A History of Stigma: Towards a Sociology of Mental Illness and American Psychiatry

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ABSTRACT

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Using genealogical discourse analysis, this project examines how American psychiatrists utilized the concept of stigma in *The American Journal of Psychiatry* as it relates to illness and treatment from 1846-2007. Once historicized, stigma takes the form of four themes, i.e. the stigma of psychiatric practice, euphemistic stigma, the stigma of treatment, and the stigma of mental illness. These themes each result in numerous strategies to diminish their effects in the population and the individual patient through national campaigns to combat stigma.

This thesis also identifies the role of an emerging medicalization of mental illness' stigma and how this medicalization has specific implications for psychiatric treatment and social inclusion. The alignment of stigma alongside particular diagnostic categories has far reaching consequences as it attempts to circumvent the critical discourse which began with the anti-psychiatry movement in the 1960s. In this way, this thesis reveals American psychiatry's effort to de-stigmatize itself through campaigns to reduce the stigma of mental illness.

Acknowledgements

For my mother

Kathleen F. Donovan

many thanks for your encouragement.

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List of Acronyms

AAAIMH: American Association for the Abolition of Involuntary Mental Hospitalization

AJI: American Journal of Insanity

AJP: American Journal of Psychiatry

AMA: American Medical Association

AMSAII: Association of Medical Superintendents of American Institutions for the Insane

AMPA: American Medico-Psychological Association

APA: American Psychiatric Association

CCHR: Citizen's Commission on Human Rights

CMHC: Community Mental Health Center

CSP: Community Support Program

MNN: Madness Network News

NAMH: National Association for Mental Health

NCMH: National Committee for Mental Hygiene

MHA: Mental Health America

NAMI: National Alliance on Mental Illness

NIH: National Institute of Health

NIMH: National Institute of Mental Health

NMHA: National Mental Health Association

NMHCH: National Mental Health Clearing House

SAMHSA: Substance Abuse and Mental Health Services Administration

TAC: Treatment Advocacy Center

WPA: World Psychiatric Association

Chapter One

Introduction to the Research Problem

I live but for one thing; i.e. to have the stigma of insanity removed.
                                                            -William Lee, Mental Patient, 1907[1]

In 1902, William Lee was forty years old, owned a house and other property,
married with three children and worked as an estimator at the iron works in New Jersey.
He lost his job when the iron works was sold to the steel trust. He resumed work as a
contractor and placed bids on constructing a new schoolhouse and making repairs to the
heating system of the Statehouse. Lee lost both bids. When he found out that he had lost
the bid for the schoolhouse, Lee broke all of the windows in the house owned by the
architect who drew up the plans for the schoolhouse. The architect's brother, owner of
the Trenton Trust and Safe Deposit Company, was the holder of Lee's bank accounts.
Having lost the bid on the schoolhouse, Lee made an arrangement with the real estate
agent who brokered the schoolhouse deal to buy the iron works for the sum of $12,000.
Lee put down $2,000 towards this purchase and began repairs. The paperwork for this
transaction was delayed by several months and when finally finished on July 17, 1902,
Lee failed to pay the residual amount of $10,000. A month later on August 11, 1902, Lee
was committed to the state hospital upon his arrest.

In the interim period between the finished contract and the arrest, Lee had several
altercations with other citizens. Several checks that Lee had written were not honored by

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[1] Lee as quoted in Hasbrouck 1911:121. All subsequent information about William Lee and his case has
been taken from Hasbrouck (1911).

the bank, including two written to the Pennsylvania Railroad Company. These checks were drawn from his account at the Trenton Trust and Safe Deposit Company. As a result, the Pennsylvania Railroad Company rescinded all credit to Lee. When Lee met the state treasurer, Senator Briggs, who had turned down his bid on the repairs to the Statehouse, Lee insulted him publicly. After this meeting, Lee sent a letter to the Pennsylvania Railroad Company threatening to kill Senator Briggs because Lee believed that Briggs was involved in ruining his credit. Around the same time, Lee smashed the window of the Trenton Trust and Safe Deposit Company to retaliate against those he thought were trying to put him out of business. Lee had also been arrested on July 3, 1902 for shooting a gun off on his property and breaking the windows of a neighbor.

Upon his arrest on August 11, 1902, Lee was examined by two physicians. Lee's wife was convinced by his attorney to petition for his committal. It was thought the ordeal would only last a few weeks if he was committed by a family member. One of the managers of the New Jersey Asylum who was responsible for Lee upon commitment was also the attorney that brokered the deal between Lee and the iron works on behalf of the elderly owner. This connection of the lawyer to the hospital bothered Lee as he suspected a conspiracy. Lee did not hold the other asylum manager, Dr. Garrett Vroom, as accountable for his commitment.

Lee escaped the asylum in November and wrote several threatening postcards to those he thought responsible for his detention. In the twelve days he was free Lee procured a certificate of sanity from a physician in New York and returned to New Jersey to present the certificate to authorities. Despite having this document, he was remanded to the asylum immediately. Lee escaped two more times, finally settling in New York

where he resumed working as an estimator for several iron works companies. However, the mark of being labeled insane and being committed to the asylum weighed heavily on Lee. He continued to write letters to newspapers demanding the resignation of those he believed responsible for his unfair committal. Lee also sent threatening letters to city officials, which led to his arrest in New York.

During his trial for hospitalization in New York, both testimony for and against Lee's sanity was given, but he was ultimately certified insane. He escaped from the Manhattan State Hospital and fled to Boston where he found work as an estimator in another iron works. Eventually, he was caught and taken to Bellevue Hospital in New York. He was released after several days of observation, but was immediately re-arrested and sent to prison. He was then reassigned to the Matteawan State Hospital due to the threatening letters he continued to send to those he believed responsible for his current situation.

From the hospital, Lee wrote a series of letters where he requested a trial in order to prove his sanity. In these letters, he made a petition to the courts on the basis of *habeas corpus*, the right to trial by jury. In a letter he wrote to Judge O'Sullivan, Lee stated, "Under the Constitution of the United States and the laws of the State of New York, I am entitled to a speedy and public trial by an impartial jury. I respectfully request you to grant me my right" (Lee as quoted in Hasbrouck 1911:127). Lee went on, in a letter to his counsel, "Please get a writ of habeas corpus and have me taken from this "hospital" where I am treated like a mad dog and taken to the "Tombs" where I am treated like a man" (Lee as quoted in Hasbrouck 1911:128).

In a subsequent letter dated almost four months after his letter to counsel, Lee threatened to kill the Governor of New Jersey. Lee wrote how he planned to become certified sane by murdering the Governor and thus removing the stigma of insanity. Lee declared to the Governor, "What I cannot endure is that you keep me classed with those unutterable things you have penned up in your State Insane Asylums. There is a way to remove that stigma" (Lee as quoted in Hasbrouck 1911:120). Lee continued, "None of the unutterable things you have penned up can kill you. I will kill you. Then the grafters headed by Vroom will be just as anxious to make it appear I am sane, so that I will be electrocuted and out of their way for all time, as they are now anxious to make it appear I am insane" (Lee as quoted in Hasbrouck 1911:120). Lee went on, "This notice is like my commitment to your State Insane Asylum there is no time limit to it. If I do not get you before your term of office as Governor expires, I will get you afterward. I live but for one thing; i.e. to have the stigma of insanity removed" (Lee as quoted in Hasbrouck 1911:121). Lee, however, never received a trial and was denied a writ of *habeas corpus* due to his medical and legal certification as insane.

This case illustrates quite clearly how the law, psychiatry, and a patient's rights become entangled resulting in interminable and involuntary hospitalization. Although Lee's case may or may not be representative of most other patients, it does show how the stigma of commitment and the stigma of being labeled insane can have deleterious effects on a patient. As far as Lee was concerned, the removal of stigma is something exceptionally vital and worth risking death.

This thesis details how the concept of stigma comes to be so important to both patients and psychiatrists alike by historicizing the concept of stigma in psychiatry from

1846-2007. Specifically, the thesis examines how stigma has come to be a medicalized entity in its own right alongside the mental diseases with which it is usually conflated. The word stigma has several connotations from its long history of usage. Stigma originates from the Greeks and is defined as a mark, brand, or a scar (Goffman 1963:1). In the *Medline Plus* medical dictionary, stigma is derived from the term stigmata, a physical symptom of a disease such as lesions, spots, or scars (U.S. National Library of Medicine 2008). In lay usage, the term stigma takes on a vast array of definitions revolving around limited opportunities and discrimination due to perceived difference. There seems to be an unlimited amount of ways in which to stigmatize someone, i.e. stigmas of race, sex, class, intelligence, mental health, physical health, body morphology, family, education, and so forth. In Erving Goffman's terms, stigma is "a special discrepancy between virtual and actual social identity," where virtual social identity refers to an imputed characterization, while actual social identity is defined as the qualities a person "could in fact be proved to possess" (1963:2-3). Goffman suggests that wherever a negative human difference can be articulated, stigma resides in the cleft between what is expected and what is real.

In the medical domain, stigma has become a word commonly associated with the mentally ill population. For psychiatrists, mental illness and stigma are both known through assessing behaviors, which can become very complicated as effects of stigma resemble effects of mental illness, i.e. low self esteem and social isolation (Shih 2004). Parceling out the effects of stigma on the course of the illness and treatment can be a difficult undertaking as the symptoms of stigma resemble those of a mental illness. Yet, stigma has historically been constructed as a phenomenon unto itself, beginning with

psychotherapy in the 1940s and continuing today. This thesis describes how the medicalization of stigma emerged and its importance for current campaigns to end stigma.

The stigma of mental illness has become a scientific concept thoroughly compartmentalized and investigated by many kinds of researchers, who define the concept in many different ways (Link and Phelan 2001:364). Sociologists, psychologists, psychiatrists, political scientists, and social geographers have all contributed to the enterprise. To many contemporary social scientists, the stigma of mental illness has become an object that is measurable with tools such as the Bogardus Social Distance Scale, quantitative surveys, or qualitative interviewing (Angermeyer 2005; Baldwin and Marcus 2006; Borenstein 1992; Cook 2006; Corrigan et al. 2003; Corrigan 2004b; Corrigan et al. 2005; Falk 2001; Lauber 2004; Wahl 1997; Wahl 1999). This research is often intertwined with developing ways to mitigate stigma in both the individual and the public (Corrigan 2000; Corrigan 2004a; Crisp 2004; Crisp et al. 2005; Dovidio et al. 2000; Fink and Tasman 1992; Hinshaw 2007; Sartorius and Schulze 2005; Thornicroft 2006). These efforts to define, measure, and re-direct stigma involve specific strategies and agendas that, once historicized, reveal broader political implications regarding governing the public and their beliefs about mental illness.

Dain (1994) recognized that stigma as a concept has been used both by psychiatrists and anti-psychiatrists in order to gain control of the mentally ill population. Dain writes, "Stigma has been a tool used by both psychiatry and its opponents in these contests. Early psychiatrists initially justified their new specialty by arguing against the stigmatization of the insane" (1994a:1011). In this thesis, I argue that this assertion does

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not only apply to early psychiatrists, but also endures today. This project aims to understand the ideological struggle in which stigma has become a justification for psychiatric practices, as well as to explore how the current focus of research on stigma has resulted in the national and international campaigns to end stigma put forward by the American Psychiatric Association, the World Psychiatric Association, and the Substance Abuse and Mental Health Services Administration.

American psychiatry began as a moral effort to provide better conditions for insane persons (Rothman 1971:138). Religious Quakers were the first to open asylums in America (Whitaker 2002:3-38). Shortly thereafter, American psychiatrists began holding annual meetings to discuss the field of psychiatry and organized the profession in order to codify practices within asylums. Through this, the American Psychiatric Association was born (Barton 1986:29). The economic downturn of the 1930s and the onset of World War II dramatically changed living conditions within the asylums as well as the practice of psychiatry (Dowbiggin 1997:110-115; Dain 1994b:427-432). Public and governmental scrutiny of custodial institutions coupled with an emerging anti-psychiatric sentiment, among other concerns, eventually resulted in legislation that would provide care in the community to the mentally ill population in 1963 (Dain 1994b; Grob 1994a; Isaac and Armat 1992; Barton 1986). Once enacted, subsequent funding problems and troubles with compulsory regulations led to issues with the quality of care offered by community mental health centers (Stockdill 2005).

By the late 1970s, funding for psychiatric research had reached a low point (Albee 2005). As well, psychiatrists were under duress from insurance companies that wanted clearer diagnostic criteria and standardized treatment options (Healy 2002; Wilson 1993).

In order to attend to these and other critical issues, the APA revolutionized the field of psychiatric practice by publishing a revised version of the *Diagnostic and Statistics Manual of Mental Disorders-III* in 1980, which theorized mental illnesses as biological disorders (Reuter 2007; Mayes and Horwitz 2005; Healy 2002). With this new classification scheme, American psychiatry was poised to claim its place as a scientific medical specialty. However, one major problem still stood in the way: stigma. With each of these turns in psychiatric history, stigma has been implicated as a limit to both psychiatric practice and the scientificity of the discipline as a whole. In more detail, I describe these transitions in American psychiatry in Chapter Five and the role stigma has played within them in Chapter Six. Chapter Seven outlines the major campaigns led by psychiatrists and the US Federal Government to disarm stigma through the creation and utilization of strategies for de-stigmatization starting in 1989 and continuing today.

Thus, the general question this thesis explores is: What is the role of stigma in the discourse of American psychiatry? Stigma is a point of contention and rally for those within the discipline of psychiatry, those who fall under the moniker of anti-psychiatry, and those organizations/groups that are situated in between. Historically within APA, the concept of stigma has been implemented as ideological justification for discontinuing some treatments, such as commitment and electro-convulsive therapy as well as implementing and continuing other therapies including out-patient treatment and psychopharmacology. I aim to show that within American psychiatry, stigma is more than just a sounding board or a way to measure discrimination, but is also a rationale for practice for psychiatrists, patients, and families who have members with mental illness. Practices can include psychiatric interventions and treatments as well as their refutations,

i.e. the construction of disease categories, public and personal discrimination, laws for public protection, programs that claim to alleviate stigma and so on. These practices intersect in the domains of ethics and security, which is where stigma becomes most pervasive.

What I mean by the phrase "discourse of American psychiatry" then, is a much more generalized context which includes those within the institutionalized psychiatric discipline, those opposed to it, and arguments that are situated in between. Michel Foucault (1990) defines discourse as "series of discontinuous statements whose tactical function is neither uniform nor stable" (1990:100). Discourses are not to be described as binary or oppositional, dominant or subservient, but rather as polyvalent, combining, shifting, and transforming through interaction with one another. Discourses frame objects in particular ways to present a meaningful understanding of an object within the context of a given discipline. Discourses shape as well as limit how objects, facts, and truths come to be accepted and repeated as such; however these rules are historically conditional and reflect a broader social and political context. By looking at the construction and transformation of stigma over time through the American psychiatric discourse, it becomes evident how and why it is implicated at contentious points in order to legitimate existing or new practices, while also illustrating how the discourses of human rights, citizenship, and neo-liberal ideals come to complicate the practice of psychiatry.

By looking at the history of psychiatry not only as an academic discipline and a medical specialty, but also as a controversial science that is publicly protested, I outline a history of science and siege through a Foucauldian governmentality framework, where

the patient is both an object of knowledge and the target of intervention. I do this using the methodology of "critical and effective history" (Dean 1994). Critical and effective history is a combination of Foucault's archeological and genealogical approaches to history through the method of genealogical discourse analysis (Dean 1994). By focusing on the ways in which the term stigma is implemented and its subsequent effects on discourse, this thesis details the history of how psychiatric practices came to change through appeals for the de-stigmatization of mental illness. I am not asserting that stigma is the singular catalyst to paradigmatic shifts, but that it is a relatively under researched part of this complicated process.

Before I proceed, it is important to outline how stigma and mental illness have come to be understood and written about in sociology in particular, as the work of Symbolic Interactionists has been the most influential among current research on stigma. An in-depth analysis of current literature on stigma follows in the next chapter. However, what becomes most evident in detailing a history of stigma is that psychiatrists rarely refer to academic literature on stigma. Instead, psychiatrists rely on their interpretation of how stigma affects the profession and patients through appeals to alleviate stigma. Within these appeals, which are explained in more detail in Chapters Six and Seven, are also agendas to gain research funding, extend insurance coverage, change public opinion on psychiatric care, and challenge biomedical authority.

Symbolic Interactionists of the 1960s were concerned with linking together stigma and mental illness. This provides the foundation for understanding how these concepts continue to be researched by social scientists. The academic study of stigma begins most notably with Symbolic Interactionists' studies on deviance. Thomas Scheff,

Erving Goffman, and Howard Becker in particular, are perhaps the best known for their studies of deviance and social perceptions of deviant behavior. Both Goffman (1963) and Becker (1963) question the validity of labeling people as deviant. They suggest that the concept of deviance denotes an established set of acceptable behaviors and social rules, as opposed to a more fluid understanding of the social world as malleable with permeable boundaries. By defining a behavior as always deviant, a social scientist is unable to acknowledge the effects of social context as a mitigating factor in how these behaviors come to be known as deviant. Becker (1963) insists that rules are made by social groups who have a stake in enforcing these rules on other social groups. Outsiders, deviants, or rule breakers are labeled as such not necessarily because of their actions, but because defining their actions as deviant is beneficial to other social groups (Becker 1963:3). Therefore, deviance comes to mean different things to different groups or people.

As a result of this, Becker (1963) suggests that both the statistical model and the medical model for understanding deviance are inherently flawed. The statistical model, which takes the mean or average as its measure of normality and judges variance as deviance can not account for the value judgments involved in the labeling of acts as deviant. He suggests that through this model, those who are left-handed or redheads are deviant because they simply vary from the mean, but have not broken any social rules (Becker 1963:4). Becker (1963) also surmises that the medical model is insufficient for understanding behavior as there is little agreement between psychiatrists about what constitutes pathology and disease (p.5). Citing Thomas Szasz, a well-known anti-psychiatry advocate who had recently published *The Myth of Mental Illness* in 1960, Becker suggests that psychiatrists use the medical model in a manner which was not

intended, i.e. to construct a symptomology of deviant behavior based around a norm or a mean. By correlating behavior to a statistical or lay norm and then judging all variations as pathological, psychiatry is somaticizing behavior. Becker writes of the medical model used by psychiatrists and states, "It accepts the lay judgment of something as deviant and, by use of an analogy, locates its source within the individual, thus preventing us from seeing the judgment itself as a crucial part of the phenomenon" (1963:6). Therefore, a psychiatric understanding of deviance misdirects the focus of studies of human behavior from a sociological or public issue to a personal trouble.

Scheff's work on labeling theory and his important book *Being Mentally Ill* (originally published in 1966) in some ways extends Becker's work on this issue and suggests that mental illness is a behavior that an individual learns from society. Scheff's main argument suggests that the labeling of a person as mentally ill is the result of an individual's repeated breaking of social rules and society's need to label this behavior as a deviant act to maintain social order. According to Scheff, over time the person labeled mentally ill comes to learn the rules of being mentally ill and eventually exhibits the symptoms corresponding to the diagnosis.

For Scheff, the organization and categorization of deviance as mental illness is a technique of social control specifically linked to stigma. Scheff declares, "Stigma is the single most important aspect of the societal reaction to deviance" (1984:30). He notes that the other two aspects of the societal reactions to deviance are labeling and segregation. Scheff (1984) concludes that stigma or "moral outrage" exists prior to any psychiatric diagnosis or commitment to a mental hospital (p.30). He argues that the stigma associated with certain behaviors actually produces the societal need for diagnosis

and treatment. With this insight, it becomes clearer how stigma comes to be understood as referring to both the diagnosis and the treatment (segregation through confinement) for a particular behavior. This point is addressed further in the historical analysis of stigma in Chapter Six as it becomes quite clear that appeals to stigma in the psychiatric discourse revolve around these major sites, i.e. the public, diagnosis, and intervention.

Goffman (1967) also defines mental illness as a sociological phenomenon and is critical of psychiatric theories of personal pathology. Goffman (1967) stipulates that what are generally taken as symptoms of mental illness are actually "situational improprieties" or "misconduct" on the part of the patient (p.139). He suggests that psychiatric symptomatology results from the negative public perception of behavior. Furthermore, Goffman (1967) views situational impropriety as a breakdown of the rules of face-to-face interaction. He notes that the spatially contingent features of interactions and the numerous things that can happen during interactions are integral to understanding how situational improprieties become symptoms in a psychological setting (Goffman 1967). Goffman writes that he does not know of any behavior that is not both normal and pathological. He asserts, "I know of no psychotic misconduct that can not be matched precisely in everyday life by the conduct of persons who are not psychologically ill nor considered to be so; and in each case one can find a host of different factors that will modify our attitude toward its performance" (Goffman 1967:147). Consequently, the value judgment invested by society in what could be seen as a problematic behavior depends on the situation and not the actual action.

Stigma, for Goffman (1963), works in a very similar way. It is not the actual trait, (a physical deformity, character flaw, or a person's race/ ethnicity) that is inherently

discrediting, but that the trait carries with it a particular value judgment of ignominy. Stigma is a preconceived notion of how a particular type of person or group is supposed to act, regardless of an individual of that category's propensity to act in that way, i.e. the difference between virtual and social identity (Goffman 1963:3). For example, a person diagnosed with schizophrenia is considered always-already dangerous because of the symptoms associated with the diagnosis, rather than any actual presence of the symptom. This is problematic as not all schizophrenics have the same profile of symptoms or present as aggressive and agitated. Therefore, it is the label and its ascribed attributes that are the basis for stigma and not the condition in itself.

Within these theories of deviance are a revaluation of both mental illness and the social perceptions of so-called deviant behavior. Whereas psychiatry locates mental illness in the individual, these Symbolic Interactionists suggest that even before the category of the diagnosis can be created; the behavior of the individual must be deemed socially abhorrent, i.e. stigmatized. This merger of deviance theories and the recasting of mental illness as a social phenomenon as opposed to an individual problem are important for evaluating how stigma becomes an issue enmeshed with mental illness and its treatment.

Conversely as this thesis shows, the seeds of these recognitions had been sown roughly one hundred years previously in the American psychiatric discourse. These claims by the Symbolic Interactionists must also be contextualized historically to show how they arise at a time when the etiology and treatment of mental illness were undergoing significant transformations, specifically in the early 1960s. Also during this time, the political conceptualization of the individual citizen endowed with human rights

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and liberties was also changing as social movements were fostering the empowerment of marginalized populations. These movements also included the empowerment of the mentally ill, who have throughout psychiatry's history made claims about their status, though it was not until the 1960s and 1970s that they were able to mobilize in a much more definitive form. A major lasting effect of this mobilization has been a change in the terminology for describing people with mental illness.

As is apparent in the history of stigma, the terms used to categorize or define people with mental illness are quite contested. Those who have sought out care (or have had care thrust upon them) generally refer to themselves as clients, consumers, psychiatric survivors, or ex-patients. Goffman refers to people with mental illness as both patients and inmates. The recent academic literature refers to them as consumers, while the medical literature uses the terms patients and consumers interchangeably. Accordingly, each term is historically specific and reveals much about the social history of stigma and the subjects of psychiatry in their own right. As a result of this insight, when drawing on medical literature I use the terminology of the author and where appropriate I use the terminology specific to an era to speak about people with mental illness.

In the next chapter, the academic literature on stigma is reviewed to give an account of how stigma is defined and historicized within academic research. This chapter illustrates a stark contrast between how many sociologists and social psychologists describe stigma and its effects in comparison to how psychiatrists publishing in the *American Journal of Psychiatry* utilize the concept of stigma in order to achieve professional goals as laid out in Chapters Six and Seven. In Chapter Three, I summarize

the major theoretical concepts in the thesis, namely Foucault's notion of governmentality and Thomas Kuhn's paradigms. These are used to define, describe, and place psychiatric practice, the mentally ill population, and stigma within a broader social and political context.

Chapter Four focuses on methodology and details genealogical discourse analysis as well as specifies the materials used in the historical analysis of stigma. These materials are mainly comprised of journal articles published by the American Psychiatric Association. Carrying out "critical and effective history" requires a series of historical contextualizations of a given topic. The first task is to describe the broader soci-historical context for the documents being analyzed (Chapter Five). The second contextualization involves outlining the documents and linking their contents to larger social and political concerns (Chapter Six). The purpose of these two contextualizations is to show how the present understanding of the given topic is embedded in relations of power (Chapter Seven).

In relation to the topic of stigma then, Chapter Five sketches three histories. First, the history of laws pertaining to psychiatry and for directing the mentally ill population is laid out. Second, the history of American psychiatry is mapped as it relates to these laws and paradigm shifts. Third, a description of the ex-patient's movement is recounted to illustrate how the mentally ill population comes to advocate for civil rights beginning in the 1940s in order to change both laws and psychiatric practice. Chapter Six utilizes these histories to contextualize how the concept of stigma changes together with these larger social processes through a historical analysis of use of the word stigma from the period of 1846-2007 in the *American Journal of Psychiatry*. Stigma takes the form of

four themes, i.e. the stigma of psychiatric practice, euphemistic stigma, the stigma of treatment, and the stigma of mental illness. These themes each result in numerous strategies to diminish their effects.

In Chapter Seven, I conduct a historical critique of the present to illustrate how current understandings of and appeals to stigma are situated alongside categories of mental disorder to direct the public's knowledge of psychiatric practice in specific ways. Consumers of mental health services are also implicated in this process as the roles they are assigned in public education campaigns are purposefully designed to promote a biological understanding of mental disorders and to portray a representative image of psychiatric patients as independent, responsible, and self-sufficient once they have accepted psychiatric care. In the concluding Chapter Eight, I describe how this medicalization of stigma has far reaching consequences as it attempts to circumvent the critical discourse which began with the anti-psychiatry movement in the 1960s and continues today by naturalizing diagnostic categories through campaigns to end stigma.

Chapter Two

Literature Review

The visibility of a stigma must be distinguished from its "known-about-ness."
-Erving Goffman[2]

C. Wright Mill's (1959) concept of the "sociological imagination" emphasizes the linking together of an individual's experience- their biography- with larger social institutions in a historical context. In doing so, the personal trouble an individual may experience along their life course can be explained sociologically- as a public issue- through an analysis of institutions. Taking my cue from Mills, the stigma of mental illness seems to illustrate rather well how personal troubles and public issues can become intricately intertwined. The personal troubles of stigma and mental illness are related to the public issues of personal and public safety, liberty, civil rights, as well as the legitimacy of the psychiatric discipline.

In employing the method of genealogical discourse analysis, it is important to understand from where all the academic literature comes and what end it serves. Understanding the range of ways stigma can be researched as well as how justifications for stigma's magnitude as increasing and decreasing with new interventions illustrates that stigma, as an academic concept, is what Mills (1959) called "ideological ammunition" (p.81). The ways in which stigma comes into play to justify bureaucratic ends needs to be understood through a historical lens to show how this process has been working and continues to work today.

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[2] Goffman 1963:49.

This literature review continues the overview of Goffman's *Stigma* (1963) that I began in the previous chapter, summarizing it in more detail and paying close attention to the internal and external dimensions of stigma. Then, I review more current configurations of stigma research, such as the problems defining stigma, historical research on stigma, the effects of stigma on the individual (including housing, work, and social discrimination), biological explanations for mental illness and stigma, and the transmission of stigma through media.

The purpose of this chapter is to give an overview of the numerous ways stigma has come to be researched since Goffman's analysis and to illustrate the complexity of studying stigma, which as Manzo (2004) claims, "has become an under-defined and overused concept" in the social sciences (p.401). It is by exploring the myriad ways in which stigma has been defined, measured, and directed by social scientists that ultimately reveals the uniqueness of stigma as it is used in American psychiatry.

Goffman's Stigma

Almost all research on stigma begins with Erving Goffman's *Stigma: Notes on the Management of Spoiled Identity* published in 1963. Goffman (1963) theorizes stigma from research he conducted at Saint Elizabeth's hospital for the Insane in 1955. Goffman defines stigma as "an attribute that is deeply discrediting, but it should be seen that a language of relationships, and not attributes, is really needed" (1963:3). This focus on the language of relationships is fundamental to understanding how stigma does not exist in 'the attribute' that gets stigmatized, but it exists in the politics of inclusion and

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exclusion between categories/kinds of people, which in turn informs rationales for practice.

In many instances, it is not the mental illness solely that is problematic in an interaction, but it is the perceived risk that is accorded to the mental illness that brings stigma into the relationship. For instance, one can have bipolar disorder and 'pass' as normal, but if this diagnosis is disclosed then stigma can arise. Goffman (1963) conceives of passing and disclosure as integral parts of the stigma process. He details the amount of work that a stigmatized individual might have to do in order to alleviate this relationship tension and to control information that is known about him/her. Consequently, Goffman (1963) suggests that those who are stigmatized may prefer the company of others who belong to the same category or may avoid social situations all together. Conrad and Schneider (1983) illustrate this point in their study of information control among epileptic individuals. They show that many who have epilepsy are inclined to only disclose the illness when the possibility of a seizure is apparent (Conrad and Schneider 1983:218). Otherwise, the person with epilepsy often opts for passing as normal to avoid stigmatization especially in situations of disclosure to an employer (Conrad and Schneider 1983:157).

Goffman (1963) provides a useful framework for understanding the internal and external dimensions of stigma. The stigmatized person uses the same cultural norms, mores, and values as those who are "normal", thus they are capable of taking themselves as the object and categorizing themselves as "abnormal" (Goffman 1963:6-7). Commonly, this internal stigmatization manifests similarly to psychiatric symptoms. However, this creates a confounding problem for psychologists and psychiatrists as it is

very difficult to distinguish what behavior is related to stigma and that which can be attributed to the mental illness itself (Shih 2004).

Externally, stigma manifests as a sense of discomfort from the normals onto the stigmatized (Goffman 1963:42). In social situations, this can be perceived by the stigmatized in such mild ways as staring or a statement of shock or pity. External stigma can also be structural (Link and Phelan 2001; Corrigan et al. 2005). Corrigan et al. (2005) writes, "Structural discrimination is formed by sociopolitical forces and represents the policies of private and governmental institutions that restrict the opportunities of stigmatized groups" (Corrigan et al. 2005:557). As Corrigan et al. found in their study of American legal decisions that used the terms mental illness or mental health, forty-two cases were related to civil liberties and of those, 75% showed evidence of structural discrimination.

These cases ranged from the limiting of rights, (specifically parental rights), to forced medication compliance based on psychiatric diagnosis, to the perceived expansion of rights under fiscal policies for research funding. This expansion of rights is framed as an equalization of rights as they claim psychological/psychiatric research should receive the same amount of government funding as other biomedical research. However, this article does not discuss other structural discriminations, such as housing issues or lack of employment opportunities, which consumers encounter regularly. Using rights based language as well as inserting the practice of discrimination into the debates on stigma is a relatively recent phenomenon in stigma research that attempts to align itself with social justice and liberation movements (Sayce 2000). In his conclusion, Goffman (1963) also

reevaluates his approach to understanding stigma in order to direct the reader's attention to problems of definition and discrimination.

Goffman (1963), in his conclusion, reveals that normality is a bit of a ruse. He stipulates that the only American who is able to live a "normal" life is the "young, married, white, urban, northern, heterosexual Protestant father of college education, fully employed, of good complexion, weight and height, [with] a recent record in sports" (Goffman 1963:128). In light of this, "the normals" is a phrase used by Goffman to describe categories of people who do not consistently suffer the effects of a stigmatized identity. However, Goffman's new configuration of normality also serves to problematize the criteria upon which normality is constructed as nearly every person is, in some way or another, stigmatized. Therefore, both the concepts of stigma and normality become much more diverse and amenable to change through his analysis.

Goffman's definition and micro-sociological description of stigma has considerable effects on sociological, psychological, and psychiatric research on mental illness. His rich analysis in *Stigma* as well as his previous book, *Asylums* (1961), opened dialogue on the ethics of mental health labeling and the politics of psychiatric diagnosis, which had been relatively static topics beforehand. It was also a very timely argument as social and political questions about mental illness' diagnosis and treatment were emerging across westernized nations in the form of new legislation and anti-psychiatric writing. As noted earlier, Thomas Scheff, Howard Becker, and Thomas Szasz were publishing texts questioning the validity of psychiatry in America, while R.D. Laing (1960; 1964), Michel Foucault (1961), and David Cooper (1967) were publishing similar sentiments in Europe at the same time. Goffman was not only among the ranks of these

anti-psychiatry proponents, but also was an active supporter of patients' rights, founding

the American Association for the Abolition of Involuntary Mental Hospitalization

(AAAIMH) with Thomas Szasz in 1970. Goffman's position on what to do for people

with mental illness is difficult to discern, but his participation in this group illustrates his

dedication to patients' rights.

Problems Defining and Measuring Stigma

Due to many types of researchers doing work on stigma, there are a plurality of

concepts and measures used to define and measure stigma. There is no specific discipline

or paradigm that employs a consistent conception or operationalization of stigma, which

leaves it open to various interpretations. In this section, I explore several recent

formulations of the definition of stigma and juxtapose them to show how they are

identifying significantly different things. As well, I look at the issue of operationalizing

stigma to illustrate how measurement is related to directing the research on stigma in

purposeful ways.

Research that looks to expand on the definition of stigma is growing. Dovidio et

al. (2000) describe stigma as a social construction that involves at least two fundamental

components: "(1) the recognition of difference based on some distinguishing

characteristic or mark; and (2) a consequent devaluation of the person" (p.3). This view

suggests that overall there is a perceived difference between individual people or

categories of people and that this perception leads to a reduction in the value of the

stigmatized person. This definition locates the perceived difference in the trait and not

inscribed with societal value judgments of the attribute itself. According to Dovidio et al. (2000) there is a causal chain which then leads to individual discrimination.

Leary and Schreindorfer (1998) suggest that stigma is "when a shared characteristic of a category of people becomes consensually regarded as a basis for disassociating from (that is, avoiding, excluding, ostracizing or otherwise minimizing interaction with) individuals who are perceived to be members of that category" (p.15). Leary and Schreindorfer's (1998) definition of stigma involves specific practices of discrimination that result from a societal agreement that belonging to a particular category is disadvantageous. In other words, conventional knowledge of problematic kinds of people gives rise to isolation practices. In contrast to Dovidio et al.'s (2000) definition Leary and Schreindorfer (1998) ascribe stigma to categories or kinds of people, while Dovido et al. (2000) suggest that stigma is an issue for individuals. However, Leary and Schreindorfer (1998) include specific practices of exclusion in their definition, while Dovido et al. (2000) do not include specific actions other than devaluation of the person. These researchers do not explicitly discuss power relations that construct or modify the common knowledge of these categories either. In both cases, stigma is defined as a somewhat natural occurrence resulting from social norms of behavior.

Kurzban and Leary (2001), through an evolutionary psychological approach, suggest that this common knowledge is actually an effect of humans' cognitive evolution which causes humans to avoid others who may carry pathogens. They contend that stigma and the consequent practices of isolation are functional parts of human nature. However, public understanding of consumers and their diagnoses stems, in large part, from psychiatric knowledge about their behaviors, which has changed significantly over

time. As Hacking (1998) demonstrates, culture and politics influence the ways in which diagnoses become codified at certain times in specific locations, as particular behaviors are not consistently recognized as pathological. As a result, the relationship of stigma between the non-mentally ill and the mentally ill has developed through a multitude of social factors and not innate cognitive changes in the population. Because Kurzban and Leary (2001) suggest that stigma is a functional aspect of human nature, they almost entirely remove the possibility for the reduction of stigma. In recognizing this, they suggest that further systemization of stigmatizing processes, through social science research and the use of the social distance scale, as well as staging interactions to measure the reactions of those involved, can lead to new ways of mitigating stigma (Kurzban and Leary 2001:202).

With regard to the operationalization of stigma, some researchers looking at stigma observe and measure negative attitudes according to diseases such as dementia and schizophrenia from both the perspectives of the patient and the public (Sartorius and Schulze 2005; Pointon 2004). Other researchers look at stigma with regard to legal and psychiatric interventions such as hospitalization, medication compliance, and admission procedures to understand how attitudes towards the mentally ill are positive/negative according to the current mode of treatment for mental illness (Borenstein 1992; Corrigan 2000; Crisp et al. 2005; Hinshaw 2007). These studies focus mainly on methods for decreasing stigma and they adopt the concept of stigma simply as a symbol of disgrace or a discredited attribute which presupposes stigma as a naturalized aspect of social life.

Similar to the way Becker (1963) and Goffman (1963) problematized the use of the term deviance, stigma is also not a consistently measurable concept because particular

social groups may have a stake in defining or modifying the stigma accorded to particular attributes. As Pilgrim and Rogers (2005) suggest, the naturalization of psychiatric stigma as a public perception that affects an individual's treatment outcome is actually "social engineering" (Pilgrim and Rogers 2005:2546). According to Pilgrim and Rogers (2005), it is the alignment of stigma with specific diagnoses and/or treatment regimes that, in turn, attempts to direct social perceptions of mental illness. In the psychiatric context, stigma becomes the object as well as the target of intervention in both the patient and the public.

The codification of stigma as an observable and measurable concept stems from the malleability of its definition. Researchers who seek to define stigma as a natural concept inherent in social life and align it alongside psychiatric, sociological, or psychological practice, ignore the historically contingent events that have led to the current configuration of knowledge about stigma.

Histories of stigma

Historical research on perceptions of mental illness offers insight into the emergence of the discourse on stigma. However, few studies have been conducted to investigate the historical perceptions of mental illness and the emergence of stigma specifically (Fabrega 1990; Fabrega 1991; Hinshaw 2007; Porter 2004; Foucault 2006). Hinshaw (2007) contextualizes his analysis of ways to reduce stigma by providing a cursory investigation into the historical conception of mental illness. He looks at historical perceptions of mental illness mainly to develop an agenda for overcoming stigma. Fabrega (1990; 1991) also writes a history of stigma through looking at social

perceptions of mental illness over time. He incorporates much of the literature from psychiatry and anti-psychiatry in his review, but does not specify any ways to lessen the effects of stigma.

Fabrega (1990; 1991) details the stigma accorded to mental illness in the classical, medieval, early modern and modern periods of western culture. For the medieval and classical periods, Fabrega (1990) concludes that there is a perceptible stigma against psychiatric illness, but notes that this focus is directed on the mentally ill who are poor and visible in society. Through the early modern period, Fabrega (1991) contends that there is still a similar focus on poverty and madness which were considered threats to social order. Governmental intervention into the problems of poverty and insanity were characteristic of the early modern and modern periods. During these periods, workhouses, banishment, punishment, and forced medication were considered appropriate treatments for the mentally ill. The mad poor and the sane poor, as well as other sick, disabled, and vagrant populations, were considered to be "*less or lower* than human" and not only deserved, but required inhumane treatments (Fabrega 1991:104).

Compounding this issue was the view that these people were an economic and social burden and a danger to the "healthy and normal" community (Fabrega 1991:105). Fabrega (1991) notes that in England poor relief policies purposely intended to stigmatize paupers (p.105). Purposeful stigmatization through law is a theme that is also raised in *American Journal of Insanity* in reference to suicide in 1857, as a way to reduce suicide attempts (American Medico-Psychological Association 1857).

Fabrega (1991) links the development of a psychiatric stigma to the birth of the nation-state, the transformation of psychiatry into a distinct medical specialty, and the

segregation of the mad into asylums. As Fabrega (1991) writes, "As individual freedom, autonomy, and the exercise of civil liberties became increasing attributes of personhood in Western societies, the mad took on the anomalous identity of sequestration, dependence, and enforced nonparticipation in social and civil affairs" (p.111). The isolation of the mad in asylums led to the phenomenon of the "museums of madness" where the lay public would pay to view the mad. This is consistent with Foucault's analysis in *History of Madness* (2006a). However, Fabrega (1991) dismisses Foucault's account of madness in *Madness and Civilization* (1965) due to its "blatant antipsychiatry bias" (Fabrega 1991:106). Fabrega's main critique of Foucault's *Madness and Civilization* (1965) is that he tends to "magnify the brutal and work exploitive aspects of moral therapies" which negates the positive consequences of psychiatric intervention (Fabrega 1991:106).

Fabrega (1991) concludes that the anti-psychiatry "revisionist histories" of Foucault, Scull, Szasz, and Castel have "slanted historical developments, minimized the many positive consequences that have accrued to the "mad/ insane", and ignored the growth in knowledge about psychiatric illness that has progressively accumulated" (p.116). Fabrega also acknowledges, however, that it is rather difficult to describe the many historical interpretations compiled by psychiatrists and anti-psychiatrists to arrive at a history of stigma that is factually aligned with the history of psychiatry.

Fabrega does single out one contribution to the theory of psychiatric stigma generated by these "revisionist histories." He states, "The mad and insane are seen to constitute the social segments that "justify" society's effort to control and incarcerate in the pursuit of its aims of surveillance [which constitutes a] blurring of civic duty and

civic accountability under the guise of illness and treatment" (Fabrega 1991:112). It is with the aim of defending society through prevention that psychiatry became aligned with the law and the state as a policing function (Castel 1991).

A psychiatric diagnosis could excuse mental patients from having to work and from legal responsibility. However, the failure to locate somatic causes for psychiatric illness led to further stigmatization as the detection of deception was always a central concern. Fabrega notes, "[T]he social stigma associated with dependence and marginality in a market economy where inability to work brings social discredit is added to the stigma devolving from an association with social fraud and deception" (1991:113). Fabrega (1991) explains that the issues of deception added to the inability to work and to support oneself intertwine to form a negative image of the mentally ill and those living in poverty. It is difficult to separate the public attitudes about mental illness from poverty when dealing with stigma as one issue may, in turn, exacerbate the other (Fabrega 1991).

As a final point, Fabrega (1991) writes of those who have critiqued the history of hysteria, "these and other writers have clearly pointed to a pattern of negative stereotyping and condemnation in clinical writings that have come to play important roles in modern Western culture" (p.115). What is apparent in the critiques of clinical writing is that there are particular kinds of people involved in stigmatization; those that are poor, unable to work, unable to communicate, considered dangerous to themselves and others, immigrants and so on. These kinds of people have come under the supervision of psychiatry in very specific ways. For this reason, it seems that the process of stigmatizing a certain kind of people through psychiatric illness serves a specific social function. Goffman (1963) has suggested that psychiatric stigma can be a form of social

control (Goffman 1963:139). I take this insight in another direction and look at stigma in

terms of social control not as repression, but instead as producing relationships of force

using Foucault's theory of governmentality.

The Effects of Stigma on the Individual

There is extensive investigation into the effects of stigma on the recovery of those

with mental illness and also on stigma as it relates to the production of coping techniques

(Hinshaw 2007; Falk 2001; Corrigan 2004a; Thornicroft 2006; Fink and Tasman 1992).

For example, as Mitchinson (2004) suggests, simply listening to the patient and

demonstrating understanding can result in the patient feeling less stigmatized, at least,

within the clinical setting. Mitchinson's confounding conclusion suggests that

psychiatrists practicing psychiatry is a tool for de-stigmatization. However, for those

who have sought treatment, it is sometimes isolation or suicide which allows them to

avoid being stigmatized by their family, friends, and coworkers. Stigma also leads many

to not seek out care (Corrigan 2004b; Lehman 1999).

Until recently, the subjective experience of those living with mental illness and

stigma was relatively ignored in this field of research. Much more is now being done to

incorporate the consumer's viewpoint into research as an empowering way to develop

new techniques to cope with stigma (Wahl 1999; Shih 2004). However, stigma is not

solely in the domain of the institutionalized psychiatric discourse as consumer's views

are being incorporated into stigma research in a multitude of ways.[3] Stigma research that

focuses on the subjective dimension can also provide for the development of a counter-

discourse as a way for consumers to speak about their situations in order to change

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[3] This process is also occurring in sociological research on stigma.

psychiatric practice. Foucault states of the counter-discourse, "to speak on this subject, to force the institutionalized networks of information to listen, to produce names, to point the finger of accusation, to find targets, is the first step in the reversal of power and the initiation of new struggles against existing forms of power" (Foucault as quoted in Deleuze and Foucault 1977:214). However, this turn in the research may lead to further individualization and responsibilization of the consumer to deal with stigma on an individual basis. Cruikshank (1993) shows how strategies of empowerment, self help, and democratic participation are "also practical techniques for the subjugation of individuals" (p.327). I will discuss these concepts in more detail in the theoretical framework (Chapter Three).

The external dimension of the effects of stigma on the individual's life as a discriminatory practice has been most notably researched through the concept of 'Not in My Back Yard' (NIMBY). NIMBY campaigns to stop the building or use of group homes or psychiatric hospitals have often relied on stigmatized perceptions of mental illness. NIMBY as a type of community organizing is specifically linked to relations of stigma and perceived dangerousness of stigmatized individuals (Huey 2003; Julien 1990; Rabkin et al. 1984). Much of the literature on NIMBYism analyzes the attitudes of residents within certain neighborhoods about their perceptions of those who have disabilities (Piat 2000; Cowan 2003; Borenstein 1992). In relation to those with mental illness, some studies have used a modified Bogardus Social Distance Scale to measure hypothetical situations (Harasymiw et al. 1976; Tringo 1970). Other studies have focused on perceived negative effects of having a group home in the neighborhood such

as declining property values (Farber 1986; Rabkin et al. 1984) and loss of quality of life (Baron and Piasecki 1981; Eynon 1989).

Wolff et al. (1996) suggest that public education prior to the placement of a group home in a neighborhood would increase tolerance and contribute to building a friendly atmosphere towards those with mental illness. Public education is seemingly very rare; as many group home providers wait to provide information or educate the neighborhood in order to prevent NIMBY movements until after they have established housing for the consumers (Piat 2000). Also, Cowan (2003) states that community consultation and the specific nature of the consultation presents many more unique problems as it hinders the right to privacy of the occupants of the group home. As can be seen in this example of stigma and NIMBY campaigns, the actions taken to subdue community concerns are weighed against the rights of the consumer to occupy a particular space. This balance also plays out similarly in the realms of employment and recreation (Baldwin et al. 2006; Corrigan et al. 2003; Wahl 1999; Cook 2006).

Biological Explanations of Mental Illness and Stigma

Biological explanations of mental illness remain largely contested notions. Horwitz writes, "The pendulum of the dominant scientific thought community has swung from a denial of biological effects on human behavior to a primary focus on the brain" (2002:155). Some studies have shown that emphasizing the biological dimensions of mental illness may lead to more stigmatization in the form of isolation and social exclusion, as there is a perceived danger of unpredictability that may not be able to be managed because of its biological nature (Lauber et al. 2003; Feinberg 1998; Phelan

2005; Phelan et al. 2006). This emphasis on mental illness as biological lends credence to the belief in the stigma of dangerousness as it suggests a "kernel of truth" to this stereotype of the schizophrenic (Watson et al. 2003:144). This also reflects how discoveries in science, especially neuroscience and genetics, can lead to changes in the construction and effects of stigma.

Genetic explanations of "madness" are argued to alleviate the internal stigma around the responsibility for one's disease as well as result in a reduction of external stigma (Rose 2006:216). Phelan (2006) suggests that genetic explanations may also result in a more pervasive family stigma. Kuppin and Capiano (1996) found that when mental illness was attributed to genetics, the interventions most recommended were psychiatric hospitalization and prescription medications, not therapy. This finding is also congruent with Rose's (2006) assertion that when mental illness came to be seen as a combination of chemicals then psychopharmacology became the prominent mode of treatment (Pp.187-223).

The history of neurasthenia provides an interesting example of the intersection of biological knowledge and stigma. Around 1860, neurologists had failed to find a biological basis to explain the symptoms of fatigue, anxiety, despair and nightmares attributed to the disease of neurasthenia (Porter 2004). This resulted in the patients becoming stigmatized by medical doctors as lacking "moral courage" or as "the terror of a busy physician" (Porter 2004:11). Porter suggests that failing to find a biological etiology for mental illness has implications for stigma because recourse to a somatic diagnosis is one type of de-stigmatizing strategy. As the paradigm of psychiatry is moving towards neurological and genetic explanations for behavior, the insistence on the

factual causes of mental illness and the prescribed course of medical treatment will be intricately involved in transforming the discourse of stigma.

The Transmission of Stigma

The transmission of stigmatizing rhetoric is another dimension of current research on stigma. This kind of research seeks to understand how stigma is disseminated within the public sphere through entertainment and news sources. The simple answer tends to be that every kind of communication can affect stigma from the media, cultural norms, to interpersonal relations, and so on. This thesis provides for a sociological view of stigma that will implicate specific actors and historical shifts in the discourse of stigma to identify how stigma is talked about and communicated within American psychiatry.

Many ideas have been proposed as to how scientific knowledge becomes public knowledge. More specifically, social psychologists of stigma have looked at newspapers, movies, television, websites, and books (fiction and non-fiction) as promoting negative stereotypes of mental patients, consumers, and psychotic criminals (Wahl 1995). Newspapers and television programming have also been credited with developing health and sciences sections and programming which has led to demystification of mental illness (Borinstein 1992). Therefore, media plays a specific role in the public's understanding of mental illness both positively and negatively.

This project is not generally concerned with understanding entertainment media as a vehicle for stigma. I recognize this as a distinct field of stigma research and am aware of its potential impact on public attitudes towards consumers, psychiatrists, and the mental health field. Government and their constituent agencies have developed

campaigns against stigma that do use media-oriented strategies for the purposes of de-stigmatization. The campaigns which emanate from psychiatric organizations (the American Psychiatric Association, the World Psychiatric Association, and the Substance Abuse and Mental Health Services Administration) form part of the history of stigma and is analyzed as they develop within the historical analysis.

Conclusion

By looking at the many ways in which stigma has come under the purview of social scientists, it becomes apparent that stigma is a complicated concept to define and measure. However, this does not result in the abandonment of the concept, but rather results in numerous definitions and justifications for practices. This has broad implications for historical studies on stigma because as Fabrega (1991) noted, the history of stigma is difficult to discern because of the varied positions taken up by the historians themselves.

Research on stigma has responded to many issues identified by those within the field of psychiatry, anti-psychiatry, and by consumers/survivors/ ex-patients. Within this research, conflicts have developed between how to define and recognize stigma as well as how to diminish it, not just for the benefit of consumers but also for the general field of psychiatry. As a result, research on stigma has led to several campaigns which have attempted to overcome stigma through targeting the disciplines of medicine, law, and psychiatry.

The emphasis in psychiatry now tends to be on how to get patients not to feel stigmatized, rather than teaching the public not to stigmatize them in the first place.

Social perceptions of the mentally ill have become a particularly complex target for intervention as the term stigma becomes aligned with psychiatric discrimination. Historicizing the professional and academic efforts to define, measure, manage, and control stigma enables us to see how this concept has come to symbolize freedom from oppression, domination, and the constraints of mental illness, while simultaneously revealing the discipline of psychiatry's concern with presenting itself as a legitimate and highly scientific field of medicine. In this way, this thesis reveals American psychiatry's effort to de-stigmatize itself through campaigns to reduce the stigma of mental illness. The next chapter explicates the theoretical concepts which aid in understanding how this process can be perceived historically.

Chapter Three

Theoretical Framework

I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area [...] I don't write for an audience, I write for users, not readers.
                                                    — Michel Foucault[4]

In this chapter, I explain the lens through which I view a history of stigma. Because stigma involves numerous points of contact between the public, psychiatry, and patients, on both macro and micro levels, a Foucauldian approach utilizing the concept of governmentality provides the appropriate tools to explore stigma as a rationale for practice. Where rationality is "any form of thinking which strives to be relatively clear, systematic, and explicit about aspects of 'external' and 'internal' existence, about how things are or how they ought to be" (Dean 1999:11), and practices are the ways in which psychiatrists define their objects of study and intervene on them.

I begin this chapter by situating Foucault's work in the broader context of his life, the political uprisings of the 1960s, and the anti-psychiatry movement. From here, I outline the Foucauldian conception of governmentality as it pertains to the development of a neo-liberal political rationale. The section following this, explores the situation of the psychiatric patient through these changing political rationales and the problems mental illness poses to citizenship. Subsequently, this leads to a section on Foucault's work on science (*episteme*) and its clarification through Thomas Kuhn's notion of

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[4] Foucault 1994b:523-524.

paradigms. I conclude with a discussion about the use of these concepts in the history of stigma.

Situating Foucault

Foucault's histories of psychiatry and the human sciences illustrate the relationship between scientific knowledge and power. Foucault (1990) wrote, "[I]t is in discourse that power and knowledge are joined together" (p.100). Discourses "define and establish what is 'truth' at particular moments" as well as invalidates or prevents other accounts of truth from emerging (Carabine 2001:268). Foucault developed the dual concept of power/knowledge, where knowledge and power do not function independently, but instead coexist and legitimate one another in accordance with the political rationality of specific historical periods. The confluence of power/knowledge gives rise to practices that not only limit the possibilities of human action, but also produce ways of thinking and acting. These ways of thinking and acting manifestly depend on the social, political, and historical contexts which led to their existence as well as how others come to understand and implement these ways of being in the course of their lives.

Foucault's concern with psychiatry and its practices can be traced to an experience interning on a psychiatric ward. Early in his career, Foucault interned on the psychiatric ward at Sainte-Anne Hospital on route to becoming a trained psychologist in the 1950s (Whitebook 2005:317). During this internship, Foucault moved about the ward between the attendants and the patients, which led him to begin to question the necessity of the practices of psychiatry. Whitebook (2005) recounts that Foucault witnessed a

patient undergo a lobotomy, but when the patient did not respond to the treatment, Foucault was affected in very profound ways.

After this experience, Foucault published his doctorial dissertation, *Histoire de la Folie,* in 1961, which was quickly taken up by those in the anti-psychiatry movement as a treatise on problems defining and describing mental illness. Foucault claimed to have no prior knowledge of anti-psychiatry before its writing (2006b:13). The anti-psychiatry movement which became pronounced in the 1960s, was led by Foucault in France, R.D. Laing in Britain, and Erving Goffman and Thomas Szasz in America (Sedgwick 1982). Anti-psychiatry, said Foucault, "brings out the relationships of domination peculiar to the institutional relationship" (2006b:345). Whereas psychiatric practice determined how asylums functioned, the relationship between doctor-patient, and the forms of medical intervention; anti-psychiatry questioned these practices as strategies of social control.

Foucault maintained that the critical questioning of institutions, which forms the basis of anti-psychiatric thought, began with psychiatrists and psychoanalysts questioning the validity and necessity of asylums in the 1930s and 1940s (2006b:39). The development of anti-psychiatry then has its roots in the critique of institutional psychiatry by psychiatrists themselves. When the therapeutic value of asylums came under attack in America, especially post-World War II, (by state governments looking to reduce custodial costs, by psychoanalysts seeking increased insurance coverage for out-patient treatment, and by ex-patients groups lobbying to revise commitment laws), the intellectual anti-psychiatry movement was poised to mount an international attack against psychiatric practice purporting that psychiatry was a method of social control. Turner (1997) suggests that due to the context of the anti-psychiatry movement Foucault's work

on mental illness was bound up with the social control thesis of anti-psychiatry (p.x). It would not be until later that Foucault would emphasize the productive elements of power over the repressive and controlling aspects of domination.

Although Foucault's *Madness and Civilization* was pertinent to this movement, his subsequent books were even more influential, given that they covered such issues as the creation of the subject of the human sciences which Foucault addressed in *The Order of Things* (originally published in French in 1966) and that of the impositions of language on the development of science which was the subject of *The Archeology of Knowledge* (originally published in French in 1969). Each of these books utilized the history of psychiatry to critique the humanistic understanding of reason underpinning psychiatric practices. Foucault aimed to make visible the relations of power that directed these practices of creating and codifying the subject of science. It was not until later in the 1970s that Foucault's work sought to understand the relationships between science, government, citizenship, and self. It is through Foucault's concept of governmentality that his early studies of discipline and later work on technologies of the self become more clearly related (Turner 1997:x-xiv).

Governmentality

Governmentality refers to an art of governing by which a state seeks to act upon the conduct of individuals and populations to maintain the safety, security, and well-being of its inhabitants (Rose 1999:6). This is done through divesting the state of overt repressive power, while simultaneously making the state appear as sovereign in order to employ a much more articulated system of agencies, bureaus, and organizations which

gather information, define a normal way of thinking and acting, and implement programs that direct the population towards these norms (Foucault 2007). This section on governmentality describes the development of the political rationality of neo-liberalism which involves both the management of risk and the emphasis of choice as strategies of responsibilization and empowerment in order to produce a self-governing citizen. These strategies seek to direct the behavior of individuals and to diminish the problem of welfare and dependence on the state (Rose 1999:268-269). I begin with introducing Foucault's theory of power, which underpinned the development of his concept of governmentality.

Foucault worked upon a theory of power over his career which was augmented and refined with each subsequent publication. Foucault's notion of power is most notable in his work on sexuality (Foucault 1990), prisons (Foucault 1995), the history of government (Foucault 2007). Foucault (1988a) identified a difference between power that is productive and power that is repressive and controlling. Power that is repressive and controlling, characteristic of Marxists and Neo-Marxists contemporaries of Foucault, was not a satisfactory framework to describe how individuals were called upon to speak and act upon themselves in accordance with a normative conception of being (Foucault 1990).

Foucault's work on governmentality originates from two particular theoretical formulations of power, i.e. bio-power and pastoral power. Dean (1999) stipulates that the field of governmentality research is concerned with relations of power and authority as well as self and identity. It is by looking at what is taken as truth about the nature of human beings and what aspects of that nature are worked upon that leads to new ways of

producing and understanding truth about ourselves (Dean 1999:18). In order to understand how this is accomplished, Foucault developed the concept of bio-power.

Foucault (1984) characterized bio-power as "numerous and diverse techniques for achieving the subjugation of bodies and the control of populations [...]" (p.262). The development of bio-power over the seventeenth and eighteenth centuries incorporated sovereign power, the right of the sovereign to execute his subjects, into a much more articulated and pervasive system of power which became invested in the promotion of life. The effects of power focused on life are that the individual can now be reduced to numbers and organized along a spectrum or a normal curve. As Foucault (1984) wrote, "A normalizing society is the historical outcome of a technology of power centered on life" (p.266). Therefore, deviance or abnormality comes to be understood as a distance from the norms of the population, where the norms of good health and well-being are stipulated.

Statistics and classification systems play vital roles in the discourses of normalization, which underpins the concept of governmentality. The word statistics means science of the state (Foucault 2007:101). In her historical study of the development of vital statistics in Britain for example, Rusnock (2002) writes, "The modern concept of population and its measurement were mutually constructive" (p.4). Population refers to "a mass of living and coexisting beings who present particular biological and pathological traits and who thus come under specific knowledge and technologies" (Foucault 2003a:262). Therefore, a population comes to be known as a political body with its own rates of birth, death, marriage, crime, illness and so on. This is distinct from the definition of the public. Of the public, Foucault (2007) stated, "the

public is...the population seen under the aspect of its opinions, ways of doing things, forms of behavior, customs, fears, prejudices, and requirements; it is what one gets a hold on through education, campaigns and convictions" (p.75). Thus, the public is the sentiment of the population, which must be understood and targeted in ways different from the population.

Once a population comes to be known through statistics, this population becomes both the numeric manifestation of a state's resources and the field which is to be governed. The widening use of statistical analysis of the population took place at the same time as the development of liberal politics. Liberal governments seek a "twin project" where the government intervenes as little as possible in the economy and the lives of citizens, but instead shapes conduct through presenting particular normal conceptions of the population and the individual (Rose 1999:49). Statistics and classification systems, reduction and organization, often intersect and work in unison in liberal governments through supporting one another in an effort to define what is normal and target outliers for correction. It is through the calculation of the population and individual capacities that bio-power is able to totalize a population and then use this information to conceptualize and intervene on problematic individuals.

Bio-power works along a continuum between two poles of the individual and the population. At one pole, anatomo-politics seeks to form the individual as a docile and productive machine through discipline and regimentation (Foucault 1990:139). Foucault, later, extended this anatomo-political argument in developing the concept of "technologies of the self" which suggested that it was not only the body that was extorted and disciplined through liberal governmental practices, but also the mind (Foucault

2003a). Foucault (2003a) wrote that the technology of the self is comprised of a series of techniques or practices, "which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (p.146). Foucault (1994a) offered an explanation of these techniques as often "invisible" and "linked to the direction of others" (p.277). This is a particularly salient point for how liberal governments come to direct the population through strategies of empowerment, choice and responsibilization, a point to which I return later.

At the other pole, bio-politics is concerned with the statistical calculation and subsequent intervention into population in its depth and details. The counting of the population led to the invention of representative democracy in America, for example, where delegates were allotted based on the number of citizens in a specific location (Rose 1999:221-224). To be counted was to be represented, which conferred an identity on to citizens where their civil rights and civic duty became intertwined. Therefore, to be a responsible citizen in a liberal democracy meant voting, working, paying taxes, providing for yourself and family, maintaining good health and so on for the good of the population.

At each of these poles, adds Hacking (1995), are three aspects: power, politics, and science. The bio-political pole works upon the population through collecting statistics, assessing and analyzing these statistics to classify trends and rates, and then addressing any problematic issues through governmental programs. Rose (1999) refers to this process of liberal mentality as delimiting, where a government appraises the "natural

spheres" of life such as the market, citizens, and civil society, and then shapes their contents according to its own project (Pp.48-49). At the anatomo-political pole, a broad range of bureaus, agencies and professions seek to evaluate, educate, and normalize the individual in accordance with the rest of the population. This is accomplished by investing certain professions, doctors, managers, planners, parents, teachers, and social works etc., with independent authority due to their expertise in order to establish relays between the government and the citizen (Rose 1999:49). This results in a mode of operation that Rose (1999) terms "governing at a distance", where the political rationale of the government is "translated" through these experts and the spatial distance from the government is maintained (Pp.49-50).

This is similar to Foucault's conception of pastoral power. Pastoral power is a specific relation between individuals that is significantly different from domination. Foucault (1988a) writes, "A man who is chained up and beaten is subject to force being exerted over him. Not power" (p.83). Pastoral power is evident in relations where a person directs the conduct of another person, but not exhaustively or coercively. A person's freedom is subjected to pastoral power when they are guided by the actions of (an)other person(s). Foucault (1988a) refers to this as a city-citizen game, where the citizen believes himself/herself to be led by a statesman, matched with the shepherd-flock game, where the individual is part of a collective and led by a multiplicity of shepherds through a network of pastoral power. The relation of this formulation of pastoral power to governmentality is evident as governmentality refers to "conduct of conduct", which means to guide one to behave in a certain way (Senellart in Foucault 2007:389). This guidance can come from the government at a distance or from a parent to child (Senellart

in Foucault 2007:389). Under liberalism, the government of a person by another person, or group by another group, and even class by class, and so on, involves a specific political rationale characteristic of a power that does not involve direct violence and total domination. Instead, this political rationale engenders a sense of freedom from state intervention, all the while adjusting human conduct through institutions that an individual utilizes voluntarily (Rose 1999; Foucault 1988a). In the American context, this form of bio/pastoral power is historically illustrated in the shift from liberalism to neo-liberalism.

When the political tide turned in American in the early 1900s towards progressive agendas, the doctrine of laissez-faire politics came into question as the notions of social responsibility and ethical obligations began to emerge (Rose 1999:120-127). Social control through social responsibility was promulgated through fears about impending social revolution and theories of biological degeneration (Rose 1999:121). Within the progressive agendas of this period a call for more regulation on the economy took place. As well, the issues of the protection of workers rights and instituting social insurance were raised. However, these agendas were fragmented and came to be addressed through experts in those fields (Rose 1999:124-125). The issue of worker's rights was dealt with by employers creating human relations offices and personnel management to govern their employees' activities within the workplace. This made the workplace into a social domain and a field for psychological evaluation (Rose 1999:126). Social insurance policies were largely struck down due to fears that they would replicate the corruption and scandal of previous plans for civil war pensions (Rose 1999:125). The ailing economy was addressed in the Social Security Act of 1935 by utilizing deficit financing to address unemployment.

Through this, the state began to assume more responsibility for the social welfare of the population (Rose 1999:128). As well, experts in the domain of family care emerged through professions such as school teachers, social workers, pediatricians, and psychologists. These experts calculated the risks and benefits of particular kinds of individuals through knowledge garnered from the statistical norms in the population. This focus on risk would eventually lead to new practices for the management of the mentally ill population. However after WWII, when the socialist agenda of Nazi Germany failed, many began to challenge the notion of social government and the welfare state.

Rose (1999) writes of the slow rise of neo-liberalism after WWII that "[t]he relation of the state and the people was to take a different form: the former would maintain the infrastructure of law and order; the latter would promote individual and national well-being by their responsibility and enterprise" (p.139). Neo-liberalism would retain some of the strategies of liberalism that promoted responsibility, but would also encourage the individual to participate in the market for the betterment of not just the entire population, but also of his/her community. Proponents of neo-liberalism argued that social government burdens the poor as well as the rich because welfare policies only led to more unemployment and poverty (Rose 1999:141). Neo-liberals maintained that governments should reject compulsory social welfare policies in favor of national policies that promote the growth of the market.

Within the neo-liberal rationale is the implicit charge that a government should not intervene in the lives of its citizens, but should create the conditions which allow for the market to exist (Rose 1999:139-141). Rose (1999) writes, "The powers of state thus

had to be directed to empowering the entrepreneurial subjects of choice in the quest for self-realization" (p.142). In doing so, the citizen is made responsible for themselves in matters of health and welfare through being empowered by choice. Rose (1999) explains this concept of "responsibilization" in the domain of the medical through the linking of "the public objectives for the good health and good order of the social body with the desire of individuals for health and well-being" (p.74). Therefore, the responsibility of the citizen to be healthy is ensured by normative understandings of health as described by the government and its constituent agencies. Choice manifests in many spheres of life from the choice of health insurance plans, primary care physicians, and kinds of treatment, to choice of job, neighborhood, and nutrition. It is through these choices that identity is formed and manipulated through ethical claims about fulfilling responsibilities as well as desires (Rose 1999:178-179). Empowerment rhetoric is useful in this process as it encourages the citizen to take charge of their needs, thus divesting the state of its responsibility towards the citizen.

The combination of a political rationale aimed at calculating and directing life processes "from a distance" with a declaration that people are responsible for their own well-being leaves the sub-population of the mentally ill in a very problematic space intersecting with social demands that they can not fulfill. This results in other interventions into this group from social service organizations, psychiatry, policing, and policy making. Similar to liberalism, neo-liberalism purports the values of democracy and liberation through the restriction of governmental intervention in the lives of citizens, while at the same time a massive network of agencies aimed at managing life processes pervade the lives of those citizens (Rose 1999; Dean 1994). As well, through the 1970s

and today, the mentally ill population has been a fervent target of empowerment strategies that seek to make them more responsible for their own health and well-being through appeals to human rights and citizenship. As is shown later in this history of stigma, the empowerment rhetoric aimed at the mentally ill population targets them in very specific ways in relation to choice and responsibility, where the limits of citizenship and human rights become exposed in the process.

The Psychiatric Citizen

The previous section detailed the development of the neo-liberal political rationale, where government is concerned with creating the optimum conditions for market expansion, and the role of the citizen is to participate in the market as a responsible subject exercising choice. Problems of citizenship arise when a person is unable to meet the demands of the state. For example in the present American context, because the diagnosis of mental illness calls into question a person's ability to rationalize, it also raises concerns about their ability to function ethically and responsibly. Thus inalienable rights can be rescinded in a multitude of ways, such as forced treatment, mandatory medication, and confinement to a psychiatric ward. This section explores the historical development of citizenship in neo-liberal states and its relation to the formation of the mentally ill population. I conclude with a discussion about the emergence of the management of risk and how this has led to a proliferation of professions and agencies that direct the mentally ill population.

As Hindess (2002) explains in his definition of citizenship, "Citizens are individuals who have certain rights, and a corresponding set of obligations, in relation to

the government of the state to which they belong (p.128). He goes on further to clarify

the obligations of a citizen, "Each of them would normally be expected to possess the

personal attributes and characteristics (a minimal degree of rationality, courage, moral

integrity, linguistic and cultural skills, and so on) required for the practical realisation of

those rights and obligations in the context of the particular state in question" (Hindess

2002:128). Under neo-liberal democracy, not only does the citizen have obligations to

the state, but conversely, the state is obligated to manage issues of risk that arise in the

population. Therefore, neo-liberal states are most concerned not with the welfare of all

human beings, but with the management of risks to or within their population (Hindess

2002:130). Through the social uprisings of the 1960s, which focused on extending the

rights of marginalized populations, the practice of psychiatry was recast as a threat to

liberty and democracy. This has contemporaneous parallels with the social and political

making of a psychiatric population endowed with citizenship that is limited by their

capacity to be free, not only from involuntary treatment, but also from mental illness and

stigma.

Although belonging to a state and receiving care through social programs, citizens

with mental illnesses are only accorded an "illusion of citizenship" (Sayce 2000), as neo-

liberal state citizenship also carries with it "explicit and implicit normative rankings" that

demarcate normal/abnormal or good/bad citizens (Hindess 2002:128). This view of

citizenship as a normative schematic for understanding personal conduct developed from

the ideology of liberal government, which depends on responsible citizens to participate

in the market. The governing of the neo-liberal citizen is not done by state control, but

rather through the market as a way for networks of people, places, and things to interact

on a massive scale in a rather orderly fashion. As Hindess (2002) notes, "market interaction itself is seen as a powerful instrument of civilization, inculcating such virtues as prudence, diligence, punctuality, self-control, and so on" (p.135). The neo-liberal citizenship framework is characterized by a more global understanding of citizenship and those that are unable to perform in a market based economy are seen as "autonomous agents", whose rights and responsibilities are contentious and limited (Hindess 2002:139). This applies both to what may be termed pre-industrial or third world countries as well as problematic citizens, i.e. poor, ill, or criminal, located within a neo-liberal state.

Foucauldian studies in governmentality have reiterated these points in similar ways, particularly the work of Robert Castel (1991). Castel (1991) shows how psychiatry is linked into the state as an agency that is most concerned with the management of a problematic population. Under liberal rule, psychiatry's task was to locate dangerous individuals. It was through a personalized face-to-face interaction of doctor and patient that a diagnosis could carry with it the hypothesis of unpredictability and dangerousness. Psychiatry, under liberal rule, relied on "preventive interventionism", one patient at a time (Castel 1991:283). Castel (1991) stipulates that this is why commitment was a popular treatment in early psychiatry because it represented the neutralization of a threat to society. However, Castel (1991) stipulates that these early psychiatrists did not rely on a codified knowledge of dangerousness as asylums would have swelled much beyond capacity. Moral treatment, the preferred way of treating individual patients in a compassionate manner, also relied on a heavily individualized practice. The tenets of moral treatment suggested that overcrowding institutions would have deleterious effects

on patient outcomes as each patient's length of stay was often determined by the long periods of relaxation and personal attention from staff, not from any specific diagnosis.

However in the progressive era, when the paradigm of American psychiatry shifted towards eugenic practices, managing risk as well as limiting the transmission of risk became a paramount concern. Risk was unlike any dangerousness that a certain person or sub-group may exhibit. Risk, instead, was "the effect of a combination of abstract factors which render more or less probable the occurrence of undesirable modes of behavior" (Castel 1991:287). Therefore, sterilization as a measure to "suppress future risks" could be implemented on a much wider scale than commitment (Castel 1991:285). It is not only eugenic theory or practices that were prefaced on managing risk, but also an entire constellation of agencies, bureaus, and organizations that developed during the progressive era which addressed the management of risk in America in such a way that the psychiatric citizen was made both a subject and target of intervention.

Clifford Beers, a mental patient himself, formed the National Institute of Mental Hygiene in 1911 which worked closely with lawyers, legislators and psychiatrists implementing programs in communities and schools for educating the public on psychiatric knowledge. These reforms also led to social work becoming an occupation because it entailed attending to a population and assessing needs in order to address problems before they arose. As Castel (1991) suggests, instead of prevention, the focus turned to prediction (p.288). In order to predict the degree of risk, the correlation of variables and the calculation of statistics were combined to make a problem visible before even speaking to a patient. Epidemiology as a science took on a specific character of legitimate and useful knowledge at this time because it could aggregate large amounts

of information about the population alongside a spectrum of variables from occupation, to social class, to prevalence of disease (Healy 2002:137). Once risk could be deduced, personal biographies and case files, already long established necessities of psychiatric practice, took on new meaning. New correlations between risk factors garnered from files and interviews meant new risks which led to new interventions that would, in turn, lead to new correlations and so on, ad infinitum (Castel 1991:289).

After WWII, Castel (1991) notes a shift in understanding of diagnosis and treatment. No longer is the diagnosis bound to commitment or sterilization, but a vast array of administrations follow an individual along their life course, as is the case in America with the Community Mental Health Centers program in the 1960s. This program is most commonly known for triggering deinstitutionalization, which left many patients without necessities such as food and shelter. Under this new framework for psychiatric practice, a diagnosis is given by an expert, a psychiatrist, and then the patient's care is manifestly in the hands of another organization. Rather than employ an understanding of psychiatric treatment as repression or social control of mentally ill people, Castel (1991) refers to this as "administrative assignation" that provides for the "autonomized management" of populations through reliance on expert knowledge, thus making it possible to "assign and guide" the mentally ill population without taking custody of these individuals (Pp. 290-295). This is an example of what Rose (1999) describes as "governing at a distance". This governing technique developed from the colonization of North America and other British territories and sought to manage a population through inscribing a set of techniques for self-government as well as penalties for not adhering to those norms as prescribed by appointed experts (Rose 1999:110-111).

The person who is mentally ill complicates the process of governing at a distance as navigating a network of social workers, community centers, doctor's offices, pharmacies etc is very difficult. Managing risk from a distance requires a mobile as well as flexible system of administrations that are endowed with certain powers and resources from the government (Rose 1999:148-149). However, these groups and administrations often must lobby for funding, a key feature of politics driven by a market economy. Those agencies which are too radical or diverge too widely from the aims of government will not be funded. As will be seen in Chapter Five, these funds are important for creating alternatives to psychiatric care as well as gaining a seat at the table in legislative hearings on the rights of the mentally ill.

Risky population management in neo-liberal society acknowledges the psychiatric citizen as belonging to a community, while simultaneously projecting a normative image of social order onto that community through policy decisions. The effect of the matrix of neo-liberal citizenship, the prerogative of responsibility for oneself coupled with prudent participation in the market, also made these tenets the hallmark of good mental health. Medical nosology in the early nineteenth century distinguished mental illness from mental retardation, thus separating what could be understood as temporary affliction from a developmental disability (Foucault 2006a:205). This diagnostic separation and the ensuing classification of mental illness over the course of the next hundred years led to the development of an identifiable sub-population, which in the 1940s began to organize on the basis of disease classification as well as on the grounds of having received similar psychiatric treatments (Low 1991).

In the 1960s and 1970s, under the guise of this specificity, the mentally ill population, as a *bona fide* conglomeration of citizens with all the rights and responsibilities of normal citizens, were able to organize (and in many cases be organized by family or psychiatrists) through recognizing themselves as belonging to a restricted or marginalized citizenship status which ultimately affected the kind of care they received as well as how they were treated in the community (Morrison 2005). It was through the recognition that representation would eventually lead to new kinds of treatment and the extension of civil rights, that the mentally ill population would come out from behind the asylum gates and begin speaking, thinking, and acting as citizens.

However implicitly, this call to arms was the outcome of another agenda. At the very same time that the mentally ill would come to have their say, American psychiatry was undergoing a barrage of attacks. The public denigrated the mentally ill in their communities. Insurance companies lamented the use of the *Diagnostic and Statistical Manual of Mental Disorders* because of its psychoanalytic framework. The Federal Government withdrew its funding from the American Psychiatric Association and the National Institutes of Mental Health. Anti-psychiatry proponents attacked the medical model of psychiatric expertise. Each of these forces in some way contributed to the problematization of the mentally ill population and the perception of the psychiatric profession as stigmatized. Chapter Five addresses all of these issues at much greater length, but for now I briefly discuss the history of psychiatry as a series of paradigm shifts corresponding to changes in political rationales.

Between Episteme and Paradigm

This section reviews Foucault's concept of *episteme*, or regimes of truth that open

the conditions of possibility for a field of scientific expertise to develop. I begin by

illustrating how the concept of *episteme* is related to other concepts Foucault developed

such as discursive formations and discursive practices. From here, I show how

Foucault's ideas are similar to Thomas Kuhn's definition of scientific paradigms in order

to demonstrate a practical way to examine the history of shifts in of psychiatry practice. I

then problematize Foucault's account of *episteme* on the basis of method and discuss how

Foucault's *episteme* can enhance the understanding of a Kuhnian paradigm.

Foucault introduced the concept of *episteme* in *The Order of Things* (1970), a

book whose subject was a historicization of the human sciences. Of *episteme,* Foucault

(1980) stated, "I would define the *episteme* retrospectively as the strategic apparatus

which permits of separating out from among all the statements which are possible those

that will be acceptable within, I won't say a scientific theory, but a field of scientificity,

and which it is possible to say are true or false. The *episteme* is the 'apparatus' which

makes possible the separation, not of the true from the false, but of what may from what

may not be characterised as scientific" (p.197). Therefore, an *episteme* works as a limit

on the project of science defining the boundaries of scientific practice and differentiating

the objects acceptable to scientific inquiry. The *episteme* is bound to a set of social,

political, economic, ethical, moral, and legal rules which govern the kinds of scientific

knowledge that can come into existence during a historical era.

This description is similar to Foucault's definition of discursive formations which

mediate the ways in which objects come to be known and talked about through their

relation to and between other discourses. Objects can only be talked about in specific ways corresponding to the rationale of the historical period. As Foucault put it bluntly, "it is not easy to say something new" (Foucault 1972:44). This is due to rules of speech and for the acceptance of ideas as facts within the discursive formation. This is not to say that one can not say anything, but rather that one can only say something that has the status of knowledge if the rules are followed. These rules are transformed over time by repeated representations of ideas in different ways across discourses. Therefore, resistances to power/knowledge do develop within discourse, but are also mediated by the rules of discursive formation (Carabine 2001). In relation to the *episteme*, these rules are not simply internal to a field of science, but are internalized by scientific practice, and they demarcate the types of problems which are appropriate for a field of scientific study as well as which theories will be heralded as true and which methods will be said to produce accurate findings.

Foucault's task in both *The Order of Things* and *The Archeology of Knowledge* was to reveal how these rules set out in certain historical periods developed and were constituted in scientific practice. Dean (1994) suggests that the *episteme* of the human sciences, "is germane [...] not only because of their lower epistemological status but also because of their immersion in other non-scientific, political, and ethical discourses, and their close relation between their contents and a whole range of institutional practices and the wider social and political field in which they are located" (p.30). Therefore, the *episteme* is distinguishable by locating a field of science within its discursive formation and describing discourse as a practice that "systematically form[s] the objects of which they speak" (Foucault 1972:49). It is through targeting the object of science and

describing its historicity that the ideological underbelly of science can be exposed (Foucault 1972:186). Science is a discursive practice, where knowledge is understood and located within a set of rules that delineate the kinds of objects that are appropriate for scientific inquiry as well as how to discover the truth/ fact within/of the object.

In *The Archeology of Knowledge*, Foucault described four "thresholds" of discursive formations, where discursive practices come to formulate objects and the type of study appropriate for the object (Foucault 1972:186-187). The threshold of positivity for a discursive practice has been reached when a discursive formation can be discerned. The threshold of epistemologisation is achieved when a principal means for verifying and validating an object is accepted as the norm of discursive practice. The threshold of scientificity is attained if the discursive practice has obeyed the rules of the discursive formation. Finally, the threshold of formalization occurs when the discursive practice is able to describe its own structure, the propositions internal to it, the modifications it is willing to accept, and can take itself as its own starting point. This threshold is where the *episteme* is located. This final threshold is similar to Kuhn's definition of paradigm.

Kuhn (1996) defined the term paradigm as "some accepted examples of actual scientific practice- examples which include law, theory, application, and instrumentation together- provide models from which spring particular coherent traditions of scientific research" (p.10). Kuhn (1996) went on to state, "Men whose research is based on shared paradigms are committed to the same rules and standards for scientific practice. That commitment and the apparent consensus it provides are prerequisites for normal science, i.e., for the genesis and continuation of a particular research tradition" (p.11). Kuhn asserted that the acceptance of a paradigm results in the emergence of normal science.

Within normal science anomalies can appear that lead to extraordinary science, which can in some cases invoke a crisis that may or may not end with a scientific revolution. Therefore, normal science, although very similar to a paradigm, is actually the outcome of the acceptance of a paradigm. Before the paradigm has been accepted and propagated, science and scientific practice does take place however not in the same way as under a paradigm. This conceptualization is similar to Foucault's *episteme* as the rules for scientific practice are codified in textbooks and taught to students according to regulations from within the context of normal science, suggesting that the object of study is well-defined, self-validating, and adheres to the discursive formation.

When normal science is repeatedly contested by what those enmeshed in the paradigm would consider anomalies, a crisis may ensue where scientists may have to change their beliefs about the paradigm. Within Foucault's theory of thresholds, this would be considered complications at the level of formalization. Similarly, Kuhn (1996) wrote of crises, "The proliferation of competing articulations, the willingness to try anything, the expression of explicit discontent, the recourse to philosophy and to debate over fundamentals, all these are symptoms of a transition from normal to extraordinary research" (p.91). Kuhn offers three ways in which the transition between paradigms can be resolved. First, in some crises science eventually reconciles the problem within the paradigm. Second, the scientists can leave the problem for future generations to solve. And third, a new paradigm may emerge and a battle for its acceptance will arise (Kuhn 1996:84). If a new paradigm successfully replaces the former as the dominant mode of normal science, then a scientific revolution has taken place.

However, this does not mean that the former paradigm disappears, but instead that a paradigm shift has taken place through extraordinary research. Within the humanities, this concept of paradigm shift is perhaps much more useful than the notion of normal science as one paradigm may be dominant, but competing and incommensurable paradigms are also taught to students. Kuhn (1996) writes that the humanities student "has constantly before him a number of competing and incommensurable solutions to these problems, solutions that he must ultimately examine for himself" (p.165). Handa (1986) also points out that these shifts in paradigm, particularly in the social sciences, led to changes in the institution and education as well as the public's world view. Within the domain of psychiatry then, paradigm shifts are successive, yet not necessarily progressive. As Chapter Five illustrates, solutions to new crises may come from old theories and methods as will be seen in the eventual move away from psychoanalysis and back to biological theories of behavior. This has specific implications for how other groups, particularly proponents of anti-psychiatry, view the paradigm of psychiatry and come to interact with it.

As Jean Piaget (1970) noted, Foucault's *episteme* is reminiscent of Kuhn's paradigms (Piaget 1970:132). Whereas Kuhn's philosophy of science describes intellectual crises and paradigm shifts, Foucault's analysis, if he had carried it through, would have led to an understanding of how the fundamental principles of science are interconnected within historical epochs (Piaget 1970:132-133). However, Piaget (1970) contends that Foucault's lack of methodological rigor limits his analysis. As Piaget (1970) wrote, "[F]or instead of inquiring under what conditions one may speak of the reign of a new *episteme* and what are the criteria by which to judge the validity or

invalidity of alternative interpretations of the history of science, he relies on intuition and substitutes speculative improvisation for methodological procedure" (p.132). What seems to be the crux of Piaget's argument is that Foucault's *episteme* lacks scientificity as Piaget called for the critique of science on the basis of scientific method.

The way through this methodological muddle, especially when looking at the history of a human science, is to employ a Kuhnian understanding of paradigm shift by sifting through the mire of theoretical propositions and rationales for implementing and continuing certain practices over and above other practices. Then, by contextualizing these scientific practices through social, political, and legal histories, it will be possible to understand, probably only in part, the *episteme* regulating these practices. In doing so, an understanding of the paradigm shift informed by a particular *episteme* can be enhanced. Using Kuhn and Foucault in this way also illustrates how the rules that govern scientific practice are linked into the discursive formation that directs many other facets of life. Therefore, at least within the history of psychiatry, it is possible to locate different theoretical and practical modes for understanding and intervening on mental illness that have a similar ideological basis as the political rationale of the time period. This point was illustrated in the section on *The Psychiatric Citizen* as Castel (1991) described how the practice of commitment gave way to sterilization when the shift from locating dangerousness to managing risk occurred due to changing political rationales.

Conclusion

This chapter began by locating Foucault's work in the broader social context of the 1960s and the rise of anti-psychiatry to illustrate how his work had come to be

affiliated with the anti-psychiatry movement. In the 1970s, a shift in how he formulated the notion of power separated Foucault from the social control thesis popular within anti-psychiatric thought by describing a system of power that is more fluid and dynamic. Following this, I defined and historicized the concept of governmentality both within Foucault's own work and within American politics from the liberal era through progressivism and ending in the present political rationale of neo-liberalism. The neo-liberal strategies of choice, empowerment, and responsibilization were summarized to explicate how neo-liberal government divests itself of responsibility for social welfare, while simultaneously creating the conditions for the market's existence and promoting participation in the market as a marker of good citizenship.

From here, the question of citizenship was problematized for people with mental illness. As Foucault noted, diagnosis and symptomology have significance not just for classification schemes, but also in terms of their relationship to decision and decree (Foucault 2006b:346). The development of diagnostic criteria redefined the perception of a mentally ill population, who continues to be marginalized due to the risks they may pose to normal citizens. This section also demonstrated how the changing political rationale corresponding to neo-liberal ideals has led the government to distance itself from the mentally ill population through enacting policies that promote the responsibilization of the mentally ill population to choose their own treatment, but this has been complicated by the presence of mental illness, a lack of funding for community programs, as well as a wary public sentiment.

The final section, *Between Episteme and Paradigm,* discussed the relation between Foucault's *episteme,* the constellation of rules that make up and govern scientific

practice, and Kuhn's paradigms, models of theory and practice that form the basis of a scientific research tradition. It is by tracing the history of paradigm shifts within their own political, social, and legal contexts that broader understanding of a scientific practice becomes possible; an understanding that does not hinge on appeals to progressive movements towards greater truth, but instead recognizes and makes use of historical contradictions and contingencies to illustrate that the present situation is not necessarily a result of strict advancement and progress, but is rather a complex configuration of knowledge/power.

Before ending this chapter, I must make a few remarks about how I use these concepts in sketching a history of stigma. A governmentality study of psychiatry and stigma requires detailing a history of contestation and struggle between psychiatry and the law, internal scientific conflict, and the fight for patients to obtain civil rights. It is through the "conduct of conduct" that stigma comes to play an intricate role as a rationale for both psychiatric practice and individual conduct. Psychiatry is linked into the state as a legal instrument for the policing and defense of society, while it also entails promoting aspirations of individual attainment and self-mastery (Rose 1999:260-262). Thus, psychiatry carries within it a set of moral and ethical quandaries requiring the practices of policing against the promotion of freedom and liberty.

Psychiatry is predicated on techniques of normalization, i.e. surveying, analyzing, and conveying meaning to behaviors which can then be judged as within the realm of the normal, good, and average or abnormal and bad. Fee writes, "In the modern era, psychiatric discourse is one of the scientific networks that has contrived its view of mental disorder through opposites and contrasts - health/ pathology, normal/ abnormal,

rational/ irrational- which serve to justify conceptual binaries and real-world exclusions" (Fee 2000:10). The discourse of psychiatry relies most heavily on a binary distinction between abnormal versus normal thoughts and actions. It is through this distinction that the various techniques to manage the mentally ill population are justified and legitimated despite the fact that some consider these techniques to be violations of civil rights.

In positing a theory of stigma in relation to a governmentality framework, I examine "how forms of rationality inscribe themselves in practices or systems of practices, and what role they play within them" (Foucault 2003a:251). It is through understanding the constellation of how stigma is talked about and invoked as an appeal to truth/false distinctions as well as used as a legitimation of practice that the history of stigma emerges along side a history of psychiatric practice. Rose (1999) suggests that every political rationality "in the name of the market, in the name of the social, in the name of liberty of the individual is a strategy to intervene, whether in thought or in reality upon a set of messy, local, regional, practical, political, and other struggles in order to rationalize them according to a certain principle" (p.28). This suggests that campaigns to end stigma follow a particular political rationale. The political context of the 1960s with its focus on civil rights opens the possibility for stigma to be utilized in a multitude of ways leading to new understandings of both psychiatry and the patient. However, this new understanding was wholly problematic for psychiatry as a new paradigm emerged in the 1980s more forceful than ever before and at its foundation stigma was a defining principle.

When Porter (2004) asked the question, *Is Mental Illness Inevitably Stigmatizing?* His answer was a resounding yes. The stigma of mental illness derives, not only from

paradigm crises and disagreements over psychiatric methods and theories, but also from how illness is moralized through these distinctions (Porter 1998). The modern diagnosis of mental illness is invested with value-judgments as to the character of an individual in light of knowledge of the population. The current *episteme* of psychiatry is invested with the political rationale of neo-liberal governments. This is recognizable in the concerted efforts to direct the public's opinion of psychiatry through the public education campaigns to diminish stigma that began in the late 1980s.

By looking at the problem of citizenship through the lens of governmentality, it is possible to recognize/demonstrate how campaigns for diminishing stigma are aimed at redefining the issue of citizenship and civil rights for psychiatric patients. Cruikshank (1999) writes, "Individual subjects are transformed into citizens" through "technologies of citizenship: discourses, programs, and other tactics aimed at making individuals politically active and capable of self government" (Cruikshank 1999:1). Psychiatric citizens experience a particular kind of citizenship as laws are codified specifically to grant them certain rights as well as limitations to what many consider inalienable rights. Sayce (2000) suggests that consumers are relegated to "an illusion of citizenship", which is most evident in the structural discrimination regarding inalienable rights such as life, liberty, and the pursuit of happiness (Sayce, 2000: 83). By attempting to change the public's sentiment towards stigma of both psychiatric treatment and the mentally ill person, new understandings of citizenship emerge as psychiatric practice, laws, civil rights, and patienthood become implicated in the process.

Analyzing psychiatry as bound to legal, social, and political discourses through historical contextualization yields a better understanding of the present configuration and

problematic of stigma. Dean (1999) writes, "All an analytics of government can do is to analyze the rationalities of resistance and programmes to which they give rise and to make clear what is at stake and what are the consequences of thinking and acting in such a way" (p.27). Therefore, this project makes known the analytics of government that employ stigma as a tool for working upon ourselves and others through a historical analysis of the concept of stigma.

Chapter Four

History and Genealogy

Genealogy is gray, meticulous and patiently documentary. It operates on a field of entangled and confused parchments, on documents that have been scratched over and recopied many times. - Michel Foucault[5]

In this section, I explain Foucault's methodology of critical and effective history, which utilizes archeological and genealogical approaches to history through genealogical discourse analysis. I begin by outlining a short historiography of American psychiatry to describe problems that arise when reading and writing historical accounts of psychiatry. I then summarize Foucault's archeology and genealogy followed by a section on the method of discourse analysis. From here, I proceed with a section on the historical materials used in this analysis of stigma and briefly describe how these materials are organized and thematized in the subsequent chapters. Finally, I discuss some problems and limitations of historical methods and their implications for this thesis.

Reading Histories of Psychiatry

Histories of psychiatry before the social movements of the 1960s in America were generally whiggish, meaning that these histories posit the present as the inevitable progression from the past, where the present is the pinnacle of modern science (Micale and Porter 1994). In 1937, Albert Deutsch, a self-taught public servant in the mental hygiene movement, published *The Mentally Ill in America*, which is considered the first major historical work on the history of American psychiatry. Deutsch's book is often

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[5] Foucault 2003a:351.

charged with being steeped in modernist ideals towards the progress of the discipline (Micale and Porter 1994:9). As psychiatry became more and more focused on a scientific basis, the first histories of psychiatry took on the character of recurrent histories, i.e. histories of science written from the view point of present practice that posit the progressive moves towards a greater truth (Dean 1994:30). These histories detailed autobiographies, selective pasts, and omitted negative elements (Micale and Porter, 1994: 4). These kinds of histories are useful in times of paradigm conflict and can legitimate particular theories and practices, while in turn, casting doubt on competing paradigms.

As the sentiment of anti-psychiatry developed in the early 1960s, particularly in the work of American sociologist Erving Goffman and psychoanalyst Thomas Szasz, a new wave of psychiatric histories and knowledge was documented. Foucault's *Madness and Civilization*, Goffman's *Asylums*, and Szasz's *The Myth of Mental Illness,* all published between 1960 and 1961, emerged just as public debates on how to better attend to the needs of the mentally ill population began. In 1963, the same year that legislation for deinstitutionalization was passed by the U.S. congress, Erving Goffman published *Stigma: Notes on the Management of Spoiled Identity.* Deinstitutionalization refers to laws that provided for funding to treat the mentally ill population in communities and outside of state hospitals. It is also at this point that anti-psychiatry was growing into an intellectual position, eventually becoming a social movement by the early 1970s.

Contemporaneously, gay rights activists criticized psychiatry for its mechanisms of social control during this time of social unrest. Homosexuality was a contested diagnosis which resulted concerted efforts from gay rights activists and psychiatrists alike to remove it from the *Diagnostic and Statistics Manual of Mental Disorders- II* in 1973

(Healy 2002:301). Additional historical accounts of psychiatry including Rothman's *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (1970), Ignatieff's *Just a Measure of Pain: The Penitentiary in the Industrial Revolution* (1978) and Foucault's *Discipline and Punish* ([1975] 1995) appeared within the 1970s, all examining the repressive roles of social institutions.

Reconstructing the history of psychiatry from secondary sources can be problematic as those histories written prior to the rise of anti-psychiatry's critical discourse present psychiatric practice as wholly progressive, while some of the histories written by anti-psychiatrists overtly emphasize negative events. Therefore, writing a history of psychiatry must entail elements of historiography, the process of historicizing academic works in order to locate them within the larger historical narrative to illustrate how they may have affected the discipline. History can be useful insofar as it can provide the foundation for ideologies about the progress/regress of social institutions. This is a relevant point for understanding how scientific paradigms develop and how history is part of maintaining the strength of a paradigm. As well, the history of the ex-patients' movement has only recently come to light because the problem of advocacy in the 1980s split the ex-patients' movement into many fractured elements which have been difficult to locate and detail historically (Morrison 2005). However far on the fringe these ex-patient groups may be positioned, incorporating these forgotten or untold histories into the broader historical narrative illuminates how patients participate in the discourse of American psychiatry. In order to attend to these issues, I use the methodology of a critical and effective history.

Foucault's Critical and Effective History

Dean (1994) conceptualizes much of Foucault's work in terms of the methodology Foucault used when writing histories of madness, penal institutions, political rationality, and sexuality. It is important to highlight the distinction between methodology and method. Methodology is the underlying principles for the explanation of a method, while method is the act of conducting research according to a plan. Therefore, when speaking of Foucault's own work, it is more closely aligned with articulating a methodology and not the execution of a definitive method. Carabine's (2001) treatise on genealogical discourse analysis provides a map of how to conduct research in a similar way to Foucault, which will be drawn upon in the next section. In this section, I outline Foucault's approach to archeology and genealogy and explain how these methodologies provide a unique way to construct a history of an object that may appear as natural or ahistorical. From here, I conclude by illustrating how this provides a way to understand the history of the present.

Dean (1994) looks closely at how Foucault's historical methodologies of archeology and genealogy become intertwined to produce a history of the present, which illustrates how certain ways of being and ways of knowing came to exist at certain historical moments. Foucault's only detailed methodological work, *The Archeology of Knowledge*, was later supplanted by his genealogical studies. Archeology is a term Foucault borrowed from Kant regarding the history of ideas. Kant describes archeology as "the history of that which makes a certain form of thought necessary" (1963:341). Utilizing the concept of *episteme*, archeology traces how scientific knowledge is generated and limited by the discursive formation of a given historical period. Genealogy

seeks to uncover the power relations embedded in the process of making up scientific

knowledges, by locating the fragmented struggles of subjugated knowledges, which exist

below the threshold of scientificity (Sarup 1993:80).

In *Psychiatric Power* (2006b), Foucault offers a short analysis of the difference

between archeology and genealogy; although he points out they are complementary. He

writes of archeology,

> Showing that the scientific demonstration is basically only a ritual, that the
> supposedly universal subject of knowledge is really only an individual historically
> qualified according to certain modalities, and that the discovery of truth is really a
> certain modality of the production of truth; putting what is given as the truth of
> observation or demonstration back on the basis of rituals, of the qualifications of
> the knowing individual, of the truth event system, is what I would call the
> archeology of knowledge (Foucault 2006b:238).

With archeology, Foucault begins with an object that he traces backwards and forwards

through history through discourse as a way to show the transformations in how an object

came to be understood as it is today. These transformations or "points of dispersion"

signal when the object could have taken a different form, but was lodged in a discursive

formation. Discursive formation refers to a complex system of discourse, where only

certain statements and subject positions are allowed to be said or occupied in order to

have the status of knowledge and truth (Foucault 1972:166-177). For Foucault, it is not

that the truth is already out there waiting to be demonstrated by science, but that the truth

is historically contingent.

Similar to archeology, genealogy exposes the contingencies in the history of

knowledge and further illustrates "how this technology of demonstrative truth colonized

and now exercises a relationship of power over this truth whose technology is linked to

the event, to strategy, to the hunt" (Foucault 2006b:239). Foucault's genealogy derived

from the work of Nietzsche and Heidegger (Elden 2003). With genealogy, Foucault looks at the axes of truth, power, and the subject to seek out the relations of power in the construction and dissemination of truth and knowledge (Mahon 1992). Foucault states of genealogy, "[I]t is a question of presenting a critique of our time, based upon retrospective analyses" (Foucault quoted in Elden 2003:199). With archaeology, Foucault digs through history and discourse to see how knowledge is generated, and then with genealogy he shows how this knowledge is directed and manipulated by power relations, which renders visible the conditions of the present.

It can be seen from describing these two approaches, that for science the truth is out there waiting to be discovered/ revealed. Yet, for Foucault, once this truth is established, it is a matter of showing how the truth came to be accepted as fact through archeology and genealogy. The production of scientific truth is an event which makes itself known through a strategy of demonstration. For example, scientists conducting hypothesis testing use specific methods to obtain a particular knowledge about an object, while also limiting the amount of variables which can have an effect on the object. The demonstration of the truth contained within the object is represented as more valid and reliable, as the scientist comes closer to limiting the possibility for other truths from emerging. This is characterized by Foucault as a warlike relationship of power/knowledge. Where knowledge is the power to claim truth, power is exercised in this process of producing knowledge. Thus, where archeology uncovers the statements called forth at specific times to constitute knowledge, genealogy explores the power relations circumscribing these processes of power/ knowledge.

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In this way, the historical analysis of power/knowledge is what Dean (1994) termed "critical and effective history". Critical and effective history describes how an object in the present comes to be spoken about and defined in a particular way through establishing "a historical knowledge of struggles [... in order] to make use of that knowledge today" (Dean 1994:33). Dean (1994) further explains, "Let us call history 'effective' to the extent that it upsets the colonization of historical knowledge by the schemas of transcendental and synthetic philosophy of history, and 'critical' in proportion to its capacity to engage in the tireless interrogation of what is held to be given, necessary, natural, or neutral" (p.20). Thus, critical and effective history does not posit a totalizing understanding of the truth of history. Instead, critical and effective history, through the use of archeological and genealogical approaches, problematizes the present by historicizing those objects that are assumed to be ahistorical (in Foucault's work some of these objects are madness, punishment, medical knowledge, and sexuality) in order to show that the current understanding of those objects are linked to a strategy of power. In doing so, targeting strategies of power becomes possible and tactics can be developed to augment the relationship between power/knowledge. To see how these strategies of power emerged and functioned, Foucault used a method of discourse analysis as a way to gain insight into objects and their historicity.

Genealogical Discourse Analysis

This section further defines the concept of discourse in Foucault's work through an explanation of the relationship between objects, facts, and power/knowledge. From here, I summarize Foucault's *I, Pierre Riviere, having slaughtered my mother, my sister,*

and my brother... (1975) to clarify how he used the method of discourse analysis. Lastly, I review Carabine's (2001) guide to doing Foucauldian genealogical discourse analysis to provide a map for conducting a discourse analysis of stigma.

Moses and Knutsen (2007) explain how objects become facts and then develop into discourses (Pp.212-214). They define discourse as "a lasting system of representations" (Moses and Knutsen 2007:213). It is through a series of repeated presentations of an object that it eventually becomes known as a fact. Facts are presentations that have turned into a "representation with a sense of permanence" (Moses and Knutsen 2007:213). It is through these repeated representations of facts that appear with a sense of permanence, that a discourse is formed in which claims to truth are made. Discourses though are not solely comprised of spoken or written words, but also involve practices and subject positions.

Rose (1996) writes of discourses, "Discourses are not merely 'meaning systems', but are embodied within complex technical and practical associations and devices that provide 'places' that human beings must occupy if they are to have the status of a subject of particular sorts, and which immediately position them in certain relations with one another and with the world which they speak" (p.53). As Rose suggests, discourses are not just collections of statements, but are statements and practices that signify positions between people and the world they live in, which change over time. Discourses can be located anywhere; they can be written, verbal, in observable cultural practices, and sometimes even in silences.

Carabine (2001) writes of the truth embedded within discourses, "Discourses are historically variable ways of specifying knowledges and truths, whereby knowledges are

socially constructed and produced by the effects of power and spoken of in terms of 'truths' [where discourses are] sets of socially and historically constructed rules designating 'what is' and 'what is not'[...]" (p. 275). Discourses are not confined to a single discipline as they are locatable in a gigantic web of complementary discourses and disciplines, each with their own particular sets of concepts, methods, and rules which follow a broader political rationale, i.e. the discursive formation.

Foucault (1984b) adds that discourse is also a relation of power: "[...] as history constantly teaches us, discourse is not simply that which translates struggles or systems of domination, but is the thing for which and by which there is struggle, discourse is the power which is to be seized" (p.110). Therefore, the ability to say certain things and/or carry out certain actions is contingent upon power/knowledge embedded within a discourse. In order to examine discourse and to draw out the meanings within it, Foucault contextualized discourses within larger historical and discursive frameworks to identify points at which certain ideas were marginalized, while others were propagated.

Foucault's *I, Pierre Riviere, having slaughtered my mother, my sister, and my brother...* (1975) is a demonstration of the method of discourse analysis, which is a way of critiquing how an object becomes a fact or truth through its deployment in discourse. The book is comprised of a group of documents about a single case of parricide that occurred in a peasant village in 1835. The reprinted materials include newspaper articles, medical reports, court documents, and a meticulous memoir penned by Pierre Riviere, a man who murdered three members of his family. In the short preface to these documents, Foucault (1975) suggested to the reader that these materials provide "a key to the relations of power, domination, and conflict within which discourses emerge and

function, and hence provide for a potential analysis of discourse (even of scientific discourses) which may be both tactical and political, and therefore strategic" (p.xi). It is through reading these documents that one can see a "battle among discourses through discourses" (Foucault 1975:x). The medical reports conflict with one another as Riviere's memoir complicates understandings of pathology and idiocy, which leads to critiques of psychiatric practice by legal professionals and journalists. Ultimately, the atrocity of the crime disappears from the discussion. As well, once these documents are historicized within a larger social and political context it is revealed how Riviere's memoir illustrated, implicitly, peasants' struggles with real estate law and legally binding contracts (Foucault 1996:203-206). However, Foucault does not outline how to interpret or analyze these documents to make known how he arrived at such a conclusion.

Carabine (2001) explains with great detail how to conduct a genealogical analysis of discourse based on her own reading of Foucault's work supplemented by the work of other Foucauldian scholars. It is by situating genealogical analysis alongside Foucault's conception of normalization that power is most readily identifiable. Carabine (2001) suggests that locating strategies of normalization are an important aspect of discourse analysis because normalization illustrates how power/knowledge is operating to inscribe certain thoughts and behaviors as within the realm of the normal and the good for the direction of both the population and the individual. However, in describing and formalizing objects that are to be considered normal, knowledge of abnormality is also constructed. Sarup (1993) writes of the power embedded in discourse, "knowledge is a power over others, the power to define others" (p.67). The relationship between power/knowledge is definitional and it is through these distinctions of difference where

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the strategies of normalization are deployed within discourse. Identifying where these strategies exist and are resisted is the foundation of discourse analysis.

With this in mind, Carabine's (2001) eleven point guide to doing Foucauldian genealogical discourse analysis begins with selecting a topic and sources of data (Pp.281-285). The first point she raises is about the selection of sources which speak to the topic that is being investigated. Sources for discourse analysis can and should be multiple as greater variety ensures that more viewpoints are represented. Her second point is to read the documents several times while taking notes. The third point is to identify themes, categories, and objects within the discourse. Carabine's fourth point is that one should look for evidence of an inter-relation between discourses and fifth, to seek out how these categories and themes are spoken about in other discourses by looking for cross-discourse strategies of normalization and power. The sixth and seventh points are related as one is to look for absences, silences, resistances, and counter-discourses. In doing so, point eight, identifying the effects of discourse can be discussed as it relates to the kinds of knowledges or statements that are not permitted within a given discourse or how knowledge is challenged or changes. Points nine and ten utilize the data generated by implementing these first eight points, which all related to gathering and sorting data, by conducting a two step contextualization process. This first contextualization involves developing a historical account of the time period from which the documents were culled. Then, one should conduct a second contextualization of the data which illustrates the relationship between the data, discourses, and power/knowledge within the given time period.

Genealogical discourse analysis generates a history of the present by problematizing a current object or event and then seeking out the points in history where it assumed a different form or was transformed through relations of power/knowledge. This method also highlights incongruent statements and assertions, details accounts that are difficult to access and obscure, locates resistances to power/knowledge as well as utilizes secondary sources to give an interpretation of an event or object that is assumed to be natural or ahistorical. I now turn to how I use Carabine's eleven points for conducting discourse analysis in this thesis.

Historical materials

Carabine's (2001) interpretation of Foucauldian genealogical analysis provides a pragmatic way to organize the materials and carry out a historical analysis of stigma. In this section, I describe the selection of the primary data that will be used to generate a genealogy of stigma followed by a description of how these materials are organized for analysis. Then, I provide a summary of secondary materials that are used to sketch the socio-historical context of American psychiatry and explain how these materials situate the data. Third, I explain how the data is interpreted in light of the socio-historical context to produce a history of the present that problematizes current understandings of stigma.

The primary data comes from locating the use of the word/concept 'stigma' in the *American Journal of Psychiatry* (AJP). The AJP is one of the oldest and most widely read psychiatric journals in the world. The AJP is published monthly and includes peer-review articles on a vast array of diagnoses and treatments as well as ethical and social

aspects of psychiatry. The choice to use medical articles generated by the APA is integral for investigating the possible use-value of stigma in the medicalization process. Conrad (1991) explains the concept of medicalization, "Medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (Conrad 1991:209). On the suitability of using medical articles as data, Reuter (2007) explains that medical articles and journals are "a central venue for doctors' dialogues with one another about disease" and are also "indispensable historical artefacts" (p.14-15). More specifically for this thesis, the *AJP* articles both demonstrate the strategies of psychiatry to determine the form and shape of stigma while also linking up these strategies with controversial practices.

Through the *AJP*, stigma is aligned with disease categories and it suggested that stigma can be treated similar to a symptom. As a result, limiting the search for stigma to a single disease category or to a single psychiatric intervention fails to showcase the broad horizon on which stigma operates. Restricting this analysis to the *AJP* may render some aspects of stigma difficult to discern, but the aim here is to uncover the strategies used to define and direct the content of stigma within the psychiatric discourse. These articles also reveal the tactics of anti-psychiatry and consumer advocacy groups that are acknowledged by the APA. These acknowledgements and the tactics themselves can often change the trajectory and use-value of stigma. Using the *AJP* articles as a basis and then tracing the controversies outward into a heavy contextualization demonstrates how stigma has become an ideological justification as well as a scientific concept.

The articles were selected by searching for the word "stigma" on the AJP website's search engine in the text, title, and abstract section. In total, 1,047 articles from

the period of July 1844- December 2007 were identified to contain the word stigma. The word stigma was used because it is the root of other words of interest such as stigmatization, stigmatize, stigmatized, stigmatizing, destigmatizing, and destigmatization. This search also returned articles containing the word stigmata, which describes manifestations of disease symptoms. After manually sorting through the 1,047 articles to filter out articles using the term stigmata as well as book reviews, the final sample consists of 648 articles which range from the years 1846- 2007. These articles also include editorials and letters to the editor in order to assess the dialogue generated by making appeals to stigma. The following chart illustrates the distribution of articles that reference stigma by year:

Distribution of Articles by Year	
Years	Number of Articles
1846-1863	5
1864-1881	7
1882-1899	11
1900-1917	32
1918-1935	28
1936-1953	69
1954-1971	92
1972-1989	145
1990-2007	259
	Total: 648

These 648 articles were placed in chronological order and read for content and for how the author utilized the concept of stigma in relation to the content of the article. From here, claims about stigma were thematized according to article content and the ways in which stigma was defined, described, or implemented in the article. During the reading process as new themes became apparent, past articles were reviewed to ensure that they were included in all the categories that were appropriate. Major themes

included in the discourse analysis in Chapter Six are the stigma of

commitment/treatment, stigma of psychiatry, euphemistic stigma, and the stigma of

insanity/mental illness. In order to understand the importance of these themes, they were

contextualized socio-historically to draw out how psychiatrist's presentation of the

concept of stigma differs from other discourses and attempts to direct how stigma is

understood by other psychiatrists, lawmakers, medical doctors, the public, and patients

alike.

The materials used to construct a the socio-historical context for the analysis of

stigma ranges from writings by ex-patient organizations, critical histories of psychiatry,

the institutionalized history of the APA, and other secondary sources. More specifically,

the histories and literature written by the Association of Former Patients (also known as

Recovery, Inc.), Mental Health America (formerly the National Committee for Mental

Hygiene). Madness Network News, and the National Alliance of the Mentally Ill, as well

as the writings of Symbolic Interactionists and prominent anti-psychiatry proponents

were included to ensure a broader understanding of the discourse of American psychiatry.

These sources demonstrate that stigma is not only an argument among psychiatrists about

how psychiatric practice is publicly stigmatized, but also illustrates how stigma provides

a rallying point for consumers and critics to contest treatment options. As well,

institutional histories of psychiatry and other works published by the APA were

incorporated in an attempt to balance the historical accounts of events.

By providing a historical context for the concept of stigma in Chapter Five and

then situating the data on stigma within this context in Chapter Six, an interpretation of

the present context for appeals to stigma becomes possible. Attached to each of the

themes of stigma identified in the articles gathered from the *AJP* are strategies for minimizing or combating stigma. These strategies of de-stigmatization eventually culminate in national and international campaigns to fight the stigma of mental illness. Chapter Seven offers a history of the present in order to illustrate how these strategies to combat stigma are historically dependant and rely on claims to truth about the nature of mentally ill people and the public at large.

Conclusion: The Problem of the Past

This chapter began by drawing out some of the issues within the historiography of American psychiatry. It is not that historians of psychiatry argue over whether or nor an event took place, but that the significance of the event can be interpreted in different ways. This interpretation can be useful to both maintaining paradigms as well as developing a counter-discourse. I, then, explicated Foucault's methodology of critical and effective histories through summarizing his archeological and genealogical approaches. In realizing the limits of the archeological approach which describes discursive formations, Foucault developed genealogy in order to assess and locate struggles within discourse. From here, I illustrated how the method of discourse analysis utilizes materials amassed from both primary and secondary sources to address how historicizing an object socio-historically, in relation to the way it is implemented in discourse, provides an avenue for critiquing objects or events that may seem ahistorical or natural. Lastly, I described how I apply the method of discourse analysis to historicize the concept of stigma within American psychiatry. Before I end this chapter, I address

some substantive issues for using historical methods and how discourse analysis attends to these concerns.

As Moses and Knutsen (2007) note, writing history is difficult due to four major obstacles. First, observation of an event is linked to the participants' point of view. Second, remembrance of the event can deteriorate over time giving the participants' retelling another layer of interpretation. Third, the event must be recorded in some way. Fourth, the record of the event must survive and become accessible. This all occurs before a historian can use the source. From here, the source must be considered believable and useable to be selected for analysis. Selection bias is a threat to the reliability and validity of all historical studies. Therefore, it is important not to rely solely on a single account of history, but to look at a multitude of sources and situate one's accounts among these (Carabine 2001:307). Researchers using discourse analysis, in particular, are often charged with selection bias and so should justify their choice of materials along the way in order to attend to these issues. However, this is not in order to produce a claim to totalizing truth, but to ensure that the representation of discourse is not entirely lopsided.

As well, writing history is an interpretative event. According to White (1973) the writing of history exists somewhere between writing fact and writing fiction. Given the constraints of historical narrative and a Foucauldian approach to history, a claim to a totalizing objective truth is not possible or even warranted (Carabine 2001:305). Instead, histories developed from discourse analysis emphasize "heterogeneity, multiplicity, and marginality, and the production of knowledge as opposed to truth" (Macraild and Taylor 2004:76). In doing so, the production of knowledge as a discursive practice can be

analyzed and critiqued, not on the basis of science itself and hypothesis testing, but for the effect it has on other knowledges through relations of power. Therefore, this project offers a reading of history that is a plausible account of how stigma came to be understood as it is today. The next chapter sketches the socio-historical context of American psychiatry from the 1840s until the present to provide a broader context for understanding the use of the word stigma within the discourse of American psychiatry.

Chapter Five

The Socio-historical Context of American Psychiatry: 1840-Present

> *Thousands spend their days—often for weeks at a stretch—locked in devices euphemistically called 'restraints': thick leather handcuffs, great canvas camisoles, 'muffs,' 'mitts,' wristlets, locks and straps and restraining sheets. Hundreds are confined in 'lodges'—bare, bedless rooms reeking with filth and feces—by day lit only through half-inch holes in steel-plated windows, by night merely black tombs in which the cries of the insane echo unheard from the peeling plaster of the walls.* -Albert Maisel, Journalist, 5/6/1946[6]

In his now famous photo essay published in *Life* magazine, Albert Maisel depicts the horror of life in a mental institutions following World War II. However, his description is not from German camps, but rather from the Cleveland and Pennsylvania state hospitals. Maisel's article, owing mainly to its astonishing pictures, opened new dialogue between the community, psychiatry, and the State on the ethical treatment of mentally ill people, while also stimulating skepticism towards the scientific validity and efficacy of the psychiatric profession and custodial institutions. American psychiatrists returning from their stations in WWII also met with another crisis as psychoanalysis had for the most part become the preferred method of practice, due to many psychoanalysts immigrating to the US to avoid Nazi persecution (Healy 2002:140).

WWII had also demonstrated within the field of American psychiatry that as integral as the asylum was to the patient's treatment and the profession, it was not the sole means by which rehabilitation could take place (Healy 2002:140). As mounting political concerns regarding the liberty of the individual and the perceived communist

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[6] Maisel (1946).

threat to American democracy dominated the public forum, the practice of psychiatry came to be understood by some as a threat to citizenship, liberty, and democracy.

This critical and effective history traces how this transition comes about as well as its aftereffects. In this chapter, I address how the coinciding shifts in legislation, psychiatric practice, and the conception of the psychiatric patient calls for the emergence of campaigns to combat the stigma of mental illness. I begin by recounting the changes in mental health legislation beginning with early commitment laws, the Community Mental Health Centers Act (CMHC) of 1963, the 1962 amendments to the 1938 Food and Drugs Act, and subsequent health insurance laws in the 1990s, highlighting the development of neo-liberal governmentality in relation to mental health service delivery, the sum of which changed the location of the mentally ill population and the landscape of psychiatric practices in America.

Second, I describe the changes in psychiatric theories and practices as both a stimulus and reaction to these changes in legislation and the social milieu using a Kuhnian understanding of paradigm shift. According to Kuhn, paradigms shift due to innovations in theory and methods, problems that arise when too many questions cannot be answered, and when crises threaten the existing paradigm. Here, I also outline the anti-psychiatry movement as an antagonistic and competitive approach to the claims of the etiology and treatment of mental illness resulting in a crisis posed to institutional American psychiatry.

Third, I map out the history of mental health activism linking up stigma with neo-liberal conceptions of citizenship, advocacy, and self-help to describe how the mentally ill population comes to be responsible for social perceptions of what it means to be

mentally ill and their own well-being through empowerment strategies. This chapter lays

the groundwork for an exposition of the usefulness of the concept of stigma in American

psychiatry, which follows in the next chapter.

History of Mental Health Service Delivery

Hunt and Wickman (1994) define governmentality as the "the dramatic expansion

in the scope of government, featuring an increase in the number and size of the

governmental calculation mechanisms" (p.76). To this definition, it should be added that

this increase in mechanisms for calculation is also tied to an increase in organizations,

agencies, and bureaus established for the maintenance, direction, and order of the

population, particularly to assess and diminish risk as well as to increase the safety and

security of its citizens. The history of mental health service delivery, particularly after

World War II, is evidence of an increased bureaucratization of mental health services

which limits both the rights of mentally ill persons and the practice of psychiatry. This

section sketches the making of the mentally ill population through bureaucratic means by

charting major state and federal laws that provided for civil commitment, the

development of the National Institute of Mental Health (NIMH), regulations for

prescription practices, the implementation of the Community Mental Health Centers

(CMHC) program, and legislation on health insurance policies.

In plotting these successive changing in laws concerning the mentally ill

population, it becomes clear that after the 1960s, governing this population on the federal

level has less to do with the control of a any individual risk, especially that of

dangerousness, and more to do with legitimating psychiatric practice and opening access

to psychiatric care. In turn, this made psychiatry more responsible to the government for matters not just of risk, but also of screening and predicting mental illness within the entire population.

Laws pertaining to the care and confinement of the mentally ill person were largely a matter of state government prior to World War II. During the beginnings of American psychiatry in America, particularly the moral treatment era, there were no laws pertaining to the commitment of insane persons (McGarry and Kaplan 1973:1-2). Due to their custodial functions, early asylums were filled rapidly and concerns over the rights of unfairly committed sane individuals came under the purview of state governments. Leading the charge for more stringent controls on commitment proceedings was former patient, Elizabeth Packard.

According to Spinsley (1991), Packard was committed to an insane asylum by her husband due, in major part, to disagreements about religion in 1868. Packard's case was taken to court where she was found legally sane. She established the Anti-Insane Asylum Society and was instrumental in passing the Illinois "Bill for the Protection of Personal Liberty" that guaranteed a trial to all of those who were accused of insanity. These measures brought about changes in other states' legislation and before long, legal proceedings (including jury trials) were required for involuntary commitment.

Packard's case and dedication to patient's rights was a great milestone in maintaining the rights for sane persons. As well, she formulated the grounds for her defense based on evading the stigma of insanity. In 1868, in an excerpt from Packard's *The Prisoner's Hidden Life or Insane Asylums Revealed*, she wrote: "Not knowing that Illinois had legalized this mode of kidnapping the married women of their State, I had no

idea that my personal liberty depended entirely upon the will or wishes of my husband"
(Packard 1868). She went on, "I thereupon returned to my home with a feeling of
comparative security, trusting and supposing that upon the principles of our free
government of religious toleration, my rights of conscience, and rights of opinion were
respected and protected by law, in common with other American citizens" (Packard
1868). She continued, "Still, believing that a most strenuous effort would be made to
fasten the *stigma of insanity* upon me, by my opponents in religious belief, I now began
to consider what my plea of self-defence must be when arraigned for trial on insanity,
based upon what they regarded as heresy" (Packard 1868, italics added). From Packard's
experience, it can be seen how stigma intersects with issues of citizenship, rights, and
liberty very early in the legal discourse as it pertains to the label of insanity.

After Packard's exoneration and the ensuing changes to commitment procedures,
the issue of legal commitment and the judicial proceedings became an important marker
for the understanding of stigma as it related to mental illness and legal issues. Busfield
(2006) writes, "certification served as a reminder of the legal compulsion underpinning
asylum use and became highly stigmatizing, since it required clear evidence of insanity"
(p.217). Subsequently, laws to permit voluntary admission began at the end of the
nineteenth century in Massachusetts and by 1924 twenty-eight states had followed suit
(Busfield 2006:218). However, this turn in policy was not a result of the expansion of
rights for an individual to obtain psychiatric treatment, but was more of a manifestation
of the medicalization of asylums that sought to intervene on mental illness as early as
possible to produce better treatment outcomes (Busfield 2006:218). It is not until the

1960s that legislation for mental health service delivery changed dramatically on the federal level, while commitment policies remained chiefly under the State's jurisdiction.

The post-World War II era was a very tumultuous time for people with mental illness. As sentiments of freedom and liberation rose from the Black civil rights movement in the 1950s, tensions mounted in opposition to psychiatry's lockdown of mental patients in overcrowded prison-like institutions. These places were commonly referred to as snakepits (also the name of an Oscar nominated movie from 1948 depicting psychiatric custody). The images of Nazi concentration camps, still fresh in the minds of many Americans, were shockingly similar to the photos from psychiatric hospitals that *Life* Magazine published in his depiction of American psychiatric institutions titled *"Bedlam 1946: Most U.S. Mental Hospitals are a Shame and a Disgrace."*

Also in 1946, the American government passed the National Mental Health Act to address these issues and in 1949 the National Institute of Mental Health (NIMH) was established. In 1954, the NIMH with the help of the American Psychiatric Association (APA), sought to review on a national scale the mental health delivery system (Kelly 2005:240). The Mental Health Study Act created the Joint Commission on Mental Illness and Health. This commission published eight volumes on the status of mental health care in the United States, none of which advocated for community care, but instead sought to revitalize the ailing state hospital system (Kelly 2005:240). However, these studies, in part, led to the CMHC Act or what is more commonly termed the legislation on deinstitutionalization. This Act called for a network of small and local clinics to assess and treat mental illness and to refer patients to state hospitals only when urgently

necessary, so as to protect the public from any danger or to protect the patient from her/himself.

The goal of this Act was not massive deinstitutionalization, but it became the most recognized consequence (Stockdill 2005:277). The CMHC Act emphasized ten regulations for community mental health centers: inpatient services, outpatient services, partial hospitalization, emergency services, consultation and education services, diagnostic services, rehabilitative services, pre and aftercare services, training, and finally, research and evaluation of the programs themselves (Stockdill 2005:263). In order to finance these institutions, the Federal Government provided seed money that would in a series of steps dwindle to 30% by the third year. In successive years, the funding was to be replaced by state and local funding. However, staffing and monetary problems arose as CMHC programs were unable to meet fundraising goals in subsequent years (Stockdill 2005:265).

As well, implementing these services across class divides and reaching those with serious mental illness proved difficult (Stockdill 2005:278). When the onus to seek out care and receive treatment fell on the patient and their family, it was difficult to navigate through the network of social workers, psychologists, and psychiatrists. Therefore, the Community Support Program (CSP) was developed to help explain the new mental health delivery system, but it was unable to address many of the consequences of deinstitutionalization such as homelessness and poverty (Stockdill 2005:278). Ex-patient groups attended the conferences for the CSP and were instrumental in gaining funding for patient run programs in the community (Chamberlain 1990). State mental hospitals had provided food and shelter to their patients, but CMHC programs were unable to address

these concerns because the new regulations did not include comprehensive care for serious mental illness, nor did the regulations specify coordinating social service care in the community (Stockdill 2005:278). Therefore, some patient-run organizations were able to fill this gap by proving alternative care, soup kitchens, and day programs.

In 1962, the 1938 Food and Drug Act was revised to place stricter limits on prescription practices for all of American medicine. However, this amendment did not recognize how psychiatric illnesses were diagnosed and treated at this time (Healy 2002:367). The *Diagnostic and Statistical Manual of Mental Disorders* was first published in 1952 by the American Psychiatric Association. This manual blended psychoanalysis with psychodynamic approaches to mental illness and did not emphasize a biological etiology, but suggested therapy and a change of environment as treatment approaches (Healy 2002:293). This is known more commonly as a dimensional or spectrum model of disease, which is opposed to a categorical model (also known as the medical model) that locates disease within a specific set of identifiable symptoms. The amendments to the Food and Drug law in 1962 specified that drugs were available only though prescription and that to be prescribed the drugs must target a specific symptom or disease. American psychiatry's newly developed nosological system was completely inadequate as it did not rely on the medical/categorical model (Healy 2002:367-368).

This legislation comes on the heels of Chlorpromazine (also known as Thorazine) entering the American market in 1955. After its discovery, almost every patient in state hospitals was given this antipsychotic regardless of disease classification for various reasons; one being that it quieted psychiatric wards by sedating patients (Healy 2002:97-98). In light of the revisions most notable in the DSM-III in 1980, its categorical

reconfiguration and psychiatry's coinciding shift to a biological paradigm upon its publication, the invention of psychiatric drugs coupled with the legal constraints of prescription policies is of terrific significance. American psychiatry had to adapt to a stringent medical model in order to stay viable in the market economy. This, I will explain in more detail in the next section, *Psychiatry and its Critics*.

More amendments to the CMHC Act in 1970 addressed the staffing issues, while CMHC programs in service areas designated as "poverty areas" were given more funding over a longer duration. "Initiation and development" grants and plans for poverty areas were devised, but later stymied by the Nixon Administration in their effort to drawback federal funding for CMHC programs (Stockdill 2005:265). In order to gain more support and legitimacy, the NIMH joined with other health and human service programs in 1975. Then, after Nixon's resignation, more amendments to the CMHC Act were passed including providing treatment for drug and alcohol addiction, family planning centers, home health services for communicable diseases, hemophilia programs, and nurse training, among other services. This move brought new kinds of illnesses and patients under the umbrella of CMHC services putting an additional strain on staff and budgets.

Services were added to address the ailing public sentiment towards the mentally ill population in the wake of mass deinstitutionalization. Stockdill (2005) notes, "The three screening, follow-up, and transitional services were added because of the growing concerns about deinstitutionalization of people with serious mental illness" (p.267). Complimentary to these new offerings were a new set of regulations for CMHC programs. They now needed to demonstrate effective communication with other health and social service agencies within catchment areas and be governed by representatives

that fit the demographics of the catchment area. CMHCs would also need to maintain detailed records concerning rates of enrollment, needs assessments, and quality control, all of which would be used to assess the quality and efficiency of the program when deliberating future grants. These changes were very costly and difficult to implement (Stockdill 2005:268). Again, in 1978 another amendment was made that requires any CMHC program, upon opening, to offer to all age groups the services of emergency care, screening and referral, outpatient, inpatient, follow-up after hospitalization, as well as consultation, and education.

What can be seen through these successive changes to the legislation is that the CMHC program was very much a patchwork affair. As new problems emerged, new agencies, organizations and legislation attempted to sew together the holes through which consumers/patients were slipping. As well, the public demanded more rigorous interventions as communities were fearsome of people with mental illness and also did not want to shoulder the tax burden of their treatment. NIMBYism, as discussed in the literature review, became an issue for the siting of local CMHCs and for patients living in the community.

Albee (2005) notes a shift in focus from treatment to prevention and prediction in the Carter administration. In 1977, President Carter established the President's Commission on Mental Health to assess the CMHC Act and to ultimately overhaul it. The President's Commission of the Task Panel on Prevention was developed out of NIMH initiatives as well as from input of the National Association for Mental Health (NAMH).[7] The NAMH's contribution was an epidemiological study on the social

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[7] The NAMH is also known as the National Mental Health Association (NMHA), but currently is titled Mental Health America (MHA) and is a citizen's non-government organization formed in 1950 based on

determinants of mental health. Carter developed the Mental Health Systems act to extend the funding and services of CMHCs and enacted it in 1980. This act was quickly squelched during the early years of President Reagan's term. However, the theme of prevention, through epidemiological statistics that linked poverty and social conditions to poor mental heath, endured in the NMHA through out the 1980s counter to the biological model of mental illness, which was dominant in American psychiatry and the NIMH at the same time.

In the 1980s and 1990s, laws concerning the treatment of the mentally ill on a federal scale were relatively absent, while states instituted fractured policies dealing specifically with forced treatment, now known as the more gentle 'treatment compliance' (Isaac and Armat 1992:287-334). The most controversial of these new laws is Kendra's law enacted in New York in 1999, which allows the court to order "certain people with mental illness" into assisted outpatient treatment on the basis of an allegation from a roommate, family member, psychiatrist, or agent of mental health services coupled with an examination by a physician (Office of Mental Health, New York 2008). State laws pertaining to mental illness are still concerned with the dangerousness of individuals; however, comprehensive and consistent laws vary markedly across states.

In the early 1990s, NIMH director, Lewis Judd, declared it to be the decade of the brain as neuropsychiatric approaches to mental illness and psychopharmacological treatment were the preferred ways to detect and treat illness (Albee 2005). As well, the success of genetic research on mental illness also hinges its usefulness in the prevention of disease by biological means and the possibility of pharmacogenetic drug delivery

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work done by the National Committee for Mental Hygiene (NCMH) and former patient Clifford Beers. The history of the NCMH will be expounded in the section titled *Better living through Advocacy*, as it is the first patient based group for the advancement of psychiatry.

(Hedgecoe 2004). Through this concerted effort to present behavior as biological, the search for prevention of mental illness through changing adverse social conditions has been stifled under a barrage of techno-jargon of genetics, chemistry, and receptors. Consequently, devising viable legislation based on scientific evidence that addresses social conditions became very complicated because new legislation could no longer be based on the improvement of poverty areas or service delivery, despite mounting epidemiological evidence that the confluence of disproportionate differences in social class, ethnicity, and gender effects mental health (Busfield 2006:221).

As a result, federal laws focused on the limiting of mental health services through insurance proprietors and instituted The Mental Health Parity Act of 1996, which mandates that insurance companies are to provide equal allotments for both mental health and biomedical claims. However, it does not order that health insurance include mental health coverage in their packages. As well, the insistence of this Act on privacy made it virtually impossible for any illnesses to be discussed with new or existing health insurance providers or for doctors to disclose any diagnoses to anyone, insurance adjuster or otherwise, without a large monetary penalty.

As can be seen in these details of mental health service delivery, the shift from dangerousness and custody to prediction and population management had deleterious effects for people with mental illness, as Castel (1991) has also noted. No longer were the needs of the mentally ill population provided for on a large scale after the Reagan Administration as federal public welfare policies were difficult to implement and funding for CMHCs was nearly impossible to acquire. The legislation on CMHCs disbursed the mentally ill population into the community through an array of agencies designed to

assess and treat their illnesses as quickly and efficiently as possible without the stigma of legal commitment. However, traversing this system was fraught with problems that were difficult not just for the patient, but for psychiatry too.

Psychiatry and its Critics

In this section I outline how psychiatry developed from the protection of the population from dangerous individuals enmeshed with the legal system into a medical specialty for the comprehensive screening, prediction, and management of risk in the entire population. American psychiatry is characterized by shifts in ways of seeing, knowing, and interpreting behavior. I draw attention to these major paradigm shifts from moral treatment, to the psychodynamic approach which arises around the same time as eugenics, to psychoanalysis, to the current paradigm of biopsychiatry. From here, I locate the American anti-psychiatric movement within this history as an antagonistic and competitive approach to the claims of the etiology and treatment of mental illness in the 1960s and 1970s. This, among other factors, such as comprehensive health insurance from employers and influential consumer/survivor/ex-patient groups were the driving forces towards the biologicalization of mental health.

The history of American psychiatry, as both a profession and practice generally begins with the siting of the first mental hospital. The Pennsylvania Hospital built in 1752 was the first of its kind to accept both the physically and mentally ill, as care of the mentally ill was usually entrusted to family members (Barton 1987:22). Psychiatrist, Benjamin Rush began working at the Pennsylvania Hospital in 1783. Rush is considered to be the father of American psychiatry and wrote *Medical Inquires and Observations*

upon the Diseases of the Mind (1812) which became the dominant compendium on the subject for some seventy years (Barton 1987:302). Rush suggested a variety of treatments for the cure of mania such as place, time, and company, redirection of conversation, regularity and order of work, which later became championed in the moral reform period. Moral treatment refers to a change in therapy for the mentally ill in order to prescribe a daily routine and to treat the mental illness without harsh corrective measures (Rothman 1971:138). Rush also advocated fear, pain, shame, grief, terror, and isolation as ways of impressing sanity into the mind (Rush 1812:204-213). Although Rush is considered one of the forerunners of the moral treatment movement, he did advocate bloodletting and also the use of the tranquilizer chair which from the viewpoint of the present are considered inhumane practices (Hergenhahn 2005:457).

At the end of the eighteenth century, through the influence of English and French psychiatrists as well as the Quaker religion, American psychiatry expanded as a moral effort to remove the insane from prisons and into asylums or retreats (Whitaker 2002:3-38). The words asylum and retreat originated with the Quakers in Europe (Whitaker, 2004: 25). The moral treatment effort was a renovation of the entire system of the mental hospital. Beginning with the building of the physical asylum itself, to the nature of interaction between the inmates and the doctors/staff, to the understanding of the role of rehabilitation in the lives of the inmate, moral asylums brought together an entire technology of care and/or custody that needed an immense amount of financial resources to function. In 1817, the first private moral treatment asylum was opened by the Quakers in Philadelphia followed by another in Massachusetts in 1818, then New York in 1821, and Connecticut in 1824, among others (Whitaker 2002:25). In 1833, the first public

moral treatment asylum was opened in Worcester, Massachusetts (Whitaker 2002:25).

Common to these early asylums was the structure of daily living and management by superintendents that distrusted physical interventions indicative of the Rush's methods (Whitaker 2002:27-28). Subsequently, little to no scientific research or medical treatment was carried out at these retreats (Whitaker 2004:28).

According to Viney and Zorich (1982), in the early 1840s, Dorothea Dix, a social activist, petitioned the Massachusetts government on behalf of the mentally ill. Previous to this petition, she was sent to England to stay with family following a nervous breakdown. Her mission was to move the insane out of jails, prisons, and almshouses and into specialized asylums that promoted compassionate care. In 1848, she began a national campaign to set aside five million acres of land for the building of asylums. This bill was vetoed by President Franklin Pierce in 1854. However, Dix was successful in calling federal attention to the conditions of the insane, which included overcrowding, caging, chaining, and exposure to extreme weather. She was also influential in espousing the curative features of moral treatment and in the siting of many asylums (Deutsch 1937:158-185). Also, in explaining the harsh treatment of the mentally ill, Dix was instrumental in describing the mentally ill population as a homogeneous entity with the capacity to be rehabilitated through asylum care.

In 1844, the Association of Medical Superintendents of American Institutions for the Insane (AMSAII), what later becomes the American Psychiatric Association (APA), formed three years before the American Medical Association (AMA). Medical organizations were a way for members to assure training, extend privileges, and protect member's rights (Barton 1986:29). The AMSAII refused to join the AMA's ranks as

psychiatrists believed medical doctors to be their "professional inferiors" (Dowbiggin 1997:8). Concerned with the success of moral treatment and its lack of scientification, one of the AMSAII's first resolutions stated that all asylums should employ a physician or psychiatrist as the superintendent and Chief Executive Officer (Whitaker 2004:29). As more public asylums were being built, this motion ensured that these asylums would remain under the jurisdiction of medical personnel.

The incorporation of psychiatric practice into a professional organization is a significant event in the history of American psychiatry because it streamlines practice with power in a way that had previously been unknown. Standardization of the practice begins here as the medical superintendents forge a path for the institutionalization of American psychiatry, at once, establishing credentials for higher education as well as regulating asylum conditions and treatment regimes. The history of the asylum becomes quite significant much later, as anti-psychiatrists focus their attention and critique on the failure of this "mass incarceration" (Scull 1989:301).

Dain (1994a and 1994b) argues that the anti-psychiatry outlook existed well before its codification in the late 1960s/ early 1970s civil rights movements. Healy (2002) opposes this claim and states, "There have always been reformers in psychiatry, but there was nothing remotely like antipsychiatry before 1960" (p.150). Dain (1994a and 1994b) asserts that anti-psychiatry claims were present in the legal discourse in 1838, when Dr. Isaac Ray, president of the AMSAII from 1855-1859, wrote *A Treatise on the Medical Jurisprudence of Insanity*. Ray aimed to show that jurists stigmatized the insane, while also holding them responsible for crimes that were not committed with a sound mind. In reaction to Ray's suggestion of 'moral insanity' (when one knows right

from wrong, but cannot help her/himself from doing wrong things), many clergy,

journalists, and laypersons questioned psychiatry's risk to the criminal justice system

(Dain 1994a:1011).

Dain (1994a) argues that these anti-psychiatry sentiments by lawyers, judges, and

jurists lacked an overall organization. However, the power contained within the

intersection of these spheres of knowledge had many effects on the rights of American

citizens and the perception of psychiatry. For the citizen, the responsibility for

committing a crime may sometimes be absolved by a psychiatric diagnosis. As well, if

insanity was an acceptable defense, then the punishment (commitment to a mental

institution) was to be avoided at all costs. Therefore, if being committed was considered

a punishment by law, then the medical benefits of asylum care would remain a last resort

for families who sought care for loved ones.

As well, Dain (1994a and 1994b) stipulates that new religions were some of the

first organized anti-psychiatry groups. Dain (1994a) locates the beginnings of religious

anti-psychiatry in the nineteenth century with religious stigmatization of the mentally ill.

The Christian Scientists believed that mental illness was a punishment for the soul. Most

notably in 1875, Mary Baker Eddy, the founder of Christian Science, advocated against

psychiatry and medicine, while proposing that prayer could heal all ailments. Christian

Scientists thought that if one "renounced the reality of illness, they would be freed of its

consequences" (Dain 1994a:1012). Dain (1994a) asserts, though, that if one failed to

recover they would be stigmatized for lack of faith.

According to Dain (1994b), the first organized secular anti-psychiatry

organization, the National Association for the Protection of the Insane and Prevention of

Insanity, was comprised of social workers and neurologists in New York in 1880. This organization was the result of medical superintendents of the asylums and hospitals refusing to allow neurologists a place in the mental hospitals (Dain 1994b:426). Neurology, at that time, was establishing itself as a scientific discipline and was competing for control of the mentally ill. This reformist group was eventually disbanded due to conflicting ideals between social workers who questioned the efficacy of all medical treatment (Dain 1994b:426).

In 1892, AMSAII was renamed the American Medico-Psychological Association (AMPA). As Fancher (2003) writes, "The change was more expressive of a hope than indicative of reality; for psychiatrists were already far behind the medical community at large, and neurologists in particular, in moving toward a scientific basis (or self-image) for mental health care" (Fancher 2003:64). It was at this time that American psychiatrists were concerned with their status as the authority on mental illness, not just within the medical community, but also because of the challenges brought about by legal commitment, which complicated the effective means of obtaining and rehabilitating patients. The name change in the association also corresponded to a change in the names of many asylums to insane hospitals (Whitaker 2004:38).

In 1921, AMPA changed its name again to the American Psychiatric Association (APA) which reflects a similar hope as the first name change in the effectiveness of treatment modalities and scientific legitimation. APA President, Owen Copp's (1921) address states, "Psychiatry is advancing into its rightful alignment with the science and practice of general and psychological medicine in the realm of health" (p.4). This institutional name change also corresponds to an alteration to the name of the academic

journal in July of 1921 from the *American Journal of Insanity* to the *American Journal of Psychiatry*. Tighe (2005) notes of the change of the APA's journal title, "It reflects psychiatry's strong desire to break from the past and start anew in a more scientifically and medically grounded framework" (p.256).

This name change also came at a time when institutional psychiatry was in jeopardy. During this period, declining superintendent salaries and decreasing enrollment in university programs for psychiatric practice were intensified by a rise in the prestige of neurology and medicine. This ultimately led to a fundamental disagreement about the scientificity of the term insanity (Grob 1983:268). Harkening back to Ray's (1838) claims about the insanity defense, the term insanity now denoted a legal definition that was used to measure competence and responsibility. While psychiatrists were becoming more focused on diagnosis and treatment of mental illness through research and training to compete with medicine and neurology, the use of the term insanity was no longer medical and therefore inappropriate (Tighe 2005:256).

Copp's presidential address to the APA in 1921 also lays out a map of how psychiatric care should be designed in order to be implemented on a massive scale. Copp's plan would involve developing community mental clinics, traveling mental clinics for remote areas, as well increasing the number of mental hospitals to address specific kinds of mental illnesses and provide psychiatric training. Copp (1921) advocated that having a psychopathic ward in a general hospital will lessen also the stigma associated with going to a psychiatric hospital. Moving the site of the mentally ill population would also address the isolation of the practice and circumvent some commitment laws allowing for more patients to enter psychiatric treatment more readily.

This becomes a particularly salient point for debates about stigma as will be summarized in the next chapter.

As well, Copp (1921) stated of the widening network of mental health awareness, "The path of mental health starts and ends in the community; its course leads through the home, the school, the hospital, out again into the widening network of supervisory and helpful agencies of the community; guide posts along the way are prevention, treatment, rehabilitation" (p.4). To those guideposts, prediction will eventually be added after WWII. This illustration of the proliferation of psychiatric knowledge and authority into the daily living of the population is particularly telling of an era characterized by emerging agencies, that of social workers in particular, which intervene in the lives of citizens under the auspices of social welfare.

During this time, biological theories of genetic inheritance and degeneration began to re-shape psychiatry as more of a scientific paradigm while also transforming the dominant modes of medical intervention (Dain 1994b:427). Eugenics is a term coined by Charles Darwin and his cousin, Francis Galton, which refers to "the study of the agencies under social control that may improve or impair the racial qualities of future generations, either physically or mentally" (Galton 1907:17). Psychiatric eugenicists favored implementing restrictive immigration laws, marriage laws, and segregation of the mentally retarded and mentally ill in asylums (Dowbiggin 1997). As an illustration of this, Copp's (1921) presidential address to the APA states that prevention of mental disability can be achieved through, "Eugenics by education, wise supervision, prohibition of marriage of known defectives, segregation of vicious and delinquent defectives in

institutions, sterilization in exceptional cases for specific reasons, [and] registration of defectives" (p.4).

Around the same time that some in the APA embraced eugenics, another influential psychiatrist belabored eugenic policies. Adolf Meyer, president of the APA from 1927-1928, was instrumental in advocating for a psychodynamic approach to psychiatric practice, where the understanding mental illness stemmed from investigations into the mind, body, and environment. Although Meyer was a member of both the Committee on Eugenics of the American Breeders' Association and the American Eugenics Society, his role in the promotion of eugenic practice is uncertain as he often opposed the viewpoints of eugenicists (Dowbiggin 1997:113-114).

By the 1930s, there was a symbolic reversal of the moral treatment effort as the social conditions of the depression led many mental hospitals to breach capacity as well as to become home to the ailing elderly among other dependant groups (Dowbiggin 1997:110-115; Dain 1994b:427-432). Within the APA, there existed a growing sentiment that applied eugenics would be a way to solve this crisis. The favor for eugenic reform in the APA stemmed from lack of funding and control over governmental policy (Dowbiggin 1997:234). However, the effects of applied eugenics in Nazi-Germany stifled the possibility of acceptable eugenics in America (Degler 1991).

Following WWII there was a dramatic shift in psychiatric practice and theory. During the post-WWII backlash against eugenic practices, psychoanalysis became the dominant paradigm in American Psychiatry. Psychoanalysis was largely carried out in private practices. Therefore, the move away from the mental hospital and to community treatment did not seem to be an outlandish proposition at this time. Psychoanalysis also

introduced a pluralized view of disease, where each individual is considered mentally ill to some degree (Hobson and Leonard 2001). Treating people in the community was also a legitimation of this principle, i.e. that the entire population could benefit from access to psychoanalysis in their communities. This extended the power of psychiatry in a multifarious way. Whereas being committed to a state hospital necessitated a decisive break with an inmate's life and the past (Goffman 1961:1-10), the mentally ill person, depending on the severity of mental illness, could now seek the guidance of a psychoanalyst while also maintaining relationships with their family and continuing to work.

As well, the invention of new medications in the 1940s and 1950s and the promise of new therapies such as the lobotomy, insulin therapy, and electro-convulsive therapy- all of which could be given through ambulatory care- were factors that led to the policy changes in the mental health system after the WWII (Isaac and Armat 1992). As Dain (1994b) suggests, during the 1950s, psychiatrists tended to overestimate the effectiveness of these treatments as well as the behavioral changes of those undergoing psychopharmacological treatment with the drug chlorpromazine. As well, the focus on psychoanalysis, which was conducted in private practices outside of the hospital gates, opened up the possibility for a mentally ill population to exist within the community.

These notions of community care were emerging from psychiatrists who were increasingly under pressure from the government due to the high cost of custodial treatment and from private insurance companies, such as Blue Cross Blue Shield, which saw psychiatric treatment as a bottomless pit (Rickles et al. 1950). The move towards out-patient care under the paradigm of psychoanalysis mirrored the cost containment

ethos of both the government and capitalism. In explaining the relationship between the social and medicine, Reuter (2007) states, "Medical notions both draw from and reinforce the social fabric and, in so doing, reflect an ethical agenda alongside society's social/ moral prescriptions" (p.150). As the concept of individualism was beginning to captivate many Americans during the era of McCarthyism, the notion of individualized and privatized care resonated as progressive with the public.

Due to these pressures on the cost of psychiatric care, Congress passed the Mental Health Study Act in 1955. The APA endorsed this act while providing much of the information used in its findings (Barton 1986:265). As a result of these and other studies, Congress then passed the CMHC Act in 1963, which was discussed in the previous section. President Kennedy declared the CMHC legislation to be a "bold new approach", but many of the mandates of the CMHC Act were difficult to implement because of inadequate training and resources (Kennedy as quoted in Barton 1986:269). Barton (1986) claims that the entire APA was instrumental in the move to community care, while Dain (1994b) suggests that it was mostly the work of psychoanalyst Karl Menninger, who advocated for the elimination State mental hospitals, that led the charge.

Community and social psychiatrists were also influential the move towards out-patient based treatment. Healy (2002:136) argues that by the 1930s there was some recognition that social class, employment, gender, location, among other environmental factors influenced psychiatric conditions. Developments during WWII by military psychiatrists in the combat field illustrated that augmenting the social milieu in psychiatric hospitals had significant effects on the patient. This indicated that changes to the asylum system would also work for civilian patients, as both servicemen and asylum

patients endured brutal conditions (Healy 2002:132). However, early community psychiatric milieu approaches failed to recognize consistent diagnostic criteria, therefore overemphasizing the benefits of this new treatment for severely ill patients (Healy 2002: 135).

Social psychiatrists in the same period were attempting to statistically correlate factors that prompted or exacerbated mental diseases. George Rosen, an American psychiatrist, had linked several social factors to the risk of mental disease and recommended preventative measures through what he termed "social medicine" (Rosen 1947). Healy (2002:137) suggests that this was the first psychiatric epidemiological study in America; however it was not to be called epidemiological at the time because that field exclusively surveyed infectious diseases. Subsequent advocates of social psychiatry sought to reduce the dependency of the patient on the mental hospital system through uncovering and managing risks (Healy 2002:137).

Other psychiatric epidemiological studies emerged over the 1950s and early 1960s, which combined sociological approaches to statistics with psychiatric understandings of diagnostic criteria. Psychiatric epidemiologists developed diagnostic criteria to reliably define mental disorders in the population. Hollingshead, a sociologist, and Frederick Redlich, a psychiatrist, studied the correlation between social class and psychiatric conditions illustrating that poverty resulted in poor mental health outcomes (1958). No study was perhaps more telling of the problems created by commitment to an asylum than the work of Wing and Brown (1961). In their three hospital study, these researchers demonstrated that the poor conditions of state mental hospitals led to even

greater problems for the patient, especially those with schizophrenia (Wing and Brown 1961:861).

Healy (2002) surmises, "The boundaries between social activism and epidemiological psychiatry were often difficult to determine in an era where the transformation of society seemed eminently possible" (p.138). Gerald Caplan, a psychoanalyst at Harvard University, argued that community psychiatry should develop preventative methods to address poverty, unemployment, and make available the "basic physical, psychosocial, and sociocultural supplies" for the promotion of population-wide mental health (Caplan, 1964:31-33). Therefore, by engineering the community in such a way as to prevent -what were later termed- social stressors, some mental illnesses could be avoided, while also reducing the strain on the state hospitals.

However, the shift from seeking out and treating mental illness to advocating for population-wide mental health was difficult to accomplish. The development of the Joint Commission on Mental Illness and Health by the US Federal Government illustrated that prevention of mental illness and maintenance of mental health were almost mutually exclusive. The recommendation of this committee was to institute CMHCs in order to quickly and efficiently treat mentally ill persons upon arrival at the clinic, which was considered secondary prevention by many community and social psychiatrists (Isaac and Armat 1992: 71-80). The concerns raised by community psychiatrists were that in order to prevent mental illness and promote population based mental health; the entire social environment, not just the therapeutic milieu, would have to be addressed. The data generated in these studies was used by legislators to support CMHC legislation, but the social recommendations for primary prevention were largely ignored by legislators who

sought to decrease costs and reduce the amount of patients in State hospitals (Isaac and Armat 1992: 76-85).

It is at this point that the description of history of psychiatry becomes quite diversified as critical histories of psychiatry call into question psychiatric practice alongside a concern for patients' rights. The academic anti-psychiatry movement of the 1960s is a significant uprising in the history of psychiatry as it casts doubt on the functional basis of psychiatric knowledge and methods of treatment through reinterpreting its history as an agenda for social control (see Foucault 1961; Foucault 2006a; Foucault 2006b; Szasz 1961; Szasz 1989). These critiques brought attention to the ideological basis of psychiatric practice and its relationship to the political and bureaucratic capitalist system. Particularly unnerving for psychiatrists was Michel Foucault's *The History of Sexuality: An Introduction* (originally published in 1976) which portrays psychiatry as a technology of the bourgeoisie that propagates the upper-class' hegemony over the working class (Foucault 1990:120-127). As well, Foucault's *Madness and Civilization* (originally published in 1961) asserted that the confinement of the mad was not based on altruistic medical interventions, but was more reflective of political views corresponding to specific epochs.

The term anti-psychiatry was coined by a South African psychiatrist David Cooper in 1967. It is during the civil rights movement of the 1950s and 1960s that the academic critique of psychiatry gains momentum and crosses countries as well as disciplines. R.D. Laing, Erving Goffman, and Thomas Szasz's work is cited by ex-patient's groups in the early 1970s as laying the theoretical groundwork for many of the

social movement organizations (Grob 1994b).[8] In Europe, Michel Foucault and R.D. Laing dedicated much of their careers to understanding psychiatry and institutions. Foucault's *Madness and Civilization* sought to explain the emergence of the asylum as a medium of social control. Foucault's (1961) systematic reversal of Philppe Pinel's famous act of removing the chains from the mentally ill reinterpreted the history of psychiatry and exposed its whiggish history as ideological fallacy. R.D. Laing's discontent with psychiatry arose along the same lines as Szasz, and both were trained psychoanalysts. Although, Laing never denied the existence of mental illness outright, he often questioned the medical model of mental illness (Kotowcz 1997). His work sought to dispel the notion of schizophrenia as a distinct nosological category. In 1965, Laing and others opened Kingsley Hall, an alternative treatment center for those in a state of severe psychosis (Crossley 2006:99-106). This new alternative later served as a model for alternative care facilities run by those in the ex-patients' movement.

Thomas Szasz has published his thoughts against the "therapeutic state" which he sees as the legitimation of psychiatric domination through governmental protection (Szasz 1984). In this influential book, *The Myth of Mental Illness,* Szasz (1960) wrote, "[W]hereas in modern medicine new diseases were *discovered*, in modern psychiatry they were *invented*" (p.12). Szasz sought to show that psychiatric diagnoses are bound to social norms and therefore can not be reconciled with the medical model. Szasz joined with Scientologists, a controversial religious organization, in 1969 to form the Citizen's Commission on Human Rights in order to "combat the therapeutic state" (Citizen's Commission on Human Rights 2007). CCHR is an international advocacy group focused

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[8] However, there should be a distinction made between anti-psychiatry, as an academic and intellectual tradition, from consumer advocacy groups. Some consumer/survivor/ex-patient groups prefer to be seen as separate from the radical nature of anti-psychiatry (Rissmiller and Rissmiller 2006).

on "investigating and exposing psychiatric violations of human rights" (Citizen's

Commission on Human Rights 2007). CCHR claim to be responsible for the closing of

hundreds of psychiatric hospitals world wide as well as having lobbied for nine laws

passed in the USA "saving children from the malice of psychiatry" (Citizen's

Commission on Human Rights 2007). Scientology similarly has been at the forefront of

the anti-psychiatry movement since its inception in 1950 (Christensen 2005:241).

However, what is significant about Szasz forming CCHR and AAAIMH (Szasz and

Goffman's organization against involuntary hospitalization) is that they arise at a time

when the acknowledgement of human rights and personal liberty had become a central

element to the American way of life.

A contemporary of Szasz, Erving Goffman was highly effective in garnering

support for deinstitutionalization after publishing *Asylums* (1961). It is difficult to assess

the overall effect of *Asylums* (1961) on CMHC policy, but this was an NIMH funded

project (Isaac and Armat 1992:83). Berlim et al. (2003) writes that Goffman, "provided

convincing arguments that mental hospitals were not merely profoundly antitherapeutic

institutions in practice but were almost bound to be so because of the profound power

gulf between patients and staff, and the latter's total control over the lives of the former"

(p.65). In *Asylums* (1961), Goffman developed the concept of "total institutions", which

was one of his few forays into the dilemma of structure and agency. Goffman's (1961)

analysis described how institutions stripped an inmate of their belongings and identity

through debasing rituals and then impressed a new rehabilitated identity on the inmate

that conforms to the goals of the institution. As well, Goffman's use of the terms inmate

instead of patient and asylum over hospital indicates a rejection of psychiatric illness and

the medical model (Smith 2006:80). It had been well established, before the publishing

of *Asylums* in 1961 that these terms were already highly stigmatizing within the APA.

The next chapter discusses the matter of stigmatizing words and labels in greater detail.

Goffman's very detailed description of mental hospitals as a place of social

control where rights are routinely violated as a matter of treatment is a remarkable

contrast to the neo-liberal ideals of American society, where one's individuality and

liberty were key attributes of citizenship. Berlim et al. (2003) and Grob (1994b:272-273)

note the influence of such a characterization of mental hospitals amongst, both, the

counterculture of anti-psychiatry and the professional thought of psychiatrists alike.

Goffman's (1961) analysis provided the substantive basis for health departments and

taxpayers to justify closing outdated hospitals, many of them built during the era of moral

treatment, while also saving large sums of money under the guise of the best interests of

the patient (Berlim et al. 2003; Grob 1994a).

Grob (1994b) characterizes Goffman as uninvolved in the controversies of the

1960s. However, my history shows that his participation in the AAAIMH and continued

work on theorizing mental illness opened a new kind of dialogue on mental health and

social relationships. His reclassification of mental illness as a situational impropriety

(Goffman 1967) coupled with his provocative theory of deviance in *Stigma* (1963)

provided a framework for ex-patients to be able to describe their experiences. *Stigma*

(1963) and *Asylums* (1961) offered a template for mentally ill people to understand the

effects of the label of mental illness in the world outside of the asylum, while also

describing techniques to mitigate its effects.

By and large, the reverberating effects of the academic anti-psychiatry movement and its critique of the classification and implementation of psychiatric disorders as stigmatizing propelled a reevaluation of professional psychiatric practices (Wilson 1993:402). It is during the rise of anti-psychiatry that the APA's paradigmatic shift from a psychosocial disease model towards biopsychiatry is most evident in the differences between the structure of the categories in DSM-II (1968) and the DSM-III (1980) (Reuter 2007:106). The differences between the DSM-II and DSM-III showed a complete overhaul of the framework of diagnosis while also instituting a biological understanding of illness through nosological standardization (Reuter 2007:157).

Robert Spitzer, a key psychiatrist in the APA and the chair of the DSM-III committee, was integral to both the removal of the term homosexuality in the DSM-II (due to protests at APA meetings by queer rights activists) and to the biological reclassification and standardization of mental illness in the DSM-III. Spitzer argued that the difference between the DSM-II and DSM-III had come about due to mounting concerns by other medical professionals and psychiatrists alike regarding the definition of mental disorders (Spitzer and Endicott 1978). As well, Wilson (1993) argued that the changes in the DSM-III towards increased disease specificity were driven by pressure from insurance companies, the Federal Government, and pharmacological companies in order to satisfy regulations, such as those in the 1962 amendments to the Food and Drug Act. Wilson (1993) also stipulates that from 1965-1972 funding to the APA from the NIMH reduced by 5% per year. However, from 1977-1979, the NIMH was instrumental in funding the field trials of the DSM-III, which signaled a government endorsement of the new classification system (Mayes and Horwitz 2005:261). The emergence of a

mental health industry beginning after WWII is another result of these changes. Healy (2002) suggests that the mental health industry is best illustrated in the 1980s and 1990s, as sales of the DSM generated multi-millions of dollars for the APA. As well, the APA professional meetings became "extravaganzas" which resembled trade shows (Healy 2002:328-333).

The corresponding shift in the psychiatric paradigm to a biological basis also signaled that the social conditions which early epidemiology emphasized as most indicative of health risk, such as social class and access to healthcare, were no longer in the domain of psychiatric care. In developing the DSM-III, Spitzer (1974) explained that the new classifications for mental disorders were indicative of psychiatry focusing on biomedicine as a "defense of the medical model as applied to psychiatric problems" (Spitzer as quoted in Wilson 1993:405). As Healy (2002) suggests, the current psychiatric paradigm is best summed up as "the management of problems by biological means" (p.329).

It is also by the 1980s that the effects of deinstitutionalization were being felt by a network of community organizations ill equipped to manage the rapidly growing proportion of mentally ill people. This resulted in mass homelessness and incarceration of the mentally ill population in the 1980s and 1990s (Busfield 2006; Isaac and Armat 1990). As well, psychiatry's movement towards a medical model of disease and heavy reliance on medication administration is also reflective of a health economy predicated on managed care. Managed care requires that the effectiveness of a treatment be justified statistically, as in the case of random control trials and evidence based-studies, before a treatment can be given, i.e. paid for by insurance. Psychotherapy became seen as a

precarious treatment option because it did not easily fit this new matrix of positivist efficacy and private health insurance policies would only cover a limited amount of visits. Also, identifying biological susceptibility to mental illness began to take precedence over social indicators of mental illness, which led to a rise in the use of pharmacological treatment options (Healy 2002). As Healy (2002) notes of the publication of the DSM-III and the revolution in psychiatric practice, "Spitzer [...] said the key point was that psychiatry had pulled back from a mission to save the world and was concentrating on a biomedical focus- pulling back from a mission that had brought the profession to the edge of extinction" (p.304). An evidence-based focus on practice coupled with ailing federal legislation on mental health care signaled that concerns over social welfare as well as the search for social conditions that affect mental health were diminishing, especially within the APA.

As well, psychiatrists in the mid-1980s gravely underestimated the intellect and savvy of the ex-patients' movement when networking and lobbying for rights (Isaac and Armat 1992:222). Since these groups were local and small, they were able to generate changes in state policies more effectively than Federal Government interventions. These groups worked diligently to extend the rights of patients, mainly to refuse treatment (Isaac and Armat 1992:142-160). In 1992, Paul Appelbaum, a noted psychiatrist and former president of the APA is quoted as saying, "For better or worse I think the consumer movement is going to have much less effect on [the] development of policy than any of the other actors in mental health. They're stigmatized by virtue of being crazy in the public mind. Even if they're right, they're not going to be listened to very much" (Appelbaum as quoted in Isaac and Armat 1992:222). Appelbaum's statement is

indicative of a time after the decline of academic anti-psychiatry and the ex-patients'

movement, where psychiatry experienced a reprieve from concerted attacks to its

legitimacy. It is also the period in which the APA mounted its "war against stigma". The

theme of the 1989 conference, "Overcoming Stigma", ushered in a new orientation to the

problem of stigma. Stigma was not just public discrimination against people with mental

illness, but discrimination against psychiatry too. The process by which stigma comes to

be understood in this way is illustrated in the next chapter.

In summary, the development of the CMHC legislation reflected how psychiatry

was coming into an understanding of itself as a psychoanalytic, office-based practice.

The 1962 amendments to the Food and Drug Act are matched with the invention of a

multitude of psychiatric drugs that did not target any specific disease, which then led to a

need for greater categorical based specificity. This left American psychiatrists in a

difficult position with regards to out-patient treatment and disease symptomology. As

well, the academic anti-psychiatry movement led by psychoanalysts, sociologists, and

psychiatrists influenced a large contingent of former patients to speak out against

psychiatric interventions/oppression or care/abuse. It seemed that lifting the stigma

accorded to mental illness was one such target the ex-patients' movement should tackle if

they were ever going to be able to obtain equal rights.

Better Living through Advocacy

This section identifies how the critical discourse of the anti-psychiatry movement,

coupled with the social context of the 1960s and 1970s, manifested in the organization

and proliferation of rights-based patient advocacy groups that were able to gain

government funding and provide alternative care after CMHC legislation. I begin by tracing the early history of patient groups, the National Committee on Mental Hygiene and Recovery Inc, to show how former patients became involved in the psychiatric discourse through cooperation with psychiatrists and family members. Following this, I summarize the ex-patients' movement starting in the 1960s and 1970s through *Madness Network News,* the writings of ex-patient Judi Chamberlain, and queer rights protesting of the APA to highlight the roles of self-help, advocacy, and neo-liberalism that characterize this movement after WWII. Then, I situate the takeover of mental health advocacy by the National Alliance of the Mentally Ill (NAMI), which espouses a biological understanding of mental illness and endorses forced treatment, in the early 1980s as an impetus for the homogenization of consumer views in mental health treatment. I conclude this section by briefly describing how the ex-patients' movement reorganized through the use of the internet in the 1990s and how they continue to use the internet as a means of communication and consciousness-raising about the interconnectedness of the APA, NIMH, NAMI, and pharmaceutical companies.

Often cited as the first recorded patient organized consumer advocacy group, The National Committee for Mental Hygiene (NCMH), was established in 1909 by Clifford Beers after he published his memoir, *The Mind that Found Itself* (1908). Beers was a Yale graduate and a former mental patient who aimed to demystify mental illness and raise awareness about psychiatric care. This organization is still functioning today under the name Mental Health America. Porter (1987) notes that NCMH works closely with psychiatry in order to reform the discipline and aid patients. However, when looking at Beers' life in more detail, Porter (1987) suggests that he distanced itself from the insane.

Porter (1987) writes that Beers "felt most comfortable in sympathizing with those who helped themselves, once they had become rational once more" (p.196). Adolf Meyer, former APA president, suggested the name Mental Hygiene to Beers. Meyer and Beers were informed by the eugenic paradigm to varying ends. Dowbiggin (1997) writes that the NCMH were instrumental in the passing of sterilization laws in the Deep South, especially Mississippi, but that Meyers was most interested in developing a psychodynamic approach to psychiatry.

Beers' Mental Hygiene Movement consisted of smaller local satellite organizations. These organizations did not campaign on behalf of patients, but instead they lobbied judges, lawyers, and administrators on the advantages of psychiatry. Beers suggested that every individual could benefit from psychiatric knowledge as an understanding of psychiatry led to an understanding of oneself. Beers advocated for a theory of social psychological evolution and the protection of society against degenerates, as did the eugenics movement occurring at the same time (Porter 1987:197). The Mental Hygiene Movement also advocated for the prevention and treatment of mental disease through attaching psychiatric clinics to schools, jails, workplaces, and the army, which were also complementary to the objectives of the APA.

Beers and the NCMH relied on a specific utopian vision of the American way of life, where they promoted the values of "free thought, free speech, and the right to be yourself" as well as "justice, liberty, and peace" (Porter 1987:200). Beers ([1908]1921) hoped that his book would do for the mentally ill what *Uncle Tom's Cabin* did for Black slaves (p.217). Beers (1921) wrote, "Such a book might change the attitude of the public towards those who are unfortunate enough to have the stigma of mental incompetence put

upon them" (Pp.217). Beers (1921) continued, "Of course, an insane man is an insane man and while insane should be placed in an institution for treatment, but when that man comes out he should be as free from all taint as the man is who recovers from a contagious disease and again takes his place in society" (Pp.217-218). This statement reflected similar sentiments of the APA in relation to how education can change public opinion regarding the stigma of mental illness. However, those who have contracted contagious diseases or have had family members with contagious diseases, such as leprosy and tuberculosis, must also deal with the associated stigma. The salient point to be taken from Beers' declaration is that removing stigma and changing public attitude towards insanity were important for both patients and psychiatrists as early as 1908.

It is in 1937 that The Association of Former Patients organized to "combat the stigma of mental disease" (Low 1940:2). Ironically, this organization also went by the name of "Recovery Inc." on all letters to members and in print due to the discrimination one might face if he/she was disclosed as a member of this organization. By 1938, this organization had over one hundred members that were former patients as well as two hundred associate members consisting of family and friends. The APA (1938b) writes: "The principal objective of the association is to combat the idea of a stigma attaching to mental illness. To this end it proposes legislative action to spare the mental patient and his family the humiliation of the court record" (p.752).

In 1940, the Association of Former Patients with the aid of the Northwestern University Law School devised a proposal to give greater power to psychiatrists and physicians in an effort to relieve the stigma accorded to patients with a court record. The APA (1940) endorsed Recovery Inc.'s plan and summarized it as follows "Under the new

plan a patient, after proper certification by two physicians, will be admitted to a state hospital without petition, writ or trial. The hospital staff will be required to make an examination within ten days of admission and to send a report to a State Board of Supervisors composed of physicians, lawyers and lay people" (p.990). This bill appeared in front of the Illinois legislature in 1941. However, it was vetoed as unconstitutional on the grounds that persons who are involuntarily committed to a state hospital have the right to legal counsel. Many in Recovery Inc. believed that the action was a success even though it was not passed into law (Low 1940).

Like Beers, Recovery Inc. cooperated with the psychiatric establishment, but unlike Beers, Recovery Inc. also provided support to patients for the purposes of stigma reduction. Recovery Inc. developed an intricate plan for post-hospitalization self-help, which includes participation in group psychotherapy. Recovery Inc. is also still an active, patient run organization. Castel (1991) stipulates that alliances formed between practitioners and administrators make up a specific phase in the history of mental health, which eventually led to new legislation. These alliances between former patients, lawyers, and the APA constitute part of the history of mental health before the 1963 CMHC policy. However, it is only after the civil rights movement of the late 1950s and early 1960s that an ex-patients movement emerges.

The ex-patients' movement took its most definitive shape in the 1970s through the work of Judi Chamberlain, an ex-patient and advocate for patients' rights, and *Madness Network News* (MNN), a newsletter devoted to publishing patient accounts of stays in mental hospitals and the dissidence from doctors who often published under pseudonyms. The ex-patients' movement was constituted by what could best be described as local

satellite groups across America and Canada (Chamberlain 1990). These groups varied in size as well as in agendas, but agreed on some fundamental issues which Chamberlain (1990) describes, "mental health terminology was considered suspect; attitudes that limited opportunities for mental patients were to be discouraged and changed; and members' feelings - particularly feelings of anger toward the mental health system - were considered real and legitimate, not symptoms of illness" (Chamberlain 1990). As well, some were not content to be called ex-patients as it denoted an acceptance of the medical model of disease. Terms such as psychiatric survivors, ex-psychiatric inmates, clients, and consumers proliferated and connoted differing levels of animosity and skepticism towards psychiatric practice.

Borrowing concepts such as consciousness raising from women's groups, as well as closing their ranks to include only ex-patients, similar to Black rights groups, the ex-patients' movement developed concepts such as "mentalism" and "sane chauvinism" to help define the scope of their oppression (Chamberlain 1990). Chamberlain suggests that these concepts describe how the stigma associated with mental illness limits the rights of people through a public conception of mentally ill people as "incompetent, unable to do things for themselves, constantly in need of supervision and assistance, unpredictable, likely to be violent or irrational, and so forth" (Chamberlain 1990). This view did not only permeate public perceptions, but also the patients themselves experienced an "internal oppression" (Chamberlain 1990).

Integral to unifying this movement was *Madness Network News* (MNN), first published in 1972. This magazine also held an annual conference titled "Human Rights and Psychiatric Oppression" beginning in 1973 which unified the local ex-patients'

groups. MNN sent out its last publication in 1986. As well, the Human Rights and Psychiatric Oppression conference ceased operation in 1985. These ex-patient groups were considered radical and received little to no funding from government or its agencies. However, this did not stop these groups from becoming involved in legislative hearings, psychiatric and medical conferences, as well as on community boards and local committees (Chamberlain 1990). Chamberlain (1990) suggests that lack of funding and support led to ex-patients' groups having two options: cooperation or confrontation. Many groups worked towards cooperation, while also maintaining skepticism towards the interrelation of psychiatric practice and governmental goals.

Also in the late 1960s to early 1970s, the queer rights movement was most effective in de-medicalizing homosexuality as a disease warranting psychiatric intervention. Protesting and targeting the APA's classification system on the grounds that it was pathologizing homosexuality led to the removal of homosexuality from the DSM-II in 1973 (Healy 2002:301; Drescher and Merlino 2007:101). Spitzer, Chair of the DSM-II committee, met with gay activists who claimed, "that the only way gays could overcome civil rights discrimination was if psychiatry would acknowledge that homosexuality was not a mental illness" (Spitzer as quoted in Drescher and Merlino 2007:100).

However, the removal of the category of homosexuality also exposed the social and political underpinnings of psychiatric classification, as Spitzer argued that homosexuals were not distressed by the mere fact of being homosexual, but they were troubled by "how people reacted to their being gay"; i.e. the stigma of homosexuality (Spitzer as quoted in Drescher and Merlino 2007:101). Therefore, Spitzer argued that

mental illnesses needed to either cause distress or result in an impairment of generalized functioning in order to be included in subsequent printings of the DSM-II. This led to major controversies within the APA about the definition of the term mental disorder and resulted, in part, to the drive towards biological specificity in the DSM-III. This move also did not prevent homosexuality from becoming bound up in this biologization as it was reclassified as "sexual orientation disturbance" in what Spitzer terms a "political" move to satisfy psychiatrists and activists (Spitzer as quoted in Drescher and Merlino 2007:103). As well, the biologicalization of homosexuality as a destigmatizing strategy (Porter 1994), retains a certain peripheral trajectory with psychiatry's shift towards biological explanations of behavior.

Drawing from this experience and the notion that psychiatric claims about the nature of mentally ill people contribute to civil rights discrimination, a rise in mental health advocacy (also called peer support and mutual aid) and self-help empowerment characterized the late 1970s (Chamberlain 1990; Morrison 2005). Chamberlain suggests, "By its very nature, self-help combats stigma, because the negative images of mental patients ultimately must have the reality of clients managing their own lives and their own programs. [...] Self-help is not a miracle nor a cure-all but it is a powerful confirmation that people, despite problems and disabilities, can achieve more than others (or they themselves) may have ever thought possible" (Chamberlain 1990). This kind of rhetoric about self-help empowerment is laden with neo-liberal ideals and reflects a political and social ideology where the individual is responsible for their own well-being (Rimke 2000; Cruishank 1999). It also suggests that stigma is located in the social as a misconception about mentally ill people, thus, making the mentally ill person responsible

for eradicating stigma through demonstrating the ability to be responsible for themselves and their own mental health problems.

The goal of advocacy is similar to that of self-help. Chamberlain writes, "The basic principle of the movement is that all laws and practices which induce discrimination toward individuals who have been labeled "mentally ill" need to be changed, so that a psychiatric diagnosis has no more impact on a person's citizenship rights and responsibilities than is a diagnosis of diabetes or heart disease. To that end, all commitment laws, forced treatment laws, insanity defenses, and other similar practices should be abolished" (Chamberlain 1990). Whereas the 'right to treatment' debates sprang up in court cases in the late 1950s and early 1960s against confinement in custodial institutions, the 'right to refuse treatment' appears in the late 1970s and early 1980s as a way for consumers to make choices about if, when, and how they will receive treatment (Isaac and Armat 1992). However, invoking this right is often marred with legal problems and is intricately tied to public stigma as a matter of court record. The emphasis on choice and responsibility reflects the neo-liberal model, which is profoundly complicated by the presence or diagnosis of mental illness.

By 1985, a new group of mental health advocates were on the horizon, a group that did not hold the same fundamental tenets of the ex-patients' movement and instead sought to eclipse them. This changing of the guard, so to speak, "seemed to coincide with the slowly growing recognition on the part of bureaucrats and service providers that they needed to develop mechanisms to listen to our message" (Chamberlain 2000:xii). Chamberlain pinpoints the preference for the word 'consumer' as opposed to survivor or ex-inmate as coming about through these changes. Morrison (2005) suggests that it is at

this point that consumer cooperation leads to reform, while confrontation is met with wholesale rejection by government officials (Morrison 2005:82).

Among those attempting to cooperate in order to reform policies was Joseph Rogers, founder of the National Mental Health Clearing House (NMHCH) in 1986. The NMHCH received a bulk of its funding from the government (Morrison 2005:84). The once radical ex-patients' movement fractured and could no longer represent itself as unified because its representatives in congressional meetings and psychiatric conferences no longer espoused a challenge to psychiatry as abusive and coercive. Instead, the NMHCH drew a fine line between developing and adhering to governmental policies and empowering the consumer. The NMHCH's message was of self-help, choice, and alternatives through partnership with other consumer groups, psychiatry, and government (Morrison 2005:84).

Concomitant with the development of the NMHCH was the rise of The National Alliance of the Mentally Ill (NAMI). Although founded in 1979, NAMI did not make a significant contribution to the debates until the mid-1980s (Morrision 2005:85-87). Today, this group is one of the largest and most widely recognized advocates for the mentally ill. Just as the APA in the 1980s had reoriented itself to a biological paradigm, NAMI followed suit by advocating for the medical model of brain disorders (Morrison 2005:87). NAMI was instrumental in gaining funding from the NIMH for new research on schizophrenia through family advocacy and appeals to biological research. As well, NAMI representative, American psychiatrist, and former researcher at the NIMH, E. Fuller Torrey (1988) advocated forced treatment, stating "If laws in your state have tilted too far toward the patient's right to refuse treatment, begin a campaign to restore muscle

to laws, so that patients who need treatment will be treated... advocate for wider use of outpatient commitment laws, which permit patients to live in the community only so long as they continue to take medication" (p.371).

Torrey also founded the Treatment Advocacy Center (TAC) which supports legislation and community initiatives for the forced treatment of mentally ill people. As Albee (2005) writes, "NAMI resists with passion the possibility that some severe mental disorders might be socioenvironmental in etiology" (p.312). Billing itself as "The Nation's Voice on Mental Illness", NAMI's insistence on a biological model of mental illness coupled with its federal funding has resulted in a bureaucratization of consumer's viewpoints through an appearance of unified representation. By dismissing social determinants of mental illness as hearsay, NAMI represents the mentally ill population as a biologically distinct group, similar to the agendas of the APA and NIMH.

In the 1990s, Morrison (2005) explains, it had "become quite trendy in the mental health system to invoke the 'consumer' point of view" (p.87). However, there was a competition between these points of view and the ideologies of organizations espousing them. As the managed care model of medical insurance is based on market strategies for economy and efficiency, the consumer of mental health services was called on as a customer who should be satisfied with the outcomes of the treatments being offered (Morrsion 2005:89-91). However, the government's insistence on finding consumers with more neutral views as well as the close connection with NAMI showed that the viewpoint of the consumer represented in these hearings could not encompass the wide range of ex-patients' positions.

Therefore, the radical ex-patient movement sought resurgence through technological means. In the 1990s and through today, radical groups utilize internet communication through websites, message boards and e-mail bulletins. These groups, (antipsychiatry.org, the National Empowerment Center, Madnation, MindFreedom, and the Support Coalition International) revitalized the ex-patients' movement through monitoring and reporting on advances in treatments claimed by the APA, AMA, NAMI, and TAC among others (Morrison 2005:89). These sites and groups also employed consciousness-raising techniques through e-newsletters and mailing lists informing members of upcoming conferences, legislation hearings, and demonstrations. As well, others were alerting the media to the connections between pharmaceutical companies, the APA, and NAMI in an effort to improve the public and patients' knowledge (Silverstein 1999; Mosher 1999).

The way in which the public, the government, and psychiatrists viewed the capabilities of people with mental illness was at the heart of these debates. Consumer empowerment relied heavily on eradicating misgivings about mentally ill people through a neo-liberal understanding of citizenship and human rights. Stigma became a powerful concept in this process. The next chapter describes how this turn towards stigma began with a sociological reevaluation of mental illness and later became a problem for the APA and the American government.

Conclusion

In juxtaposing the histories of mental health service delivery, psychiatry, and the ex-patients' movement, it is evident that social, political, and economic concerns affected

the placement of psychiatric facilities, the treatments psychiatrists could implement, as well as how consumers were constructed and governed in the process. The history of American psychiatry has never been simply a matter of taking a well-defined population of mentally ill persons and placing them underneath an umbrella of services that will cure their ailments. Instead, the creation of a mentally ill population endowed with the same rights and responsibilities as ordinary citizens characterizes the move towards CMHC legislation and out-patient services.

At the same time, the development of new legislation on prescription practices coupled with ardent interest in out-patient care, emerging insurance policies, declining governmental funding, and the challenges brought forth by anti-psychiatry, revitalized the significance of biology in the APA. The renewed focus on biology as the central factor determining mental health was also a reaction to the challenges posed by queer activists and ex-patient groups, who claimed that psychiatric diagnosis was the result of political agendas and social norms that ultimately led to civil rights discrimination. Did the turn to biology ultimately signal a retreat from psychiatry's "mission to save the world" as Healy asserts (2002:304)? Or have these problems only been given the new name and agenda under the guise of stigma?

Enmeshed in all of these debates was the concept of stigma as a rationale for understanding psychiatric treatment, including negative public sentiment toward it, as well as discrimination against people with mental illness. Thus, the public's perception of the consumer of mental health services became integral to its view of psychiatry as a curative science that wholly satisfied its customers. Accordingly, the consumers of psychiatric services were empowered by their re-found minds and (so long as they held

similar views as the APA and NIMH) were encouraged to join in the fight against stigma through the neo-liberal ideals of self-help, advocacy, and citizenship. The next chapter will sketch out in greater detail just how this comes about through massive professional, paraprofessional, and governmental campaigns to eradicate the stigma of mental illness. Similar to the histories outlined here, the history of stigma involves largely contested notions of the benefits of psychiatry, the etiology of mental illness, and the cost of mental health care as well as concepts of consumerhood, citizenship, civil rights, and discrimination.

Chapter Six

Genealogy of Stigma

It is time to have done with all this cant about the stigma of certification and to ask for the removal of what produces the stigma. — P.W. MacDonald, 1907[9]

This chapter is a genealogical analysis of the concept of stigma in American psychiatry. The mass of material used to generate such a history mainly originates from *The American Journal of Psychiatry* (AJP). The sample consists of 651 articles from the years 1846-2007 that use the word stigma; however, very rarely is stigma the concentration of the article. Stigma instead, manifests as a justification for implementing practices and later as a call to arms for changing the public's perception of psychiatry and mental illness. This study focuses on, but is not limited to the AJP as important changes in the concept of stigma come from outside of the AJP in writings by Symbolic Interactionist sociologists.

In this chapter, I describe the early usage of stigma in the AJP to illustrate how it was utilized before the intervention of Symbolic Interactionists. In the period from 1846 through the 1960s, stigma has an ideological value that describes the limits imposed by others on psychiatric practice. Ideology is a set of shared values and beliefs that are spoken about as truth or fact, which informs the rationale underpinning instituting practices. From here, I outline the redefinition of stigma by Symbolic Interactionists coupled with the political context of the 1960s, which provides insight into the situation of stigmatized individuals as well as opens the discourse on stigma to civil rights and

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[9] MacDonald 1907:293.

choice through debates on commitment laws, the right to treatment/right to refuse treatment, and voluntary/ involuntary admission.

Then, I sketch a subsequent operationalization of stigma that takes place in the AJP, which aligns stigma with rhetoric on expanding insurance policies through discussions about confidentiality and discrimination, the medical model, and the unfair characterization of the profession of psychiatry by insurance carriers and physicians. In this section, I also discuss the failed attempts to quantify stigma in the AJP, which indicated that stigma was not as pervasive as psychiatrists had previously represented. As a result of these shifts in the discourse on stigma, different courses of action developed to deal with stigma in the population and the individual in order to present a positive image of psychiatry. The intent was to solve the problems associated with the limits imposed by law, the rights of citizens, and insurance coverage.

The Ideological Foundation of Stigma: Early Usage

Prior to the publications by Symbolic Interactionists whose theories connected stigma, deviance, and mental illness, psychiatry had used the term stigma in multiple ways. Dain (1994a) observed that "Early psychiatrists initially justified their new specialty by arguing against the stigmatization of the insane" (p.1011). The content of stigma during 1846-1960 involved four major themes: the stigma of commitment, stigma of psychiatry, euphemistic stigma, and the stigma of insanity, each of which were addressed by strategies to mitigate stigma. The strategies included moving the site of care, educating physicians and the public on the benefits of psychiatry, changing the names of treatments and insane asylums, and addressing stigma in the individual.

Common to all of these strategies is the claim that, in the best interests of science and patients, psychiatry should be accepted as a medical profession free to practice without limitation by law or public reproach. This section outlines the themes of stigma and the strategies developed to address each theme.

One of the earliest claims about stigma in the AJP was that the stigma of commitment attaches when a person is confined to a mental hospital.[10] This stigma was thought to be damaging and demeaning to patients and their family as it requires a jury trial and court certification.[11] It was thought that through legal commitment and the permanence of the court documents that stigma then became associated with the family name.[12] This stigma not only affected the entire family, but also psychiatrists because it was said to inhibit the disclosure of personal information and biographical histories to psychiatrists.[13] It was also thought that stigmatization caused by the legal proceeding prevented patients and family members from seeking help from the same institutions that housed the criminally insane.[14] The stigma placed on patients through law was a hurdle that psychiatrists sought to overcome. It had been speculated for some time that the limits on psychiatric practice imposed by commitment laws for the protection of sane individuals, due in large part to the work of Elizabeth Packard, hindered the acceptance of psychiatry as a decisive medical specialty.

For example, Mosher (1909) published an article on the intersection of law, commitment, and family stigma as it relates to the now diversified hospital system, where

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[10] For examples see Jarvis 1860; AMSAII 1865; AMSAII 1881; Ross 1891.
[11] For examples see Ross, 1891; Jones, 1903; MacDonald 1907; Treadway 1920.
[12] For examples see AMSAII 1881; Worcester, 1896.
[13] For examples see AMPA 1902; Jones: 1904; Brush 1905; Jones 1905; Burgess 1905; Bancroft 1905; MacDonald 1908; Mosher 1909; Dynan 1914; Armstong-Jones 1918; Kline 1921; Sands, 1928; AJP 1936; Bowman 1946; Feldman et al. 1947.
[14] For examples see AMSAII 1870; AMSAII 1881; AMPA 1902; Jones 1903; Burgess 1905; MacDonald 1908; Mosher 1909; North 1914; APA 1938b.

some patients are treated in general hospitals and others in rural asylums. Neurotics present as an especially difficult case for psychiatrists because they can be treated and returned home in the span of a few days if the resources are available. Therefore, obtaining a lawyer and being committed through the court system was believed to be unnecessary for some kinds of mental illness, particularly neurasthenia, because early detection and treatment resulted in shorter stays in hospitals and better outcomes. Mosher (1909) advocated for more fluid commitment laws, voluntary or involuntary, that would produce results more rapidly and not hinder scientific progress. At the time, legal certification through court proceedings was needed to commit a person involuntarily, which often required cooperation from the family.

In relation to public outcry, law, and psychiatric practice, Mosher (1909) stated, "A better educated public sentiment, higher ideals of responsibility to the afflicted, strong family ties, now demand the best known means for cure. The family demoralized by the insanity of one of its members, and ready to expend every effort for restoration, does not look with favor upon statutory requirements based upon disproved theories of abuse, injustice and conspiracy" (p.505). Of stigma and the law, Mosher (1909) wrote, "Where the law is obstructive it is not an uncommon practice to send patients to some other state, for there is great reluctance on the part of their friends to air their troubles before a magistrate and to engage in a proceeding which they believe will prove a lasting embarrassment-sometimes referred to as a "family stigma "- should the patient be restored to participation in affairs" (p.505). And finally, in relation to the public opinion, law, and science, Mosher (1909) concluded, "This public sentiment now promises to become so pronounced as to produce an effect in lunacy legislation, that less stringent

lunacy laws be enacted, and that the lunacy system of a state be not erected into a barrier against every exercise of compassion, sympathy, and scientific progress" (p.505). For American psychiatrists, the laws which were in place to protect sane persons from being committed in conjunction with the problem of family stigma had resulted in a powerful limit to psychiatric practice as patients and families' resisted commitment. In a study of the history of commitment and gender, Tomes (1990) found that families would often seek out alternative care through both physicians and religion before opting for psychiatric hospitalization.

When laws for the protection of the sane failed to change significantly in many states, psychiatrists turned their attention to another strategy to change the stigma of commitment. In step with these claims about the stigma of commitment preventing early treatment, (due in large part to the stigma of the court record preventing some from seeking care and the ensuing hospitalization resulting in family stigma), early psychiatrists advocated for the construction of psychiatric wards in general hospitals as a way to reduce this stigma.[15] This claim against stigmatization is reiterated when psychiatrists advocated for treating patients in general wards in general hospitals.[16]

More importantly though, it was through appeals to the reduction of stigma that psychiatrists advocated for new sites for practice that would place psychiatrists alongside physicians and in the community. Implicit in these assertions was the need to diminish another kind of stigma, the stigma of psychiatric practice. There was a stigma associated

[15]For examples see Jarvis 1860; Ross 1891; Berkely 1897; Hurd 1899; Foster 1900; Burr 1900; AMPA 1901; Jones 1903; MacDonald 1907; Brush 1905; Meyer 1907; Gregory, 1908; Clarke 1908; AMPA 1908; Bancroft 1908; Meyer 1909; Briggs 1911; Anglin 1918; Cushing 1919; AMPA 1914; May 1919; Treadway 1920; Kline 1921; Truitt 1921; APA 1922; McCarthy 1922; Sands 1928; APA 1936; Palmer and Braceland 1937; Bowman 1938; APA 1938a; APA 1938b; APA 1939; Overholser 1939; Warson 1941; Keyes and Matthews 1941; APA 1942; Rosenberg and Lambert 1942; Pollock 1945; Bowman 1946; Feldman et al. 1947; Blumenthal 1948; Wilson and Suter 1948; Lemkau and Sanctis 1950; APA 1951.
[16] For examples see Warson, 1941; Keyes and Matthews 1941.

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with the profession due to placement of secluded asylums that resulted in the isolation of psychiatric practice from medicine and potential patients. Moving psychiatric practice out of rural America was seen as beneficial to all, as it would legitimize psychiatry as a medical and scientific enterprise and lead to increased knowledge of mental disorders and better treatment of patients.[17] The stigma that a patient felt as a result of being segregated in the rural asylum was not thought to be much of a concern unless the patient was released.[18]

At the same time that psychiatrists were questioning how to change the stigma of commitment and the stigma associated with psychiatric practice, concerns about euphemistic stigma began appearing in the AJP in 1893. Chapin (1893) stated that in reference to the Willard Asylum, the first asylum built for the care of the chronically insane, that the words chronic and incurable were used in place of pauper and indigent. The rationale was that physicians often used 'chronic and incurable' to describe physical ailments and therefore psychiatrists should employ a similar medical vocabulary to avoid stigma. However, the application of these terms would come to be seen as highly stigmatizing in later years.[19]

Debates over the preference for calling institutions asylums, retreats, or hospitals also begin in 1893 with a recommendation for the name change of an institution in Boston. Dr. Theodore Fisher presented a paper titled *The New Boston Insane Hospital* at a meeting of AMPA. In response to this presentation, Dr. Charles Hill stated, "But would it not be better not to call it a hospital for the insane? Technically it would be just as

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[17] For examples see Brush 1905; Meyer 1907; Bancroft 1908; Meyer 1909; May 1919.
[18] For examples see Runge 1900; Mosher 1909.
[19] For examples see McCarthy 1922; Elkind 1927; Komora 1935; Bowman 1938; Ebaugh and Rymer 1939; APA 1944; Miller 1965.

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explicit to give our asylums titles that remove the stigma of insanity entirely from the name. Private asylums rarely use the word "insane" in connection with their titles (Hill as quoted in AMPA 1893:272). Hill went on to say, "It would be better to call the establishment a home or retreat, instead of giving to it a name calculated to strike terror into the heart of the unfortunate creature who is committed to its walls. [...] We could just as well call it by any other name than an insane hospital" (Hill as quoted in AMPA 1893:272-273). The debates that ensued over euphemistic stigma followed a similar rationale about removing the word insane from hospital titles and simplifying terminology to present a positive image of psychiatry and increase public knowledge about mental disease.[20]

However, some psychiatrists suggested that euphemistic stigma is not solely a matter of words, but rather a change in public attitude must follow the change in titles.[21] Brush (1905) wrote, "[T]he very attempt to conceal the character of the hospital under some new name awakens suspicion that there is something to conceal about the character of the diseases it treats" (Pp.666-667). Brush (1905) doubted that the public could be tricked into thinking differently about insanity through a hospital name change. As for the notion that changing the name of the hospitals would reduce stigma of the insane asylum or fool the public into thinking positively of these institutions, William Lee, a mental patient, recognized this strategy and used it to advocate on his own behalf. In a letter addressed to Travers Jerome, district attorney of New York, Lee asserted: "Two hundred and twelve (212) days ago, your office had me indicted on a charge of

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[20] For examples see Chapin 1891; AMPA 1893; Runge 1900; Burr 1900; AMPA 1901; Abbot 1904; Clarke 1908; Warson 1941; AMPA 1903; Brush 1905; MacDonald 1907; AMPA 1914; Copp 1919; Kline 1921; Pratt 1933; Trapp1937; Bowman 1938; APA 1939; Overholser 1939; Warson 1941; Knapp and Weitzen 1945; Rees 1958.
[21] For examples see Brush 1905; Davidson 1953; Rees 1958.

misdemeanor. Subsequent events justify me in stating that your office procured that indictment in bad faith and that the purpose was to cause my incarceration without a trial in this State Prison for Insane Criminals which is poorly disguised under the name of "State Hospital" (Lee as quoted in Hasbrouck 1911:125). This disparaging remark symbolized that the effort to remove the stigma associated with insane hospitals through alterations to the names of hospitals was merely a figurative adjustment and not indicative of any lasting impact on stigma. Later, Rees (1958) suggested that changing the names of institutions to hospitals has been somewhat beneficial in the reduction of stigma, but he maintains that granting liberties and rights to patients as well as unlocking doors and removing gates have done more to change the image of psychiatric hospitals than any euphemistic changes.

As the interventions of changing the names of asylums and locating psychiatric wards in general hospitals were being implemented across American to address the stigma of commitment and psychiatric practice, another formulation of stigma was developing. In 1907, there was a major change in the use of stigma as it became aligned, not just with legal commitment, the stigma of the profession as unscientific, or with problems in terminology, but that stigma was a result of mental disease. MacDonald (1907) stated, "We are constantly being told that it is not the question of the disease that is the stigma, but the means whereby the disease is enabled to be treated, where it ought to be treated, in the homes and institutions provided for the purpose" (p.293). This characterization of stigma is profoundly similar to Goffman's (1963) definition of stigma as not simply referring to a discredited attribute, but rather in the way people relate to that attribute. Implicit in MacDonald's (1907) charge is that the methods of psychiatric

practice are stigmatized, particularly the use of commitment. MacDonald (1907) however, sought to change the connotation of stigma from relating to practice and instead defined stigma as a consequence of mental disease.

In a turn to question the stigmatization of method, MacDonald (1907) went on to state, "This view of the position of things reveals a veiled truth which is ruthlessly exposed by Prof. Clifford Allbutt's solemn words, "the stigma, if such there be, I rather resent the phrase, lies in the misfortune itself, and not in the red tape of the proceedings" (p.293). Subsequently, similar statements about stigma as related to mental disease and not the treatment for the disease followed in the AJP.[22] More psychiatrists began questioning the stigmatization of their profession through association with the mentally ill themselves.[23] Others suggested that stigma was a problem of human difference that could be dealt with through education and endorsement of psychiatric practice by physicians, but that stigma could probably not be eradicated.[24] Some psychiatrists stated that stigma contributed to or could make mental disease worse.[25] In order to address these notions that the stigma was a problem due to the lack of proper public education on psychiatry and that the stigma of insanity had deleterious effects on the course of mental disease itself, psychiatrists began to conclude that public education was a way to mitigate stigma in the population and medical profession as well as that particular treatments could decrease stigma in the individual. These developments each have a history of their own.

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[22] For examples see MacDonald 1907; APA 1921; Copp 1921; Pratt 1924; Elkind 1927; Reeve 1933; APA 1936; APA 1938b; Ebaugh and Rymer 1939; Warson 1941; APA 1942; Hagan and Duval 1943; Kellum 1943; Farnsworth and Wigton 1945; Rennie 1945; Burton et al. 1946; Lemkau and Sanctis 1950; Rickles et al. 1950; McCarthy 1955; Rees 1958.

[23] For examples see APA 1921; Pratt 1924; Moersch 1932; APA 1936; Knight 1941; Stevens 1949; Sirkin 1949; Davidson 1953.

[24] For examples see APA 1936; Warson 1941.

[25] For examples see Jones 1904; Terry 1929; Cobb 1940; Rosenberg and Lambert 1942; Kiev 1976.

The reduction of stigma through education about mental illness had been advocated as early at 1870 in the AJP. In 1870, the issue of early diagnosis is addressed as being significantly impeded by stigma. By this time there is mounting evidence that the earlier a mental disorder is identified and treated, the more permanent the cure. Turman, a psychiatrist, stated that family members and friends of a person who is "difficult to manage" did not want to commit the ill person into an asylum because of lasting stigma (AMSAII 1870:418). Turman claimed that once correct views on mental disorders were established in the public mind that the stigma would be abolished (AMSAII 1870:418). Comparable claims about better public understanding of psychiatric practices alleviating stigma were made throughout the period.[26] However, public education on the benefits of psychiatry could not come from psychiatrists themselves as it seemed overtly opportunistic, thus a different avenue for public education had to be explored.

It had been maintained that the stigma of commitment was only attached to those who were released from mental hospitals by Mosher (1909) and Runge (1900). However, there is evidence that those within mental hospitals had been concerned with the stigma of commitment as early as 1897 in the AJP. In case notes regarding a patient diagnosed as having alcoholic dual consciousness, the patient's view of stigma is recorded as a significant event in the patient's psychosis. Berkely (1897) writes, "November 24th.-H. has been in the corridor of the ward, and realizes his surroundings. Seems somewhat depressed, and thinks the stigma of the "madhouse" will attach itself to him forever, and that people in X- will point to him as a former madman who has been

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[26] For examples see Burgess 1905; Mosher 1909; Kline,1921; Pratt 1924; Reeve 1933; Komora 1935; APA 1936; Hamilton and Kempf 1939; Warson 1941; Brett, 1942; APA 1945; Alexander; Bowman 1946; APA 1946; du Pont 1947; Rickles et al. 1950; Davidson 1955; Fox 1967; Yamamoto 1978.

rabid and in chains" (p.501). Also, Elizabeth Packard's statement about stigma in 1868 and the case of William Lee illustrate that stigma was an issue that profoundly affected patients.

The first organized group specifically formed to address stigma was Recovery Inc. Recovery Inc.'s goal as a patient run organization was to combat the stigma of commitment by attempting to changes Illinois commitment law in the early 1940s. Hamilton and Kempf (1939) presented a paper at the ninety-fourth annual meeting of the APA which addressed current trends in treatment across the nation, citing Recovery Inc. specifically. They state, "Quite recently there developed in Chicago an interesting effort to mobilize the recovered patients of the Psychiatric Institute to create a public attitude more matter-of-fact towards the problem of mental illness. Removing the stigma of hospitalization was taken as the object of this work" (Hamilton and Kempf 1939:561).

As well, in an introductory note to the first issue of Recovery Inc.'s newsletter, Dr. Singer writes, "The present movement is unique in that it presents the united front of many persons who have regained their health. [...] The possibilities of bringing about a truly popular education and understanding are thus enormously enhanced" (APA 1938b:752- 753). The formation of Recovery Inc. signified the battle against stigma has begun to take shape through patients, conversing with each other, their families, their neighbors, their doctors, and legislators about commitment laws. Psychiatrists viewed this organization, similar to the NAMH, as a way to change public opinion about mental illness through a concerted effort to educate the public about psychiatry. By having former patients speak about their experiences, it was thought that the stigma of the

profession would reduce as the public would associate psychiatry with rehabilitation and cure, instead of interminable commitment in overcrowded hospitals.

Advocating for public education produced a number of strategies for the reduction of stigma in the population. Pont (1947) suggested using the tuberculosis, cancer, and infantile paralysis public education campaigns as a model for 'fighting prejudice and fear' of mental illnesses through the work of lay organizations and an 'army' of volunteers (Pp.152-153). As well, psychiatrists contended that physicians should be educated on mental illness in order to lessen stigma associated with psychiatric care and it was believed that this would legitimate psychiatry as a medical specialty.[27] Also couched in these early claims was the notion that mental illness was no different from physical illness and therefore should not be stigmatized,[28] or even placed under the jurisdiction of law.[29] Euphemistic stigma also appeared in these debates on public education as it was also thought that the stigma associated with psychiatry was a problem of vocabulary and that psychiatric terminology should be simplified to increase public awareness.[30]

However, what Recovery Inc. brought to the fore, more so than the issue of stigma reduction in the public, was that the stigma of commitment and being labeled insane has substantial effects on the individual. Beginning in the 1940s, one of the more popular applications of stigma as a rationale for practice was the claim that group

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[27] For examples see Burr 1900; Briggs 1911; Kline 1921; APA 1921; Reeve 1933; APA 1936; Ebaugh and Rymer 1939.

[28] For examples see AMSAII 1854; AMPA 1914; Anglin 1918; Elkind 1927; Reeve 1933; APA 1936; Warson 1941; Keyes and Matthews 1941; Knight 1941; APA 1942; Brett 1942; Bowman 1946; du Pont 1947; Rickles et al. 1950; Koren et al. 1951.

[29] For an example see AMPA 1914.

[30] For an example see Kline 1921.

psychotherapy could reduce the stigma a patient feels for being diagnosed mentally ill.[31]

Dreikurs and Corsini (1954) write that group psychotherapy removes the stigma attached to mental deficiencies through the production of values and norms within the group that promote equality, more so than a democratic society which "intensifies emotional isolation" (p.573).

Also surrounding the claims about stigma being dispelled through effective treatment were statements about the stigma associated with epilepsy,[32] homosexuality,[33] alcoholism,[34] and schizophrenia,[35] being vastly reduced through group psychotherapy. These diagnoses were often stigmatized as moral failings and weaknesses in the individual. Still arguably highly stigmatizing even today, early appeals to the stigma of these diagnoses form a basis of the medicalization of stigma following the increasing specification of psychiatry's nosological categories in subsequent editions of the DSM. This point I address in more detail the next chapter. The important issue for now is that stigma was slowly becoming an issue for psychiatry as an aspect affecting mental disorder that needed to be attended to in the course of the treatment similar to a symptom. It also indicated a divide in the concept of stigma as associated with the population and stigma as felt by the individual, which would both need to be addressed with different strategies. Interestingly, a variety of techniques for diminishing stigma would be developed during the 1940s through military psychiatry due to concerns about the economic burden of mental illness.

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[31] For examples see Cobb 1940; Hagen and Duval 1943; Rome 1943; Roseman 1944; Farnsworth and Wigton 1945; Rennie 1945; Knapp and Weitzen 1945; Ross 1948; Fetterman and Victoroff 1948; Robie 1950; Laughlin and Hall 1951; Dreikurs and Corsini 1954; Davidson 1955; West and Swegan 1956; French 1957; Bowman 1957; Burnell et al. 1972; Fiman et al. 1973; Frank 1974; Goodstein and Page 1981.
[32] For examples see Cobb 1940; Roseman 1944; Fetterman and Victoroff 1948; French 1957.
[33] For examples see Haden 1958.
[34] For examples see West and Swegan 1956; Bowman 1957.
[35] For examples see Ross 1948; Robie 1950.

On the one hand, military psychiatry became concerned with the mitigation of stigma due to employment and housing discrimination of discharged servicemen, but on the other hand it had also been demonstrated that discharge due to mental disorder resulted in problems of economy and efficiency. For the latter, stigma needed to be addressed in terms of prevention. In relation to the stigma of discharge due to mental defect, veterans were often denied pensions and benefits if they had been diagnosed and given a dishonorable discharge. This discharge was a matter of public record and therefore also considered a stigma which led to other forms of discrimination.[36] More persuasive than arguments about stigma and discrimination, however, was the contention that changing the stigma associated with seeing a psychiatrist would curtail costs of training unfit cadets.

Psychiatrists suggested numerous techniques to accomplish this goal. These techniques included changing intake procedures,[37] giving a preferred neurological as opposed to a psychiatric diagnosis,[38] instituting widespread education on how to recognize the symptoms of mental illness and emphasizing the possibility of rehabilitation.[39] By implementing these practices, movement into the sick role could be expedited. The sick role is a concept developed by sociologist Talcott Parsons (1951). Parsons suggests that once diagnosed a sick person is dismissed from their normal social responsibilities because their illness is considered beyond their control. As a result, the sick person is obligated to get well through seeking help from professionals.

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[36]For examples see Hadden 1943; Caldwell 1948; Brill and Beebe 1952; West et al. 1958.
[37] For examples see Hagan and Duval 1943; Rome 1943; APA 1944; Weinberger and Gay 1949; Grold and Hill 1962; Fiman et al. 1973.
[38] For examples see Kellum 1943; APA 1945; Burton et al. 1946.
[39] For examples see Rome 1943; Roseman 1944; APA 1945; Knapp and Weitzen 1945; Farnsworth and Wigton 1945; Rennie 1945; West and Swegan 1956.

The combination of these military psychiatry strategies to reduce the stigma of being treated for a mental disorder sought to move cadets with mental illness into the sick role faster and with more efficiency than before in order to save the cost of training unfit recruits and to reduce risk during combat.[40] Rosenberg and Lambert (1942) wrote of the mentally ill soldier, "Yet to the individual the interruption in his usual routine life, the discouragement of being unable to meet the requirements of army service, the confinement and unavoidable sense of stigma of hospitalization on a psychiatric ward and subsequent discharge for disability are not without psychic trauma. This type of soldier is a burden to the army. He wastes valuable hours of training [...]" (p.167). This suggested that strategies to mitigate stigma hinged on improving help-seeking behavior in the population. However, the stigma associated with the treatment had continued psychological effects on the patient, which so far had only been attended to through psychotherapy. More strategies for dealing with stigma in the patient would be developed as the next section will explain.

In summary, it was through claims about the stigma of commitment, the stigma of psychiatric practice, euphemistic stigma, and the stigma of insanity that strategies to reduce stigma were developed. The ideological basis for the reduction of stigma formed around two poles. First, stigma as a problem of the population was to be diminished through the location of psychiatric wards in general hospitals, changing the names of asylums, and public education. These techniques were thought to lead to quicker entrance into the sick role and result in better treatment outcomes. Second, stigma in the individual was treated as a symptom of mental illness as those that did seek treatment felt isolated and alienated due to their diagnosis.

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[40] For examples see Rosenberg and Lambert 1942; APA 1944.

Through the work of Recovery Inc, the concept of stigma became as important for patients as it was for American psychiatrists. Stigma referred to a constellation of limits imposed on the practice of psychiatry by laws, families, and the public as well as restricted the quality of life for former patients. The reasons for psychiatrists and former patients to address and reduce stigma were mounting. Yet, it was not until the social and political context of the 1960s and its emphasis on civil rights that would stigma would undergo a profound redefinition and transformation.

The Revaluation of Stigma: On liberty and civil rights

This section describes how ongoing debates about commitment laws through the 1960s-1970s resulted in appeals to stigma on the grounds that patients should have the right to voluntarily commit themselves and that all patients had the right to effective treatment of mental disorders. When the need for psychiatric care was argued on the basis of choice to be treated, then the civil rights of the patient came to be a significant rallying point in this process. From here, I discuss how another formation of stigma began to take shape as patients' rights groups were formed through common ties of diagnoses (particularly epilepsy) around the same time that the question of voluntary commitment/treatment was posed. These groups campaigned for changes in laws to lessen the stigma associated with having a disorder or being treated for mental illness.

Then, I outline how the issue of the location of treatment reemerged and became especially pertinent during this time as the move to out-patient treatment was considered less stigmatizing (if not entirely free of stigma) and would therefore encourage more people to seek out treatment. This was similar to previous claims made about creating

psychiatric wards in general hospitals. Contemporaneous with these issues being debated

over the rationale of stigma, the academic anti-psychiatry movement developed in

America. Symbolic Interactionists, especially, focused on the concept of stigma and its

meaning for psychiatry. The simultaneous publication of Goffman's *Stigma* (1963) and

the passing of the CMHC legislation affected the content of stigma in the AJP,

particularly with reference to the new out-patient treatment. However, confusion about

CMHC programs and patients' preferences for biological diagnoses resulted in

psychiatric patients seeking care from physicians. These, among other issues, such as the

ongoing stigma of the profession and the stigma of insanity, was claimed to have led to a

crisis in insurance coverage for mental health problems.

On the heels of Recovery Inc's claim that a change in laws will positively affect

the stigma associated with commitment,[41] the Committee on Legal Psychiatry published a

mission statement in the AJP in 1942 concerning the streamlining of psychiatric

procedures and law in order to lessen the stigma associated with legal commitment. They

suggest that the patient's treatment must be expedited through revising court procedure to

commit a patient based on the examination of two psychiatrists. This move put decidedly

more control in the hands of psychiatry to carry out treatment as early as possible. The

rationale for this new commitment practice relied heavily on stigma. The committee

wrote, "The stigma of the adjudication of insanity is not to the best interests of the

patient, his family or society, is lifelong and often impairs successful treatment although

under our present legal admission procedure, it is a legal prerequisite to hospital

treatment for mental illness" (APA 1942:237). They continued, "Furthermore, technical

legalistic or slow procedures often impair effective treatment of persons mentally ill. The

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[41] For an example see APA 1938b.

insane are sick people and insanity is a medical problem" (APA 1942:237). The committee identified that the legal proceedings attached the stigma of a court record prevented speedy entrance into the hospital and the best way to address this is to revise admissions procedures. They advocated for voluntary admission, removal of the court's involvement in certification, and for involuntary commitment to be based on the certification of insanity by two psychiatrists. Similar claims such as this began to appear most steadily in the AJP beginning in the late 1950s, particularly supporting voluntary commitment.

On the subject of voluntary versus involuntary commitment, psychiatrists argued that voluntary commitment would reduce stigma because it allowed the patient to maintain their civil rights.[42] Barr (1967) suggested that voluntary imprisonment for the rehabilitation of criminal offenders may lessen the stigma attached to imprisonment similar to voluntary hospitalization for psychiatric patients. He contends that those who volunteer retain their civil rights and suffer less stigma, while those that are committed to a hospital or prison involuntarily lose their civil rights and self-esteem. In a rebuttal, Dr. Robitscher calls Barr's example arbitrary and suggests that without the stigma of the criminal procedure, a lawyer may not be motivated to adequately protect the rights of the accused (Barr 1967:83). This raises an important question about the purpose of stigma and implies that applying stigma as a matter of court record is a necessary component of the process of commitment because it ensures the protection of the patient's rights. However, Recovery Inc. and the NAMH were both fighting to remove the legal barriers to commitment reasoning that it would lessen stigma.

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[42] For examples see Gottlieb and Tourney 1958; APA 1965; Terrence 1965; Robinson et al. 1966; Barr 1967; Greenland 1969; Lipsitt 1971; Mcgarry 1973.

Maintaining one's civil rights throughout the process of commitment and after hospitalization was a key factor in the case being made for voluntary admission throughout the late 1950s-1970s. As well, other laws that reduced the mental patient's rights were also targeted. Stevenson (1957), a representative of the NAMH, addressed these issues and called for revisions in other stigmatizing laws. He stated, "[M]ere talk against stigma and prejudice is futile as long as patients are routinely handicapped by abrogation of civil rights and privileges such as voting and automobile driving permits. These breeders of stigma must be eliminated before the public will believe our protests" (Stevenson 1957:854). As talking about stigma had failed to capture public attention, Stevenson suggested that laws which limit civil rights place a stigma on patients and that the rescission of these laws would be the only way to remove such a stigma.

The problem of stigma and civil rights was most pointedly addressed through epilepsy as this diagnosis carried (and still does) a significant stigma of uncontrollability (Cobb 1940). Straddling the line between a neurological disorder and a psychiatric diagnosis, epileptics were the first to speak out against stigmatizing laws that limited their rights, mostly those that prohibited marriage and driving permits.[43] What is important for understanding the issues raised by stigma and civil rights is that patient groups begin to rally around a specific diagnosis as in the case of epileptics, targeting legal issues that arose as a result of being diagnosed mentally ill. Eventually, as the next chapter illustrates, the content of stigma began to vary widely as other diagnoses come to be aligned with stigma. As well, enmeshed with the issue of civil rights was a call for the

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[43] For examples see Cobb 1940; Shanahan 1928; Selling 1943; Fetterman and Victoroff 1948; APA 1956; French 1957; Overholser 1959.

end of custodial treatment as patients' advocated for the right to be treated while

committed (Isaac and Armat 1992:117-121).

At the same time that the right to treatment became an issue, CMHC legislation

was diversifying the points of contact between psychiatric treatment and patients. The

push for out-patient treatment as a technique to minimize stigma evolved from the

debates on instituting psychiatric wards in general hospitals to placing mental health

clinics in community settings. Before the CMHC law took effect in 1963, the stigma

mitigating effects of out-patient care were argued on the basis of particular treatments,

such as electro-shock therapy,[44] tranquillizers and other pharmacological treatments.[45]

Also, well before the CMHC legislation, some psychiatrists argued that providing small

institutions in metropolitan settings would benefit the community and by locating the care

in the community it would lessen the stigma associated with utilizing psychiatric

services.[46] Leading up to and surpassing the CMHC legislation these claims carried

connotations that mental illness did not have to be confined to psychiatric wards or state

hospitals as treating patients outside of asylums would also benefit the patient because

there would be no record of commitment, i.e. no stigma.[47]

While debates about commitment laws, voluntary treatment, civil rights, and the

benefits of out-patient treatment were being argued utilizing stigma, sociologists in the

Symbolic Interactionist tradition sought to reorient debates about stigma and mental

illness. Thomas Scheff's *Being Mentally Ill* ([1966] 1984) suggested that the

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[44] For examples see Feldman et al. 1947; Robie 1950.

[45] For examples see Greenblatt et al. 1958; Pennington 1959.

[46] For examples see Overholser 1939; Warson 1941; Stevens 1949; McCarthy 1955.

[47] For examples see Overholser 1939; Warson, 1941; Feldman et al. 1947; Stevens 1949; Sirkin 1949 Robie 1950; McCarthy 1955; Greenblatt et al. 1958; Pennington 1959; Yamamoto and Goin 1965; Robinson et al. 1966; Chasin 1967; Swartz et al. 1972; Rogeness and Bednar 1973; Vaughn et al. 1973; Du Mas 1974; Weissberg 1974; Stein et al. 1975; Greenblatt and Budson 1976; Patterson 1976; Goldmeier et al. 1977; Allen et al. 1980; Feldman 1981; Fenton et al. 1998 Swartz et al. 2003.

stigmatization of the mentally ill lay deep in the roots of psychiatric practice as a form of social control. According to Scheff (1984), it is by stigmatizing certain types of behavior as abnormal that the practice of psychiatry as social control is publicly sanctioned. This stigmatization then leads to the practices of labeling and segregation. Therefore, the entire practice of psychiatry is predicated upon stigma and mental illness as a label is actually a consequence of stigma. As well, Howard Becker (1964) questioned the validity of psychiatry's use of the medical model to determine abnormal behavior. Becker (1964) asserted that the rules that govern acceptable behavior are made by social groups who have a stake in maintaining those rules and that the stigmatization of people or groups as deviant is for the benefit other groups.

Goffman's book *Stigma* (1963) was the first definitive treatise on the topic that looked at how interactions are shaped by stigmatized attributes. The relationship between "the own" and "the wise" can be very complex (Pp.19-31). The own are those who are stigmatized due to a particular discredited attribute, and the wise are defined as those who are normal but have a connection to a stigmatized person or group. Issues of secrecy, disclosure, passing, and recognition leave the stigmatized person at odds, constantly negotiating their status and relationships. Goffman stipulates that the interaction between the own and the wise can manifest in relationships of representation, especially in the case of the mentally ill. This is especially pertinent when speaking of battling or combating stigma as will be seen in the next chapter.

Atkinson (1975) claims that Goffman and others may have "overstated the case for stigmatization" (p.392). Atkinson (1975) writes that the effects of stigmatization must be understood not only "in terms of the interaction among a patient, his family and

community, and his specific hospital experience", but that factors such as lack of

aftercare, economic status, and other demographic variables are more "decisive

determinants" of long term disability than length of hospital stay and the ensuing

stigmatization (p.392). However, the course that stigma was to take after the Symbolic

Interactionists' redefinition in the 1960s shows quite decisively that psychiatry too was to

make egregious claims about the case for stigmatization.

After the CMHC legislation was passed into law and Goffman's *Stigma* was

published in 1963, there was a rise in the amount of articles using stigma as a rationale

for the promotion of out-patient psychiatric practices. Yamamoto and Goin (1965)

asserted that popular entertainment and media coverage have changed the publics'

opinion of psychiatry; however, this change was not entirely positive. According to these

researchers poorer patients were unaware of out-patient treatment and continued to

stigmatize psychiatric treatment for fear of being incarcerated in an "asylum" (Yamamoto

and Goin 1965:267). Therefore, they suggested that the stigma of psychiatric practice

must be changed though promoting the effectiveness of psychopharmacology and group

psychotherapy, instituting temperate intake procedures, and adopting procedures for

appointment-taking because patients in poorer social classes must remain in the

community while in treatment.

Other psychiatrists reiterated similar points on the lessening of stigma through

changing intake procedures (this included having the patient speak to a social worker or

mental health professional during intake instead of a nurse or psychiatrist),[48] providing

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[48] For examples see Robinson et al. 1966; Swartz et al. 1972; Weissberg 1974; Patterson 1976; Allen et al. 1980; Feldman 1981.

group psychotherapy,[49] instituting day programs,[50] providing other services to the

community at CMHC locations that do not involve psychiatrists,[51] involving psychiatrists

in the CMHCs who specialize in private practice,[52] utilizing pharmacological

interventions,[53] as well as providing the patient with training for daily living in the

community.[54] The techniques developed to mitigate stigma by military psychiatrists to

improve economy and efficiency in the 1940s were becoming more useful to psychiatrists

now located in the community. Heralding the effectiveness of community treatment,

Greenblatt and Budson (1976) declared, "[T]here is a lack of stigma and greater

anonymity for patients treated in the community; some can be treated in the community

at less cost than in hospitals" (p.920).

As well, because of the diversity of CMHC programs, stigma began to be

addressed as a matter of degree, where the less psychiatric or medical the treatment, the

less stigma was thought to apply. Du Mas (1974) explored the medical, nonmedical, and

antimedical models of CMHC programs, all of which offer care without the stigma of

hospitalization. Du Mas (1974) questioned why the medical model of psychiatric care

was failing to be implemented in CMHC programs. First, he focused on nomenclature

used to describe the subject of mental health services. He stated that within the

nonmedical model, the term client was used as opposed to patient in the medical model.

The term client does not imply sickness, while utilizing the word patient ascribes a sick

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[49] For examples see Burnell et al. 1972; Fiman et al. 1973; Frank 1974; Goodstein and Page 1981.
[50] For an example see Chasin 1967.
[51] Rogeness and Bednar (1973) studied the effects of teenage 'helpers' in CMHC programs by using Black inner-city teenagers as tutors for local elementary schools. They found that the role of the teenage helper is socially valued, while the role of the patient carries a social stigma. Therefore, teenagers conducting tutoring in the CMHC changed the perception of the center from "only for people who are crazy" to a place for community enrichment (Rogeness and Bednar 1973:936).
[52] For an example see Vaughn et al. 1973.
[53] For examples see Bilodeau and Hackett 1971; Donlon and Tupin 1974.
[54] For an example see Stein et al. 1975.

role. Du Mas' (1974) conjecture about the antimedical model was based on his intuition about CMHC programs in the future. He predicted that these antimedical programs would refer to clients/patients as citizens endowed with rights as this was thought to be less stigmatizing than psychiatric patient.

Second, Du Mas (1974) rated the models according to a hierarchy of effectiveness of treatment. Du Mas (1974) placed the medical model in very high regard due to the training and prestige of psychiatrists, but noted that with the trends in deinstitutionalization and politics, the use of the nonmedical model was rising. This was due in large part to mental health professionals becoming more commonly used in the treatment of mental illness. Du Mas (1974) suggested that the antimedical model was the future of CMHC programs as this model is based on a managerial framework where maintenance and bureaucracy would replace treatment and care.

Given the emergence of the mental health industry (Healy 2002), the combination of the nonmedical model and the antimedical model have resulted in a more bureaucratized system of mental health services. In the early 1970s, Judi Chamberlain others in the ex-patient movement pushed for changes in terminology to reduce euphemistic stigma through removing the medical and chronic connotations of the term patient. This signals another tactic against stigma forming from outside of the APA. Now, former patients were fighting for their civil rights to refuse treatment and to be seen as active participants in their own treatment.

The emergence of the patient as a consumer of mental health services is particularly telling of issues raised by stigma as the consumer of such services is treated precisely as a customer. Seeking satisfaction based upon the right to effective treatment

and the right to refuse treatment, the stigma associated with psychiatric treatment, coupled with diversity in CMHC programs resulted in a greater need for psychiatrists to address help-seeking behavior. Potential patients often sought the advice of physicians before psychiatrists and indicated a preference for biological diagnoses. Du Mas' (1974) classifications of the models of service provision is useful as it could also be that the medical model of psychiatric care was jeopardized not solely because of competing models of CMHC programs, but also because biological diagnoses were often thought to be less stigmatizing.[55]

As Morill (1978) stipulated, the development of primary health care practices after the CHMC legislation had resulted in two systems for the care of the mentally ill. In other words, primary health care professionals were treating more and more patients with psychiatric problems, yet not referring them to psychiatric services due to the stigma associated with mental illness.[56] Therefore, some patients had choice in what kind of professional, medical or psychiatric, that they would see. Morrill's (1978) solution was that primary care physicians should consult with psychiatrists on the behalf of the patient which would also reduce the stigma associated with being referred to mental health services. However, most insurance coverage failed to cover psychiatric visits and even when covered many patients sought medical care to avoid stigma. The next section will address how this problem arose in the 1950s and continues to be a pervasive issue for stigma today.

In conclusion, the APA sought to lessen the stigma of commitment by advocating for voluntary commitment without a court record on the basis of civil rights. Patient

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[55] For examples see Rickles et al. 1950; Koren et al. 1951; Schoenberg et al. 1978; APA 1990; APA 1993.
[56] For examples see Edwards et al. 1977; Harman et al. 1981; Nadelson 1993.

groups began to form around particular diagnoses in order to combat stigma through changing laws that undermined the rights of citizens with mental disorders. This manifested in the AJP in discussions about the rights to be treated quickly and voluntarily as a strategy to lessen stigma associated with diagnosis and treatment. Each other strategy developed by psychiatrists to mitigate stigma in this period, such as changing intake procedures, re-locating the mentally ill population, advocating for effective out-patient treatment, and voluntary admission, involved getting the patient into psychiatric care as quickly and efficiently as possible.

These strategies did not significantly differ from those of the previous period, only that claims about public education as a strategy to reduce stigma were completely absent. This was more than likely due to the crisis in American psychiatry brought about by the anti-psychiatry movement and the paradigm shift towards a biological understanding of brain disorders. It is during this time that no dominating codified view of psychiatric practice could take hold and be exalted as the path towards scientific progress. In fact, on the subject of the lack of public education campaigns to reduce stigma and to increase the chances of employment for former patients, Mollica (1976) surmised that "we recognize that no legal or administrative provisions for these actions exist in many states and that even if they do exist they are not enforced or are circumvented" (p.130). The call for public education campaigns to reduce stigma would reemerge in greater force in the late 1980s and continue throughout the 1990s and 2000s. These campaigns will be addressed at length in the next chapter.

At the same time as old strategies for the reduction of stigma were being reconceptualized in the 1960s-1970s, the Symbolic Interactionists, Goffman and Scheff,

sought to redefine mental illness through the concept of stigma. These academics explained stigma as the basis of psychiatric practice (Scheff 1984:30-31) and that stigma could be used in the practice of social control (Goffman 1963:139). Goffman suggested that stigma could be mitigated through a series of techniques for changing the perception of the public through the formation of representative groups that promoted the rights of the stigmatized people; namely that the wise should come to represent the own. On the individual level, the stigmatized person could practice techniques of passing and disclosure in social situations to avoid feeling stigmatized. These two insights of stigma as an issue of representation in the population and an issue of disclosure for individuals would come to play a major role in the development of stigma in the coming decade with the ex-patient's movement fragmenting and NAMI proclaiming itself to be the 'nation's voice on mental illness'.

Out-patient treatment was thought to lessen stigma on two fronts. First, instituting CMHC programs mitigated the effects of the stigma of hospitalization, but did not significantly address the stigma associated with actually being in treatment. Second, it provided the patient with treatment choices through medical and nonmedical models, each heralded as less stigmatizing than the last. As well, this opened up the possibility for a restructuring of euphemistic stigma by the patients. The consumers of mental health services sought to diminish euphemistic stigma by referring to themselves as former patients, ex-patients, clients, consumers, and/or psychiatric survivors.

These changes complicated the practice of psychiatry as patients found it difficult navigate the CMHC programs and often sought help through primary care physicians, who did not want to stigmatize patients by referring them to mental health services. The

stigma of the profession, stigma of insanity, and the stigma of not just commitment but all psychiatric treatment persisted. This led psychiatrists to advocate for more stringent confidentiality protocols in order to reassure patients that their rights would not be affected if they sought treatment for mental illness. Bound up with the process of disclosure was employment discrimination based on insurance claims for psychiatric services, which was to become a hotly contested issue.

The Operationalization of Stigma: Measuring Interests

No claims about stigma in the AJP were more consistent than those having to do with health insurance coverage. The following section addresses the statements made about stigma in relation to health insurance. Psychiatrists' initial attempts to quantify stigma in relation to health insurance revealed a particularly salient point about stigma and the public's perception of psychiatry. As Foucault (2007) argued, the calculation and qualification of variables that may seem far removed from a population can actually affect the targeted population in multifarious ways (Pp.71-72). Thus, after Goffman and the Symbolic Interactions identified and defined stigma as a central concept impinging upon the mentally ill population and those that govern it, stigma had to be investigated in order to assess and modify its effects. However, when these quantitative studies of stigma failed to show any significant effect on the public's utilization of psychiatric services or on doctors' choices of subfield specialties, psychiatrists had to adjust their conceptualization of stigma.

Since the development of group health insurance, psychiatrists have been fighting inadequate coverage for mental illness on the basis of stigma through to the present.[57] Employers started offering employee benefits in the form of health insurance as it reduced the cost of care and expedited payments to doctors and hospitals in the 1940s and 1950s. Strong labor unions often bargained for better working conditions and increased insurance coverage, which resulted in more services offered to employees. However, in the American context, having health insurance through employment is exceptionally problematic as those who are even moderately mentally ill may not be able to be employed for any length of time.

In 1965, Medicaid and Medicare were developed to address the issues of aging and disability as a federal responsibility to insure poverty-stricken patients who were not working or were simply too old to work (Hoffman 2001:183-184). The profitability of health insurance for physicians, group providers, and employers ensured that national plans designed for the compulsory care of the population would not come to fruition in American after WWII as regulations on cost containment and fee disbursement were often met with rigorous disapprobation by labor union lobbying groups and the AMA alike (Hoffman 2001:182-187). As well, population wide socialized medicine was seen as part and parcel of the perceived communist threat to American democracy during the era of McCarthyism.

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[57] For examples see Wilson and Suter 1948; Stevens 1949; Rickles et al. 1950; Davidson 1955; Bennett 1959; Hoch 1965; Pfeiler 1966; Hall 1966; Auster 1969; Langsley 1973; Hall 1974; Glasser et al. 1975; Brown 1976; Brown 1977; Lamb and Rogawski 1978; Sharfstein et al. 1980; Towery et al 1980; APA 1981; Sharfstein and Biegel 1984; Nadelson 1986; Tischler 1990; Hartman 1991; Benedek 1991; Sederer 1992; Sharfstein et al. 1993; APA 1993; Leo et al. 1995; England 1996; Leslie and Rosenheck 1999; Druss et al. 2000; Perkins 2000; Druss et al. 2001; Desai et al. 2002; Yudofsky and Hales 2002; Erikson and Wilcox 2006; Libby et al. 2007.

American psychiatry was put in a precarious position by the development of employer based health insurance, which occurred at the same time that the turn towards psychiatric care in general hospitals became more common place. As state hospitals were funded by state governments, the debates about health insurance coalesced around stigma and discrimination in the late 1940s as psychiatric treatment in general hospitals was rarely covered by insurance plans (Rickles et al. 1950). On the rationale that stigma was resulting in poor insurance coverage, psychiatrists explored several angles for the reduction of stigma in order to increase insurance coverage, thus removing the economic barrier to treatment. The strategies included appealing to the right to privacy and decreased discrimination due to disclosure through advocating for confidentiality laws, claiming that mental illnesses were just as debilitating as physical illnesses and should not be stigmatized, as well as charging the entire health insurance industry with unfairly stigmatizing the psychiatric profession and the mentally ill.

Psychiatrists had become concerned with confidentiality for two reasons. First, employers had access to employees' insurance claims information, which was thought to lead to discrimination.[58] Second, the stigma of disclosure also was thought to inhibit patients from revealing all pertinent information to the psychiatrist, thus affecting the course and outcome of treatment.[59] To remedy these issues of disclosure, some psychiatrists advocated for stringent confidentiality laws so that psychiatrists would be legally bound to keep patients information private.[60]

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[58] For examples see Menninger and English 1965; Langsley 1973; Noll 1976; Sharfstein et al. 1980; Roback et al. 1996.

[59] For examples see Goldstein and Katz 1962; Grossman 1971; Tischler 1990; Houston et al. 2002.

[60] For examples see Goldstein and Katz 1962; Menninger and English 1965; Grossman 1971; Zarin et al. 1998; Hyman 2000; Goldman 2001.

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Extending this argument, Grossman (1971) asserted that insurance companies should have limited access to a patient's case files as confidentiality and the stigma attached to disclosure of psychiatric illness affected treatment outcomes. As Grossman (1971) recognized, one major problem complicating this claim was that the diagnostic and statistical information provided to the APA by the insurance companies had been an invaluable resource in developing the DSM. However, Grossman (1971) pointed out that the nosological system used by the APA, specifically the DSM-II, was heavily criticized by insurance companies because it focused on inorganic disorders treated by psychodynamic and psychoanalytic approaches. Others were concerned that certain diagnoses, such as schizophrenia and alcoholism, were being underreported to insurance companies due to stigma and this resulted in inaccurate statistics on the prevalences of these disorders.[61] Demonstrating the need for psychiatric treatment based on the prevalence of disorders and the pervasiveness of stigma would need to be addressed.

Grossman suggested that this dissatisfaction with the DSM-II had much to do with the cultural value judgments placed on psychiatric illnesses by the public and insurance companies alike, which resulted in continued insufficient insurance coverage (Grossman 1971:68). The combination of the development of private insurance coupled with the Food and Drug Act amendments of 1962 led to pressure to redefine psychiatric illnesses and the methods of treatment more so than negative cultural value judgments (Healy 2002; Wilson 1993). As Hall (1974) demonstrated, insurance companies that covered mental health services imposed stringent limits to the coverage. These limits include only covering the first few visits to psychotherapy or short stays in institutions. Also at this time there was a large system of publicly funded hospitals and CMHCs for

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[61] For examples see Sharfstein et al. 1980; Towery et al 1980; Tischler 1990; Sharfstein et al. 1993.

psychiatric care that could be utilized by those in need with or without insurance coverage. It was only private psychiatric practices that were largely affected by the issue of insurance coverage. The arguments based on stigma overwhelmingly neglected to mention this detail.

The trends towards greater specificity in disease symptomology and treatment regimes have continued due to mounting pressure by insurance companies and proponents of managed care. This has significantly limited the kinds of treatment psychiatrists can offer to patients. The formulation of stigma as a limit to the free practice of psychiatry as a scientific medical specialty reappeared in arguments for increased insurance coverage on the rationale that stigma was impinging upon utilization of psychiatric services. Goldman and Taub (1988) emphasized that insurance providers limited the number of out-patient visits a patient could utilize due to several factors such as "discretionary, interminable treatments of questionable value, great cost, and considerable stigma" (p.25). As well, the divide between the mind/body by insurance carriers continued the stigmatization of psychiatric treatment.

The concept of mind/body dualism, where the mind and the body are seen as separate entities, emerged from the seventeenth century writings of Rene Descartes. The mind, in particular, is seen as a nonphysical phenomenon. Williams and Bendelow (1992) claim that mind/body dualism is the basis of modern medicine. They write, "The body came to be seen as the subject of the natural sciences, including medicine, whilst the mind or *geist* was the topic of the humanities or cultural sciences" (Williams and Bendelow 1992:26). These researchers claim that the mind is seen as a disembodied phenomenon, which has resulted in the divide between medicine and psychiatry.

As psychiatrists argued the case for health insurance coverage on the grounds of reducing stigma, appeals to biological illness as similar to mental illness became so common that by the time of the publication of the DSM-III in 1980, mental disorders had become overwhelmingly theorized as biological illnesses. In early claims about the issue of mind/body dualism, Davidson (1955) wrote, "We in psychiatry have put vast effort into the campaign to convince the public that a psychiatric diagnosis is not a stigma, that it does not essentially differ from a medical or surgical diagnosis" (p.932). Davidson concluded that the stigmatization of mental disorders by insurance companies and their failure to reimburse patients for psychiatric treatment relies on the distinction between medicine/psychiatry and mind/body (Davidson 1955:931-932).

In order to combat this divide, the APA supported federal insurance plans for the poor and elderly. As Pfeiler (1966) explained, Medicare, federal health insurance for the aged, and Medicaid, federal health insurance for the poor, included mental health coverage for those who qualify for the program due to lobbing from the APA, NIMH and NAMH. Pfeiler (1966) states, "The new legislation will help overcome two of the obstacles-the financial barrier and the medical stigma-which have prevented the aged and other handicapped and medically needy people from obtaining good psychiatric care" (Pfeiler 1966:196). Pfeiler stipulates that the incorporation of mental disorders in the federal insurance legislation legitimates psychiatry's claim as a medical specialty. As mental illnesses became increasingly aligned with physical illness, so did psychiatry with science and medicine.

However, Auster (1969) explained that the stigma of the word mental affected how mental illnesses were talked about by insurance carriers. Carriers often used other

terms such as "troubles or emotional disturbances" to speak about benefit packages and this was a result of not wanting to label mental illnesses as "real illnesses" due to diagnostic issues with the DSM-II and the unreliability of chronicity and cost of care (Auster 1969:700-701). Euphemistic stigma, from outside of the APA, was continuing to create problems for legitimating psychiatry as a medical practice.

In order to delve more thoroughly into the concept of stigma, measurements were developed in the early 1970s to assess the impact of stigma on health insurance and patients' outcomes at CMHC programs. Crocetti et al. (1971) sought to investigate if the community's views on mental health and stigma were important measures of the success of CMHC programs. Crocetti et al. (1971) measured the attitudinal social distance of the United Auto Workers Union on former mental patients and the effectiveness of psychiatric treatment. The union members were covered for mental health claims through Blue Cross and Blue Shield Insurance. As variables, these researchers measured the stigma associated with chronicity and curability as pessimistic attitudes towards the ability for a mental patient to be cured.

Crocetti et al. (1971) found that within blue collar workers, many (89%) reported that they believe mental illness could be "cured with the proper treatment" (p.1125). Crocetti et al. (1971) concluded that there was no evidence that blue collar workers rejected ex-patients or held a pessimistic view of mental illness. These researchers suggested that mental health professionals should not assume that such a stigma exists as these assumptions may lead to "errors in planning, distorted communications with public leaders; they might even boomerang into a self-fulfilling prophecy" (Crocetti et al. 1971:1126). Runge (1900) had made a similar statement about stigma being an assumed

rather than detrimental entity. Also on the topic of the existence of stigma, Gayle (1951)

challenged the obviousness of stigma in relation to placing psychiatric wards in general

hospitals. Gayle (1951) surmised that stigma may not actually exist, but since stigma is

talked about by doctors and nurses as a real problem, there was no effort to overcome the

belief in stigma.

Despite Crocetti et al.'s (1971) failure to establish stigma as a quantifiable

phenomenon, other researchers carried on and developed measures for stigma that

addressed stigma as an "obstacle to treatment",[62] as evidence of competency to

voluntarily commit oneself,[63] as an issue for medical students when choosing psychiatry

as a specialty,[64] as a contributing factor to mental illness,[65] and as modifiable through

clinical interventions.[66] However, each ensuing study did not question the existence of

stigma, but instead tailored its description in order to highlight its effect as a limit to

psychiatric practice. For example, Glasser et al. (1975) investigated "obstacles to

treatment" and identified stigma as a primary area of concern. They used stigma as an

indicator for assessing the attitudes toward mental health among workers in the United

Autoworkers International Union, referral agents (doctors, nurses, and other health

practitioners), and insurance providers. Stigma was measured along four dimensions: the

stigma attached to receiving treatment, the belief in effective treatment, acceptable

proximity to ex-mental patients, and general negative attitudes towards mental illness.

They found that the referral group was most concerned with the effects of stigma

and were less likely to refer a worker to mental health services if it could be avoided.

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[62] For an example see Glasser et al. 1975: 715.
[63] For an example see Appelbaum et al. 1981.
[64] For an example see Lee et al. 1995.
[65] For an example see Wilkinson-Ryan and Westen 2000.
[66] For an example see Sirey et al. 2001.

Amongst the union members, stigma was shown to have an insignificant effect on all indicators of stigma. The researchers contended that removing "attitudinal obstacles" would allow for greater access to mental health services, especially after the monetary barrier was also removed (Glasser et al. 1975:715). Again, it seemed that stigma was an assumed entity by doctors and nurses, but that it did not significantly affect the public's opinion of psychiatry. A different method for demonstrating the effect of stigma on psychiatry would have to be developed.

In the meantime, another avenue for changing the negative stigma accorded to psychiatry was emerging through public relations. As popular media became more accessible to the general public, the portrayal of psychiatric patients and the profession became a concern for American psychiatrists.[67] In 1981, the APA developed a division of public affairs to promote positive images of psychiatry in the media. The APA (1981) claimed, "The image of psychiatry and the stigma that still clings to mental illness are intricately tied to the proliferation of providers and therapies and to the lack of adequate third party reimbursement" (p.1661). It was thought that by representing psychiatry as a unified medical specialty that the stigma which affected paltry insurance coverage could be overcome. However, it was only through a change in public opinion and increased demand for psychiatric services that these changes could be implemented. Therefore, the strategy of public education was set to reappear as a much more focused and concerted effort to demonstrate the need for psychiatry through combating stigma.

The radical transformation of the DSM between 1968 and 1980 came about through debates about the practicality of insuring mental patients, the critical discourse of the anti-psychiatry movement, and ex-patients' groups advocating for civil rights among

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[67] For examples see Yamamoto and Goin 1965; Dansak 1976; Clark et al. 1970.

other intricate issues involving psychiatry's uncertain position as a medical science. Mental illnesses were relegated to a marginal position by the health insurance companies because of doubts as to the reality of the illness and the effectiveness of the treatment. The refusal to speak about mental illnesses as a medical issue by insurance companies illustrated a rejection of the medical model as it had been formulated in the DSM-II. This was to be resolved, in part, through the revision and publication of the DSM-III (Wilson 1993). As issues equating mental illness and physical sickness became intertwined with debates about insurance and stigma, the claims about diminishing stigma through reference to the biological etiology of mental illness came about after the publication of the DSM-III.[68] Through this, approaches to treating mental illness that could not demonstrate evidence based efficacy, such as psychotherapy, were marginalized even further than before in this process.

As an illustration of later conceptualizations of the nexus of mental illness as physical illness and insurance stigma in the AJP, Padres et al. (1989) discussed the norms of counseling patients on genetic information. These authors suggested, "A point worth emphasizing is that recognition of a genetic factor can, in some instances, free patients and their families from self-blame and some aspects of stigma" (Padres et al. 1989:441). However, they contended that other aspects of stigma such as problems of insurance, family guilt, and chronicity may be magnified. They emphasized that lessons can be learned from how AIDS patients receive their diagnoses as AIDS is stigmatizing and lacks effective treatment methods. They postulate for the future, that if predictive tests for mental illness are effective then a number of new serious problems may arise such as employment discrimination, reduced health benefits, and increased stigma. However,

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[68] For examples see Nadelson 1986; Padres et al. 1989; Benedek 1991; Sederer 1992; APA 1993.

they hypothesize that the stigma of mental illness might also be mitigated by mental illness finally being elevated to the status of a physical illness and thus covered wholly by health insurance (Padres et al. 1989:442). Even though the DSM-III had gained ground in advocating for the usefulness of medical model as applied to psychiatry, stigma still was seen as a limit to the absolute acceptance of mental disorders as biological illnesses.

In summary, debates about the stigmatization of psychiatry through health insurance have endured since the inception of employment-based health insurance in the 1940s. Within the statements about stigmatization by insurance carriers are also claims about the issues of confidentiality and disclosure as well as an assertion that mental illnesses are not different from physical illness, and therefore should not be stigmatized as a fault of the patient. Demonstrating the quantifiable effects of stigma on psychiatric practice proved to be difficult as stigma was shown to be a negligible factor in the public's perception of psychiatry. More often than not, it was medical professionals and paraprofessionals' insistence on avoiding stigma which then made stigma a limit to patients entering into psychiatric treatment.

Overwhelmingly, more strategies developed to diminish stigma targeted opening access to psychiatric care and removing the stigma associated with the profession and treatment. It was through euphemistic stigma that insurance companies illustrated their disbelief in the reality of psychiatric illnesses as physical illness. Psychiatrists attempted to dispel these issues on two fronts simultaneously. First, the APA sought to promote positive images of psychiatry in the media to attend to the concern about stigma which was thought to greatly affect access to treatment through inadequate insurance policies.

Second, the revisions of the DSM-III failed to remove the stigma of psychiatric illness,

the stigma of psychiatric treatment, or the stigma of the profession as talk about the

pervasiveness of stigma continued to persist in the AJP.

Conclusion

Contained within strategies to deal with stigma was the notion that stigma

represented a limit to the public acceptance and free exercise of psychiatric practice.

Psychiatrists were hampered by commitment laws and sought to change them on the

basis that the court record produced a family stigma. When commitment laws failed to

be changed, psychiatrists advocated for the use of psychiatric wards in general hospitals

to lessen family stigma, which coincidentally also circumvented some these laws. This

strategy of moving patients into general hospitals close to the community also attended to

the stigma of the psychiatric profession. It was believed that the discipline of psychiatry

was viewed as unscientific due to the remote locations of asylums, which segregated

psychiatrists from medical hospitals and research centers. It was also debated whether or

not changing the names of asylums to hospitals and other nominal changes may affect the

stigma associated with commitment or seeing a psychiatrist. In the end, these changes

proved to be minimally effective.

During the early twentieth century, stigma became associated with mental disease

itself through psychiatrists who wanted to understand how their practice could be

publicly denigrated despite what they exalted as highly-specialized scientific and medical

practices. A focus on the prevention of psychiatric disease sought to strengthen public

awareness of psychiatric practices in order to increase the chance of cure through early

detection. Public education through the cooperation of former patients groups was considered to be a practical way to reduce stigma associated with psychiatric practice and increased public acceptance of former patients. During WWII, decreasing stigma associated with psychiatric treatment in the military was seen as cost effective and emphasized harm reduction, however, the effects on the individual patient were more difficult to ascertain. As the psychiatric paradigm shifted from eugenics and towards psychoanalytic and psychodynamic approaches after WWII, decreasing stigma became a way to emphasize the progress made through psychotherapy particularly for such disorders that were seen as moral failings and character flaws.

The ideological foundation of the usefulness of the concept of stigma was built upon limits imposed by legal interventions and the psychiatrist's interpretations of the public's supposed misunderstanding of the benefits of psychiatry. The 1960s brought about radical changes in social and political thought. Stigma was recast as a problem of discrimination against a patient's civil rights. Patient groups formed around diagnoses and the common ties of being formerly committed to address legal issues. Psychiatrists argued that the recession of commitment laws and increased attention to the right to effective and voluntary treatment would lessen the stigma associated with psychiatric treatment. This move would also allow patient's who entered the hospital voluntarily to retain their civil rights; however this claim was complicated by the fact that the right to a court hearing to determine sanity was also predicated on a similar rationale. Therefore stigma contained a latent value, largely underrepresented by psychiatrists. Stigma was also a productive force which motivated some to question the validity of psychiatry.

However, this questioning came not just from lawyers and judges who were historically intertwined with the discourse of psychiatry, but also by academics in the 1960s.

This latent value in stigma is what Goffman (1963; 1967) and Scheff (1984) used to underpin the claim that stigma forms the basis of psychiatric practice. Scheff (1984) argued that the stigmatization of certain behaviors as deviant led to the labeling of mental illness and social segregation in mental hospitals. Goffman (1967) suggested the stigmatization of social improprieties result in psychiatric diagnoses, but that improper behaviors are largely context dependant and not an entirely an indicator of illness.

Talk about mitigating stigma through public education was absent in the period of the 1960s-1970s. The anti-psychiatry movement had delegitimized the profession of psychiatry as a scientific medical specialty and further divided medicine from psychiatry. As well, the re-siting of the mentally ill population in satellite CHMC programs across communities changed the practice of psychiatry. Far less stigma was averred to attach to out-patient treatment; however confusion over how to utilize these services as well as the rise in employment bases health insurance resulted in many patients seeking out less stigmatizing biological diagnoses from primary care physicians.

Psychiatrists advocated for increased insurance coverage for mental health claims as the gap between medicine and psychiatry was ever widening on this front. Medical care was routinely covered by insurance carriers, but psychiatry was seen as a bottomless pit of costs which could result in interminable care. Psychiatrists looked to open access to care by lessening the chances of discrimination. They demanded stricter confidentiality laws between insurance carriers and employers and emphasized the right to privacy. In these proposals, they asserted that mental illness was no more the fault of

the patient than physical illness and should not be stigmatized. Psychiatrists also attempted to quantify stigma in order to assess its prevalence, but this proved to be quite difficult. The quantification of stigma suggested more bluntly that physicians and paraprofessionals in the medical establishment were applying a stigma to psychiatric treatment and avoiding referring patients to psychiatrists, more so than the public. Therefore, the denigration of psychiatry by medical personnel would need to be addressed much more ardently.

With the publishing of the DSM-III in 1980, mental illnesses were proclaimed to be brain disorders (Mayes and Horwitz 2005). This signaled a move by American psychiatrists to confront the stigma of the profession as unscientific and nonmedical. It also attended to many other concerns raised throughout the history of psychiatry under the rubric of stigma. This classification system would be more productive in terms of demonstrating the effectiveness of treatments for insurance companies; the symptomology would indicate clearer diagnostic criteria to allow for the prescription of pharmaceuticals; as well it would close debates raised by the anti-psychiatry movement about the etiology and medicalization of psychiatric diagnoses and treatment. Furthermore, it would bring psychiatrists closer to the medical profession, provide opportunities for future research, and result in better care for the patients. For all of these reasons, psychiatry was poised to break free of the stigma that had endured since, at least, the middle of the nineteenth century. However as we shall see next, this would not turn out to be the case.

Chapter Seven

History of the Present

The stigma attached to psychiatry is the most critical problem facing the profession. All other problems can be traced to this singular problem.
- Paul J. Fink, President of the American Psychiatric Association 1988-1989[69]

In this chapter, I identify the current use of stigma in American psychiatry as a rationale for practice by summarizing the national and international campaigns for combating stigma. These campaigns reveal more about the medicalization of stigma and direction of public perceptions than about promoting egalitarian views of the consumer of mental health services. Concomitant with these campaigns, the medicalization of stigma alongside disease categories has become more and more prevalent as the APA implements stricter diagnostic categories. The effects of the medicalization of stigma are manifold, as stigma becomes described as a limit to psychiatric research as well as a symptom to be treated not just in the patient, but also in the public. In doing so, the public is presented with a codified view of institutional psychiatry as a well-defined medical specialty that treats biological diseases.

I begin this chapter by outlining the development of the APA's war on stigma to illustrate how stigma became spoken about as the most critical problem facing American psychiatrists. The APA's campaign to "overcome stigma" utilized the strategy of public education to attend to the stigma of treatment and the stigma of psychiatry. Its effect on euphemistic stigma and the stigma of mental illness is more difficult to discern. From here, I describe the historical details of how stigma has come to be talked about alongside

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[69] Fink 1986:818.

disease categories and its implication for campaigns to end stigma. Then, I conclude this

chapter by positing some ideas about how these campaigns, especially a recent internet

based campaign headed by the Substance Abuse and Mental Health Services, obscure the

larger social problems facing consumers/ex-patients/survivors, while simultaneously

directing the public's attention towards the stigma of psychiatry.

The War on Stigma

In this section, I describe the historical conditions that led to the APA beginning

the battle on stigma. I illustrate the content of the APA's campaign as well as how it

utilized the strategy of public education to address stigma as a problem of public

misunderstanding and disbelief in the efficacy of treatment. As will be seen, the war on

stigma emerges not due to an altruistic understanding of the plight of patients, but

because the psychiatric profession was in crisis during the 1980s as enrollment in

university programs and research funding declined.

In 1989, the APA declared "war on stigma" through the leadership of Dr. Paul

Fink, then president of the APA (Sabshin 1989:1379). Previous to Fink's reign as

president of the APA, he was concerned with the stigma of mental illness as a problem

greatly affecting enrollment in the psychiatric profession (Fink 1983). Fink (1986)

contended that stigma, through deriding the scientificity of psychiatry, had become so

prevalent that efforts must be made to diminish stigma amongst psychiatrists, physicians,

and the public. As a call to arms, Fink (1986) stated, "The stigma attached to psychiatry

is the most critical problem facing the profession. All other problems can be traced to

this singular problem" (p.818). He asserted that stigma reduced the effectiveness of the

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discipline as a whole, due in large part to psychiatrists feuding with one another and with physicians over the etiology of disorders and the efficacy of treatments within the practice and the media (Fink 1986:814). Fink (1986) wrote, "Competition for patients and payment leads the mental health professions to disparage each other" particularly in the media, which ultimately "weakens the psychiatric profession" (p.814). The solution Fink (1986) proposed was to call an end to critical discourse and interdisciplinary war by unifying the profession through codifying policies and practices as well as participating in organized medicine to increase the legitimacy of psychiatry as a medical specialty. In doing so, the stigma that surrounds psychiatry as a profession would fade, while also allowing psychiatrists to prepare the field for future psychiatrists.

Also leading up to his presidential decree on the battle against stigma, Fink (1987) published an editorial on Mental Illness Awareness Week. Fink (1987) made stigma the prime focus for the week's activities. Fink (1987) stated about the need to address stigma, "Why do mental illnesses and those who suffer from them fare so poorly in our society? It should be no surprise to psychiatrists that the cause, in large measure, is stigma" (p.1298). During Mental Illness Awareness Week, the APA and Federal Government aired public service announcements and public lectures on the radio. As well, newspapers and magazines featured articles on mental illness and stigma. Fink (1987) urged that "combating the stigma and prejudice against mental illness and psychiatric treatment that exist within the rest of medicine and other healing professions is a major challenge for us" (p.1299). Therefore, physicians should be educated on the benefits of psychiatric care in overall healthcare as a major component in the fight against stigma. What this claim also reveals is that the stigma against psychiatric diagnosis and

the belief in the effectiveness of treatment was reemerging as a point of contention between psychiatrists, patients, medical doctors and the public, similar to the way it was cast in debates about health insurance.

Initially, Fink (1987) discouraged patients from taking part in the war against stigma, stating that "Psychiatrists must take the lead in this effort, for we are in a unique position to do so. Generally, our patients cannot or will not be advocates for themselves" (p.1299). Fink (1987) goes on to say about the role of psychiatrists: "We know the illnesses they suffer and we know the pain. We know how to evaluate and treat those illnesses and we know that treatments work. We have a responsibility to speak out to our friends, our medical colleagues, our local community decision makers, and our legislators at all levels" (Pp.1299-1300). Whereas the psychiatric paradigm had shifted away from psychoanalysis and towards a biological approach, stigma still remained a looming problem for psychiatry becoming accepted and legitimated as a medical specialty. The way forward was to change the hearts and minds of physicians, law makers, and the general public in order to de-stigmatize psychiatry. This would not come from the de-stigmatization of mental illness by the ex-patients' movement, but would take on the character of empowerment through representation by psychiatrists and the like-minded NAMI and through, most importantly, the medicalization of stigma.

Fink's call for a positive representation of psychiatric practice in medicine was especially timely. The 1980s was a tumultuous decade for American psychiatrists. Edelman (1985) contends that during the 1980s psychiatry was dealing with problems in many domains. This stemmed from lack of funding opportunities, declining enrollment in university programs, a general frustration with the lack of scientific rigor, negative

public opinion, and unrealistic expectations of the discipline. This was compounded by social and economic conditions that could have led to psychiatry's disappearance as enrollment in university programs and job opportunities dwindled. Porter (2004) notes that "psychiatrists often complain their own specialty is itself, by association, tainted with the stigma of mental illness" (p.4). These problems facing psychiatry in the 1980s are what opened the field of stigma to a possibility of 'overcoming'. As stigma involves numerous points of contact, relays, and formulations of truth about not only the consumers, but also psychiatrists, the strategic deployment of campaigns to end stigma resulted in a political agenda to gain research funding from the NIMH and to present the profession of psychiatry as scientific.

This campaign to "Overcome Stigma" in 1989 brought together APA and NAMI to gather support for new policies and NIMH grants. A book, *Stigma and Mental Illness*, was published in 1992 which included many papers presented at the APA's 1989 annual conference (Fink and Tasman 1992). Fink and Tasman (1992) defined stigmatization and its scope as "the marginalization and ostracism of individuals because they are mentally ill. This ostracism often also extends to families of mentally ill individuals and to the professionals who treat mental illness" (p.xi). They continue, "Stigma associated with mental illness can cause those afflicted to delay seeking treatment or to conceal the illness in an attempt to escape the shame and isolation of being labeled disturbed or other" (Fink and Tasman 1992:xi). Fink and Tasman (1992) go on to explain the conundrum of inadequate insurance coverage for mental health expenses, which is due to stigmatization by insurance carriers. As well, they assert that those with adequate health insurance avoid seeking help for fear of stigmatization.

Stigma and all that it entailed was heralded as the most important problem facing

psychiatry, mental health professionals, and patients. It was suggested that only through

a concerted effort to raise awareness about stigma could proper treatment take place.

Fink (1988) urged psychiatrists to join the fight against stigma, "I maintain that

psychiatric stigma is best handled not by battering our heads against stone walls, not by

insisting that people stop hating us, fearing us, deriding us, undercutting us, and

competing with us, but rather by establishing that we are at the forefront of the modern

medical paradigm" (p.1067). As well, Fink and Tasman (1992) wrote, "Ultimately, the

destigmatization of mental illness will be accomplished when people understand what

psychiatric disorders are and believe they are treatable" (p.xii). It is through this

campaign that stigma is defined, not as an issue of the relationship between an attribute

and reaction, but as a problem of understanding and social beliefs. This claim

reverberated in subsequent presidential addresses in very similar ways.[70] In order to

illustrate how this campaign affected the discourse on stigma, I turn next to describing

the medicalization of stigma through its origins and transformations after the APA's

declaration of war.

The Medicalization of Stigma

As the volume of literature dedicated to explaining and mitigating stigma began to

accumulate in other disciplines such as sociology and social psychology in the 1980s and

through today, psychiatry's understanding of stigma revolved around a specific set of

goals and limits. The goal of psychiatry was to eliminate stigma in order to better care

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[70] For examples see Benedek 1990; Hartmann 1992; Sharfstein 1994; Weiner 1994; England 1995; Goin Appelbaum, 2003; 2004; Riba 2005.

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for patients as well as to remove stigma as a limit to the enterprise of scientific research. This was to be accomplished through the medicalization of stigma alongside disease categories. According to Pilgrim and Rogers (2005), it is the alignment of stigma with specific diagnoses and/or treatment regimes that, in turn, attempts to direct social perceptions of mental illness. In the psychiatric context, stigma becomes the object as well as the target of intervention in both the patient and the public through this transformation.

This section details the history of this medicalization through early claims about stigma and epilepsy, homosexuality, alcoholism/substance abuse, and schizophrenia. Within each of these claims about the stigma attached to these disorders, I also describe the strategies used to combat the different forms of stigma when aligning it with specific disorders. Then, I illustrate how appeals to stigma began to diversify after the publication of the DSM-III in 1980. From here, I summarize how appeals to stigma in the AJP extended to numerous disorders after the 1989 campaign, especially in descriptions of depression. This leads to the near disappearance of appeals to stigma by 1997 and a recurrence of claims about stigma in 1999, markedly more numerous and diverse than before.

As medical notions about mental illness became more specific, so too did debates about the stigma accorded to different diagnoses. It had been asserted as early as 1923 that patients preferred neurological over psychiatric diagnoses. Farrar (1923) contended that classifications were arbitrary between the mental and neurological, but that patients and relatives insisted on neurological distinctions due to stigma. However thirty years later, Davidson (1953) claimed that the stigma attached to psychiatry has spread to

neurology because of their alignment. Nearly fifty years after Farrar's supposition,

Lipowski (1972), for example, called for psychiatry and neurology to work together to

uncover the somatic causes of epilepsy as it carried a social stigma. As well, other

psychiatrists identified problems with diagnosing epilepsy specifically due to social

stigma and discrimination.[71] It seemed that a more forceful claim to the biological

etiology of psychiatric disorders through cooperation with neurology would free

psychiatrists and neurologists from stigma, and patients from the ensuing discrimination.

But nowhere did the issue of stigma as discrimination manifest more resolutely than in

the diagnosis of homosexuality.

The stigma of homosexuality emerged in the AJP in the 1950s as a matter of

discrimination through records of military discharge.[72] West et al. (1958) argued that the

stigma of homosexuality and dishonorable discharge made it difficult for homosexuals to

obtain housing and reintegrate into society after military service. Therefore, stigma

needed to be eliminated by granting general discharges to "true" homosexuals provided

they had not been disruptive during their service (West et al. 1958:399). It was through a

concerted effort to remove the term homosexuality from the DSM-II that the issue of

discrimination based on stigma was addressed in the general public. This was

accomplished using a similar logic as the military psychiatrists. It was by normalizing

homosexuality and agreeing that it posed no significant problem to a person's quality of

life, aside from the stigma attached to it, that it could be debated as a useful diagnostic

category.

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[71] For examples see Shanahan 1928; Cobb 1940; Selling 1943; Fetterman and Victoroff 1948; APA 1956; French 1957; Overholser 1959; Frank 1974; Gross 1979; Sachdev 1998.
[72] For examples see Bowman and Engle 1956; West et al. 1958; Hadden 1958.

Homosexuality was removed from the DSM-II in 1973, historically stigmatized, its removal from the DSM-II was, in part, de-stigmatizing. Porter (2004) contends that due to the DSM's contentious history, this endorsed normalization of homosexuality was not tantamount to a victory over stigma. Instead, linking mental illness to biology is actually a more effective de-stigmatizing strategy. Porter (2004) writes, "[T]o choose to be gay is to opt for evil, being born that way would logically remove the blame" (p.11). However, Phelan (2006) argues that when mental illness becomes biological, stigma manifests as doubt surrounding the effectiveness of treatment. Therefore stigma is a catch-22; as the most persuasive strategy for removing stigma, i.e. biologization of mental disorders, only manages to redirect stigma and not eradicate it.

It is through the debates about stigma and resistances to psychiatric classifications as well as issues about health insurance coverage that the usefulness of the medical model in psychiatry is called into question. The relationship between the medical model, homosexuality, and stigma is analyzed by Blaney (1975) to ascertain the effectiveness of equating physical illnesses with emotional disorders. Blaney (1975) suggested that the medical model absolves the patient for responsibility of their illness. In doing so, the stigma attached to the illness is mollified as the illness is understood as a biological entity that has the power to absolve the patient of social and legal responsibilities.

In relation to mental illness, Blaney (1975) noted that the usefulness of calling emotion disorders "illnesses" reduced the stigma and shame associated with these illness in the public, however the changes in attitudes were somewhat "cosmetic and unsubstantial" (Blaney 1975:913). Blaney (1975) asserts, "Moreover, to concur that the medical idiom has had salutary effects on public attitudes is not to deny that a very

effective public information program could be designed that would avoid the strategy of inducing the public to equate physical with mental disorders" (p.913). Blaney cites the campaign for the de-medicalisation and de-stigmatization of homosexuality, which is contemporaneous with the publication of his article, as an indicator that the medical model must be balanced with value-free terms for diagnosis and that certain behavior patterns are not sick, but are more of an ethical and moral issue. Thus, the de-stigmatizing strategy of appealing to a biological cause, which was initially deployed to fight stigma by health insurance carriers, was seen as effective. However, a different strategy had to be developed for disorders, (a term I use loosely here), that were social, ethical, moral, and in Spitzer's words, "political" (Spitzer as quoted in Drescher and Merlino 2007: 103).

Homosexuality and epilepsy were not the only diagnoses utilizing stigma in unique ways though, as alcoholism/substance abuse and schizophrenia, each made claims regarding the effectiveness of treatment and negative public perceptions of these diagnoses long before the APA campaign against stigma in 1989. For alcoholism and substance abuse, the issue of accountability and responsibility for one's addiction takes on a salient meaning as a moral failing.[73] The issue of fault versus no fault illness and the medical model are also bound up in this process. Fox (1967) illustrated this point: "Recognition that alcoholism is a disease and not a moral weakness will help remove the stigma which prevents so many persons from seeking help" (p.776). Fox suggested taking a prevention approach through public education to address the matters of seeking help and stigma. Psychiatrists argued that when an alcoholic is treated in a biomedical setting, some physicians were reluctant to label an alcoholic as such to avoid stigmatizing

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[73] For examples see Fox 1967; Straus 1968; Hart 1970; Fiman et al. 1973; Frank 1974; Edwards et al. 1977.

the patient.[74] Other psychiatrists also contended that treating alcoholism through biomedical personnel in general hospitals reduced stigma.[75] Moore (1977) even concluded that the stigma of being an alcoholic is sometimes avoided when one gets arrested and put in jail rather than taken to a detox center.

This issue of the stigmatization of substance abuse disappeared from the AJP in the 1980s.[76] However in 1996, the APA addressed this issue in a Position Statement on Substance Abuse Disorders. The APA (1996) wrote, "American society has been slow to accept substance-related disorders as treatable diseases. The alternative conceptualization of these disorders (as voluntary, self-inflicted, and immoral behaviors) has produced a powerful stigma to which society has responded in a punitive way, often using criminal justice in preference to public health interventions" (p.853). More recent appeals to stigma regarding substance abuse reiterated similar claims as to the ability of psychiatrists to treat substance abuse,[77] as well as debates about including stigmatizing terms such as addiction versus dependence in revisions to the DSM.[78] These claims about the stigma of alcoholism/substance abuse imply the stigma against treatment is still a major concern for psychiatrists and that euphemistic stigma must still be addressed.

Psychiatrists and neurologists debated the effects of euphemistic stigma through arguments about use of the words dependence and addiction in the forthcoming DSM-V. In a series of letters to the editor, neurologists and psychiatrists laid out their claims. Neurologists concluded that the word addiction is stigmatizing based on accounts from

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[74] For examples see Fiman et al. 1973; Straus 1968; Edwards et al. 1977; Harman et al. 1981.
[75] For examples see Smith et al. 1958; Fiman et al. 1973; APA 1991.
[76] For the only two references to stigma and alcoholism/substance abuse in the 1980s, see Sharfstein et al. 1980; Harman et al. 1981.
[77] For examples see Brower et al. 2001; Wu and Ringwalt 2004.
[78] For examples see O'Brien et al. 2006; Fainsinger et al. 2006; Erikson and Wilcox 2006.

"people in recovery" (Erikson and Wilcox 2006:2015). Neurologists stated,

"Stigmatization is one reason we have insufficient research dollars for the study of drug actions on the brain. We fear that continued use of the term "addiction" would forever prevent society from destigmatizing this chronic medical illness" (Erikson and Wilcox 2006:2015). Therefore, the de-stigmatization of addiction by supplanting it with the word dependence is a strategy to reduce euphemistic stigma and is also a way to increase funding for neurological research.

In contrast, psychiatrists who treat patients with opioid dependence stipulated that viewing the patient as an addict is necessary because it prevents psychiatrists from prescribing opioids to these patients. These psychiatrists wrote, "Whatever the terminology that is used for substance use disorders, the assumption that if a patient is not an addict they can be treated freely with opioids will not diminish suffering and will often increase it" (Streltzer et al. 2006:2016). Whichever term the publishers of the forthcoming DSM-V eventually decide to use can not appease all involved in the debate. Therefore, those that participate in the argument over these terms will often allude to stigma as a rationale for their preference.

Whereas the stigma of alcoholism/ substance abuse was fought on the basis of euphemistic stigma and appealing to the effectiveness of treatment, the stigma associated with epilepsy was mitigated in some respects by the division and specification of nervous disorders and psychiatric disorders. The stigma of homosexuality was attended to by de-medicalizing it within the practice of psychiatry and this to some extent normalized the concept of homosexuality in the public. The stigma attached to schizophrenia, however,

presented different challenges as both diagnosing and effectively treating this disorder is difficult and often has limited results.

Schizophrenia is heralded by the World Psychiatric Association (WPA) as the most stigmatized disease, which led this organization to develop a campaign attending to this problem (Sartorius and Schulze 2005). Much before the campaign by the WPA though, the stigma associated with schizophrenia formed around two problems in the AJP. The first issue was that the treatment of schizophrenia with antipsychotic drugs reduced the risk of institutional dependency through shorter hospital stays. This, in turn, was argued to diminish social stigma and result in economic savings to the patient and institutions (Donlon and Tupin 1974). However, Travin and Protter (1982) noted that schizophrenics were unwilling to take antipsychotic medication for fear it would stigmatize them as mental patients. The second problem of the stigma attached to schizophrenia was that psychiatrists feared that the stigma associated with schizophrenia led other psychiatrists to inaccurately record less stigmatizing illnesses on insurance claims due to possible discrimination from disclosure (Sharfstein et al. 1980). Towery et al. (1980) conducted a study to test Sharfstein et al.'s (1980) hypothesis, but found that stigma was not a factor in psychiatrists' disclosures to insurance companies because schizophrenia and other severe mental illnesses occurred in very few patients. The issue of stigma and schizophrenia remained rather stagnant in the AJP until after the 1989 war on stigma, but received the most attention by the WPA in 1996.

The WPA launched a campaign against stigma in 1996 called "Open the Doors". It focused specifically on schizophrenia in order to make "programme activities less complicated and the evaluation of success easier" (Sartorius and Schulze 2005:7). The

aim was to create a coordinated international project to "attract the attention of government and other authorities to the need to support care for people with schizophrenia and their families- arguably the most wretched group among those struck by mental illness" (Sartorius and Schulze 2005:7). Despite describing people with schizophrenia and their families as wretched, this campaign was implemented in twenty countries and claims to have developed approximately 200 anti-stigma interventions.

Taking as their primary targets physicians, health care professionals, the media, and secondary school students, this programme sought to educate these groups about mental illness. Also on the agenda of the WPA were businesses and employers, law enforcement and lawyers, government agencies, family members and friends, as well as other psychiatrists and mental health professionals. Specifically in the United States, the programme was put into action in Boulder, Colorado. The main targets in the US were employers, the media, police, and members of the criminal justice system. The strategy of public education about mental illness and treatment was implemented in order to lessen the stigma of schizophrenia within the community. Unfortunately, the WPA reported that even after the educational intervention, "employers remain one of the most stigmatizing groups and one of the most resistant to anti-stigma efforts" (Sartorius and Schulze 2005:82).

Due to lack of funds and resources, the local action committee in Boulder was unable to carry out many of their objectives or spread the initiative to other communities. However, the WPA did report some positive effects including that knowledge of schizophrenia among police officers in Boulder increased from 47% to 74% after the presentations by the local action committee; as well some judges reported a change in

their sentencing activities (Sartorius and Schulze 2005:86). It is not stipulated what these changes in practices were or how they were received by the public. It is also not clear how an increased knowledge of schizophrenia affected the stigmatization of patients.

The WPA's campaign was analogous to the APA's 'Overcoming Stigma' as increased knowledge of the etiology and symptomology of mental disorders along with a belief in the effectiveness of treatment were heralded as de-stigmatizing. The effectiveness of de-stigmatization through public education is nebulous as it does not attend to the problems patients face through discrimination. This strategy is more revealing of the de-stigmatization of psychiatry by removing obstacles between psychiatry and the law and representing the classification of mental disorders as scientific and stable. Here it is seen how stigma acts as a red herring, as it obscures the politics of classification which underlie the war on stigma.

In the 1990s throughout today appeals to stigma regarding schizophrenia have diversified quite markedly. The claims range from appeals to stigma as a factor exacerbating schizophrenia,[79] as to changing the name of schizophrenia due to the stigmatization by the media,[80] as a problem in the terminology as a nonorganic mental illness,[81] as a problem of public misunderstanding about schizophrenia,[82] as a factor in discrimination by employers,[83] as well as landlords,[84] and as a limit to psychiatric

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[79] For examples see Cohen et al. 1990; Beiser et al. 1993; Beiser et al. 1994; APA 1998; Sachdev 1998; Gitlin et al. 2001; Carpenter 2001; Auslander and Jeste 2004.
[80] For an example see Greenberg 1992.
[81] For an example see Spitzer et al. 1992.
[82] For an example see APA 1993.
[83] For an example see Bowie et al. 2006.
[84] For an example see Williams and Foulds 2007.

research.[85] Only recently has the stigma of dangerousness and criminality begun to appear within the AJP as associated with schizophrenia.[86]

The sheer volume of psychiatrists arguing about disease classification, terminology, and treatment options on the basis of stigma has ballooned far beyond the limited claims about epilepsy, alcoholism/substance abuse, and schizophrenia of the 1940s through early 1980s. Slowly, more psychiatrists were introducing the concept of stigma alongside diagnoses to explain problems associated with disclosure to psychiatrists, social psychological effects on disease and treatment, and help-seeking behavior throughout the 1980s. For example in relation to help-seeking, social-psychological effects disclosure, Goodstein and Page (1981) suggested that incidents of battered women's syndrome were underreported due to the social stigma of being abused, combined with isolation that a controlling husband might impose. In turn, Goodstein and Page (1981) asserted that these women are also less likely to see a psychiatrist because of further stigma associated with being treated for a mental illness.

As well, claims were made about stigma effecting treatment of hypochondriacs. Barsky and Klerman (1983) suggested that clinicians have stopped using the diagnosis because its meaning is unclear and they fear that the stigma associated with the diagnosis would preclude the patient from receiving needed medical attention if a serious problem does arise. Baiggo (1985) surmised that the stigma of incest can lead to further isolation of the victim, thus preventing treatment from taking place. Claims about the stigma of a legal record also started appeared in relation to specific diseases, such as Tourette's

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[85] For an example see Arnold et al. 1995.
[86] For examples see Larsen et al. 2001; Wallace et al. 2004.

syndrome,[87] and post-traumatic stress disorder.[88] Cultural differences in the diagnosis

and prevalence of eating disorders were explained on the basis of stigma, as the low rate

of bulimia in Blacks was argued to be the result of obesity not being considered a stigma

amongst black women.[89] As well, studies of AIDS patients concluded that the stigma

associated with having a communicable disease and being in a high risk group had

psychosocial effects and weakened social support systems.[90]

It can be seen that as American psychiatrists were streamlining the profession

through the DSM-III in the 1980s, stigma began to take on more and more meanings as

the years progressed. Still evident were claims about stigma and discrimination, but also

a scientification and medicalization of stigma as a factor in diagnosing a disorder and

being attended to in treatment began to manifest much more visibly. In 1989, the

utilization of stigma in the AJP reached an all time high coinciding with the APA's

yearly theme, "Overcoming Stigma". In the years that followed, stigma came to be

talked about as an issue arising in the diagnosis and treatment of premenstrual

syndrome,[91] post-traumatic stress disorder,[92] sexual abuse,[93] eating disorders,[94] obesity,[95]

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[87] For an example see Comings and Comings 1982.

[88] For an example see Sparr and Atkinson 1986.

[89] For an example see Lawlor and Rand 1985.

[90] For examples see Faulstich 1987; Mahorney and Cavenar 1988.

[91] Gitlin and Pasnau (1989) argued that naming PMS a syndrome in the DSM-III-R may have contributed to "adverse stigmatizing connotations" as a culturally biased attitude towards women (p.1420). Spitzer et al. (1989) addressed the debates about stigma and PMS. The authors discussed the renaming of PMS to late luteal phase dysphonic disorder. They suggest that debates about the inclusion of this disorder in the DSM-III-R revolved around questions about the stigmatization of women, especially in the workplace and ensuing employment discrimination. As well, due to the lack of effective treatments for PMS, some questioned if including the disorder with its possibility for stigma was even needed. However, these researchers concluded that there were several other diseases which had no treatment but were included in the manual. The authors write, "[T]he concern with the category's stigmatizing effect on women demonstrates a pervasive fear in our culture that the gains women have made toward equality in recent years can be easily undermined by recognition of women's special health needs" (Spitzer et al. 1989:896).

[92] There have been numerous propositions put forward about the relationship between stigma and PTSD. Yehuda and McFarlane (1995) suggested that the social and political perspectives on PTSD has assisted in the recognition of this disorder as affecting the rights of stigmatized victims to receive treatment. McCarroll et al. (1996) claimed that trauma victims with PTSD may be less likely to seek help due to

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anti-social personalities,[96] borderline personality disorder,[97] somatization disorder,[98]

ulcerative colitis,[99] chronic fatigue syndrome,[100] pedophilia,[101] mass hysteria,[102] sadistic

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perceived stigma of emotional distress. Stotland (2000) asserted that PTSD was less stigmatizing than borderline personality disorder in issues of marital and parental custody suits. Weiner (2000) proposed that that the development of the diagnosis of PTSD removed the stigma that servicemen felt for the disorder. Friedman (2006) stipulated that those with PTSD avoid seeking treatment due to stigma. With regard to PTSD being treated by physicians, Hoge et al. (2007) advised that "Early detection and treatment strategies in primary care settings may help to reduce stigma and barriers to care" (p.152).

[93] Jacobson (1989) found that of those who were sexually assaulted were more likely to report physical assault than sexual assault. Jacobson (1989) indicated that social stigma associated with sexual assault as well as denial might be contributing factors to this claim. Briere and Zaidi (1989) stated that the stigma of molestation and associated shame indicated to these researchers that over-reporting of abuse in their study was highly unlikely.

[94] Heatherton et al. (1995) concluded that the stigma of obesity may be one reason why college students within their sample were rarely overweight in their study on eating disorders. As well, they claim that because of the stigma associated with eating disorders, some may have been reluctant to disclose information. Bulik and Kendler (2000) reported that when interviewing respondents about eating disorders, some interviewees indicated a positive stigma through being part of an "eating disorder club" (p.1759). On the issue of treatment for eating disorders, Robb et al. (2002) claimed that by medicalizing nocturnal nasogastric refeeding for the treatment of anorexia and implanting the feeding tube upon admission provided "little or no context for bargaining, delay, or stigmatization" or perceived coercion (p.1348). Frost et al. (2003) stated, "Many health professionals hold stigmatizing attitudes toward eating disorders, based on the belief that they are self-inflicted" (p.363).

[95] On the issue of stigma and obesity, Fagoilini et al. (2003) wrote, "Obesity has psychosocial consequences, including discrimination and stigmatization in multiple areas of daily life, such as health care, education, and employment" (p.115). Kalarchian et al. (2006) sought to determine the comorbidity of obesity and psychiatric problems. They stated, "Psychiatric disorders may also be a consequence of severe obesity in a culture that stigmatizes obesity, or obesity and psychiatric disorder may have a shared diathesis" (Kalarchian et al. 2006:331). They also postulated that social stigma and discrimination may exacerbate anxious or avoidant behaviors in obese individuals. For example, they wrote, "With respect to sexual trauma in particular, obesity may serve an adaptive function for some by reducing sexual advances, or decreasing sexual impulse, in a societal milieu that stigmatizes obesity" (Kalarchian et al. 2006:332).

[96] Gerstley et al. (1989) deduced that the stigma associated with antisocial personality disorder as well as poor treatment prognosis warrants a reevaluation of the disorder in the DSM-III and DSM-III-R to reassess which current patients meet the diagnostic criteria (p.509).

[97] Herman et al. (1989) argued that categorizing borderline personality disorder as a complex posttraumatic syndrome is complicated as stigma and secrecy concerning the traumatic event effects how and if the event is disclosed. However, disclosure of the event and its connection to the symptoms leads to better treatment outcomes. This suggests that stigma associated with disclosure affects treatment outcomes. Wilkinson-Ryan and Westen (2000) use membership in a stigmatized group as an indication of identity disturbance in assessing borderline personality disorder. In reference to clinician's avoidance of diagnosing borderline personality disorder during admission procedures, Westen (2001) discussed his approbation, "I applaud the clinicians' reluctance: giving a patient a stigmatizing diagnosis in an official record available to third-party payers after seeing the patient only briefly" (p.325). In summarizing why clinicians may be discouraged from diagnosing personality disorders, Zimmerman et al. (2005) wrote, "This may be because of a belief that scattering symptoms over two axes is not fruitful, that axis II has substantial overlap within it, that personality disorder diagnoses are particularly stigmatizing, or that a personality disorder diagnosis does not substantially alter the treatment plan" (p.1912).

[98] In advocating for the continued inclusion of somatoform disorders in the DSM, Rief et al. (2006) stated, "Former diagnoses (e.g., hysteria, neurasthenia, functional syndromes, and psychosomatic complaints) were stigmatizing, unreliable, and rarely used even in psychiatry. The category of somatoform disorders improved the description of syndromes and the reliability of classification and was the basis of an

personality disorder,[103] acute stress disorder,[104] anxiety,[105] adjustment disorder,[106] child

abuse,[107] and mood disorders.[108] Arguably though, no diagnostic category was aligned

with the concept of stigma more forcefully or diversely than depression in the AJP after

the APA's declaration of war on stigma in 1989.[109]

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overwhelming development in psychiatry" (p.747). In a letter addressing disagreement with Rief et al.'s (2006) position that somatoform disorders should remain in the DSM, Sharpe et al. (2006) wrote, "They also point out that the label of somatoform disorder is arguably less stigmatizing than previous diagnoses, such as hysteria. However, it is our view that it is not the precise label that is inappropriately stigmatizing but the fact that all persons with such somatic symptoms are given psychiatric diagnoses" (Sharpe et al. 2006:748). The place of stigma in arguments about disease classification retains a political salience, especially today.

[99] North et al. (1990) claimed that early patients who complained of ailments associated with ulcerative colitis were stigmatized with a psychosomatic label.

[100] Abbey and Garfinkel (1991) indicated that the patient's preference for a medical diagnosis for chronic fatigue syndrome illustrates the stigmatization of psychiatric illness and emotional distress (p.1645).

[101] Berlin and Malin (1991a) maintained that the stigma of pedophilia and paraphilia makes it difficult for families or those afflicted to seek out or find help. As well in relation to help seeking, Berlin and Malin (1991b) suggested that previously pedophiles could seek counseling with confidentiality, although stigma and shame complicated this process. However, changes in the law now require mandatory reporting of child abuse and help-seeking for this behavior is expected to diminish.

[102] Small et al. (1991) contended that mass hysteria is difficult to study as communities are reluctant to accept psychological explanations because of the stigma of being weak-willed or suggestible (p.1204).

[103] Spitzer et al. (1991) argued that placing the diagnosis of sadistic personality disorder into the DSM-IV may be used to stigmatize incarcerated persons, which could lead to physical abuse (p.877).

[104] On revising the DSM Pincus et al. (1992) wrote, "While the major goal of DSM-IV is clinical, research, and educational utility, we will be especially cautious about new diagnoses that might be stigmatizing or have an adverse forensic impact" (p.115). As an illustration of this problem, they site the ICD-10 including acute stress disorder as stigmatizing all disaster victims as mentally ill for however short a period of time.

[105] In an editorial regarding awareness and advocacy, the APA (1993) declares, "To live up to our name, we must continue to help our patients not only by healing illnesses of the mind, but also by decreasing stigma and increasing knowledge among the lay public, so that those who suffer from depression or anxiety or schizophrenia will not have to suffer as well from shame and guilt" (p.1444). What is particularly striking here is the inclusion of anxiety with depression and schizophrenia, as the latter two disorders were already entrenched in the fight against stigma for sometime. Stein et al. (2004) somewhat clarifies the position of stigma as it relates to anxiety. Stein et al. (2004) investigated the issue of the diagnosis of anxiety disorders by primary care physicians and they concluded that "although major efforts have been made in the past decade to destigmatize depressive disorders, the anxiety disorders lag behind in terms of public (and, perhaps, physician) awareness" (p.2230).

[106] Greenberg et al. (1995) asserted that clinicians use the diagnosis of adjustment disorder, despite its lack of 'theoretical rigor' because it is less stigmatizing for those entering treatment (p.459).

[107] Egami et al. (1996) concluded that self-reporting child abuse is difficult to measure due to stigma.

[108] Zarin et al. (1998) contended that psychiatrists often diagnosed patients with mood disorders because it is a less stigmatizing diagnosis. However, with heightened confidentiality the effect of stigmatization can be mitigated. In reporting increased utilization of psychotherapy for the treatment of depression and mood disorders, Olfson et al. (2002) concluded that, "Increased public awareness of depression and its relative destigmatization may have further increased help seeking for mood disorders" (p.1917).

[109] For examples see Liebowitz 1989; Mayeroff 1991; APA 1993; Kirmayer et al. 1993; Cochran and Mays 1994; Magruder et al. 1995; Ragurram et al. 1996; Blazer 1996; Sirey et al. 1999; Wassink 1999; Sirey et

Liebowitz (1989) proclaimed that in order to alleviate the stigma surrounding depression, it should be reevaluated to make more clear distinctions about how to define and diagnose depressive illnesses, similar to the way neurosis was reassessed in the DSM-III. Neurosis was subsequently eliminated from the DSM-III due to a lack of consensus on the term (Liebowitz 1989). Liebowitz (1989) claimed that by making the diagnosis of depression more specific and changing the name to "unipolar disorder", the stigma of seeing a psychiatrist will be alleviated and the euphemistic stigma of depression would also be removed (p.560). Many claims about the effects of stigma were expressed alongside depression. Statements were made about physicians misdiagnosing depression to avoid stigmatizing the patient.[110] The stigma of being diagnosed with other mental illnesses was alleged to lead to depression.[111] As well, claims were made about depressive symptoms being magnified by stigma.[112]

Most interesting was a claim made in 1996 about stigma and depression. Blazer (1996) explained that for patients with depression, reintegration into family and society is difficult, not because of stigma, but due to embarrassment. Blazer (1996) wrote, "Psychiatric illness is an embarrassment even if it is not a stigma. It is not easily explained to friends. Therefore, months are required for patients to reintegrate themselves into their former networks" (p.1623). The notion that embarrassment, more so than stigma, affected how people diagnosed with mental illness interacted with family and society indicates that the patient is responsible for these internal feelings; as if those around the patient are not accountable for how they react to disclosure of a mental illness.

al. 2001; Ciesley and Roberts 2001; Druss et al. 2001; Oquendo et al. 2002; Houston et al. 2002; Olfson et al. 2002; Stein et al. 2004; Simon et al. 2004; Sirey et al 2005; Alexopoulos et al. 2005; Libby et al. 2007.

[110] For an example see Kirmayer et al. 1993.
[111] For an example see Mays 1994.
[112] For examples see Ragurram et al. 1996; Ciesley and Roberts 2001.

This point is important because the crisis of stigma in psychiatry had lost much of its momentum by this time. Stigma garnered only one mention in the AJP by 1997.[113]

After this decline, stigma resurged alongside depression and numerous other illnesses during and after 1999. This is due in large part to the Surgeon General publishing a report on mental health in 1999 that specifically called attention to the problem of stigma facing psychiatry. After this report appeals to stigma varied distinctly, especially those pertaining to depression. It was suggested that depressed patients refused to take medications for fear of stigma.[114] Others maintained that schizophrenics were being misdiagnosed with depression because depression was less stigmatizing.[115] It was indicated that older patients with depression allowed perceived stigma to affect their treatment more so than younger patients, even though younger patients reportedly perceived more stigma than old patients.[116] Additionally, some suggested that the stigma against depressive disorders manifests in hidden costs to employers.[117] It was also proposed that depression was under treated due to fear of stigma.[118] Others still argued that increased public awareness and de-stigmatization of depression would improve help seeking behavior.[119] It was asserted that stigma manifests as a barrier to treatment for depressed patients.[120] A more recent claim was that stigma is a limit to the generalizability of studies on depression as interviewees may not disclose all necessary information to the researcher.[121] As well, claims about stigma and dementia,[122] post-

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[113] The single citation of stigma is located in Marzuk 1997.
[114] For an example see Sirey et al. 1999.
[115] For an example see Wassink 1999.
[116] For examples see Sirey et al. 2001; Alexopoulos et al. 2005.
[117] For an example see Druss et al. 2001.
[118] For an example see Oquendo et al. 2002.
[119] For examples see Houston et al. 2002; Olfson et al. 2002.
[120] For an example see Sirey et al 2005.
[121] For an example see Libby et al. 2007.

partum depression,[123] obsessive compulsive disorder,[124] self-injury,[125] kleptomania,[126] attention deficit hyperactivity disorder,[127] caffeine dependence,[128] conduct disorder in children,[129] and gambling addiction,[130] appeared during and after 1999. The next section describes historical conditions that led to this revitalization of the war on stigma.

In medicalizing stigma, four distinct themes emerge. First, stigma prevents some from seeking help. Second, stigma affects the course of treatment as disclosure of symptom details may be omitted by the patient. Third, stigma affects treatment outcomes. This is due to patient's resistance to treatment because of fear of stigma, especially those with diagnosis of schizophrenia and depression, which, in turn, leads to poor treatment compliance. Fourth, and finally, stigma can be treated. A recent affirmation of this by Sirey et al. (2001), in their study on the effects of stigma on depression, concluded "As perceptions of stigma are potentially changeable, an

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[122] Schultz (2000) claimed that the diagnosis of dementia is particularly stigmatizing because of the implication of ensuing degeneration is compounded by the lack of effective treatment.

[123] In relation to stigma and post partum depression, Lee et al. (2001) wrote, "The juxtaposition of the joy of having a new baby with the distress brought about by a stigmatizing mental illness renders the experience particularly traumatic and difficult to cope with" (p.220).

[124] Fireman et al. (2001) suggested that some patients would be given a less stigmatizing and vaguer diagnosis than OCD on rare occasions.

[125] Skegg et al. (2003) looked at the correlation between sexual orientation and self-harm. They suggest that stigma may have affected disclosure of both same-sex attraction and self-injurious behavior. However, they also asserted that "a willingness to disclose socially stigmatizing information about one's sexuality might be associated with a similar willingness to disclose suicidal behavior, depressive symptoms, or substance misuse" (Skegg et al. 2003:545). Therefore, those that are willing to speak about one stigmatized behavior may be more willing to disclose other information.

[126] Bayle et al. (2003) concluded that the prevalence of kleptomania is unknown because "this disorder is probably rare and because social stigma discourages patients from seeking treatment" (p.1509).

[127] Olfson et al (2003) wrote about the effect stigma may have on the accuracy of their research data. In a phone survey regarding ADHD, these authors suggested that stigma, inaccurate recall, and problems classifying the symptoms of ADHD may have led to imprecise data (Olfson et al. 2003:1075).

[128] Svikis et al. (2005) stated, "Because there is little social stigma attached to caffeine use, self-reports may be more accurate for caffeine dependence than for problematic use of alcohol or drugs" (p.2350).

[129] Kin-Cohen et al. (2005) wrote of the diagnosis of conduct disorders and stigma: "Others believe that children falsely identified as having conduct disorder may be stigmatized, and unnecessary referral for treatment may waste health care resources" (p.115).

[130] Slutske (2006) found that respondents' reasons for not seeking treatment for pathological gambling were "wanting to handle their problems on their own, feeling that treatment was unnecessary, embarrassment/pride, stigma, and ignorance of treatment or availability" (p.301).

implication of these findings is that patient stigma may be a useful target for intervention with the aim of improving treatment adherence and outcomes of depression" (p.480). By dealing with stigma clinically, as proponents of psychotherapy had argued in the 1940s-1960s, patients work to comply with treatment plans more readily. This, of course, hinged on patients being provided the 'factual' information about their illness and believing in the effectiveness of treatment, a hallmark of the anti-stigma campaigns.

Obscuring Stigma

This section outlines how the Federal Government's entrance into the war on stigma coupled with this increasing medicalization of stigma added a new strategy to the war on stigma. This intervention combines strategies developed by the APA and NAMI and incorporates an interactive website with videos and print materials on stigma for family members and friends of potential patients. What is shown by looking at these campaigns and their historical development is that the stigma of mental illness and the concerns of consumers are obscured by psychiatry's effort to de-stigmatize itself.

After the stall in the AJP in 1997, stigma reappeared as a fervent topic for psychiatry and the NIMH through the *Mental Health: A Report of the Surgeon General* (1999). This report was generated by the National Institute of Health (the NIMH is a subsidiary to this institute) and The Substance Abuse and Mental Health Services Administration (SAMHSA), which is a granting agency that provides funding to professional and citizen run organizations. In this report, the Surgeon General declared stigma to be an obstacle to mental health. The main target of the report was the stigma against seeking help and receiving treatment. The strategy of appealing to confidentiality

which developed during the 1960s coupled with a reformulation of the strategy of providing public education on the effectiveness of psychiatric treatments were heralded as helpful ways to mitigate stigma.[131] This report proposed that stigma no longer be tolerated as it prevented some mentally ill persons and their families from seeking help and that stigma can be dispelled through effective treatment of mental illness. Supplemental to the Health Insurance Privacy and Portability Act of 1996, which limited the disclosure of health information, this report advocated for much more stringent controls on patient information citing the reduction in stigma as a rationale.

Around the same time, NAMI also developed a vast array of ways for its members to actively engage in the stigma discourse through email alerts to their "StigmaBusters" bulletin, which targets television, print and media sources that portray what NAMI considers incorrect or stereotypical images of mentally ill people.[132] As well, NAMI instituted the "In Our Own Voice" campaign beginning in 1996 as an anti-stigma measure.[133] This is a public education campaign in which trained consumers speak on their own behalf about the experience of recovery from mental illness. Through this program, the public is educated about mental illness and treatments as a de-stigmatizing strategy. Mental illnesses are described as biological disorders and treatment compliance is strongly advised.

As was seen with the 'de-medicalization' and de-stigmatization of homosexuality, even though it was symbolically removed from the DSM, it was and continues to be

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[131] For examples, see Menninger and English 1965; Grossman 1971; Sharfstein, and Towery, et al. 1980; Roeback and Moore 1996

[132] For more information or to read the content of the alerts go to www.nami.org/stigma

[133] See http://www.nami.org/template.cfm?section=In_Our_Own_Voice for more information.

bound to a biological etiology despite no evidence to support that claim.[134] Roy Porter

(2004) suggests that failing to find a biological etiology for mental illness reflects in

stigma, because recourse to a somatic diagnosis is the most effective de-stigmatizing

strategy. As the paradigm of psychiatry is moving towards neurological and genetic

explanations for behavior, the insistence on teaching appropriate ways of conceptualizing

mental illness and the prescribed course of medical treatment will be intricately involved

in transforming the discourse of stigma. Stemming from this insight and given NAMI's

contentious history within the ex-patient's movement, it seems that these public

education campaigns for de-stigmatization have more to do with instantiating and

perpetuating the biological paradigm of mental disorders as well as advocating for

compliance with psychopharmacological treatment options. In union with this, the

campaigns by NAMI, WPA, APA and the Surgeon General all assert that stigma prevents

people from getting help.

The *Mental Health: A Report of the Surgeon General* was not alone in positioning

stigma as an obstacle or barrier to treatment. This claim has its historical roots in the

AJP.[135] As well, academic writing on stigma in the 2000s referred to stigma as a barrier

to getting patients into treatment and also contends that treatment outcomes are affected

by stigma (Perlick 2001; Cook 2006; Corrigan et al. 2003). As Pilgrim and Rogers

(2005) stress in their study of the anti-stigma campaign implemented by the Royal

College of Psychiatrists in Britain, the naturalization of psychiatric stigma as a public

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[134] On gay, lesbian and bisexual issues, the APA writes, "No one knows what causes heterosexuality, homosexuality, or bisexuality...Currently there is a renewed interest in searching for biological etiologies for homosexuality. However, to date there are no replicated scientific studies supporting any specific biological etiology for homosexuality" (APA 2002).
[135] For examples, see Jarvis 1860; Worcester 1896; Foster 1900; Abbot 1904; Burgess. 1905; MacDonald 1907; Mosher 1909; APA 1938; APA 1939; Warson 1941; APA 1942

perception that affects an individual's treatment outcome is social engineering (Pilgrim and Rogers 2005). Social engineering refers to the attempt to direct public knowledge and sentiments to achieve certain ends. I have already put forward that stigma obscures the politics underpinning the formation of a diagnostic category. As well, stigma campaigns also provide a platform for psychiatrists to define ethical issues surrounding help seeking, thus obfuscating the right to seek and/or refuse treatment. The effects of anti-stigma campaigns are that the individual patient is completely subsumed by representation, mostly by claims made by NAMI and the APA that define who consumers are and establish what issues are considered important. Another effect is that consumers' civil rights become further marginalized in the process. The most compelling example of this is happening currently in the SAMHSA anti-stigma campaign.[136]

SAMHSA, the organization that provided data for the Surgeon General's report in 1999, in conjunction with the Federal Government, recently launched a national anti-stigma campaign that targeted 18-25 year olds. SAMHSA's mission statement reads "Stigma is not just a matter of using the wrong word or action. Stigma is about disrespect. It is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma, and the resulting discrimination, discourages individuals and their families from getting the help they need" (Substance Abuse and Mental Health Services Administration 2008). The slogan used in this campaign, "What a difference a friend makes", suggests that the motive of the program is to garner social support for those with mental illness. As well, it is implied that stigma, not the presence of mental illness, prevents potential patients from seeking help, holding jobs, and living independently.

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[136] For more information, see http://www.whatadifference.samhsa.gov/

The legitimacy of the claims made by SAMHSA are questionable at a time when a biological medical model dominates American psychiatry, which simultaneously resists acknowledging the social conditions that perpetuate poor mental health and the lack of access to and funding for community care centers. In this campaign, an internet site, television commercials, and print advertisements urge friends and family of potential patients to intercede. As well, those who have friends or family members diagnosed with a mental illness are advised to support the patient's treatment and encourage recovery. Stories from patients are posted on the website that reflect patients' experiences of living with the stigma of schizophrenia, bipolar disorder, anxiety, depression, and eating disorders. This illustrates how the medicalization of stigma operates within a larger campaign as these diagnostic categories are not problematized or questioned.

This campaign is emblematic of a neo-liberal political rationality that seeks to divest the state of social responsibility, while putting the onus on individuals to care for themselves and those around them. In doing so, the responsibility to obtain treatment is placed on the family and friends of potential patients, which reduces the patient's choice to seek out treatment. With this change in the discourse on stigma, the identification of new mental health norm for psychiatry is also revealed.

Revitalizing the war metaphor used by the APA in 1989, SAMHSA writes,

> The opportunity for recovery is more likely in a society of acceptance, and this initiative is meant to inspire young people to serve as the mental health vanguard, motivating a societal change toward acceptance and decreasing the negative attitudes that surround mental illness. Mental health recovery is a journey of healing and transformation, enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential (Substance Abuse and Mental Health Services Administration 2008).

This mission statement from the SAMHSA initiative indicates that community-wide acceptance of mental illness, which must therefore include psychiatric treatment, enables

the patient to effectively utilize the recovery model of mental health. The recovery

model involves:

> a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony 1993:527).

This definition of the recovery model is attributed to William Anthony, a psychiatrist, but

its acceptance by professional psychiatry validates concerns raised by the ex-patients'

movement and Symbolic Interactionists about the medical model. Whereas stigma was

attributed to the medical model beginning in the 1960s by Symbolic Interactionists,

stigma continues to be described as an obstacle to the public's acceptance of a recovery

model.

The recovery model was intended to provide opportunities for empowerment and

choice not just of treatment options, but also for everyday living through increased social

support. The recovery model echoes some of the concerns raised by community and

social psychiatrists on primary prevention in the 1950s and 1960s, which were largely

ignored by legislators when developing the CMHC Act. Anthony (1993) suggests that

patients must also "recover from the stigma they have incorporated into their very being;

from the iatrogenic effects of treatment settings; from lack of recent opportunities for

self-determination; from the negative side effects of unemployment; and from crushed

dreams" (p.527). This model was endorsed by the APA in 2005 (Sharfstein 2005:3).

Sharfstein (2005), former APA president, stipulates that this model also requires

compliance with a medication regime and a long term doctor-patient relationship in order

to foster an attitude of hope and prosperity in the face of personal impediments.

Stemming from this, the recovery model of mental health embodies neo-liberal conception of the rational citizen, who is responsible for their own mental health and empowered by the choice to make appropriate decisions about health needs. Within psychiatry though, there is an added caveat that these decisions must be aided by psychiatrists and others involved in the treatment team. Through this, the notion of social support has been recognized to some degree as a variable contributing to a person's overall mental health. Therefore, targeting stigma as the lack of social support, as the SAMHSA campaign does, aids in promoting normative health-seeking behavior. In doing so, the sick role is assumed more readily through the cajoling by family and others as to the need for proper psychiatric treatment.

Conclusion

In some ways, the issues debated in the 1960s on the right to treatment, the right to refuse treatment, and the right to choose to be treated by a particular professional, have plagued psychiatry since the beginnings of deinstitutionalization with the growing utilization of private health insurance. In order to attend to these and other professional issues, the APA declared war on stigma in 1989. The consequence of this declaration was a massive medicalization of stigma alongside dozens of diagnostic categories. The ways in which stigma was conceptualized in subsequent articles after 1989 illustrated that stigma was negatively effecting help-seeking behavior, the course of treatment, insurance coverage, disclosure by patients, diagnoses by psychiatrists, limiting the reliability of research, treatment outcomes and so on.

The campaigns to end stigma following the APA, such as those by the WPA, NAMI and SAMHSA, bolstered this medicalization of stigma by making claims about the stigma associated with specific mental illnesses. The de-stigmatizing strategy of public education proposed by these campaigns located stigma at the core of patient's problems and its resolution through the public's belief in the efficacy of psychiatric treatments. Supporting these claims was testimony by consumers who were recovering from mental illness and professing the advancements of psychiatric care, especially within the NAMI campaign.

The present discourse on stigma has, in some respects, turned away from empowering patients to take charge of their treatment and live independently, as Judi Chamberlain (1990) asserted was a way for patients to attend to stigma in their daily lives. Instead, the notion of social support in the recovery model acknowledges the role of family members, doctors, psychiatrists, employers and others in the patient's treatment and utilizes their input to various degrees. As well, making appeals to stigma on the basis of the urgency and efficacy of treatment, which was a prominent claim when advocating for the removal of commitment laws, is reappearing in a new form in order to get potential patients into treatment for better outcomes and long-term adherence to treatment plans. The empowerment of families through a strategy of compassion for these potential patients, so far, has not been assessed to have any salutary or lasting effects. However, it does indicate that the rhetoric of total consumer empowerment is receding, as families are being urged to do what is in the best interest of potential patients.

In the next chapter, I conclude by summarizing major arguments throughout this history of stigma and critique this analysis to draw out how this thesis too obscures

consumer/ex-patient/survivor concerns, but also clarifies how the "war on stigma" utilizes strategies of neo-liberalism (choice, empowerment, and responsibility) to call for national participation in order to open psychiatric treatment to all potential patients. Implicit in these campaigns is and attempt to silence the critical discourse of anti-psychiatry by categorizing critical discourse as stigmatizing and damaging to the overall mental health of the population.

Chapter Eight

Conclusion

> *[T]he perceived undesirability of a particular personal property, and its capacity to trigger off these stigma-normal processes, has a history of its own, a history that is regularly changed by purposeful social action.*
>
> - Erving Goffman [137]

The aim of this thesis was to uncover the historical contingencies that have resulted in the formation of stigma as it is used today in American psychiatry. Early appeals to stigma in the AJP were formed around four major themes, i.e. the stigma of commitment/treatment, stigma of psychiatry, euphemistic stigma, and the stigma of insanity/mental illness. During 1846-1960, it was thought that stigma could be changed in several ways. The rescission of commitment laws, which were described by Mosher (1909) as being an impediment to scientific progress, were thought to be an avenue where the problem of stigma could be addressed. Changes to the names of institutions were argued to result in less ominous sentiments towards these hospitals. However, these euphemistic changes produced limited results.

In the late 1930s, it was thought that public education on the value of psychiatric treatment by ex-patients would raise awareness about mental disorders and their effective treatment. This would, in turn, reduce stigma and move patients into treatment faster and without resistance. Unfortunately, this too did not reveal any significant changes in public sentiments towards psychiatry or mental illness as stigma only became more and

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[137] Goffman 1963:138.

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more emblematic of the problems facing psychiatry. For many psychiatrists, stigma

defined the limits imposed by law, medicine, and the public on the practice of psychiatry.

After WWII, stigma's effect on health insurance was being debated using the

rationale that mental illnesses were like physical illness (as in they were real afflictions

that had definite effects and manifested as a result of a confluence of biopsychosocial

factors).[138] This move in the discourse on stigma, however, proved problematic as it

came about at a time when patients were being encouraged to seek out treatment options

in the community. And opt they did for care by general physicians and not psychiatrists.

To attend to this problem, psychiatrists advocated for strict confidentiality laws in order

to reduce possible stigmatization and discrimination from disclosure to employers and

insurance companies alike.

A failed strategy, occurring in the 1970s, was to quantify stigma in order to assess

its contents and consequences. It was thought that by being able to prove the existence

and prevalence of stigma, especially in relation to the utilization of health insurance

policies, that psychiatrists could once and for all change public stigma against psychiatric

practice. However, what these studies revealed was that competition for patients led

physicians to unabashedly treat patients on their own or refer patients to neurologists in

order to avoid the stigma of psychiatric care.

During this period, Symbolic Interactionists were using the concept of stigma in a

multitude of innovative ways. Goffman (1963; 1967), Becker (1963) and Scheff

([1966]1994) posited that defining individuals as deviant or abnormal served as a

function of social control. They, Scheff in particular, asserted that psychiatry as a

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[138] For examples see Rickles et al. 1950; Davidson 1955; Pfeiler 1966; Langsley 1973; Hall 1974; Glasser et al. 1975

discipline was predicated on the public's stigma against certain problematic behaviors and that this stigma resulted in diagnosis and treatment. Goffman (1963) offered an analysis of stigma which contended that the strategies of representation in the public by the wise and selective disclosure by the own could alleviate some of the effects of stigma. Psychiatrists eventually took up these strategies in campaigns to end stigma in the late 1980s and through today.

To address critics who called psychiatric care non-medical and unscientific, the APA overhauled the DSM in 1980. Mental illnesses, through the publication of the DSM-III, came to be understood as brain disorders and consequently unjustly stigmatized by the public. As the definitions of mental illnesses were becoming more specific, strategies to minimize stigma began to flourish alongside nosological categories. Eventually, stigma came to be understood as a limit to the generalizability of psychiatric studies as certain personal histories, particularly of abuse or sexual activity, were often omitted by the patient when being interviewed by researchers. As well, psychiatrists claimed that stigma was something that could and, as a matter of fact, should be treated along with the mental illness. In attending to stigma clinically, patients would be more likely to accept treatment without disagreement.

The medicalization of stigma has historical roots in the disorders of epilepsy, homosexuality, alcoholism/substance abuse, and schizophrenia. Each of these disorders was met with strategies to reduce the stigma of mental illness, as well as to dispel a problem facing psychiatrists. Epileptics were stigmatized due to laws which prevented them from obtaining driving permits and marriage licenses. This stigmatization was fought by patient groups and doctors who designated the diagnosis as neurological and

not psychiatric. Homosexuality was seen as an affront to heteronormativity and publicly

stigmatized. Activists demanded its removal from the DSM, and through the cooperation

of psychiatrists it was accomplished, not on the basis of homosexuality disappearing as a

diagnostic entity, but by attending to the euphemistic stigma of the term. The stigma of

alcoholism as a moral failing was addressed by psychiatrists proclaiming the

effectiveness of treatment and heralding the removal of fault as a way to get these

patients the help they needed. Finally, the stigma against schizophrenia was described as

patients' refusal to take anti-psychotic medications due to fear of stigma and because

psychiatrists believed that other psychiatrists would underreport diagnoses of

schizophrenia due to stigmatization by health insurance carriers and employers. This, in

turn, would affect the APA and subsequent revisions in the DSM, as the APA culls the

statistical information on disease prevalence from insurance companies.

The declaration of war on stigma by the APA in 1989 is highly important. The

use of the war metaphor in medicine is not novel, but suggests that forces must be

mobilized in order to combat a devastating enemy (Lupton 2003:65-72). Sontag (2001)

suggests that the use of the war metaphor "overmobilizes, overdescribes, and it

powerfully contributes to the excommunicating and stigmatizing of the ill" (p.182).

However, Sontag (2001) asserts that simply describing the war metaphor as a rhetorical

device does little to divest it of meaning, instead the use of the war metaphor in relation

to illness must be exposed and criticized based on the ways in which it is implemented

(Pp.182-183). Therefore, there is a great paradox in the use of a war metaphor as it

relates to the social inclusion of people with mental illnesses. The metaphor confers a

value judgment on stigma as well as mental illness and invests them with the meaning

that everything must be done to battle their presence. In doing so, social exclusion persists.

Concomitant with the APA's campaign to overcome stigma was a large scale medicalization of stigma alongside dozens of other mental illnesses. All of the campaigns to end stigma discussed in this thesis, beginning with the APA in 1989 through SAMSHA's current campaign, suggest that stigma is the result of misinformation about mental illness. However, the usefulness of stigma as a concept is apparent when looking at it historically. In early American psychiatry writing, stigma is used to promote notions of economy and efficiency when instituting new treatments. Later, Symbolic Interactionists linked stigma to problems of psychiatric diagnosis and treatment.

These notions were taken up by American psychiatrists as well as the ex-patients' movement to differing ends. This opens the field to new interventions aimed at reducing stigma through public education and advertising messages. Campaigns to end stigma are litigious as they serve to promote a codified and scientific perception of American psychiatry, which has long since deinstitutionalization been under scrutiny by the government, the public, and respected academics. Instead of focusing anti-stigma campaigns at demonstrated discrimination in housing, job, or insurance markets, these campaigns signal a concerted effort not to de-stigmatize the consumer of mental health services but psychiatry as a whole. The recent strategies used by psychiatry to accomplish this goal illustrate how the 'conduct of conduct' is carried out in neo-liberal states to regulate and manage public sentiments.

Governmentality is an "art" of governing that "acts on the actions of individuals, taken either single or collectively, so as to shape, guide, and modify the ways in which

they conduct themselves" (Burchell 1996:19). Within this framework, the term government takes on a multitude of meanings and is not only located in the direct power of the state, but also in agencies and authorities that are imbued with power and jurisdiction over certain populations. Psychiatry, in particular, is an expertise that seeks to develop a knowledge of individuals for the purpose of transforming them into normal and productive citizens. It is through appeals to stigma as a rationale and program for justifying practices that psychiatrists attempt to direct the public understanding of psychiatric practice.

The governmentality of neo-liberal states is most concerned with rationally regulating human conduct through techniques of self-governance. Most recently, the discourse on stigma reveals a concerted effort to modify the help-seeking behavior of potential patients and their families. In doing so, secondary prevention and early treatment are largely left up to those individuals and their families who actually seek out the hospitals, agencies, and organizations in their area that provide services. Primary prevention as described by Caplan (1964), such as reducing poverty and increasing social welfare to better the mental health of the population, does not reappear in these campaigns. This is, however, indicative of a neo-liberal political rationality that espouses the value of minimized governmental intervention in the lives of citizens. In doing so, there is also a reduction of the economic burden on the government to attend to the needs of citizens. No place in the history of psychiatric care was this more evident than in the development of the CMHCs over the 1960s and the subsequent under-funding by the Reagan Administration in the 1980s.

The organized professional campaigns to end stigma, which began during this tumultuous time in the 1980s, are an effort to reinvigorate public concern about the mental health and well-being of individuals and their loved ones, thus perpetuating the responsibilization of the citizen to attend to the twin project of neo-liberal governments. It is through the linking of "the public objectives for the good health and good order of the social body with the desire of individuals for health and well-being" that this takes place (Rose 1999: 74). In doing so, stigma becomes not just an obstacle to treatment, but also a barrier to responsibility, which is addressed in these campaigns through the idioms of empowerment and choice.

In summary, this history of stigma shows that the use of stigma as a concept is laden with ideological claims about the belief in the effectiveness of treatment and how information about mental illness should be communicated. Invoking this concept, particularly in sociology and psychiatry, is fraught with problems as to the orientation of the researcher with regards to what could best be termed a political agenda. I contend that the usefulness of stigma to the consumer/ex-patient/survivor may very well be a red herring as this historical examination has shown that the battle against stigma obscures the politics of classification and attends to the limits imposed by the public, law, and medical professionals on psychiatric practice. Concepts such as "mentalism" and "sane chauvinism" fell short of becoming common knowledge in the wake of NAMI's takeover of mental health advocacy. As well, American psychiatrists, especially Paul Fink, did more to undermine the concept of stigma than understand it, by directing the public's knowledge of psychiatry in ways that addressed the goals of professional psychiatry.

A subsequent obfuscation of the right to refuse treatment occurs when these campaigns attempt to direct family members and friends to seek help for potential patients. Help-seeking is a difficult ethical problem, especially in neo-liberal societies, where the citizen is supposed to rely on their own resources. By subjugating persons into psychiatric treatment, the free citizen becomes the psychiatric citizen whose risk to the community must be managed and rights abrogated. As Roy Porter (2004) suggests, mental illness is inevitably stigmatizing because diagnosis is an affront to one's conception of self. After all, being diagnosed with mental illness gives more than just a label to an individual. For some, it relegates them to the status of abnormality which has specific effects on their rights and citizenship. For others, it offers hope that recovery is possible.

Diminishing stigma is complicated as not all de-stigmatizing strategies work and some produce further stigmatization. Porter (2004) suggests that the only way to get rid of the stigma of mental illness would be for "the public acceptance, without shame, of mental disorder" (p.12). This solution, he writes, is akin to "crying for the moon" (Porter 2004:12). Because psychiatric diagnoses are based on a humanistic conception of people as rational beings, diagnosis confers a spoiled identity on to patients. Symptoms of psychiatric illness are descriptions of sets of thoughts and behaviors that define the patient. Broadly speaking then, stigma as a rationale for practice is the description of the boundaries of both the practice of psychiatry and the normalization of individuals. Stigma limits how psychiatrists can speak of, formulate, and act on objects, which has substantial effects on the formalization of the psychiatric paradigm as was seen in this history. Stigma also marginalizes those who are mentally ill in the public through

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practices of discrimination. It is by asserting that mentally ill persons are qualitatively and problematically abnormal through the process of medicalizing behaviors that stigma persists.

The medicalization of stigma alongside nosological categories (which are formulated somewhere between politics and science) ensures that the battle against stigma will be fought through diagnoses. As Fink (1986) had anticipated, the compartmentalization of stigma and its ensuing specification of strategies to diminish its potency allows for the implicit public acceptance of diagnostic categories, while the debates about terminology and symptomology can be meted out within academic journals and outside of the media. The strategy of public education in particular seeks to present the knowledge of psychiatry as scientific by asserting that mental illness is a biological disorder in order to reduce stigma and remove the fault from the patient. In doing so, stigma is aligned with categories of mental disorder, which are presented as already established and stable, thus precluding critical discourse from emerging as appeals that problematize these claims are seen as stigmatizing in and of themselves. It is also by locating strategies for responsibilization, self-help, choice, and empowerment of the mentally ill population ingrained in the discourse of stigma that the possibility for a critical discourse on stigma can be based. However, anti-stigma campaigns which target family members and friends of potentially ill persons, perhaps ironically, reduce opportunities for empowerment, choice, and self-help for the patients themselves.

The discourse on stigma, particularly as it is presented by psychiatrists, must be seen as a challenge to the skepticism that the public, including persons with mental illness, has when dealing with psychiatric institutions and governmental intervention. As

the ongoing clamor about stigma is reverberating throughout academia, a call to end stigma in psychiatry, at least, is now synonymous with a call to end the critical discourse which developed during the 1960s. Getting patients to accept diagnoses swiftly without confrontation, to enter the sick role more quickly and efficiently, and to comply with treatment regimes without legal interventions are all part of these new de-stigmatizing strategies put forth by the APA, WPA, NAMI, SAMSHA, and the Federal Government. Remaining watchful and critical of social programs and advancements in bureaucracy and psychiatry are principles of the ex-patient movement. It is through this genealogy of mental health services, American psychiatry, mental health activism, and the deployment of stigma as a concept, that the appearance of new social programs for stigma reduction could be understood, not simply as anti-discrimination, but also as an attempt to direct the discourse on stigma to achieve the de-stigmatization of psychiatry.

As a final note, an analysis such as this one also directs attention away from actual problems that people with mental illness face in their daily lives, such as employment and housing discrimination. However, this is not to suggest that stigma is not a concern, but rather to illustrate that the medicalization of stigma is still being formulated. Critiquing the underlying strategies of stigma reduction opens new possibilities for attending to the problem of stigma as it manifests in discrimination against consumers in clinical settings and the public. Whereas stigma may be described as a barrier by psychiatrists and as a red herring in this thesis, it is also possible for mentally ill persons and potential patients to use it to resist medicalization. Fear of stigma, as psychiatrists have called it, is being apprehensive about the consequences of diagnosis and treatment. It may be the case that this fear is predicated on a resistance to

being medicalized, i.e. of being defined through pathology and treated accordingly. Future research on stigma should be attentive to this possibility.

As well, this analysis may have overly problematized the conundrum of forced treatment depending upon the viewpoint of the reader. By conceptualizing stigma as a red herring, it is possible to reevaluate the issue of psychiatric citizenship and the representation of this population. The mentally ill population straddles the fine line between normal citizenship and domination. Neo-liberal citizenship entails the choice to openly participate in the market, enjoy the fruits of one's labor, while also being responsible for one's actions (Hindess 2002). Those who can not, for whatever reason, participate in these activities are marginalized and resigned to a system that blends humanitarian compassion with capitalist industry. By looking at how campaigns to end stigma are framed, as being in the best interest of the patient, it is possible to expose how these campaigns overwhelmingly attend to the problems posed to professional psychiatrists. Attention to these details offers the possibility for devising local and heterogeneous anti-discrimination campaigns that promote consumer participation in reducing the barriers to employment, housing, and overall healthcare.

Whereas in the 1970s, ex-patients were mobilizing and representing their points of view, however radical, in conferences and congressional hearings, this representation has taken a new form. No longer are empowerment, choice, or responsibility espoused for the mentally ill person in the same way as they were in the 1970s, but now the entire population is being asked to join the fight against stigma through these national and international campaigns. As well, the mentally ill patient is empowered to participate in the fight alongside psychiatrists, to address problems of stigma in therapy, and to be

responsible to accept treatment for their illness. In doing so, it is asserted that stigma can be alleviated, once and for all, as soon as people stop resisting and start believing.

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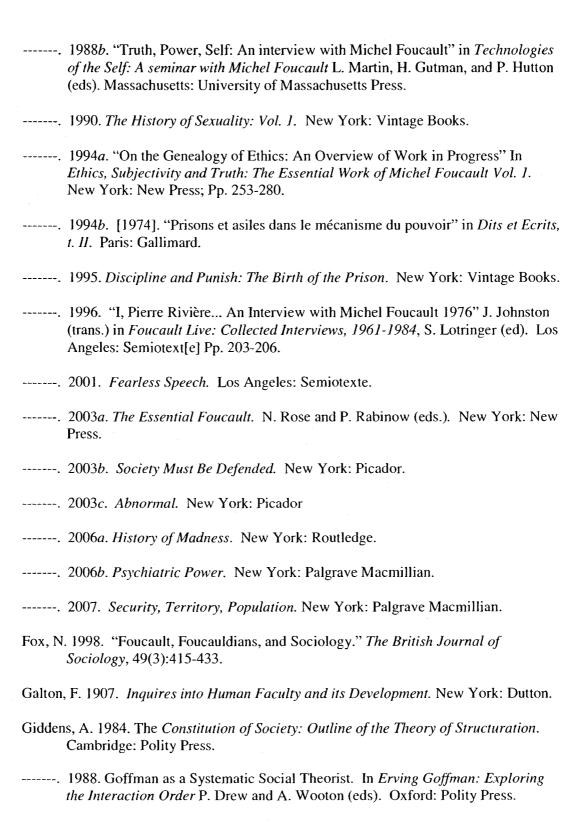
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