Psych Unit Gangs: An Autoethnography

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Abstract

The stigma against people with mental illness is a well-worn subject; however, stigma between groups of people with different mental illnesses is rarely discussed. Within the context of a psychiatric hospital, hierarchies form among patients based on symptomatology and diagnosis. In this perspectives piece, I explore, how, in my experiences with being on the bottom of this hierarchy as a person with a schizophrenia-spectrum psychotic illness in a psychiatric hospital. I, and my fellow "psychotics," were stigmatized and outcasted by other groups of individuals who were diagnosed with mental illnesses that are considered less serious than psychosis. I explore how one stigmatized, outcasted group (people with substance use and mood disorders) construct power relationships over an even more highly stigmatized, marginalized group (people with psychotic disorders). Utilizing Goffmanian and Tajfel theories, the perspective explores stigma within a total institution, and the formation of in-groups and out-groups. I explore how people, upon entering the psychiatric hospital unit, know almost immediately whether they belong to the dominant group or the subordinate group, and I conclude with recommendations to reduce the stigma of psychotic disorders within popular culture.

Keywords Stigma · Psychotic disorders · Mood disorders · Total institution · Autoethnography

Introduction

Middlesex Psychiatric Hospital[1] is in the suburbs of a large city on the west coast of the United States. It has five units, including the South Unit. At the time of my hospitalization during March and April 2022, the South Unit had eighteen residents,

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[1] All people and place names have been changed, except for that of the author.

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two nurses, two staff, several psychiatrists, many medical doctors, and a multitude of therapists. Of the eighteen residents, there were six who were diagnosed with psychotic disorders and formed an exclusive group. Included in the "psychotic group" were myself, Holland, and an individual who went by "Music." Holland and I were diagnosed with schizoaffective disorder, and Music was diagnosed with schizophrenia. The remainder of the residents were diagnosed with either substance use disorders or mood disorders. Similar to how I was part of the "psychotic group," the residents diagnosed with substance use disorders and mood disorders formed a group. The de facto leader of the "mood disorder group" was Lise, who had been hospitalized for alcohol use.

Groups like the Hearing Voices Network (Hearing Voices Network, n.d.), Madness Network News (Madness Network News, 2022), and other groups that are part of the mad pride, psychiatric survivor, or ex-patient movements emphasize the freedom in discarding medicalized labels. However, each patient in the South Unit was recognized by their diagnostic label. Not only did we all know each others' diagnoses, but we were known *as* them. Music was the "schizophrenic," Lise was the "drunk," and Holland and I were the "schizoaffectives." There was no room for resistance within the confines of the total institution. We embraced psychiatry's view of ourselves, and we reinforced this taxonomy by understanding each other through these labels.

This perspectives piece aims to utilize three distinct experiences during my hospitalization for schizoaffective psychosis and mania to argue that there are stigmatizing dynamics between different groups of marginalized individuals. I describe and analyze events that occurred between groups of patients diagnosed with psychosis and those diagnosed with mood and substance use disorders. My aim is to explore stigma within a psychiatric hospital between different patient groups and describe the formation of in-groups and out-groups in a constantly changing hospital community (Butz & Besio, 2009). My argument is significant because it shows how in-groups and out-groups are constructed, and how out-groups can be othered, even when both groups are marginalized by broader society (Arpin et al., 2017).

I also write this autoethnography as a form of activism and advocacy, as I believe that "coming out" is a powerful way for people with mental health diversities to decrease stigma. For many people with psychiatric diagnoses, mental health diagnoses are concealable identities, and visibility management is a dynamic and ongoing process (Lasser & Tharinger, 2003). Disclosure-based activism is a way for members of discreditable groups to reclaim their identity (Corrigan et al., 2009; Goffman, 1986), and ex-patient movements have generated a rich literature about the impact of medicalization on self and society (Hearing Voices Network, n.d.; Richie, 2019; Scheff, 1974; Zola, 1972).

Why Autoethnography?

Autoethnography as a personal experience narrative is most closely associated with the work of the sociologist Carolyn Ellis (Ellis, 1993; Ellis et al., 2011). One way that members of disadvantaged groups, such as those diagnosed with severe

psychiatric illnesses, can react is by becoming academics themselves and by contributing to the academic construction of the groups to which they belong. These scholars often study their own groups and experiences from the standpoint of opposition to existing academic representations of their marginalized group (Butz & Besio, 2009). Autoethnographies that come out of this tradition are called "native ethnographies" or "indigenous ethnographies."

The concept of insider research shares many characteristics with indigenous ethnography. Autoethnographers from the insider research tradition are academic researchers who study a group or social circumstance of which they are a part (Butz & Besio, 2009). This "insider-ness" is used as a methodological and analytical tool, and makes autoethnography a political, socially just, and socially conscious act (Butz & Besio, 2009; Ellis et al., 2011). Insider research can be considered an analytic autoethnography if the researcher is (1) a full member in the research group or setting, (2) visible as such as a member in published texts, and (3) committed to developing theoretical understandings of broader social phenomena (Anderson, 2006). To meet the second criteria, this autoethnography marks my academic "coming out" as a full member of the psychiatric diagnosis community. This autoethnography has features of an indigenous ethnography and an insider ethnography, and it can also be considered an example of a personal experience narrative (Denzin, 1989). I will combine these three forms of autoethnography into a form that is befitting of my story.

It is also worth noting that there is a small sub-genre of academic autoethnographies who have experienced and written about psychiatric hospitalization (Clarke, 2018; Fixsen, 2021; Johnston, 2020; Muncey & Robinson, 2007). These peer-reviewed papers, and dozens of unpublished dissertations, are often written from the perspective of someone who has experienced their first hospitalization, but some additionally explore the dangers associated with revealing a mental illness diagnosis to all of academia (Fixsen, 2021). Beyond these papers, there is a broader anthropological autoethnographic tradition of writing about mental health. Otto and Van Roekel (2022) explore experiencing depression while conducting ethnographic research about depression, and Schneider (2020) explores the emotional trauma caused by a case of sexual violence that occurred during ethnographic fieldwork. Both papers address mental health challenges that appeared while conducting ethnographic fieldwork and discuss the resulting reflexivity of the researcher subject. This paper has a different focus as I was not conducting ethnography at the time of my hospitalization.

Stigma and Stigmatizing Identities

At its core, my argument relies on Goffmanian theories of the total institution (Goffman, 2017) and stigma (Goffman, 1986), and the presentation of self (Goffman, 1959; Goodman, 2013; Hope et al., 2022; Jenkins et al., 2022). Goffman (2017) defines total institutions as social arrangements that are "living spaces" where people share a similar social situation (i.e., a psychiatric diagnosis) and are cut off from wider society (Goodman, 2013). These social arrangements arise from human

interaction and the potent combination of values, culture, and taken-for-granted social practices that mix when two or more people get together (Goodman, 2013). Goffman's research was often focused on mental illness, which can be seen in his groundbreaking work on stigma and the spoiled identity (Goffman, 1986).

Goffman's stigma theory (1986) describes the social processes by which people deal with culturally undesirable characteristics such as having a mental illness, and social constructionist perspectives describe how certain symptoms come to be seen as problematic (Szasz, 1960, 2010). Illness, and especially mental illness, is intimately connected to concepts of deviance and abnormality (Goffman, 1986; Horwitz, 2003; Szasz, 2010). As a result, people with "spoiled identities" are more likely to try to pass and not be seen as different or abnormal. Goffman (1986) wrote:

> Given these several possibilities that fall between the extremes of complete secrecy on one hand, and complete information on the other, it would seem that the problems people face who make a concerted and well-organized effort to pass are problems that wide ranges of people face at some time or another. Because of the great rewards of being considered normal, almost all persons who are in a position to pass will do so by some occasion by intent.

Similarly, the decision to hide or conceal a condition such as mental illness is often the result of stigma or perceived stigma (Goffman, 1986; Joachim & Acorn, 2000) and can be an attempt to avoid the associated stigma (Goffman, 1986; Olney & Brockelman, 2003). As such, people are more likely to try to pass as not having a particular condition based on the level of societal acceptance for that condition (Goffman, 1986; Taleporos & McCabe, n.d.). While it is impossible and unethical to "rank" disorders, as severity should be evaluated independently from functional impairment (Zimmerman et al., 2018), psychosis diagnoses are often more heavily stigmatized than other psychiatric diagnoses (Lien et al., 2015; Link & Phelan, 2014; Ross et al., 2019; Wood et al., 2015; Yang et al., 2013).

Recently, Tyler (2023) has reconceptualized and updated Goffmanian theory to position stigma as an instrument of state power and oppression. Tyler (2023) and Parker and Aggleton (2003) describe how stigma's purpose is to reinforce structures of existing inequalities, and Tyler (2023) also emphasizes that stigma is a political process and a tool of hierarchical power relations. Tyler argues that stigma should be examined from the standpoint of its function as a deliberate and purposeful production to control people undesirable to capitalism (Tyler, 2023) rather than looking at the interpersonal phenomenon of stigma, as I do in this paper.

Moving away from stigma, Henri Tajfel's theories of in-groups and out-groups (Tajfel, 1974; Tajfel et al., 1971) provide an important perspective for the events referenced in this autoethnography. According to Tajfel, an in-group is a social group to which an individual feels they belong while an out-group is constructed of individuals whom the in-group views as being different, foreign, and, often, less-than the members of the in-group. In general, people identify with, are influenced by, and have an affinity for in-groups. Members of an in-group are often perceived as diverse (Leyens et al., 1994; Quattrone & Jones, 1980), and may share positive characteristics (Jackson, 2011). Conversely, members of an out-group are often perceived as homogenous, especially in terms of negative characteristics (Leyens

et al., 1994; Quattrone & Jones, 1980). These perceptions can lead to discrimination against out-groups due to favoritism towards in-groups (Brewer, 1999). Similarly, out-group members are often considered unpopular and they may be perceived as threatening to members of an in-group (Hewstone et al., 2002). As a final point related to in-groups and out-groups, Tajfel found that people can form self-preferencing in-groups within a matter of minutes and that these groups can form based on completely arbitrary, invented, and discriminatory characteristics (Tajfel, 1974; Tajfel et al., 1971). This finding is especially important to this autoethnography as the patients housed in the South Unit were constantly changing.

One final concept critical to this autoethnography is Crenshaw's (2023) concept of intersectionality, as many of the patients in the South Unit reflect intersectional characteristics. For example, people with lower socioeconomic status at birth are more likely to be diagnosed with schizophrenia (Werner et al., 2007), and psychiatrization, which intersects with medicalization, pathologization, and psychologization, is more likely to be aimed at people in poverty (Mills, 2015). Similarly, women are more vulnerable to the psychiatriziation and medicalization of behavior, and feminist theory points to the patriarchal brutality of the psychiatric hospital setting (Finkler, 1993). According to mad activists, women are often victims of psychiatric oppression (Hodges, 2003). Likewise, the mental health effects of racism are often dismissed as individual-level problems, which diminishes the social nature of racial violence and instead implicates socially constructed, individual-level psychiatric problems as the source of distress (Gray, 2016). This is an example of psychocentrism, which is a form of social injustice where human problems are centered on a biological flaw or deficit in the bodies or minds of individuals (Rimke, 2016). In the psychocentric view, individual reformation, rather than social and economic justice, is promoted, and the perspective that mental distress is the consequence of systemic social inequalities that reproduce social injustice, is lost (Rimke, 2016).

Stigma, Group Identity, and Othering: Exploring Intergroup Dynamics

From my Hospital Diary: Monday, Day 1, South Unit

Holland and I were standing in line for dinner, and we started talking about the network. Our doctors call it a delusion, but the fact that our so-called 'delusions' are almost exactly the same point to the fact that they are real! The doctors are sheep just like everybody else, they don't know what's going on. We both see the signs and the symbols. He told me that he had told his mom and his pastor about the network, but they didn't believe him. But he said his pastor acknowledged that the network existed. I told him about the signs, and what the Spokesman said. We got so excited, because finally, for once, we were talking to somebody who believed us, and who understood! Holland GETS me. He knows about the things that come over the radio. I know about the signs he gets from church. I am so excited to meet somebody who is like me!

Lise overheard us, and said, "What do you mean, what network?" Holland explained that there were things going on in the universe that she doesn't know

about, and only special people can know about them. Then Christian broke in and said, "How do you know about this?" I told him I heard it on the radio. Then Jim said, in a totally rude and demeaning voice, "Do you believe in ghosts? Do you believe in UFOs? You can't believe everything you hear on the radio!" First of all, Jim thought I was talking about FM radio, but you can't hear anything over FM. I get the messages from Andy's ham radio at home.

That just sucked. I felt so bad. And Holland looked like he didn't know what to do. He's really out of it. They were calling us crazy- calling us nuts. Like Lise has been sober for 3 days, and those other guys are all depressed and Bipolar. Like they have something over us.

From my Hospital Diary: Tuesday, Day 2, South Unit

Today while I was waiting for music group to start, Lise and Liz were talking about a conversation they had with Music last night. Lise said, "He was like a normal person! It was amazing!" Liz added, "I can't believe he's schizo! I mean, he talked to me totally normally. Did you know he has been married twice and has kids?" "You'd never know he was schizophrenic," Lise said. "Until he forgets his name!" Liz said, and then they both laughed.

I didn't know what to do to stand up for Music. I should have. I feel guilty for just letting them sit there and talk about him like that, but I didn't know what to do. They've obviously never met a person with schizophrenia before. They acted like he was a freak. It was horrible.

After dinner I told Holland about what Lise and Liz said, and he said, "Is it time for me to stand up for us?" Holland is in no position to be standing up for anyone- he walks around wrapped in a sheet and sleeps all day. I told him I would. Somebody must do something.

From my Hospital Diary: Thursday, Day 4, South Unit

Today was Lise's last day before she went to residential, so I knew I had to say something. She is like the ringleader of the drug users and mood people. They've formed a group against me and Holland and Music and the other psychotics. I've never seen this before. Usually everyone gets along, but here, it's like they've ganged up on us. If anything is going to change, it has to come from her. Richard is also leaving to rehab today, and Liz is going home, so maybe all this bullshit will stop.

I caught Lise in the group room before process group, and I asked if I could talk to her. I said, "you are in AA, and are all about open and honest conversation, right?" She said," yes, oh shit, did I do something to offend you?" I reminded her about the conversation about the UFOs and ghosts, and she was like, "well, you both seem like smart people so I have no idea why you could believe something so crazy." I told her it was part of our illness- I didn't understand her drive to drink, but it was the same thing. Then I brought up the whole Music thing and him having schizophrenia, and she was like, "I've never met a schizophrenic before and he's just really different from what I imagined they would be like." And then I said that we were all here for a reason, and no one is crazier than anyone else. Then, she

said she was sorry. She didn't mean to offend us, but then she said something just as offensive! She said, "I just find you guys fascinating and really interesting." Like we are bugs under her examining glass! I don't find her alcoholism fascinating. Maybe I should. But I don't think having schizoaffective is fascinating. We don't exist for her enjoyment.

This has really stressed me out. I'm used to being respected, even by people who know I have psychosis. I've never seen this group stuff go on before. But I'm glad I talked to her, even though she didn't understand. We don't deserve to be ganged up on.

While the three encounters above have been described as three distinct events, they really form an extended narrative of the single experience of being stigmatized and out-grouped due to a psychiatric diagnosis. As Tajfel (1974) wrote, people learn which group to identify with within moments of being in a new social situation. Within the South Unit, new patients with psychotic diagnoses found the "psychotic group," while new patients with mood disorder diagnoses found the "mood disorder group." Although the individual members of each group were constantly changing due to incoming and outgoing patients, the group identities were persistent and the stigmatizing behavior continued. This persistence in group behavior deserves future study as the mechanism of how this persistence of group behavior was maintained is unclear. The presence of a charismatic leader, Lise, may account for some of this persistence, but the stigmatizing behavior continued even after she and fellow group members were no longer on the South Unit. Equally confounding is how the "psychotic group" persisted even after Holland, Music, and everyone other than myself left the unit. When new patients who had psychotic diagnoses entered the unit, they quickly gravitated toward me and the "psychotic group" identity was continued with new members. My experience as a member of the "psychotic group" led me to analyze these data I collected and to identify three primary themes that will be discussed below.

The first theme I identified was that people with severe psychiatric diagnoses stigmatize those who are perceived to have an even more serious psychiatric diagnosis. In Burke et al.'s (2016) study of stigma experienced by people with psychosis, participants reported that others treated them differently because of their mental health problems. Participants described overt discrimination relating to their experiences of having psychosis. This included being ignored, dismissed, insulted, humiliated, excluded, and bullied. I experienced all of this as a part of the "psychotic group."

Unlike depression and anxiety, psychosis is not openly discussed in American society. As a result, most people have never knowingly met a person who has experienced psychosis and are influenced largely by the frequently negative portrayal of psychosis in print and televised media (Bowen et al., 2019; Vilhauer, 2017). Television advertisements for medications traditionally prescribed for psychotic disorders (De Fruyt et al., 2012) are marketed for depression, sleep (Boodman, n.d.), and anxiety disorders, but not for the psychotic disorders that they were developed to treat. For example, advertisements for the antipsychotic medications Abilify and Vraylar focus on their use as adjunctive therapy for major depressive disorder rather than for the psychotic disorders that they were originally designed to treat (Drug-Claim, n.d.; Vraylar, n.d.) A notable exception to this trend is Caplyta, which is a

new antipsychotic drug that has advertisements featuring people with schizophrenia. In addition to the lack of individuals with psychosis in drug advertisements, there is a lack of positive role models in the media of people with psychosis. This leads to stigma, as the average media consumer is rarely exposed to individuals with psychosis and even more infrequently exposed to individuals with psychosis who are portrayed positively. Due to this lack of exposure, psychotic experiences are not normalized, and they are frequently the subject of misinformation and fear. This is despite the fact that some studies show up to 5.8% of people in the non-psychiatric general population across 18 countries have at least one psychotic experience in their lifetime (McGrath et al., 2015).

The second theme that emerged from these data was that people feel power, prestige, and well-being when they belong to a group composed of people similar to themselves. The "psychotic group" and the "mood disorder group" both provided this boost of self-esteem to their members, because members of each group were held in positive regard by the other members of their respective groups and they were surrounded by similar others (Eck et al., 2017). While both groups internally boosted their own members, the "mood disorder group" clearly had more power (Keltner et al., 2003) and prestige than did the "psychotic group."

The dynamics of a majority group that have been documented in previous research were exemplified within the South Unit. Higher-power individuals, such as the role Lise took in the "mood disorder group," have been found to perceive that they have greater control over resources and others (Keltner et al., 2003). Also, research has shown that majority groups facilitate feelings of belonging, give members consensual validation from similar others, and provide members with recognition of existing and being worthy of attention (Eck et al., 2017). Lastly, as seen within the "mood disorder group," majority groups have associations with positive attributes such as good, right, secure, and privileged (Kruglanski & Mackie, 1990) and contribute to maintaining a reasonably high self-esteem, because self-esteem can be seen as a mirror that reflects a person's inclusionary status (Eck et al., 2017).

The third and final theme that came from these data was that people can strengthen their group identities by out-grouping or othering members of other groups. The concept of othering was originally presented by Said (1979) in *Orientalism* to address the power relations between different cultural groups. Othering specifically refers to the process by which a dominate group attributes a subordinate status to a subordinated group and creates an "us" vs. "them" culture. This "us" vs. "them" culture was palpable on the South Unit between the "mood disorder group" and the "psychotic group." The othering process described in this paper is particularly interesting because both groups are subordinated groups in broader society. The idea of a subordinate group stigmatizing an even more subordinate group appears to be a gap in existing literature to which this paper can contribute. Subordinate groups have been recorded stigmatizing the dominant group (Kusow, 2004), but othered groups such as the "mood disorder group" bolstering their own group identity by stigmatizing groups with even less social capital, such as the "psychotic group," does not appear in exist in current mental health or stigma literature.

One potential exception to the idea of othered groups stigmatizing different subordinated groups being a gap in existing research is the literature about multiple

subordinated identities (Fellows & Razack, 1997). For example, a white woman is in a subordinate position within the broader American society but holds a position of power over an even more disadvantaged black woman. Similarly, individuals who would be members of the "mood disorder group" are subordinated in mainstream society, but not as much as individuals who would be members of the "psychotic group." It is possible that the multiple subordinated identity literature and the rich literature on Crenshaw's concept of intersectionality (Crenshaw, 2023) could provide insight into the phenomenon observed on the South Unit of the Middlesex Psychiatric Hospital.

Conclusion

This autoethnography has explored the experiences of stigma, group identity formation, and othering within the context of a psychiatric hospital. By analyzing personal narratives and interactions between patients diagnosed with psychotic disorders and patients diagnosed with mood and substance use disorders, this study has highlighted the complex intergroup dynamics that emerge within a marginalized population and contributes to the understanding of the complex interplay between stigma, group identity, and power dynamics within marginalized populations.

The study has also detailed the value that individuals derive from belonging to groups composed of people with similar experiences. Membership in these groups promotes feelings of power, prestige, and well-being, while also contributing to the boosting of self-esteem. Both the "psychotic group" and the "mood disorder group" provided these benefits to their respective members, but the findings also exemplify how group identities can be strengthened through the process of out-grouping and othering. By attributing a subordinate status to another group, individuals can bolster their own group identity. This phenomenon was particularly evident in the South Unit where it was shown that othering can exist within groups subordinated by broader society as individuals with substance use disorders and mood disorders were shown to stigmatize those with psychotic disorders.

The observation of a stigmatized group stigmatizing another, even more subordinated group, appears to be a gap in the existing literature on mental health stigma and drives the need for further research on the experiences of individuals with psychotic disorders and the ways in which stigma operates within and between marginalized groups. Future research could explore the persistence of group identities and stigmatizing behaviors in constantly changing social environments, such as psychiatric hospitals. Investigating the role of charismatic leaders in shaping and maintaining these dynamics could also provide valuable insights. Moreover, drawing upon the literature on multiple subordinated identities and intersectionality may offer a framework for understanding the phenomenon of stigmatized groups stigmatizing even more subordinated groups.

In conclusion, this autoethnography serves as a powerful testament to the lived experiences of individuals navigating the complexities of stigma, group identity, and othering within the context of mental health and underscores the importance of increasing positive representations and open discussions about psychosis in society

to combat stigma and misinformation. By shedding light on these dynamics, it contributes to the ongoing dialog on mental health stigma and advocates for increased understanding, acceptance, and support for individuals with psychotic disorders and other marginalized identities.

Declarations

Conflict of interest The author reports no conflicts of interest in the preparation of this paper.

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