

2015

# What's in a Name? Effects of the "Mentally Ill" Label on Autonomy

Miriam E. Cruz

*Claremont McKenna College*

---

## Recommended Citation

Cruz, Miriam E., "What's in a Name? Effects of the "Mentally Ill" Label on Autonomy" (2015). *CMC Senior Theses*. Paper 1099.  
[http://scholarship.claremont.edu/cmc\\_theses/1099](http://scholarship.claremont.edu/cmc_theses/1099)

This Open Access Senior Thesis is brought to you by Scholarship@Claremont. It has been accepted for inclusion in this collection by an authorized administrator. For more information, please contact [scholarship@cuc.claremont.edu](mailto:scholarship@cuc.claremont.edu).

CLAREMONT MCKENNA COLLEGE

**What's in a Name?  
Effects of the "Mentally Ill" Label on Autonomy**

SUBMITTED TO  
PROFESSOR PAUL HURLEY  
AND  
DEAN NICHOLAS WARNER

BY  
MIRIAM E. CRUZ

FOR  
SENIOR THESIS

SPRING 2015  
APRIL 27<sup>TH</sup>, 2015



## **Abstract**

Over the past years, mental health has attracted increased attention throughout the world, in the form of initiatives, programs, support groups, etc. all with goals to increase awareness and support of mental health. The stark discrepancy between the vision driving this mental health movement and our reality comes from a basic misunderstanding. While there are both legislative and cultural efforts in place to reform our mental health system, the two must work hand in hand in order to affect substantial change. Rather than producing a collaborative effort, our legislators and society tend to ignore each other, resulting in isolated attempts at reform that are doomed to failure without the support of the other side.

This thesis examines the obstacles that mentally ill individuals face in the U.S. today after receiving formal “mentally ill” diagnoses. In our current system, these individuals face limited options, all of which include a number of steep costs. This thesis proposes a shift toward a more collaborative approach in order to transform the costs and fear of diagnosis into benefits and desire for diagnosis. However, an approach such as the one suggested can only be successful after a fundamental shift in the perception of mental illness occurs. Whether or not such a shift is possible – and if so, how? – is a question too large to explore in the confines of this thesis, but one that the reader should consider.

# Table of Contents

<b>Acknowledgements</b> .....	<b>1</b>
<b>Introduction</b> .....	<b>2</b>
<b>Chapter 1: On the Definition of Mental Illness</b> .....	<b>9</b>
<b>Chapter 2: The Costs of Diagnosis</b> .....	<b>20</b>
Theories of Autonomy .....	21
Threats to Autonomy.....	24
The Costs of Diagnosis .....	28
Figure 1: The Consequences of a Correct Mental Illness Diagnosis Today .....	30
<b>Chapter 3: The Ideal Path of Diagnosis</b> .....	<b>39</b>
Figure 2: The Benefits of a Correct Mental Illness Diagnosis in an Ideal World.....	40
<b>Chapter 4: Our Reality</b> .....	<b>44</b>
<b>Chapter 5: Next Steps and Questions</b> .....	<b>58</b>
<b>Bibliography</b> .....	<b>66</b>

## **Acknowledgements**

Before all else, thank you to my family. I have already deleted so many sentences, trying to find just the right words to show how much you mean to me. Expressing this effectively – I am now discovering – is a task infinitely more difficult than writing this thesis. It is near impossible. Mama und Papa, you are two of the most impressive individuals I will ever know. Though I've told you, more times than any of us can count, how very much I hope not to turn into either of you, I will finally confess that I am rarely as proud as when friends tell me I am just like you.

Thank you to Professor Hurley for being curious about this with me and learning with me throughout this process. Thank you for always helping me sift through my thoughts and for sharing your own.

This thesis is dedicated to my sister.

## **Introduction**

*15 years old, 2003:*

Celia and Christina lay in silence, both trying to fall asleep in the bedroom they share. Their mother opens the door and walks toward Christina's bed, where the two begin to negotiate in aggressive, muted whispers, thinking Celia is fast asleep. Celia, 10 years old, cracks open her eyelids just in time to see Christina, 15 years old, reach under her pillow to pull out a pair of scissors, which she then hands to their mother.

Although Celia watches the exchange, its significance is lost on her. Cutting anything but paper – let alone skin – is a foreign concept.

Christina begins to smoke and drink regularly.

*15-17 years old, 2003-2005:*

Celia and Vincent, 14 years old, hear Christina argue with their parents every night. Evenings filled with stories and laughter are quickly replaced with accusations of lying and declarations of hate. Celia and Vincent never once discuss what they hear – not with each other, not with Christina, and not with their parents. Both know something is terribly wrong but, without an explanation, they are left to extract bits and pieces of information from fights that are too loud to be drowned out.

Christina sees a therapist regularly, who tells her parents after several months that Christina's actions manifest the behaviors of a rape victim: intense

mood swings, extreme hostility, inability to maintain previously close relationships, general poor health, etc.

Celia and Vincent are never directly told about their sister's rape; they overhear as it is referred to in one of the many fights between Christina and their parents.

Christina's relationship with her parents grows worse each day as she repeatedly lies to them about her whereabouts and her drinking and smoking habits.

*17 years old, 2005:*

Christina moves out of her parents' house to begin a 6-year medical school program. Her father shakes her hand goodbye, and neither parent offers to drop her off at medical school, a 4 hour drive from their home.

While in medical school, Christina joins the Navy, en route to becoming a Navy doctor after graduation.

Christina's relationship with her parents slowly improves as she calls on an almost daily basis with positive news. She reports that classes are going well, she is in a relationship, and her best friend enjoys cooking almost as much as she does.

*23 years old, 2011:*

Christina visits Celia at college and breaks down. Her 6-year program has extended into seven years because she failed one of her courses. She tells Celia that she has contracted an STD through excessive, careless sex and that she wants to stop and get her life in order. Christina promises Celia that she will be a better

older sister and role model, and that she will never again put Celia in the position of having her older sister break down to her.

Celia asks Christina to take a break from alcohol after Christina notes there is always a point of the night beyond which she cannot remember anything.

Back at medical school, Christina recognizes she needs help and turns to her administration. After being reassured that seeking help is always the right decision, her medical school encourages her to attend a 2-week rehabilitation program for alcoholics. Administration assures her that her graduation date will not be affected as long as she works with her professors to make up work upon her return.

Christina's father uses the rest of his retirement savings to pay for the 2-week rehabilitation program. Despite the financial burden, her family is relieved that she is finally getting help.

Upon her return from the program, administration notifies Christina that she will not be graduating with her class; she needs to take courses over the summer to receive her diploma.

Christina resents her decision to seek help in the first place.

To cope with her frustration, Christina drinks more than ever. Her friends grow more and more tired of Christina's compulsive lies and violent mood swings.

Christina is kicked out of the Navy when asked to explain her 2-week medical school absence, after the deadline to apply to residency programs has passed.

*25 years old, 2013:*

Christina moves back into her parents' house after graduation. She finds jobs waitressing and babysitting to pass the year until applications for residency programs reopen.

*26 years old, 2014:*

Christina's parents kick her out of their house after one too many episodes of arguing about piles of unpaid bills, neglected court dates, excessive drinking, and constant lying. For the first time in her life, Christina's entire family breaks off all contact with her. Even Celia and Vincent find excuses not see her when they are in town.

Christina moves in with a boyfriend she has known for one week, only for him to kick her out two weeks later.

Christina moves in with a co-worker: a fellow waitress. Her family has no idea where in the world she is or what she is doing.

After several months without any news, Celia receives a phone call from her mother letting her know that Christina is in the psych ward. Christina's roommate found her unconscious in bed next to an empty bottle of pills and a beer. According to the doctors, she had ingested a more than lethal dose and there was no explaining how she survived.

Christina wakes up in a psychiatric ward, where she stays for one week.

Christina's plan to apply for a spot in a residency program this year is thrown off track as she misses the deadline during her hospitalization.

Christina moves back in with her parents after being formally diagnosed with alcoholism and borderline personality disorder. She struggles with the clinical diagnoses, afraid of how they may impact her future, but agrees to undergo treatment after her family convinces her to do so.

*27 years old (1 year later):*

Christina calls Celia and talks openly with her about her mental health history and her daily struggles; she apologizes for never having done this before. Christina's relationship with her family is stable.

Christina moves out of her parents' house and into a house with two other recovering alcoholics.

She reaches one year of sobriety for the first time in her life since she started drinking and she continues to attend several Alcoholics Anonymous meetings each week.

The same week Christina receives her "1 year" chip at Alcoholics Anonymous she is rejected from all residency programs. As it is her last year of eligibility, her MD degree now no longer serves as a route to becoming a doctor.

\*\*\*\*\*

The timeline of Christina's life is uniquely difficult only in her mind. Brought up in a society that continues to undervalue the importance of mental health, one year of sobriety and stability after twelve years of untreated alcoholism and borderline personality disorder is - by many measures - an accomplishment. An accomplishment, however, that in itself incurs further stress and anxiety, as it is one that cannot be shared openly or easily due to a fear of shame and disapproval.

While this timeline could be far more comprehensive, I hope - at the very least - it provides some cause for concern. Christina's experiences mirror those of millions more in the U.S. According to the National Alliance on Mental Illness: 1 in 17 American adults lives with a serious mental illness such as schizophrenia, major depression, or bipolar disorder; about 9.2 million adults have co-occurring mental health and addiction disorders; about 60% of adults and ½ of youth (ages 8-15) with mental illnesses received no mental health services in 2012; mood disorders are the third most common cause of hospitalization in the U.S.; adults living with serious mental illness die on average 25 years earlier than non-mentally ill Americans, largely due to neglected treatable conditions; suicide is the tenth leading cause of death in the U.S. and the third leading cause for ages 15-24, with more than 90% of those who die by suicide having at least one mental disorder.<sup>1</sup> Each of these numbers, while comforting to some (the ability to see and understand through statistics the commonality of one's situation or symptoms), should be a major red flag and should be reason enough for reform. Though baby steps have been made toward improving our mental health system, it is time for our society to take bigger and more impactful strides toward supporting and standardizing mental health programs. Consequences of poor mental health range in gravity, but we should not continue to wait for something palpable, such as a rising death toll, in order to consider implementing change.

The purpose of this paper is to spark more substantive conversations about mental health in the United States today and to influence a deeper consideration of mental health

---

<sup>1</sup>Ken Duckworth, "Mental Illness: Facts and Numbers." Fact sheet. National Alliance on Mental Illness. Arlington, VA. Mar. 2013. Web. 10 Feb. 2015. <[http://www2.nami.org/factsheets/mentalillness\\_factsheet.pdf](http://www2.nami.org/factsheets/mentalillness_factsheet.pdf)>.

in policymaking. Throughout these chapters I will draw on Christina's story as a single case study for the sake of tangible applicability and grounding of the various topics.

While I understand that using a single case study subjects this thesis to the criticism of being too narrowly focused, I urge these critics to keep in mind that the case study is purely supplemental to the material – there for the benefit of the reader rather than to complete a successful analysis.

First, I will begin by unpacking the term 'mental illness' – the evolution of its definition and how widely understood and applied it is today. Second, I will consider the various costs, internal and external, of a correct mental illness diagnosis for an individual (Internal costs refer to those visible only to the individual himself; external costs refer to those observable by society as a whole as it enforces and perpetuates them.) Third, I will present what I believe the path of a clinical mental illness diagnosis should look like in an ideal world. Fourth, I will discuss the tangible steps we have taken thus far with respect to supporting mental health and I will emphasize the shortcomings of a purely legislative approach, specifically as it relates to equal employment opportunities for mentally ill. Finally, I will suggest broad recommendations for next steps and pose questions that must be thoughtfully considered in order to move from our reality toward a culture supportive of mental health.

## Chapter 1: On the Definition of Mental Illness

Today, the term “mental illness” operates under several different definitions, continuously redefined by doctors, psychiatrists, philosophers, society at large, etc. Three very commonly adopted definitions of mental illness classify it as: a diagnosable disease;<sup>2</sup> a response, but not a quality;<sup>3</sup> and a disorder of personhood.<sup>4</sup> Many more interpretations of the term “mental illness” take shape in our daily lives, whether through individual judgments or official policies. However, I will focus on the definition of mental illness as a diagnosable disease. An understanding of mental illness as a diagnosable disease provides a strong foundation to understand well the many other conceptions of mental illness. The first time an individual is formally diagnosed as “mentally ill,” the diagnosis must align with the criteria for diagnosis in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. However, together with others’ (either formal or informal) judgments of what it means to be mentally ill, a tangled web of overlapping and conflicting interpretations forms. Individuals who live with the “mentally ill” label are caught at the center of the web (where each individual’s or group’s own definition of the

---

<sup>2</sup> “Dsm.” *American Psychiatric Association*. N.p., 2013. Web. 27 Jan. 2015.  
<<http://www.psychiatry.org/practice/dsm>>.

<sup>3</sup> Craig Edwards, “Ethical Decisions in the Classification of Mental Conditions as Mental Illness.” *Philosophy, Psychiatry, and Psychology* 16.1 (2009): 73-90. Web. 19 Sep. 2014.  
<[http://muse.jhu.edu/journals/philosophy\\_psychiatry\\_and\\_psychology/v016/16.1.edwards.pdf](http://muse.jhu.edu/journals/philosophy_psychiatry_and_psychology/v016/16.1.edwards.pdf)>.

<sup>4</sup> Jerome C. Wakefield, “Mental Disorder and Moral Responsibility: Disorders of Personhood as Harmful Dysfunctions, with Special Reference to Alcoholism.” *Philosophy, Psychiatry, and Psychology* 16.1 (2009): 91-99. Web. 22 Sep. 2014.  
<[http://muse.jhu.edu/journals/philosophy\\_psychiatry\\_and\\_psychology/v016/16.1.wakefield.pdf](http://muse.jhu.edu/journals/philosophy_psychiatry_and_psychology/v016/16.1.wakefield.pdf)>.

term meets), put there by those who first classify them as mentally ill, in accordance with DSM guidelines. Thus for the purpose of understanding how the term “mental illness” is applied today, the DSM definition is certainly the most important.

The DSM, widely referred to as the “psychiatrists’ bible,”<sup>5</sup> provides the standard classification of mental disorders used by mental health professionals in the United States. The most recent edition (DSM-V), published in May 2013, classifies a mental disorder as:

[A] syndrome characterized by clinically significant *disturbance* in an individual's cognition, emotion regulation, or behavior that reflects a *dysfunction* in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant *distress or disability* in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above [emphasis added].<sup>6</sup>

My goal is not to judge the quality of such a definition (because I, too, lack the proper knowledge to assign any concrete definition to the term “mental illness”), but to demonstrate the pervasive normative judgments upon which today’s preeminent definition is based. This scientific definition folds social judgments into each layer (of which there are three) that builds the formal classification of “mentally ill”.

---

<sup>5</sup>Richard Bentall and Nick Craddock, “Do We Need a Diagnostic Manual for Mental Illness?” The Guardian. N.p., 10 Feb. 2012. Web. 11 Feb. 2015.

<<http://www.theguardian.com/commentisfree/2012/feb/10/diagnostic-manual-mental-illness>>.

<sup>6</sup>American Psychiatric Association (2013), *Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition DSM-5*. Arlington VA: Author, p.20.

The three pillars of mental illness in the DSM-V model (what has come to be called the Bio-psycho-social model)<sup>7</sup> are “disturbance” (line 1), “dysfunction” (line 3), and “distress or disability” (lines 5-6). Each of these three is grounded upon current social norms. What qualifies as a “disturbance,” a “dysfunction,” or a “distress or disability”? Medicine cannot provide us with a clear-cut answer for any of these, but society does. This medical definition does not empirically ground any portion of itself, and while it is not a requirement that it be empirically grounded, it is something worth noting; there is often an illusion that the diagnosis of diseases is purely empirical, that medicine is a world firmly rooted in objective truths and empirical laws. The further we slip into this illusion of medicine as purely empirical and objective, the we lose sight of the many social norms deeply embedded in – often even driving – the scientific world, making the social and the empirical inextricable from one another.

The medical definition stipulates mental illness as primarily an inability to function well within the current social structure’s norms, more so than as owning a particular tangible quality. In itself, this is not a problem, but we do need to recognize the normative component of this definition rather than assume that a medical diagnosis indicative of the ownership of an unwanted, tangible quality. The prior leading definition of mental illness, in the DSM-IV, more explicitly states the importance of normative judgment in diagnosing mental illnesses: “The syndrome or pattern must not be merely an expectable and *culturally sanctioned* response to a particular event, for example, the death of a loved one. It must *currently* be considered a manifestation of a behavioral,

---

<sup>7</sup>Erick Ramirez, “Philosophy of Mental Illness.” *Internet Encyclopedia of Philosophy: A Peer-Reviewed Academic Resource*. Web. 14 Jan. 2015. <<http://www.iep.utm.edu/mental-i/>>, p.4.

psychological, or biological dysfunction in the individual [emphasis added].”<sup>8</sup> Although the updated definition eliminates this portion, it is interesting to note how explicitly the medical definition has acknowledged the cultural context that breeds mental illnesses. Because that context is bound to change over time, such a definition of mental illness transforms along with it. Though no longer formally worked into the definition, the three pillars of today’s prevailing definition illustrate that mental illness diagnoses still depend upon an individual violating current social norms. Each pillar – “disturbance,” “dysfunction,” and “distress or disability” – judges an individual’s actions in relation to the norm. Too often, doctors downplay the normativity built into these pillars and treat mental illness diagnosis empirically, in 3 parts, to get from one point to a mental illness diagnosis. However, the “mentally ill” label is a combination of both an individual’s mental health state and the judgment of he who diagnoses the individual.

The consequences of the diagnoser making these normative judgments poorly can be detrimental; it is entirely plausible that society could get it wrong, condemning entire populations to cope with the extreme internal and external costs that a diagnosis brings. One such example is the American Psychiatric Association’s prescription of homosexuality as a mental illness in the DSM from 1952-1974.<sup>9</sup> The (continuing) shift in the perception of homosexuality from 1952 to the present demonstrates well how much of a cultural phenomenon mental illness truly is. This is also evident going back even further, hypothesizing about how remarkable individuals from the past would be treated in today’s world. For example, Michelangelo di Lodovico Buonarroti Simoni (1475-

---

<sup>8</sup>American Psychiatric Association (1994), *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition DSM-4*. Arlington VA: Author, p.xxi.

<sup>9</sup>“The History of Psychiatry.” *LGBT Mental Health Syllabus*. N.p., n.d. Web. 23 Jan. 2015. <[http://www.aglp.org/gap/1\\_history/](http://www.aglp.org/gap/1_history/)>.

1564), widely considered one of the greatest artists of all time, suffered from autism (or possibly Asperger's disorder).<sup>10</sup> Because of this, Michelangelo's communication skills were low (he often turned around and walked away mid-conversation, without reason), negatively impacting his ability to nurture and maintain relationships.<sup>11</sup> However, his autism also directly fed his artistic brilliance, driving him to skip bathing or changing his clothes in order to spend more time painting because he was so deeply enraptured by his work.<sup>12</sup> So while Michelangelo's functionality in everyday life was compromised, we value the work he was able to produce - because of this different functionality, or dysfunctionality - above most all work produced by normally functioning artists. And yet, placing Michelangelo in today's context, a success narrative would involve identifying and treating his mental illness at an early age in order to create an individual who is better able to function within and integrate into normative culture (i.e. a Michelangelo who is able to hold a conversation, bathe himself regularly, take interest in something other than just art, etc.). Consequentially, a successful diagnosis and treatment by today's standards would likely result in no statue of David or beautifully painted Sistine Chapel ceiling. So the question we must ask ourselves is: do we value more greatly a normally functional Michelangelo who is able to hold a conversation, or a differently functional or dysfunctional Michelangelo who is able to create and transform marvels like the statue of David and the Sistine Chapel? If we choose the latter, our system should provide a

---

<sup>10</sup>Jeanie Lerche Davis, "Did Michelangelo Have Autism?" *WebMD*. N.p., 26 May 2004. Web. 19 Jan. 2015. <<http://www.webmd.com/mental-health/news/20040526/did-michelangelo-have-autism>>.

<sup>11</sup>John Bayne, "7 'Eccentric' Geniuses Who Were Clearly Just Insane." *Cracked*. N.p., 18 Aug. 2008. Web. 19 Jan. 2015. <[http://www.cracked.com/article\\_16559\\_7-eccentric-geniuses-who-were-clearly-just-insane.html](http://www.cracked.com/article_16559_7-eccentric-geniuses-who-were-clearly-just-insane.html)>.

<sup>12</sup>Jeanie Lerche Davis, "Did Michelangelo Have Autism?" *WebMD*. N.p., 26 May 2004. Web. 19 Jan. 2015. <<http://www.webmd.com/mental-health/news/20040526/did-michelangelo-have-autism>>.

method of incorporating these talented yet mentally ill individuals into our society (something I will touch upon later).

The Michelangelo anecdote illustrates the complexity of mental illness: something can simultaneously enhance ability and be part of a disability. Situational context that calls upon the three-pronged foundation of mental illness (as defined by the DSM) could be interpreted by one as a disturbance, a dysfunction, and a distress or disability, while interpreted by another as a different occurrence, a different function, and different ability. While arguments can be made for Michelangelo to fit each of the three criteria necessary to be diagnosed as mentally ill, they can be made equally as well in the opposite direction. Certainly Michelangelo was disturbed; he often kept his shoes on for such long periods of time that his toenails would rot and curl and his skin would begin to shed like a snake's.<sup>13</sup> But things also differently occurred to him; he envisioned and created pieces of art others could never have even imagined. Certainly Michelangelo was dysfunctional, he was often incapable of holding conversations with others and so he turned around and walked away midway through; but he was also differently functional, what he lacked in social skills he overcompensated for with artistic ability that others could only dream of. Certainly Michelangelo was distressed or disabled, he could not tolerate human interaction or relationships enough to make an effort to attend his brother's funeral;<sup>14</sup> but he was also differently abled, he dedicated his life to his art with a vigor most never come to know. These two sides – the costs and the benefits – of each criterion or pillar of mental illness demonstrate the complexity of the diagnosis. Rather

---

<sup>13</sup>Ibid.

<sup>14</sup>Jeanie Lerche Davis, "Did Michelangelo Have Autism?" *WebMD*. N.p., 26 May 2004. Web. 19 Jan. 2015. <<http://www.webmd.com/mental-health/news/20040526/did-michelangelo-have-autism>>.

than qualifying each criterion negatively and forcing treatment upon an individual, taking into account the simultaneously positive and negative effects of mental illnesses (the term ‘mental illness’ itself could be rebranded) would be more conducive to a society in which individuals maintain (more of) their autonomy while also enhancing and applying their abilities.

Though physical and mental illnesses face certain similar problems (i.e. we call a bipolar personality a disability, but many who are bipolar would argue otherwise; we call deafness a disability, but many who are deaf would argue otherwise), the empirical fixes the content to a greater extent in the physical, whereas the mental is open to far more arbitrary judgment. While both types of illnesses are contextually defined (we call an autistic individual “ill” because he deviates from the healthy norm of being able to interpret and respond well to social cues or form meaningful relationships, etc. much as we call someone suffering from a stroke “ill” because he deviates from the healthy norm of not suffering from strokes in our society), the current definition of mental illness invites us to read our own biases and hostilities into the definition to a larger degree, allowing judgment to go awry with each layer of normativity built into the formal definition. Past mistakes demonstrate the particularly difficult task of pinning down the criteria for mental illness (i.e. the diagnosis of homosexuality as mental illness), as the empirical support for mental illness diagnoses remains intertwined with the power of cultural norms.

At the core of both mental and physical illnesses lie indisputably “ill” individuals, who would serve to benefit from a correct diagnosis and treatment. For example, the schizophrenic individual who believes he is constantly being attacked by innocent

passersby and thus carries a gun in order to shoot the next pedestrian who passes him (before the pedestrian can attack him) is very clearly unable to function normally in daily life, and he (and society at large) would benefit greatly from treatment that would allow him to function at a (more) normal mental capacity. Similarly, the individual suffering from a stroke that results in severe paralysis for the rest of his life is also unable to function normally in daily life would benefit greatly from treatment that would allow him to function at a (more) normal physical capacity. Both of these individuals, society largely agrees upon, are ill - in one form or another - and few would contest the benefits of correct diagnosis and treatment for either.

It is when we move beyond this core of individuals - those who are indisputably mentally or physically ill - and toward the penumbra, where lines are hazier as judgments grow further and further susceptible to dispute. However, the core of mental illnesses is significantly smaller in both size and density than that of physical illnesses. Thus traveling beyond the core to the penumbra of mental illnesses takes no time at all, while for physical illnesses there are considerable stops to make before approaching the haziness and uncertainty of the penumbra. Even so, once the physical illnesses' penumbra is breached and increasingly difficult judgment calls are made, the consequences of misdiagnosing a physical illness can have far fewer consequences in today's culture than the consequences of misdiagnosing a mental illness. For example, misdiagnosing a cold-hearted, compulsive liar as having borderline personality disorder (when, in fact, she simply has a gift of compulsively lying and being able to detach herself from others) can be detrimental to her life and dramatically reroute the course she originally sets on taking or is now able to take. However, misdiagnosing a boy with large ears that stick out as

having a physical deformity of unnaturally large ears, and thus requiring him to seek treatment in the form of surgery to get them pinned back, is perhaps life-changing but not detrimental. This boy will not be discriminated against for having ears that are now closer to his head and less obtrusive. He will not have to live with a stigma that follows him wherever he goes, and he can very easily choose not to disclose his diagnosed “illness” with anybody, should he so choose. We would not accuse him of hiding his true identity if we eventually discovered this information about him as we might feel betrayed by the girl who hides her borderline personality disorder diagnosis, something that we tend to view as the true essence of her personality and being. Thus, as the severity of the illness lessens, the difficulty and gravity of the judgment grows, with a larger number of these judgments made for mental illnesses than for physical.

Whether or not to diagnose both the cold-hearted girl and the big-eared boy is a judgment call, and holds a significantly greater amount of weight for the lying and detached girl than for the big-eared boy. The similarity in the two individuals’ diagnoses is that we only see the negative side of both. We do not value large, obtrusive ears any more than we value compulsive lying and detachment. However, because it is more often harder to tell if a person is mentally ill than physically ill, it is also harder to deal with the person who claims they are not mentally ill than the person who claims they are not physically ill. Because we only focus on the negative aspects of the girl’s borderline personality manifestation, we see her as mentally ill. The girl sees herself, however, as having a gift for prioritization and working hard on what truly matters to her, instead of wasting time on people and things that she does not truly care about (as she sees so many around her do). She attributes her successes in life to the very same characteristics we call

her illness. For the boy, we also only focus on the negative aspects of his large, obtrusive ears. But the difference is that he also probably only feels negatively about his large ears, seeing little reason to be proud of them as their large size serves him no functional purpose. The diagnosis and treatment lacks a nuance that is bound to be present in the girl's. Our need to force each individual into a binary of "ill" or "not ill" enables us to disregard the dual nature of mental illnesses and consequently to wipe out the benefits of mental illnesses, ignoring the detriments of doing so.

If an individual has a serious mental illness such that he is unable to function in the most minimal sense (like the delusional schizophrenic who cannot maintain jobs, relationships, etc.) it would be extremely beneficial for us to correctly diagnose him; it would be every bit as beneficial as correctly diagnosing a physically ill individual (some might argue even more so). The questions that we must answer today then remain: are we identifying people who really need to be helped, and are we effectively avoiding those who are just different? For the gray areas, do we need to be more careful about who we diagnose as mentally ill? Are we recognizing that there exist individuals to whom things occur differently, who function differently, and who are differently abled? If so, are we finding a way to allow them to function within our society?

Layers of normative judgment in the definition of mental illness (disturbance, dysfunction, distress or disability) run deep; with no set empirical criteria for identification or measurement, we are left entirely to our judgment, inviting any hostilities or prejudices to play into our final classification of mental illnesses. If it is the case that a phenomenon is based upon normativity - as mental illness is - then it must be our duty to ensure that its application is very thoughtfully applied, and not manipulated to

bend to an individual arbiter's hostilities or prejudices. As it stands, we are not yet making these judgments thoughtfully enough; the costs of a mental illness diagnosis are steep and often outweigh the benefits.

## Chapter 2: The Costs of Diagnosis

Autonomy lies at the core of mental illness discussions and debates, despite the frequent omission of the term itself. Many who criticize the current diagnostic labeling system place stigmas or discrimination at the crux of their argument, drawing distinctions between types of discrimination or grouping stigmas into sub-categories i.e. self-stigmas,<sup>15</sup> public stigmas,<sup>16</sup> hidden stigmas,<sup>17</sup> institutional stigmas,<sup>18</sup> etc. to describe the costs of applying mental illness labels to individuals. However, stigmas and discrimination, as well as other consequences of mental illness diagnoses, are ultimately questions of autonomy. We would benefit from recognizing each of these costs not as individual consequences removed from one another, but as deeply dependent upon and supportive of one another, working together to undermine an individual's autonomy. I will introduce the distinction between external and internal threats to autonomy, while also demonstrating their co-dependability, in Figure 1. But first I will attempt to provide an effective framework to do so well.

---

<sup>15</sup>Nicolas Rüsçh, Matthias C. Angermeyer, and Patrick W. Corrigan. "Mental Illness Stigma: Concepts, Consequences, and Initiatives to Reduce Stigma." *European Psychiatry* 20 (2005): n. pag. Web. 14 Feb. 2015. <[http://ac.els-cdn.com/S0924933805000908/1-s2.0-S0924933805000908-main.pdf?\\_tid=7106e1c2-b4bc-11e4-ab61-00000aab0f01&acdnat=1423968397\\_a45d8c8cdb7aab012573d486474ae576](http://ac.els-cdn.com/S0924933805000908/1-s2.0-S0924933805000908-main.pdf?_tid=7106e1c2-b4bc-11e4-ab61-00000aab0f01&acdnat=1423968397_a45d8c8cdb7aab012573d486474ae576)>.

<sup>16</sup>Ibid.

<sup>17</sup>Patrick W. Corrigan, "How Clinical Diagnosis Might Exacerbate the Stigma of Mental Illness." *Social Work: A Journal of the National Association of Social Workers* (2007): 31-39. Web. 11 Feb. 2015. <<http://sw.oxfordjournals.org/content/52/1/31.full.pdf+html>>.

<sup>18</sup>Amresh Shrivastava, Megan Johnston, and Yves Bureau. "Stigma of Mental Illness-1: Clinical Reflections." *Mens Sana Monographs* 10.1 (2012): 70-84. PMC. Web. 15 Feb. 2015. <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3353607/>>.

## **Theories of Autonomy**

A comprehensive understanding of the costs of a mental illness diagnosis requires a comprehensive understanding of autonomy: the thing most deeply undermined by both mental illnesses and their diagnoses. Though there are many theories of autonomy, each with varying levels of specificity, I will focus on Marina A. L. Oshana's model. Oshana draws a distinction between two different levels of personal autonomy: external (or social) autonomy and internal (or psychological) autonomy.<sup>19</sup> She then goes on to argue that the internal account of autonomy (which she calls the internalist's account) lacks in ways that the external account (which she calls the externalist's account) does not.<sup>20</sup> Though I, too, will choose to focus on the externalist's account, first I would like to discuss both types of autonomy - external and internal - for they will serve as the foundation for further discussion of the labeling of mental illness. The threats to autonomy that arise from the "mentally ill" label fall under both internal and external camps. The two are difficult to separate entirely on a large scale (i.e. when observing the effects of diagnosable mental illness labels), but to grasp well what is happening in each component of the large scale, an understanding of both types of autonomy is crucial.

Broadly speaking, the internal theory of personal autonomy depends entirely upon an individual's mental state. For internal theorists, "there need be no special relation between...autonomy-constituting attitudes and either the past circumstances that caused

---

<sup>19</sup>Marina A. L. Oshana, "Personal Autonomy and Society." *Journal of Social Philosophy* 29.1 (1998): 81-102. Wiley Online Library. Web. 22 Feb. 2015. <<http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9833.1998.tb00098.x/epdf>>, p.81.

<sup>20</sup>Ibid.

these attitudes or the present circumstances in response to which they move us to act.”<sup>21</sup>

In other words, no matter the past or present external circumstances, as long as an individual occupies a point of view from which he supports or embraces his actions, he is said to be autonomous; autonomy is entirely “a matter of the condition of a person’s psychology.”<sup>22</sup> Internal theories of autonomy do not differentiate between a free individual who bakes a cake at his own will, because he loves to bake cake; and an enslaved individual who bakes a cake because his master demands it, but he loves to bake cake and thus does so happily. Because the action (baking cake) coheres with the individual’s point of view (baking cake is a pleasurable activity), that in itself suffices to dub him autonomous. Thus under the internal theory of personal autonomy, an individual who seems to be very clearly restrained or influenced by outside factors can indeed be autonomous, provided he embraces his actions within his environment.

On the other hand, the external account of personal autonomy depends not only on the psychological state of an individual, but also on the external circumstances motivating or restraining the individual. In order to be autonomous (again borrowing from Oshana’s classification system), an individual must have both psychological autonomy through the ability to critically reflect (compatible with internalist accounts), and procedural independence, access to a range of relevant options, and social-relational properties that would allow her to pursue her goals in a safe environment.<sup>23</sup> External theories of autonomy thus build upon the internal theory of autonomy, adding layers of

---

<sup>21</sup>“Personal Autonomy.” *Stanford Encyclopedia of Philosophy*. 2013. Web. 20 Feb. 2015. <<http://plato.stanford.edu/entries/personal-autonomy/>>, p.4.

<sup>22</sup>Marina A. L. Oshana, “Personal Autonomy and Society.” *Journal of Social Philosophy* 29.1 (1998): 81-102. Wiley Online Library. Web. 22 Feb. 2015. <<http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9833.1998.tb00098.x/epdf>>, p.85.

<sup>23</sup>*Ibid.*, p.93-94.

prerequisites in order to reach autonomy. Externalist theories of autonomy differentiate between the free individual who chooses to bake cake by his own will because he loves to bake cake and the enslaved individual who bakes a cake because his master demands it, but because he loves to bake cake he does so happily. The latter is without doubt not autonomous, as he lacks procedural independence, access to a range of relevant options, and social-relational properties that would allow him to pursue his goals in a safe environment. His actions are restricted by his master's will; he cannot choose any other option without the threat of punishment; and his relations with his master would not allow him to pursue a goal independent of his master's own goals for him in a safe environment. The former (the free individual), however, is fully autonomous as long as both his love of baking cake and his decision to bake a cake are not motivated by any external circumstance, he has several other options that are known to him and within his abilities to execute, and doing so would still allow him to be comfortable and safe in his environment.

Moving forward, I will apply the external theory of autonomy to my analysis. While an internal account of personal autonomy holds certain value, the external account of personal autonomy absorbs the value of the internal account while also incorporating the larger-scale picture. Particularly with respect to mental illness, taking into account the big picture as well as individuals' psychological experiences allows us to contextualize each individual's narrative and better serve the mission of finding a way to change these narratives for the better. I therefore prefer an external account that includes the individual's psychological state and also takes into account the shutting down of choices by external factors such as arbitrary norms.

## **Threats to Autonomy**

In addition to internal and external theories of autonomy, there exist both internal and external threats to autonomy. However, this is not meant to invite an understanding that internal threats apply only to internal theories of autonomy and external threats apply only to external theories of autonomy. Within external autonomy (the account I have determined to focus on), there are both internal and external threats to autonomy. Two authors effectively demonstrate both types of threats in their accounts: Cass Sunstein notes how our autonomy can be restrained or controlled through the formation of certain norms or stigmas in our social structures, and Ian Hacking discusses the control of labels over autonomy.

Cass Sunstein explores both internal and external threats to autonomy through roles that our society at large (ruled by our government) plays. Sunstein defines a society as autonomous “to the extent that its citizens face a range of reasonably good options and exercise capacities of reflection and deliberation about their choices.”<sup>24</sup> Thus his account incorporates both theories of autonomy: external (face a range of reasonably good options) and internal (exercise a capacity of reflection and deliberation about choices); absorbing and supplementing the internal theory of autonomy, Sunstein can comfortably be classified as an external theorist. As Sunstein writes, “It should be clear that social norms, meanings, and roles may undermine individual autonomy. Above all, this is because norms can compromise autonomy itself, by stigmatizing it.”<sup>25</sup> He focuses primarily on external threats to autonomy - social norms, meanings, and roles that inhibit

---

<sup>24</sup>Cass R. Sunstein, *Free Markets and Social Justice*. Oxford: Oxford UP, 1999. Print, p.62.

<sup>25</sup>Ibid.

procedural independence, a range of relevant options, and safe social-relational properties. However, Sunstein also touches upon the internal threat: “In some cases, existing norms undermine people’s autonomy, by discouraging them from being exposed to diverse conceptions of the good and from giving critical scrutiny to their own conceptions, in such a way as to make it impossible for them to be, in any sense, masters of the narratives of their own lives.”<sup>26</sup> Each component - the existing discriminatory norms (external threats), narrow exposure to conceptions of the good (external threat), and inability to critically evaluate one’s own conceptions (internal threat) - undermines autonomy either internally or externally, demonstrating both types of threats within the external theory of autonomy.

To make clearer Sunstein’s point, take into consideration a woman with homosexual desires. If social norms, meanings, and roles foster stigmas and discrimination against homosexual women, each stigma, meaning, and role regarding homosexual women serves to threaten the autonomy of every woman with homosexual desires. These norms and stigmas will inevitably dictate these women’s narratives, discouraging the women to explore a diverse set of options for partners (external threat) and influencing them to scrutinize their own desires (internal threat). Society and the women are thus influenced in a manner such that the homosexual woman will not be able to choose the course of her life freely and safely without the threat of punishment. By an external theorist’s account, the homosexual is by no means autonomous in this society that warrants discrimination against homosexual women (though it should be noted that by an internal theorist’s account, it is still possible for the homosexual woman to be

---

<sup>26</sup>Ibid., p.59.

autonomous in this society, provided that she embraces her actions). External threats to autonomy in this case include norms, discrimination, and stigmas - all fueling the reality that the homosexual woman individual grapples with and dictating much of what she chooses to do or say. Internal threats to autonomy in this case include the internalization of all the norms, discrimination, and stigmas such that they inhibit woman's ability to have control over her own thoughts and actions.

Ian Hacking also explores internal and external threats to autonomy through something he calls "making up people."<sup>27</sup> He describes how we essentially "make up" people within a framework of labeling theory, a notion that "social reality is conditioned, stabilized, or even created by the labels we apply to people, actions, and communities."<sup>28</sup> Hacking writes, "Except when we interfere, what things are doing...does not depend on how we describe them. But some of the things that we ourselves do are intimately connected to our descriptions."<sup>29</sup> Thus labels simultaneously give us a new way to be and preclude us from other ways of being; we create certain (types of) individuals through our classification systems. By making categories that a number of the population will inevitably fall under (if the criteria are just broad enough), we homogenize the group and make assumptions about all of its members based on the few things they have in common. It becomes increasingly difficult for the labeled individuals to break free from their assigned category and recognize themselves as something independent of the category. For example, in today's culture, a well-groomed, homosexual man is often seen as being well-groomed *because* he is homosexual; his attention to his grooming

---

<sup>27</sup>Ian Hacking, "Making Up People." *The Science Studies Reader*. Ed. Mario Biagioli. New York: Routledge, 1999. Print.

<sup>28</sup>Ibid., p.163.

<sup>29</sup>Ibid., p.166.

reinforces his identity within the “homosexual” category. He is not seen as being “well-groomed” and “homosexual,” independent of one another, but instead is seen as a “well-groomed homosexual.” Within the broad group labeled “homosexual,” one of the defining characteristics is being well-groomed; this forces any well-groomed homosexual to perpetuate the norm attached to his sexual orientation or to risk facing further discrimination for not complying with the label that makes him up.

Creating and awarding labels undermines an individual’s autonomy both externally and internally. Externally, the label controls the individual living with it. Once society awards an individual his label, he no longer has access to a safe environment in which he can pursue his own goals that are independent of the label. Internally, rather than his own critical evaluation guiding him, an individual feels motivated to act in accordance with his label, bringing his psychological state into conflict with his actions. The principal external threat to autonomy in this case is the limited range of choices that come with the label, forcing an individual into a homogenously treated group with those who share his label. The principal internal threat to autonomy in this case is the internalization of stigmas, influencing the individual to conform to society’s expectations of those with his label, deeply undermining his autonomy.

In summary, borrowing Oshana’s framework, there are two theories of autonomy: internal autonomy and external autonomy. Internal autonomy concerns itself solely with the psychological state of the individual; an individual must psychologically embrace his actions to be called truly autonomous. Internal threats to autonomy therefore must be threats to the individual’s psychological stability, such as an internalization of a stigma that inhibits the individual’s ability to condone or embrace his current situation, or a drug

addiction that undermines the individual's ability to embrace his drug habits while he wishes he could control himself long enough to get clean. External autonomy concerns itself with the external circumstances and constraints an individual faces (in addition to the individual's psychological state). Threats to external autonomy include norms, public stigmas and discrimination that ultimately undermine the autonomy of any individual who fits into a particular category (or categories); the stigma and discrimination all individuals within the category feel creates an environment in which a labeled individual pursuing his own goals, independent of the label, would feel unsafe.

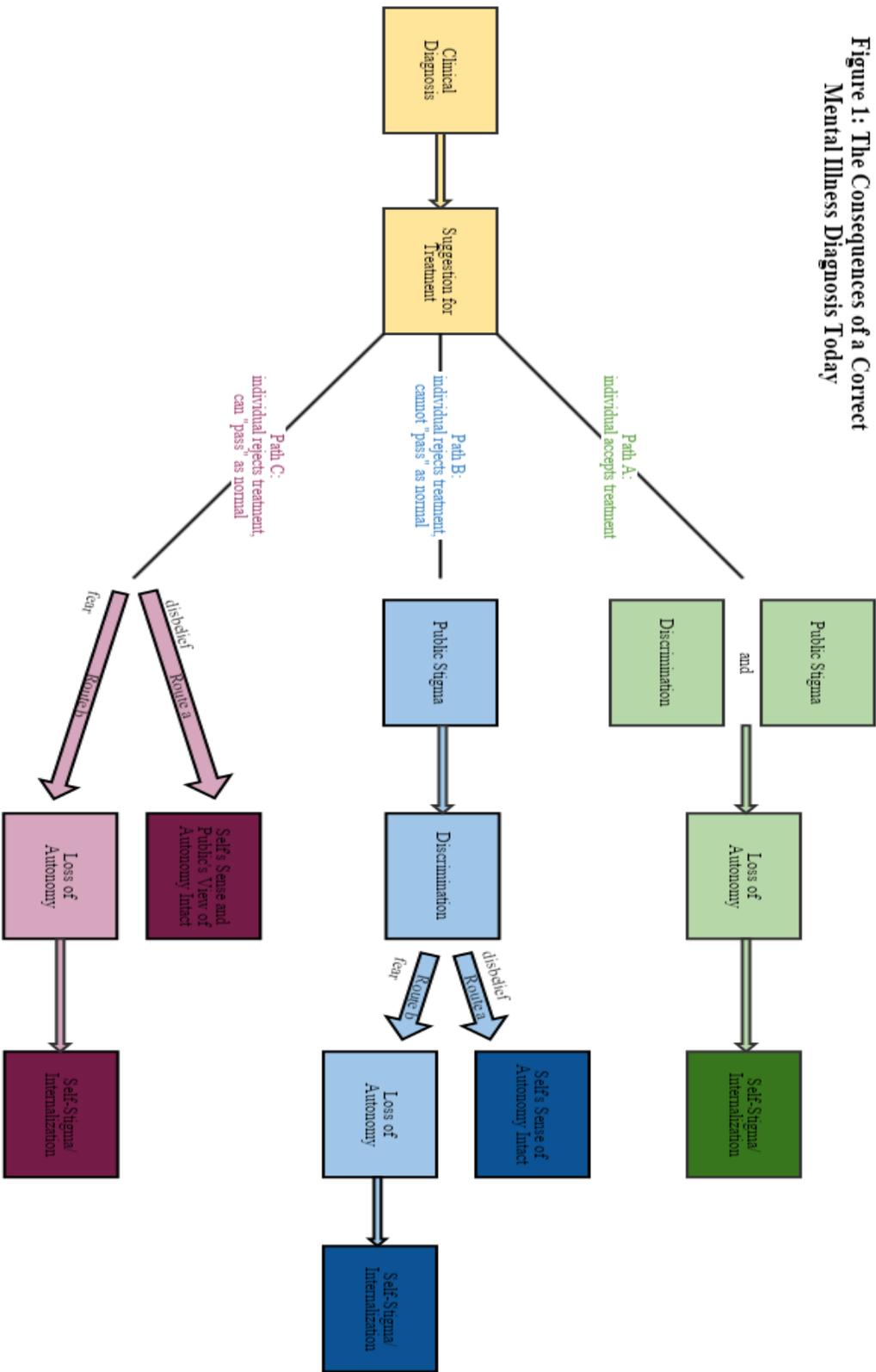
### **The Costs of Diagnosis**

Figure 1 (see page 30) illustrates the many consequences of a mental illness diagnosis today, each one an internal or external threat to an individual's autonomy. The figure builds in two important assumptions. One assumption is that all clinical diagnoses are made correctly, meaning every time a patient is diagnosed as mentally ill, the diagnosis is accurate and in accordance with DSM-V requisites. This is, of course, optimistic, but should not hurt the integrity of my analysis. After accounting for the consequences involved in even the best case scenario (being that the patient receives an accurate diagnosis for his condition), I trust the reader to understand the added costs for an incorrect diagnosis (namely, an individual faces all of these autonomy-undermining costs when perhaps he should never have been diagnosed as mentally ill in the first place). Another assumption in Figure 1 is that the goal of diagnosing patients as mentally ill is to open up to them the possibility of receiving treatment in order to restore their internal autonomy (I say 'internal' because the treatment individuals undergo focuses on

restoring their internal autonomy so that they may better cope with, reduce or eliminate externally autonomy-undermining factors, rather than the other way around). However, while the benefits of treatment can be tremendous (in the best case scenario), the concern is that a diagnosis that works to address the restoration of autonomy also brings with it severe threats to autonomy, as shown in Figure 1.

Figure 1 provides a visual representation of the internal and external threats to autonomy described above. Regardless of an individual's response to his diagnosis, he experiences a loss of autonomy in one of several ways. I will explore the consequences of each "option" an individual has, beginning with Path C and working my way up to path A - presumably the best case scenario. The three broad paths, each of which begin at the point of a mentally ill diagnosis after which treatment is suggested, go on to yield five plausible (but only three unique) outcomes. The path each individual follows depends on two factors: himself (whether he chooses to accept treatment or not) and society (whether he "passes" as normally functioning and mentally healthy or not). An individual who chooses to reject treatment and does not pass as normally functioning will follow Path C; an individual who chooses to reject treatment but passes as normally functioning will follow Path B; and an individual who chooses to accept treatment will follow Path A (regardless of whether or not he passes as normally functioning). Though three distinct paths, embarking upon one path does not preclude an individual from ever taking another. I will draw from Christina's narrative (see Introduction) demonstrates the very real likelihood of a single individual jumping between all three paths over time. However, throughout her entire narrative she experiences setbacks and obstacles in three

**Figure 1: The Consequences of a Correct Mental Illness Diagnosis Today**



distinct stages characterized through the three different paths presented in Figure 1 (Path A, Path B, and Path C).

Path C tracks the consequences that face an individual who is correctly diagnosed as mentally ill yet chooses to reject any form of treatment and “passes” as normally functioning to the general public. The individual rejects the label for either one of two reasons: fear or disbelief. Depending on which, the consequences he faces vary. An individual who rejects his diagnosis on the basis of disbelief (Figure 1, Path C, Route a) appears to have the least amount of consequences; he truly believes that his diagnosis is inaccurate and rejects treatment on the grounds that he is fully functioning and therefore has no use for treatment. Because this individual passes as normal, both his own sense of his autonomy and the public’s view of his autonomy remain intact. Yet an individual who occupies this position risks never receiving any form of treatment because of his ability to “pass” to both himself and the public, safely hidden from the scope of treatment or any real recognition (other than by the diagnoser, bound by confidentiality). In summary, this individual’s autonomy only appears to remain intact on all levels while in fact he continues to suffer from his (autonomy undermining) mental illness, although he cannot or will not recognize it.

An individual who rejects his diagnosis on the basis of fear (Figure 1, Path C, Route b) faces different consequences. Though he believes his diagnosis could be or is valid, his fear of the label and all it implies drives him to reject treatment and continue to pass as normally functioning. Though by the public view this individual’s autonomy remains intact, he struggles with his own sense of a loss of autonomy; the diagnosis undermines his own sense of his ability to function fully as an individual, and he

internalizes the public stigmas that others with the same or similar diagnoses face, feeding a self-stigma that wears down his internal sense of autonomy. In summary, this individual's autonomy appears intact to the public eye while the individual remains acutely aware of his undermined autonomy and the stigma and discrimination it carries in his society, fueling his decision to reject the label and treatment.

Path B tracks the consequences that face an individual who is correctly diagnosed as mentally ill but chooses to reject any form of treatment, even though he does not "pass" as normally functioning to the general public. Again, as in Path C, the individual rejects the label out of either disbelief or fear. However, the fact that the individual cannot pass as fully functioning to the public changes the costs of his diagnosis. Along this path, an individual who rejects treatment due to disbelief (Figure 1, Path B, Route a) truly sees himself as fully functional, but others do not see him as such and thus apply their stigmas and discrimination to him despite his denial. Because he remains in disbelief he does not internalize these stigmas and thus while his external autonomy is undermined, his own sense of autonomy (his internal autonomy) remains intact. In summary, the individual faces public stigmas and discrimination, but his own sense of autonomy remains intact such that he will not seek treatment because he believes his diagnosis to be inaccurate and himself to be fully functional.

An individual who rejects treatment out of fear (Figure 1, Path B, Route b) faces not only public stigma and discrimination but also a loss of internal autonomy. Afraid of the implications of his diagnosis, the individual senses a loss of self-control and proceeds to internalize the stigmas against his mental illness (and now him), making him even more afraid to accept the diagnosis and seek treatment, for fear of public shame. For this

individual, the loss of external autonomy and the loss of internal autonomy come hand in hand. The individual is unable to pass as normally functioning to the public and thus faces the stigma and discrimination that come with a mental illness diagnosis, undermining his external autonomy. At the same time, he feels a loss of internal autonomy, but rather than seeking treatment to regain his internal autonomy, the formal diagnosis and all it implies fears the individual enough for him to reject the diagnosis and leaves the individual without any treatment for his condition.

Path A, presumably the best case scenario, tracks the consequences that face an individual who is diagnosed as mentally ill and chooses to accept treatment for the diagnosis. The moment an individual formally accepts the “mentally ill” label, he faces both a loss of internal autonomy (he accepts the treatment because he knows his diagnosis to be true, admitting his inability to control his own self) and deep-seated public stigma and discrimination (threats to external autonomy). His diagnosis serves as a red flag, letting the public know by means of a label, whether or not others would have judged him as mentally ill prior to his being labeled, that he is not and cannot possibly be awarded full autonomy over his self. Because his self is compromised by his mental illness, the aim of his treatment is to (re)build his ability to (re)claim his autonomy over his self. However, the, mental illness labels encourage the public to categorize all “mentally ill” individuals as a single, homogenous group<sup>30</sup> and to make sweeping generalizations that foster and perpetuate stigmas about individuals with mental illnesses and the dangers of interacting with them. Following an individual’s internal battle (loss of

---

<sup>30</sup>Patrick W. Corrigan, “How Clinical Diagnosis Might Exacerbate the Stigma of Mental Illness.” *Social Work: A Journal of the National Association of Social Workers* (2007): 31-39. Web. 11 Feb. 2015. <<http://sw.oxfordjournals.org/content/52/1/31.full.pdf+html>>, p.33.

internal autonomy) and external struggle (facing the public stigma), he faces discrimination - for jobs, housing, relationships, etc. Finally, the individual fosters a self-stigma after internalizing all of the negative perceptions and reactions to his diagnosis, further undermining his internal autonomy.

In 2003, 15-year-old Christina faces Path C as her psychiatrist diagnoses her as a rape victim suffering from depression. Though she finally recognizes the rape, she refuses to believe she suffers from anything. Rather than focusing on herself and her path to recovery, she channels a deep hatred for her parents for making her visit a therapist in the first place; for her therapist for referring her to a psychiatrist; and for her psychiatrist for offering to help her with depression she does not feel. Thus Christina follows Path C, Route a. Many of her friends at school feel similarly frustrated by their families, making her situation commonplace in her mind and certainly not worth seeking professional help. Because her own sense of autonomy remains intact and because the public continues to recognize her as fully autonomous, she feels no pressure to accept the diagnosis and she chooses not to. In the meantime, she begins to drink and smoke frequently and argues with her parents almost daily over anything and everything: classes, disrespectfulness, attitude, lying, etc. Although Christina's depression undermines her autonomy, she believes she is autonomous and is seen as fully autonomous by others, making her entirely responsible for all she says and does. Christina transforms into a selfish and self-interested daughter and sister over the next several years, pulling her family apart with the pain she inflicts through her actions and words.

From 2005-2011, Christina transforms from a 17-year-old on Path C to a 23-year-old on Path B. Though never clinically diagnosed, her previous therapist had warned her

of rape victims' susceptibility to alcoholism. Christina's drinking habits preclude the possibility of her passing as normally functioning anymore. Blacking out every night and pushed by those around her to seek help, Christina faces stigmas and discrimination by many who observe her unmistakable alcoholism and refusal to seek help. Several of her closest friends turn their backs on her, and her best friend reaches out to her younger sister to let her know that Christina no longer has any emotional support at medical school (including his). Shocked by the drama and exaggerations of those closest to her, Christina grows more and more upset. She believes her enrollment in a prestigious medical school program should be more than enough to prove she is not an alcoholic; Alcoholics Anonymous meetings seemed to be for those who had truly reached rock bottom – with no family, no friends, no home, no education, etc. She tells herself she could stop drinking if she really wants to, but that she should not have to prove anything to anyone. Christina's external autonomy is undermined by the stigma and discrimination she faces in her community, but she feels her internal autonomy is intact (despite the reality that it is not as she no longer has agency over all her actions). Thus she rejects the "alcoholic" diagnosis and label due to disbelief (Figure 1, Path B, Route a) and continues without seeking treatment.

In 2012, 24-year-old Christina faces Path A as she finally reaches out to her school's administration to seek treatment for her (as of yet undiagnosed) alcoholism. Though she gains access treatment, it is short-term – two weeks – and ineffective. Not only that, but undergoing treatment results in her postponed graduation date and her discharge from the Navy, despite the assurances of her school's administration that her graduation and post-graduation plans would not be affected. Recognizing the costs of

treatment, Christina regrets her decision to ask for help and instead wishes she had kept her struggles hidden. On her path to restore her internal autonomy (the ability to embrace her actions), what little help she manages to get is used against her and further undermines both her external autonomy (discrimination by administration who reevaluates her graduation date despite previous assurances that it would not be affected) and her internal autonomy (in the face of discrimination, Christina becomes more ashamed and aware of her illness, which in turn makes her feel less stable and in control than ever). Over the next year she jumps back to Path B (but now Route b) as she tries to shed her label and re-identify herself as fully functional in an effort for others to see her as such; her efforts are in vain as those around her continue to observe the behavior of an alcoholic, undermining her claim to autonomy.

In 2014, 26-year-old Christina abruptly jumps back to Path A as she wakes up in a psychiatric ward and is clinically diagnosed with alcoholism and borderline personality disorder. After receiving both diagnoses, Christina's parents allow her to move back in with them if, and only if, she undergoes rigorous treatment for both of her illnesses. Rattled by her unplanned attempted suicide, and afraid of again waking up in a psych ward, Christina complies with her parents' guidelines and begins attending Alcoholics Anonymous (AA) meetings almost every day, taking medication to stabilize her mood, and meeting her therapist each week. For the first time in her life, she feels fully supported by her family. They better understand what she is going through and they are able to support her more fully after talking to doctors about her diagnoses and doing research on their own. For the first time since she was 15, Christina is sober for a year and has stable relationships with her family and friends. However, despite working hard

to rebuild her internal autonomy, external circumstances constrain her. Residency programs are unkind to recovering alcoholics, rejecting Christina in her final year of eligibility after she explains why she did not begin her residency within her first two of graduating from medical school. The rejection forces her to redefine her goal in life, as being a doctor is no longer a viable one. New friendships at her job worry her; she does not want to disclose her alcoholism too freely for fear of being judged and so avoids outings that might involve alcohol, including meals and parties. However, she finds a strong group of friends through AA who are all able to relate to her, making these friendships sources of support rather than stress. And so, despite many daily struggles, Christina feels she is inching toward recovery with the support of those closest to her.

As demonstrated by Christina's story, the consequences of traveling along any of the three post-diagnosis paths can be severe enough for an individual to reasonably avoid the paths at all costs, even if that cost is their mental health. Although a diagnosed mentally ill individual controls one portion of his fate, the public controls the rest, with the combination of these two determining factors placing the individual on Path A, B, or C. While it is plausible he will jump back and forth between the paths over time, a jump entirely out of Figure 1 is highly unlikely if not impossible (for today), as it would require a restructuring of our system and our perceptions. However, although each of these paths begins with a diagnostic label ("mentally ill"), exploring the restructuring of our system should not mean removing all labels. As evident through Hacking's theory of making up people, we must be aware of the meaning of the labels we create and the weight they carry, taking care to apply them thoughtfully. We cannot simply remove all

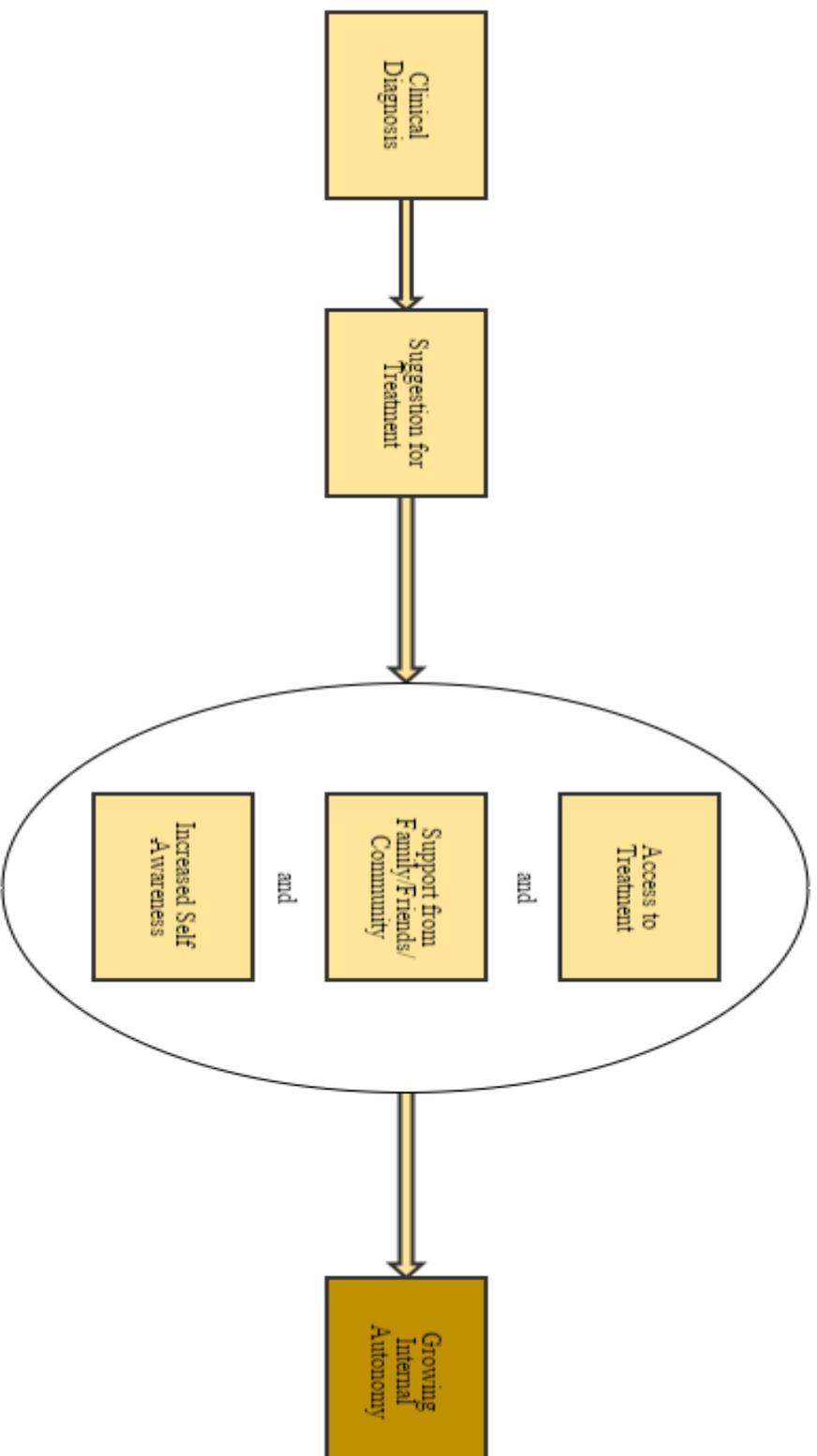
labels, as we need them to function well as a society. However, we can and should explore more productive and less harmful ways to apply and incorporate them.

## **Chapter 3: The Ideal Path of Diagnosis**

Although we are a long way off from a perfectly ideal world, I would like to explore what that might look like in the context of mental health. As our mental health system stands today, there is a failure of some sort at each step beyond the initial clinical diagnosis and suggestion for treatment, as shown in Figure 1: public stigma, discrimination, loss of autonomy, self-stigma and internalization, and harmful misperceptions of intact autonomy allowing for the evasion of treatment. In Figure 2 (see page 40), I propose a path of benefits, rather than of consequences, that begins with a clinical diagnosis and can only exist in an ideal world - a world free of external threats to autonomy that hamper an individual's progress toward internal autonomy. Rather than three bleak paths, each of which brings heavy external consequences and few (if any) internal benefits, a single path brings much-needed benefits along the road to recovery from mental illness without undermining an individual's self-respect as a functional person. Thus, in an ideal world, a clinical diagnosis would serve as the start of a path toward full (or growing partial) autonomy, making it something positive and desirable for those who need it.

Figure 2 shows the benefits of clinical diagnosis and treatment for an individual (or, more specifically, for his autonomy) in a world in which external consequences have been worked around and beyond, diminishing their force and significance and eventually eliminating their role as factors in the mental health discussion altogether. The three paths littered with negative repercussions and limited benefits transform into one path saturated

**Figure 2: The Benefits of a Correct Mental Illness Diagnosis in an Ideal World**



with benefits. An individual in this ideal world naturally inclines toward accepting his suggested treatment because of the opportunities and benefits that a clinical diagnosis brings (in comparison to living with a mental illness that remains undiagnosed and untreated). In this ideal world, a formal diagnosis brings an individual access to treatment (again, still operating under the assumption that his diagnosis is accurate, in which case treatment would certainly help); increased self-awareness increases as he learns more about his own actions and thought processes and gains respect for himself, which was missing before his diagnosis, when he and those around him attributed his actions to poor character; and support from family, friends, and other community members who finally better understand his behavior and help him through treatment. Within such an incredibly supportive environment, a clinical diagnosis feasibly leads to restored (full or growing partial) internal autonomy for the diagnosed individual, transforming clinical diagnoses from condemnations into desirable mechanisms to recovery.

The realization of this world requires a marriage between legislative and cultural reform that serves to build a single path to strengthen the individual's internal autonomy. A well-built path requires careful arrangement and implementation of material components by workers who all understand and agree upon the goal of the path, including its optimal route and destination. A well thought out draft of a beautiful, functional path serves no one without construction workers to build the path. Similarly, the success of a mental health system that is both productive and rehabilitative depends upon not only legislation dictating external factors (i.e. health care reform, support groups, effective treatment) to support such a system, but also a population that will support those factors.

One potential collaborative strategy involves coordination among multiple agencies, which is something our current system sorely lacks. Legislation to protect the rights of mentally ill individuals must work together with support programs and mental health professionals who help ready these individuals for life beyond the confines of their mental illnesses. A collaboration like this in the job market, for example (an example I will continue to explore in the following chapter), would combine the efforts of: a) legislators who create laws to support mental health/mental illness recovery and rehabilitation; b) the individual who undergoes treatment in order to achieve all requisite qualifications to be a competitive job applicant; c) the mental health professional who works with the individual on a regular basis to prepare him for life beyond his mental illness as a functional member of society; d) the firm that seeks candidates best fit for the job regardless of their mental history, in accordance with anti-discrimination laws; e) the mental health professional on call for the firm who is ready and able to work with the firm's employees to ensure their mental health as well as their ability to add value to the firm; f) society at large that takes into account mental illness when necessary but does not stigmatize it by incorporating it as a factor when it should be irrelevant.

Unfortunately we are far from any such collaboration. On the contrary, individuals with mental illnesses are systematically blocked from functioning as autonomous individuals by our legislation and our culture. As I will explore in the next chapter, the underrepresentation of those with mental illnesses in the workforce today demonstrates the need for significant changes in our system to allow for more mentally ill individuals to receive treatment that will allow them to gain self-autonomy and eventually to contribute productively to our society (in our workforce). Legislation would

need to couple with rehabilitative programs or initiatives that aim to make these individuals employable, or “qualified,” for the laws to truly help them or be of any significance to them whatsoever. Most importantly, in order for these laws to truly succeed, society must shift its norms to provide individuals the opportunity to rehabilitate without facing stigmas that discourage or hinder their progress and thus the aim of the efforts.

## **Chapter 4: Our Reality**

The vision of an ideal world in which those with mental illnesses receive adequate support for rehabilitation and reintegration rests upon an important foundation that we lack today: the elimination of stigmas against mental illnesses and those who are mentally ill. While legislative efforts provide the framework for further reform (i.e. cultural), laws have a limited reach and require certain cultural foundations in order to be effective. The function of a legislative framework should be to support the content within its jurisdiction. Despite the legislative framework we have in place today to protect those with mental illnesses, even more powerful than our laws are our deep-seated stigmas that work to counteract building a substantial foundation for the framework to support. With these stigmas in place, the impacts of our laws can only be marginal compared to their potential to impact systemic change in a stigma-free world. This is especially evident in our legislation to ensure equal opportunities for mentally ill in the workforce.

Legislation serves as a principal mechanism implemented to protect the rights of mentally ill individuals, with laws designed to ensure their equal opportunity to be productive, contributing members of society through labor force participation. Two particular federal laws in place to secure equal employment rights for mentally ill individuals are the Americans with Disabilities Act and the Rehabilitation Act. However, the nature of legislation forces employers to comply with anti-discrimination laws by necessity, rather than choice, doing little or nothing to alter their previously held stigmas. As I will discuss later, laws can mandate certain behaviors but cannot directly address

stigmas. The result is little overall progress (as measured by the rehabilitation of mentally ill individuals and their subsequent integration and inclusion into society); employment statistics suggest not only minimal, but perhaps even backward progress for those living with mental illnesses.

Our modern economy seeks “motivated, independent employees who are able to deal with complex interpersonal as well as high cognitive demands in the workplace,” as the workplace “has shifted from physical to mental demands.”<sup>31</sup> The service sector of the U.S. economy continues to grow and provide a large number of jobs, while the agriculture and industry sectors shrink. This shift in the type of work consequently demands a different type of worker, and many employers feel their increased demand is not being met. Three fourths of employers in a survey “believed college graduates were lacking in critical thinking, complex problem solving, written and oral communication, and applied knowledge in real-world settings.”<sup>32</sup> With the number of jobs requiring highly skilled workers increasing, the discontent of both employers and hopeful applicants will grow as even college graduates become less desirable as employees. The increasing importance in the workforce of the mental over the physical ensures that individuals with mental illnesses will have an even harder time than they already are in acquiring the same positions as mentally healthy individuals, as even mentally healthy individuals are ill-qualified because they fail to meet the demands of the rapidly changing labor market. Unemployment of individuals served by public mental health systems is

---

<sup>31</sup>Aart Schene, Hiske Hees, Maarten Koeter, and Gabe de Vries. “Work, mental health and depression.” *Improving Mental Health Care: The Global Challenge*. Ed. Graham Thornicroft, Mirella Ruggeri, and David Goldberg. West Sussex: John Wiley & Sons, 2013. Print, p.163.

<sup>32</sup>John Aziz, “Is a Lack of Skilled Workers Hurting the Labor Market?” *The Week*. N.p., 14 Aug. 2014. Web. 27 Jan. 2015. <<http://theweek.com/articles/444554/lack-skilled-workers-hurting-labor-market>>.

already more than three times that of the general population,<sup>33</sup> perhaps a reflection of the measures in place to ensure equal job accessibility and opportunities.

Having a job “helps us to define ourselves, both in relation to other people and in relation to our direction and purpose in life.”<sup>34</sup> Jobs are a means by which individuals often measure both internal (or personal) success and external (as measured by society) success. With the number of mentally ill individuals increasing (either that or more are accepting their formal diagnosis and treatment) and the ease with which they are able to secure positions in the labor market decreasing, the unemployment rate for the mentally ill creeps up. Individuals living with mental illnesses are unemployed at a rate of 82.2% nationwide in 2012 (up from 77% in 2008)<sup>35</sup> and are “the largest and fastest growing group of public disability income beneficiaries.”<sup>36</sup> This is damaging to both the rejected mentally ill job applicant specifically and the entire population of people living with mental illnesses as a whole. The individual faces stigma and discrimination in the workforce as he is effectively barred from entry because the economy calls for higher-level mentally functioning applicants; and the entire population of mentally ill individuals finds itself in a cycle that reinforces the exclusion of mentally ill in the workplace as the workforce places a higher and higher value on what the mentally ill lack, making them

---

<sup>33</sup>Sita Diehl, Dania Douglas, and Ron Honberg, “Road to Recovery: Employment and Mental Illness.” *National Alliance on Mental Illness*. N.p., July 2014. Web. 5 Apr. 2015. <[http://www2.nami.org/Template.cfm?Section=Policy\\_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=169263](http://www2.nami.org/Template.cfm?Section=Policy_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=169263)>, p.3.

<sup>34</sup>Aart Schene, Hiske Hees, Maarten Koeter, and Gabe de Vries, “Work, mental health and depression.” *Improving Mental Health Care: The Global Challenge*. Ed. Graham Thornicroft, Mirella Ruggeri, and David Goldberg. West Sussex: John Wiley & Sons, 2013. Print, p.165.

<sup>35</sup>Sita Diehl, Dania Douglas, and Ron Honberg, “Road to Recovery: Employment and Mental Illness.” *National Alliance on Mental Illness*. N.p., July 2014. Web. 5 Apr. 2015. <[http://www2.nami.org/Template.cfm?Section=Policy\\_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=169263](http://www2.nami.org/Template.cfm?Section=Policy_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=169263)>, p.4.

<sup>36</sup>*Ibid.*, p.3.

less valuable to functioning society. This regress promises little hope for the rehabilitation and incorporation of mentally ill individuals into society as functional and autonomous beings and is an indication of our failure to ensure equal employment opportunity through legislation alone.

Our laws to protect mentally ill individuals from employment discrimination are extremely limited in their effectiveness due to both the nature of laws in general and the wording of our laws in particular. First, by nature, laws can do little to change an individual's own perceptions and prejudices. An employer must comply with anti-discrimination laws in order to avoid penalty; however, the law ends in the workplace, beyond which an individual may hold any stigma he so chooses. Anti-discrimination laws may force an employer to rehabilitate his actions, and consider mentally ill candidates as employees, but will do little to rehabilitate his mindset. For example, a law may force a sexist employer to consider a female applicant, and though he may hire her (should no equally qualified male come along), this does little to rehabilitate the employer's mindset toward females in general. He will probably continue to treat women poorly without giving it much thought. Similarly, abiding by anti-discrimination laws for the mentally ill will not necessarily leave society as a whole more open to aiding in the rehabilitation and incorporation of mentally ill individuals. In fact, employers upset by the legislation could retaliate in a number of ways, both public and private (i.e. publicly rebutting the laws to draw more attention to them and to gain the support of others who are opposed to them, or privately cultivating even harsher opinions of mentally ill individuals which manifest themselves outside of the employer's workplace). Thus, while anti-discrimination laws could allow more individuals with mental illnesses to work, outside of their workplaces

(and even within them) they continue to face stigmas that counteract their progress along their path toward internal autonomy and hinder their efforts to become fully autonomous individuals.

Second, looking specifically at the laws we have in place, both of the primary anti-employment discrimination laws to protect mentally (and otherwise) disabled individuals apply the prerequisite that an individual be “qualified” in such a way that hides two relevant distinctions. Sections 501, 503, and 504 of the Rehabilitation Act of 1973 (last amended in 1998) each prohibit forms of discrimination by various agencies against “*qualified* [emphasis added] individuals with disabilities,” with two of the three sections additionally calling for the application of affirmative action to these individuals in the “hiring, placing, and advancing” processes.<sup>37</sup> The Americans with Disabilities Act (ADA) of 1990 (last amended in 2008) “prohibits private sector employers who employ 15 or more individuals, and all state and local government employers, from discriminating against *qualified* [emphasis added] individuals with disabilities in all aspects of employment.”<sup>38</sup> While this language seems to be serving those with mental illnesses, the use of the word “qualified” masks the amorphousness and lack of supportiveness of the word, which translates to the amorphousness and lack of supportiveness of the laws themselves.

One problem with the use of the word “qualified” is its nebulous nature that allows for its subjective application. While the word seems to call upon particular tangible qualifications (i.e. a skill set, degree, license, etc.) and thus an objective

---

<sup>37</sup>Deborah Leuchovius, “ADA Q & A: The Rehabilitation Act and ADA Connection.” *Pacer Center: Champions for Children with Disabilities*. N.p., n.d. Web. 1 Apr. 2015. <<http://www.pacer.org/parent/php/PHP-c51f.pdf>>, p.2.

<sup>38</sup>*Ibid.*

application process, data and experiences like those of Christina suggest that “qualified” factors in more than just these tangible and objective qualifications. In particular, illness remains as an important disqualifying factor in the question of qualification (which works directly against the purpose of the laws). This means candidates are judged not only by their tangible qualifications, but also by their mental health in receiving these qualifications (or, as employers might see it, their “mental qualification”). With illness factored into an individual’s level of qualification, an individual with a history of mental illness may be deemed unqualified for a job, regardless of his number of tangible qualifications, because of our strong stigmas against those with mental illnesses. The word “qualified” allows for flexibility in application and blurs the question of employment eligibility for the mentally ill, more often than not working against them. This is clear in both the big picture and in individual accounts. From a broad perspective, the likelihood that all 82.2% of unemployed mentally ill in 2012<sup>39</sup> lack the requisite degrees, certifications, licenses, etc. for the positions they are applying for is extremely slim if not impossible. (However, more data on the breakdown of why exactly these individuals are unemployed is lacking and should be collected.) From a narrower scope, individual narratives like Christina’s demonstrate that “qualified” incorporates more than tangible qualifications because Christina fulfills all prerequisites and still every residency program rejects her, presumably weighting her mental illness history on the scale against her eligibility for qualification.

---

<sup>39</sup>Sita Diehl, Dania Douglas, and Ron Honberg, “Road to Recovery: Employment and Mental Illness.” *National Alliance on Mental Illness*. N.p., July 2014. Web. 5 Apr. 2015. <[http://www2.nami.org/Template.cfm?Section=Policy\\_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=169263](http://www2.nami.org/Template.cfm?Section=Policy_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=169263)>, p.4.

The amorphous quality of “qualified,” at the crux of employability, allows employers to judge applicants with mental illness histories through the context of their illness rather than by their employment qualifications. Though an individual’s mental illness could actually make him a stronger candidate and bolster his employment application, our stigma-ridden culture only encourages (both conscious and subconscious) discrimination against him. For example, in one sense Christina has all the qualifications required to obtain a spot in a residency program: an MD degree, community service hours, glowing letters of recommendation, etc. And yet every residency program rejects her. In her applications, Christina explains that her delayed graduation date is the result of taking two weeks of a semester off to go to rehab, and that her delay in applying for a spot in a residency program is due to not receiving effective treatment for her alcoholism and borderline personality disorder diagnoses, which she finally has today. Despite the progress she has made in handling her illnesses, Christina’s rejection leaves her unsurprised, as she understands her undesirability as a candidate. Mentors have already warned her that programs are unlikely to accept a doctor battling with known mental illnesses – an unspoken truth. Mental illnesses therefore remain informally factored into the “qualified” prerequisite, a startling realization as this directly inverts the purpose of the anti-discrimination laws. As informal factors, they escape the scope of the law as long as employers find loopholes to incorporate the illnesses as factors while complying with the diction of the anti-discrimination laws. Laws designed to protect the mentally ill while allowing for mental illnesses to remain in the “unqualified” bucket serve no real purpose for mentally ill individuals unless employers are required to apply the laws thoughtfully, a rare endeavor in a stigma-ridden culture.

Illness remains deeply intertwined into an individual's employability regardless of its effect or lack thereof on his ability to perform his job well. However, this is more strongly exacerbated with mental illnesses than with physical illnesses because of the wider range of imperceptible mental illnesses. Employers can judge the impact of a wider range of physical illnesses than mental illnesses on an individual's ability to work well, leaving many mental illnesses out of the scope of objective qualification and entering the realm of biased judgment. On one end of the range, an armless individual who applies to be a fireman can be fairly rejected due to the nature of the job for which he applies: it is impossible to effectively fight fires or carry children out of burning homes without the use of one's arms. On the other end of the range, an individual with back pain who says he can work with a back brace might be qualified for a fireman's job and might not, depending on the judgment of the employer. Similarly, if an active schizophrenic (one whose symptoms are in full bloom) applies to be a teacher, he can be fairly rejected due to the nature of the job for which he applies: it is impossible to create and deliver effective lesson plans with disorganized speech and hallucinations. However, an individual undergoing treatment for mild borderline personality disorder might be qualified for a teacher's job and might not, depending on the judgment of the employer. Because of the nature of mental illnesses, it is particularly difficult for employers to judge their impact of a wide range of mental illnesses on an individual's ability to work well (whereas with physical illnesses the range of uncertainty is narrower). This results in less employment decisions grounded in indisputable facts and more grounded in the judgment of the employer. As the unemployment rates tell us, more likely than not this leaves the mentally ill individual jobless, or "unqualified," as the manner in which mental illnesses

are factored in to the employment question is not in favor of the mentally ill; the strongest force guiding judgments today seems to be stigma.

In Christina's case, thoughtfully factoring her mental illnesses into her education history might make her a more attractive candidate. Not only does she have all of the necessary qualifications, she achieved them while dealing with two untreated mental illnesses. Competing against her classmates, she manages to keep up (or catch up) with the same course load and receives the same diploma as each of her classmates. Her mental illnesses obstruct her possibilities for success only once the next step to success (in Christina's case, becoming a doctor) entails disclosing her illnesses. She fails to keep up not by function of her inability, but by function of her lack of opportunity. The strength of the stigma against mental illnesses in our culture blinds employers from considering that her candidacy may be stronger yet than an individual with the exact same tangible qualifications who has not had such formative life experiences.

For example, two individuals who graduate from the same high school who have a .2 difference in GPA and score 60 points apart on the SAT may be judged as having different levels of intelligence and ability. If, say, the individual with the higher GPA also has the higher SAT score, he is typically judged to be slightly more intelligent (or driven, or capable, etc.) than the other individual. However, a college considering both students might be interested to know that the seemingly more intelligent student comes from a very wealthy family, lives very close to school, drives himself to school in his own car, and receives private tutoring in every subject as well as SAT test preparation. On the other hand, the seemingly less intelligent student comes from a very poor family, often struggles to come up with bus and metro fare for the hour-long commute to school, and

cannot afford tutoring for any of his subjects or for his SATs. After taking this all into consideration, it seems the poorer student might be even better qualified and prepared to attend college than the wealthier student. The poorer student manages to graduate from high school with good grades and test scores all while struggling with his low socio-economic status and the hardships and obstacles it brings. Taking into account what the poorer student has had to overcome to reach his accomplishments sheds light on how much more he might be able to accomplish provided he has better access to good resources (which, presumably, at college, he would).

Similar to the poorer student, Christina reaches her accomplishment (graduating from medical school) without any treatment and support for her mental illnesses (barring the isolated two weeks of rehab and the inconsistent trips to the therapist). Considering how far she makes it without any treatment implies that now, with consistent and effective treatment for one year (that will continue into the future), Christina will be able to accomplish even more. Instead, the very experiences that could help make Christina a great doctor are used against her to keep her from ever achieving that goal. Not only does mental illness factor into “qualified,” but so does the stigma it carries, turning a potential advantage into a barricade and hindering truly qualified individuals from fulfilling roles as productive members of society.

Another problem with the use of the word “qualified” is that it expects individuals to apply “qualified” or else to lose their opportunity when deemed “unqualified.” The word does not provide any sort of comprehensive program or support system to help mentally ill individuals to gain the required qualification. As Project Atlas highlights (a World Health Organization initiative to collect and disseminate information related to

mental health resources around the world), “[mental health] law is often not comprehensive and does not adhere to the international legislation concerning human rights.”<sup>40</sup> Rather than creating and nurturing a constructive environment to allow individuals to become appropriately qualified and excel beyond their illness, mental health law demonstrates a minimal effort to protect mentally ill individuals rather than a concerted effort to help them. Project Atlas’ findings ring true as the “qualified” criterion of our own laws discriminates against all who have not yet managed to excel beyond their illnesses and barricades mentally ill individuals from playing a valuable role in society.

With little to no standardized effective support in place for mentally ill diagnosed individuals, a diagnosis at its best opens access to treatment while at its worst ensures discrimination for needing that treatment. One author notes that “the stigma of mental disorder has sometimes worse consequences than the disease itself,”<sup>41</sup> as it reroutes individuals from potential difficulties to certain insurmountable obstacles and failures. Today, the most robust, comprehensive measures of legislation enacted to incorporate the mentally ill into our workforce call for affirmative action. Affirmative action itself creates the assumption that an individual did not get the job based on merit or qualification, and thus perpetuates the stigma of mental illness. Without the opportunity to build the relevant skills to even qualify as “qualified” (and not just for affirmative action), mentally ill individuals are stuck in a discouraging and limiting narrative.

---

<sup>40</sup>Benedetto Saraceno and Shekhar Saxena, “Mental Health Resources in the World: Results from Project Atlas of the Who.” *World Psychiatry* 1.1 (2002): 40-44. Web. 14 Apr. 2015. <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489823/pdf/wpa010040.pdf>>, p.42.

<sup>41</sup>Norman Sartorius, “Some wobbly plans in the platform of mental health care.” *Improving Mental Health: The Global Challenge*. Ed. Graham Thornicroft, Mirella Ruggeri, and David Goldberg. West Sussex: John Wiley & Sons, 2013. Print, p.395.

Perhaps because of the short timeline to date, a program has yet to be developed and implemented on a large scale (e.g. federally) that supports and allows mentally ill individuals to gain proper qualifications to fulfill the “qualified” criterion of our legislation. As a fairly “new” topic, mental health is gaining attention throughout the world, with several efforts in place to bolster the strength of mental health programs and policies.

The brief timeline I will highlight begins in 1991 with the UN’s call for the improvement of mental health care; the UN adopts the Principles for the Protection of Persons with Mental Illnesses and for the Improvement of Mental Health Care, which include provisions for admission to treatment facilities.<sup>42</sup> In 1995, UN Secretary-General Boutros Boutros-Ghali affirms that “to secure mental health for the people of the world must be one of the objectives of the United Nations in its second half century.”<sup>43</sup> In 1996, the World Health Organization (WHO) launches *Nations for Mental Health*, a global program with the goal to create a worldwide movement for mental health.<sup>44</sup> In the same year, *Nations for Mental Health*’s International Women Leaders for Mental Health pledges to promote and establish international mental health programs and to work with NGOs concerned with raising awareness for mental health initiatives.<sup>45</sup> In 2001, WHO introduces the slogan “*Stop exclusion – Dare to care,*” on World Health Day to increase awareness and reduce stigmas against mental illnesses.<sup>46</sup> Today, the WHO is in the midst

---

<sup>42</sup>*Nations for Mental Health: Final Report*. Rep. World Health Organization: Mental Health Policy and Service Development Department of Mental Health and Substance Dependence, 2002. Web. 15 Apr. 2015. <[http://www.who.int/mental\\_health/media/en/400.pdf](http://www.who.int/mental_health/media/en/400.pdf)>, p.6.

<sup>43</sup>*Ibid.*, p.8.

<sup>44</sup>*Ibid.*, p.9.

<sup>45</sup>*Ibid.*, p.12.

<sup>46</sup>*Ibid.*, p.60.

of its Mental Health Action Plan for 2013-2020.<sup>47</sup> The plan has four objectives: 1. to strengthen effective leadership and governance for mental health;<sup>48</sup> 2. to provide comprehensive, integrated and responsive mental health and social care services in community-based settings;<sup>49</sup> 3. to implement strategies for promotion and prevention in mental health;<sup>50</sup> and 4. to strengthen information systems, evidence and research for mental health.<sup>51</sup> As a WHO member country, the U.S. is among the group of countries for whom these objectives are intended. However, as the action plan itself states, “These options are neither comprehensive nor prescriptive, but provide illustrative or indicative mechanisms through which actions can be undertaken in countries.”<sup>52</sup> The objectives are but suggestions, with little in place in member countries (including the U.S.) to see them through by 2020.

Despite the increased attention to mental health and the many suggestions to improve mental health systems over the past decades, we still lack any comprehensive, wide-scale implementation of a plan that supports mentally ill individuals such that they can gain easy access to treatment and the ability to earn the necessary qualifications to fulfill the “qualified” criterion of our current legislation. However, while the “qualified” criterion in our current anti-discrimination laws does not provide a comprehensive program or support system, it does provide a legal framework that could serve to support such a program. On the other hand, initiatives such as the WHO’s Action Plan provide

---

<sup>47</sup>World Health Organization. *Mental Health Action Plan 2013-2020*. Geneva: World Health Organization, 2013. Web. 15 Apr. 2015. <[http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf)>.

<sup>48</sup>Ibid., p.11.

<sup>49</sup>Ibid., p.14.

<sup>50</sup>Ibid., p.16.

<sup>51</sup>Ibid., p.18.

<sup>52</sup>Ibid., p.23.

plans for comprehensive programs without any legislative support to ensure the successful implementation of the programs.

With the labor market demanding more highly educated and highly skilled workers,<sup>53</sup> our current laws to protect the mentally ill will increasingly discriminate against the very individuals they are meant to protect. The language of the laws does little to shift the negative perception of mentally ill individuals or to make the necessary education and skills required to be “qualified” more accessible to mentally ill.

While laws such as the Americans with Disabilities Act and the Rehabilitation Act appear to help individuals with mental illnesses gain equal access to employment opportunities and thus incorporation into society, they only help “qualified” individuals who, as it turns out, make up a very small portion of the growing mentally ill community. This criterion serves to exclude a large number of mentally ill individuals (a number that will probably grow due to a number of factors, lack of adequate treatment among them)<sup>54</sup> from normally functioning society rather than to aid their integration into it. The current protection for “qualified” mentally ill job candidates allows for the judgment of mentally ill individuals to be based on their illness rather than their credentials and neglects to include any accommodations for future rehabilitation or incorporation.

---

<sup>53</sup>Aart Schene, Hiske Hees, Maarten Koeter, and Gabe de Vries, “Work, mental health and depression.” *Improving Mental Health Care: The Global Challenge*. Ed. Graham Thornicroft, Mirella Ruggeri, and David Goldberg. West Sussex: John Wiley & Sons, 2013. Print, p.163.

<sup>54</sup>Norman Sartorius, “Some wobbly plans in the platform of mental health care.” *Improving Mental Health: The Global Challenge*. Ed. Graham Thornicroft, Mirella Ruggeri, and David Goldberg. West Sussex: John Wiley & Sons, 2013. Print, p.394.

## Chapter 5: Next Steps and Questions

A clear understanding of our current situation and how we got here is fundamental for the future of mental health. Before designing any new laws, initiatives, or programs, we must know exactly what questions we are looking to answer and what problems we are trying to solve. Implementing fundamental change without understanding the complexity of the problem at hand can be counterproductive and incur a number of unforeseen costs, both internal and external.

First and foremost, we must understand what definition of mental illness we are working under or seeking to transform. Although several definitions and understandings of mental illness exist, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders provides the principal working definition today. The three pillars of mental illness in the most recently updated DSM, the DSM-V, are "disturbance," "dysfunction," and "distress or disability," all three of which are grounded in the normative. Because the medical world publishes the definition, we are often under the illusion that its components are purely empirical, objective measurements to identify mental illnesses. However, a closer look reveals the normative layers baked into the definition, rooting it more deeply in cultural norms than empirical truths.

Autonomy lies at the core of mental health discussions and debates; in an ideal, mentally healthy world, each individual would have full personal autonomy. The external theory of autonomy (which absorbs the internal theory of autonomy) states that personal autonomy depends upon both the psychological state of an individual and the external

circumstances motivating or restraining an individual. If either one of the two is compromised, an individual is said to be not autonomous. Mental illness undermines an individual's internal autonomy and how society perceives an individual can undermine his external autonomy. The purpose of treatment is for an individual to rebuild his internal autonomy, but as long as external threats to autonomy remain intact, an individual is constrained from reaching a state of full autonomy.

The various internal and external threats to the autonomy of mentally ill individuals – operating under the external theory of autonomy – include public stigmas, discrimination, loss of autonomy, self-stigma and internalization of discrimination, and a harmful misperception of undermined autonomy as intact. Today, each of these threats is a cost along three different paths that mentally ill individuals follow, beginning with their clinical diagnosis. Because of the magnitude of the costs, it is conceivable that individuals will do their best to avoid the paths at any price, which inevitably forces them onto Path B (individual rejects treatment, cannot “pass” as normal) or Path C (individual rejects treatment, can “pass” as normal).

An ideal world would institutionalize a collaborative approach to mental health, capitalizing on the various resources available in order to help both individuals with mental illnesses and society at large. Both parties would benefit from a more comprehensive and robust rehabilitative system to transform mentally ill individuals into fully autonomous, contributing members of our society. A system such as this might incorporate collaboration between legislators, mentally ill individuals, mental health professionals who work with the individuals on a regular basis, employers, mental health professionals on call for the employer, and society at large.

Comparing collaboration such as this with the state of our mental health system today shows how much work remains to be done. Two of the principal laws protecting mentally ill individuals' rights are the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, both protecting equal employment rights for the disabled. Although these only regard one facet of functional life – the workforce – from which mentally ill individuals are systematically pushed out, we can learn from the results of implementation of these laws. The key takeaway from our legislative efforts thus far is that they must be supplemented with (or preceded by) cultural reform. Without cultural reform, the diction of laws will be manipulated to bend to the stigmas in place as employers find loopholes in the ambiguities of the laws. Though there are certainly cases in which mental illnesses are fair grounds for employment ineligibility, these should be the only cases in which mental illnesses preclude individuals from the workplace (and not cases in which individuals with mental illnesses or mental illness histories who are qualified and able to work are precluded due to stigmatization).

The ultimate goal must be for mental illness not to be a stigma determining the ineligibility of an individual, but the factor that it ought to be and nothing more. The complexity of mental disabilities calls for a collaborative approach to mental health; rather than a bipolar approach - discriminating against all candidates with a mental illness or prioritizing acceptance of all candidates with a mental illness - in a happy medium, employers and individuals can work together to both contribute productively to society. In order for significant change to be implemented in favor of mentally ill individuals, we must package laws with other solutions.

We currently fail to incorporate many highly skilled and educated individuals into our society due to deeply rooted stigmas against mental illnesses and all who have suffered from them. Recognizing this wasted capital might move us more strongly toward finding an effective way to capture this talent and adapt our system to incorporate these individuals as valuable members into our society. Legislation on its own thus far has proven inadequate, but we should leverage what we have in place and improve upon it. Rather than abandoning legislation altogether, we should strengthen it with other initiatives (for example, WHO's Action Plan for 2013-2020).

Individuals like Christina can certainly add value to our society and culture if given the opportunity to do so; this opportunity does not exist today under the protection of the Rehabilitation Act or the Americans with Disabilities Act. Christina is an educated, qualified individual who fails to secure a spot in a residency program because of her mental illness history. Once our culture moves beyond its stigma against mental illness, individuals like Christina can be helped through treatment and made into productive members of society, benefiting both the individual and society. The stigma must shift into a factor, nothing more. A stigma influences mental illness to matter when it should not; a factor allows mental illness to matter only when it must.

Comparing today's system with the ideal best case scenario highlights major discrepancies, begging for mental health reform. After 12 long years, Christina finally reaches the best case scenario for a clinically diagnosed mentally ill individual - not only is she on Path A, receiving consistent and effective treatment, but she has achieved the major accomplishment of being one year sober, she has repaired broken relationships with her friends and family, she has acquired an interim job, and she has moved out of

her parents' home. Yet even with all this progress, Christina still faces the harsh consequences of having been mentally ill in our society: she will never be a practicing doctor because of the stigma and discrimination she continues to face despite her dedication to her mental health and her dramatic recovery. Even though many doctors themselves struggle with mental illnesses (including alcoholism and borderline personality disorder), many choose not to report it or the timing of onset is such that their early careers are not negatively impacted, and therefore they do not all face the same consequences as Christina. Although she now may be an even stronger candidate than her peers in medical school, due to the resilience and dedication of her character by this point in her life, the very illnesses that have molded her resilience and dedication and would make her a better doctor preclude her from the field.

Legislation to protect equal employment rights for mentally ill individuals must work together with mental health programs (i.e., supported employment programs) and mental health professionals who help ready these individuals for employability (along with which they regain their internal autonomy and become functional people in our society). Supported employment models such as Individual Placement and Support (IPS) help mentally ill individuals find jobs by integrating employment services into the individual's mental health treatment.<sup>55</sup> Proven to be successful, individuals participating in IPS programs have 36% higher employment rates than those who are not; an enormous impact when current employment rates for mentally ill are so dire.<sup>56</sup> Other mental health

---

<sup>55</sup>Sita Diehl, Dania Douglas, and Ron Honberg, "Road to Recovery: Employment and Mental Illness." *National Alliance on Mental Illness*. N.p., July 2014. Web. 5 Apr. 2015. <[http://www2.nami.org/Template.cfm?Section=Policy\\_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=169263](http://www2.nami.org/Template.cfm?Section=Policy_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=169263)>, p.7.

<sup>56</sup>Ibid.

professionals contribute by continuing to work regularly with the individual to ensure a smooth transition (back) into the working world. Each company might also be required to have a mental health professional on call, bridging the separate worlds the individual might feel to inhabit (his therapy or mentally ill life, and his work or productive life). However, while the success of collaboration such as this would surely be greater than the approach in place today, it will still be hindered by continuing norms and stigmas against mental illness. The law governs a finite realm and cannot rule individually-held stigmas, which leads us to ask when and how the deep-seated stigma against mental illness will give way. Legislation can certainly guide the way, but must be supplemented by a comprehensive program, both of whose success depend upon a fundamental shift in perception of mental illness within our society.

Implementing a fundamental norm shift is no simple task, and Sunstein points out the collective action problem of norm-changing. The cost for an individual to defy a deeply-rooted norm (e.g. having a mental illness should be grounds for stigmatization) is high, discouraging everyone from speaking out against this norm, regardless of how harmful the norm may be. As Sunstein writes, the “fear of [shame] can be a powerful deterrent to behavior.”<sup>57</sup> However, government can remove the shame that fuels the norm by shifting the focus of the facts and the beliefs that surround mental illness.<sup>58</sup> Following or accompanying the removal of shame, Sunstein suggests norm shifts can occur through either of two experiences: norm bandwagons or norm cascades.<sup>59</sup> A norm bandwagon describes the process of an increasing number of people rejecting the current norm,

---

<sup>57</sup>Cass R. Sunstein, *Social Norms and Social Rules*. Working paper no. 36. The University of Chicago, 1995. Web. 14 Apr. 2015. <<http://www.law.uchicago.edu/files/files/36.Sunstein.Social.pdf>>, p.8.

<sup>58</sup>*Ibid.*, 22.

<sup>59</sup>*Ibid.*, p.9.

lowering the cost of doing so, and leading to a “‘tipping point’ where it is adherence to the old norms that produces social disapproval.”<sup>60</sup> A norm cascade describes a rapid shift toward new norms imposed upon a society.<sup>61</sup> With current legislation and initiatives (i.e. Americans with Disabilities Act, Rehabilitation Act, *Nations for Mental Health*, etc.), we certainly seem to be leaning more toward a norm bandwagon experience. Yet our society would be better served if more of us jumped onto the bandwagon, accelerating the tipping point’s approach to allow us to move forward with new norms that embrace the recovery and inclusion of mentally ill individuals into our society.

There are many questions left to answer before we can bring about the kind of fundamental shift in perception of mental illness I have argued is necessary. How can we eliminate the external threats to autonomy as illustrated in Figure 1? Should we focus on an educational approach? Can we implement effective ad campaigns? Should we build an incentive structure? How can we mitigate the horror an individual feels upon being diagnosed as mentally ill? How can we build paths to recovery that are free of counteracting stigmas and discrimination? How can we build a culture of support around mental illness? What can we do to eliminate internal and external opposition? How can we eliminate the external consequences of the paths in Figure 1 and instead build a single positive path filled with benefits, as shown in Figure 2? What programs and initiatives can we introduce to allow laws to be maximally effective?

All of these questions are important to consider when thinking about the future of mental health and whether or not we are able to make the fundamental shift from mental illness as a stigma to mental illness as nothing more than a factor. What would be

---

<sup>60</sup>Ibid.

<sup>61</sup>Ibid., p.9-10.

effective in making this shift is beyond the scope of this discussion, though law is clearly inadequate and would ideally be complemented or supplemented by other measures. I invite others to explore different ways that we could go about making this change and to create a lasting impact by means other than the law.

## Bibliography

- Aziz, John. "Is a Lack of Skilled Workers Hurting the Labor Market?" *The Week*. N.p., 14 Aug. 2014. Web. 27 Jan. 2015. <<http://theweek.com/articles/444554/lack-skilled-workers-hurting-labor-market>>.
- Bayne, John. "7 'Eccentric' Geniuses Who Were Clearly Just Insane." *Cracked*. N.p., 18 Aug. 2008. Web. 19 Jan. 2015. <[http://www.cracked.com/article\\_16559\\_7-eccentric-geniuses-who-were-clearly-just-insane.html](http://www.cracked.com/article_16559_7-eccentric-geniuses-who-were-clearly-just-insane.html)>.
- Ben-Zeev, Dror, Michael A. Young, and Patrick W. Corrigan. "Dsm-v and the Stigma of Mental Illness." *Journal of Mental Health* 19.4 (2010): 318-27. Web. 14 Feb. 2015. <<http://www.likeminds.org.nz/file/Newsletter-Archive/PDFs/dsm-v-and-the-stigma-of-mental-illness.pdf>>.
- Bentall, Richard, and Nick Craddock. "Do We Need a Diagnostic Manual for Mental Illness?" *The Guardian*. N.p., 10 Feb. 2012. Web. 11 Feb. 2015. <<http://www.theguardian.com/commentisfree/2012/feb/10/diagnostic-manual-mental-illness>>.
- Corrigan, Patrick W. "How Clinical Diagnosis Might Exacerbate the Stigma of Mental Illness." *Social Work: A Journal of the National Association of Social Workers* (2007): 31-39. Web. 11 Feb. 2015. <<http://sw.oxfordjournals.org/content/52/1/31.full.pdf+html>>.
- Davis, Jeanie Lerche. "Did Michelangelo Have Autism?" *WebMD*. N.p., 26 May 2004. Web. 19 Jan. 2015. <<http://www.webmd.com/mental-health/news/20040526/did-michelangelo-have-autism>>.
- Diehl, Sita, Dania Douglas, and Ron Honberg. "Road to Recovery: Employment and Mental Illness." *National Alliance on Mental Illness*. N.p., July 2014. Web. 5 Apr. 2015. <[http://www2.nami.org/Template.cfm?Section=Policy\\_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=169263](http://www2.nami.org/Template.cfm?Section=Policy_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=169263)>.
- "Dsm." *American Psychiatric Association*. N.p., 2012. Web. 27 Jan. 2015. <<http://www.psychiatry.org/practice/dsm>>.
- Duckworth, Ken. "Mental Illness: Facts and Numbers." *Fact sheet*. National Alliance on Mental Illness. Arlington, VA. Mar. 2013. Web. 10 Feb. 2015. <[http://www2.nami.org/factsheets/mentalillness\\_factsheet.pdf](http://www2.nami.org/factsheets/mentalillness_factsheet.pdf)>.

- Edwards, Craig. "Ethical Decisions in the Classification of Mental Conditions as Mental Illness." *Philosophy, Psychiatry, and Psychology* 16.1 (2009): 73-90. Web. 19 Sep. 2014.  
<[http://muse.jhu.edu/journals/philosophy\\_psychiatry\\_and\\_psychology/v016/16.1.edwards.pdf](http://muse.jhu.edu/journals/philosophy_psychiatry_and_psychology/v016/16.1.edwards.pdf)>.
- Hacking, Ian. "Making Up People." *The Science Studies Reader*. Ed. Mario Biagioli. New York: Routledge, 1999. Print.
- Leuchovius, Deborah. "ADA Q &A: The Rehabilitation Act and ADA Connection." *Pacer Center: Champions for Children with Disabilities*. N.p., n.d. Web. 1 Apr. 2015. <<http://www.pacer.org/parent/php/PHP-c51f.pdf>>.
- Link, Bruce G., Jo C. Phelan, Michaeline Bresnahan, Ann Stueve, and Bernice A. Pescosolido. "Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance." *American Journal of Public Health* 89.9 (1999): 1328-33. Web. 11 Feb. 2015.  
<<http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.89.9.1328>>.
- Nations for Mental Health: Final Report*. Rep. World Health Organization: Mental Health Policy and Service Development Department of Mental Health and Substance Dependence, 2002. Web. 15 Apr. 2015.  
<[http://www.who.int/mental\\_health/media/en/400.pdf](http://www.who.int/mental_health/media/en/400.pdf)>.
- Oshana, Marina A. L. "Personal Autonomy and Society." *Journal of Social Philosophy* 29.1 (1998): 81-102. Wiley Online Library. Web. 22 Feb. 2015.  
<<http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9833.1998.tb00098.x/epdf>>.
- "Personal Autonomy." *Stanford Encyclopedia of Philosophy*. 2013. Web. 20 Feb. 2015.  
<<http://plato.stanford.edu/entries/personal-autonomy/>>.
- Ramirez, Erick. "Philosophy of Mental Illness." *Internet Encyclopedia of Philosophy: A Peer-Reviewed Academic Resource*. Web. 14 Jan. 2015.  
<<http://www.iep.utm.edu/mental-i/>>.
- Rüsch, Nicolas, Matthias C. Angermeyer, and Patrick W. Corrigan. "Mental Illness Stigma: Concepts, Consequences, and Initiatives to Reduce Stigma." *European Psychiatry* 20 (2005): n. pag. Web. 14 Feb. 2015.  
<[http://ac.elscdn.com/S0924933805000908/1-s2.0-S0924933805000908-main.pdf?\\_tid=7106e1c2-b4bc-11e4-ab61-00000aab0f01&acdnat=1423968397\\_a45d8c8cdb7aab012573d486474ae576](http://ac.elscdn.com/S0924933805000908/1-s2.0-S0924933805000908-main.pdf?_tid=7106e1c2-b4bc-11e4-ab61-00000aab0f01&acdnat=1423968397_a45d8c8cdb7aab012573d486474ae576)>.
- Saraceno, Benedetto, and Shekhar Saxena. "Mental Health Resources in the World: Results from Project Atlas of the Who." *World Psychiatry* 1.1 (2002): 40-44.

- Web. 14 Apr. 2015.  
 <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489823/pdf/wpa010040.pdf>>.
- Sartorius, Norman. "Some wobbly plans in the platform of mental health care." *Improving Mental Health: The Global Challenge*. Ed. Graham Thornicroft, Mirella Ruggeri, and David Goldberg. West Sussex: John Wiley & Sons, 2013. Print.
- Schene, Aart, Hiske Hees, Maarten Koeter, and Gabe de Vries. "Work, mental health and depression." *Improving Mental Health Care: The Global Challenge*. Ed. Graham Thornicroft, Mirella Ruggeri, and David Goldberg. West Sussex: John Wiley & Sons, 2013. Print.
- Shackle, E M. "Psychiatric Diagnosis as an Ethical Problem." *Journal of Medical Ethics* 11 (1985): 132-34. Web. 24 Sep. 2014.  
 <<http://ry6af4uu9w.search.serialssolutions.com/?genre=article&isbn=&issn=03066800&title=Journal%20of%20Medical%20Ethics:%20The%20Journal%20of%20the%20Institute%20of%20Medical%20Ethics&volume=11&issue=&date=19850901&atitle=PSYCHIATRIC%20DIAGNOSIS%20AS%20AN%20>>.
- Shrivastava, Amresh, Megan Johnston, and Yves Bureau. "Stigma of Mental Illness-1: Clinical Reflections." *Mens Sana Monographs* 10.1 (2012): 70–84. PMC. Web. 15 Feb. 2015. <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3353607/>>.
- Shrivastava, Amresh, Megan Johnston, and Yves Bureau. "Stigma of Mental Illness-2: Non-Compliance and Intervention." *Mens Sana Monographs* 10.1 (2012): 85–97. PMC. Web. 15 Feb. 2015.  
 <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3353608/>>.
- Sunstein, Cass R. *Free Markets and Social Justice*. Oxford: Oxford UP, 1999. Print.
- Sunstein, Cass R. *Social Norms and Social Rules*. Working paper no. 36. The University of Chicago, 1995. Web. 14 Apr. 2015.  
 <<http://www.law.uchicago.edu/files/files/36.Sunstein.Social.pdf>>.
- "The History of Psychiatry." *LGBT Mental Health Syllabus*. N.p., n.d. Web. 23 Jan. 2015. <[http://www.aglp.org/gap/1\\_history/](http://www.aglp.org/gap/1_history/)>.
- Wahl, Otto F. "Stigma as a Barrier to Recovery from Mental Illness." *Trends in Cognitive Sciences* 16.1 (2012): 9-10. Web. 14 Feb. 2015.  
 <<http://www.sciencedirect.com/science/article/pii/S136466131100235X>>.
- Wakefield, Jerome C. "Mental Disorder and Moral Responsibility: Disorders of Personhood as Harmful Dysfunctions, with Special Reference to Alcoholism." *Philosophy, Psychiatry, and Psychology* 16.1 (2009): 91-99. Web.

22 Sep. 2014.

<[http://muse.jhu.edu/journals/philosophy\\_psychiatry\\_and\\_psychology/v016/16.1.wakefield.pdf](http://muse.jhu.edu/journals/philosophy_psychiatry_and_psychology/v016/16.1.wakefield.pdf)>.

World Health Organization. *Mental Health Action Plan 2013-2020*. Geneva: World Health Organization, 2013. Web. 15 Apr. 2015.

<[http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf)>.