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Jennifer Leigh Harrison
A Discontinuous Space: Postmodern
Perspectives on Mental Health Discourse

ABSTRACT

Language in the mental health field is rich with powerful metaphors, hyperbolic phrases, and linguistic symbols of historical, political and social meaning. At a closer look, a dominant discourse rooted deep in the grounds of empirical science is revealed. In this theoretical study, mental health language is deconstructed using Critical Discourse Analysis and other related theories to locate and analyze a dominant discourse, which opens space for a non-dominant discourse. Postmodern theory assumes that power, entangled with and interdependent on powerlessness, is an absolute phenomenon, and that power abuse can be revealed through the study of a discourse itself. The purpose of this thesis is to locate the way power in a dominate discourse is practiced and spoken in common, everyday mental health language, in order to connect this power to an 'Other' discourse whose ideology and voice is marginalized. Although there are numerous alternative discourses, one that is gaining recognition and posing hard challenges toward the dominate discourse is the Recovery discourse, a language that speaks clearly about this place of discontinuity and oppression. As all people are subject to and participants of the dominant discourse (to one degree or another), this investigation aims to focus on how social workers participate in the dominant discourse and investigates the role of consciousness regarding power and oppression in therapeutic settings, posing questions about the role and place of social workers, regarding language use in the mental health field.

A DISCONTINUOUS SPACE: POSTMODERN PERSPECTIVES
ON MENTAL HEALTH DISCOURSE

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements for the
degree of Master of Social Work.

Jennifer Leigh Harrison

Smith College School for Social Work
Northampton, Massachusetts 01063

2009

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Thank you to Fred Newdom for his contagious passion for social justice, and for bringing me joy, laughter, and hope to all my Smith summers with his constant support and presence. Thank you to my parents for their continuous loving support. Thank you to Andy, Sarah, and Shawn for believing in this discontinuous space...

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CHAPTER I

INTRODUCTION

Words are not neutral (Fiske, 1994) linguistic forms of free floating thought, rather words are reflective of and agents to the historical, social and political practices of our time. Words are not arbitrary (Sheyholislami, 2001), but vehicles to that which we construct, and hold close, in our world of meaning. Words can locate ideologies and practices in a particular time and words can shift the ideologies of that time. Acting as powerful agents of therapeutic passage as well as representations of harm, words have the ability to claim as well as dislocate truth. Foucault describes his playful reaction to reading Borges' unfamiliar divisions of animals, a moment when he realizes that the familiar order of words has been abandoned:

. . .the laughter that shattered as I read the passage, all the familiar landmarks of my thought—*our* thought . . . breaking up all the ordered surface and all the planes with which we are accustomed to . . . where could they ever meet except in the immaterial sound of the voice pronouncing their enumeration, or on the page transcribing it? Where else could they be juxtaposed except in the non-place of language? (Foucault, 1973, p. xv-xvii)

In using words, one has the power to create another reality, another understanding that may be unfamiliar. For it is in the non-place of words where text and verbal speech bring forth a collection of ideas of which the psyche translates and impresses itself upon. In this way, words create a continuity of understanding as much as words can create a discontinuity of understanding—a discontinuous space, perhaps of hidden meaning, of silence, of another interpretation—a space that challenges or debunks what is familiar or certain in a dominant discourse. Words can elicit cognitive dissonance or go so far as to

fracture thought in a way that creates disengagement or dissociation from that thought. Words, local to a place and time, hold power—a power which can be strengthened or weakened by mere repetition, representation, and distribution of those words.

Discourse is used to discuss, interpret, understand, categorize, reference, treat, document, and educate within that field of knowledge. Language produces thought, truth, and meaning, but also has the ability to suppress each of these in a way that is justified and agreeable to a given community. Concomitantly, language becomes a product of what is intended as well as a functional part of intent. We are conditioned to see things in a particular way through language. Speaking outside the dominant discourse (as Borjes demonstrates) of which one has been conditioned may create awkwardness, rejection, liberation or an inability to hear or grasp the meaning of one's words. For example, it is unlikely a social worker would refer to a client, in the middle of a clinical meeting as a "lunatic". "Lunatic", once agreeable to the ears of mental health professionals at large, is now, decidedly, offensive and arcane, or at the very least, not clinical.

Around the 19th century, leading up to the mental health field as a burgeoning science in its own right, the word "lunatic" was a scientific word used to reference what we now call "people labeled with psychiatric disabilities", "people with mental illness", or not long ago, and still common in many settings (such as the clinical social work setting), despite many marginalized groups speaking out against being called such things—"mentally ill persons". The word "lunatic" has been used synonymously with other terms like "crazy", "psycho", "loon", and "sicko". Now a derogation to its modern counterpart, "lunatic" was once a well-accepted, well-documented term used by professionals and public lay persons alike.

Taken from the root word “lunar”, “insanity” was understood to be a result of being born under a full moon, or of being an infant who slept under the light of a full moon. “Lunatics” were considered to be possessed by the devil. As a result, many procedures were instituted to help these individuals, by driving out the demonic forces in the body employing “medical treatments”. Ice baths were used, in which the individual was submerged until loss of consciousness occurred. Doctors performed “bleeding practices”, drawing the “bad blood” out of the body which often resulted in death. Other medical treatments included massive brain shock, long periods of seclusion within cement celled walls where persons were often shackled and bound. These “treatments”, only the beginning of mental health practices, would soon be followed by other procedures such as lobotomies, segregation into “insane asylums”, genital mutilation, and other often fatal or permanently disabling “medical treatments”. This history of mental health practice and the treatment of persons with psychiatric disabilities can be located historically in the common words of that time.

The word “lunatic” is demonstrative of a social position as well as a political response to madness. Given that “lunatics” were not considered to be an adequate, or even acceptable, part of the work force (or society for that matter), the word also harbored economic meaning. Porter (1987) describes this phenomenon, emphasizing the role mainstream society had on ‘othering’ those with psychiatric experiences: “The sequestration of lunatics was primarily an expression of civil policy, more an initiative from magistrates, philanthropists and families than an achievement – for good or ill – of the doctors” (p. 89). Porter explains that it was the request of common people that “lunatics” be dealt with and separated from society. In this way, an early peek at some

of the power dynamics in the discourse is revealed—in this instance, the influence of power is located in a public majority that requested separation from “lunatics”, perceiving them to be a flaw to the greater society. And with this discursive distance, it became acceptable to physically and mentally harm people who were given the label “lunatic”.

There were other words used in mental health that have separated people due to differences that were decidedly not agreeable to society. Homosexuality was considered a disease, and a dominant discourse agreed that treatment for those who identified and came forth was necessary. “Gender identity disorder” remains a much disputed category of ‘othering’. Going further back into history, other labels were used to promote political and social biases of race, gender, sex and even political choice. “Drapetomania” was a label given to African American slaves who escaped their slave masters, as it was considered a “mental illness” to desire freedom from slavery. During the location of place and time that this word was used, many deeply believed that slaves were “sick” or genuinely “disordered” for not wanting to follow the oppressive rules of a dominant discourse. In this way, many words have been used to control and harm, as these words have become familiar, and seemingly continuous and concrete in the dominant discourse. What was discontinuous (slavery is immoral, unethical, cruel, horrendous, etc.) eventually entered into the dominant discourse, through the language of a non-dominant discourse, such as that of Martin Luther King, Jr.

Words, and language as an active system, have a fundamental part in how we understand and connect to one another—which is perhaps why the words we use in mental health are constantly changing as our understanding of humanity changes. People

with psychiatric disabilities are no longer seen as demonic, it is no longer ethical to experiment on humans—at least not using arbitrary surgical procedures on the anatomical brain (though one might argue the pharmaceutical industry has taken experimentation to a whole other level). Nor is it socially acceptable to be overtly racist in the public sphere. However, in the mental health field, people who identify as a gender that does not match their biologically-identified sex are seen as “disordered” and “abnormal”. There are over two hundred ways that one can be seen as “abnormal” in society today, and despite efforts to narrow clinical diagnostics from which we reach, the numbers continue multiplying, making it likely that anyone who enters the mental health system to be assessed will fit into some diagnostic category and return home with some label. Though most people who have a psychiatric label are not institutionalized, many are segregated from greater society, and many are discriminated against at all levels of social participation.

Questioning the Importance of Language: What this means to social work

Martin Luther King, Jr. once said “In the end, we will not remember the words of our enemies, but the silence of our friends” (King, 1968). In the field of clinical social work, where social workers act as advocates for and clinicians to those seeking services for mental health problems, our place of understanding the collective trauma of those entering our services becomes a necessary part of the social work mission. However necessary, it is questionable how often clinicians take into account this collective identity as it impacts those seeking services. Regardless, our choice of words as much as our adherence to the dominant system of words (the dominant discourse or hegemony) acts as an expression of our own historical, social, and political position in the mental health

field. In other words, what we say and how we say it expresses our identity and our belief system, as well as our symbolic representation in the mental health field, as a whole collective and as individuals promoting change. There are ways of using words to satisfy insurance companies, ways we speak in clinical settings that allow other mental health staff to understand and relate to a clinical situation, ways we relate to clients, ways in which we as social workers express humor and agitation, power and control by mere discourse.

Discourse can be used to locate an institution of ideology and of hidden power that carries with it a relation of oppressing the 'other'. By looking at the history of discourse, one can begin to unravel this history and begin to understand how this oppression still exists today, in many subtle forms that can be examined via discourse. The focal point becomes one of questioning where the "center" of a language resides, and of how, upon dislocating the center, other linguistic features emerge, perhaps foreign to that of our own ideology. For in this de-centering, one may understand power abuse in a way that was not readily acknowledged before, and choose to do something different.

Little investigation has been done regarding language of social workers in the mental health field as it relates to a collective group of people labeled with psychiatric disabilities. Is this because the language is not our own? If it is not our own, who have we adopted the language from? And if we had our own mental health language, what would it suggest? What emphasis would it place on the individual that comes to us with reported struggles? Is the language we use a conscious choice? Is it a conscious process? Should it be conscious? In this thesis, the language in the mental health system will be looked at as a way to consider power abuse that is hidden, but accessible in the immediate discourse.

Upon examination, some may find the discourse social workers subscribe to is an outright verbal assault, an epidemic of structural violence that we do not contemplate but instead commit (and commit to) with our mouths on a daily basis.

To follow, there is a common assumption that social workers reject tendencies to ‘other’ or to speak negatively about people with psychiatric labels. This assumption is one of many that will be considered throughout this thesis. The more accurate assumption may be that the social worker, referring to what identity the field of social work projects, makes careful statements not to pathologize the ‘other’ or discriminate against the ‘other’, without consciousness of how the services and dominant discourse they adopt is an act of ‘othering’. Further, there exists a tendency to idealize said intentions, and to assume such intentions are met, while overlooking actions that may reveal a fine line between helping and harming. This thesis recognizes that although social work is invested in locating and working against the various ‘isms, the field itself has yet to formally recognize the oppression of people in the mental health system as a major and significant agenda of social work, located broadly in the spectrum of micro and macro clinical practices.

How Discourse Will be Explored in the Following Chapters

To pursue these possibilities, an intermingling of discourses inside and outside the dominant frame will be brought in. Some central questions become: What is the non-dominant discourse? How does it differ and how is it categorized as different? How is it silenced? What narrative creates discontinuity in the dominant discourse? What is the

resistance to the common discourse and how is this resistance revealed? How do social workers participate in the dominate discourse? As this discourse is looked at more carefully, the underlying message is that consciousness of the power in discourse can transform social situations of oppression (Fairclough, 2000), given that when the power abuse is revealed, it is plausible that social workers will not only listen, but act.

It is a well distributed statistic that 1 in 4 people meet DSM-IV diagnostic criteria in a given year (Kessler et al., 2005). Regardless of inclinations professionals may have to perceive themselves as a collective group of persons unaffected by mental health problems, these statistics dismantle such assumptions and reveal perhaps a false divide between those who are and are not meeting criteria for psychiatric disabilities. As the mental health language is deconstructed, and the various ways in which people are classified is put into question, there exists further contemplation for the role of ‘othering’ in the mental health field, as labeling becomes something of a cultural phenomenon—shared, sometimes hidden in ways that continuously question the existential space of such seemingly concrete representations.

This thesis will begin with an explanation of the theoretical framework used to analyze and deconstruct a discourse in the mental health field. A theoretical focus on postmodern thought and critical discourse analysis will be present throughout. Using the strategic tools and philosophical underpinnings of the theories outlined in chapter two, a brief discussion of some of the historical elements of language in the mental health field will be discussed in chapter three. Chapter four will consider dominant themes in mental health discourse, outlining some of the social linguistic features and ways that persons with labels form identity in response to these themes. Once the groundwork, history, and

truth claims have been brought to the fore, some of the common linguistic patterns in the mental health field will be deconstructed in chapter five, followed by a literature review of existing oppression of those with psychiatric labels in chapter six. Woven in and emerging in various places of the thesis will be a non-dominant voice, acting as a point of reflection and contemplation to dislocate the center of the dominant space.

Though there are many voices that offer this ‘other’ discourse, the emerging discourse of recovery, over time, has produced a challenging message to the dominant discourse, a message that creates discontinuity. Though there is a wide and unique range of individual voices that captivate the recovery discourse, this thesis will predominately honor the voice of Patricia Deegan, a clinical psychologist who openly speaks of her recovery process and of being diagnosed with schizophrenia as a teenager. While there are many reasons this voice in particular has been selected, one worth mentioning is that Deegan does not announce herself as “cured”—a claim that raises skepticism and dissociation within those on the other extreme end of a non-recovery, dominant discourse. Rather, Deegan explains:

One of the biggest lessons I have had to accept is that recovery is not the same thing as being cured. After 21 years of living with this thing it still hasn’t gone away. So I figure I’m never going to be cured but I can be in recovery. Recovery is a process, not an end-point or a destination (1993, p.10).

Recovery . . . does not mean that one is simply stabilized or maintained in the community. Recovery often involves a transformation of the self wherein one both accepts ones limitation and discovers a new world of possibility. This is the paradox of recovery i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do. Thus, recovery is a process. It is a way of life. It is an attitude and a way of approaching the day’s challenges (Deegan, 1996, p.17)

It is through Deegan's voice that some of the marginalized thoughts and processes will be revealed and utilized to understand what is included, what is excluded, and what role a dominant mental health language plays in 'othering' a collective group which has perhaps made itself more known through various social movements over the years—the antipsychiatry movement, ex-patients movement, consumer movement, etc. Deegan has a way in recognizing the gaps in the mental health field, and looking for ways that a recovery discourse and mental health discourse can join to create more continuity and inclusion.

As both discourses are considered, the purpose of such demonstrations is not to motivate social workers to change language, necessarily, as something as transformative as shifting one's discourse occurs from within and at will. Instead, this thesis poses questions about the nature of social work discourse, allowing curiosity to emerge about the consciousness of discourse and of how it reflects larger social issues. Given the theoretical axis of this exploration, it is safe to be clear that undertaking an investigation of deconstructing an already constructed discourse becomes an act of constructing more discourse. This is not missed, yet in following the process of questioning the symbols, the metaphorical meanings, the euphemistic distances kind words create while harming, the linguistic markers of possession and control, there is a process of deepening understanding while unearthing the very matter of everyday language in which we participate—sometimes as conscientious objectors, sometimes as fools—in which the space of constructing new meaning may instead serve as a bridge between two paradigms of thought, both working to create less harm, both seeking better ways to do just this.

CHAPTER II

THEORETICAL FRAME: COLLECTIVE TRAUMA, FOUCAULTIAN POWER AND CRITICAL DISCOURSE ANALYSIS

There has been little criticism of the dominant discourse of the mental health field that has not been heavily judged or rejected, often using *ad hominem* arguments to discredit the resistance that comes in various forms of countered first-person narratives, research, rhetoric, and dialectics. This small space for alternative perspective, where non-criticism often bulges at its own seams, is a measure of the dominant frame's strength, as it is the exclusion or repression of any counter-belief that is rife within a given field of power. In this chapter the theories used to examine power and resistance within a discourse will be introduced. The dominant discourse of mental health will mainly be examined through the lens of postmodernism and Critical Discourse Analysis, in addition to an understanding of collective trauma and group identity formation. The culmination of social identity theory, critical social theory, and neo-Marxist perspectives add background to these theoretical approaches of investigating power and abuse as revealed via discourse. Below is a brief description of each theory's significance to this thesis, with emphasis on how they build on or challenge one another.

Background Theories

Social Identity Theory

Developed by Tajfel and Turner in 1979, social identity theory was originally developed as a way to understand intergroup discrimination (Tajfel, 1981). The theory looks at ways that groups form and maintain categories of difference, and how

individuals maintain multiple “social identities” that cultivate one’s self-concept as it is defined relationally to the group with which one identifies. Categories, or groups, are implemented to simplify the complex social world one lives in, and in this relational agreement, individual perception is influenced by the group. There is a tendency for the in-group to favor and differentiate itself from the out-group, which creates a perceived “us” and “them” divide between social groups. For example, a person who has been given a psychiatric label may, in dominant social frames, be perceived as part of the out-group.

Ervin Staub (1999) looks at the collective identity of groups, and how the individual identifies with a group and by doing so inherits the collective group identity as part of one’s own identity. With this, one may also inherit a history of collective trauma. Staub has examined this phenomenon particularly in groups that have been part of genocide, mass killings and collective trauma where racism and poverty are often main factors of oppression. Incorporating the concept of collective trauma into the group of persons with psychiatric disabilities, the introduction of this thesis touched on the collective trauma that is considered to be part of the identity of those labeled with psychiatric disability. In this way, one who identifies with the collective group of persons with psychiatric disabilities (or of persons with a particular diagnosis) experiences and identifies with the shame, the oppression, and attitudes and beliefs attributed to or experienced by that group.

Critical Social Theory

An outgrowth of Marxist thought, critical social theory looks at the oppression in social and political institutions, with an interest in decreasing that existing oppression

(Leonard, 1990). The theory is, by its own claim, essentially useless without the application of addressing oppression in practice. Though the theory was founded in 1923 at the Frankfurt School (Institute of Social Research), there are many theoretical differences within the theory. However, as a whole, critical social theory seeks to determine, from a historical perspective, the relationship between people and dominant ideologies as they exist. Critical Social Theory, as relevant to this thesis, will be further contextualized as other theories are presented below.

Logical Positivism and Marxism

Critical Social Theory rejects the logical positivist belief that there is absolute truth, or that truth claims can be made. Logical positivism was founded by the Vienna Circle in 1922, drawing much of its thought from Ludwig Wittgenstein who placed importance on the “verification principle” which states that knowledge must be empirically verified in order to be meaningful (Runes, 1967). Inherent in this claim is the premise that objective truths can be observed through sensory perception, that these truths are value-free, and that this valuelessness makes the empirical analytic process the only reliable and respectable way of understanding the causality between things. Non-scientific views were, therefore, not dismissed as not true but instead seen as meaningless to the field of knowledge. This contested religion, as well as most territory mapped in the social sciences, placing pressure on other knowledge fields to adopt empirical practices when seeking upward hierarchical mobility.

In this way, logical positivism placed empirical science in the throne of all knowledge fields, claiming any subjective knowledge to be subordinate. Following World War II, the loftier positions of logical positivism were dropped, for one growing

obvious reason being that the theory itself subjected all knowledge to the “verification principle” with the exception of its own claims, which inevitably could not be verified (Runes, 1960). What lingered was the enhancement of a Newtonian idealization of scientific knowledge, which would influence the role human behavior (as measurable) would have on the social sciences.

Extending Marxist claims of the working class having a false consciousness (an illusion that their work would advance and afford them the same rights as bourgeois society), Critical Social Theory adds that people are deluded by and conform to many ideologies, constructed out of power (Dreyfus and Rabinow, 1983). Habermas (1971) pointed to this phenomenon existing in other areas, such as social sciences where humans were being controlled by a dominant group and a dominant interpretation of human existence. In response to rising trends in behaviorism, which applied the verification principle to human behavior, Habermas cautioned the use of stating truth claims about humans, and the tendency for scientific inquiry to treat humans as subjects where emotional experiences could be measured and determined.

Another contribution from Wittgenstein worth mentioning, was his “critique of language” in his famous *Tractatus Logico-Philosophicus* (1922), which inspired what would become the territory of linguistic analysis, followed by his emphasis on intelligible and non-sensical discourse. This turn in intellectual interest would act as one of the precursors to postmodernism.

Postmodernism and Deconstructionism

In many ways the antithesis to logical positivism, postmodernism situates social problems in their political, historical and social context, and finds relevance between

these problems and their surroundings (Lindlof & Taylor, 2002). Social interpretation, as a collective meaning, is a pivotal marker of postmodern thought. Thus, meaning itself in this process is not considered stable, as it changes with the social surroundings. As Kuhn posited, truth conditions are not independent of the historical paradigms in which they are claimed (Kuhn, 1962). Ideologies become holding environments for stated truths, readily present in a given discourse. Postmodernism places emphasis on the process of discourse, or the function of words, over the concepts of ideological constructs (the focus of critical social theory), and takes a different approach with linguistic analysis, deconstructing the terms and concepts in which scientific claims are made, often drawing attention to ways that humans are naturalized in the process.

Postmodernism is the criticism of universal norms in their local context (Alexander, 1992), and prefers local over generalist stories, and yet still honors the research and findings (of a generalist nature) that support what is revealed in the discursive process. By looking at discourse, the postmodernist wishes to discover the power dynamics involved in social interaction, with particular interest in the relation of power and resistance between dominant and non-dominant discursive processes. Integrating social identity theory into postmodern thought, one can begin to examine how norms are constructed within groups as a strategy of separation, autonomy, and power play and how these norms are facilitated through discourse. A deeper understanding of postmodernism will be revealed below, as emphasis is placed on Foucault's critique of power, an inexhaustible view that has been tailored to the constraints of this thesis.

Power as Construct: Attributes of Linguistic Power

Power is the foundation, a matrix to be observed in this thesis. It is also the construct under investigation, as power is one of the most primitive—yet most complex theoretical tools utilized in acts of oppression. The chosen theoretical explanation of power, as a way of discovering power in mental health discourse, is mostly taken from Foucault’s 1978 description in his introduction to *History of Sexuality*. Foucault explains (in much greater detail than provided here) that power exists in a matrix of combined forces that are organized, goal-oriented and relational tensions that exist on every level of social interaction. As a force, power is exerted in multiple directions, constituting a fluidity of existence where continuously changing levels of power and resistance occur. Power is not owned by one acting agent; power is dependent on the actions, the discourse, the interplay of multiple agents—those resisting (passively and actively), those enacting, those strengthening and maintaining its goals. To understand the approach of this thesis, one must grasp and hold firm this idea of power being reinforced on dominant as well as subjugated levels of participation.

Foucault describes the convergence of power and knowledge, or “power/knowledge”, to be a joint force that holds itself in direct relation to resistance. Knowledge is power, and capitalism of knowledge has existed since the age of Enlightenment, since Descartes, making knowledge, in a metaphorical sense, the currency of power. Power and knowledge are synergistic entities, as Foucault describes in this passage:

Perhaps, too, we should abandon a whole tradition that allows us to image that knowledge can only exist where power relations are suspended and that knowledge can develop only outside its injunctions, its demands and its

interests... We should admit rather that power produced knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.... In short, it is not the activity of the subject of knowledge that produces a corpus of knowledge, useful or resistant to power, but power-knowledge, the process and struggles that traverse it and of which it is made up that determines the forms and possible domains of knowledge (Foucault, 1975, pp. 27-28)

As relationally dependent, power cannot exist without powerlessness or non-power; both define one another. In this dynamic relationship of power and non-power, divisions occur, whereby patterns of discourse become included or excluded. Power and non-power produce a tension that constantly shifts, transforms and re-directs a dominant language so that the discourse itself is always changing, in sometimes small, unnoticeable ways and other times revolutionary shifts that transform the very ideology maintained. These constant shifts embody a power matrix that displays an us/them divide among variant discourses, plotting the demarcation of the other from the hegemonic frame (or ideology). There is always the possibility of a non-dominant discourse becoming dominant. Examining the discourse is, therefore, one of the intricate approaches to seeing power, and consequently gaining consciousness of the power dynamic that serves to oppress groups of people.

Foucault, having focused much attention on the social sciences' subservience to the natural sciences, has also referred to power as *biopower*, placing emphasis on the naturalization of humans as subjects of science and the understanding of humans from an empirically driven archaeology of knowledge that produces essences, or pure understandings of what is "normal". These essences become reified into constructs, such as the aforementioned term "lunatic" became the construct to prescribe and mistreat a

group of people, in the name of science, and in the separation of power and non-power. The normalcy given to a construct (as a concrete entity) is a false consciousness that allows for an elusive separation between what is normal and not normal. This separation lends justification to the ways in which non-dominant groups are dehumanized, allowing for the oppressive acts to occur. Historically, this has been done through naturalization, or constructing biological reasons for defining and treating a person as an ‘other’ in a way that can become dehumanizing and extreme.

Foucault’s loyalty to the bare structures and isolated features of discourse allowed him to make grand statements about the power abuse hidden in discourse, guiding those who followed him to observe the most intricate ways that control inhabits the words we speak and how we speak them. This was exemplified by his deconstruction of the language, as he unraveled the “genealogy” (a term Foucault borrowed from Nietzsche) of words and sentence structure, breaking down the intergenerational shifts and domination of words used, to discover the underlying order of how words gained power through common practice in the dominant discourse. Much of this required the excavation of truth claims held by certain words and phrases selected from the familiar ideology.

For the purposes of this thesis though, this is where my objective departs from Foucault, as it is not my intention to focus solely on the autonomous function of language as a source of power in mental health discourse. I will not entirely deconstruct the scientific claims that mental health sits upon—this has been done in more lengthy marginalized texts. Rather, I wish to look at power in the way that he defines it relationally, stressing that power is not a property owned and maintained by the elite, but is rather a condition that emerges continuously (Mohr, 1999) on every level of social

interaction. Placing emphasis and investigation on the relationship revealed within the discourse from a power dynamic perspective, the discourse becomes a signifier of how society positions itself regarding the treatment of people in the mental health system.

A Critical Discourse Analysis Approach

Defining CDA

Power in discourse can be examined in multitudes of ways, one of these being through Critical Discourse Analysis (CDA). CDA bears its origins in critical social theory and linguistic analysis, and has been used to analyze the power dynamics inherent in social relations (Fairclough, 1995; Lupton, 1992) by looking at how micro and macro discourses form a unified whole (van Dijk, 2003). CDA tries to determine the relationship between actual text (oral and written) and the process of creating text, to draw connection between the use of power and language (Thompson, 2002), and to understand how the other is legitimized in social settings (Henry and Tater, 2002) as is revealed through language. In harmony with the above theoretical descriptions, CDA is curious about how sources of power are maintained, reproduced, and transformed within the various webs of social, economic, political and historical context (van Dijk, 1988). Through the analysis of discourse, CDA looks at the discursive formation of common ideologies. These ideologies, according to CDA, are historical by nature and form social action that can be interpreted and explained (Fairclough and Wodak, 1997).

CDA asserts that discourse is learned and can be described as a way of being in the world that reinforces particular social identities (Gee, Khalaf & McGarty, 1990), emphasizing the power of learned roles in society. The main objective is to reveal these power dynamics as they exist in language, thereby encouraging acts of seeking social

justice (Foucault, 2000) in response to consciousness raised about the identified oppressions. There are many ways to reach this objective; CDA, being a multifaceted multidisciplinary approach to the analysis of language, has no unitary theoretical frame, though there are many diverse ways of applying CDA to a discourse, some of which will be demonstrated in this thesis.

Operationally defining discourse and discursive practice

Discourse, though it has been understood in variegated but similar ways, is defined for the purposes of this thesis as any linguistic exchange, oral or written, that demonstrates recognizable patterns of knowing in a given field of knowledge. Attention to discourse is inclusive of details like what is implicitly and explicitly said, how something is said, the historical, symbolic and metaphorical meaning of words used, the function of those words in social context, what is not said, as well as the more technical parts of speech that include tense, tone, texture, caesura, etc. *Discursive practice*, therefore, refers to “the overt and covert rules that govern the thoughts, actions and speech of various social positions one maintains in life” (Alvermann, Commeyras, Young, Randall, & Hinson, 1977), such as negotiations made between the roles of patient and doctor or the rules underlying discourse in a therapy session regarding who talks when, who assumes authority in a given context, etc. When looking at discursive practice, one may ask “according to what rules has a particular statement been made, and consequently according to what rules could other similar statements be made?” (Foucault, 1969, p.27).

Following postmodern notions of power, CDA observes that local discourse (as a phenomenon) overlaps and spreads to other disciplines/fields of knowledge (Fairclough,

1995), and is reflexively influenced by knowledge brought in by other knowledge fields. As power is cultivated in a field, it increases strength by forming an ideology of constructs that are homogenous, continuous, and that demarcate a seemingly precise separation between what is power/status quo (dominant discourse) and what is non-power/other (non-dominant or subjugated discourse)—or in social identity terms, us/them or agent/target. To reiterate, all individuals and groups are part of constructing and maintaining a dominant discourse that teaches and reinforces these roles, whether they assume a position of power, submission, or resistance to the discourse. Paradoxically, as revealed in various parts of this thesis, resistance can itself be an act of strengthening the dominant frame, more often in an unconscious way. Other times agents who set out to give power to non-dominant groups gain power for themselves instead, reinforcing the already existing power. This can be framed, for instance, in the notion of “harming while helping” and this has happened in all helping professions, including the field of social work.

Applying CDA to Mental Health Discourse

In the following chapters, theoretical strategies of CDA will be employed as a way to investigate the structural components of language in the Mental Health field. When looking at discourse, we must ask ourselves *who* is the agent and *what* is the frame (slant, agenda, ideology) within the dominant perspective? Investigating discourse allows for those observing the power dynamics to then interpret the situation and then make decisions about what direction will be taken, if any, and whether one should assume more responsibility for the power situation. In this way, CDA does not offer a solution, but rather helps to identify the problem, namely that oppression exists and is

constituted via discourse. It is therefore useful to identify, by looking at discourse, how the dominant as well as the non-dominant groups remain unconscious about the power dynamic, and inevitably how the power abuse occurs, as these unconscious structures may be a deeper underlying explanation for how a group remains oppressed. Questions that arise include: How is the dominant perspective being perpetuated, supported, reinforced, and sustained? What role does silence play in this dominant perspective? Given the many competing perspectives on mental health, how does a particular strategy or focus become superior and status quo? In other words, what truth claims does the field of mental health work from? And how do social workers participate in this process?

CHAPTER III

CONSTRUCTING A MENTAL HEALTH DISCOURSE

As Critical Discourse Analysis (CDA) considers discourse itself to be a function of its historical context (van Dijk, 2003), it is useful to consider a selection of historical components that has guided shifts in the hegemonic frame, while making some concepts more concrete. This selection of history will not be exhaustive, but rather a snapshot of some of the unique tensions within the field that underlie current power dynamics of both dominant and non-dominant discourses. In this initial exploration, the discourse of those with psychiatric labels will not be illuminated, the intention being to focus on power development in the field on the upper tier of hierarchy where an overt language was first developed. Following this brief history of discourse development, considerations on how participation in the dominant discourse occurs will be discussed.

The Influence of the Natural Sciences: Mental Health's Upward Gaze

Empirical science, historically rooted in ideological strains of logical positivism, has had an impenetrable influence on the social sciences, and is uniquely pervasive in the dominant mental health discourse today. As noted in the previous chapter, the “verification principle” laid a heavy hand on social science developments, trumpeting empirical knowledge (*a posteriori*) as being superior to analytic knowledge (*a priori*). The natural sciences, through their classifications of nature (which included causal theories of the natural world) signified the development of taxonomies. This approach of empirical categorization placed a heavy economic, social and political burden on the social

sciences' efforts to be included in the knowledge field where power/knowledge was suspended on a plane of scientific determinism. Without a significant demonstration of empirical data, the natural sciences were separated from the social sciences.

A CDA concept called “the order of discourse” considers the power positions of one discourse to be at the hierarchical mercy of another. The social sciences, having less ability to make truth claims, if any, about human behavior, were ordered as soft and secondary to natural science. Lewin (1951) describes the position of mental health at this time: “In its first steps as an experimental science, psychology was dominated by the desire of exactness and a feeling of insecurity” (p. 169). What followed from this order of discourse is that empirical science, as superior, had more symbolic resources (knowledge, money, force, fame, etc.), and therefore more power to create and control a dominant discourse (van Dijk, 2003).

Natural and social sciences, within a power matrix, both maintained a relationship of tension, one in which the field of mental health often succumbed to, simultaneously giving power away to the natural sciences, adhering to their emphasis on *a posteriori* contributions by seeking ways to make truth claims about human behavior and psychiatric experiences. Doing so was not a seamless effort, as this historical depiction of Freud's struggle with the language is described:

Although Freud regarded hysteria as a disease, he clearly understood it far better than his language allowed him to express it. He was in a sort of semantic and epistemological straitjacket from which he freed himself only rarely and for brief periods (Szasz, 1974, p. 73).

These limitations (as interpreted and put forth by Szasz) of a man who in many ways set the initial parameters as well as the language of psychotherapy, express the way molding

one's ideas into the hegemonic ideology of the time, via discourse, breeds discursive silence, even among those who are well-equipped to speak on the subject. As no discourse bares origins in a vacuum, Freud was inevitably making efforts to fit his knowledge schema into the dominant discourse that was becoming medicalized, so that his own findings (theories, rather) could be endorsed as an accepted part of the mental health frame. Objective understanding of human behavior became a major focus of mental health initiatives, a focus that sought twinship from the dominant medical model.

For the mental health field to become a respected science in its own right, a language needed to be developed, a distinct way of communicating knowledge generated by the field—knowledge that gave it a separate identity, while simultaneously allowing it to join forces with the powerful medical establishment from which it could draw strength. Mental health's upward gaze toward the empirical sciences is best demonstrated in the field's decision to implement a classification system that mirrored the medical model. To start, diagnostic categories were officially adopted in 1918 (Grob, 1999). The federal bureau of the census required data of people who were seeking and receiving mental health services, and this signified forces outside the mental health field itself, which implied promise for potential increases of symbolic resources.

As psychiatric experiences were grouped and categorized, pressures to see and understand diagnosis from a medical perspective ensued. Heavily influenced by the late 19th century work of Emil Kraepelin, whose method focused on separating the individual unique experience from the categorical disease, this split between human being and disease became a well-participated process in understanding and treating individuals (Runes, 1960). This shift guided perceptions of "lunacy" into directions of "illness" as

well as an act of removing the human from the treatment situation, allowing for harm to be a more acceptable practice on individuals who were seen primarily as their “disease”. As individuals were grouped into certain classifications, the label became the guiding force in understanding and treating the individual. Szasz goes on to point out the absence of “illness” in Freud’s earlier descriptions of the “patient”, rooting out the tendency of psychotherapy at the time to “squeeze psychology into behaviorism,” as he eventually concludes: “Thus, psychology and psychoanalysis were given only second-class citizenship in the land of science, their emancipation remaining contingent on the discovery of the physicochemical basis of 'mind' and behavior.”

Classification as Power

As a discursive practice, classification is itself a power move which maintains a system of inclusion and exclusion. What actualized was madness and non-madness, sanity and insanity, or what Foucault would stress to be the fertilization and actualization of the “human sciences” (Mohr, 1999). Foucault (1972) underscores the power inherent in this process of classifying what would be or not be considered a norm, as he questions who has the power to create such a classification scheme.

...who is speaking? Who, among the totality of speaking individuals, is accorded the right to use this sort of language (langage)? Who is qualified to do so? Who derives from it his own special quality, his prestige, and from whom, in return, does he receive if not the assurance, at least the presumption that what he says is true? What is the status of the individuals who – alone – have the right, sanctioned by law or tradition, juridically defined or spontaneously accepted, to proffer such a discourse? (Foucault, 1972, p. 50).

Indeed, who was positioned and sanctioned to define “mental health” and “mental illness” and draw this line between “sanity” and “insanity”? A closer look at this process is helpful. Although psychiatry has often been noted as the agent of power in creating the

classification system, CDA recognizes the inherent relationship of power, and the necessity of looking beyond any describable body of power, or body of men. The discourse chosen to illustrate the dominating forces that created a language for mental health, therefore, is not one that invites blame toward psychiatry, but rather a discourse that considers the underlying complexity of this power dynamic, while resisting trends that oversimplify the process. In selecting discourse examples, a discursive strategy called “complexification” can be used to illustrate the many forces that create power in a dominant discourse (Macgilchrist, 2007) by neutralizing the agents of a discourse and focusing on the ideological supports of power/knowledge instead.

To reiterate the forces at play, there is the tension between the social sciences and their upward gaze toward the natural sciences, there is the tension between diversified groups in the mental health field and their subservience to psychiatry as the dominating force to create such a classification system, there is internal tension among psychiatrists, and there is the tension, of a more silent type, from those who became the “subjects” of this developing field. Surrounding these detailed forces, there are social, political, and economic interests rising and falling.

As classification went underway, there was much tension and resistance among the dominant perspectives within the mental health field (Grob, 1999) as to the usefulness and potential limitations of a categorized system. Taken from “Origins in DSM-I: A study in appearance and reality,” Grob describes some of the paradigmatic struggles of the mental health field during this time in which a language was being selected and created. He quotes one of the founding psychiatrists:

In the present state of our knowledge,” he wrote, “no classification of insanity can be erected upon a pathological basis, for the simple reason that, with but slight exceptions, the pathology of the disease is unknown. . . .Hence, for the most apparent, the most clearly defined, and the best understood foundation for a nosological scheme for insanity, we are forced to fall back upon the symptoms of the disease—the *apparent mental condition*, as judged from the outward manifestations. (1999, p. 423)

To clarify, a decision is being made about how to classify diagnoses, as the psychiatrist acknowledges that no internal pathology has determined these “diseases” as biological occurrences, which implies a need to classify by symptoms. What underlies this statement is the place of assumption in these initial claims of determining psychiatric experiences to be biological; regardless, the founders maintain the word “disease” which implies a medical condition for which they have no proof. In this passage, “we” denotes the field of psychiatry, as this choice of words underscores their linguistic power in the decision making process; paradoxically, the content reveals a stance of not knowing, and places the role of psychiatry in a vulnerable position, in which it chooses to rely on the discursive formulations of natural sciences to outline pathology. This is underscored by the description of “insanity” as “symptoms of disease”, a notably medicalized framing of psychiatric disability.

Grob (1999) explains the further complexity of the situation, namely the tension brought forth by other non-dominant groups of interest within the field of mental health who encouraged psychiatry to create a more formal classification scheme. Though it was a process that carried much dispute, the field came to place importance on gathering statistical research on behavior, an empirically driven phenomenon, which inevitably required categorical frames, as a way of gathering knowledge about recovery rates, and

later a desire to place adjacent fields of knowledge on common ground (Grob, 1999). This desire was supported outside of psychiatry, and encouraged by other professionals within the mental health field. Intended to maintain some consistency and agreement about mental health presentation and treatment, a more formal classification, that of the 1954 DSM-1 was developed by the American Psychiatric Association in addition to 10% of the American Psychological Association who participated by survey (Grob, 1999).

Categorical ways of knowing and speaking of mental health stabilized the field, granting a sense of control and mastery, as classification made the medicalization of mental health a structural, concrete phenomenon, rooted in science, with a discourse of its own. Efforts to universalize this system were well underway. This also placed assurance among mental health professionals, as well as those experiencing psychiatric symptoms for which they sought treatment. Labeling in many ways became a useful tool for sharing knowledge and treating psychiatric problems. In this way, psychologists, social workers and other mental health advocates gained power in their own domain by adhering to the categories put forth by psychiatry.

This classification system would also discursively mark a symbolic act of power over those defined within its parameters, controlling how individuals would be viewed, treated and situated on an economic, political, and social terrain. However controversial, the classification system, and the discourse that supports it, has come to exist in virtually every corner of the mental health field, and beyond, serving as the dominant language for mental health discourse, discursively projecting an illusion that labels are concrete and easily identifiable manifestations in the individual.

How Participation in the Dominant Discourse Occurs

Participation in the dominant discourse occurs on many levels, each of which can be a conscious or unconscious process. Van Dijk (2003) sums up four ways that a dominant discourse controls the minds and actions of those participating in the discourse. The following paragraphs detail how participation occurs through acceptance, obligation, and limited knowledge of understanding. First, participants accept the knowledge, beliefs and opinion of the dominant discourse. This acceptance occurs in power relations where the dominant discourse is maintained via authority and trust (Nesler, Aguinas, Quigley & Tedeschi, 1993). Essentially, recipients of these dynamics who are part of the discourse, but not necessarily in agreement with the ideology, still adopt the frame.

For example, it is not uncommon for social workers to adopt scientific claims about a psychiatric disability without having any basis for understanding these claims, a compliance that often results in misinterpretation of the data and consequently, misinterpretation of a person's psychiatric experience or outcome. Another example is the common resistance social workers have, especially initially, when learning to use and implement psychiatric labels. Social workers know the people they serve are much more complex than the labels given to them, yet as a field, social workers agree to use the labels, since doing so allows for compensation as well as ongoing therapy for the person seeking services. This often passive agreement is yet another demonstration of the power matrix, and how adherence to the dominant discourse occurs. Another example is the tendency of clients to accept their label, and/or to also accept their psychiatric experience as a biological condition that must be controlled with medication. All of these examples

are ways that clients, social workers and other mental health participants accept the dominant discourse of the field, not necessarily consciously.

Secondly, participants are obligated, by the rules or procedures of a given discourse, to adhere to the dominant frame (Giroux, 1981). This obligation can be seen in the discursive practices held by a mental health agency, such as the use of the DSM classification system to diagnose and communicate with insurance companies and other knowledge fields that include policy, legal issues, employment, etc. In adhering to this obligation, it is expected that professional language will be used in this communication so that other parties understand clearly the situation. Another example would be obligations the client has in treatment, such as “medication compliance” or acceptance of a label upon entry into a mental health setting. A more subtle example is the diversity of mental health settings in choosing to refer to those labeled with different nomenclature, a choice that often reveals some political position of the agency in how it chooses to label “clients” as “consumers”, “mentally ill persons”, “people with psychiatric disabilities”, “patients”, etc. As an agency chooses its preference of words and terminology, workers are often expected to comply with these agreements as part of the agency’s “culture”.

A third way that a dominant discourse maintains participation is by not allowing, not exposing or not providing an alternative discourse (Downing, 1984). Though this phenomenon will be explored in more detail through the recovery discourse, an alternative discourse may be perceived as anything outside of the dominant frame, ranging from spiritual explanations for a perceived psychiatric experience to peer services that allow for an entirely different discursive practice that is based on removing hierarchical structures within a therapeutic setting. Not being exposed to an alternative

discourse may imply that one is unaware of any alternatives, and therefore may likely conform more readily to what one has been taught in the dominant frame. For example, there is evidence of people with psychiatric disabilities choosing not to take medication, but to instead maintain a certain lifestyle that augments health through natural practices of nutrition, exercise and mind/body techniques. It is not uncommon for people being treated for psychosis to not have awareness of alternative treatments.

Finally, participants may not have access to the knowledge that would imply there is a need to challenge the dominant discourse (Wodak, 1987). In other words, participants may be unaware of any tension or resistance by the part of groups within the discourse. They may be unaware that the dominant ideology they participate in can be harmful in some way. This follows the implications of the previous strategy, as in the example of those being treated for psychosis not having any awareness that recovery is an existing phenomenon and that there are strategies set forth by those in another discourse that outline an alternative form of treatment. Each of these methods of discourse control is implicated throughout the following chapter, as acts of exclusion and omission are identified in the dominant mental health discourse. These strategies will be discussed and critiqued, placing emphasis on patterns of what is being said, how it is being said, and rules of maintaining the discourse. Throughout the remaining chapters, common discourse has been selected to illustrate the particular strategies.

Chapter IV

TOWARD A BIOLOGICAL DETERMINISM, THE DUAL'S DUEL AND THE CLINICIAN'S ILLUSION

...how can we be sure that we will not find ourselves in the grip of all those over-hasty unities or syntheses concerning the speaking subject, or the author of the text, in short, all anthropological categories? Unless, perhaps, we consider all the statements out of which these categories are constituted – all the statements that have chosen the subject of discourse (their own subject) as their 'object' and have undertaken to deploy it as their field of knowledge? (Foucault, 1972, p. 30)

This chapter will focus on statements and assumptions that have become continuous patterns in the dominant mental health discourse. As these patterns are surfaced and challenged, one may continuously ask how these assumptions and statements influence the social worker, the clinical practice, and the person labeled with a psychiatric disability. Reflecting on the classification in the mental health field, it cannot be ignored that persons given psychiatric labels have become the objects of a knowledge field to which scientists, scholars, and professionals make statements and determinations about their experience and constitution while often having no identification with that experience themselves. This is one of the underlying power dynamics of the discursive practice, as the professional has the power to identify and put words onto the experience of another. Mental health discourse is predominately situated in a biomedical frame, where the discourse and discursive practice hinge on medical ways of knowing and understanding "illness". The themes presented below build on one another, and set up a series of examples to be discussed at the end of the chapter.

Biological Determinism

As part of the discursive structure, mental health professionals have come to use words that support this ideology of determining psychiatric experiences to be biologically based, thereby equating psychiatric diagnoses with “mental illness” and “disease”. It is important to note that not all social workers claim to participate in this dominant ideology, yet most do work within the model, which has an influence on one’s perspective in multiple ways. For one, working in a medical model implies participation of the dominant discourse, as described in the previous chapter. For example, referring to psychiatric disability as a “disease” and those being “treated” as “patients” encourages the doctor/patient metaphor by association. This association activates connections between mental health and medical practices. The discursive exchange, upon entrance into the mental health field, is described here:

What do we mean when we say that a person is ill? We usually mean two quite different things: first, that he believes, or that his physician believes, or that they both believe, that he suffers from an abnormality or malfunctioning of his body; and second, that he wants, or is at least willing to accept, medical help for his suffering. The term “illness” thus refers, first, to an abnormal biological condition, whose existence may be claimed, truly or falsely, by patient, physician, or others; and second, to the social role of patient, which may be assumed or assigned. (Szasz, 1974, p. ix)

Following this metaphor of “sickness”, the person becomes labeled in a way that guides the direction of treatment focused on becoming well again or managing the sickness. Allocated treatment time, the likelihood of becoming well again, the prescriptions to manage symptoms, all become part of the discursive exchange. “Medication compliance” and “non-functioning” become common phrases that position a person as a subject/object

to be measured against standardized behavior descriptions that typify an “ideal” diagnosis—one that naturalizes the psychiatric experience, and therefore the individual.

In this classification process, something powerful occurs. Discursively, the person labeled is reduced to that of the object being observed and interpreted. Professionals begin referring to the client as “the schizophrenic”, “the bipolar”, “the narcissist”, etc. Pat Deegan describes her experience:

I was told I had a disease that was like diabetes, and if I continued to take neuroleptic medications for the rest of my life and avoided stress, I might be able to cope. I remember that as these words were spoken to me by my psychiatrist it felt as if my whole teenage world . . . began to crumble and shatter. It felt as if these parts of my identity were being stripped from me. I was beginning to undergo that radically dehumanizing and devaluing transformation from being a person to being an illness; from being Pat Deegan to being “a schizophrenic” (1993, p. 7).

As psychiatric experiences are reduced to these medical ways of knowing (called biological reductionism) and treating “disease”, the person with the label is not looked at through the lens of her experience, rather, she is seen by the particulars of her label—and in this discursive process, the definition of her label, as well as the empirically supported treatment protocol of her label, becomes the substance of her, her experience, and her trajectory in the mental health field.

Now certainly social workers refute this description of reducing the person to the label; however, upon examining the discursive practices that occur in treatment team settings, documentation, educational discussions, etc, the discourse reveals something else, perhaps not held in close-consciousness. Not only do social workers depend on medical terms as a way of communicating about persons with diagnoses, there is a tendency to fit a person’s behavior into a diagnosis (Bateson & Martz, 1979) or to equate

diagnosis with the person (Corrigan, 2007). Wehowsky illuminates this discursive process:

The client, who is called patient, has to be ill. This may affect the therapist in several ways. First, he may be motivated to present the patient as worse off in his report so that the insurance company will pay. Secondly, his perception of the client may be affected by the insurance company's rules and required system of diagnosis. He may shift his awareness more on the pathological and problematic side of the client, and less on the client's resources and solutions. Thirdly, over time, the therapist's theoretical matrix may get corroded by adjusting to standards which do not represent the full spectrum of intersubjective discourse of psychotherapy but only the accepted methods of which insurance companies think that they fit their economic interests best (2000, p. 244).

While it is likely that corrosion of one's theoretical matrix runs parallel to "burnout" and "hopelessness", the effort of maintaining a separate way of knowing the client requires effort that often works against biological determinism, which is perpetuated at every angle. The administrative process of seeing the client as "ill" flows in multiple directions, and can encourage a "pharmacocentric view of the world" (Baldessarini, 2000). One study reports sociological trends revealing that an introduction of a new medication is positively correlated with increased diagnosis of that "illness" as well as scientific interest of that "illness" (Stoll, 1993). Other studies similarly point to this trend in biological determinism, regardless of whether it directs the treatment toward psychiatric medication. In 1987, Wahl found the general public understood "schizophrenia" to be due to "environmental stress"; In 1999, a general survey revealed 85% cited "chemical imbalance" and 67% cited "genetic or inherited" to be the understanding of schizophrenia, in addition to stress in the environment (Link, Phelan, Bresnahan, Stueve & Pescolido, 1999). These attitudes and ecological patterns underlie the strengthening

and reinforcing nature of the dominant discourse, as Morall and Hazelton (2000) describe the stability of the power matrix:

Whatever social, political or economic discordance exists in Western society, the system remains remarkably stable, and unremittingly committed to a capitalist mode of production. Moreover, although there have been serious threats to its dominance (e.g., through the growth of ‘complementary’ medicine, an increased interest in spirituality, the intellectual posturing of postmodern philosophy) scientific rationality persists as the core explanatory paradigm (Sokal & Briemont, 1997). Capitalism has now a global market, and techno-scientific discoveries . . . that permeate virtually every culture in the world (pp.93-94)

The Dual’s Duel: Bifurcations in the Dominant Frame

Psychiatric labels distinguish a person’s constitution as “insane” or “sane”, “mentally ill” or “not mentally ill”, “bipolar” or “not bipolar”, etc. False dichotomies, or what I will call “The Dual’s Duel” is the act of splitting information into two distinct, and often extreme poles of knowledge content, creating a situation where the participant must choose either ‘X’ or ‘Y’, the false dichotomy being that it is not always exclusively either/or, but more likely both/and and sometimes neither/nor. In short, the “middle” has been removed, and the discursive positioning of either/or removes theories of understanding behavior on a continuum.

Perceiving a person with a label as being on one extreme pole creates a discursive permanence and distancing that justifies separation between “not bipolar” and “bipolar”. To make this polarity effective, the label must be highly definitive, oppositional, and defined through a relational context of ‘X’ not being ‘Y’ or ‘Y’ not being ‘X’, emphasizing the placement of objects, or persons, in an us/them divide. Through this division, a diagnosis becomes absolute and oversimplified, making the choice of one or the other problematic, as Theodor Adorno states: “And how comfortless is the thought

that the sickness of the normal does not necessarily imply its opposite, the health of the sick” (1974, p. 60).

These absolute ways of knowing can be devastating for a person who has been labeled, as it reinforces an act of giving power away, as described here:

Before diagnosis, there was a continuity of knowing for Jim and Cathy. Through diagnosis there is experience of indisputable illness, declared by ‘a knowing that knows’. The diagnosis is experienced as knowing that cannot be challenged, a knowing that highlights a dissonance within ‘self’. The distress caused by this knowing is distinct from what may be happening to ‘the self’ as a result of illness. It results from that ‘pure knowing’; from hearing a medical term that is taken as absolute and irrefutable ‘fact’ (Hayne, 2003, p. 725).

The “knowing that knows” in this passage represents the power inherent in the dominant discourse that claims, with absolute certainty to know what is happening in the person.

As Hayne describes, this absolute fact of “indisputable illness” fractures the understanding in the individual, creating a dissonance of not knowing or trusting the “self” anymore, and instead giving understanding away to the professional. Once more, this marks an exchange of power where dominant and non-dominant forces support and participate in strengthening a dominant discourse.

The infamous Dual’s Duel exists in other planes of mental health knowledge. Eisenberg (1995) has criticized the highly charged ‘either/or’ discourse that psychiatric disability is either biological/’no one’s fault’ or psychological/’caused by sociological factors. This divide has become a standard pattern within the dominate discourse. To support this, studies show there is a social tendency for western culture to blame internal disposition rather than external conditions (Ross, 1997). The nature/nurture debate, aside from being a continuous lesson in history’s discontinuity, is the ongoing, ever-exhausting oversimplification of the scientific and social fields of knowledge where nature currently

prevails, and continuously manifests itself in ways of understanding and discovering psychiatric disabilities.

The Clinician's Illusion

“You are at a critical juncture, a very important time. The professionals are telling you that you are a schizophrenic. Your family and friends are beginning to refer to you as ‘a schizophrenic.’ It is as if the whole world has put on a pair of warped glasses that blind them to the person you are and leaves them seeing you as an illness. It seems that everything you do gets interpreted through these warped glasses (Deegan, 1993, p. 9).

The Clinician's Illusion is a tendency for practitioners to assume that patients remain “seriously ill” when outside of the clinical care setting (Cohen & Cohen, 1984). This illusion can be the result of seeing extreme cases of a diagnosis as typical for everyone who has the diagnosis, even when the presentations vary. Both biological determinism and the dual's duel support this illusion. Diagnostic labels become a mark of permanence, discursively set by words like “chronically” and “persistently” and further indicated by words like “always” and “never”, etc.

Diagnostic labels may be perceived as static and unchanging (Anderson, 1991; Kashima, 2000). The use of labels, as a discursive practice, challenges the reality that people actually do move beyond their psychiatric experiences, one obvious reason being that there is no clinical practice that exercises the discursive removal of that label at the end of treatment. This permanence may also lend to the idea that a label indicates something is fundamentally wrong. Studies suggest that even after a person improves in treatment (Link et al., 1997), the values and beliefs about a given diagnosis remain a part of how the person is perceived, and the person's diagnosis becomes a static part of their identity.

This can be played out when clinicians fall into the common habit of using all-or-nothing thinking when applying a label. From a more technical perspective, Haight and Littlewood (1995) employed a sociolinguistic analysis of the word “schizophrenic”. They explained that placing a modifier before a noun linguistically situates that modifier (“schizophrenic”) to be part of the noun’s (the person’s) constitution. For example, “*schizophrenic* patient gives an impression of permanency that *patient having schizophrenia* or *patient with schizophrenia* may not” (p. 408). In addition, the suffix “-ic” can be semantically loaded. The authors compare “schizophrenic” to “syphilitic” and explain that both are indicators of “an unusual degree or amount” of the given nominal device (“schizophrenia”).

When a person begins attaching their own understanding (bias, beliefs, etc.) of schizophrenia to the label, other emotions and values get loaded into the word. The authors also explain how the use of the suffix –ic can create a distancing effect, whereby using an adjective (“schizophrenia” as in symptom) as a noun (“schizophrenic” as in person) “may rob the individual of his other aspects as it subsumes personhood and agency into illness” (p. 409). “Having” schizophrenia and “being schizophrenic” then becomes crucial to individual identity as well as the treatment process from a clinical perspective.

Thematic Patterns of Discourse

This section illustrates examples of the patterns described above. To start, one social worker describes a person with a psychiatric disability: “Max is a 37-year-old man who is paranoid and delusional” (Berzoff, Flanagan & Hertz, p. 273). Max, instead of experiencing paranoia and delusions discursively becomes that of his symptoms—

enacted by the word “is”, a process that takes power away from the individual and submits him to the matter of his symptoms. Another tendency, loading one’s own beliefs and values into the diagnosis, is illustrated by the same social worker: “Christine is a 27-year-old woman whose speech is frequently incoherent and whose affect appears silly and inappropriate” (p. 273). This social worker, while recognizing some of the personal attributes of Christine initially, describes her affect as “silly” and “inappropriate”, descriptions that signify value-judgments without clinical relevance, positioning the social worker in a power position of deciding what is or is not appropriate.

The following quote illustrates tendencies to homogenize individuals in a given labeled category: “Narcissists feel justified in their claim for special status, and they have little conception that their behaviors may be objectionable, even irrational” (Millon, 1981, p. 167). There is confidence in the statement above, as there are no indicators such as “some” “narcissists” or even “it is typical for...” The definitive nature of the statement makes it so that all narcissists feel this particular way all the time, which homogenizes the experience of narcissism and attributes permanence to the individual’s psychiatric experience. Further, “little conception” of one’s pervasively negative behaviors suggests it is unlikely for persons in this category to ever gain enough awareness to actually improve their negatively valued situation. The framing of the diagnoses is a framing of hopelessness, and is an exaggeration of what it means to have narcissistic personality disorder.

Here is another: “Most borderlines exhibit a single, dominant outlook or frame of mind, such as a self-ingratiating depressive tone, which gives way periodically, however, to anxious agitation or impulsive outbursts of inappropriate temper or anger” (Millon,

1981, p. 349). Value-laden statements are a product of the reified label: a person labeled with “borderline personality disorder” becomes “the manipulative, easily angered child” instead of a person experiencing extreme states of emotion that may result in a tendency to act out of fear and with a difficulty of managing that fear. Stating that “borderlines” have a dominant outlook of “self-ingratiating depressive tone” is pejorative and an oversimplification of one’s day-to-day experience. The author goes on to suggest that the only time this tone changes is when it “gives way” to another negatively valued experience. In short, Miller confines a person with this label to the parameters of having only negative experiences. The human condition is much more varied than that, and people labeled with personality disorders can experience an array of emotionality, none of which is permanent, and all of which has potential to be transformed. When values like these are attributed to the label, what happens to the hopefulness of social workers when working with persons who have these labels?

The clinician’s illusion is a demonstration of hopelessness in the mental health field. The question becomes what does it mean to perceive the client as diseased? What happens when we call a person by a given label? How likely is the individual to be hopeful about “recovery” if told one has a “biological disease”? A psychotherapist, Nancy McWilliams, in her appeal to the scientific notions held within the dominant discourse, states:

...the pervasive message [is] that psychotherapists should not be trying to understand and mend the broken heart, or heal the tortured soul, or promote the acceptance of painful realities. Instead we should be trying to medicate, manage, reeducate, control, and correct the irrational behavior of people whose suffering is inconvenient to the larger culture (2005, p. 140).

The Influence of Dominant Themes on Collective Identity

Following the aforementioned themes, it is useful to reflect on how these impact the person being labeled in the mental health field from a group identity perspective. Regarding biological determinism, specifically, one study found that the general public, when asked to rate the likelihood of recovery for those who have a “mental illness” that is biologically based versus psychologically based, a significant number of participants perceived that the psychologically based “mental illness” is more likely to be cured and is significantly less disabling (Lam, 2005). Labels that are understood to be biologically-based are positively correlated to prejudice, fear, and social distance (Read, Haslam, Sayce & Davies, 2006). In addition, perceiving one’s psychiatric disability as a biological condition may lead to feelings of shame (Kessler et al., 1996).

When a person enters treatment, one officially, whether or not consciously, accepts a label, and this label, by association, activates difference between groups (Mohr, 1999). The individual is able to identify with “mental illness”, assumes the role of the ‘other’, and takes this into one’s personal identity. What becomes part of that label is the value-laden attribution, even if not overtly disclosed in the therapeutic relationship, attached to the person, as these attributions can be communicated by the public, through the media, through online access, etc. When participating in the dominate discourse, the linguistic apparatus of separating those with diagnoses from the general population becomes a bidirectional process. As professionals see a person labeled as different or as ‘other’, the person labeled comes to expect those external to her to perceive her as different and begins to see herself as different. This perception strengthens the divide

between those labeled and those not, increasing the feeling of difference and the anticipation of rejection.

Labels have the power of eliciting negative beliefs about the person that can have damaging consequences (Link et al., 1989). Beliefs become personally relevant and potentially very harmful to self esteem (Rosenfield, 1997; Link et al., 2001), social interactions (Farina et al., 1968), social network ties (Link et al., 1989; Perlick, Rosenheck, Clarkin, Sirey, Salahi & Struening 2001), and quality of life (Rosenfield, 1997). This can create conscious awareness of the power dynamic in therapeutic relationship as well as the negative attributes being placed on the person, as Deegan describes:

Professionals' reification of the diagnosis of schizophrenia was oppressive because it subjugated my humanity such that everything I did was interpreted as part of my psychiatric disability. . . I am describing the arrogant and unapologetically clinical gaze that captures me, re-interprets me and hands me back to myself as damaged goods; disabled; off-spec; not-right; broken-brained; neuro-chemically imbalanced; genetically defective; a special person with special needs, requiring special services in segregated places (2004, p. 2).

As negative attitudes and beliefs are perpetuated, a person labeled becomes aware of a gap between the self and other (Crawford, 1994), followed by a tendency to compare the self to what is “normal” and a desire to see the self as “normal” (Pickens, 1999), where the stereotypes placed on the identified group create more feelings of social distancing. Studies reveal that these stereotypes can be viewed to be as distressing as the psychiatric symptoms themselves (Hocking, 2003). As one becomes more aware of social separation, feelings of shame and humiliation can become internalized (Heatherton, Kleck, Hebl, & Hull, 2000). Regarding internal group dynamics, comparisons within a diagnostic group (both heterogeneous and homogeneous) can occur. Finlay and Lyons

(2001) found in-group downward comparisons among persons diagnosed with schizophrenia, supporting studies that suggest a tendency to compare the self to others who fare worse, in effort to feel better about one's situation. This comparison is an example of how a dominant discourse of 'othering' is supported inside a non-dominant exchange.

Patterns of Harming When Attempting to Help

Patterns of harming when attempting to help can be located in the dominate discourse. In one study, Parker and Aggleton (2003) focused on the social process of negative attitudes and beliefs among the general public. They reported that individuals who identify as being part of the in-group fear a particular psychiatric label and seek to determine differences that separate them from the out-group (those who have labels). This is perhaps best illustrated in a case example of a social work student who "was so fearful that her own anxiety was a sign of schizophrenia that she began calling in absent. When confronted by the supervisor, she tearfully stated her fears" (Miller & Mason, 2006, p. 80).

Though the authors use the above example to teach supervisors training skills with developing social workers, they (perhaps unintentionally) illuminate the us/them divide, and go on to encourage that fears can be attenuated once students understand "the biological nature of the disease". This process, however unintentional, is what Parker and Aggleton (2003) describe as a social process whereby those who fear the diagnosis maintain control by creating social distance between themselves and those diagnosed.

Another example of harming while helping occurs on a more ethnocentric level where professionals assume, for example, that the DSM criterion of diagnoses is

applicable to other populations outside the culture in which it was produced: “The World Psychiatric Association has recently initiated a global program against stigma and discrimination because of schizophrenia” (Sartorius, 2002, p. 1470). This statement maintains an interesting placement of linguistic terms. Initiating a program against “stigma” “because of schizophrenia” can be read in many ways, and suggests, perhaps unintentionally, a direction of blame toward schizophrenia—as a symptom, a label—it is unclear. Aside from the linguistic connotations, the assumption that schizophrenia is a global issue positions the dominant discourse to assert knowledge and power over other non-dominant and perhaps non-knowing populations.

Another similar example of ethnocentrism, offered by Bentall, is the World Health Organization’s “conclusion that the incidence rate of schizophrenia . . . does not vary across the world. They therefore inferred that there must be a uniformly distributed liability to schizophrenia and that ‘This liability must have a genetic basis.’” (2003, p. 124). What is discontinuous in this statement? Bentall goes on to point out other studies, more anthropologically-based, that reveal “schizophrenia-like psychoses are less common in non-Western societies than in the developed world” (p. 126), and offers explanations of schizophrenia as a “stress-related disorder”.

Beyond categorizations of a global nature, other ways of harming while attempting to help are more local. In Corrigan’s book *Don’t Call Me Nuts: Coping with Stigma of Mental Illness*, he describes a “stigma-busting presentation” strategy that teaches those with diagnoses how to share their personal story, as modeled in Kyle’s story:

Hi. My name is Kyle. . .and I'm here to tell you about a disease I have called bipolar disorder or manic-depression. The disorder I have, when it's untreated, can cause severe mood swings. The actual disorder occurs in the brain and neuro-pathways. Illnesses like depression, manic-depression, and schizophrenia are referred to as neurobiological brain disorders (2001, p. 263).

Kyle limits his understanding to a story of biological reductionism. Corrigan's book, supported by NAMI (National Alliance of Mental Illness), introduces other ways of "reducing stigma", which on a deeper reflection, may be seen as harmful on micro and macro levels, especially where there is an intermingling of power and non-power groups of discourse. NAMI has been largely funded by Eli Lilly (a pharmaceutical industry invested in global strategies to increase drug revenues) and serves to promote its biological messages that claim depression, bipolar disorder, and other psychiatric experiences are "diseases" to be treated pharmacologically. NAMI, a supporter of the Mental Health Act of 1995, gave police the right to force individuals into mental health clinics against their will (Sayce, 2000). NAMI teaches families and individuals with labels that the psychiatric experiences are biologically based, and they have been known to distribute pamphlets on ways to strategically coerce individuals to stay on medications that often are harmful or producing side effects that are worse than the psychiatric symptoms themselves. In this way, NAMI maintains an extreme pole of seeing and treating psychiatric experiences as biologically-based, a position to be explored in more detail in chapter five.

CHAPTER V
DISCONTINUITY: DECONSTRUCTING A DOMINANT
MENTAL HEALTH LANGUAGE

I have undertaken, then, to describe the relations between statements. I have been careful to accept as valid none of the unities that would normally present themselves to anyone embarking on such a task. I have decided to ignore no form of discontinuity, break, threshold, or limit (Foucault, 1972).

The goal of this chapter is to locate the discontinuity in the dominate discourse—the spaces of inconsistency that, upon identifying, allow for another truth to emerge in another discourse. To locate these spaces of discontinuity where an ‘other’ has been silenced, marginalized, disavowed, it becomes useful to deconstruct the patterns and the existing claims of continuity. Continuity is seen as that which appears to be stable, consistent, and agreed upon. CDA looks at what arguments and argumentation schemes are used to enact exclusion, discrimination, suppression and exploitation of the other (Wodak and Reisigl, 2003). These and other forms of maintaining a dominate discourse will be considered in this chapter by considering what is discontinuous and offers another explanation or truth to that of the dominant discourse.

Label Reliability and Construct Validity

To begin, one of the more challenged discontinuities is that of labeling reliability and construct validity. Labels do not have a history of being continuously reliable or valid in their definition and construction, which becomes problematic since psychiatry depends on the medicalization of mental health, and more specifically on the integrity

and consistency of the diagnostic labels which link these behaviors to illness (McPherson & Armstrong, 2006). This dependency creates a direct need for power over any other alternative approach to mental health problems that may challenge their position as well as the benefits that position reaps (by way of the pharmaceutical industry, as well as insurance companies).

Studies point to trends in label consistency and inconsistency as dependent upon social processes within the mental health field (McPherson & Armstrong, 2006) as well as the origins of categorization relative to psychiatric ideology and current social trends (Grob, 1991) and having less to do with the diagnostic principle of the illnesses themselves. Though the DSM has remained a basic tenet of the mental health field, reliability has remained a steady issue that pushes against its existence. Though mental health professionals intellectually understand that labels are constructs and not entities, the discourse that has been reviewed thus far has suggested that labels are framed in a way that makes them concrete, a part of the individual, and consistent in the eye of the observer (or professional).

In one study that looked at reliability of the DSM-III-R, there was a 68% to 72% reliability agreement (Williams, Gibbons, First, Spitzer, Davies & Borus, 1992). One of the most publicized studies was developed by Rosenhan (1973). In this study, eight “pseudopatients” were advised to apply for admission to different psychiatric hospitals, and to complain of auditory hallucinations (stating the words they were hearing were “empty”, “hollow”, and “thud”). Once admitted into the hospital, the pseudopatients were advised to cease reporting any hallucinations and assume their typical behavior. The results were piercing: some pseudopatients were kept in the hospital for up to fifty-two

days, and it was common for mental health professionals to repeatedly perceive and document their “normal” behavior as “disordered”. Some mental health staff made verbal assumptions about pseudopatients that revealed a perception of them as not only disabled “mentally” but cognitively impaired as well. The pseudopatients experienced devaluing as a result of their treatment in the hospitals. Further, in spite of each pseudopatient presenting with the same exact “symptoms”, diagnoses were not entirely consistent.

Other inconsistencies of diagnostic labeling have become more public, centered on human rights issues, as reviewed in the first chapter regarding biases and social control of sexual identity and preference, race, gender, etc. In light of these inconsistencies, studies continuously point to diagnostic categories as being clinically useful, but not valid (Kendall & Jablensky, 2000). Criticisms of diagnoses becoming “out of hand” are common, as described by this medical doctor:

The DSM currently admits close to 300 mental and behavioral disorders. Given that clinical appearances forge diagnoses, a particular patient can satisfy the criteria for several disorders and many dissimilar patients can meet criteria for the same disorder. Because the manual fails to identify what underlies the symptomatic expression of a condition, it cannot suggest intelligible principles relating one disorder to another or illuminate why some of them bunch together. For these reasons, faith in the criterion method has gradually faltered” (McHugh, 2005, p. 2536).

This criticism is supported by clinical disparities in awareness of particular bipolar symptoms, for example, that contribute to misdiagnosis (Ghaemi, Ko, & Goodwin, 2002). Diagnosis can take an average of 7 years before some individuals are properly diagnosed and “treated” (Ghaemi, Boiman, Goodwin, 2000). Further, there are blurred boundaries between trauma and bipolar disorder, as researchers indicated there is a broad relationship between both (Levy, 2007). To complicate matters more, alternative

explanations such as nutritional deficits, Lyme Disease, Korsakoff's, Wilson's Disease, brain tumors, Celiac Disease, neuroendocrine disorders, etc, are often overlooked by the clinician who is not trained to recognize or make distinctions between what is physical and what is mental, a distinction that has become a confusion on multiple levels.

Clinical Discontinuity: Examples of Common Fallacies

Turning toward more clinical descriptions, the following passage is taken from a social work text that has been written for the training purposes of master's-level social work students, and will be used to deconstruct a number of issues:

Schizophrenia is a syndrome that alters a person's capacity to sustain coherent, reality-based thoughts, and that creates a disturbance in a person's affective life and behavioral patterns. For those afflicted, it can be experienced as a painful struggle for emotional survival. Although the nature vs. nurture debate about the cause of schizophrenia has raged for decades, almost everyone now agrees that biological vulnerabilities are at the core of schizophrenic disorders. In the absence of brain dysfunction and/or hereditary predisposition, social and psychological factors alone have not been shown to produce schizophrenia (Berzoff, Flanagan, and Hertz, 2000, p. 271)

While there are multiple discursive aspects of which can be deconstructed in this passage, perhaps the most discussed strategy thus far has been the false dichotomy. Hertz invites the nature/nurture debate into her description as a way to acknowledge competing theories of schizophrenia etiology. She accepts the bifurcation, and participates in the dominant discourse by accepting the extreme pole of biological explanations regarding schizophrenia, thereby determining schizophrenia to be a biological disease.

As Hertz excludes explanations outside the dominant discourse, she coerces the reader to also accept biological explanations by making claims that 'almost everyone agrees' there is a biological explanation for schizophrenia. Who is "almost everyone"? In

this statement, Hertz commits the *ad populum* (“to the people”) fallacy of asking readers to believe her conclusion because “everyone” else agrees to biological explanations. Absent of any supportive evidence provided by Hertz, it is assumed the readers will uncritically accept her position as the truth. In this way, the social worker uses her authority instead of any intelligible explanations about schizophrenia, a strategy that is an unfortunate (yet common) part of learning texts, and a deprivation to educational environments that present as spaces for critical thought. Students, in accepting these claims, commit the *appeal to authority* error of believing claims put forth by social workers who are in no position to make such claims, without supportive scientific documentation.

Another way social workers demonstrate participation in the dominant frame is in using the “appeal to ignorance”. Hertz explains that because no evidence supports trauma or socially informed explanations of schizophrenia it must be the case that biology explanations are true. This is a sweeping statement that has been used to advance the dominant discourse, the driving theory being that biological explanations are the only explanation, a claim worth deeper investigation where one might find, hidden under the discursive practice, another truth, another voice, and perhaps another reason that ruptures the continuity of biological determinism.

First, there is a tendency for scientific suggestions and findings to be misinterpreted. While twin studies do report findings of neurological ‘soft signs’ in schizophrenia diagnoses (Neithammer, Weisbrod, Scheisser, Grothe, Maier & Peter, 2000), scientists admit that no identified causal alleles have been found—in other words, no “schizophrenia gene” has been located (Hamilton, 2008; Harrison and Weinberger,

2005; Owen, Williams, O'Donovan, 2004). Furthermore, genetic researchers state that the discovery of causal genes for psychiatric illness is highly unlikely (Kenler, 2005). Other theories of brain abnormalities have been suggested; for example, studies on brain structures such as that of the frontal cortex and limbic system have been implicated in schizophrenia. However, other studies find that these “brain abnormalities” occur in “normal” populations as well as various other neurological and psychiatric conditions (Cleghorn, Zipursky & List, 1991; Garza-Trevino, Volkow & Cancro, 1990), which acts to discredit previous claims.

To add, perceiving schizophrenia as a biological disease creates a permanence truism; in other words it can perpetuate the belief that those with labels will never recover from or be without psychiatric symptoms once labeled (as discussed in the Clinician's Illusion). The purported truism also holds a discursively intuitive claim that people with psychiatric diagnoses are biologically inferior. For what has led us to believe, other than the dominant discursive positioning of linguistic categories, that identical twin studies are an absolute indication of genetic disposition? One cannot claim a genetic disposition through heritability studies; one can only speculate or hypothesize.

Looking once more at the remainder of the above passage, Hertz claims that “in the absence of brain dysfunction . . . social and psychological factors alone have not been shown to produce schizophrenia” (Berzoff, Flanagan, and Hertz, 2000, p. 271). This statement is unclear, and seems paradoxical. Hertz has made the claim that schizophrenia is a biological condition, but then complicates, or perhaps equivocates using the phrase “brain dysfunction” by considering it a symptom, an etiology, as well as a definition of schizophrenia. The statement, in its whole form, is a question-begging argument, where

Hertz has inserted the answer (brain dysfunction) into the question (of schizophrenia as a brain dysfunction) after already laying down her premise that schizophrenia is a biological disorder supported by theories of brain dysfunction. Once more, this social worker is asking the reader to accept her conclusion without providing any real evidence. Further, what authority or evidence exists that necessitates a direction toward finding what “produces” a psychiatric disability? The process becomes circulatory and not rooted in educational substance. Hertz’ position is perhaps more revealed throughout her continuous referencing of the person diagnosed with schizophrenia as “the schizophrenic”.

Hertz’ exclusion of alternative information, in the immediate space of making biological claims, overlooks the greater macro issues of who funds scientific research, what views are supported that invariably become public information, etc., despite the author’s eventual inclusion of other possibilities. In short, many of her claims abandon the notions of what a social worker claims to seek in explanations of psychiatric presentations— namely environmental, cultural, familial factors that contribute to alternative ways of considering psychiatric disability.

There are more dated theories, such as intergenerational transmission of collective harm, of Bowenian understandings, of trauma informed theories, stress theories, socioeconomic theories, all of which present additional problems when attempting to fit a unique individual into a particular constructed frame. Herman (1997) suggests that 40 to 60 per cent of individuals who receive mental health services have a history of childhood physical and/or sexual abuse. Environmental contributions to psychiatric disability are often overlooked, as these understandings have a tendency to be grouped into an extreme

category of placing blame on the family, a taboo subject which groups like NAMI effectively polarize, adding weight to biological reductions of understanding.

What these findings suggest is an epidemic of not only dominant discursive practices, but the risk of asserting imperialistic notions used to describe and treat individuals well beyond our capacity of understanding. More universal studies reveal that persons diagnosed with schizophrenia who live in undeveloped countries have a better outcome due to family support, tolerance in the community, and work opportunities (Jablensky, Sartorius, Ernberg, Anker, Korten, Cooper, et al., 1992) as opposed to more developed countries that rely on psychopharmacology. However, there is much inferred in such statements. The point is not to dislodge the biological assumptions, but rather to open space for other competing assumptions that have been excluded from the dominant discourse. Interestingly, just seven pages prior to the claims about schizophrenia in the social work manual, the authors coach students on the humanism of each individual:

...we are not necessarily different than or separate from those who are labeled with mental illness. We all have elements of suffering and disharmony in our lives. Biological, psychological, and social forces will combine to determine where we fall in a given moment along the continuum from mental illness to mental health. As Harry Stack Sullivan (1940) noted: "In most general terms, we are all much more simply human than otherwise; be we happy and successful, contented and detached, miserable and mentally disordered or whatever" (Berzoff, Flanagan, and Hertz, 2000, p. 264).

In this passage, the authors describe psychiatric experiences as being on a continuum, and interestingly one that can fluctuate 'in a given moment'. This perspective of a mental health continuum, as more inclusive and continuous, dismisses the permanence engendered in biological claims and frees the individual from discursive patterns of hopelessness. It suggests the possibility that persons labeled with

schizophrenia also have room on the spectrum for experiences other than value-laden and deterministic claims of a “painful struggle for emotional survival”. It creates the possibility that persons with this label may go on to live schizophrenia-free lives.

Granting the authors some credit for their efforts of inclusion, this humanistic approach coincides with scientific findings supported by other competing claims. However, in the seemingly benign message there lies yet another contradiction. As the authors quote Sullivan, the quote seems to distort their initial efforts as placing those who are “miserable and mentally disordered” on the continuum, once again laying harsh value judgments on one’s pathologized constitution, linguistically placing permanence on “mentally disordered” while grouping this homogenized label with “miserable”, all of which may negatively influence a new student, as Deegan speaks of the underlying power the authors and the student both have:

When we make the transition from being a student to being a professional clinician, our culture and human service grant us a broad range of power over the lives of people who are in distress. With that power comes enormous responsibility and great risk. . . I have found myself needing to ask some difficult questions about the power granted to clinicians: about the way we assume this power as privilege; about how our use of this power can erode our values and ideals; about how our use of this power can systematically disempower those we are supposed to be serving; about how it can oppress and sometimes hurt the people who come to us for help (1990, p. 302).

Moving on from Hertz’ passage, participation in the dominant discourse, while accepting a medical model frame of clients as described above, can easily lead one to maintain a pervasive hopelessness about those diagnosed, as one psychiatrist describes his experience of being a “label maker”:

Back in my office, I watched Miss B. struggle to make sense of the simplest of my questions. Her affect was flat, and her eyes were forlorn. She was being bombarded with stimuli that only she could see and hear. I felt pangs of sorrow

for her and her family as I began fashioning her diagnostic label, shaping her view of herself for years to come. My pen wrote “Schizophreniform Disorder.” It was as if a scene from *The Scarlet Letter* was playing out before me: “They have doomed Mistress Prynne . . . for the remainder of her natural life, to wear the mark of shame upon her bosom.” I labeled her for medical accuracy in my charting, and I labeled her for the insurance company that pays for her treatment. But I had a hard time believing that my labeling was going to be of any therapeutic value (Raj, 2005, p. 687).

This level of hopelessness, as the psychiatrist describes his assuredness that Miss B. will move into a further decline, is not uncommon. Raj explains his participation in the dominant discourse begrudgingly. His sense of control and dominance, with regard to Miss B’s future, is remarkably present as he talks of “fashioning” and “shaping her view of herself”. It is not that he wishes this for her or that he even wants to participate in delivering such a prognosis; rather Raj believes that Miss B. is doomed. In an earlier passage, Raj describes some of the discursive practices that support this stance:

Mental illness is more than a diagnostic label. It is an identity label. Patients with schizophrenia do not just *have* schizophrenia, they *are* schizophrenic. The outward appearance of a schizophrenic may be completely normal and unchanged, while the inner workings of his or her mind is a kaleidoscope of twisted reality (Raj, 2005, p. 687).

Perhaps this is an ideal example of how the dominant discourse harms, for Raj has begun to see those labeled with schizophrenia as their labels and groups them into one ideal type of homogeneous presentation and outcome. More poignant, he does this consciously, as if there is no other alternative way of knowing. Raj also painstakingly admits that these labels cause harm and are often misused:

Sadly, mislabeling and overlabeling have been major issues with far-reaching implications. I routinely encounter patients who are hospitalized carrying their diagnostic labels like proverbial crosses—labels created in haste but indelible over time. These labels, regardless of accuracy, end up dictating the treatment and

tyrannizing the self-image of the patient they were supposed to benefit (Raj, 2005, p. 687).

Raj not only spells out clearly how labels can harm, but he also demonstrates how powerful the dominant discourse can be, not only toward those with labels, but toward his own perception as a psychiatrist. What is not included in the dominant perspective is the prevalence of recovery, a message that is noticeably missing in Raj's language as representation of the dominant discourse. As one person given a label states:

Recovery has only recently become a word used in relation to the experience of psychiatric symptoms. Those of us who experience psychiatric symptoms are commonly told that these symptoms are incurable, that we will have to live with them for the rest of our lives, that the medications, if they (health care professionals) can find the right ones or the right combination, may help, and that we will always have to take the medications. Many of us have even been told that these symptoms will worsen as we get older. Nothing about recovery was ever mentioned. Nothing about hope. Nothing about anything we can do to help ourselves. Nothing about empowerment. Nothing about wellness (Mead & Copeland, 2000, p. 1).

What the voice of this non-dominant discourse knows is that recovery does exist, that hopelessness is an active misconception in the dominant discourse, and hope, a form of discontinuity. What Copeland speaks about is awareness of having been marginalized, and of once participating in a dominant discourse that did not serve her, a discourse that did not include this possibility of hope of recovery. This recovery discourse points to longitudinal studies, some global, revealing that many people fully recover from "major mental illness" with and without the use of psychiatric medications, and go on to live symptom-free lives (Davidson, Harding, Spaniol, 2005; DeSisto, Harding, Ashikaga, et al., 1995; Huber, Gross, Schuttler, 1975; Ogawa, Miya & Watarai, 1975).

Recovery is one of the main discontinuities that exists in the dominate discourse, that if accepted might present a different or transformative stance on psychiatric disability. One is left to question if the professional's own hopelessness maintains a distance from this discourse of hope. For what scientists have found and discovered is the brain's ability to regenerate cells in areas that are considered insufficient and recompensate in areas where regeneration is limited (Begley, 2007). Science calls this neurogenesis and neuroplasticity, and it is an emerging part of the non-dominant discourse, being excluded in circles while simultaneously dislodging the complacent and careful Clinician's Illusion, the Kraepelin methods, the Cartesian ideology that the brain is hard-wired, fixed, and doomed to be permanently biologically diseased in those who have been labeled with psychiatric diagnoses.

Neuroplasticity is the brain's ability to rewire, or change neuronal networks. Neurogenesis is the creation of new brain cells, a process that occurs throughout the lifecycle. The growing science of neuroplasticity demonstrates ways that the brain is malleable to internal and external stimuli, and can be transformed, changing in structure and network. In the late 70s and early 80s, Michael Merzenich began observing plasticity in the cortical mapping of the brain—others observed this previously, though most findings were challenged with the continuous claims that childhood brains, after a certain period, were immutable (Schwartz & Begley, 2002). Merzenich challenged this by demonstrating ways that the cortical maps become changeable when exposed to somatosensory experiences. Other researchers in the therapeutic fields began drawing connections between mental focus and decreased “psychiatric symptoms” that led toward the unraveling of biological permanence as an absolute truth claim.

Norman Doidge, a psychiatrist and researcher, brought this discussion of neuroplasticity forth to the greater public, along with others like Jeffrey Schwartz. Doidge (2007), in his book *The Brain that Changes Itself*, explains how thought can turn genes on and off, and rewire the brain as he illustrates story after story of personal accounts in which a woman with brain damage remapped her brain to be wholly functioning again, or how the power of thought changed one's response to stress, or increased one's IQ, or reversed a learning disability, etc. Schwartz, in his therapeutic discoveries that defied the biological permanence of obsessive compulsive disorder, describes how persons labeled are able to overcome their "symptoms" entirely by focusing the mind on a cognitive process that Schwartz calls "the four step method" (Schwartz & Begley, 2002). As the individual relabels, reattributes, refocuses, and revalues a given experience, the brain begins to re-map another process that replaces the supposed "pathological" former thought process. These researchers, by adjusting Cartesian assumptions, have re-inserted volition back into biology, reminding those in the mental health field of the resiliency of human beings, as Schwartz quotes one researcher: "willful redirection of attention is efficacious" (Schwartz & Begley, 2002, p. 297). In this way, a person's situation becomes not so hopeless but hopeful.

Neuroplasticity and neurogenesis in the brain signify the brain's power to heal itself. Beyond these scientific findings, research points to the power of focusing one's attention in order to transform and induce neurogenesis in the brain, a dominant discourse in other cultures where meditation, for example, is a healing, transformative practice. Changes in the brain as a result of meditation and focused attention have been shown by fMRI studies (Lutz, Greischar, Rawlings, et al., 2004).

In the dominant discourse, where biological reductionism reigns, these reputable, scientific reports remain marginalized, publicly questioned and dismissed, for much is at stake if the brain can, in actuality, heal without medication. What would happen to the pharmaceutical industry, psychiatry, the insurance companies . . . and what would happen to the narrative between social worker and client in session? So often, what shifts a discursive ideology is the reconstruction of another, for the recovery discourse holds a truth that existed long before scientific evidence of neurogenesis and neuroplasticity:

We have learned that we are in charge of our own lives and can go forward and do whatever it is we want to do. People who have experienced even the most severe psychiatric symptoms are doctors of all kinds, lawyers, teachers, accountants, advocates, social workers. We are successfully establishing and maintaining intimate relationships. We are good parents. We have warm relationships with our partners, parents, siblings, friends and colleagues. We are climbing mountains, planting gardens, painting pictures, writing books, making quilts, and creating positive change in the world. And it is only with this vision and belief for all people that we can bring hope for everyone (Mead and Copeland, 2000, p. 2).

Yet, despite these exuberant reports of hopefulness, there are those who do not go on to remit symptoms, and there remains a dominant discourse that continues to focus on this as expansive of a greater psychiatric population. Many of these professionals, in the practice of trying to decrease “internalized stigma”, while carrying some awareness of the hopelessness that can become internalized in the individual, often harm when trying to help. In “Stigma and schizophrenia: Directions in student training,” Mason and Miller (2006) direct social workers on helping “clients recognize and cope with stigma so that the potentially negative effects can be lessened” (p. 73). In a group discussion about the etiology of schizophrenia, a social worker states: “Schizophrenia is about a chemical

imbalance causing people not to be their usual selves” (p. 84), discursively takes any power or volition out of the equation of possibilities for the person labeled..

To be clear, no “chemical imbalance” has ever been measured in the brain (Lacasse & Leo, 2008; van Karmen & Kelly, 1991) and there is no identifiable brain “abnormality” associated with psychiatric disability that is conclusive, as studies below will attest. Despite the dominant discursive strategy of explaining certain psychiatric diagnoses as “chemical imbalances” or as “brain diseases” there is no founded evidence to support this discourse, only inferential reasoning, exaggeration and/or misinterpretation of scientific findings, as reported by Congress of the United States (1992):

Research has yet to identify specific biological causes for any of these disorders. Mental disorders are classified on the basis of symptoms because there are as yet no biological markers or laboratory tests for them (p. 46).

If higher concentrations of dopamine are associated with schizophrenia, then higher concentrations of these chemicals would be expected in persons with schizophrenia. The results are inconclusive (p. 78).

It is useful to deconstruct this further: where does the saying “chemical imbalance” come from? The statement is derived from, once more, a reductionist reasoning that deduces the following: a person has schizophrenia, so he is given psychotropic medications to “treat” this “illness”. Because his symptoms decrease or go into full remission while on the medication, the medication which activates chemically altering properties, must have altered the brain chemically enough to “fix” the condition. If this is so, then one can infer that a chemical imbalance exists which can be treated with medication. The Congress of the United States reiterates this hypothesis here:

In fact, many initial advances in understanding the biochemistry of mental disorders came from studies of drug actions in the brain. If a drug is found to be effective in treating a disorder, examination of that drug's chemical action in the brain may lead to the discovery of an intrinsic pathology (1992, p.74).

What science reveals is that no exact or "right" amount of chemical in the brain has been measured, determined or decided to be definitively normal. Logically, if there is no baseline for comparison, such claims rest on faulty premises. Studies reveal that levels of dopamine have been found to be no different in persons with or without a diagnosis of schizophrenia (Bentall, 2003). However, studies do reveal that a depletion of dopamine, for example, can decrease cell proliferation (Hoglinger, Rizk, & Muriel, 2004), which can be restored by dopamine agonist neuroleptic medications.

To revisit reductionist claims regarding medication, the "dopamine hypothesis" (and likewise, the serotenergic hypothesis), at a deeper look, raises questions about the efficacy of standard antipsychotics, as follows: Psychotropic medications take approximately three weeks before showing any benefit or symptom remission in the person (a common fact of which the dominant discourse acknowledges along with the admission that this phenomenon is not understood). The hypothesis states further that upon the first dose administered, the person's synapses are immediately flooded with the dopamine that is reportedly depleted in the brain, yet, despite this replenishment, psychiatric symptoms remain and continue sometimes for weeks, leaving scientists puzzled.

There has been discovery of neuron-growth being stimulated by the psychotropic medications, explaining this to be the healing factor in medicine, not the flood of serotonin correcting a "chemical imbalance" (Lehrer, 2006). Studies have also revealed

the power of mind to stimulate new cell growth. The propensity for both medication and mental focus to stimulate neurogenesis presents an interesting competition for the power matrix, one in which the dominate discourse continuously demonstrates preference for medication over mind, or profit over the individual's own resources.

Other competing theories are brought forth by findings of neurogenesis. Schwartz, in reintroducing the will, also points to scientific notions of the “Heisenberg Uncertainty Principle”, another marginalized explanation for interpretations of a chemical imbalance. He explains that in the synapse (where neurotransmitters fire and seemingly produce “psychiatric symptoms”)

...there is a probability associated with whether the calcium ions will trigger the release of neurotransmitters . . . a probability, that is, and not a certainty. There is, then, also a probability but not a certainty that this neuron will transmit the signal to the next one in the circuit without which the signal dies without leading to action” (Schwartz & Begley, 2002. p. 357).

Schwartz, supported by other neuroscientists, explains this probability is due to thermal fluctuations as well as the ion channels' “extremely narrow” tunnels that make the possibility of neurons firing to be a hit or miss situation. Then, Schwartz goes on to explain once more the power of the will in this probabilistic phenomenon, once more placing human decision into the scientific equation:

Let's take the example of a person suffering from OCD. In this case, one possible brain state corresponds to “Wash your hands again.” Another is, “Don't wash—go to the garden.” By expending mental effort—or, as I think of it, unleashing mental force—the person can focus attention on this second idea . . . As a result, the idea—whose physical embodiment is a physical brain state—“Go to the garden” is held in place longer than classical theory predicts. The triumphant idea can then make the body move, and through associated neuroplastic changes, alter the brain's circuitry. This will change the brain in ways that will increase the probability of the “Go to the garden” brain state arising again.”

Social workers who have used Schwartz' four step method in therapeutic settings with individuals experiencing OCD can attest to the power of this mind over matter process, as can the recovery discourse which provides a similarly parallel process described in chapter seven. Other studies reveal ways that individuals' psychiatric experiences discontinue. As mentioned in a previous chapter, Ross (1989) acknowledges that many persons with a bipolar disorder diagnosis do not need mood stabilizers and can "get better" on their own, while others discontinue the medications after time, effectively (Ross, 1989).

Although these findings have more scientific inquiry and testing to come, neurogenesis remains on the cutting edge, as well as on the fringe of the dominant discourse, where the possibility of impermanence threatens the economic gain of invested pharmaceutical systems in the mental health field—that is, unless cell proliferation can be treated with medication. Researchers are still studying where neurogenesis occurs and whether or not this can occur naturally, and scientists are finding ways to explain how neurogenesis can be manufactured by psychiatric medications.

Despite ample support for adhering to medication protocols, studies show persons labeled with schizophrenia may do better with little or no psychiatric medication (Harrow, 2007; Whitaker, 2004; Bola and Mosher, 2002). It is not uncommon for social workers to be unaware of this information. For example, in the aforementioned study of social workers seeking to decrease internalized "stigma" in persons with diagnoses, the authors coach social workers from the dominant medical model about how "stigma . . . is almost always a factor when compliance with medication is poor" (Mason and Miller, 2006, p. 87). One interesting aspect of this statement is that the authors locate "stigma" as

something the person labeled creates. This is a confusion of the term, where many professionals seem to interpret “stigma” as a product of the person instead of the societal acts of stereotyping, discrimination, and fear that is projected onto the person, having less to do with the individual’s behavior and more to do with the negative attitudes and beliefs associated with the label. Also, the social workers explain that medication non-compliance may result in more symptoms which increase a person's experience of "stigma". In this way, Mason and Miller coach social workers on the importance of “medication compliance”, while not giving any indication of the client’s feelings or experience regarding medication compliance.

CHAPTER VI

SYSTEMIC OPPRESSION IN THE MENTAL HEALTH FIELD

In preparing my talk I reflected on what the most important message was I could share with these young people who would soon enter professional practice. The message I felt called to share was rather simple: *People with disabilities are people*. When we forget that people with disabilities share a common humanity with us then the human is stripped from the human services and the stage is set for the emergence of the inhuman and the inhumane. The inhuman and the inhumane emerge from that rupture which occurs when one human being fails to recognize and reverence the humanity and the fundamental sanctity, sovereignty and dignity of another person. Such a rupture in mutual relatedness occurs often in the helping professions and for this reason helping professionals sometimes hurt rather than help people with disabilities. Too often the human services dehumanize and depersonalize. Many people with disabilities refer to this special kind of hurt as “spirit breaking” or “how the system tries to break your spirit (Deegan, 1990).

This chapter will review findings that show individuals who have been labeled become socially devalued, stereotyped, discriminated against in and outside of the mental health field. As Link states, the power relationship includes “. . . elements of labeling, stereotyping, separation, status loss, and discrimination [that] occur together in a power situation that allows them’’ (Link & Phelan, 2001, p. 377).

Prevalence of Negative Attitudes and Beliefs about Psychiatric Labels

Numerous studies support the prevalence of social separation between those with and those without labels. The longstanding debate for and against labeling theory was a discussion of whether or not social rejection of those with labels was a result of the “stigmatizing” label itself or the “bizarre” or “abnormal” behavior displayed by those with labels (Scheff, 1966; Gove, 1970). Since, efforts to identify and address attitudes and beliefs about mental health problems have been in progress for the past 50 years

(Nunnally, 1961). Goffman (1963) described the label one is given upon entering the mental health field as being “an attribute that is deeply discrediting”. This was coined as “stigma”. Weinstein challenged labeling theory in 1983, arguing the proponents and opponents of the theory had failed to explore how those diagnosed perceived their labels. This sparked some directives set out to determine the existing attitudes and beliefs and how, if at all, they were internalized by the person. It was in these movements some attention was given to the discursive power of diagnostic labeling.

Negative Attitudes and Beliefs of the General Public

In a multi-field meta-analysis study of negative attitudes and beliefs about individuals with psychiatric labels and researchers found that “stigma” was “strong enough to be observed in everyday life” (Mak, Poon, Pun and Cheung, 2007). Despite assumptions that the Olmstead Act (1999) would improve attitudes and beliefs following deinstitutionalization, studies show that those with labels in alternative settings are also looked down upon (Liggins & Hatcher, 2005). In two identical UK public opinion surveys, little change was recorded over 10 years, with over 80% endorsing the statement that “most people are embarrassed by mentally ill people”, and about 30% agreeing “I am embarrassed by mentally ill persons” (Huxley, 1993).

Accompanying these general negative attitudes and beliefs is often a lack of knowledge about psychiatric disabilities. Though the general public can distinguish between diagnoses, overall knowledge about psychiatric disability is low (Lauber et al., 2003) and poorly understood (Byrne, 2000). Wolff, Pathare, Craig, and Leff (1996) found that lack of knowledge about mental health is associated with negative attitudes and that attitudes can be improved through psychoeducation.

Negative attitudes and beliefs can exist on many levels within the public and among professionals. Socio-demographic factors can determine attitudes (Wolff et al., 1996) and these perceptions can vary in degree, depending on the specific diagnosis and socio-cultural group (Lau & Cheung, 1999; Lee, Lee, Chiu, & Kleinman, 2005). Agency and organizational factors in mental health settings may only have a slight contribution to the variation of “stigmatization” (Verhaeghe & Bracke, 2007). Negative attitudes have been observed in undergraduate students (Corrigan, 2001), in media depictions (Philo, 1996), and even among family members. Families may distance themselves from members who have been labeled, due to negative attitudes and beliefs of the public or even fear of how they may be treated by others outside of the family (Rudge & Morse, 2004). For these reasons, Miller and Mason (2002) found that many clients choose not to tell friends or less immediate family members.

Negative Attitudes and Beliefs of Professionals

Studies show that mental health professionals also harbor negative attitudes and beliefs about individuals with diagnoses. Negative values can be part of the therapeutic countertransference from social worker to client (Trull, 2006). Wahl (1999) found 28 out of 100 of people he interviewed who had been labeled reported mental health caregivers as giving “discouraging advice”, along with “disparaging remarks and rejecting behavior”. One respondent, for instance, reported mistreatment by mental health care professionals: "I have worked at [a psychiatric facility]. As with many other facilities in which I have worked, the patients are spoken about with disrespect, sometimes mocked, and often spoken to in shaming ways" (p. 473). Another respondent, while a medical student in training, stated: "The treatment of psych patients in all rotations was awful.

They would laugh at them, poke fun at them on rounds, disbelieve any physical complaint they had" (p. 473). In a study on the use of language recorded in nurse documentation on inpatient units, only 1% out of over 4000 entries demonstrated a positive regard toward the patient, whereas 20% of the language was rated as 'pejorative, punitive, inane and nonsense' (Mohr, 1999, p. 1056). Examples included "is controlling and engages in power plays with staff" "mostly superficial and manipulative – focuses on [herself] exclusively", etc.

Though psychiatrists may hold more favorable attitudes than the general public (Kingdon, 2004), there is a tendency for medical personnel and psychiatrists to be unaware of stigmatizing attitudes and beliefs they carry that directly affect the client (Sartorius, 2002). Studies suggest psychiatrists perpetuate many concepts underlying biased and "stigmatizing" attitudes, and suggest that the way in which psychiatry is structured maintains the status quo (Fink & Tasman, 1992).

"Stigma" may be more devastating, life-limiting and long lasting than the primary illness (Schulze et al., 2003). Wahl (1999) surveyed 1301 'consumers' (all NAMI participants) and interviewed 100 of these to look at personal experience as well as attitudes and beliefs. He found that 80% of respondents overheard hurtful or offensive comments about people with 'mental illness'; 77% encountered offensive media portrayals; 27% were advised to lower their expectations in life; 7 of 10 were treated as less competent once they disclosed their disability; 95 of 100 perceived long-term consequences due to negative attitudes and beliefs about their diagnosis. One study found that 70% of caregivers of those with diagnoses believe the label is devaluing to the person (Struening, Perlick & Link, 2001). Negative attitudes and beliefs about mental

illness have been shown to contribute to employment and income in a harmful way (Link, 1982), poverty and lack of access to socially valued roles (Wolfensberger, 2000), discrimination (Dinos, Stevens & Serfaty, 2005; Phillips, Pearson, Feifei, Minjie & Yang, 2002), and marginalization (Police, McCormick & Dewees, 1995)

Stereotyping Individuals with Psychiatric Labels

Stereotypes are described as exaggerated differences between groups that are emphasized through categorizations that create an us/them divide (Townsend, 1979). Stereotypes include perceiving those with psychiatric labels in distancing ways that include thoughts about the other as being different. Persons with labels have been perceived as being unpredictable, dangerous, and blameworthy (Jones et. al., 1984); dangerousness (Nunnally, 1961; Phelan, 1997). There are beliefs that persons labeled with schizophrenia and bipolar disorder are predisposed for violence (Link 1998). In a recent survey, Crisp, Gelder & Rix (2000) found those with a range of seven psychiatric disabilities were perceived by the general population as hard to talk to, different and unpredictable; 70% of respondents thought that people with schizophrenia, alcoholism and drug addiction were dangerous, and those with substance abuse problems were to blame for their problem. According to one study, employers' main concerns about those with labels include perceptions of dangerousness, reduced productivity, presence of strange behaviors, and risk of relapse (Tsang, Angell, Corrigan, Yueh-Ting Lee, Kan Shi & Lam, 2007).

Stereotypes can be heterogeneous attributions toward all persons with a label, or they can be particular to a diagnosis. For example, schizophrenia (Sartorius, 2002) and personality disorders are more negatively viewed (Lancee, & Garfinkle, 1989; Lewis &

Appleby, 1988). Markham (2003) found that Registered Mental Health Nurses (RMNs) expressed less social rejection towards patients with a diagnosis of schizophrenia and perceived them to be less dangerous than patients with a BPD label. Health Care Assistants (HCAs) made no such distinctions on these measures. Staff were least optimistic about patients with a BPD diagnosis and were more negative about their experience of working with this group compared to the other patient groups; Clinicians and researchers have also emphasized that staff often experience extreme emotional responses to such patients and draw attention to the potential disruption and harm that may ensue to both staff and patients (Beck et al., 1990; Main, 1957). Supportive of these findings, Lewis and Appleby (1988) found in surveying psychiatrists on their responses to vignettes that described particular diagnoses, responded with value judgments, such as “unlikely to improve”, “likely to annoy”, “manipulative”, etc.

Discrimination of Persons Given Psychiatric Labels

The APA (1992) reports:

For decades, persons with disabilities have been identified by their disability first, and as persons, second. Often, persons with disabilities are viewed as being afflicted with, or being victims of, a disability. In focusing on the disability, an individual's strengths, abilities, skills, and resources are often ignored. In many instances, persons with disabilities are viewed neither as having the capacity or right to express their goals and preferences nor as being resourceful and contributing members of society. Many words and phrases commonly used when discussing persons with disabilities reflect these biases (p 1).

Discrimination of those with psychiatric labels occurs in every aspect of social and economic existence (Dinos et al., 2005; Fink & Tasman, 1992; Read & Reynolds, 1997; Byrne, 1997; Thompson & Thompson, 1997), is considered a universal problem (Kabir, Iiyasu, Abubakar, & Aliyu, 2004; Tsang et al., 2007), as well as one that is local to

communities, families, churches, coworkers, and mental health care givers (Wahl, 1999). Though social support contributes to self esteem (Mechanic, McAlpine, Rosenfield, & Davis, 1994) and socially valued roles are considered to be a healing factor for those with diagnoses, studies reveal that those with diagnoses are often denied access to social roles (Wolfensberger, 2000) and as a consequence can experience social isolation (Aubry, Teft & Currie, 1995). One way persons with psychiatric labels are discriminated against is in the pursuit of higher education. One individual states: "Frequently psychologists and doctors [seem to believe that] all schizophrenics aren't capable and cannot achieve a higher education" (Wahl, 1999, p. 79). College administrators and staff often lack understanding of psychiatric disability and how this affects students' treatment regarding psychiatric experiences (Frankie et al., 1996).

Also common in mental health settings is a tendency for those labeled to be dissuaded from seeking employment. One mental health professional states:

The second civil violation that may occur is the stigmatizing of the patient due to their diagnostic label. How many retail shops will want to hire a schizophrenic? If one sees the label "schizophrenic," it hardly seems to matter that the individual is on medication and stable, and has been so for nearly a year. Instead, the public tends to think only of the label and serious civil rights violations may arise (Trull, 2005, p. 135).

Cnaan (1988) states that work is an essential part of being in the community. To add, employment is one of the characteristics of "rehabilitation" for those who have been labeled with a psychiatric disability (Anthony, Cohen, Farkas, 1990). Though the label may account for some unemployment situations, lack of access seems to be a larger issue. According to Powell (2002), 70% of "consumers" want to work while less than 15% are working and less than five per cent have access to supported employment. Mental health

professionals contribute to employment discrimination; According to Wahl (1999), more than 25% of 100 persons interviewed reported being advised by case managers to lower their job expectations well below their educational, training, and intellectual levels (Wahl, 1999); As one person interviewed by Wahl (1999) describes: "I've had case managers hint not to push for the highest accomplishment I can do. Sometimes it would be nice if they would push for something more than just sitting in chairs all day (p. 9)." Still another interviewee described how the doctor who first diagnosed her bipolar disorder told her that "people with your problem will have a very low level type of life (p. 9)" (Wahl, 1999). Additional studies reveal those who have a psychiatric disability experience continued problems finding employment and housing (Pickenhagen & Sartorius, 2002).

To follow, having a psychiatric label is related to lower socioeconomic status, homelessness and imprisonment, and systematic exclusion (Kelly, 2006). Those with psychiatric labels are systemically denied access to equal healthcare. Studies reveal that those with psychiatric diagnoses experience poorer quality of care for physical illnesses (Pickenhagen & Sartorius, 2002), leading to discrimination of services for treating physical illness and lower standards in diagnostic procedures (Fang & Rizzo, 2007). To extend this dilemma, mental health services remain poorly funded (Carlisle, 2003). Kelly (2006) found these exclusions to be a lack of emphasis on mental health issues on both social and political level agendas, exclusion of individuals with diagnoses from civic and social life, and ongoing failure to address the deficiencies of health and social services provided for those with diagnoses, and considered these to be an act of structural violence. Perhaps one of the more interesting social exclusions is revealed by the law

itself. Szasz (1990) states, “Today, Americans live under two sets of laws: one applicable to the sane, the other to the insane.” Those with psychiatric disabilities, though this is changing, have historically had very little part in policy level decisions, as one person states:

We are excluded systematically, we don't have the rich lobbyists, we don't have the pipeline to Washington. The policy wonks are the ones that are making all these decisions about us and for us, and we need to find a way to get our people represented in a genuine, participatory fashion, in housing decisions, Social Security decisions, and HCFA health care decisions. (NCD, 2000)

Systemic Abuse of Persons with Psychiatric Labels

Studies reveal ways that antipsychotic medications, while creating “symptom remission” for some, have also harmed—a fact that is underestimated among professionals, hidden in public discourse, and in some instances lied about by pharmaceutical companies profiting off the medication at the expense of others’ lives. There are reports that reveal the government supports cheaper medications even if these have devastating effects compared to more expensive options (Sartorius, 2002). There are reports that psychiatrists do not listen to persons who report harmful side effects of their medication. When the person who is taking the medication is not involved in the psychiatric process, the result can be power abuse.

Prescribed antipsychotics for children increased fivefold between 1995 and 2002 in the United States (Cooper, Arbogast, Ding et al., 2006). Although second generation antipsychotics do not produce some of the older side effects of Extra Pyramidal Symptoms (e.g. tardive dyskinesia) come with their own set of detriments, including potential weight gain, and hyperglycemia, and hypertension (Correll, Pnezner, and Parikh, 2006) in addition to negatively affecting the cardiovascular, neurological,

endocrine and hematological systems (Bryden, Carrey, and Kutcher, 2001). Examples of these affected systems include hyperprolactinemia and sedation (Pappagallo and Silva, 2004). Risk of treatment-emergent diabetes in individuals under 24 years of age is four times greater than that of the general population (Harrison-Woolrych, Garcia-Quiroga, Ashton et al., 2007). The span of iatrogenic harms can include anything from death to common side effects such as sexual dysfunction, inability to concentrate, depersonalization, etc.

As it stands today, mental health parity is only granted to those who are considered to have “biologically based” diagnoses; in other words, only diagnoses that are supported by the dominant discursive practice of biological determinism. Those who have psychiatric experiences that are not biologically claimed are, therefore, excluded. The one exception being that of involuntary hospitalization, an act many consider to be a human rights violation in itself. Hospitals have had to undergo legislative changes so that the rights of “patients” in institutions include basic allowances, such as making a phone call or receiving visitors. Voting privileges are rarely requested for those in inpatient settings. There remains a longstanding history of harm and abuse that has occurred within the system, a history that is well beyond the scope of this paper. Deegan illustrates her experience:

But there are some sounds you can never get used to. Like the sound of a man strapped down in restraint and crying out “Help. Help me. Someone please help me.” . . . When I first heard him crying out, I jumped out of bed and ran down the hallway. What I found amazed me. There, outside the door of the seclusion room, was a mental health worker sitting with his legs swung casually over the side of a soft lounge chair. He had parked the lounge chair outside of the open door from which the cry was emanating. The mental health worker was flipping through a magazine. He appeared to not hear the cry of the man in the seclusion room. Actually, it was as if he didn’t even recognize that the patient in that room was a

person who was in great distress. . . Quietly, I slipped past the mental health worker and looked inside the seclusion room. An old man, probably about sixty or so, with white hair and very thin, was strapped down on a green rubber mattress. Heavy leather cuffs lashed his wrists and ankles to the cold steel of a metal bed frame. He was stripped naked except for his underwear. . . When I saw that mental health worker sitting in a casual comfort outside of the room in which a man was restrained, humiliated and crying out for help, I froze in terror and disbelief. For a moment I could not move. I felt numb. Then I felt a tearing inside my heart. . . You see, if you are a patient in a mental hospital and you hear a fellow patient who is in restraint and who is crying out for help, you are not allowed to answer the cry. You are not allowed to be fully human, to be whole and therefore able to respond to another human being compassionately. You are not allowed to go into that room next to the old man and talk softly to him. You are not allowed to bring him drink of water or to wipe his brow or to just sit there with him so that he will not feel so abandoned (Deegan, 1990, p. 304).

Internalized Oppression

DeNiro (1995) describes three forms of social disconnection that people with labels experience: loneliness, isolation and lack of solidarity (“not fitting in” or “being different Individuals who have been labeled internalize discriminatory behaviors and negative attitudes and beliefs, anticipate distancing or rejection, and develop coping strategies (secrecy about diagnosis or withdrawal from social interactions) to avoid rejection. This often leads to self-deprecation and hopelessness about having mastery over one’s life (Wright, Gronfein & Owens, 2000). As previously mentioned, individuals who have been labeled may cling to the group they identify with (those with same diagnoses or heterogeneous groups of those diagnosed) for protection (Goffman, 1963). Comparison to others with diagnoses seen as “worse off” (Pickens, 1999) sets up a hierarchy of oppression internal to the oppressed group as a whole. Individuals labeled with psychiatric disabilities may experience barriers to community integration (Prince & Prince, 2002), sensitivity to social disapproval (Boydell et al., 2002), feelings of isolation, fears of not being understood by friends and families, and expectations of being rejected

by community members (Prince & Prince, 2002; Williams & Collins, 1999). Obstacles to social integration: fear of rejection, ambiguity about what to disclose, poverty, and low motivation or energy levels (Boydell et al., 2002; DeNiro, 1995) all contribute to group identity devaluation, and thus personal devaluation.

Concealing Labels

Individuals who are able to detach themselves, maintain some privacy and protect themselves from accepting negative characterization by others are able to fare better in the community (Boydell et al., 2002). Hence there is a tendency to not disclose as Kay Redfield Jamison describes:

The problem with mental illness is that so many who have it—especially those in a position to change public attitudes, such as doctors, lawyers, politicians, and military officers—are reluctant to risk talking about mental illness, or seeking help for it. They are understandably frightened about professional and personal reprisals.

Studies suggest those who are receiving treatment for psychiatric disability may demonstrate poor performance, feel less appreciated, and more anxious interacting with others if their label is not concealed (Farina et al., 1971). It is not uncommon for those with labels to conceal information (Sayce, 2000).

Treatment Avoidance

Perhaps it is no surprise there are negative views associated with the mental health system (DeNiro, 1995), as acceptance of psychiatric care signifies the client's acceptance of a label (Pearlin, 1999) which, as described above, carries a plethora of negative attitudes and beliefs, some of which may already exist in the person before a label has even been given. Studies reveal a direct relationship between treatment adherence and negative attitudes and beliefs (Sirey, Bruce, Alexopoulos, Perlick,

Friedman & Meyer, 2001), as well as reports that negative attitudes inhibit service use (Leaf & Bruce, 1987). Less than 40% of individuals with initial onset of psychiatric symptoms seek professional help within a year (Andrews et al., 2001). Individuals with diagnoses of schizophrenia are found to be particularly sensitive to social rejection (Boydell et al., 2002), which may add to treatment avoidance.

Hopelessness has perhaps been the impetus for a new discourse outside the dominant frame. Deegan explains passionately how a discourse of recovery begins out of this hopelessness in the dominant discourse. She emphasizes the experiences of hopelessness:

We were going to make it. We were never going to come back to the hospital again. . . Some did make it. But most of us returned home and found that nothing was the same anymore. Our friends were frightened of us or were strangely absent. They were overly careful when near us. Our families were distraught and torn by guilt. They had not slept and their eyes were still swollen from the tears they cried. And we, we were exhausted. But we were willing to try. And I swear, with all the courage we could muster we tried to return to work and to school, we tried to pick up the pieces, and we prayed for the strength and perseverance to keep trying. . . our winter deepened into a bone chilling cold. Something began to die in us. Something way down deep began to break. Slowly the messages of hopelessness and stigma which so permeated the places we received treatment, began to sink in. It seemed that the system tried to break our spirit and was more intent on gaining, even coercing our compliance, than listening to our needs. . . We found ourselves undergoing that dehumanizing transformation from being a person to being an illness: “a schizophrenic”, “a multiple”, “a bi-polar” . . . we were coached by professionals to learn to say [it] . . . And each time we repeated this dehumanizing litany our sense of being a person was diminished as “the disease” loomed as an all powerful “It”, a wholly other entity, an “in-itself” that we were taught we were powerless over (Deegan, 1996, p. 5).

To many, the mental health field is rooted in pessimism, and maintains a posture of pessimism. As other voices of recovery echo Deegan’s sentiments: “People have gotten used to their identities and roles as ill, victims, fragile, dependent and even as unhappy.

Long ago we learned to “accept” our illnesses, give over our control to others and tolerate the way of life” (Mead and Copeland, 2000).

Although the dominate discourse maintains a position of managing illness over the whole person (Mueser, Rosenberg, Goodman & Trumbetta, 2002), and often steers away from alternative approaches and theories of care (Merry, 1995), persons with disabilities are creating their own paths for healing, and some are asking health care providers to hear them and join them. Many suggest there is a need for radical change in theory, mindset, and foundation (see Read and Reynolds, 1996) of how psychiatric disability is interpreted and understood. Bentall suggests that the main problem in mental health services is one of ‘ideas’. He states:

I will suggest that we have been laboring under serious misunderstandings about the nature of madness for more than a century, and that many contemporary approaches to the problem, although cloaked with the appearance of scientific rigor, have more in common with astrology than rational science. Only by abolishing these misunderstandings can we hope to improve the lot of the most impoverished, neglected and vulnerable of our citizens (2003, p. 8).

Radical change in ways of knowing and treating psychiatric disability is perhaps what a recovery discourse embodies, as it is unfortunately in this time of mental health, that the voices of those directly affected by our system have not systematically been included.

“Radical” becomes first the act of including those voices.

CHAPTER VII
SHIFTING THE FRAME: TOWARD A CONSCIOUSNESS IN THE MENTAL
HEALTH FIELD

A recovery discourse offers suggestions for change directly from those who have been labeled by the mental health system. In this way, turning toward a recovery discourse, if only to better understand what is happening in the field of mental health, becomes of value to the social worker. The social worker then considers the option of making change from a more informed and inclusive position, emphasizing a consciousness of that position as it grounds the social worker to make intentional decisions about the discourse and the practice. In contemplating change for the mental health professionals, Deegan distinguishes the difference between superficial change and conscious change, while focusing on one of the core values of the recovery discourse, as demonstrated in the following passage:

I worry we will content ourselves with superficial change . . . in the fifties it was the doctors and the patients. In the sixties it was the staff and the clients. In the seventies it was the providers and the consumers . . . Yes, the names we call each other have certainly changed. . . But I would argue that the fundamental relationship between those labeled with mental illness and those who are not, has remained essentially unchanged. . . You see, I would argue that . . . until the radical power imbalance between us is at least equalized, until our relationships are marked by true mutuality . . . until we recognize the common ground of our shared humanity and stop the spirit breaking effects of dehumanizing in the mental health system, then the gaping hole will continue to sink the best of our efforts. . . mental health programs and the community must change if people are going to move from just surviving to the journey of recovery (Deegan, 1996, p. 11).

This investigation of mental health discourse will conclude by creating space for a curiosity about a recovery discourse, a discourse that points to a need for the mental health field to undergo a fundamental change of cultivating a deeper understanding of the power dynamics inherent in the dominant discourse, while creating space for a recovery over illness model. This fundamental change becomes a directive shift, not the washing over of an epiphany that presupposes immediate change. Foucault once said, “One cannot speak of anything at any time; it is not enough for us to open our eyes, to pay attention, or to be aware, for new objects suddenly to light up and emerge out of the ground” (Foucault, 1972, p.44). What Foucault means is that having sight and awareness of the language, and what it represents in the mental health field is not enough, that a new language and a consciousness of inclusion do not just emerge—it must be cultivated through a deeper understanding. One way of beginning this process is by contemplating this message of recovery discourse.

One way to begin this process is by listening without defense and judgment to those who feel they have been harmed, avoiding the traps of discrediting the voice, or determining the discourse as not worthy. Another way is by seeking to find and understand what voice, what experience has become marginalized. This comes with recognizing, as social workers, the long history of these patterns of speaking out against the dominant mental health discourse and being dismissed. Then one may choose to act. Action requires consciousness, not just of the language, but as postmodern thought suggests, a willingness to look underneath the language, at the history, at all of the forces of power that have produced this language. For this has been the work of this thesis, to go

back and look at some of the historical facts and figures that have created and maintained a discourse of power.

Contemplating Hope

A recovery discourse poses statements about hope, which can be contemplated:

No one is beyond hope. Everyone has the ability to make choices. Even though health care professionals have traditionally been asked to define treatment and prognosis, they have to look through the layers of learned helplessness, years of institutionalization, difficult behaviors, then they can creatively begin to help a person reconstruct a life narrative that is defined by hope, challenge, accountability, mutual relationship and an ever changing self concept (Mead & Copeland, 2000, p. 1).

One can contemplate the above passage in many ways, or one can simply agree with it.

Agreeing with it may be a way of idealizing the text, of idealizing the role of the social worker by assuming that the field of social work does maintain such levels of hope, perhaps because proclamations are made by professors or by the agency that suggest this place of hope. In this way, the social worker can create a discursive distancing between the stated place of social work versus the actuality of what others' voiced experience of the field might be—that in fact, some do experience a theme of hopelessness. Deegan encourages mental health workers to “understand that we are faced with recovering not just from mental illness, but also from the effects of being mentally ill” (1993, p. 10).

In contemplating this more deeply, one can ask how the social worker genuinely engages with such notions as “hope”—are these notions limited to certain clients? Is hope a mutually shared phenomenon in the therapeutic relationship? How does the idea of mutual relationship work in the social work profession? Does the social worker have a deep grasp on what mutual relationship means, or is the social worker perhaps turned off by this notion of “mutual relationship” in a way that obscures the underlying meaning of

what mutual relationship actually infers? Does the social worker become curious about this “mutual relationship” – enough to allow a cognitive dissonance to occur? Perhaps enough for the social worker to contemplate the more hidden aspects of power in the therapeutic relationship? How would the therapeutic relationship look if social workers were able to allow space for “mutual relationship” and “hope” while still upholding the values of the social work field? Or how has history shaped the group identity of those with psychiatric disability, and how can the field of social work respond to this collective trauma in a therapeutic way? Does the social work field contribute to “learned helplessness”? One can contemplate these things in a myriad of ways.

The remainder of this chapter is written in the interest of contemplating what shifts may occur when including this practice of hope, an ever-emerging, fluid concept in the discourse of recovery. This chapter is not for those for whom this thesis has been a hollow discussion of mechanical thoughts about language. As Nietzsche states, “Our supreme insights must – and should! sound like follies and sometimes like crimes when they are heard without permission by those who are not predisposed and predestined for them” (1966, p.61). This chapter responds to the criticism of social work having placed too much emphasis on the DSM in psychosocial pedagogy instead of focusing on theories of strength and sociological influences (Lacasse and Gomory, 2003), and of social work students who feel their education does not focus enough on practice issues regarding those with “severe mental illness” (Miller & Mason, 2002; Mowbray, 2002). It is a response of remembering that the mental health system cannot provide all of the clients’ needs, but that a community that embraces difference, instead of pathologizing that

difference, and distancing that difference, can. Deegan explains this focus of hope and hopelessness to be at the core of a recovery discourse:

I try to help students understand that although they do not have the power to change or motivate the person with a psychiatric disability who is hard of heart, they do have the power to change the environment, including the human interactive environment, in which that person is surviving. When working with a person with a psychiatric disability who is hard of heart, who has given up and who is motivated not to care anymore, we must understand that this is a person who feels they have no power. They experience all the power to be in the hands of others. They experience what psychologists call an external loss of control. For such people it is imperative to create an environment in which there are choices to be made. I am speaking here not of forced choice such as either take your medications or you go back to the hospital . . . but of real choices (Deegan, 2001, p. 10).

Studies support this notion of hope in mental health workers as being the main ingredient for many of those who emerge from their psychiatric struggles in a mental health setting (Chinmen et al., 1999). As this notion of hope in a recovery discourse is further suspended, the following passages will briefly discuss a few discursive strategies for change, followed by a closing reflection on the recovery discourse as it relates to the field of social work.

Discursive Strategies for Making Change

In this thesis, many discursive strategies have demonstrated (without drawing attention to them as demonstrations) how change occurs in discourse. Positive Discourse Analysis (PDA) points to some strategies that may create shifts in the dominant discourse, challenging the underlying belief systems and domination within the knowledge field. Discursive strategies are common practices used every day, though awareness of them can become an adaptive skill of change-making that can be utilized. Some of the discursive strategies implemented in this thesis include complexification,

inversion, a bit of parody, and reframing. All strategies are outlined by Macgilchrist (2007) in “Positive Discourse Analysis: Contesting discourses by reframing the issues”, as she emphasizes the fluidity of power and the ever-emerging opportunity for shifts to occur in which the otherwise marginal discourses can become more central. Though Magilchrist implements these strategies as a way for news journalists to shift a perspective, these strategies can also be used in other discursive practices, such as the mental health field, as will be demonstrated in the following paragraphs.

In chapter four, “complexification” was used to explain that the history and the power dynamics in the mental health field are not a simple mode of hierarchy where psychiatry reigns. Being inclusive of multiple meanings of power and the angles from which they are derived “complexifies” an issue so that it can be understood more deeply, while removing the defensive stance of oversimplifying the issue. Complexification allows for ownership of one’s own role in power dynamics, for what is emphasized is that there is not one party (such as the body of psychiatry) to blame; rather, power is a multidirectional force that is fed by dominant and non-dominant parties. It is by excavating part of the history that has been omitted that allows for a deeper understanding of how social injustice is supported by unassuming parties. This allows the social worker to consider ways in which the field of social work also has a role in the oppression that occurs in the mental health field. Complexification can be used by the social worker to gently create a more dispersed share of taking responsibility for the power dynamics that exist.

Another strategy, “inversion”, is exactly what it sounds like. In responding to the dominant view where a truth claim is made, the discursive strategy is to invert the

information by arguing that “no, in fact it is not” true (Macgilchrist, 2007). This is precisely the strategy used in chapter five, as a counter truth was presented after each dominant claim of what psychiatric disability means. Inversion can be useful, especially to those social workers engaged in understanding what science in fact supports, and what people claim it supports. These social workers hold understanding of the knowledge field and how it is abused. They have counter evidence to offer in a classroom where inaccurate information is being taught, or counter evidence to offer to a client who feels he is doomed with no hope for recovery. Social workers can reveal that, in fact, people recover all the time, and offer examples of how.

“Parody” is a strategy that is more complex, the point being to bring the shared knowledge of a dominant discourse to the fore as a way of engaging the person or audience, and then to follow that shared knowledge by interrogating its validity. This is done often by those who attempt to discuss the problems of the dominant frame. Often, social workers seeking to share or integrate a new discourse find there is no language to use that can be heard or understood by those who have not been exposed to the alternative discourse. Finding a way in becomes difficult. Using parody, the speaker engages the dominant discourse using language familiar to the discourse, as a way to turn the conversation in the direction of considering that discourse as not being the whole truth. For example, choosing the language to use in this thesis was a difficult process. Though calling those with labels “mentally ill persons” feels pejorative in light of what I know about the harm such language has caused, I wondered if more readers would be more attuned to the message of the thesis if I did in fact use the language that dominates the mental health field. Parody, then, is often accompanied with inversion, as the reader is

drawn into a language that is familiar, the writer then can create space for questioning that language.

In this way, reframing was a strategy used in this thesis. As Macgilchrist (2007) states, “reframing can be defined as shifting an issue away from its conventional ‘location’ within one set of shared assumptions and construing it within a different set of knowledges”. Reframing can include techniques of inversion, and can be incorporated in partial or more radical contexts. Often, social workers who attempt to reframe issues within their agency will use “partial reframing” where the discourse is challenged with counter information offered by the social worker. The reframe is considered “partial” because the social worker may not use direct inversion, or point blame in any direction. “Radical reframing” takes this a step further, and explains how the dominant discourse uses language to perpetuate information that is not true, based on the counter information provided by the other discourse. By referring to the strategies used in this thesis, social workers can reflect on how a process of change may begin in the dominant discourse.

Contemplating a Recovery Discourse

Recovery discourse encourages a therapeutic environment that takes the whole person into account, not just the person’s diagnosis and treatment agenda. Inclusive is the individual’s collective identity and how this identity has served to create narrative themes of hopelessness in the individual. Creating narratives of hope is at the heart of the recovery discourse. The question becomes: What can the social worker do to help cultivate hope? Deegan, speaking from the recovery discourse, reminds the mental health professional:

It is not our job to pass judgment on who will and will not recover from mental illness and the spirit breaking effects of poverty, stigma, dehumanization, degradation and learned helplessness. Rather, our job is to participate in a conspiracy of hope. It is our job to form a community of hope which surrounds people with psychiatric disabilities (Deegan, 1996. p. 11).

So the process becomes one of questioning the practice as well as the practice environment in which the social worker contributes. The discourse of recovery processes these questions, continuously reflecting on a more radical definition of hope, a hope that is not only lived out but ingrained in the professional who takes up the discourse.

This undertaking of radicalizing the notion of hope has not emerged without criticism. In becoming a discourse, recovery has been challenged at onset. The voice of recovery, in defining its mission to speak about recovery has been criticized for the operational term, “recovery”. Specifically, the use of the word has been criticized for not being evidence-based (Remington & Shammi, 2005), not being operationally defined (Lieberman & Kopelowicz, 2005), and having unrealistic expectations (Satel, 2006). It goes without saying that these criticisms echo the earlier accusations of logical positivists’ positions against the field of mental health, as it became its own respected entity. Critics state that the term “recovery” has been used so broadly and loosely that it is becoming meaningless (Lester & Gask, 2006).

“Becoming meaningless” is a useful point to reflect on in this thesis, as consciousness of language becomes the distinguishing factor of what is linguistically relevant. The question becomes “Becoming meaningless to whom?” Though these criticisms may be warranted in some ways, there underlies a defensiveness that keeps one from truly engaging with the word “recovery”, for criticism stultify that which has emerged and become something more, throughout history, in the person as well as the

movement. And criticism of this word “recovery”, scientific or otherwise, has not stopped masses of people from speaking out, from working together to be heard and to make it known that they are opposed to a dominant discourse that excludes not only notions of recovery, but the research that reveals recovery, toward a wish to offer a more inclusive discourse that acknowledges these truths. In the recovery discourse, then, there will be acknowledgement that positive change has occurred outside the dominant discourse as well as outside the mental health system. This creates resistance in a dominant discourse, where there is evidence that people with psychiatric struggles are not entirely dependent on the mental health field for change, that indeed the change lies within them.

Operationally Defining "Recovery"

In this way, recovery truly resides in the person, as does the recovery discourse. Recovery has been defined in many ways, as Deegan states “the concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings” (2001, p. 3). As social workers contemplate this definition, one may question if this statement is in any way falsified or diminished within the mental health practice. Ridgway (1999) suggests that the potential for growth and transformation in the labeled individual has been overlooked by the mental health system, a system rooted in a deficiency model of knowing and treating, and underscores these core values:

recovery is often described as a process in which an individual confronts challenges using a unique combination of strengths, vulnerabilities, and available resources. Recovery is often said to be a nonlinear process that involves making progress, losing ground, and pressing forward again. (Onken, Craig, Ridgway, Ralph & Cook , 2007, p.10):

Though the remainder of this thesis is not intended to educate social workers on the values and procedures of the recovery discourse, some aspects will be touched on, as a final way of closing this discussion on language. There are many aspects of recovery language, one being that of “peer support” as a way of integrating the faces and voices of hope into the mental health system, by literally bringing those with labels into the mental health setting to work as individuals who are in recovery. These individuals act as peers to those who participate in mental health settings. They advocate for the rights and voices of those receiving treatment in the system, and they produce a constant reminder of hope and of possibility. They represent transformation. Peer support has been recognized as one of the fundamental parts of recovery (Samhsa, 2006), as it “challenges the more linear, dynamic view that there is a problem to be fixed . . . peer support by definition assumes relationship and reciprocity” (Mead and MacNeil, 2008). As one person with a label states,

In order to recover, one needs to find peer support, and in order to do so, one needs to have alternative healing techniques, one has to have access to those kinds of people and treatments that one can control oneself, and not perpetually have to be dependent on medication and doctors, and a psychiatric system that does not necessarily have our best interests at heart. (NCD, 2000)

Following this intent, a recovery discourse talks about having a mutual relationship. Surrey (1987) encourages empowerment between client and clinician, and that clinicians need to learn how to have “power-with” and not “power-over” those seeking services. As one person with a label explains, “We believe that healing and recovery are possible only in an atmosphere in which we control our own lives and make free informed decisions about treatment” (NCD, 2000).

Mutual relationships include awareness of power (Onken et al., 2007) and an emphasis on an individual's own self-determination, a concept rooted in the sense of agency, or self-agency. It carries the belief that individuals have the competency to, as quoted in Onken et al. (2007), "surmount the challenges posed by a psychiatric disability." Recovery is about finding meaning and purpose, and finding new ways of coping that are not based on an illness model, embracing wellness, thriving toward something better, and realizing the existence of recovery (Onken et al., 2007).

Ridgway (2004) suggests that recovery and resiliency are interrelated. Resiliency, though left up to the person to define, can mean any of the ways that a person copes with adversity and incorporates a new sense of self. Resiliency can include self-initiated therapeutic techniques that affirm this process. In a qualitative study, Deegan interviewed 29 people with psychiatric diagnoses to understand their capacity for resilience. She found one common theme to be "personal medicine", which includes self-initiated activities that contribute to self care. This may be linked to findings discussed in Chapter five on the benefits of focusing the mind and shifting one's attention. Interestingly, Deegan found that this technique, valued by the interviewees as one of the main components of their recovery process, was not generally disclosed to mental health clinicians. Further, clinicians rarely asked about these self-help processes. In another article, Deegan illustrates this experience of not having her own self-help processes included in the mental health setting:

The fact that I was a good athlete, that I enjoyed being in nature, that I was the oldest child from a large working class family was of little interest to the professionals around me. What mattered most in their eyes was that I was a schizophrenic. . . everything I did was interpreted as part of my psychiatric disability (2004, p.2).

The study also offered some alternative understandings to medication non-adherence, as Deegan found that non-adherence was often a result of psychiatric medications interfering with one's ability to continue personal medicine.

Holding a curiosity to this contemplation of recovery discourse, does the social worker value this unique combination? Does the field of social work, or the field of mental health, operate on an understanding that progress in the individual is a nonlinear process? As one engages the discourse, one will find resourceful ways to begin understanding and grasping the complexity of these simple questions. One way of beginning this process is by first by recognizing that the recovery discourse is not born in the mental health system, but resides in it. Listening and hearing a Recovery discourse is not about adopting a language or transplanting a fast-paced anti-stigma program; rather it is about understanding a language, taking it in deeply, contemplating the words and thoughts that have been chosen, questioning where the words are in relation to this fundamental change, considering words that create distance or nearness, holding a curiosity for why this language has been kept out of the dominant mental health discourse, locating the discontinuity, and finally questioning where or how it can be let in. And then, as the social worker contemplates this other discourse, one may witness a shift in the language, a shift that is deeply intentional and anything but mechanical. Making this shift becomes an act of inclusion for the social worker who wishes to integrate a recovery discourse, as Deegan states:

My real hope for re-humanizing the human services rests with people with disabilities as we begin learning that we can organize, that we have power in our numbers, and that we can overcome oppression through expression. The days of silence are over. As professionals and as fellow human beings, we have a great

deal to learn from the people we seek to serve. It is important to listen to people with disabilities (1990, p. 310).

So, the question becomes one of asking how social workers can integrate this voice on an agency and policy level. Perhaps by questioning first the values and integrity of social work, one can see the parallel to the recovery discourse. The preamble to NASW's Code of Ethics states:

Social workers promote social justice and social change with and on behalf of clients. . . and strive to end discrimination, oppression, poverty, and other forms of social injustice. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems (NASW,1996).

To "enhance the capacity of people to address their own needs" is indeed one of the underlying fundamental aspects of the recovery discourse, as well as a striving to end various forms of oppression. In this reflection, what is revealed is the proclivity of the social worker to naturally engage with and incorporate a recovery discourse. Indeed, many social workers are. To take this further, the NASW states in section 1.12: "Social workers should not use derogatory language in their written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients" (NASW, 1996).

Perhaps this gets at the crux of discourse and of the social work field's stated position on harmful language. For it is written clearly that harmful language must be taken seriously. In contemplating a space for the recovery discourse, the question becomes: Accurate and respectful language according to whom? Should social workers be listening to those who are stating that the language used is inaccurate as well as disrespectful? While questioning the hollow space of idealized words may be

contentious, the contradictions within the social work profession are brought to light. While sitting with resistance, there exists an opportunity to recognize the hardened heart that exists in the social worker, as well as the client. The space to be filled, perhaps measured by language, is the opened-up place where seeking social justice and equality in the mental health field begins to grow, take form, become something more than the words themselves.

But those maintaining and creating a recovery discourse also contemplate: “Do we change the personal narrative or change the dominant discourse? To a certain extent we are more comfortable in the prolonged processing of these questions” (Onken et al., 2007). An interesting point to end on, this space that those creating a recovery discourse take to nurture the relevance of change from within before challenging the dominant discourse is worth noting. In closing this thesis, questions remain about this change of the dominant discourse, and about the place of social work regarding this change.

Though the field of social work has not embraced efforts toward a consciousness of language, nor much regard for this contemplation of a recovery discourse, some bodies of knowledge within the mental health field have looked toward creating a shift that is more conscious and more inclusive of those with disabilities. In 1992, the APA produced guidelines for publication that reflected values held within the recovery discourse. These values include using person-first language (not calling someone by their disability, and not considering a person’s disability before the person), avoiding the labeling of individuals outside of diagnostic procedures, avoiding calling individuals “patients” or “invalids”, avoiding overextending the severity of a disability by using terms like “chronic mental illness”, focusing on emotionally neutral expressions, emphasizing

abilities instead of limitations, avoiding offensive expressions such as “crazy” or “paranoid” which can be replaced by “symptoms of”, and focus on the right and capacity of individuals to express their own goals and preferences (APA, 1992).

In light of these efforts, the questions seemingly become clear. In looking over these past few years of my social work education, questions arise about the field of social work, the social work identity, and its place in recognizing and responding to oppression in the mental health field. Social workers, at large, still use most of the descriptors the APA cautions against in their suggestions for non-biased language, as does the mental health field at large. Social workers may provide many reactions for why the use of harmful language is necessary. Resistance aside, this thesis poses questions about the place of social work in the mental health field, and how it differentiates itself as a field of taking the environment and not just the individual into account. Where power lies, paradoxical intentions collide, and from a recovery discourse perspective, these requests of using respectful language are merely small steps toward encompassing a greater, more conscious inclusion of the individual. Recovery discourse is starting from the inside first, and this healing process of great value, seems to be worth the inquiry of the social worker. Yet, the silence of social work as a field on this matter remains a mystery to which the social worker is left to contemplate.

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