Normal/Pathological

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DURKHEIM AND NORMALITY

Normality and pathology are terms which initially might seem better applied to matters of health and illness than to social life. The speciality of pathology within medicine is devoted to seeking out abnormalities (pathologies) of body organs that cause disease. Historically, amongst sociologists Durkheim comes closest to a view of society that parallels this medical perspective on the body. He tended to see the sociologist as a sort of diagnostician of the ills of society, skilled in identifying social pathology (such as an unusually high crime rate) and in recommending restorative treatment for implementation by politicians. Unlike scholars of medicine, though, who tend to see the normal body as a fixed entity, duly described in anatomical textbooks, Durkheim had a surprisingly relativistic[1] view of what constituted normality. Thus he believed that what counted as normal in a particular society might not be normal for another. Nevertheless, Durkheim felt that it was possible to judge what was normal for a given society at a particular point in time by applying an objective knowledge about laws of social development according to which societies could be ranked and categorized.

Durkheim's sociology in this area has been quite extensively criticized (e.g. Giddens 1986). In particular, his view that what was generally the case in a particular 'type' of society (e.g. a particular class of acts are designated as 'crimes') was therefore normal for that society has been said to support a rather conservative approach to normality. Additionally, the view that societies can be ranked and categorized as if they were biological organisms

in some sort of evolutionary family tree is now regarded as rather outdated (Lukes 1973). These criticisms, however, should not obscure Durkheim's contribution, which stems from a desire to explore quite fundamental aspects of social organization. In particular, Durkheim was interested in the basis of social solidarity, the desire of people to feel bound together in a common enterprise, seeing this as the source of moral and social order. For Durkheim, pathological social forms involved the loosening of such solidarity. In such circumstances, individuals in increasing numbers feel detached from social norms, which are the moral rules that regulate conduct and promote a sense of solidarity, this in turn leading to a general increase in anomie, of feeling outside society. This is the root of Durkheim's interest in suicide as an indicator of social breakdown, and in religion as a moral and integrative force.

Any discussion of normality and pathology as sociological concepts must locate itself in relation to this Durkheimian vision, and acknowledge the linkage of the concepts to ideas about social solidarity and **membership**. As in Durkheim, this chapter will seek to understand the idea of normality in terms of the forces that bind people together, that drive them to seek membership in each other's society. Pathology, conversely, will be understood as the forces that divide people from each other. In contrast to Durkheim, however, the chapter will focus on the active construction of normality, using examples from medicine in particular. The power to define what counts as 'normal', and the role of statistical thinking in the **social construction** of normality, will be addressed. The chapter will also explore the consequences of living in a late modern age where the rules that govern what is to be counted as normal are widely discussed and debated. Before considering these matters, however, we will explore the roots of the desire to be normal.

MEMBERSHIP: WANTING TO BE NORMAL

Human social life, the capacity to communicate with language, to pass understandings between people, even to recognize each other as people rather than some other class of being, depends on our capacity for a basic sense of trust. The development of trust begins in early childhood. The baby must trust that the parent will return when he or she leaves the room, and sometimes experiences difficulty in this. A basic sense of optimism about continuing in life depends on a perception that there is an order and a meaning to life, in which the person has a secure place. Giddens has described these first stages in the formulation of self-identity as 'a sort of emotional inoculation against existential anxieties – a protection against future threats and dangers which allows the individual to sustain hope and courage in the face of whatever debilitating circumstances she or he might

later confront' (1991: 39). Thus an orientation towards life rests on what Giddens (deriving the term from psychoanalysis) calls 'ontological security' – a security about being in the world. Durkheim's concept of anomie (as well as his concept of egoism) can be opposed to this, representing the breakdown of ontological security as a sense of aimlessness overwhelms the individual. Significantly, this points the individual towards death, and Durkheim (1897) documents 'anomic' suicide as the consequence of such a dissolution.

In other parts of his work, Durkheim (1912) was concerned to show how religious ritual helps social groups to defend against disintegration and promote solidarity. Religious rituals in their original ('elementary') forms were not simply matters of affirming belief, but were occasions for the generation of emotional energy. In such rituals sacred objects or symbols ('totems') are invested with the values of the community involved. Such rituals are of particular importance at times of major transformation such as birth, puberty, marriage and death, as is shown in the chapter 'Life/Death'. The Durkheimian anthropologist Van Gennep (1909) made a special study of these, calling them 'rites of passage' to indicate their capacity to generate new social identities for individuals involved. In Giddens's terms, one might understand such occasions as generating optimism by reinforcing the ontological security of members.

Later sociologists have extended the Durkheimian interest in the major ceremonies of traditional social groups to an analysis of the small-scale interactions of everyday life. Thus for Goffman (1967) ritual permeates daily social life, indicating, for example, status divisions by words and body movements that convey deference, or demonstrate membership of particular groups by styles of dress, manners or displays of 'right' attitudes. Garfinkel (1963) has exposed the precarious nature of the agreements on which everyday social interaction is based in a series of 'experiments' designed to disrupt expectations. Thus, he reports the following interaction:

> *S*: [*waving his hand cheerily*] How are you?
> *E*: How am I in regard to what? My health, my finance, my school work, my peace of mind, my . . .
> *S*: [*red in the face and suddenly out of control*] Look! I was just trying to be polite. Frankly, I don't give a damn how you are.
>
> (adapted from Garfinkel 1963: 222)

The second speaker (E) disrupts the ritualized greeting that is expected by the first speaker (S) by contradicting taken-for-granted assumptions about normal behaviour. Norms of conduct guard against such 'misunderstandings' by indicating agreed definitions about the meaning of particular actions or forms of words. By demonstrating their understanding of such

'agreements' people indicate their membership in the social group amongst whom such agreements are current.

The sociology of Talcott Parsons (1951) tends to depict social norms as static, independent entities, commanding widespread consensus and exerting a constraining influence on the individual, being rules to which people either subscribe or do not. This is inappropriate for understanding late modern social conditions, where self-identity is actively constructed through the strategic selection of a multitude of available memberships. For example, disavowing a norm can be a means of asserting membership elsewhere, as in the following interaction, where an adolescent responding to a parent's question conducts a Garfinkel-like experiment to reject the norms of family membership in favour of an alternative identity:

P: Where are you going?
A: Out.
P: What are you going to do?
A: Nothing.

(adapted from Giddens 1989: 96)

However, broadly speaking everyday social interaction can be seen as a continual negotiation of membership through interaction ritual, routinely contributing to the ontological security of members who thereby reinforce their own and others' agreement to continue in the enterprise of normal social life.

PATHOLOGY AND SOCIAL EXCLUSION

Because of the capacity of sociology to expose what lies behind everyday social consensus, and to make explicit the rules which normally bind people together, it has tended to attract individuals who are particularly interested in exploring marginal situations. Studying people who stand outside the group, who challenge the norms held by the majority, or who are strangers, is attractive to the individual sociologist who may identify aspects of his or her own biography with that of the marginalized (e.g. Becker 1963). The study of people who break or do not know rules can provide moments of particular analytic insight (e.g. Schutz 1964b). Making what is 'normal' seem strange is a fundamental methodological orientation in sociology and anthropology, and has led at times to quite extreme positions about the nature of knowledge and morality, implying the impossibility of sustaining universal standards of truth or goodness.[2]

The variability of norms is demonstrated in the development of 'manners', documented by the historical sociologist Norbert Elias (1939),

whose investigation of this apparently minor aspect of social life has revealed that the standards expected at the dinner tables of modern society are historically and culturally specific, suggesting a raising in the threshold of shame and disgust over a period of centuries. This is shown in a series of quotations from European books on manners, presented with dates of authorship:

1558 It does not befit a modest, honourable man to prepare to relieve nature in the presence of other people. . . Similarly, he will not wash his hands on returning to decent society from private places, as the reason for his washing will arouse disagreeable thoughts in people.

1560 It is a far too dirty thing for a child to offer others something he has gnawed, or something he disdains to eat himself, unless it be to his servant . . . he must not lift the meat to his mouth now with one hand and now with the other . . . he should always do so with his right hand, taking the bread or meat decently with three fingers only.

1672 If everyone is eating from the same dish, you should take care not to put your hand in it before those of higher rank do so.

1714 Wherever you spit, you should put your foot on the saliva . . . At the houses of the great, one spits into one's handkerchief. (from books on manners, quoted in Elias 1939: 107, 74, 75, 127)

All of these describe behaviour that today would be considered abnormal, marking out a person as socially inferior, blameworthy and in need of correction. Yet they were taken from books that were trying to show their readers the standards of behaviour necessary to gain entry to the highest social circles, showing that norms considered acceptable in one society are not necessarily appropriate in another.

The existence of books on manners also reveals that norms can become matters for debate and reflection, and their manipulation can become a part of an individual's strategy for seeking social advantage. Thus the social climber seeks to learn the behaviour considered appropriate in the group to which he or she aspires, and the snob specializes in identifying the marks of bad behaviour that reveal inferior social origins. **Stigma**, the deliberate marking of an individual as offensive, inferior and blameworthy, is a type of inflicted social pain. It is commonly used by individuals to affirm their own membership of a desired group and thus sustain their own ontological security. As described in the chapter 'Life/Death', the application of stigma can be understood as a minor rehearsal for killing, part of a victorious affirmation of survival which depends on the identification of an enemy who carries the burden of death on behalf of the 'normal' person.

Stigma is therefore a strategy of power, and its workings have been described in detail by Erving Goffman (1968). The stigmatized individual may be chosen on the basis of blemishes of the body (e.g. leprosy), of

character or of behaviour (e.g. alcoholism), or some tribal stigma may be gained by virtue of belonging to some disfavoured social group (e.g. Jews). The stigma applied to people with AIDS is unusual in combining all three of these: the physical appearance of illness, allegations of promiscuity, and membership of what doctors call the 'risk' groups for AIDS: homosexuals, drug users and prostitutes, who are already stigmatized. A 'master status' or 'label' is bestowed upon the person thus stigmatized, which 'spoils' all other aspects of identity. Once known, the label confirms that all aspects of the person's behaviour can be understood as being due to this new identity. Thus if people with mental illness become angry it is understood as a sign of their illness rather than being due to some other cause (Rosenhan 1973). A variety of subterfuges may be engaged in by individuals with stigmatized conditions, involving passing as normal, covering up stigmas, controlling information and, ultimately, seeking consolation and companionship in subcultures of others (one's 'own') with the same condition (e.g. the leper colony, the self-help group).

TOLERANCE

In late modern social conditions, however, tolerance is a widespread social value. The unpleasant effects of stigma are widely recognized and stigma champions (whom Goffman 1968 called the 'wise') rapidly arise to combat the marginalization of the stigmatized. Tribal sentiments are generally condemned as primitive, and laws to promote social harmony and inclusion (e.g. race relations law, equal opportunities) command general support. Softer social labels have emerged to describe categories of person previously referred to by words such as 'blind', 'deaf', 'feeble minded', 'retarded', 'mad', 'cripples', 'idiots' or 'bastards'. Once considered acceptable, these labels now too nakedly convey connotations of inferiority. As a further example, the case of AIDS is again illustrative. The homophobic sentiment generated by newspaper headlines (e.g. 'the gay plague') has attracted official opprobrium, and the medical profession and government have united to propose a more 'tolerant' view, that will not 'drive it underground'.[3]

In these circumstances people have difficulty in finding safe enemies to hate. One or two still surface from time to time (e.g. child abusers), and particular efforts may be devoted to stigmatizing the intolerant (e.g. racists), but the individual in late modern society is constantly confronted with potential enemies whose basic humanity threatens to surface and generate feelings of sympathy. If this does not happen straight away, supporters and explainers will emerge, suggesting psychological motives for bad behaviour that induce the listener to see things from the other's point of view. The political debates about criminality reflect this basic tension: is the criminal

bad and therefore worthy of punishment, or is the criminal motive understandable in the circumstances, the product of nurture rather than nature, and the criminal therefore deserving of rehabilitation, inclusion and a renewal of social membership amongst the 'normals'?

The historical growth in empathy (the capacity to see things from others' point of view) in European societies has been described by Norbert Elias (1939) as a part of a great 'civilizing process'. Associated with the monopolization of the means to violence by central authorities, firstly by powerful kings, then by democratically elected states, disputes between individuals have gradually come to be settled by means of words rather than resort to violent assaults. The means to power for the medieval knight depended on bodily strength and his readiness to use martial skills to physically subdue enemies. With the development of courtly society (which depended on regal powers to inhibit such violent behaviour), manners, artifice, strategy, calculation and manipulation came to govern individuals' relations with each other. Whereas the traditional individual led the life of a warrior, the modern person came to lead the life of a diplomat, carefully negotiating a myriad of complex norms, weaving in and out of different groups, strategically claiming membership according to taste, lifestyle or personal advantage. This way of life requires finely tuned social skills, and the stress of failure in this complex enterprise has become the subject of psychological expertise. Stress, in fact, has become a catchword of our times, seen as causing all manner of modern ailments, and standing as a metaphor for the difficulties of modern living.

The path of the **deviant**, however, is not always one that is conferred or adopted by human agency. People are sometimes marginalized through no actively applied stigma, nor through more or less conscious decisions to break rules, but by virtue of the deterioration of their bodies. The problem of embodiment has only recently become a topic of major sociological concern (e.g. Turner 1984; 1992), but it provides an additional insight into the nature of pathological social identity, exclusion and inclusion.

PAIN AND THE UNMAKING OF THE WORLD

Phenomenological sociology aims to explore the way in which human consciousness constructs meaning from an otherwise undifferentiated, chaotic stream of experience (Berger and Luckmann 1966). Berger (1969), for example, describes how individuals use religion to construct worlds of meaning. Making a world of meaning contrasts with the 'unmaking' effect of certain illnesses, which threaten the individual with a resurgence of chaos and the destruction of meaning. Illness, in fact, can be understood as a sort of Garfinkel-like 'experiment' with shared meanings, threatening to disrupt these and force the individual to reassess his or her relationships

with others. Examples of this can be found by studying people with chronic pains.

Chronic pain differs from the normal pain of which we all have experience in that it does not cease once tissue damage has healed, and no obvious physical cause can be found. It commonly attracts labels such as 'low back pain' or 'chronic pain syndrome' which are residual categories used by medicine in which to place problems that are ill understood and for which there is no evident remedy. The lack of an established medical cause can be profoundly disturbing, as is demonstrated in the words of some sufferers:

> When my leg went numb in March of '77, then . . . it really hit me. I almost flipped out, in a sense, because I knew that there it was again, and it would be like a sore tooth. It would never go away. That's when it really threw me in an emotional turmoil – [a] crisis. (Hilbert 1984: 367)

> I honestly don't know what it is. And *that's* pretty frustrating a lot of times. Just the fact that *I* don't know what it is, you know. I've been frustrated with that. Well, what *is* this goddamn thing? Why do I *have* these headaches? (1984: 368)

This experience gives people the feeling that they are experiencing their bodies incorrectly. When others begin to find the chronic nature of the pain puzzling this can lead to a degree of intolerance that is akin to stigma. Constant unexplained pain produces feelings of isolation and difference from others who inhabit a more normal world. Here are the words of another person with chronic pain:

> Sometimes, if I had to visualize it, it would seem as though there there's a ah . . . a demon, a monster, something very . . . horrible lurking around banging the insides of my body, ripping it apart. And ah, I'm containing it, or I'm trying to contain it, so that no one else can see it, so that no one else can be disturbed by it. Because it's scaring the daylights out of me, and I'd assume that . . . gee, if anybody had to, had to look at this, that . . . they'd avoid me like the plague. So I redouble my efforts to . . . say . . . I'm gonna be perfectly contained about this whole thing. And maybe the less I do, the less I make myself known, and the less I . . . venture out . . . or display any, any initiative, then I won't let the, this junk out. It seems like there's something very, very terrible happening. I have no control over it. (Good 1994: 121–2)

Hilbert, a sociologist who has studied people with chronic pains, has described their experience as 'continuously approaching the amorphous frontier of non-membership . . . They are falling out of culture' (1984: 375). These troubles represent an extreme end of our experience of embodiment. For the most part we possess adequate 'explanations' for physical pains, these being powerfully underwritten by scientific narratives. In fact, the

institutionalized narratives provided by medicine are actively sought out and appropriated in the world-making activities of individuals concerned to discover a meaning to the experience of bodily suffering. Medical narratives in modern society have in general taken the place of religious narratives in explaining the problem of human suffering, and in sustaining the hopes of the suffering individual to claim membership and assert normality. Medical treatment – whether technically successful or not – can be understood as a ritual of inclusion, proceeding by documenting the varieties of the pathological so that concepts of normal illnesses can be sustained, generating new membership categories for people's use. Medicine is therefore a key institution for defining normality and for distinguishing and containing pathological conditions. Its power to define what counts as normality means that it is implicated in strategies of power.

GOVERNING NORMALITY

It will be clear now that the achievement of membership by espousing normality is a basic feature of social life. It is threatened by actively applied stigma or, as in the section above, by illness. It is also the case that what counts as normal is socially constructed, and that different versions of normality are actively appropriated into individual projects of self-identity. Sustaining particular definitions of what is normal, and the gathering (or coercing) of people's allegiance to one's definition, is an aspect of power. People can be encouraged to participate in a disturbing range of behaviour on the grounds that this is 'normal'. Thus the Nazi bureaucrats who organized transportations to concentration camps were 'normal' citizens with 'normal' families and lives, doing a 'normal' job (Bauman 1989).

The very word 'normal' is itself used strategically to gain power. Ian Hacking has made a particular study of the statistical construction of normality as it has been applied to social life, commenting that: 'the benign and sterile-sounding word "normal" has become one of the most powerful ideological tools of the twentieth century' (1990: 169). He points out the role that numbers and statistics have played in regulating European populations since the early nineteenth century. Counting aspects of social life, particularly those which threatened social order, such as suicide, crime, vagrancy, madness, prostitution and disease, became very widespread, and was carried out by government agencies (as indeed it still is today). This led to a particular style of reasoning based on statistical probabilities, so that the likelihood of crime, the risk of suicide, the potential for madness, were all subject to rational calculation, representing a taming of chance and a gain in control and predictability. These became deeply embedded in the mentality of government, and increasingly entered the thinking of citizens.

Auguste Comte (1798–1857), who coined the term 'sociology', derived his

inspiration from an emerging medical view of the body and disease. His 'positive philosophy' portrayed society as an organism continually aspiring to a state of normality. Coupled with emerging statistical ideas about normality, this type of thinking came to be associated with a view of pathological states as progressive deviations from the norm, which was itself often defined in terms of statistical averages. The word 'normality' increasingly came to conflate what *is* the case with what *ought* to be (a linking of fact and value). Thus the average life, defined as an absence of pathology, was increasingly seen as desirable, and sociology in its origins was implicated in promoting these conservative ideals. Indeed, Durkheim played a part in this progression of ideas.

SOVEREIGN POWER AND DISCIPLINARY SURVEILLANCE

In conjunction with the rise in statistical definitions of the normal was a shift in the manner in which power was exercised. This has been described by the French social theorist Michel Foucault, who distinguishes between two forms of power: *sovereign* and *disciplinary*. Sovereign power was characteristic of the sixteenth- and seventeenth-century rule of European kings. Under this regime, power depended on physical coercion and public punishment for wrongdoing. Ceremonies of punishment and retribution, such as public executions, demonstrated to the population at large that criminal acts were understood as an assault upon the authority of the king, and were duly punished by exacting revenge upon the body of the criminal. For the witnesses of public executions, the criminal was thereby defined as the other, placed outside humanity, devoid of the rights of membership as an example of pathology. Public executions strengthened the allegiance of the population to the king (who was also a god) by providing a safe enemy to stigmatize and kill.

In various ways this type of regal authority had declined in European countries by the nineteenth century (the French cut off the head of their king), and was replaced by a new form of disciplinary power. This operated by constructing and promoting, with the aid of statistical information, particular definitions of normality. From being coerced to follow the will of the king, citizens learned to survey themselves as bearers of normality. Foucault illustrated this by referring to the panopticon (meaning 'all-seeing'), Jeremy Bentham's design for a prison which symbolized the new form of power. The design of this prison is such that the guard in a central tower can observe the inmates' actions without being seen by the prisoners themselves. The prisoners, then, survey nothing but their own selves, thereby becoming their own jailors. Foucault is particularly critical of people advocating 'humane' penal regimes. In relation to the supposed liberation of the insane from their chains in Parisian asylums in the

eighteenth century, for example, he argues that these substitute for what he calls the 'free terror of madness, the stifling anguish of responsibility' (Foucault 1967, reprinted in Rabinow 1984: 145). Self-surveillance involves the internalization of standards of normality, so that under disciplinary power people constantly monitor themselves for signs of pathology. Thus people draw upon a widespread knowledge of what it is to be sane, healthy and good, and of their opposites, madness, disease and criminality. The role of psychology in promoting particular versions of mental hygiene, and a particular view of the good life, has been documented extensively by Rose (1989). A particular technique of disciplinary power is the confession, whereby people admit to bad (or 'unhealthy') behaviour, thus speaking themselves into a discourse about what it is to be normal. Rose regards psychotherapy as a form of such confession.

While definitions of normality are clearly implicated in strategies of power, the accounts provided by Foucault and his followers often lack analysis of how particular definitions further the interests of particular social groups (beyond some vaguely defined 'government'). Power appears to be diffused so widely, and constructed so readily in discourses that often appear to come from nowhere, that the term loses its capacity for indicating a technique for gaining social and material advantage over others. Indeed, in recent formulations, disciplinary power is equated with the creative expression of novel forms of selfhood.

THE ROLE OF MEDICINE

It was shown earlier that medical analogies have influenced the development of ideas of normality in sociologists such as Durkheim and Comte. Foucault (1967; 1976), too, pays particular attention to the role of medicine in defining what it is to be normal. As a social institution, medicine can be seen as having taken over from religion in a process of secularization, becoming increasingly influential in defining the good life (Turner 1987). Doctors play an important part in policing social pathology.

This was first described by Parsons (1951) in his account of the 'sick role'. Basically, doctors are entrusted with distinguishing malingerers from the 'truly' sick, acting as gatekeepers to legitimate entry to the socially accepted sick role, which itself contains certain rights and responsibilities (for example, to try to get better). It was shown earlier that the experience of pain can be experienced as a fall out of membership. Doctors, in a sense, 'catch' the falling individual by providing legitimating labels for the sick which satisfactorily explain their condition in the eyes of others – justifying, for example, failure to carry out 'normal' activities such as going to work. The problem for some individuals with chronic pains is that some doctors believe them to be malingerers, so that not only do they face the existential

terrors of a body beyond their understanding or control, they may also experience stigma.

Parsons presented an analysis that was basically supportive of doctors, assuming a consensus about their altruistic motives. Subsequent critics (e.g. Freidson 1970; Navarro 1976) have noted that medical definitions of normality – the criteria by which doctors police the sick role – are often distorted by professional interests and by the state using the medical profession to promote its interests against those of patients. Thus doctors may be more likely to admit for treatment an 'interesting' case that is likely to result in a satisfying cure, and less likely to admit a person who is incurable or otherwise troublesome. The state may try to exert a particular influence to restrain doctors from signing too many sickness notes to allow people to avoid work or claim benefits.

More broadly, medical knowledge and practice play a part in categorizing, ordering and containing a variety of pathologies – in other words, constructing them. The application of Foucauldian ideas suggests that medicine plays an important part in making available to people ways of thinking about pathology. Foucault paid particular attention to the role of hospitals and asylums in dividing different categories of deviance, and in constructing statistical definitions of normality. Thus the distinction between mental and physical illness, and the distinction of madness from badness (criminality), only emerged gradually, and under medical supervision. Surveys of institutions of confinement existing previous to these divisions revealed how thoroughly mixed these categories once were:

> In 1690 a survey of 3000 internees at Salpêtrière . . . revealed that the majority of them were paupers, vagabonds and beggars, while the rest were, in the terminology of the survey, 'ordinary folk', 'prisoners of *lettres de cachet*', 'decrepit women', 'infirm and dotty old women', 'epileptics', 'innocent dwarfs and deformed', 'feeble minded', 'violent mad', and 'incorrigible girls'. Almost a century later, in 1781 . . . in a Berlin workhouse 'idlers', 'rogues and libertines', 'infirm and criminals', and 'destitute old women and children' all mixed together. (Cousins and Hussain 1984: 110)

Diagnosis, as a 'dividing practice', represents the application of medical categories which are now used to separate classes of the people described above. The advantage of the Parisian hospital system, Foucault (1976) argues, lay in the fact that large numbers of relatively powerless patients were congregated in one place. Doctors could therefore begin to see their patients as 'cases' or 'numbers', carriers of diseases rather than unique individuals with unique diseases. Disease was therefore separated from the patient, studied, ordered and categorized in its own right, exhibiting characteristics that were separate from the biography of individual patients. Statistical norms concerning the frequency of disease and its appearance in the body could then be constructed.

This style of thinking helped to make people's behaviour (their disease) into a thing, with a rule-governed life of its own, that people 'caught' (as in infectious diseases) or fell into (as in categories of madness). In the field of mental illness, many categories used in the past have come to be regarded as ideological constructions of pathology, serving the interests of social control. Thus there is an extensive critique of the diagnosis of hysteria as a device constructed by a patriarchal medical profession to pathologize and thus control women rebelling against the restrictive Victorian norms governing appropriate female conduct (summarized in James 1994).

CONCLUSION

In this chapter it has been argued that the desire to be normal, and to exclude and stigmatize the abnormal or pathological, is linked to the desire for membership and security that is a basic motive for participation in social life. Durkheim's sociology is centrally preoccupied with issues of social solidarity and social order, but is itself somewhat normative in spite of its analytic strengths. Thus Durkheim paid scant attention to the role of power in the social construction and manipulation of standards of normality. Durkheim himself adopted a statistical definition of normality as the average, a perspective that must be seen in the context of his own times.

Defining normality and pathology, and the widespread diffusion of such definitions, so that people come to judge themselves according to such definitions, is an important feature of disciplinary power, often exercised on behalf of professions or by the state. Sociology possesses the capacity to reflect upon these strategies of power, and the chapter has sought to provide the outlines of sociological perspectives on medical definitions of normality. This should not obscure the fact that other institutions (e.g. law, religion, the penal system, armies, schools) can also be analysed in this way.

KEY CONCEPTS

NORMAL Normal phenomena in social life are usually the most stable and enduring ones, things that last the longest and provide most continuity – this does not mean that they are necessarily 'good'. Attitudes that last can be racist, sexist and prejudicial but their endurance can make them seem normal.

PATHOLOGICAL Pathological phenomena in society are usually the most fleeting or transitory. This does not mean that they are sick or injured but that

they do not have a lasting impact on the social structure. Thus their pathology stems from their instability.

Membership Sociologists use membership to imply belonging to a society, group or culture. That belonging means that the member will be conscious of all of the rules and expectations that hold that group together as that group. Membership therefore indicates that becoming a member requires social learning and not just a natural development.

Social constructionism This is a fairly recent form of social theory which derives from phenomenology. It suggests that social phenomena are made up according to the times and places in which they occur thus their meaning has to derive from their social context. So, for example, there has always been child abuse, for what reasons are we so concerned with it at the current time?

Stigma This concept came into sociology through the work of Erving Goffman. He produced the thesis that some people suffer from spoiled personalities because of disabilities, special needs, malformations or incapacities which they carry with them as if they were bearing a 'stigma'. A stigma, then, is anything that impedes the full integration of the self into the collectivity.

Deviance This is a way of talking about behaviour that breaks normal rules. In societies rules breakers are usually punished and thus the normal features of a society are upheld. Deviants are not, however, a constant group, as you move through history in our own society you will find that actions once regarded as crimes are no longer thought of as such e.g. homosexuality, and as we move across societies you will find variance in their definitions of what counts as deviant e.g. use of marijuana.

Surveillance This is a concept that has come into social theory through the works of Michel Foucault. It means that power operates in a modern society through the strategies we have developed for watching each others performance and also the socio-psychological ways in which we have come to watch ourselves through guilt and shame.

NOTES

1 See the chapter 'Relativism/Absolutism' for a definition.
2 This is the position of relativism, discussed in the chapter 'Relativism/Absolutism'.
3 Durkheim would have understood these exhortations to altruism as an appropriate balance to the excessive egoism found in late modern society.