 26
percent \((N = 7)\) were non-professionals and only 6 percent \((N = 4)\) of the sample actually referred themselves for services (see Table IV). All professionals referred to the Mental Health Team as part of their professional duties within the service agency they worked for. All service agencies involved provide either direct or indirect services to the elderly. An example of a direct service would be that of a nurse in a nursing home where as an indirect service would be that of a police officer who helped an elderly person in the function of his/her duty but whose role is not exclusively that of caring for the elderly. Out of 57 professionals and non-professionals who referred to the Team, 42 percent \((N = 24)\) provided a direct service to the elderly and 58 percent \((N = 33)\) provided an indirect service to the aged. Finally, only 14 percent \((N = 9)\) of individuals referring were working as professionals in some form of mental health service.

These percentages indicate that professionals who have more frequent contact with the elderly or work in a mental health setting do not necessarily refer the elderly more frequently for community psychiatric care than people who have less frequent contact with them or professionals who do not work within the mental health system. However, it is evident that professionals tend to refer significantly more to the team than non-professionals do (68% versus 26%), excluding self-referrals).
Table IV

Source of Referral by Referring Agent and Service Agency

From Review of 1987 Referral Forms Sample

(N = 65)

<table>
<thead>
<tr>
<th>Referring Agent</th>
<th>Service Agency</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Professionals in other services than</td>
<td>Long term care, nursing home</td>
<td>22</td>
<td>32</td>
</tr>
<tr>
<td>mental health services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-Apartment Managers</td>
<td>B.C. Housing, private apartment building.</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>3-General Practitioner</td>
<td>Self-employed</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>4-Professionals-Mental Health Services</td>
<td>Hospital psychiatric ward</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>5-Relatives/friends</td>
<td>----</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>6-Self</td>
<td>----</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>7-Police Officers</td>
<td>Police Dept.</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>65</td>
<td>100%</td>
</tr>
</tbody>
</table>
The higher propensity of professionals to refer to the team can be explained by their greater awareness of that service being available to the mentally ill. In the sample of case studies, all five referring agents had made at least one previous referral to the Team and were quite aware of the nature of its service. In one case, one referring agent attempted to obtain help from three other service agencies for a man who frequented her constituency office in a confused state before finally contacting the Mental Health Team as a last resort. She was aware that a geriatric specialist was operating on the Team and even knew him by his first name from previous dealings with him on a similar case. Yet, that referring agent had only limited knowledge of mental illness and described the elderly man's problems as "there is something wrong with him".

This case is somewhat typical of other referring agents in the case study sample as none of the other agents interviewed had in-depth knowledge of mental illness processes despite the occasional attempt to diagnose the referred person's problem. These amateur diagnoses were invariably disconfirmed by the team's psychiatrists. For example, a nurse in a nursing home referred an elderly female resident for "paranoid behavior". She was assessed by one of the team's psychiatrists and was found instead to be depressed. In another case, an elderly man was referred because he had "unpredictable physical outbursts" and because he was "violent and depressed". On the insistence
of the nursing home director who had referred this man, the Mental Health Team assessed him on three different occasions with three different psychiatrists who all found him to be "logical and coherent", not "depressed and demented", and "quite approachable and pleasant in his manners".

In both of these cases however, the referring agents had previously made numerous referrals to the Team and were familiar with the geriatric specialist's role on that team. In fact, approximately two years prior to the above mentioned referrals, both nursing homes had been approached by that specialist in an effort to promote his specialized services to them. This move had occurred for the purpose of establishing what the geriatrician called "an early warning system" of individuals in the community who could detect early signs and symptoms of mental illness in the elderly, and subsequently refer them to the Mental Health Team for assessment and treatment.

The people targeted in the community for this system included a wide range of lay individuals as well as professionals who were regularly in contact with the elderly. They were caretakers of apartments or hotels where a large number of elderly lived, nurses and health care workers in nursing homes, members of senior citizen organizations, long term care assessors, and administrators working for the Provincial Housing Corporation which manages two large subsidized apartment buildings for seniors. Furthermore, the geriatric specialist also appeared on
community television on a program specifically geared towards the aged.

The ultimate result of this educational process was to generate a network of amateur diagnosticians who were sensitized to any behavior in the elderly which deviated from the accepted norm for that population. It became essentially a large net which dragged in, along with some cases pathology requiring professional help, a large array of deviance which even psychiatry has yet to categorize as illness.

An example of this 'early warning system' operating in that way is the case of an elderly woman living in a shoddy hotel in a not so sanitary section of downtown. The manager of that hotel made a referral to the Mental Health Team because he felt this woman was acting out, being aggressive, and causing damage to property. He suspected this woman to be suffering from a serious mental problem and that she felt should be sent to a mental hospital.

The geriatrician and myself went to investigate the situation. Upon our arrival at the hotel, we met with the client, a woman in her 70's who was in the process of cooking some lunch for herself. She welcomed us, offered us some tea, and spoke to us in a most pleasant and rational manner. She admitted to having been verbally abusive towards the manager of the hotel because she felt he was charging her excessive rent. The whole thing resulted in a heated argument between the two of them and out of
frustration, she kicked a hole in the wall of her room. Not surprisingly, the geriatrician concluded that this woman was in no way mentally ill or in need of hospitalization.

After our assessment, we met with the hotel manager, a middle-aged oriental man, and the geriatrician informed him of his verdict. The manager stared at us in disbelief and in his broken English, said, "Her, go to hospital . . . crazy", while tapping the side of his head with his index finger. Alas to his disappointment, we left without sending the elderly woman to an insane asylum. Unfortunately, as we learned the next day, she was summarily evicted from the hotel by the manager after what we assumed must have been another heated argument since he also hit her over the head with a frying pan in the process of doing so.

This case also illustrates how the elderly gain access to the Mental Health Team mostly against their will. In fact, they are referred to the team in a proportion of 94 percent by a third party who usually occupies a position of authority, e.g., general practitioner, apartment or hotel manager. Only 6 percent of those third party referrals are made by friends or relatives and most referrals are done without the awareness or consent of the referred elderly. Therefore, one can conclude that they have little say in determining whether or not they receive mental health services. It is true that the service is voluntary in nature and that when approached by a mental health worker, an elderly person can always refuse the service. However,
the elderly are also vulnerable in regards to making informed decisions regarding accepting or refusing services. Their understanding of mental health services is different from that of younger cohorts and they may be afraid that refusing to see a professional may mean that they will be forcefully carted away to the asylum (Lasoski, 1986). This problem can be further aggravated by how such service is introduced. In a number of instances for example, the geriatrician from the Mental Health Team introduced himself as being from the 'Health Department' in order to access the elderly who were reluctant to see a mental health professional.

THE NATURE OF THE DEVIANCE REFERRED BY AGENTS

Regardless of the specific content of behavior, the essential nature of deviance identified by the referring agents lies in the departure of the elderly from certain norms which are accepted and at times enforced by the specific groups to which they belong. Some of the norms broken tended to be more universal in their scope, e.g., generally recognized as such by society, whereas others tended to be specific to the institutions providing services to the elderly, such as refusing to participate in a nursing home activity program. Key norm breaking behaviors were invariably given to the intake worker upon the referral and listed on the referral form.
Further information on these behaviors was given by the agent upon the visit of the team staff responding to the referral. Team staff, usually one therapist and a psychiatrist, spent much time discussing the nature of such behaviors with the agents in an effort to assess the elderly's level of pathology. Quite often time spent with the agents exceeded time spent with the referred elderly.

Eight key norm breaking behaviors were identified as the most common ones reported by referring agents from the case study sample and the referral form sample. They will be described below.

**Hygiene Neglect**

Personal hygiene is a norm which is very much emphasized in society judging by the amount of publicity on beauty products destined to eradicate any suspicious odors coming from any parts of the anatomy one cares to expose to other fellow human beings. Anyone smelling and looking dirty tends to stand out in this kind of environment, especially if they happen to be older than most.

The inability of the elderly to care for their hygiene was one of the most common reasons cited by referring agents as indicators of mental illness. In one of the case studies, it was the primary reason and in two others, poor hygiene was mentioned as a secondary reason supporting the agents' primary attribution of illness. As for the sample of referral forms, hygiene neglect was the second most
mentioned reason for attributing mental illness next to depression (14 percent of all referrals).

The perceived severity of hygiene neglect by the referring agent appeared to vary according to the context in which this norm breaking behavior was identified. The factors influencing their evaluation of severity seemed to be a function of both occupation and location of the labeler of deviance. Professional caretakers such as a nurse or an office manager tended to notice neglect more readily than non-professionals and peers because it stands out more readily in environments where cleanliness is more of a norm, e.g., a nursing home, office.

As comparative case examples of the role of context on the definition of deviance, we will consider the cases of Mrs. S. and Mr. W. Mrs. S. is an elderly woman residing in a nursing home run by a Catholic order of nuns. At the time of her referral to the mental health team, she suffered from an urinary tract infection which made her occasionally incontinent of urine in most inopportune places. On one occasion, this woman accidently voided herself in the chapel. The incident did not go unnoticed by the nursing staff, all of whom were nuns. It was charted in her file by the following sentence underlined in red: "Mrs. S. voided in the chapel!" Mrs. S. had desanctified the most sacred of places within that home. Later, Mrs. S. took to her room not daring to venture outside into the building, most probably for fear of voiding again. This behavior was
referred to as "paranoid" by the same nursing staff who were offended at her "unhygienic" behavior in the chapel.

Other unhygienic behavior reported in the case included her reluctance to wash her face and comb her hair in the morning. Yet, when I interviewed this woman in her room I certainly could not detect either visually or olfactorally any signs of hygiene neglect.

Now compare that case with the case of Mr. W. who lived independently in the community before his referral to the team. It was subsequently found that he suffered from major brain damage due to primary dementia. This condition had been occurring approximately eight months prior to his referral. Appearance wise, Mr. W. showed very obvious signs of neglect. His clothes were dirty with stains and smelled. His fingers had large nicotine stains on them, his thinning unwashed hair was lumped together by grease, and he had not been shaving for a few days. Interestingly enough, Mr. W. lived in a large apartment complex for senior citizens and interacted on a daily basis with the other residents in the building and with the caretaker. It appears that none of these people thought his appearance and lack of hygiene were unusual enough to warrant reporting him to the mental health team or for that matter of fact to any authority, e.g., police. Yet, the caretaker knew of the existence of the team from previous consultations with the geriatric specialist. In fact, Mr. W. was referred to the team by the manager of a nearby constituency office who had noticed that
Mr. W.'s appearance had been deteriorating over the few months of her contact with him.

This case comparison illustrates that the definition of deviance can be influenced by factors external to the inherent behavior of the individual. In this case, the lack of tolerance of the referring agents for the individuals' hygiene neglect contributed to a speedier referral to the mental health team. These people presumably assumed that anyone not keeping themselves clean is incapable of doing so and therefore must be suffering from some form of mental impairment.

It should be noted however, that in some cases, hygiene neglect had been identified as deviant behavior along with other behaviors. Therefore in such cases, it is the combination of deviant behaviors as opposed to a single behavior that led labelers to ascribe mental illness in a given individual. Possibly, a lack of hygiene although insufficient in itself to motivate an agent to refer, nevertheless, attracts his or her attention to other behaviors more symptomatic of mental illness.

Disorientation

The proper functioning of our society depends on each individual's capacity to remain oriented to his or her ascribed identity. If for whatever reason, one day everyone was to forget where they lived or what their name was, and at that, lose all their identity cards, then most likely
modern industrialized society as we know it would be irreversibly altered.

One is given a specific identity, a first and last name, to which is attached a series of information essential for everyday survival: birthdate, social insurance number, medical number, and so on. It is impossible to open a bank account or cash a cheque without proper identification, or to tell someone that you are who you claim you are unless you can prove it with the right papers. Finally, cities have become mazes of streets and shelters each with a specific address in the form of names and/or numbers. Finding an address today can require both the instinct of an Indian hunter and the memory bank of a modern super computer. Our society also demands previously unheard of timing from its members to ensure its smooth running. People must arrive and leave work at given times, they must keep appointments and the transportation they take has to come and go with precision.

Overall then, being oriented to time, date, and place, and to one's formal identity has become an essential norm in our society. It is easy for the elderly to deviate from this norm as they tend to remember things in the long term range (the "old days") and forget the 'here and now' details - today's date, the number of their apartment, etc. This tendency contravenes the norm established by the younger segment of society which the elderly come in contact with through various services. Often to access such services,
the elderly must conform to that norm by being aware of
dates, time, address, and various identity numbers. Their
inability to do so makes them vulnerable to being labeled
deviants by service providers.

In the referral form sample, referrals for reasons of
disorientation accounted for 6 percent (N = 4) of all
referrals to the team. Comments on the forms included the
following: "wanders and gets lost - fear for safety";
"disoriented to time, place, and people"; "confused";
"wanders in hallways, daughter wants him in a nursing home."

In the case study sample, disorientation was mentioned
in only one case out of five, that of Mr. W. It was given
as the primary reason for referral:

"On November __, 198_, __________'s office
referred this 69 year old gentleman who, as a
regular caller to their office, had been
exhibiting what they felt was a deterioration of
his mental condition over the past several months.
Specifically they felt that he was confused as to
the day, where he lived, and where his money was".

Disorientation is also a form of deviance within
institutional settings such as in nursing homes for example.
Individuals who tend to walk away from a home, and can not
remember how to get back can pose serious management
problems for the staff who must then attempt to relocate
their missing resident. Disorientation therefore becomes
deviance which needs to be controlled to ensure the smooth
running of an institution. This control can take many
forms: locked doors, tying up residents to their chairs, or
confining them to their room, or tranquilizers. One
interesting form of control I observed was the case of this elderly gentleman in a nursing home where the staff figured that if he was to wander off from the home, people out in streets would most likely bring him back. To make sure of that, they sewed a large patch of fabric on the back of his shirt. On it was written: "I am lost - please call 272-513_" which was the home's number. Social control indeed takes many forms.

Dementia

Of all the qualifications used to describe deviance in the elderly, dementia is probably the most commonly used one. The stereotype that old age equates senility is prevalent in our society. Old age is associated with a multitude of problems which invariably relate to some brain malfunction. If older people can't remember something, they're demented; if they can't figure out the right change for the bus or are not moving fast enough in a line up, they are also demented. Senility is even part of the younger generation's popular language. How many times do we say "I must be getting old" if we cannot remember something.

In the referral form sample, the term demented was not always used directly. It was indirectly referred to in 20 percent of the cases (N = 13) where the referring agent explained the behavior of the elderly person with some form of brain disorder. The following comments were noted: "something is wrong with her mind"; "he may be paranoid or
demented"; "public health nurse received calls from apartment manager stating possible mental deterioration in this elderly woman".

In the case study sample, dementia was cited as the primary reason for referring Miss D. to the team. This woman who had been referred to the team a number of times previously had the peculiar habit of entering parked cars and shuffling through their glove compartments. This behavior had brought her before the courts on several occasions. Despite numerous arrests and warnings however, she kept breaking into cars. Her probation officer made a referral to the team because she felt that the only plausible explanation for Miss D.'s behavior was some form of brain impairment. She rationalized her explanation by stating that this woman's behavior was a recent one in occurrence, and that she was receiving a steady pension and therefore did not need to steal money for her subsistence. There was also the fact that this woman was hit over the head when playing baseball as a child.

Interestingly enough, the geriatrician's assessment of this woman read: "I could detect no evidence of a dementing process nor delirium. Further there was no disturbance in form or content of thought or perception, nor was there gross disturbance in vegetative signs". In regards to her deviant behavior however, he diplomatically remarked that "There is chronic impairment in her judgement and insight with respect to her constantly entering into parked cars".
This case also serves to illustrate the mechanism by which deviance is created. Social groups create deviance by making the rules whose infraction constitutes deviance. In this case, the infraction was a criminal one and therefore deviance was ascribed by professionals within the legal system. Unfortunately, repeated infractions of the rules by Miss D. put the legal system in a bind: should they further enforce the rules and attempt to control this elderly woman of 73 by putting her in prison? Instead, an alternative explanation was sought for her behavior in an attempt to redefine her deviance. Mental illness in the form of dementia seemed to be a logical alternative—she was elderly after all. Such explanations then shifted the responsibility of rule enforcement from the legal system onto the mental health system, to the relief of many in the judicial system who would have had the imprisonment of an old woman on their conscience.

Violence

In someways, society has come to tolerate a certain amount of violence within its population in the form of various crimes ranging from assaults to murders. This form of violence is concentrated mainly amongst the younger population and is higher for the 18-24 age group than for any other group (Diniz et al., 1975). Older people are not usually associated with violence and the crime scene. The over 65 are more often than not victims of violence rather
than the instigators. Not surprisingly, none of the elderly in the referral form sample were referred for reasons of violence towards others. Some referrals involved various acting out behaviors such as banging on the walls or verbal abusiveness but no physical altercations or violence were mentioned.

However, in the case study sample, 2 out of 5 people had violence as a main concern. In the case of Mr. M. violence towards staff was cited as the primary reason for referral. The referral form cited this man as "a behavioral problem . . . at times angry with unpredictable physical outbursts". The manager of his nursing home was also quoted as saying that this man had a propensity to hit staff and was all in all "a dangerous man". It should be noted that Mr. M. suffered from Huntington's disease and was wheelchair bound most of the time.

Yet after assessing this man on three different occasions, each time using a different psychiatrist, the team geriatrician concluded that this man was not demented, not suffering from any psychopathology, that he was most pleasant and cooperative, and that he was definitely not aggressive. The geriatrician recognized that at times this man may appear to hit others but attributed this tendency to his illness which produced "gross abnormal chorea-form movement which could result in his arms swerving about without his control". Further investigation from my part seemed to confirm this theory, as one of the nurses who
witnessed one of these "assaults" could not say with any certainty whether Mr. M. had intended to hit the staff. If anything, it looked like Mr. M. did not have control over what he was doing.

In the second case, that of Mr. W., violence became a serious concern for the nurse who interviewed him to determine whether or not he was a suitable candidate for admission to the geriatric day hospital she represented. The interview took place in the conference room of the apartment building he resided in and throughout the whole process, Mr. W. was most compliant in answering all the questions put to him. He attempted to answer them to the best of his ability despite his confused state, sometimes making what could be called "smart ass" comments to cover his disability as illustrated here:

**Nurse** - (serious) When did you retire, Mr. W.?

**Mr. W.** - (laughter) Retire? I've worked all my life.

**Nurse** - (somewhat annoyed looking) Well, when was the last time you worked?

**Mr. W.** - I don't know . . .

**Nurse** - (somewhat sarcastically) Do you ever have problems with your memory, Mr. W?

**Mr. W.** - (somewhat annoyed looking) Yeah . . . sometimes. But I've always been like that.

This style of interviewing went on for about five minutes and then the nurse abruptly ended her assessment. She had concluded that this man was unsuitable for her day
hospital because she felt he was "agitated and a risk to the frail elderly woman already on the ward". She added that she vaguely remembered this man as a psychiatric patient from before although she wasn't quite sure, and that the hospital did not offer services to mental patients because they presented a risk to other elderly patients. She also added that this man was probably suffering from a brain tumor and therefore there was nothing they could do about it.

Hence, with a five minute assessment, this nurse had determined that this elderly man who had complied to all her questioning and had no history of aggressiveness in his previous dealings with the Team, was in fact a brain tumor mental patient with the potential to assault frail elderly women.

Both of these case studies exemplify how violence as a form of deviance gets attributed to the elderly to prevent them from entering an institution as in the case of Mr. W., or to remove them from one, as in the case of Mr. M. Why were these two elderly men perceived as aggressive individuals?

A number of factors can be identified here. One is possibly gender. Both men were assessed by professional females who may be more readily interpreting aggressiveness in their male patients' behavior than their male counterparts.
Another factor relates more to the institutional context in which both elderly patients were assessed. Whether it be a nursing home as in the case of Mr. M, or a hospital ward as in the case of Mr. W., each setting sets certain norms to insure the smooth functioning of the institution and give it some predictability. This characteristic allows for the creation of a highly efficient environment in which to provide maximum care to patients with minimum output of staff time.

Deviation from these norms by a patient disturbs an institution's routine and jeopardizes its efficient functioning. Violence is such deviation. Aggressive patients require more staff to handle, and may injure either staff or other residents in the process. They also undermine staff morale because of their physical and verbal abuse and disturb other residents. Patient aggressiveness is to an institution an expensive and disruptive form of deviance.

Hence, institutions are extremely cautious in dealing with either overtly aggressive patients, e.g., Mr. M., or potentially aggressive patients, e.g., Mr. W. The most expeditious way of dealing with such disruption is to either transfer them to another institution or simply to prevent them from entering the institution in the first place.

Failing this, the institution may seek other means of control. In the case of Mr. M., he was eventually sedated with massive doses of tranquilizers.
As for Mr. W., lucky for him, he was eventually admitted to the day hospital despite his poor performance on the assessment. The admitting nurse who had interviewed him grudgingly phoned back the team to say that they would "bring him in, do a physical, clean him up, and ship him back home". In the end however, the nursing and medical staff found him so pleasant, and his case to be so interesting from a clinical point of view, that they kept him for a full four week assessment, and the medical resident even used him as a case study for one of his presentations!

Depression

By far the most common reason for referring an elderly person to the mental health team was the perceived presence of depression. In 22 percent of the cases \(N = 14\) in the referring form sample, agents mentioned concerns with an elderly person's mood stability as the primary reason for referral. In virtually all the cases, the word "depressed" was used to describe the referred elderly. Phrases such as "feeling depressed" or "seems depressed" were most commonly used. The two other most frequent terms used in conjunction with the term "depressed" were "suicide" or "suicidal" \(29\) percent; \(N = 4\) and "isolated" \(14\) percent; \(N = 2\).

These findings seem to correlate with various epidemiological studies, which report that depression is the most common disorder in up to 20 percent of all persons
above 65 years of age (Fry, 1986). This age group also accounts for 25 to 30 percent of all known suicides (Blazer, 1982).

Depression and related suicides in the elderly can be linked to their low socio-economic status which negatively impact both their physical and mental well-being.

The elderly are more vulnerable to illness because of their declining health, which can be linked in part to the unsanitary and dangerous work environments with which most of them were faced prior to retiring (Olson, 1982). Many of the work related illnesses manifest themselves as what has been labeled chronic degenerative diseases of old age by the medical profession.

Retirement also has an impact on the elderly's health. The loss of employment means a drastic reduction of income and consequently a lower social class membership if old age pension is all they are left with. Studies have shown consistently that lower class status predicts shorter life expectancy, and higher death and morbidity rates from all diseases (ibid). It also can result in lesser opportunity for adequate lodging and food, leisure opportunities and contribute to more stressful living conditions. Such conditions in turn have an impact on the elderly's emotional well being. Gurland et al (1983) report strong and consistent relationships between depression and physical illness. Eastwood (1980) similarly correlates suicide rates with depressive disorders. Therefore, what has been
construed as a personal problem of psychopathology in the aged can be reframed as a social class problem resulting from the exploitive conditions existing in a capitalist society which create debilitating work conditions and unequal distribution of wealth. As Olson (1982) puts it, the problem of health in the elderly is "rooted in the larger issues of social relations of production, structural inequalities and class privilege, and dominance of profits over human beings" (p. 225). Viewing the problem of depression (and possibly that of other psychiatric disorders) in the elderly as individual psychopathology only serve to mask the real issue of social inequality and perpetuate the acceptance of the status quo of an exploitive economic system.

The process of 'blaming the victim' for his or her problems is well illustrated by the case of Mr. L. who was referred to the Mental Health Team for follow-up care following his discharge from the psychiatric ward of a general hospital.

Mr. L's admission was prompted by a suicide attempt in which he ingested large quantities of anti-freeze. His gesture was deliberate and he performed it at his home having full possession of his faculties. After drinking the poisonous fluid, he went to his bedroom and lay on his bed awaiting his death. However, his wife walked in the bedroom and realizing something was wrong phoned the ambulance. Mr.
L. was rushed to emergency, his stomach pumped and subsequently, he was transferred to the psychiatric ward.

When questioned about his motives, Mr. L. described his gesture as "a moment of temporary insanity" prompted by the belief that he had become an "useless individual". He often referred to himself as "half the man I used to be" because of a series of illnesses on which medical technology had little impact: chronic lung obstruction, arthritis, chronic heart condition, on-going feelings of "giddiness" which prevented him from walking more than two or three blocks at a time, and memory loss. Upon retirement, he also had lost his main life interest, and felt very much isolated and bored especially since he did not get along with his wife. He also had come to be envious of her because she still worked part time and her health was such that she remained quite active and could drive herself to her various appointments while he remained by himself at home. Mr. L. imputed his depression and suicide attempt to his isolation, lack of role, and poor health.

The mental health system dealt with Mr. L.'s condition by isolating him for a period of one and a half months on a psychiatric ward. Mr. L. described his treatment as "a farce" and recalled how patients received minimal attention and support from staff, and had little say in determining the course of their hospitalization. He described how most of his demands, whether it was permission to visit with his wife over the weekend, or getting an extra dose of sleeping
medication were met by the same ritualistic answer: "I'll have to check with your doctor". Mr. L. also described how patients adapted to this rigid environment by learning to say and do the right things. For example, during mandatory community meetings, patients were asked by nursing staff to say what they would do to help themselves while in the hospital. Because most patients, including himself, resented the impersonal and mandatory nature of these meetings, they learned to give the answer expected by the staff. It consisted of three parts: "I'll go for a walk" (physical activity); "I'll read a book" (intellectual activity); and "I'll talk to my nurse" (treatment). Such answers seemed to please the staff as it implied that patients remained active on the ward while seeking treatment. The reality of it, however, according to Mr. L. was that nursing staff were so involved in charting, dispensing medications, and talking to the doctors that they rarely had time to spend with the patients outside of group time.

In the hospital records reviewed for this case, there were also no accounts of any efforts to address the issues that lead Mr. L. to despair. Health problems were mentioned once briefly in one sentence on his assessment along with two words "marital discord" to describe the state of his relationship with his wife. Two paragraphs of this assessment however, were written on his psychiatric
diagnosis (Axis I-Depression) and on his medication regimen of anti-depressant and anti-anxiety drugs.

Upon his discharge from hospital and referral to the Mental Health Team, Mr. L. was faced with a similar scenario. During his first assessment by a psychiatrist and nurse, the main theme of the interview exclusively related to whether or not his anti-depressant medication should be increased. Mr. L. commented that although at first he did not know what to expect from his first visit at the team, he soon realized that "this was the exact same gig as at the hospital".

Mr. L.'s case of depression illustrates how psychiatry through hospital based and community services fails to address the larger socio-political issues reflected in individual cases of deviance by attempting to isolate and control its symptomatology through bio-medical technology such as drug therapy.

Refusal of services from other agencies

Deviance in the elderly is controlled through a number of services other than mental health. These mainly include medical services such as health clinics or personal physicians, and home support services.

It appears that refusal of a given service or uncooperativeness to it was a sufficient reason to motivate the distributor of such services to refer their client for psychiatric assessment. Two such cases (3 percent) were
identified in the referral form sample. One referral was made by a long term care assessor on the grounds that her client had been verbally abusive towards the homemakers she had sent in to help him clean his apartment, and also had been uncooperative towards the service by not being in his apartment when the homemakers were scheduled to come in. She subsequently withdrew the services and sent her client a letter telling him he had been referred to the Mental Health Team for psychiatric assessment.

The second referral was made by the Public Trustee for an elderly woman because she had refused support services to help her keep her room clean and because she had not been compliant in taking her medications.

It seems therefore that some professionals tend to ascribe mental illness in clients who turn down the services offered to them. The reason behind such behavior is uncertain but one could venture that these professionals possibly believe that their services are so essential to the elderly that no one in their right mind would refuse them. The use of mental health services therefore is oriented towards increasing the compliance of clients towards the services they do not want. This intrusion of psychiatry in the delivery of non-mental services to the elderly could effectively prevent them from complaining about the poor quality of a service, or refusing it if they feel they don't need it, without being exposed to the risk of being labelled
mentally ill. In fact, this risk may already be a reality as demonstrated in the next section.

Complaining

A number of referral forms (N = 5, 8 percent) cited complaining behavior as a reason for referral. In one case, an apartment manager referred an elderly woman after she had written him many letters of concern regarding the running of the apartment building. The geriatrician who took the referral wrote:

Mrs. E.B., a 74 year old resident of Towers, was referred by the manager as he felt that her plethora of letters of concern were now becoming of such a nature that they warranted psychiatric assessment. Specifically, there was a certain paranoid theme now developing in her letters which he wished us to investigate.

The manager stopped short of proposing a diagnosis for this woman's condition, but possibly that of 'Acute Complaining Disorder' would have been adequate. Unfortunately for him, the geriatrician did not agree with his assessment and felt she did not warrant psychiatric intervention.

Other "complaint referrals" were relatively similar in nature. One elderly man had been referred after he had been accusing neighbors in other apartment suites of bothering him, and writing letters of complaints about it to the management of the building who felt that such complaints were unjustified and required an assessment for "paranoid, depressed, or demented behavior." In another case, the
Police Department referred a woman who had repeatedly been calling them to complain about other tenants in her building. One more referral was made by a general practitioner who felt that one of his patients needed counselling for numerous psychosomatic complaints. She would often call his office with complaints about her bowels of which medical investigations revealed no pathology.

One cannot help but draw parallels between complaining and refusing services as forms of deviance. It appears that the expected normative behavior here is for the elderly to accept what is given to them in terms of services without criticizing it. Complaining about a service or refusing it contradicts the passive role of receiver which the elderly are often assigned by society. The reaction has been to attempt to deal with such behavior by interpreting it as another form of deviance, that of mental illness, which can then be dealt with by more controlling services such as mental health or the police.

Causing a disturbance

Causing a disturbance is a term which serves to describe behaviors identified by referring agents as disruptive and/or offensive to them, or to other people. Eight percent ($N = 5$) of the referral forms included public disturbance as reason for referral. Some of these included one elderly woman who had been preaching in the cafeteria of a hotel and distribute religious literature on the streets;
a 70 year old man who had been banging on the walls of his apartment, disturbing other tenants in the building; an 87 year old woman who was yelling off her balcony; and finally an aged woman who was observed picking food scraps out of a "Smithright" garbage bin and sleeping in lane alleys. On this last case, team staff made a couple of "home visits" but were unsuccessful in locating her.

In those cases, the elderly who created a disturbance were attributed the status of mentally ill. However, it would be interesting to compare similar behaviors in younger people to see if a similar attribution would be elicited in the referring agents. I suspect that a referral to the local police department would more often be the chosen course of action for the younger deviants.

An important factor which may serve to elucidate the propensity of agents to ascribe mental illness in these cases, is the fact that three out of the five referring agents had previous contact with the geriatric specialist at the Team. They were part of his "early warning system". The other two referrals were indirect referrals in the sense that the individuals referring had not directly witnessed the behavior for which the elderly had been referred, but were passing on a referral made to them by the person who originally had witnessed that behavior. The original or primary referring agents were lay people who in all likelihood had no previous knowledge or dealings with the geriatric services of the mental health team.
In one of the cases, an elderly man had been observed banging on the walls of his apartment keeping other residents awake at night. The primary agent in this case, the apartment manager, referred him first to the police department who in turn made a referral to the Team. In the second case, an elderly woman had been observed eating out of a garbage bin and sleeping in the alley at night. A resident of the area originally phoned the Ministry of Social Services and Housing to enquire if anything could be done to help this woman. It was the social worker at the Ministry who later phoned the Mental Health Team.

These cases illustrate that awareness of and/or previous contact with the Mental Health Team is a factor which makes a given witness of deviance in the aged more likely to attribute mental illness and consequently initiate a referral to the Team. More specifically, it is related to their previous contact with the geriatric specialist on that team. People without prior knowledge of the Team tended to refer to other non-mental health services such as the police or M.S.S.H. presumably because they did not attribute the deviant behavior they observed to mental illness.

Problems of Living and Mental Illness

One of the hypotheses of the study is that psychiatry tends to control an increasingly wider range of deviance by broadening the concept of mental illness to include many
problems of living. In this last chapter, I have shown how community agents contribute to this tendency by identifying these problems as symptomatic of mental illness in the elderly who then are referred to the Mental Health Team for treatment. In some cases, problems of living, e.g., poor hygiene, are indicative of an underlying brain dysfunction which can impair the individual's ability to care for himself as in the case of Mr. W. However, in many other cases, these problems of living are just that, problems individuals encounter in their lives and which they deal with in the best manner they know. It can be the case of Mrs. S. who suffered from an urinary tract infection and decided to remain in her room for fear of voiding herself in public as she did previously at the home's chapel. Yet that problem was described by the nurse in charge of the home as paranoid behavior, a psychiatric disorder characterized by a fear of people.

Other forms of deviance, e.g., criminal behavior, can also be redefined as mental illness as in the case of Miss D. whose habit of breaking into parked cars, which is a criminal offense, became a symptom of brain dementia when legal authorities were faced with the difficulties of sending a 73 year old woman to prison for repeatedly failing to appear in court on her charges.

Similarly, in the case of Mr. M., whose Huntington's disease and lack of motor control made him a liability for nursing staff due to his arms flying about uncontrollably,
it was a medical condition that was transformed into mental illness.

At times, the deviance referred to the Team says more about the referring agent's motive than about the nature of the psychopathology itself. However, the tendency of community agents to medicalize problems of living does not appear to be inherently motivated but rather it is very much the result of the efforts by the geriatrician to educate them in recognizing the signs and symptoms of mental illness while increasing their awareness of the Mental Health Team's capacity to deal with such illness. In the next chapter, I explore in more depth the role of the Team, in medicalizing deviance in the elderly.
CHAPTER 5
MEDICALIZING DEVIANCE: THE ROLE OF THE COMMUNITY MENTAL HEALTH TEAM

In chapter four, I described the process by which elderly people in the community are referred for psychiatric services to the Mental Health Team by various referring agents. In this chapter, I will further analyze this process to reveal that the mental health team, and more specifically its geriatric specialist, are active contributors to the process by which referring agents identify and sanction mental illness in the elderly.

This contribution takes the form of the geriatrician aggressively promoting geriatric mental health services to various community agents who regularly come in contact with the elderly. Agents range from highly trained health care professionals e.g., nurses, to lay people without specific knowledge about the elderly, e.g., apartment manager. The purpose of this promotional effort is to educate and sensitize community agents to the signs and symptoms of mental illness as defined by the psychiatric model. His aim is to create a network of amateur diagnosticians functioning within the bio-medical framework who are trained to recognize and refer mental illness. This is what the team's geriatrician refers to as his "early warning system". Its purpose is to ensure a continuous flow of client referrals to the team, hence creating and perpetuating a demand for a
geriatric specialist's position within that team. Hence, deviance as mental illness in the elderly becomes a commodity which benefits both the Mental Health Team and the geriatrician.

PROMOTING GERIATRIC MENTAL HEALTH SERVICES IN THE COMMUNITY: THE ROLE OF THE GERIATRIC SPECIALIST

The familiarity of many of the referring agents with geriatric services the Team has to offer them seems to indicate that the geriatric specialist is an active contributor to the labeling of deviance in the elderly population.

The position of geriatric specialist (also referred to as that of geriatrician in text) was created in 1983. Despite the existence of six other teams in the organization, the investigated team was the only one to receive that particular designation. Two political factors account for this. First, the Team serves a catchment area which has the highest concentration of elderly of any of the areas served by the other teams.

Concomitant to this factor was the geriatrician's own interest in the elderly which resulted in him receiving all referrals of older people to the Team. Other workers with one exception had little if no interest in providing treatment to that group. Some in fact positively stated that they would hate to work with older people and in fact
were glad that they had one worker on their team to deal with them.

The geriatrician started to advocate to his superiors both within the Team and at the administrative level which oversees all teams, for the creation of a specialist's position. He made his requests known about 2 years before its actual creation. Concomitantly, the geriatrician, who was then a regular worker, was carving his speciality by acquiring his caseload of most if not all elderly clients referred to the Team, and by networking with various community agencies providing services to the aged, making them aware of his presence on the Team and of his particular interest so they could refer people they felt needed psychiatric care. This promotional effort served to increase the number of elderly referrals to the team, hence creating a need for a specialist's position. His demands were finally met in 1983.

The geriatrician's promotion of his services was aimed at various levels of community agents ranging from lay people to professionals in management positions who offer some form of service to the elderly. The services targeted can be divided in two general categories: residential services and support services.

Residential services refer to all services directed at housing to the elderly. These ranged from residences, with minimal supervision such as apartment buildings or hotels, to semi-supervised residences such as government subsidized
housing projects for seniors, and fully supervised facilities such as nursing homes. Supervision is ensured in the first case, by government hired caretakers and/or a part-time nurse; and in the last case, by full-time nursing staff. All of these individuals were identified in the referral form sample and in the case study sample as common referring agents of elderly people to the mental health team.

Support services refer to any services which are not directly involved with providing a residence to the elderly but do in some way support them in their daily activities. These are: long term care services which provide elderly with home support; the Ministry of Social Services & Housing for financial assistance; general practitioners who see elderly in their practice, and various senior's organizations offering programs ranging from bingo night to peer counselling. Finally this category also includes other agencies which are not specifically involved with the elderly but can provide them with some services. These are the Police Department, and various social services agencies.

Staff working in support services have also consistently appeared as referring agents on both the sample of referral forms or in the case studies. Therefore, it appears that there is at an informal level a strong correlation between the geriatrician's promotion of his services to staff in elderly services and their propensity to refer elderly people to the Community Mental Health Team.
for psychiatric services. For example, in all five case studies, each of the referring agents had had previous contact with the geriatrician from previous referrals made to the team regarding elderly people. Three out of the five referring agents knew specifically of the existence of the geriatric specialist on the Mental Health Team and only one agent knew of his status as a mental health worker but did not know of his specialist position. Finally, one case was referred to a worker other than the geriatric specialist but who also took an interest in working with the elderly. The correlation between promotional efforts and the sample of referral forms analyzed in the study was more difficult to ascertain. The breakdown of this sample of referring agents by occupation is given in Table V.

In reviewing these referral forms individually and ascertaining the identity of each of the referring agents, I concluded that at least 62% of these agents (N = 40) had been approached prior to their referral by the geriatrician in some form of promotion. The identity of these agents was known to me from my nine months of field work at the Team during which time I had either personal contact with these agents, or was able to confirm their identity with the geriatrician himself.

A prime example of the impact of the promotional efforts is the case of professionals working for Long Term Care which provides home support to the disabled elderly. The level of care provided is determined by assessors who
<table>
<thead>
<tr>
<th>Occupation</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Professionals in other services than mental health (e.g., MSS&amp;H workers; LTC care workers)</td>
<td>18</td>
<td>28</td>
</tr>
<tr>
<td>2. Professional in mental health services (e.g., nurse on psychiatric ward)</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>3. Apartment Managers</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>4. General Practitioner</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>5. Nursing home staff</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>6. Self</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>7. Relative or friend</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>8. Police</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>65</td>
<td>100%</td>
</tr>
</tbody>
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visit the elderly at home and have regular contact with them throughout the period of time they require assistance. Therefore, because of their front line position, they are primary candidates for identifying people who could require psychiatric service - and thus to be part of the Team's "early warning" system. The promotional efforts targeted to this group consisted of the geriatrician attending monthly meetings of all the assessors and their supervisors working in the catchment area of the Team. During the first few meetings of the sort, the geriatrician gave a description of the Team and of the specialized services he offered. Further attendance at these meetings became somewhat symbolic as little information was exchanged between him and the assessors. However, his presence continued to reinforce the existence of the geriatric service to the assessors, and periodically when a new assessor would arrive on staff, they would then be promptly informed of such services.

Referrals by LTC assessors, which were classified under the category "Professionals in services other than mental health", totaled 12 percent (N = 8) of all referrals for the year 1987, which is the second largest source of referrals from professionals, the first one being general practitioner at 15 percent (N = 10), and the third largest overall source of referral from a single service group, the first one being apartment managers at 17 percent (N = 11).

Of course, these percentages would be more significant if they were compared to the percentage of referrals by
these agents prior to their being approached by the geriatrician. Alas, such percentages were not tabulated due to the limited time available for the completion of the study. However, comments by the geriatrician indicated that since his arrival on the Team, there has been a marked increase in the referrals of elderly people to the Team, and more specifically of referrals by the three categories of agents above mentioned.

Perhaps the most significant of such an increase is that of apartment managers, who form the single most important single group of referring agents. As a group, they were heavily targeted by the geriatrician as a source of referral since most elderly in the team's catchment area live in apartment buildings. Again it is not known what percentage of referrals came from apartment managers prior to the presence of the geriatrician on the Team. However, one could expect that most apartment managers would not be aware of specialized geriatric mental health services in the area, let alone be able to determine when an elderly person would be in need of such service. They have little contact with professionals in health services, and usually disturbances or problematic tenants are handled through a referral to a better known service, the police department. Yet, apartment managers made for 17 percent of all referrals to the Team, higher even than professional groups who were most aware of the Team's existence such as LTC assessors and general practitioners. Their presence as referring agents
is a testimony to the effectiveness of the geriatrician's promotional efforts. He singled them out as one of the most important groups for his "early warning system" because of their front line position, not unlike that of LTC assessors. Many times during my field work, when on home visits to an elderly client of the Team living in apartments, I was struck by the familiarity and friendliness existing between the specialist and many of the apartment managers. Often, when a client was reluctant to let him come in the building, the geriatrician would simply ring the manager of the building who would readily let him in. In some cases, he would consult with some managers in regards to referred clients, asking questions regarding their behavior, the cleanliness of their suites, etc, hence, gathering data which would then be used to help him formulate a diagnosis.

Overall then, one can conclude that the geriatrician's promotional efforts in the last five years or so since his entrenchment as a specialist for the elderly within the Community Mental Health Team have resulted in an increase of elderly clients referred by both professionals and non-professional agents who were specifically targeted by such efforts. These promotional efforts also contributed to medicalize the type of deviance identified by community agents, hence, making it possible for them to refer elderly clients to the mental health system which otherwise would have been directed to other services, e.g., police. In the next section, I will discuss the consequences of this
medicalization of deviance for the elderly living in the community.

MEDICALIZATION: TRANSFORMING DEVIANCE INTO MENTAL ILLNESS

The geriatrician is a key actor in influencing community referring agents to transform deviance in the elderly into mental illness which then can be controlled by the Mental Health Team. This influence is very much related to his training which is rather unusual for this type of work. He did combined undergraduate studies in both sociology and biology and then furthered his education by taking a diploma course in gerontology at Simon Fraser University. He then obtained registration with the Board of Social Workers. He utilizes the letters R.S.W. after his name on his business cards, which stands for Registered Social Worker.

His professional interests do not lie necessarily with the elderly as a disadvantaged people, nor does he particularly identify himself with their political struggle or even with their personal struggle, whether it be with personal growth or family issues.

Rather, his interests are of a more diagnostical nature. As he mentioned to me, what he enjoyed most about working with the elderly, is not so much who they are as people, but more the type of problems they present. He is analytical and deductive in his way of looking at a given
problem, very much in the bio-medical tradition. In fact, he often refers to himself as a "diagnostician" and prides himself in being able to correctly identify the appropriate psychiatric diagnosis for his clients, which he then often compares to the clinical impressions of his psychiatrist colleagues. This ability is for him a source of professional satisfaction. In fact, he once declared to me that at one time, his ambition was to become a psychiatrist. Well, in many ways, he is one.

Therefore, what we have here is a mental health worker functioning very much within the bio-medical model who specializes with the elderly population. His promotional efforts consist of a first step to make community agents aware of the existence of his specialized services at the Mental Health Team; and secondly to educate them about the common psychiatric disorders in the elderly and how to recognize the signs and symptoms of such disorders. Such educational processes tend to vary in complexity depending on the level of professionalism displayed by these agents. An apartment manager for example, may be asked to phone the Team if he or she feels that the elderly person is behaving in unusual ways whereas a nurse working for the Long Term Care system may be given more information as to which behaviors are indicative of mental illness. Hence, the geriatrician effectively created through this process a network of amateur diagnosticians who like himself, are
trained within the bio-medical framework to recognize and refer deviance as mental illness.

What are the consequences of the existence of this network for the elderly living in the community? The network can refer forms of deviance which in some cases truly require medical attention, e.g., stroke patient suffering from an Organic Brain Syndrome, but in other cases, it can identify deviance which falls more in the category of "problems of living". The concept of problems of living relates to the notion that mental illness is not illness but a bogus invention that allows behavior, any behavior, to be categorized as disease. As Szasz (1970) puts it:

When I assert that mental illness is myth, I am not saying that personal unhappiness and deviant behavior do not exist. The expression "mental illness" is a metaphor that we have come to mistake for a fact . . . we call people mentally ill people when their personal conduct violates certain ethical, political, and social norms . . . . But the mental illness metaphor actually prevents us from understanding the behaviors called "mental illness" for what they are: problems of living. p.21.

Although the purpose of this study is not to determine what is true mental illness and what is not in the referred cases, it is important to recognize that some of the individuals observed were suffering from medical conditions affecting their brain function hence producing the deviant behaviors, e.g., confusion, disorientation, which prompted the agents to refer them to the team; however, in many cases referrals were initiated for behaviors which although
presented as mental illness, have more to do with either other forms of deviance, e.g., crime, or with incompatibility between the referred person and his or her referring agents.

To illustrate this point, let us take the cases of Mr. W. and Miss D., who had been both referred to the Team because of their demented behaviors.

In the case of Mr. W. the behaviors which prompted his referral to the team included amongst other things a lack of personal hygiene. Hygiene neglect is in itself in our society a fairly drastic departure from the given social norms of cleanliness. In other words, people who smell bad and wear dirty clothes are quite noticeable and easily labeled. Mr. W.'s clothes were stained and smelled. He had large nicotine stains on his fingers, his hair was greasy, and he was perpetually unshaven. Other deviant behaviors identified were his lack of orientation to time and place, also very noticeable departures from social norms.

Therefore, from this brief analysis of Mr. W.'s deviance, one could conclude that mental illness here is really a series of "problems of living" which transgress certain norms rather than a psychiatric illness.

However, further medical investigation using a brain scan in facts, confirmed his psychiatric diagnosis. His brain showed significant damage in certain areas which are responsible for the cognitive skills necessary for orientation or taking care of one's self.
So, in this case, deviant norm breaking behavior served as an indicator of an underlying illness not directly visible but nevertheless present. A referral to the Mental Health Team could be considered appropriate as Mr. W. required medical intervention to address his condition. This case also speaks in favor of the geriatrician's early warning system where a community agent who he previously approached, made what could be considered here to be an "appropriate" referral.

However, many cases observed were more representative of what Szasz described as problems of living being transformed into mental illness. Consider the case of Miss D. who was referred to the Team by a social worker from a government funded social service agency which deals with difficult non-compliant clients. Miss D. had been referred to that agency by her probation officer because she had been arrested by the police for breaking into cars, and also failed to appear in court on her charges. Because of her age, 73, her probation officer was reluctant to issue a warrant and send her to prison until the date of her court appearance.

The probation officer and the social worker at the agency were at a loss to explain the motive behind her criminal act since she had been working as a clerk in a large hospital until her retirement at age 65 and she was receiving nine hundred dollars of pension money every month. So, money could not be the motive. Furthermore, she had
been observed doing other unusual things in the past. She had been reported sleeping on an abandoned couch in a street alley, and foraging for food in a "Smithright". Her hygiene although not grossly neglected was not the best. Her clothes were old and not exactly in fashion and her hair was disheveled. Finally, she had a continuous tremor of her head over which she had little control and also claimed that as a child she had been hit over the head by a baseball bat. So, they concluded based on the above information that Miss D. must be suffering from dementia.

A referral was made to the team to investigate her dementia. The geriatrician paid this woman a home visit. He conducted a full psychiatric assessment and stated in his report:

"I would detect no evidence of a dementing process nor delirium. Further there was no disturbance in form or content of thought or perception, nor was there gross disturbance in negative signs. I feel, however, that there is a chronic impairment in her judgement and insight with respect to her constantly entering into parked cars".

Notice here the rather profuse use of psychiatric jargon, which is somewhat typical of his style of assessment report. What is said here is that Miss D. is perfectly sane although she should know better than going around breaking into parked cars. In fact, this elderly woman had been referred on three previous occasions to the Team for similar reasons and each time, she was found "... not amenable to psychiatric intervention".
So, as opposed to Mr. W., the case of Miss D. is one of "problems of living", in this case criminal behavior, along with other less prominent problems, e.g., somewhat neglected hygiene and an unusual lifestyle, which seem to have been confirmed as such even by the geriatrician.

The referral of Miss D. reflects the negative aspect of the geriatrician's early warning system which, by helping the community to medicalize deviance, tends to foster the use by people of the stereotype of the elderly as senile individuals to explain norm breaking behavior.

This tendency is further evidenced by reviewing the behaviors earlier identified for which elderly people get referred to the team. For example, eight percent (N = 5) of the referral forms cited complaining in one form or another as the reason for referral. In one case, one apartment manager justified referral because he had noticed "a certain paranoid theme" developing in the letters of complaints he was receiving from one of the residents. What is important to notice here is that apartment managers do not as a rule, analyze their letters of complaints to determine whether or not the person writing them is suffering from a paranoid disorder. Yet, this uncommon use of psychiatric jargon is indicative of how lay people who have been approached by the geriatrician have become sensitized to the psychiatry framework of mental illness.

One could expect the Mental Health Team, and more specifically its geriatrician, to be careful as to not
involve in psychiatric care elderly who have been inappropriately referred and that do not present with significant psychopathology as in the previously mentioned case of Miss D. After all, the organization under which the Team operates specifically states in its policy and procedure manual that "as a first priority, [it] provides treatment to seriously mentally ill adults . . ."

However, this is not the case necessarily as the geriatrician also operates under the constraint of the availability of deviance in the elderly referred to the team necessary to justify his position as a specialist. Such a position brings him both status amongst his peers as well as increased salary. Hence, the more mentally ill elderly referred to the Team, the better for him.

However, the supply of truly demented people referable to the Team such as the case of Mr. W. is rather limited. Furthermore, truly demented elderly are not amenable to psychotherapy or rehabilitative psychiatric care because of the usually degenerative organic nature of the illness. Therefore, there is a need for the geriatrician to find other forms of mental illness among the cases referred to him. Most of these as said earlier belong to the category of problems of living not really psychiatric care, a fact even recognized by the geriatrician himself (as in the case of Miss D.). But what if there is a means of transforming these problems of living into clinically valid mental
illness? This is where medicalization of deviance operates at its best.

To illustrate this point, let us take again the case of Miss D. who was assessed to show no sign of dementia or severe psychopathology. Therefore, how to justify this woman's attending the Team if she is not really mentally ill? Ah but she is . . . Her criminal activity of breaking into cars and rummaging through glove compartments for money can be explained in psychiatric terms. This woman is truly suffering from a psychiatric disorder. Let's hear the geriatrician expand on what Miss D. is suffering from:

G- "Some people [who are depressed], take their worthlessness to the extreme and actually harm themselves . . . Some people punish themselves in less dramatic ways, some people will commit crimes, small things, shoplifting is the most common one, because you're pretty sure you'll be caught. This is the way they find society to punish them in relatively safe ways . . . It occurs all the time when treating someone for depression".

R- "So the case of D. - breaking into cars would be similar to shoplifting in these people?

G- "It could be. We do know she's not after the money and she does not vandalize the car . . . [and] she's got some losses. Her retirement . . . so she lost her job and both of her parents died very suddenly. She also had a sister married into an affluent family and she has a brother who is a bit of an alcoholic who she worries about. There is enough material there to think there would be a depression".

And there you go, the geriatrician reframed Miss D.'s problems into depression and concluded in his assessment that:
There is chronic impairment in her judgement and insight with respect to her constantly entering into parked cars . . . [and] . . . although not clinically depressed, I feel there is a chronic sadness within this woman which would warrant psychotherapy.

As a result, the geriatrician developed a treatment plan in which he "will develop further her history and involve a psychiatrist [and] liaise with probation and the courts regarding her . . . treatment".

And what was Miss D.'s perception of the geriatrician's involvement in her life? [It should be noted here that at this point he had not told her of his assessment, clinical impression, or who he really was - except to say that he would come to see her once in a while] Let's see what she says:

r- Do you know where M. [the geriatrician] works?
D- No, I don't.

r- The place is actually called the Mental Health Team.

D- Well, it seems kind of odd that he would be coming in my direction. You know . . . because there's nothing wrong with my mental health.

r- You don't see yourself as mentally ill?
D- No, I certainly don't [laugh]. I don't think I could go to Main St. and collect three cheques and pay my rent and go out and get groceries and all the rest of it . . . you know . . . and I mean it doesn't sound like there would be anything warped about that.

This excerpt shows that Miss D. does not feel she needs to be involved with the Mental Health Team. However, things turned out differently as the geriatrician started to "liaise" with her probation officer and the courts, making
them aware that Miss D. was effectively in need of mental health care because of her depression, the most likely cause of her deviant behavior. What happens next is a good illustration of the negative consequences for elderly people whose deviance is medicalized by mental health authorities.

Upon the request of Miss D's probation officer, the Mental Health Team was used extensively to ensure that this woman would present herself to court on her charges so she could be sentenced, an event which she had been successfully avoiding before our involvement. I was asked by the probation officer if I would volunteer my time to drive this woman to court, which I did (it also provided me with a wonderful opportunity to interview my "subject" and observe the court procedures). Miss D. received a suspended sentence and the judge specifically requested on her probation order that "under the direction and supervision of a Probation Officer, [you] accept counselling as may be available to you from time to time". The counselling the judge was referring to was the Mental Health Team. He further recommended that if Miss D. breached her probation order, a criminal act which would normally require her to appear in court again and most likely to be sent to jail, she should not be brought in front of him again. This request according to Miss D.'s probation officer stemmed from the judge's belief that this woman "should get [psychiatric] help . . . he felt [so] because of her age and the explanation she gave to the police which was somewhat
irrational". He added that "this is very unusual for a judge to do that. He is very compassionate, very understanding . . . [and] doesn't want to put her in prison."

Hence, Miss D. was mandated by the terms of her probation order to "receive counselling", that is to attend the Mental Health Team for psychiatric treatment despite the fact that this woman was assessed to be suffering from no psychiatric disorder and that previous assessments in 1983, 1986, and 1987 concluded that Miss D. "was not amenable to psychiatric intervention [and], in fact, there was no psycho pathology severe enough to warrant our aggressive interventions". As an aside, a question can be asked about why Miss D's probation order read "accept counselling" rather than the more specific "attend the Mental Health Team", which was what the judge and her probation officer wanted her to do during her probation period. The explanation was given to me by the geriatrician. His organization's policy forbids referrals of client who have been mandated through their probation order to attend a mental health team. The reason behind such policy is that a team's services are voluntary and therefore, clients should not be forced to receive treatment by them.

One way to bypass this policy is to make the terms of a probation order vague enough so as not to mention the need for a client to attend the Mental Health Team, but rather to state a need to receive counselling or therapy. Prior to
Miss D's appearance in court her probation officer and the geriatrician tactically agreed to request the judge not to be specific in dictating the terms of his probation order. The judge complied to such a request as evidenced by the terms of Miss D.'s order, but nevertheless recommended verbally to her that she attend the Mental Health Team. Hence, although she was under no legal obligation to receive psychiatric treatment, she was skillfully given the impression that she had to.

The case of Miss D. illustrates how the geriatrician with the cooperation of other professionals can effectively engage elderly into receiving mental health care seemingly against their wish despite the voluntary nature of the service. This is achieved through skillful manipulation of the information given to them and of the policies and laws governing the services - whether legal or psychiatric - which they come in contact with during their career as deviants. The geriatrician as a representative of the psychiatric profession tends to act as a powerful agent of social control. His strength lies in his ability to transform the elderly's problems of living into mental illness to justify psychiatric intervention 'for their own good.'

However, it is important to locate the geriatrician's actions within the system in which he operates. In doing so, one realizes that as a professional, he responds to constraints similar to those encountered by psychiatrists.
within the larger social context. Interesting parallels can be drawn between those two levels of analysis, which I will explore in greater depth in the next section.

SOCIAL CONTROL AND MEDICALIZATION: THE ROLE OF THE GERIATRIC SPECIALIST REVISITED

Social control and medicalization of deviance are concepts that go hand in hand. Social control can be conceptualized as "the means by which society secures adherence to social norms; specifically, how it minimizes, eliminates, or normalizes deviant behavior" (Conrad, 1981, p. 7). The power of social control comes from the authority the dominant class has to define certain behaviors as norms to which members of society are expected to adhere to. Norm adherence is then monitored and enforced through various institutions such as the justice system or the Church. Individuals who deviate from established norms can be subjected to various forms of control to ensure their return to normative behavior, or if all else fails, their removal from active life within society. Such forms of control can range from a simple parking ticket to a death sentence for example.

Psychiatry is considered here as an institution of social control which serves the interests of the dominant class, while by the same token securing for its members a privileged position within the class order of capitalist
society. Psychiatrists act as agents of social control by transforming deviance into individual problems of pathology, hence effectively isolating it for the social context which contributes to its occurrence in the first place. For example, by defining a troubled elderly as demented and sick, the focus is placed on the problems of one aging person. What is ignored are the social conditions faced by that person: poverty, insufficient income, dangerous working conditions endured earlier in life, and the stigma and isolation resulting from living in a youth oriented society. All of these conditions can be contributors to the problems of living affecting the elderly, and no amount of therapy can change that. What is needed are political interventions to modify the political order perpetuating these conditions.

However, psychiatrists do not make money by doing radical politics. Rather, their income is dependent on fee-for-service refunds through a third party, usually private insurance schemes like in the United States, or state funded insurance, like in Canada. Psychiatrists are in fact private entrepreneurs who function under the constraints of a capitalist economy where increased income depends on increased growth. Simply put, the more services rendered, the more fee refunds collected. This not only creates an incentive to provide more services, but also to expand these services to new markets by devising new categories of illnesses needing treatment. For that purpose,
psychiatrists have become agents of social control in a variety of non-medical settings such as the prison system, the armed forces, and the community.

Another means by which medical professionals increase their income is through specialization (Evans, 1984). Specialized treatments such as those offered by psychiatrists command higher fees-for-service and generate greater income, hence further securing their privileged position as members of the upper class.

There is also an inherent drive within the psychiatric profession to assert its status as a valid and rigorously scientific branch of medicine. Psychiatrists are trained as medical doctors and are thereby socialized into the medical perspective in dealing with the mentally disturbed. Recent discoveries in the bio-chemical and genetic origins of mental disorders have fostered renewed enthusiasm for the possibility of finding a medical solution to mental illness. As a result, psychiatrists more than ever are becoming full-fledge partners with other medical specialists to increase their professional status, hence moving further away from the political and social models of mental illness.

Now, let's examine the parallels between the constraints faced by the geriatric specialist (also referred to the geriatrician in text) in the exercise of his functions within the Mental Health Team, and those psychiatrists have to conform to as agents of social control.
First, the geriatrician works in an environment which is bio-medical in its orientation. The society which funds the Team he works for subscribes to the DSM-III-R nomenclature of mental disorders in describing the type of clientèle it delivers services to. Its policy and procedure manual (reference withheld for confidentiality purposes) states that:

3.7 patients accepted for treatment will likely have one of the following primary diagnosis:

- Schizophrenia Disorders
- Paranoids Disorders
- Affective Disorders
- Organic Mental Disorders
- Personality Disorders
- Disorders of Childhood and Adolescence.

The manual further states that the services offered by the Team include "prompt psychiatric assessment and diagnosis; comprehensive treatment including psychiatric diagnosis, medication, and individual and group therapy; and outreach, where appropriate, to patients who have dropped out of treatment or are reluctant to start treatment." Therefore, the geriatrician is expected to function within the psychiatric model of mental illness in his work, and needs to be familiar with the diagnostical categories of the DSM-III-R. Such expectations are further entrenched in Team's everyday functioning as approximately 80 percent of its staff are trained in the psychiatric model either as psychiatrists or psychiatric nurses.
The role of the staff is mainly to assess either alone or with a psychiatrist, a patient's psychiatric disorder, and to determine the needed course of treatment. Treatment interventions are invariably focused on the individual patient requiring assistance rather than looking at the conditions within the community which made such assistance necessary. Description of a worker's role in the policy and procedure manual essentially centers around his or her clinical responsibilities towards patients, hence neglecting any political interventions at a community level. Social change is not part of the Mental Health Team's mandate. Rather, the focus is on 'blaming the victim' for inadequate social conditions, and the role of geriatric specialist is no exception to that.

A question can also be asked as to why the geriatrician decided to specialize in caring for the elderly if, as mentioned earlier, he does not really identify with their struggle as a disadvantaged people. This can be answered by looking at how staff gains power within the Team. The only means for workers to acquire status and increase their income is through specialization, not unlike in the medical profession. Only two specialist position exist within a mental health team, that of Family and Child worker and that of Geriatric Specialist. Either positions are dependent for their implementation on a demonstrated need for such service within a given catchment area. The Team investigated here has only one child and family worker (as opposed to two or
three for other teams) for there does not seem to be a 'need' for psychiatric services for the families and children in its catchment area; whereas it boasts the only geriatric specialist position for all teams because the need for such position was demonstrated by the geriatrician who increased the number of referrals of elderly people through skilful promotion of his services, not unlike psychiatrists creating new categories of mental disorders to expand their market (the geriatrician's promotional efforts were discussed earlier on in this chapter).

There is also a built-in incentive for the geriatrician to perpetuate the flow of referrals of elderly to his Team to ensure a demand for his services. Although not paid on a fee-for-service basis, it is in his interest to continue to show to his superiors how needed his speciality is to avoid his dismissal to the lower rank of non-specialist, and hence lose the prestige and increased income he acquired.

Finally, because of the nature of his specialized services, the geriatrician has come to serve as a agent control in various institutional settings dealing with the elderly, e.g., nursing homes, which have come to expect such function from him, not unlike psychiatrists in prisons or in the armed forces.

Overall then, the geriatrician's actions in creating and expanding a new market on deviance in the elderly should not be viewed as simply those of an individual motivated by greed or power. Rather, they are conforming responses to
the constraints imposed on him and his colleagues by a system which functions within the psychiatric framework, hence shifting the responsibility of inadequate social conditions onto individuals rather than on an unjust social structure benefiting the dominant social class.
CONCLUSION

The nature of deviance essentially lies in the departure of certain types of human behaviour from the normative expectations of a given society at a particular time. Deviance is socially defined and sanctioned as such usually by the dominant members of society in an attempt to preserve a given socio-economic order from which they benefit.

Mental illness is considered a form of deviance because it involves departure from normal rational behaviour. With the growth of the medical sciences, a number of people started to theorize that the mentally ill were not responsible for their behaviour as their deviance was primarily a disease brought on by an organic impairment of the brain. Mental illness became sick behaviour.

The pathological definition of a certain type of deviance into mental illness greatly benefitted psychiatry. By gradually increasing the range of deviant behaviour it could define as illness, and by developing specialized methods to treat it, it started to acquire status and power as a medical speciality. This resulted in financial rewards to psychiatrists and the health care related industries.

However, medicalizing deviance effectively isolates it from its social context and makes it an individual problem. Some authors such as Szasz (1983) go as far as saying that mental illness is a myth which the medical profession has
created to treat a wide range of problems of living stemming from differences in personal needs, opinions, social aspirations, and values between the social classes.

The elderly, because of their lower socio-economic class, tend to experience many problems of living due to their generally poor living conditions, illness, and differing needs and values from the younger population. They also are more likely to be labeled mentally ill by psychiatric entrepreneurs who are seeking to expand their market of deviance.

This study demonstrates how the process of medicalizing deviance in the elderly operates within a community mental health team through the doings of its psychogeriatric specialist. By aggressively promoting mental health services to various professionals and non-professionals working with the elderly, he effectively created a network of amateur diagnosticians trained to recognize and refer deviance to the team.

Much of the deviance referred to the team, however, has more to do with the problems of living outlined by Szasz than with the supposedly organic illnesses psychiatrists treat. Because the geriatric specialist operates under the same constraints as psychiatry for preserving his privileged position within the team, his tendency is also to continue to medicalize these problems to justify their entry into the Mental Health Team.
His approach is very much related to his interest which does not lie in the political realm of the elderly as a disadvantaged people, but rather in clinical realm, with the bio-medical problems this population presents. His aspirations have been at one time to become a psychiatrist.

This approach in a way is representative of the larger dilemma facing the social work profession. Historically, social workers have been activists advocating for improved social and economic conditions for the disadvantaged. There was a sense within the profession that the betterment of the poor, the disabled and the destitute were "rooted in the larger issues of social relation of production, structural inequalities and class privilege, and dominance of profits over human needs" (Olson, 1982, p. 225). This sense still exists but its urgency has been diminished by a gradual shift of the profession towards a clinical specialization, treating the "sick" individual rather than addressing the larger political issues of class inequalities. This shift is evidenced by the growth of social workers involved in a wide range of therapeutic enterprises whether it be of the individual, family's, or group type, in various setting such as hospitals, ministries' offices, and even schools of social work. Interestingly in the latter settings, there is often an irreconcilable division between the teachings related to the problems of individuals versus the teachings of the political struggles faced by the social groups these individuals belong to. Therefore, a student of social work
has to make a choice between becoming clinical specialist or a community worker, as if a therapist could not be a community activist or vice versa.

Therefore, the tendency of social workers (the geriatrician represented himself as a registered social worker) to therapeutize (or medicalize) people's troubles into personal problems is a move towards blaming the victim. What is needed is not more therapy to help the troubled and disadvantaged to conform better to an unjust society. Personal problems have to be relocated into the larger political arena were they belong. Isolating deviance as illness, crime, or disability only serves to perpetuate acceptance of the status quo and the inevitability of class inequality. Radical reforms in the structure of society are needed. These should not be based on the systematic requisites of capitalism, e.g., increase pensions but retain mandatory retirement, but rather on working class and community needs. They involve the mobilization of society's surplus of production to satisfy people's needs and requirements, which would result in a more equitable distribution of wealth, income, and power in society, hence eliminating many of the conditions responsible for deviance.

Such reforms, however, will not be coming from the ruling class and its agents who are benefiting from capitalism. Demands for reform will have to be made based on the requirements not just of specific groups such as the elderly - such demands only serve to perpetuate intergroup
rivalries - but on the needs of the working class (in which the elderly are included). The purpose of such demands would be to reveal the incapacity of the actual capitalist order to serve such needs without creating further repressive measures and categories of deviance (the elderly class being one of them).

According to Olson (1982), what is needed are "unreproductive demands" in the form of policies and programs which tend to destabilize and undermine the basic social relations of capitalism and challenge the underlying profit maximization premises on which capitalism is based. The author adds that destabilizing demands on the system would prepare the way for a dialectical struggle to a higher and higher level where possibly the working class would gain the power and strength to measure themselves against the power of capital and impose their will on it.

The elderly as members of the working class can play a key role in destabilizing the existing order of capitalists as they are possibly the greatest source of "unproductive demands" on the system. There will be a increase in their political power as the size of their population and their level of education increases along with their life expectancy. Already, the elderly have come to exercise influence on local and national government decision-making. If this trend continues to increase, it could well be that the elderly will become a political entity to be reckoned with along with unions and other socialist elements of
society. The rise of the Gray Panthers in the U.S.A. since 1970 is a testimony to the radicalization of the elderly in the past twenty years or so. The Gray Panther Movement has been a prominent critic of the standards of health care for older people and has been organizing confrontations and marches at meetings of the American Medical Association. This group also organized a convention to explore alternatives to compulsory retirement and new approaches to the health care system and politics.

Finally, social workers can play a key role in the mobilization of the working class against the existing social order. They can act as social agents to inform social groups on means of pressuring the government for 'unreproductive programs', while remaining advocates of deviants struggling against the systems put in place to control them. This mobilizing effort however can only work if social work as a profession makes a conscious decision not to be used by the dominant class as an agent of control. Then and only then will social workers as members of the working class be able to politicize deviance rather than contribute to its medicalization.


