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Racial, Ethnic, and Mental Illness Stereotypes: Cognitive Process and Behavioral Effects

In the past decade numerous researchers have reported that widespread acceptance and use of The Diagnostic and Statistical Manual of Mental Disorders-III (DSM-III) has increased reliability and validity of psychiatric diagnosis and minimized the influence of sexist and racist bias (Spitzer et al. 1980; Kass et al. 1983; Fabrega et al. 1990). Some researchers also report that clinicians’ racial and sexual attitudes have moved toward more objective and less stereotyped views (Brems and Schlottmann 1988; Kaplan et al. 1990; Fabrega et al. 1990). In contrast, other studies suggest that racist and sexist biases persist in psychiatric diagnosis and treatment despite the widespread use of DSM-III, and that racist and sexist stereotypes play important roles in clinicians’ perceptions and decisions (Loring and Powell 1988; Cleary et al. 1990; Redman et al. 1991; Fernando 1988; Waisberg and Page 1988; Lindsay and Paul 1989). The purpose of this chapter is to illuminate the dynamics and effects of stereotypes in the mental health field by comparing the stereotypes of mental illness with ethnic and racial stereotypes, and by examining recent empirical reports for evidence of the effects of racist and sexist stereotypes.

In his extensive study of prejudice, Ehrlich (1973) concluded that ethnic stereotypes are distinct, exclusive, consensual, persistent, and widespread. Because these stereotypes serve as guidelines and boundaries for social relations between groups, they do not change until the actual social relations change. Barth echoed a similar sentiment: “Revision only takes place where the category is grossly inadequate—not merely because it is untrue in any objective sense, but because it is consistently unrewarding to act upon, within the domain where the actor makes it relevant” (1969,
Stereotypes

This chapter deals primarily with materials from the United States, but some research from other western nations will be included. For convenience, the terms, attitude, conception, and image will refer to any statement, depiction, or belief about gender, race, ethnicity, or mental illness in which no question of truth or falsity is at issue (Nunnally 1961; Brigham 1971). In contrast, the term stereotype will refer to those exaggerated beliefs and images that are popularly depicted in the mass media and folklore whose inaccuracy can be demonstrated (Brigham 1971; Scheff 1966; Nunnally 1961; Glassner 1979; Redman et al. 1991; Littlewood 1992; Fernando 1988; Loring and Powell 1988). The term function will be used not in the eufuncational sense but rather in that of a phenomenon having reinforcing effects, anticipated or inadvertent, upon other social processes or institutions (Hempel 1959; Davis 1959; Nagel 1961; Spiro 1961). These effects may have positive or negative implications for particular groups, or for society as a whole (Schrag 1978).

In his classic work *Public Opinion* (1930), Walter Lippmann introduced and explicated the concept of social stereotype. He argued that all perception was necessarily selective. The myriad stimuli impinging upon an individual's sensory apparatus are sorted into categories. The categories are to some extent culturally determined and the sorting process itself becomes largely unconscious and automatic. The categories are inevitably stereotypes in the sense that they obscure important differences among members of a group and exaggerate the differences among the groups.

Since Lippmann's seminal work, an immense literature on ethnic and racial stereotypes has accumulated. Although generalizing from these studies is difficult (Brigham 1971), several propositions pertinent to our argument can be stated at this time. First, selective perception as described by Lippmann (1930) does seem to be a universal fact of human cognition. People all over the world group phenomena into categories and exaggerate the differences among these categories (Levi-Strauss 1965; Needham 1978). Second, when these categories involve human beings, they may serve to define the boundaries and relations between groups. The perceived, exaggerated differences between two groups help to justify the behavior of people in one group toward those in the other. The exaggeration of stereotypes thus can militate against the in-group per-

cieving out-group traits in themselves or perceiving in-group traits in outsiders (Littlewood 1992; Fernando 1988; Shibutani 1970; Ehrlich 1973; Klapp 1972; Barth 1969; Berreman 1972; DeVos and Romanucci-Ross 1975). To be sure, research has shown that a trait praised in the in-group can be used prejudicially against outsiders (the stereotypical competitiveness and success of Jews in business for example); but the insiders invariably feel that the outsiders express this trait unfairly or in unseemly ways (Allport 1958; Glassner 1979).

These general statements about ethnic stereotypes suggest two propositions about stereotypes of mental illness: (1) if popular images of mental illness act like ethnic stereotypes in demarcating an in-group out-group boundary, we should expect these images to be greatly exaggerated; and (2) passing from one group to another occurs in some situations with relative ease, but when the dominant group considers the subordinate group distinctly inferior, crossing over becomes difficult, if not impossible (Fernando 1988; Ehrlich 1973; Goffman 1964; Barth 1969; Eideheim 1969; Glassner 1979; Brigham 1971). Since insanity is by definition a grossly inferior condition, we should expect the threshold for redefining an in-group person as mentally ill to be very high. In fact, available evidence suggests that public images of mental illness remain extremely distorted and that crossing the boundary between sanity and insanity is problematic (Townsend and Rakfeldt 1985).

Exaggeration

The most consistent elements in our images of the mentally ill are violence and dangerousness. This is true of attitudes measured with abstract instruments as well as content analyses of media images. For example, an analysis of upstate New York TV Guide program listings (Townsend 1979) revealed that 54 percent of all allusions to mental health topics for 1976 portrayed the mentally ill as markedly bizarre and/or dangerous. Persons labeled "mentally ill," "psychotic," or 'psychopathic' were depicted as appearing and behaving in obviously strange ways: disheveled or bizarre costume, catatonic stupor, glassy eyes, maniacal laughter, homicidal tendencies. In fact, 24 percent of all allusions suggested a direct link between mental illness and homicidal behavior. Research indicates that the situation is similar in West Germany and has changed little in either country in the last thirty years (Townsend 1978, 1979; Townsend and Rakfeldt 1985; Loring and Powell 1988; Lindsay and Paul 1989). Empirical data on the behavior of ex-mental patients strongly contradict these images. Extensive studies of dangerousness have shown that crime rates among ex-mental patients are no higher than among corresponding persons in the general population. In fact, the reverse may be true. Recent
increases in arrest rates among ex-mental patients are apparently attributable to the increasing tendency to channel persons with arrest records into the mental health system (Townsend and Rakfeldt 1985; Lindsay and Paul 1989; Steadman, Cocozza, and Melick 1978; Steadman 1980, 1982).

Another commonly recognized image of mental illness is that of the delusional personality, that is, people believe they are Napoleon, Christ, or some other famous figure (Nunnally 1961; Scheff 1966; Schneider and Wieser 1972). Among twenty-five thousand patients Rokeach (1964) found only a handful of such people: only three patients without brain damage consistently believed they were Christ, and there were no Napoleons, Caesars, Krushchevs, or Eisenhowers. The evidence thus suggests that two of the most common stereotypes, violence and delusional personalities, are inaccurate.

Crossing

Barth has argued that ethnic boundaries only emerge in situations where the categorizations have a self-fulfilling character: "With such a feedback from people's experiences to the categories they employ, simple ethnic dichotomies can be retained, and their stereotyped behavioral differential reinforced despite a considerable objective variation. This is so because actors struggle to maintain conventional definitions of the situation in social encounters through selective perception, tact, and sanctions" (1969, 30).

Selective perception and self-fulfilling prophecy allow ethnic boundaries to persist despite a flow of personnel across them and despite campaigns that demonstrate their obvious inaccuracy or unfairness (Barth 1969; Ehrlich 1973). The sanity-insanity boundary is similar. The studies I shall examine below suggest that popular and professional conceptions of mental illness share four specific traits with ethnic stereotypes: (1) they are exaggerated and serve to dichotomize between the in-group and the out-group; (2) they are maintained through selective perception; (3) they erect high thresholds for "crossing"; and (4) they persist despite the flow of individuals across boundaries and despite campaigns to alter them.

In a now classic study from 1955, Star (1962) found that, when presented with textbook examples of mental disorders, the public defined only the most bizarre disorders (such as paranoid schizophrenia) as mental illness. Cumming and Cumming (1957) used the same psychiatric descriptions to study public attitudes. Like Star, the Cummings discovered that the public harbored much narrower, more concrete conceptions than the professionals' more psychological, normative, and continuous criteria. Public images of insanity apparently functioned to dichotomize between sanity and insanity. Because these images performed important cognitive functions, they were not easily altered by campaigns. Indeed, the Cummings' efforts to alter public conceptions were met with heated resistance. A replication of the Cummings' study in the same location (D'Arco and Brockman 1976) indicated that people's recognition threshold for mental illness had not changed substantially in the preceding twenty years. These studies suggest that the public's exaggerated images of mental illness reflect a cognitive dichotomy between sanity and insanity. Typically, people's behavior has to be "really crazy" for them to earn the title "mentally ill."

In a study that remains unexcelled for richness of detail, Yarrow et al. (1955) found that husbands had to breach wives' expectations repeatedly before they would finally be recognized as mentally ill. The wives repeatedly rationalized and normalized their husbands' symptomatic behavior because of the unpleasant and threatening consequences of redefining the behavior as symptoms of mental illness. After the "recognition" occurred, the wives tended to redefine past behaviors as symptoms of the incipient disorder. The husbands' behavior became qualitatively different in their eyes. Other studies have produced similar results (Sampson et al. 1962; Silver 1955; Bakwin 1963; Smith et al. 1963). More recently, Townsend and Rakfeldt (1985) found that in patients' first contacts with the mental health system, patients harbored extremely negative images of the mentally ill and mental hospitals, and they continued to use definitions of mental illness that excluded them. This use of stereotyped images of insanity and mental hospitals as contrast conceptions, however, was more problematic for the patients who had been admitted to state mental hospitals than for those who had been diverted to other forms of treatment. Apparently the threshold for crossing the sanity-insanity boundary is high for in-group members. When an individual has been designated as "normal," he or she must repeatedly exhibit deviant behavior to be reclassified by the family, self, or other in-group members.

Ethnic stereotypes share important similarities with the stereotypes of mental illness. A person's actions, appearance, or behavior is often less important in how individuals will be perceived than the labels or categories attached to them. For example, when presented with pictures of faces that varied in skin tone from whitest to blackest, subjects attributed stereotypes to the faces according to the experimenter's random labeling of them as Black or White. Thus, a relatively Black face, if labeled White, elicited White stereotypes (Secord 1959). Naturally, there were some exceptions to this tendency. Most subjects would not attribute White stereotypes to the blackest faces (or the converse) but did follow the suggestion effects of the label attached to the intermediate faces. It is interesting to note, however, that a small group of subjects were so prejudiced that they
sometimes followed the label regardless of the objective appearance of the stimulus. Similar results were achieved by changing the ethnic surnames attached to faces in the pictures (Razran 1950). We shall see later that mental health care professionals exhibit a similar tendency: a label previously attached by another professional or someone in the community appears to be a powerful determinant of how a clinician will perceive a prepatient.

Reentry

The role of stereotypes after initial labeling is less clear than in the initial stages. Smith et al. (1963) found that the incidents preceding rehospitalization increased in apparent dangerousness and disruptiveness. This suggested a raised threshold for rehospitalization, but it is not clear from the study whether this difference was actually behavioral or the result of a lowered cognitive threshold, that is, the second “last straw” was perceived as being more disruptive than the first (although not in reality). Some authors have suggested that labeling lowers the recognition threshold to the point where virtually any behavior could be perceived as a symptom. This seems to be particularly true in the context of the mental hospital (Goldman et al. 1970; Rosenhan 1973). In the community, however, it appears that crossing or recrossing the sanity-insanity boundary is more due to “negotiation” (Edgerton 1966, 1969). Some families may come to see the relative’s problem as psychiatric, but many do not categorize him or her as “crazy.”

This argument is consistent with the evidence indicating that some families refuse to define the patient as “mentally ill” even after extensive treatment. Lewis and Ziechnier (1960) found that 16 percent of the families in their sample persisted in such denial, while family attitudes ranged from sympathetic understanding to overt hostility. Greenley (1972, 1979), found that rehospitalization correlated negatively with the family’s desire to have the patient at home. Family attitudes that were significantly related to the number or readmissions included: keeping the patient at home. Family attitudes that were significantly related to the number or readmissions included: keeping the patient at home. Family attitudes that were significantly related to the number or readmissions included: keeping the patient at home. Family attitudes that were significantly related to the number or readmissions included: keeping the patient at home. Family attitudes that were significantly related to the number or readmissions included: keeping the patient at home. Family attitudes that were significantly related to the number or readmissions included: keeping the patient at home.

It thus appears that the sanity-insanity boundary is maintained by the same mechanisms as ethnic boundaries: exaggerated stereotypes and selective perception. In both situations people struggle to maintain conventional definitions by selectively perceiving and by rationalizing their categorizations. In this way their stereotypes can exist side by side with their actual experience with a member of the out-group. In ethnic and racial prejudice, this process of rationalization allows the bigot to like some members of an out-group because “they’re not like the rest” (Alipor 1958, Ehrlich 1973).

Professional Conceptions

In the preceding section I argued that the public’s initial tendency to diagnose mental illness is conservative. The public’s initial recognition threshold (at least for family members) is high in part because they do think of mental illness in stereotyped terms. This high threshold becomes particularly significant when one considers that initial recognition does occur in the community. Representatives of the mental health system usually see the prepatient only after lay persons or non-psychiatric professionals in the community bring the prepatient to their attention (Yarrow et al. 1955; Mechanic 1962; Townsend 1979; Townsend and Carbone 1980; Canny et al. 1990; Redman et al. 1991). This means that the mechanisms of social control are set in motion before the mental health professional sees the offender, and the public’s high recognition threshold acts as a kind of conservative filter, repeatedly normalizing deviant acts until the last straw is reached.

Numerous authors have argued that psychiatrists and the courts act as filtering agents of social control once the public’s recognition threshold has been exceeded. It is then their task to protect society from further disruption (Mechanic 1962; Scheff 1966, 1975; Szaaz 1963, 1970). If this is true, then psychiatrists cannot employ the same recognition criteria as the public; otherwise they, like the public, would tend to normalize most of the deviant behavior and send the deviants back to the community. Logically, if psychiatrists are to perform their social control functions, compared to the public they must have rather broad criteria for recognition.

Broadness

In the late 1960s and early 1970s, several studies of diagnosis supported the notion that American psychiatrists had relatively broad criteria for the recognition of psychosis. Kendell et al. (1971) matched groups of British and American psychiatrists who viewed videotapes of patient interviews. Agreement was high in the major diagnoses of patients who exhibited classic, textbook symptoms. In contrast, the tapes that were
chosen specifically to represent nonpsychotic disorders caused serious disagreement. The American audience tended predominantly to diagnose schizophrenia (69-85 percent) whereas the British shunned this category (2-7 percent). This glaring difference was not caused by semantics but rather by psychiatrists’ actually perceiving different symptoms in the patients’ behavior. One patient, for example, was rated by a majority of the Americans as showing delusions, passivity, and thought disorder. Only about 7 percent of the British psychiatrists gave similar responses. The author concluded that the diagnosis “schizophrenia” was used so freely in America as to be virtually meaningless.

Temerlin (1968) had a professional actor portray an ideal, normal man in an audiotaped clinical interview. Before hearing the tape, each group of experimental subjects heard a prestigious confederate remark that the man appeared neurotic but was really psychotic. Control subjects heard that the man was perfectly healthy. Of the experimental subjects, 60 percent of the psychiatrists, 28 percent of the psychologists, and 11 percent of the graduate students diagnosed psychosis. In contrast, all control subjects agreed unanimously that the man was not psychotic. Thus, in the Kendall and Temerlin studies, American psychiatrists seemed to have a perceptual set to assign a labeled “out-grouper” to the most extreme out-group, and the broadness of their criteria allowed them to do so. Like the experiments in ethnic stereotyping (Secord 1959; Razran 1950), the label attached to a person played a more important role in determining what qualities were attributed to that person than the individual’s actual appearance or behavior.

Some researchers would claim that widespread use of DSM-III has increased reliability and validity of psychiatric diagnosis to the point that influence of nonpsychiatric factors has been minimized if not eliminated, and findings like those of Kendall and Temerlin are no longer valid (Spitzer et al. 1980; Kass et al. 1983; cf. Kleinman 1988a). As we saw previously, however, initial “diagnosis” of mental health problems is typically made by lay persons in the community, or by nonpsychiatric professionals. For example, Bart and Grossman (1976) cite the following results from a sample of 250 questionnaires collected and analyzed by the Woman in Midstream group. Although only about 60 percent of the sample sought medical treatment for organic symptoms of the climacteric from their family physicians or gynecologists, 75 percent received estrogen therapy. For 11 percent no treatment was prescribed, and for 9 percent psychiatric therapy was recommended. The most alarming finding was that 55 percent received prescriptions for psychotropic medications.

In a pioneering study of symptom variation, Donovan (1951) found that the method of taking clinical history places disproportionate emphasis on the symptoms to which the physician directs the patient’s attention. The author, over a period of several months, repeatedly interviewed women who were diagnosed by physicians as suffering from “menopausal syndrome.” Of these women, 95 percent appeared to have highly suggestive and had a series of similar complaints before menopause. Donovan concluded that symptoms of emotional stress occurred with menopause only if there had been a past history of emotional problems, and that considerable variability appeared in the reporting of symptoms in different interviews with the same woman.

Actually, all symptoms of disease that become organized into illness behavior do so through a process of negotiation. The impact of sociocultural factors, however, on this “construction of clinical reality” (Kleinman et al. 1978; Kleinman 1988a, 1988b) is most pronounced when symptoms are relatively amorphous and ambiguous. Certainly, this is true of mental disorders (Edgerton 1969; Rushing and Esco 1977; Rushing 1978; Townsend 1978, 1979, 1980). Most psychosomatic and psychological symptoms are nonspecific and amorphous (Strauss et al. 1979), and in many respects resemble symptoms of some of the folk illnesses described in medical-antropological literature: headaches, dizziness, fatigue, anxiety, insomnia, general aches and pains, indigestion, depression (Madsen 1964; Kleinman 1988a, 1988b; Kleinman et al. 1978). When general complaints such as these are not tied to any demonstrable organic cause, they are especially vulnerable to the impact of social factors that shape illness behavior. These studies suggest that amorphous complaints and malaise produced by psychocultural factors become organized through clinicians’ selective perception and broadness of criteria into psychiatric syndromes, and nonpsychiatric as well as psychiatric professionals play an active, albeit inadvertent, part in recruiting women into these roles (Kleinman 1988a, 1988b; Townsend and Carbone 1980). The two studies that follow suggest that primary-care physicians continue to play crucial roles in this process (Redman et al. 1991; Cleary et al. 1990).

A study of diagnoses made by primary-care physicians in Wisconsin compared the results of the General Health Questionnaire (GHQ) and the Schedule for Affective Disorders and Schizophrenia-Lifetime Version (SADS-L), with patients’ medical records (Cleary et al. 1990). More women than men were diagnosed as having mental health problems. Using the GHQ as a measure of the tendency to self-report problems and the SADS-L data as a measure of physician-diagnosed psychiatric symptoms, the thesis that women are more likely to report symptoms and that this accounts for the frequently documented finding that women are more often diagnosed as having mental problems than are men, was not substantiated. Rather, patients with more severe psychiatric symptoms
more likely to be identified by their primary-care physicians as having psychiatric symptoms, recognition of psychiatric symptoms by primary-care physicians was poor: correct positives and negatives for women comprised only 35.7 percent, and for men only 26.7 percent. But women had significantly higher false positive rates (19.0 percent) than men did (10.7 percent). The authors conclude that some women without psychiatric problems are less likely to receive needed psychological attention or referral from their primary-care physicians.

A study in New South Wales, Australia, yielded even more dramatic evidence of gender bias in primary-care physicians’ diagnoses (Redman et al. 1991). In a sample of 1,913 patients, males and females showed equal levels of psychiatric symptoms when assessed by the GHQ; fifty-six doctors, most of whom were male, diagnosed more female than male noncases (as assessed by the GHQ) as having psychiatric symptoms; 77 percent of the doctors who diagnosed more than twenty cases ascribed a higher proportion of false positives to women. A second study of male and female interns yielded similar findings, but only male interns diagnosed a higher percentage of female noncases as having mental problems. The authors propose that female interns are more feminist in their sex role attitudes than the male interns and are, therefore, less likely to harbor and be influenced by sexist stereotypes. High scores on the GHQ signified greater symptomatology. There were fewer false positives and negatives for high scorers, and there was no gender difference in the proportion of false positives for high scorers. These findings thus also support the view that nonclinical factors like gender, race, and social class have their greatest impact when symptoms are less discrete and severe and more ambiguous (Townsend 1978, 1980; Townsend and Rakfeldt 1985; Redman et al. 1991).

Loyal supporters of DSM-III might argue that when it is used by experienced psychiatrists, systematic bias such as that found in the diagnoses of primary-care physicians is improbable, if not impossible. To test this claim, Loring and Powell (1988) had 488 psychiatrists, comprising equal numbers of Blacks and Whites, and males and females, diagnose two actual cases that had previously been diagnosed as undifferentiated schizophrenia. Equal numbers of subjects read that the cases were either Black or White, or male or female, or received no information at all on the sex and race of the cases. Approximately equal percentages of the four groups chose the modal diagnosis, that is, the category that had previously been assigned these cases in real life: undifferentiated schizophrenia. The control subjects had no information on the cases’ gender or race and their concordance rate was superior to those of the experimental groups, and alternative diagnoses assigned to the control cases showed no distinctive pattern.

In the alternative diagnoses assigned to the cases labeled by gender and race, however, systematic gender and racial bias appeared. In general, subjects were more accurate (that is, more likely to assign the modal diagnoses) when diagnosing cases that coincided with their own race and gender. The authors had predicted this result in terms of common experience and empathy: that greater familiarity with clients’ experience and social position would lead to greater accuracy in interpreting the meaning of deviant acts. The one exception to this finding was the tendency of White female psychiatrists to assign the alternative diagnosis, brief reactive psychosis, to White female patients. The authors speculate that in this case, greater familiarity led to greater empathy (and perhaps greater sympathy) and caused the White female psychiatrists to assign a diagnosis that is less severe, that is a reaction to psychosocial circumstances rather than the manifestation of biological predispositions and that, therefore, has a better prognosis. Apart from this finding, the heterogeneity in diagnoses is suggestive.

As alternative diagnoses for female cases, male psychiatrists tended to assign depressive disorder for Axis 1 and histrionic disorder for Axis 2, suggesting that male clinicians continue to endorse the stereotype of women as having emotional problems (Chesler 1972; Kaplan 1983; Kass et al. 1983; Fabrega et al. 1990; Cleary et al. 1990). Black male patients tended to receive paranoid schizophrenia as the modal alternative diagnosis from all four groups—although of the four groups, Black male psychiatrists were the least likely to assign this category. This finding supports the view that members of an in-group are less likely to view other members in stereotyped terms (Townsend, 1978, 1979; Townsend and Rakfeldt, 1985). Paranoid schizophrenia contains elements of suspiciousness, dangerousness, and violence. Both male and female Black cases tended to receive paranoid personality disorder as the Axis 2 alternative diagnosis, whereas the modal diagnosis was dependent personality disorder. In contrast, when Black psychiatrists evaluated same-sex White patients, they chose either the modal diagnosis or less severe disorders.

The authors suggest that, compared to their alternative diagnoses for same-sex Black cases, this finding may indicate that Black psychiatrists internalize White standards during their medical training. If this is true, in terms of our model of stereotypes, these Black psychiatrists are using (perhaps unconsciously) White standards as their reference group, and the Black cases as contrast conceptions—albeit not to the same extent as
do their White peers. Loring and Powell conclude that although the use of DSM-III has probably reduced the effects of race and gender bias, it has not eliminated them. Some significant effects remain and, even with carefully drawn standards, psychiatric diagnosis is to some degree still a subjective activity.

The results of these studies are not merely of academic interest. Some diagnostic differences carry weighty implications. A person labeled "psychotic" is much more likely than a nonpsychotic to be involuntarily committed; to be treated with major tranquilizers and shock therapy (ECT); to have his or her legal rights and responsibilities suspended.

The breadth of clinicians' recognition criteria probably springs from several sources, not just the suggestion effects of prior labeling. First, family and community members see a prepatient in a social context and are therefore more likely to observe coping strengths and assets as well as disordered behavior. Mental health professionals usually see the prepatient in a clinical context and are thus less likely to observe aspects that militate against a diagnosis of mental illness. Second, clinicians are trained to look for pathology. Because no demonstrable organic pathology exists for the functional mental disorders to validate diagnosis, there are fewer objective checks than in other clinical fields on the professional's tendency to look for pathology (Townsend 1980; Townsend and Rakfeldt 1985; Kleinman 1987). This may explain why, before DSM-III, large-scale psychiatric screening of the public turned up so many unreported "psychotics" (for example, Srole et al. 1962; Beiser 1971). Unquestionably, the systematic use of stringent diagnostic criteria can produce acceptable levels of reliability in research settings (Kendell 1975; Kleinman 1988a). In everyday clinical practice, however, breadth of criteria and selective perception continue to allow nonclinical factors to influence diagnosis and treatment.

A third reason American psychiatrists may have relatively broad recognition criteria for mental pathology is their basic assumption about normality. Beiser points out a common assumption: in the absence of symptoms, a person should be happy, productive, and competent (1971, 254). This assumption ignores the reality that any normal life involves some setbacks, some unhappiness, some depression. A comparison (Townsend 1978) of American and German ideology suggests that Americans tend to assume a more idealistic view of life than do Germans, and these basic ideological differences also appeared in American and German mental health professionals' conceptions of mental illness. Thus, harboring this assumption about normality, American professionals may be particularly liable to perceive pathology in normal people.

Selective Perception

Apparently, both public and professionals maintain their conventional definitions of situations through selective perception and rationalization. But compared to the public's relatively high initial threshold for recognition (at least for in-group members), professionals' thresholds appear to be lower, particularly if labeling by other mental health professionals has already occurred. In the 1970s, researchers who had themselves admitted as patients to mental hospitals corroborated this view (Rosenhan 1973; Goldman et al. 1970). Compared to the public, psychiatrists were able to perceive their stereotyped images in a much broader range of behaviors. The following examples indicate that some recently trained clinicians still maintain their definitions of out-groups through selective perception, rationalization, and behavioral sanctions.

Waisberg and Page (1988) had 45 male and 38 female psychotherapists evaluate case studies: experimental subjects read cases that exhibited gender inappropriate symptoms, (that is, males evinced emotional disorders and females exhibited antisocial disorders). Cases described as exhibiting gender inappropriate symptoms were evaluated as more psychologically disturbed by subjects, but this difference was strong only for male patients described as depressed. The authors concluded that Chesler's (1972) thesis—females' gender nonconformity is perceived as more threatening than males' and is therefore punished more strenuously—was not supported. Waisberg and Page argue, however, that recent research does support Broverman's original finding that women are perceived by professionals as intrinsically more maladjusted (Broverman et al. 1970).

The effects of selective perception, breadth of criteria, and stereotyping emerged in Townsend and Rakfeldt's (1985) investigation of first-admission patients. The interviewer, Jaak Rakfeldt, observed the admission of a 43-year-old woman who had had one previous, short admission and was reluctant to enter the hospital. She also was very much opposed to taking medication. After the admitting room doctor had asked the routine questions, the patient was admitted to the hospital. The doctor then grappled with how to diagnose the patient according to the standard nomenclature. The following dialogue ensued:

**DOCTOR:** (looking through DSM-III): Let's see . . . what do we have here? Which type of schizophrenia is she? [He discussed the matter with an attendant who had been helping with the admission procedure. He then looked over at the researcher and asked] What do you think?

**RESEARCHER:** She seems to know who she is, where she is, and when all this is happening. Also, her brother said she has been "slightly odd since she was four-
Schizotypal Personality Disorder—you know, like a characterological problem. Perhaps, with the new classification in the DSM-III, she could be defined as a "teen," and has, according to her brother, had those strange thoughts for years. Perhaps, with the new classification in the DSM-III, she could be defined as a Schizotypal Personality Disorder—you know, like a characterological problem.

DOCTOR: But if it’s a personality disorder, she should be out there [gestured with his hand pointing out the window] not in here. People with personality disorders are out there. And how can I give her Thorazine [which he had already prescribed], if she is a characterological problem? This [medication] is for schizophrenia.

RESEARCHER: Well, those are just my thoughts.

On the admission papers she was diagnosed as “schizophrenia, undifferentiated, subchronic” (DSM-III 295.91), and the phenothiazine was administered. This woman was certainly not more symptomatic than many others who were observed or interviewed and who were not admitted, but unlike those others, she lacked community supports such as family and friends. For example, the researchers observed a young man who refused treatment at Crisis Residence although his family and girlfriend reported that he had recently become verbally abusive and had experienced auditory hallucinations. He finally agreed to receive outpatient treatment from a local psychiatrist. Thus, although this patient exhibited some definitive symptoms of schizophrenia, he was not hospitalized, whereas the middle-aged woman with less obvious symptomatology but with a previous hospitalization was admitted. These cases support the thesis that family supports and history of previous hospitalizations often are more potent determinants of disposition than symptomatology (Lamb and Talbott 1986; Talbott 1974; Greenley 1972; Strauss and Carpenter 1972; Leff 1976; Mendel and Rapport 1969; Harder et al. 1990).

In the case of the 43-year-old woman, the impact of the labeling process became evident when, after the decision had been made to commit and to medicate the patient, the diagnostic label was then used to justify this action. Furthermore, the psychiatrist used contrast conceptions when he stated that persons who are not psychotic should be “out there,” but if someone is in the hospital, then “they must be psychotic.” Finally, there did not appear to be great concern about stigma and disruption to this person’s life. Perhaps because her life was already disrupted and she had previously been hospitalized, the admitting psychiatrist may not have considered these issues important. This is in marked contrast to the orientation and methods of the staff interviewed in a Crisis Residence Center (Townsend and Rakfeldt 1985). Ironically, the patient stated during the routine interview that a major part of her problem was that she had been “depressed about not being with her husband.” She added that “after I was in the hospital [she had experienced one very brief hospitalization] several years earlier] he [her husband] said he was afraid of me. He said he didn’t want to be with me.”

Lindsay and Paul (1989) note that poor, uneducated persons who lack family and community supports still predominate in state and county hospitals despite deinstitutionalization (Kiesler 1980; Kiesler et al. 1983). Blacks are overrepresented in custodial institutions, and more so in urban settings. Furthermore, Black patients are even more disproportionately represented among involuntary commitments. Compared to other admitted groups, Black patients tend to have slightly lower socioeconomic levels and are assigned more severe diagnoses. Otherwise, Blacks show no consistent differences from other groups that would account for these overrepresentations.

Lindsay and Paul’s extensive review (1989) revealed that empirical investigations offer little evidence that the state’s use of coercive power for involuntary commitments was justified by committed patients’ having more severe symptoms. The criterion of dangerousness may have been consistently applied: that is, those individuals committed under this standard appeared to have committed more violent or dangerous acts. But the evidence that the criterion of grave disability had been consistently applied was singularly unconvincing. Moreover, even the best of these studies were marked by sloppy methodology and lack of controls, and they presented no explanation or justification of racial differences in the rates of involuntary commitment. The lack of cogent evidence to justify involuntary commitments is particularly critical in view of the increasing number of tort liability cases resulting from errors in commitment decisions, and because of current pressures to broaden the criteria for involuntary commitment, with consequent increases in the proportion of involuntary admissions and perhaps in overall admissions as well (Lindsay and Paul 1989, 179; see discussion of Lamb and Talbott 1986, below).

Even voluntary commitments are frequently not so voluntary. One study showed that in a majority of voluntary admissions, the individuals were already under some form of official custody and were faced with the threat of involuntary commitment proceedings as the principal alternative. When individuals decide on voluntary commitment, they waive certain constitutional rights, often without full cognizance, and frequently during all these proceedings they are living under heavy medication (Gilboy and Schmidt 1971). Lindsay and Paul point out that in studies of the justification of involuntary commitment, patients who sign in voluntarily under duress represent false negatives, whereas patients whose involuntary commitments cannot be justified on the basis of their
symptomatology (false positives) "represent a serious error in the assessment/decision-making process, an error in which racial or other biases are suspect" (1989, 175).

Examining the records of 19,400 adult patients in Los Angeles County treated between 1983 and 1988, Flaskerud and Hu (1992) found that patients in lower socioeconomic levels had fewer sessions with their primary psychotherapist, received fewer prescriptions for psychotropic medications, and were less likely to be treated by professionally certified psychotherapists. Black race or ethnicity correlated with fewer sessions with the primary therapist, but Blacks received more treatment with psychiatric medications, despite the fact that Blacks were overrepresented in the lower socioeconomic strata. Receiving less psychotherapy and more medication is associated with poor prognoses, recidivism, and chronicity.

In the Loring and Powell study (1988), male and female Black patients received paranoid personality disorder as the modal, alternative, Axis 2 diagnosis, and Black males received paranoid schizophrenia as the modal, alternative, Axis 1 diagnosis. The tendency to stereotype Black patients with these more threatening diagnoses, and then give them more drugs but less psychotherapy, may help to explain Blacks' overrepresentations among admissions, readmissions, and in particular, involuntary commitments. Furthermore, as Adebimpe has noted, even if it could be shown that symptomatic differences between Blacks and Whites were "merely" the effects of social class—something which has not been demonstrated—the overrepresentation of Blacks in the lowest socioeconomic groups means that any problems associated with belonging to those classes will afflict even larger numbers of Blacks, and clinicians and society have the responsibility to analyze and ameliorate those conditions (Adebimpe 1981, 284; see also review of Harder et al. 1990, below).

Social Control

In the 1970s, British psychiatrists apparently had much narrower conceptions of psychosis than did American psychiatrists (Kendall et al. 1971). One possible explanation for this discrepancy concerns our mental health care system's social control function. If this system functions to control (and help) a broad range of deviants, including geriatric cases, indigents, and otherwise helpless people, then American professionals must have extremely broad criteria for mental illness. Insofar as some other countries have better welfare systems, fuller employment, and less sexist, racial, and class exploitation, they can afford stricter criteria for "mental illness." Some evidence points in this direction (Townsend 1978; Taube and Redick 1973; Braginsky et al. 1969; Stearns and Ullman 1949).

In the United States, criteria for commitment and definitions of mental illness have fluctuated with the availability of public funding and with the public's awareness of (or annoyance with) mentally disordered individuals. As resources became scarce, and civil libertarian pressure for reform mounted in the 1970s, statutory and policy revisions narrowed the criteria for commitment and treatment. Agencies frequently manipulated labels and categories to avoid taking on patients with a bad prognosis, and an increasing number of patients were "dumped" on other agencies (Robbins et al. 1977). For example, the criminal justice and mental health systems both manipulated labels to channel repeaters into each other's system (Steadman et al. 1978; Lamb and Grant 1982, 1983). Similarly, mental health agencies redefined or more strictly defined certain conditions (chronic brain syndrome, for example) to shift chronic patients to nursing homes and other agencies (Hoyer and Tars 1978). By the early 1980s, several states had consciously adopted policies to divert patients from hospitals and back into the community (Townsend and Rakfeldt 1985).

Townsend and Rakfeldt's (1985) interviews with crisis staff and mental health officials in upstate New York revealed a strong awareness of the problem of institutionalism. These professionals realized that state hospitals function as havens for people who have few options in mainstream society. These "chronics" are often less symptomatic than first-contact patients, many of whom are acting out or suicidal, but the former group wants to be in the hospital—or at least in some refuge—and will produce the necessary behaviors to be admitted (Braginsky et al. 1969). Mental health officials particularly feared that inflation and rising unemployment rates would contribute to a sharp increase of young, unemployed males in the mental health system. Interviews with three male repeaters showed that they matched the official definition (or stereotype) of young chronics: relatively young males with no marketable skills, a history of drug and/or alcohol abuse, and no strong ties to family and friends. These men were transient and looked to the hospital as a last resort (Braginsky et al. 1969). As one of these men remarked, the hospital gave him a roof over his head and he could work there, go to the gym, and make enough to buy soap, cigarettes, and razor blades. Another noted that the hospital was superior to jail in most respects, but it worried him that he could not smoke in the hospital when he wanted to.

Our model of stereotypes suggests that professionals maintain their definitions of those who have crossed the boundary not only by selective perception and rationalization but also by behaving in such a way as to "fulfill the prophecy." Merely appearing at an admissions unit thus often constitutes prima facie evidence that the patient probably needs hospital-
ization. An interview with a top-level mental health planner and policy analyst supported this view (Townsend and Rakfeldt 1985). This official noted that a study conducted in upstate New York indicated that 80 percent of the people who appeared at an admissions service were admitted, regardless of what alternatives existed in the community. He concluded, “This finding seems to say that if you locate an admissions service in a hospital, there is a good chance people will be admitted.” Another administrator explained that the primary policy initiative had become management in the least restrictive setting: Don’t admit patients if they can be handled in day care, don’t treat them in day care if you can handle them in clinic, and don’t get them into the mental health system at all if they can be managed in the community. Evidently, statements of mental health staff and administrators—and indeed the entire diversion policy of New York state in the early 1980s—constituted a relatively explicit acknowledgment that treatment, in and of itself, within the mental health system contributed to recidivism and chronicity, and that, therefore, the best intervention was often the least possible intervention (New York State Office of Mental Health 1982).

Attempts such as New York state’s diversion policy to reform the mental health system enjoyed only limited success. Bagby and Atkinson (1988) conclude that, in general, attempts to reform commitment procedures by reducing medical discretionary authority and replacing it with evidentiary and objective criteria have met with substantial resistance from the psychiatric community. In several states, tightening diagnostic and commitment criteria produced only brief reductions in admission rates, which then steadily climbed back until they reached or exceeded their prereform levels. In some jurisdictions, tightening criteria merely increased the number of patients committed without adequate evidence, and for extralegal reasons such as “lacks insight” and “refuses treatment” (Bagby and Atkinson 1988; Hasebe and McBane 1987).

The American Psychiatric Association has proclaimed that policies of deinstitutionalization and diversion to the community have set adrift a vast population of mentally ill indigent and homeless (Lamb and Talbott 1986). As the authors remark, “Society has a limited tolerance for mentally disordered behavior” (1986, 499). Consequently, to meet the needs of these unfortunate, and to protect their relatives and the community, the entire mental health system must be greatly expanded, including the criteria for voluntary and involuntary commitments. The authors note that many indigent patients, especially the young, tend to drift away from their families and supervised residences because they are “trying to escape the pull of dependency,” or, if they still have goals, because they find an inactive, low-pressure lifestyle extremely depressing, or because they want more freedom to drink or use street drugs.

Once they are on their own, they typically stop taking their medications. Therefore, adequate “psychiatric and rehabilitative services must be available and must be provided assertively through outreach services when necessary” (500), with “easy access to short- and long-term inpatient care when indicated” (499). Evidently, the American Psychiatric Association now wants to reacquire the “young chronic” we identified earlier—exactly those patients that New York state officials wanted to exclude in the early 1980s.

The stigmatizing of disadvantaged economic, ethnic, and racial groups, and their relegation to public institutions in the United States has a long and unseemly history (Rothman 1971; Prudhomme and Musto 1973). In the past, stereotypes of mental illness have not only functioned like ethnic stereotypes, at times they actually were ethnic stereotypes. For example, Protestant New Englanders frequently labeled Irish immigrants “degenerate” or “mentally ill” and in the mid nineteenth century the Irish became the predominant population in Worcester, Tewksbury, and other state hospitals in the Northeast (Rothman 1971).

Several authors have noted that contemporary mental hospitals in America tend to serve the same populations as the old almshouses of the nineteenth century (Miller 1965, 1967; Braginsky et al. 1969). Stearns and Ullman’s (1949) investigation of one such institution revealed that over a period of ninety-four years the inmates had not changed much—only society’s label for them had. Before, they were merely helpless and poor; now they had become mental patients. Stearns and Ullman list the characteristics that made recent immigrants particularly vulnerable to such labeling: they have come to this country usually without funds and are sought out only as unskilled laborers; they speak a foreign dialect or language; when unemployment increases, they are the first to lose their jobs; they have few resources in family or friends. On examining the contemporary patient population, the authors concluded that most of the patients were there for the same reasons: they lacked family, friends, and the skills and connections that would enable them to cope in the outside world. It should be noted that these same traits characterize today’s urban poor, particularly poor Blacks, and may help to explain the reported correlations among living in poverty, being Black, and having chronic mental illness (Pierce et al. 1985; Lamb and Talbott 1986; Lindsay and Paul 1989; Harder et al. 1990).

In an earlier study, Turner and Gartrell (1978) argued that the frequently reported correlation between low socioeconomic status and poor psychiatric outcome was a selection artifact. People’s social competence
allegedly determines their length of stay in hospitals, and their social position and resources have no impact on outcome when one controls for social competence. The authors' measure of social competence (derived by means of some rather dubious statistical procedures) is a person's position and resources have no impact on outcome when one controls for social competence. The authors concluded that social status, good family connections, and work performance themselves do not help to determine outcome but, rather, arise as a consequence of conditions within individuals. These conditions are describable as psychopathology on the one hand and social competence on the other (1978, 378).

There are several serious problems with this interpretation. First, the literature just reviewed would suggest that diagnoses used in research settings may already contain bias introduced by the processes of stereotyping. Most researchers, including Turner and Gartrell, attempt to control for bias by having a “blind” evaluator rate the psychiatric interview material. But the original interviewers were not blind, nor were the patients' original clinical evaluators. Indeed, it is doubtful whether anyone can ever be totally blind to a respondent's gender, race, ethnicity, or poverty (Adebimpe 1981; Fernando 1988; Littlewood 1992; Loring and Powell 1988). This suggests that the bias introduced by selective perception may affect not only the makeup of the original population but also subsequent research procedures.

A second objection to Turner and Gartrell's conclusion is that some extremely elegant studies have documented the relevance of family desire and social status to patient outcome (Greenley 1972, 1979; Steadman and Cocozza 1974). These studies controlled for various measures of positive social functioning and found that family desires nevertheless remained a potent determinant. Their broader measures of social competence seem more convincing than Turner and Gartrell's rather narrow, abstruse, and possibly artificial measure. Furthermore, Rushing (1978) demonstrated that, controlling for other significant variables, lower social status correlated with involuntary commitment. People with more resources are able to avoid being committed, their symptoms being equal.

A third problem with Turner and Gartrell's argument is their insistence on locating the determinants of outcome exclusively within individuals. Earlier we saw that psychiatric diagnosis can operate like ethnic stereotypes in defining social relations between groups, including relationships of power. The attempt to locate the causes of deviance and social “failure” exclusively within individuals preempts an examination of these relationships of power and possible sociocultural determinants of human misery (Caplan and Nelson 1974). The assumption embodied in such thinking is convenient for those already in power and very much in the American grain. The assumption is that people cannot “make it” if they really try, regardless of external circumstances (Arensberg and Niehoff 1975; Hsu 1972; Townsend 1978). A corollary of this assumption, clearly embodied in Turner and Gartrell's definition of social competence, is that people who are not upwardly mobile—that is, do not have a more prestigious occupation than their fathers—are somehow inferior to those who do. This seems a rather arbitrary, but very American, value judgment. It is quite possible that, viewed from another perspective, some of those behaviors that contribute to upward mobility might be considered selfish, stress-producing, alienating, or otherwise undesirable (Hsu 1972; Henry 1963). The emphasis on self-reliance and upward mobility, however, is deeply entrenched in American ideology and social policies. A comparison of Germany and America (Townsend 1978) demonstrated that these values also permeate American popular and professional conceptions of mental health. It is not surprising, therefore, that these values should also crop up in American mental health policy and research.

At first glance, the findings of Harder et al. (1990) appear to support Turner and Gartrell's (1978) argument regarding social competence. In a longitudinal study of first-admission patients, Harder et al. (1990) found that social competence was a powerful predictor of psychiatric outcome. As in numerous prior studies, patients' social class emerged as a significant predictor for outcome functioning and level of health or sickness. But psychotic and schizophrenic symptoms increased disproportionately among Blacks even when the influence of patients' social class was statistically controlled. Of all predictor variables, patients' IQs showed the strongest correlations with all outcome measures and with the increases in symptomatology between the initial and follow-up surveys. Patients' gender, age, and amount of interim life-event stress were not significant predictors of outcome. The authors concluded that a general “social competence factor”—comprising premorbid marital adjustment, social functioning, and IQ—predicts psychiatric outcome across the entire spectrum of severe disorders. The authors speculate that a higher degree of chronic environmental stress, as opposed to specific life events, may account for Black patients' greater increases in symptomatology.

To their credit, Harder et al. (1990) do not attempt to locate the causes of poor people's greater recidivism and symptomatology solely within individuals—unlike Turner and Gartrell (1978). Harder et al. also opine that Blacks may suffer from greater chronic environmental stress, which was not controlled in their measures. The authors used Hollingshead's two-factor index to control for social class. Although this measure is adequate for some research purposes, it is probably too crude to differentiate and control for psychocultural factors that might explain Black patients'...
disproportionate increase in symptoms. It is also possible that a relatively small percentage of Blacks in higher socioeconomic levels in the sample precluded valid statistical control of this factor. Finally, the authors' conclusions ignore a long history of criticism of IQ tests as culturally and socioeconomically biased. Fernando, for example, argues that researchers and clinicians continue to use IQ and personality tests without consideration of cultural and racial bias because such tests confirm their everyday observations and substantiate their stereotypes (1988, 137).

Conclusion

Evidently, institutionalized patients have particular relevance for the study of stereotypes of powerless groups. In both cases the stereotypes held by the dominant group may prescribe not only how they will act toward the subordinate group, but also how they will allow the subordinate group to act (Fernando 1988; Glassner 1979). Thus, if White slaveowners thought that Blacks were lazy, shiftless, and childlike, the slaveowners' own behavior may have contributed to the fulfillment of that prophecy (Elkins 1961). Similarly, if hospital staff expect female patients to suffer from emotional problems, and Black patients to be paranoid and potentially violent, their own treatment of the patients may help to fulfill their prophecy. There is considerable evidence, in fact, that patients become institutionalized at least partially because they are often rewarded for adjustment to hospital routine rather than for normal, extra-institutional behaviors (Goldman et al. 1970; Barton 1959; Wing 1962; Braginsky et al. 1969; Townsend 1976; Townsend and Rakfeldt 1985). The evidence that we have examined here suggests that stereotypes of race, gender, and mental illness significantly affect this process.

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