Changing Conceptualisations of Mental Illness and Exclusion: Revisiting the concept of Stigma?

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The dominant Western approach to understanding mental 'illness' is relatively recent in its formation, and culturally distinct in nature, driven predominantly by the medical profession. In this article Dominic Page discusses the historical conceptualisation of mental health and the influence of medicine on how mental illness is understood. It presents a summary of the criticisms of this dominant approach, before outlining emerging responses from the sociological literature, particularly the concept of stigmatisation. However, it highlights the clear limitations of such an approach in the context of employment exclusion, and presents an alternative model informed by concepts of structuration, the social model of disability and embodied impairment.

Introduction: Concepts of mental health

The development of psychiatry as a medical discipline and response to 'madness' originated relatively recently in the 18th and 19th Century (Scull, MacKenzie and Hervey, 1996). As highlighted by Klerman the consideration of mental illness as a medical concern was 'an invention of the Enlightenment' and the age of reason (1977: 222). This was linked to broad changes across western Europe which saw shifts from lunacy being viewed as supernaturalistic to naturalistic, mirroring a shift from protestant to secular values. Subsequently the care of the mentally ill became the responsibility of the medical profession as opposed to the church in most Western nations, giving rise to the profession of psychiatry as recently as 1840, and hospitalisation at a similar time (Klerman, 1977). Social attitudes towards the mentally ill have, at least in the west, been underpinned by lay 'medical' understanding; mental illness is an abnormality. These social attitudes are perhaps most effectively highlighted in Hogarth's *A Rakes Progress*.

Painted in the 18th Century, the work follows Rakewell as his mental health deteriorates and ultimately he is imprisoned in the infamous Bedlam, or Bethlam Hospital[1]. This painting shows us much about the social attitudes towards mental health at the time, but also reveals the roots of contemporary understanding and conceptual approaches to madness, whereby health and morality became intertwined. Unpredictability, violence, loose morals (gambling, drinking, and visiting whorehouses) and ultimately social deviance and abnormality all became viewed as part of the experience of mental illness justifying exclusion from mainstream society as part of the development of English sense and sensibility (Honour, 2002).

Changing societal understanding of mental health?

To what extent have societal attitudes towards mental illness changed from those so clearly illustrated in Hogarth's work of the 18th Century? While there are growing social movements with a focus on changing attitudes, for example, the outstanding *Time to Change* campaign, the depiction of mental illness in visual images, the media and popular culture often remains hugely problematic. Such attitudes are prevalent in the context of employment[2], and are apparent in much of the economic literature:

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> "Mental health problems lead to diminished rationality and reduced agency … they are less capable to act on their own behalf and in their own best interest, and this leads to increased market failure." (Weehuizen, 2008: 155)

It is clear that the dominance of these medicalised concepts of mental illness, with their foundation in defining an individual as 'abnormal' do not just persist in lay public perception, but also in the treatment of mental health. In the contemporary 'treatment' of mental illness the discipline of psychiatry continues to be wholly embedded within the medical world which remains concerned primarily with 'identifying sick individuals (diagnosis), predicting the future course of their illness (prognosis), speculating about its cause (aetiology) and prescribing a response to the condition, to cure it or ameliorate its symptoms (treatment)' (Rogers and Pilgrim, 2005: 2). The psychiatric profession is predominately focused upon the identification of abnormality in the mentally ill individual.

[1] This is the final painting by Hogarth in which he is depicted in Bethlam
[2] See Page, D (2013) need full reference here

The medical model of mental illness is an approach which assumes such illness is comparable to physical illnesses, therefore this approach to mental illness is essentially biological, or organic and attributed to the body (Clare, 1976). A fundamental assumption of this model of mental illness is that psychological problems are caused by biological disorder, the psychological problem is an indicator that something has gone wrong with normal biological processes. The medical treatment of mental illnesses through psychiatry is, according to this model, no less scientifically based, value-free or objective than the treatment of any other form of 'disease' (Clare, 1976). As a result, under the medical model prominence is placed on 'genetic, biochemical, physiological and neuroanatomical' factors in the aetiology of mental illness. (Joyce, 1980: 234; Schwartz, 1999). The evidence is that such assumptions may well lead to the exclusion of people with mental health disabilities from a range of social settings, not least employment. Mental health disability is widely accepted as one of the leading causes of poor health across the world (Grove, 2003). Furthermore, epidemiological research[3] has demonstrated a relationship between poverty and mental health. Grove *et al*. (2005) highlight that this is predominantly caused by the absence of employment with estimates in the UK of 20 per cent employment rates, falling to five per cent in the case of serious mental health disabilities such as schizophrenia. The consequences of this are profound, restricting social lives and maintaining over 1.5 million people in the UK of working age in economic inactivity (Black, 2009).

The medical model of mental illness is an approach which assumes such illness is comparable to physical illnesses

The explanations for these striking patterns are the subject of significant debate. Underpinned by such a medical approach, 'possessive individualism' (Byrne, 2005) lays the blame for unemployment squarely on the shoulders of the individual and in this case, their mental 'illness', disregards structural explanations and is myopic to disadvantage and discrimination. From such a bio-medical perspective mental 'illness' is conceptualised as incapacitating people in a workplace context, limiting their ability to undertake paid employment and their value to an employer. The predominant explanation for exclusion or disadvantage in the labour market is that people with poor mental health are inherently unemployable as a result of low human capital, poor work motivation and incapacity caused by the clinical symptoms of mental 'illness'. Essentially this rationalises exclusion as one of a natural sifting of less capable people, a risk to be minimised (Grove *et al*., 2005). Here, lack of

[3] There are clear limitations to such research; however such data is notably useful in highlighting macro level labour market patterns of inequality.

employability and subsequent labour market experience are associated with a lack of effort, willingness or ability to adapt to or engage with labour market realities. There is considerable evidence of the dominance of such assumptions in individual attitudes towards mental health, HRM policy and practice and government policy, not least the reform of welfare in the United Kingdom.

Despite the dominance of these explanations, there has been consistent criticism since the 1960s of such medical models. The 'traditional' medical research into mental health underpinning such policy has been condemned by the post-psychiatry movement and sociologically-informed disability studies. In both cases the conceptualisation of disability as an individual pathology or medical problem and the assumption that mental illnesses are 'ultimately defined by a sub-optimal social functioning' (Rogers and Pilgrim, 2003: 4) have been increasingly challenged, not least as an explanation for economic disadvantage. As highlighted by Tew (2000), the inclusion of mental health within a framework of 'medical conditions' is particularly problematic on conceptual grounds. It obscures the reality of the social impact of mental health and the impact of relationships of power. The societal meaning and political responses evoked by mental health have yet to be explored with any vigour (Porter, 2002). In contrast, alternative sociological explanations for exclusion have emerged that reject these medical and 'rational' approaches.

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Social construction of health and illness

As highlighted by Rogers and Pilgrim (2005) one of the most influential theoretical positions in the field of health and illness has been the concept of social constructivism and this has driven much of the sociological research. This is based upon the central assumption that positivism oversimplifies the nature of illness as 'objective' and 'observable'. In contrast, the key tenet of social constructivism is the view that reality is not fixed, stable, self-evident and waiting to be revealed, but rather that it is a product of human activity and in this sense, constructed by humans. Under this framework mental illnesses are not 'natural kinds' (Zachar, 2000) but rather a socially produced and created category. A variety of perspectives emerge within this paradigm, as outlined by Brown (1995). The first, social production, is an approach not concerned with demonstrating the 'reality' or 'cause' of a social phenomenon - rather it explores the social forces which define it, how it is produced and how society reacts to issues and hence it has been linked to psychological literature on labelling and stigmatisation.

Social production, social reaction, labelling theory and stigmatisation

In terms of labelling theory, some of the most influential work was developed by Scheff who argued that 'societal reaction' to deviance helps explain the experiences of mental health 'patients'. In addition, the stigma of mental illness has been highlighted as hugely influential on the subsequent experience of illness as well as the severity of symptoms (Bury, 2005). The influential work of Foucault (1967) has been presented by critical sociologists as an alternative conceptualisation of mental illness to that of the medical profession, in particular psychiatry, which is viewed as complicit in the 'production of mental illness' as a form of social control (Bury, 2005). For Foucault, this was best exposed by the 'great confinement' in eighteenth and nineteenth century France, 'leading to the repression of "unreason" and the policing of troublesome and threatening behaviour' (Bury, 2005: 68), with the state and the medical profession viewed as complicit in the physical exclusion of those with mental illnesses. The social responses to mental illness are fundamental when discussing the associated experiences of health. This concept of social reaction is at the heart of the social-psycho theory of stigmatisation.

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Mental health continues to present particular difficulties, especially when people 'translate disgust into the disgusting and fears into the fearful' (Porter, 2002: 62). This concept of stigma in general is explored by Goffman (1963) who describes stigma as resulting from an attribute, which is deeply socially discrediting. The perception of the possession of this attribute by others leads the person to be regarded as abnormal and reduced to being a tainted or discounted person. Goffman presents stigma as being the product of a relationship between a particular attribute and the stereotypes held about that attribute. Link and Phelan (2001) have expanded this, specifically in relation to mental illness stigma, offering the following definition of stigma: "the co-occurrence of its components: labelling, stereotyping, separation, status loss and discrimination." (Link and Phelan, 2001: 363). Link and Phelan's model regards stigmatisation as a process in which a person is labelled with a difference that has social relevance. The social label makes it possible to separate "us" from "them" and the labelled person or group of people can then be regarded as being fundamentally different from everyone else. Once an individual has been labelled, stereotyped and separated in this manner, a foundation has been established which allows them to be devalued and excluded. Corrigan (1998) proposes an approach in which stigma is categorised

as either public stigma or self-stigma. Public stigma describes the public's attitudes towards others with mental illness.

Criticisms and limitations of the 'stigma' model

The notion of stigma dictates the discourse about the exclusionary experiences of people with mental health problems. However, there have been a number of important criticisms levelled at the use of stigma as a conceptual framework. Sayce argues that stigma is conceptually problematic because it locates the problem within the person with the mental illness (Sayce, 1998). This has the effect of individualising what is really a social problem (Harper and Vakili, 2008). The notion of stigma carries with it the implication that there is something inherently discreditable about the person who is stigmatised. Sayce argues that the 'mark of shame' which stigma represents ought not to be attached to the mental health service user but instead with the people who behave unjustly towards them. He further argues that such issues are far from semantic and that different conceptual models actually carry great power in terms of understandings about where responsibility ought to lie.

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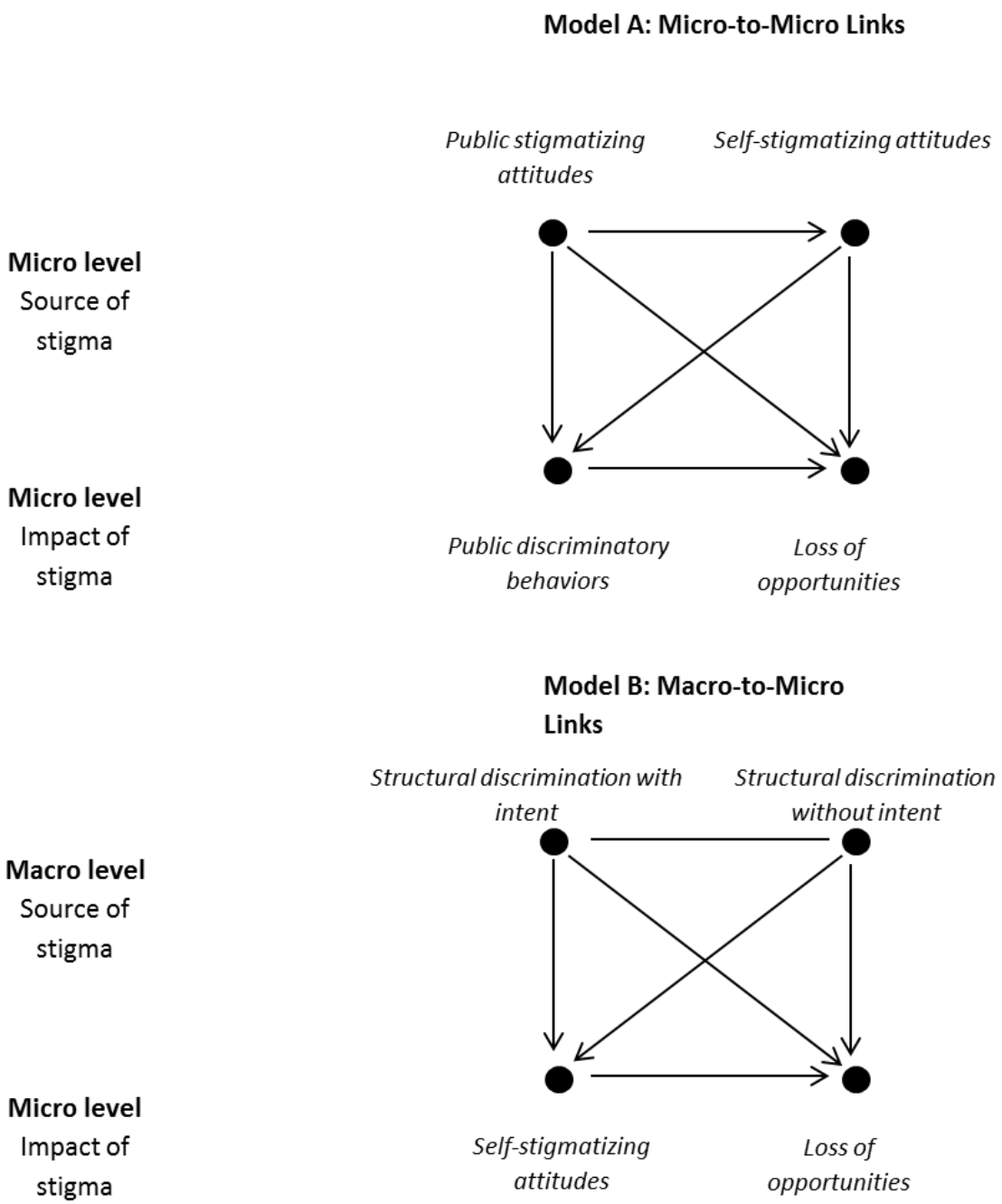
As Liska (1990) notes, analysis of micro-level interaction is problematic and the clear gap which emerges here is how micro and macro-level processes interact. Importantly this highlights that the process of discrimination is not reduced to the level of individual interaction, but structural macro-level processes interact with micro-level analysis. Corrigan et al. (2004) argue for a structural model of discrimination. They highlight that stigmatisation has its roots in individual level psychological paradigms and utilise the concepts of structural discrimination including policies of private and governmental institutions that intentionally and unintentionally restrict the opportunities of people with mental illnesses. Their model contrasting micro and macro-level approaches is presented below:

Figure 1: Micro and Macro levels of analysis in mental illness and stigmatisation



Corrigan *et al.*, 2004: 488

This model demonstrates the need for structural level analysis when considering the impact and production of stigma as an explanation for the exclusion of people because of mental illness. It highlights that the predominant approach to stigmatisation has focused on micro-level interactions between agents with little consideration for the implications of structural discrimination. The challenge is clear, how can the concept of stigma be integrated into a broader social model of mental

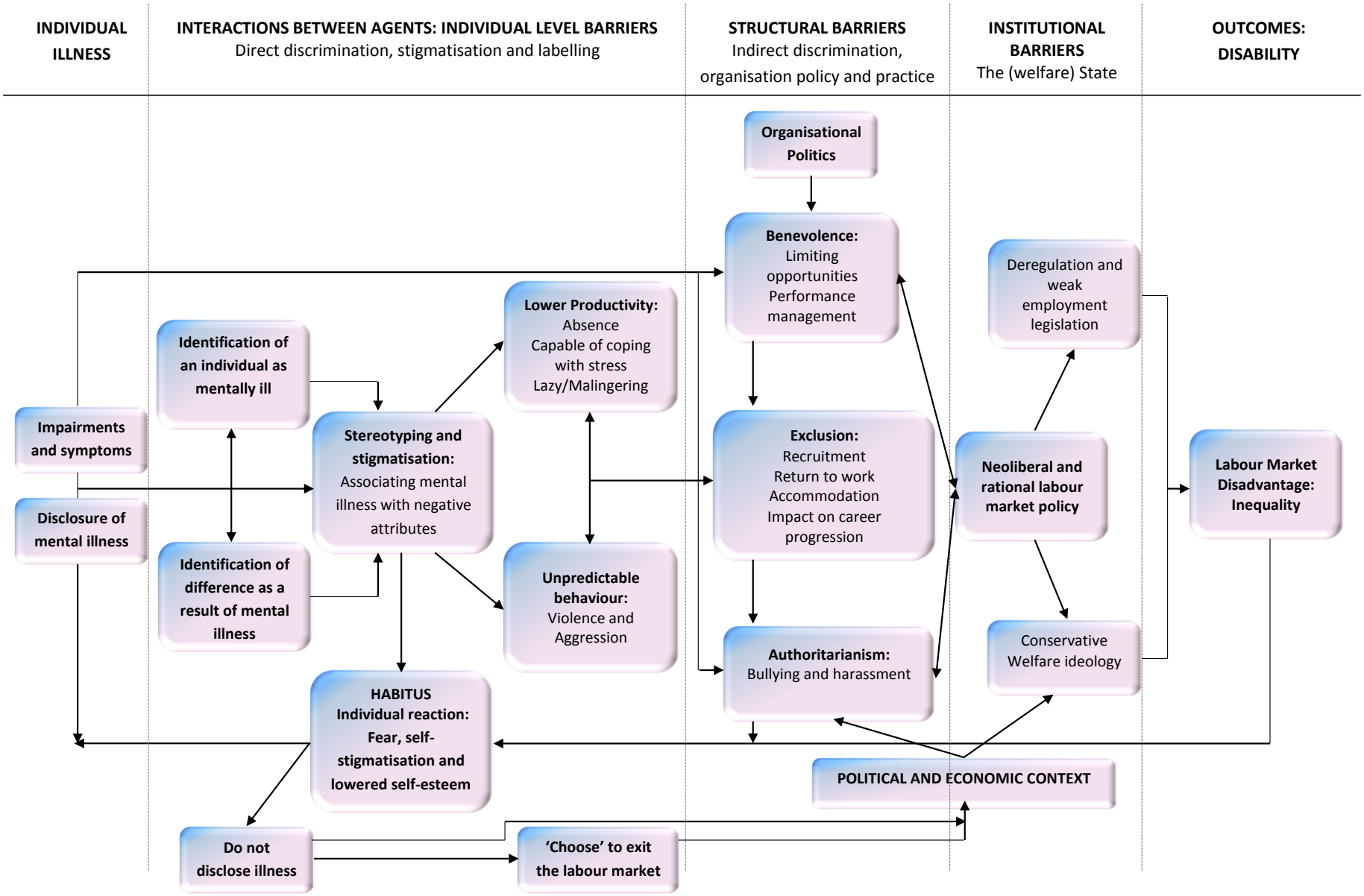
illness that incorporates structural, political and economic concepts? One solution is to draw on a range of existing sociological traditions, including the social model[4] of disability. Despite its importance the social model has been the subject of significant criticism, not least for its exclusion of mental health, but also its focus on social construction and reaction. The contemporary work of disability researchers highlights first, the limitations of conceptualising social barriers in crudely simplistic and determinist terms and secondly, the importance of acknowledging impairment, agency and difference.

Reconsidering and integrating stigma into a social model of mental illness

There is a need to revisit the approach adopted by social researchers to understanding mental health. The social model developed in response to the criticisms outlined here comprehensively rejects individualised neo-classical models that explain the disadvantage of those with mental health disabilities as an issue of either choice or ability (see Page, 2013). In contrast it presents an explanation influenced by the sociological tradition of constructionism, yet does not reject in its entirety materialism. In the case of mental healththere is no doubt that there is an objective experience, that the body is 'impaired'. However, an assumption of a direct causal relationship with incapacity to work is firmly rejected. The research used to develop this model (see Page, 2013) argues that the concepts of incapacity and disability are socially constructed, but in line with the social realist perspective of health and illness, this is constructed through a process of interaction between the agent and structure: between the impaired person and social 'barriers'.

As a result the following model can be presented:

[4] For a detailed discussion of the social model of disability see Barnes (1995)


INDIVIDUAL ILLNESS
INTERACTIONS BETWEEN AGENTS: INDIVIDUAL LEVEL BARRIERS
Direct discrimination, stigmatisation and labelling
STRUCTURAL BARRIERS
Indirect discrimination, organisation policy and practice
INSTITUTIONAL BARRIERS
The (welfare) State
OUTCOMES: DISABILITY
Organisational Politics
Benevolence: Limiting opportunities Performance management
Deregulation and weak employment legislation
Lower Productivity: Absence Capable of coping with stress Lazy/Malingering
Identification of an individual as mentally ill
Impairments and symptoms
Stereotyping and stigmatisation: Associating mental illness with negative attributes
Exclusion: Recruitment Return to work Accommodation Impact on career progression
Neoliberal and rational labour market policy
Labour Market Disadvantage: Inequality
Disclosure of mental illness
Identification of difference as a result of mental illness
Unpredictable behaviour: Violence and Aggression
Authoritarianism: Bullying and harassment
Conservative Welfare ideology
HABITUS Individual reaction: Fear, self-stigmatisation and lowered self-esteem
POLITICAL AND ECONOMIC CONTEXT
Do not disclose illness
'Choose' to exit the labour market

In sum, the model supported by this article suggests that social 'status' (socio-demographic characteristics of both the person with mental health disabilities and those in a position to support or reject them) influences the experiences of the labour market that individuals have regarding mental health. In turn, these shape the attributions and assessments that individuals make regarding persons with mental health disabilities. Together, these factors affect both prejudice and discrimination. This process occurs within a larger social, cultural, economic, human, political and institutional context, which sets the parameters for individuals' responses and result in the emergence of a variety of barriers to labour market inclusion. This importantly highlights that the process of discrimination is not reduced to the level of individual interaction, but structural macro-level processes interact with micro-level analysis. This formulation draws on structural level theory, presented more commonly in the literature on race and gender, to inform a structural model of discrimination. This structural model helps to demonstrate how prejudice and discrimination arise at the level of the institution and reflect economic, political and historical forces. Sociologically it is underpinned by social realism and embodied impairment, arguing that both mental health and inequality are constructed by an interaction between the agent and structures, but that mental illness is material, it has a bodily component, yet how that manifests itself in terms of experience is not something controlled purely by the individual.

This structural model helps to demonstrate how prejudice and discrimination arise at the level of the institution and reflect economic, political and historical forces.

Conclusion: A social model of mental health?

My contribution (Page, 2013) is to highlight that the study of disability and mental health should include both the analysis of disabling environments and the experience of embodied impairment. This overcomes the failure "to link personal experience to structural issues" (Mulvany, 2000: 592). Therefore, rather than providing a mechanistic 'cause and effect' explanation of the relationship between one's social environment and poor mental health this approach recognises that causality is an interaction; it is complex and occurs not between two inert objects but instead:

> "In complex cases, one cannot ignore the feedback of the vehicle of the action on other interacting bodies. ...To sum up, all processes in the world are evoked not by a one-way or one-sided action but are based on the relationship of at least two interacting objects." (Spirkin, 1983: 245)

As a result, the focus shifts away from the individual towards understanding the process of social disadvantage and oppression and the mechanisms of institutional oppression. There is a significant gap between this approach and a enduring study of mental health focused almost exclusively around cause, effect, and medical treatment. The alternative social model presented offers one solution to researchers attempting to address this gap.

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