

Commentary

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Commentary: Psych Unit Gangs- An Autoethnography

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In my autoethnographic account of my experiences in a psychiatric hospital², I explore intergroup dynamics, stigma, and identity formation among individuals with different mental health diagnoses. Here, I will reflect on the key insights, strengths, and implications of my work while considering potential limitations and areas for further exploration.

Before examining the intergroup dynamics I observed within the psychiatric unit, it is essential to understand the broader societal context that shapes attitudes toward psychosis. The stigma I documented between patient groups reflects and reproduces deeply embedded cultural fears and misconceptions about psychotic disorders that have historical, media, and scientific dimensions.

Historically, psychosis has been intrinsically linked to cultural conceptions of “madness”⁶. This association has created profound anxiety about psychotic disorders that differs qualitatively from attitudes toward other mental health conditions. While conditions like depression or anxiety have increasingly been framed as relatable human experiences, psychosis continues to evoke primal fears about loss of control, rationality, and self-determination. These cultural anxieties manifest not only in public stigma but also in how individuals with other mental health diagnoses relate to those with psychotic disorders.

Media representation plays a crucial role in perpetuating these fears. News coverage frequently highlights violent incidents involving individuals with psychotic disorders while failing to provide crucial context about their experiences, social circumstances, or treatment challenges. This selective reporting reinforces associations between psychosis and unpredictability or danger, while rarely presenting counter-narratives about recovery, successful treatment, or the many individuals with psychotic disorders who lead stable, productive lives. The resulting public narrative shapes not only societal attitudes but also how patients within psychiatric settings view and interact with each other.

Adding to these challenges is the scientific uncertainty surrounding psychosis. Despite significant advances in understanding, many questions remain about the precise mechanisms and triggers of psychotic disorders. This uncertainty can fuel fear and misunderstanding, as people often fear what they cannot fully explain. Within treatment settings, this knowledge gap can manifest in how patients with other diagnoses distance themselves from those with psychotic disorders, perhaps reflecting broader societal discomfort with the unknown aspects of these conditions.

These broader contexts directly inform the intergroup dynamics I observed within the psychiatric unit. The social hierarchies that emerged between patients with mood disorders and those with psychotic disorders cannot be fully understood without recognizing how they reflect and reproduce these deeper cultural narratives and anxieties. Patients enter treatment settings already having internalized societal attitudes about different mental health diagnoses, and these preconceptions shape how they form social groups and interact with others.

Understanding these broader contexts helps explain why the stigma directed toward patients with psychotic disorders persists even within mental health treatment settings. The intergroup dynamics I document represent a microcosm of larger societal processes, demonstrating how cultural narratives about mental illness shape social interactions even among those who have experienced mental health stigma themselves.

One of the most striking aspects of my experience was witnessing the social hierarchies and group dynamics that formed within the psychiatric unit. I documented the formation of distinct groups among patients, particularly those with “psychotic” and “mood disorder” diagnoses. This phenomenon, rarely discussed in mental health literature, revealed the presence of stigma and discrimination between different groups of individuals with mental illness. I found this particularly eye-opening, as it challenges the common perception of mental health patients as a homogeneous group and underscores the complex social structures that can emerge even within marginalized populations.

By applying Goffmanian theories of total institutions and stigma to my experiences, I aimed to provide a deeper understanding of the social processes within the hospital. These theories helped me to see that stigma operates on multiple levels, not only between those diagnosed with mental illness and broader society but also within the mental health community itself. This more nuanced perspective adds depth to our understanding of how stigma pervades mental health care environments.

Goffman's concept of total institutions describes organizational settings that are isolated from wider society and where all aspects of daily life occur within a single, regulated environment under a central authority. These institutions, which include psychiatric hospitals, prisons, and military barracks, create unique social worlds where traditional social roles and identities are stripped away and replaced by institutionally defined ones. Within these settings, individuals experience what Goffman termed “mortification of the self” - a process where their previous social identities are systematically dismantled through various institutional practices and routines⁴.

Goffman's theory of stigma provides complementary

insights into how certain attributes or conditions become socially discredited, leading to what he called a “spoiled identity”³. He argued that stigmatized individuals often engage in complex forms of identity management, including attempts to conceal their stigmatized status or selectively disclose it. Particularly relevant to my observations is Goffman's concept of “courtesy stigma”³, where individuals associated with stigmatized groups may themselves become stigmatized, and his analysis of how stigmatized individuals sometimes distance themselves from others they perceive as more heavily stigmatized.

These theoretical frameworks illuminate key aspects of my experiences within the psychiatric unit. The total institution context created conditions where patients rapidly formed new social identities and hierarchies, despite the temporary nature of their stays. This environment, cut off from normal social life, intensified the significance of diagnostic labels in shaping social relationships. Meanwhile, Goffman's insights about stigma help explain the complex ways patients with mood disorders attempted to manage their own stigmatized identities by distancing themselves from those with psychotic disorders, essentially creating what I observed as a “hierarchy of acceptability” within an already marginalized population. The intersection of these theories provides a powerful lens for understanding how institutional structures and stigma management strategies combined to create and maintain the social dynamics I witnessed.

I also drew on Tajfel's theories of in-groups and out-groups to analyze the rapid formation and persistence of group identities within the hospital. I found it intriguing that these dynamics persisted despite the constant turnover of patients. This suggested that the social structures within psychiatric units might be more stable and influential than previously thought, potentially affecting patient experiences and treatment outcomes.

Tajfel's social identity theory (1974)⁷ posits that people's sense of self is significantly influenced by their group memberships, and that individuals naturally categorize themselves and others into social groups, leading to in-group favoritism and out-group discrimination. His research demonstrated that even arbitrary group assignments could rapidly generate group identification and intergroup bias, a phenomenon known as the minimal group paradigm. This theoretical framework provides crucial insights into why patients in the psychiatric unit so quickly sorted themselves into distinct social groups based on diagnostic categories, despite their relatively brief stays. Just as Tajfel's experiments showed that randomly assigned groups could develop strong group identities and biases, patients with mood disorders appeared to rapidly develop a shared group identity that positioned them as distinct from, and often superior to, patients with psychotic

disorders. This process occurred despite all patients sharing the broader categorization of “psychiatric patient,” suggesting that the need to maintain a positive social identity through group membership remained powerful even within an institutionalized setting. The speed and consistency with which these group formations occurred across different patient cohorts aligns with Tajfel’s findings about the fundamental nature of social categorization and group identity formation in human social behavior.

One of the strengths of my work, I believe, is its authenticity and emotional resonance. By sharing my personal experiences and reflections, I provide an insider’s perspective that might be difficult to capture through traditional research methods. Including excerpts from my hospital diary gave the narrative more depth and immediacy, helping readers empathize with the emotional intensity of the social dynamics I encountered.

In my discussion of the broader implications of my findings, I highlight the significant role that media representations play in shaping public understanding and attitudes toward mental illness, particularly psychotic disorders. The persistent lack of positive, nuanced, or humanizing portrayals of individuals with psychosis in media and popular culture actively contributes to stigma and misunderstanding. When people with psychotic disorders do appear in media, they are often portrayed as dangerous, unpredictable, or incompetent, reinforcing harmful stereotypes that impact both social attitudes and self-perception among those diagnosed with these conditions.

These problematic media narratives have real consequences in treatment settings, where they influence how different diagnostic groups perceive and interact with each other. Patients with mood disorders, who often see more diverse and sympathetic representations of their conditions in media, may internalize and reproduce these hierarchical distinctions in their interactions with patients diagnosed with psychotic disorders. The media’s tendency to present certain mental health conditions as more “relatable” or “acceptable” than others contributes to a hierarchy of stigma that manifests even within mental health treatment settings.

Furthermore, the scarcity of first-person narratives from individuals with psychotic disorders in mainstream media perpetuates a cycle of silence and misunderstanding. While there has been increasing visibility of personal stories about depression, anxiety, and bipolar disorder, accounts of living with psychosis remain largely absent from public discourse or are filtered through clinical or sensationalized perspectives. This absence reinforces the notion that individuals with psychotic disorders lack agency or insight into their experiences, further contributing to their marginalization.

The role of social media and digital platforms in shaping mental health narratives deserves particular attention. While these platforms have created new opportunities for sharing diverse mental health experiences, the algorithmic amplification of certain narratives over others may reinforce existing hierarchies of acceptability in mental illness. Additionally, the pressure to present “recovery narratives” that conform to popular expectations may exclude or minimize the complex realities of living with persistent psychotic symptoms.

I believe that increased visibility and normalization of psychotic experiences are crucial steps toward reducing stigma and promoting a more inclusive understanding of mental health. This requires not only more representation but better representation - portrayals that capture the full humanity, capabilities, and diverse experiences of individuals living with psychotic disorders. Media makers, mental health advocates, and individuals with lived experience must work together to challenge existing narratives and create space for more authentic representations of psychotic experiences in public discourse.

Another important insight from my experiences is the observation that even within subordinated groups, such as psychiatric patients, stigma can flow in multiple directions. Subordinated groups may engage in stigmatizing behaviors toward even more marginalized individuals. This finding challenges the notion that stigma is only a top-down phenomenon and suggests a need for more nuanced approaches to addressing discrimination in mental health settings. I propose that this dynamic could be tied to multiple subordinated identities, an idea that could be explored through future research on intersectionality and social justice in mental health.

Despite the valuable insights from my autoethnographic approach, I acknowledge its limitations. My account reflects my individual experience, and while I grounded my observations in established theoretical frameworks, my experiences may not be representative of all psychiatric units or patients. However, I believe that the social processes I observed are reflective of broader dynamics within similar settings.

One area requiring deeper exploration is the complex ethical terrain of conducting and publishing autoethnographic research, particularly in mental health settings. While autoethnography can provide valuable insights into lived experiences, it raises significant ethical challenges that extend beyond traditional research considerations. In sharing my own story, I must navigate not only personal vulnerability but also my responsibility to others whose lives intersect with mine in these narratives.

The ethics of representation become particularly fraught when discussing other patients encountered during hospitalization. Even with identifying details altered, there are complex questions about consent and privacy. These individuals were in an extremely vulnerable state and did not consent to being part of a research study. While their experiences contribute to understanding the social dynamics I aim to analyze, I must carefully balance the scholarly value of these observations against potential harm or privacy violations. This raises questions about how to ethically represent others' experiences while maintaining their dignity and right to privacy.

Another ethical consideration is the potential impact of disclosure on both personal and professional spheres. While sharing my experiences may contribute to destigmatizing mental illness in academia, it also creates permanent public documentation of my psychiatric history that could affect future opportunities or relationships. This connects to broader questions about the ethics of self-disclosure in autoethnographic work: How do we balance the scholarly and activist potential of personal narratives against the potential for professional or personal consequences? What responsibilities do we have to ourselves in terms of privacy and self-protection?

The temporal nature of consent also presents ethical challenges. When writing about past experiences, particularly those involving mental health crises, questions arise about the capacity for informed consent at different points in time. How do we reconcile our past selves' experiences with our present desire to share them? Furthermore, how do we address the possibility that future perspectives might lead us to regret current disclosures?

There are also ethical considerations regarding the impact on readers, particularly those who may have experienced similar trauma or psychiatric hospitalization. While these narratives can provide validation and recognition, they might also trigger traumatic memories or emotional distress. This raises questions about how to present sensitive material responsibly while maintaining its authenticity and emotional impact.

Finally, there are ethical implications in how such research might influence mental health care practices and policies. While personal narratives can highlight important issues within psychiatric institutions, we must consider how these accounts might affect public perception of mental health treatment and whether they could inadvertently discourage others from seeking necessary care. This requires careful attention to how we frame and contextualize our experiences within broader discussions of mental health care.

While my primary focus was on patient interactions, further exploration of staff members' role in shaping and

responding to group dynamics would provide a more comprehensive understanding of social hierarchies within psychiatric settings. Staff members, through both direct actions and implicit behaviors, likely influence how these social groups form, persist, and interact. Their responses to different diagnostic groups may inadvertently reinforce existing hierarchies or create new ones.

For instance, staff members' differential treatment of patients based on diagnosis deserves closer examination. Do nurses and mental health technicians spend more time with certain diagnostic groups? Are safety protocols or monitoring practices applied differently to patients with mood disorders versus those with psychotic symptoms? These institutional practices could reinforce social divisions among patients and contribute to internalized stigma. Additionally, the language staff members use when discussing different diagnoses - in both formal medical contexts and casual conversations - may reflect and perpetuate hierarchical attitudes about mental illness.

The power dynamics between staff and patients also warrant deeper investigation. How do staff members mediate conflicts between patient groups? Do they recognize and address instances of inter-patient stigma, or do institutional pressures lead them to focus primarily on maintaining order? Understanding how staff members conceptualize their role in managing social dynamics could provide valuable insights into institutional responses to patient-formed hierarchies.

Treatment approaches themselves may inadvertently contribute to group stratification. For example, the practice of separating patients into different therapy groups based on diagnosis, while potentially therapeutically beneficial, might reinforce social divisions and stereotypes. Similarly, the allocation of privileges or restrictions based on perceived stability could create visible markers of status within the patient community.

Future research could examine how staff training and institutional policies address (or fail to address) these social dynamics. Are healthcare providers aware of how their actions might influence patient group formation? What tools or strategies do they employ to promote inclusive environments? Understanding these aspects could inform more effective approaches to reducing stigma and promoting positive social interactions within psychiatric settings.

Moreover, exploring staff perspectives could reveal institutional constraints that affect their ability to address social hierarchies effectively. Limited resources, high patient turnover, and pressing safety concerns might prevent staff from engaging more deeply with these social dynamics, even when they recognize their importance. This organizational context is crucial for understanding

how and why certain social patterns persist in psychiatric settings.

Additionally, future research should examine not only how staff interact with patient hierarchies but also how power dynamics and hierarchies operate among staff members themselves. The relationships between different types of mental health workers - psychiatrists, psychologists, nurses, mental health technicians, and other support staff - likely influence how they collectively respond to and manage patient group dynamics. Understanding these staff-level hierarchies and their impact on unit culture could provide valuable insights into how institutional power structures either reinforce or challenge existing social hierarchies among patients. The intersection of professional hierarchies with patient social dynamics represents an important area for future investigation that could inform more effective approaches to creating equitable treatment environments.

The growing presence of peer support specialists in psychiatric settings adds another important dimension to these social dynamics that warrants further investigation. As individuals with lived experience of mental illness who now occupy professional roles, peer workers occupy a unique position that potentially bridges the traditional staff-patient divide. Their dual identity as both service providers and members of the mental health community may influence how group hierarchies form and operate within psychiatric units. How do peer professionals navigate their relationships with both patients and clinical staff? Do their presence and perspectives help challenge diagnostic hierarchies and stigma, or do institutional pressures lead them to reinforce existing social structures? Additionally, examining how peer workers' own diagnostic histories affect their interactions with different patient groups could provide valuable insights into the complexities of power, identity, and professional role boundaries in psychiatric settings. Their unique positioning makes them valuable informants for understanding how these social hierarchies might be effectively challenged or transformed.

Despite these minor limitations, I believe that my work makes a significant contribution to our understanding of social dynamics and mental health stigma within psychiatric settings. By shedding light on the phenomenon of intergroup stigma among patients, I open up new avenues for research and intervention.

For mental health professionals and policymakers, my insights suggest that more attention should be paid to the social dynamics within treatment settings. Addressing intergroup tensions and promoting inclusive environments could improve patient experiences and outcomes. For media professionals and public health communicators, my work highlights the importance of presenting diverse and

nuanced representations of individuals with mental illness, particularly those with psychotic disorders.

The growing body of mental health autoethnographies from academics is vital for challenging stigma, fostering understanding, and contributing to identity development within academia. As highlighted in my recent paper *Mad Academics: Mental Health Autoethnographies from the Academy*¹, autoethnographic work allows scholars to share deeply personal narratives that challenge traditional psychiatric approaches and emphasize the subjective, moral, and social dimensions of mental health experiences. By offering an insider's perspective, these accounts bridge the gap between personal experience and societal structures, contributing to broader social change and advocacy. Furthermore, these narratives serve as acts of resistance against dominant, often pathologizing mental health narratives, offering alternative perspectives grounded in lived experience. Despite the risks of professional repercussions or re-traumatization, mental health autoethnographies have transformative potential, as they help destigmatize mental illness in academic institutions and beyond, advocating for more inclusive environments that recognize and value the diverse experiences of individuals living with mental health conditions.

Increasing the visibility of people with mental health conditions in academia is crucial for fostering a more inclusive and supportive environment. Academia often perpetuates a culture of high achievement and resilience, which can discourage individuals from disclosing their mental health challenges for fear of being seen as less capable. By increasing visibility, we can challenge these stigmatizing norms and encourage open conversations about mental health. This visibility allows for the normalization of mental health conditions, highlighting that many successful scholars navigate such challenges while making significant contributions to their fields. Furthermore, as more academics come forward with their experiences, it creates a more diverse representation of mental health narratives, breaking down stereotypes and fostering a greater understanding of the complexities surrounding mental health. This shift not only benefits individuals with mental health conditions by providing them with validation and support but also encourages institutions to implement policies that prioritize mental well-being, creating a more compassionate and accommodating academic culture.

Writing this autoethnography has been an empowering yet deeply vulnerable experience. On one hand, telling my story felt like reclaiming power over a narrative that has often been shaped by external forces—medical professionals, societal stigma, and academic norms. Sharing my experiences offered a sense of agency, as I aimed to

disrupt the silence surrounding mental illness in academic spaces. However, the process also filled me with fear about exposing myself, particularly because I am currently on the academic job market. I have been advised not to highlight this paper in my application materials, as it might bring unwanted attention to my diagnosis of a serious mental illness. This internal conflict—between the desire to advocate and the fear of professional repercussions—has made the act of disclosure feel risky.

Nevertheless, disclosure as activism is one of the main reasons I wrote this paper. I see it as a deliberate and necessary step toward actively decreasing stigma within the academy. I have continued this project of activism by presenting the paper at the American Sociological Association's annual conference and by publicly discussing my mental illness in a separate paper in *Bipolar Disorders*⁵. In these efforts, I aim to push against the boundaries that maintain silence and exclusion for those with mental health conditions in academia.

The use of autoethnography as a form of academic activism presents both powerful opportunities and significant risks that deserve careful consideration. While this methodology can effectively challenge stigma and create space for marginalized voices within academia, it also exposes scholars to various forms of vulnerability and potential professional consequences. On the positive side, autoethnographic accounts of mental illness can disrupt traditional academic hierarchies, challenge the presumed separation between researcher and subject, and contribute to institutional change by making visible the experiences of scholars with mental illness. This visibility can foster solidarity among similarly positioned academics and encourage institutions to develop more inclusive policies and practices. However, the professional risks are substantial and often disproportionately affect early-career scholars and those in precarious academic positions. These risks include potential discrimination in hiring and promotion, challenges to scholarly credibility, and the possibility of being pigeonholed as a "mad scholar" rather than being recognized for the full range of one's academic contributions. There are also personal risks to consider, including the emotional labor of repeatedly engaging with one's own trauma through scholarly work, the potential for retraumatization through peer review and public presentation, and the permanent nature of published accounts that may affect future opportunities both within and outside academia. Moreover, the increasing incorporation of mental health narratives into academic discourse raises questions about the potential commodification of trauma and the risk of institutions using individual stories of struggle and resilience to deflect attention from necessary structural changes. These complexities suggest the need for more robust support

systems and institutional protections for scholars engaging in this form of activist scholarship.

As I develop my scholarly identity, I find that it is increasingly shaped by a combination of rigorous sociological analysis and autoethnographic techniques. Integrating my personal biography into my academic work has not only expanded my methodological toolkit but has also allowed me to align my scholarly endeavors with my lived experiences. This approach to research and writing feels both authentic and politically engaged, as it challenges the traditional detachment expected of scholars while inviting new ways of understanding mental illness and identity within academic structures.

The social hierarchies and stigma dynamics observed within the psychiatric unit reflect and reproduce broader societal attitudes toward mental illness, while also revealing how marginalized groups internalize and perpetuate systems of social stratification. The formation of status hierarchies based on diagnosis, with mood disorders being perceived as more "socially acceptable" than psychotic disorders, mirrors wider cultural narratives about mental illness in media representations, public discourse, and even mental health advocacy. This finding has significant implications for how we understand the intersections between institutional practices, cultural representations, and lived experiences of mental illness. The persistence of these hierarchies within treatment settings suggests that even spaces designed for healing can inadvertently reinforce harmful social distinctions. Furthermore, the observation that patients with mood disorders sometimes distance themselves from those with psychotic disorders reveals how stigma operates not just through top-down institutional processes, but through horizontal social relationships within marginalized groups. This dynamic speaks to broader patterns of how subordinated groups may attempt to gain social legitimacy by dissociating from those perceived as more stigmatized, ultimately reinforcing rather than challenging systems of social exclusion. These findings call for a more nuanced understanding of how mental health stigma operates across multiple social levels, from institutional policies to interpersonal dynamics, and suggest the need for interventions that address both structural and social dimensions of mental health discrimination.

This paper's examination of inter-patient stigma and social hierarchies within psychiatric units addresses a significant gap in mental health research. While existing literature has extensively documented stigma between mental health patients and broader society, or between healthcare providers and patients, the dynamics of stigma between different diagnostic groups within treatment settings remains understudied. By documenting how

patients with mood disorders and psychotic disorders form distinct social hierarchies, this work reveals how stigma operates not just vertically from society or institutions to patients, but horizontally between patient groups themselves.

The application of Goffman's theories of total institutions and Tajfel's in-group/out-group dynamics to these inter-patient relationships provides a novel theoretical framework for understanding social processes within psychiatric units. Particularly noteworthy is the finding that these social hierarchies persist despite constant patient turnover, suggesting institutional structural patterns that transcend individual interactions. Furthermore, this work makes new connections between media representations of mental illness and internal patient group dynamics, demonstrating how broader cultural narratives about different diagnoses shape interactions within treatment settings.

Methodologically, this paper offers unique insights through its autoethnographic approach. As both a patient and academic researcher, I provide an insider's perspective on psychiatric unit social dynamics that bridges experiential and theoretical understanding. This dual positioning enables a nuanced analysis of how individual experiences reflect broader social processes and institutional structures. While autoethnography has been used in mental health research before, its application to examining institutional social dynamics and inter-patient relationships represents a methodological innovation.

Through these contributions, this work advances our understanding of how stigma and social stratification operate within mental health treatment environments. The findings suggest that addressing mental health stigma requires attention not only to societal attitudes and institutional practices but also to the complex social worlds

that emerge among patients themselves. Future research can build on these insights to develop more comprehensive approaches to reducing stigma and promoting inclusive treatment environments that recognize and address these previously hidden social dynamics.

This research thus provides both theoretical and practical contributions to mental health scholarship. Theoretically, it expands our understanding of how stigma operates across multiple social levels. Practically, it suggests new directions for improving treatment environments by attending to inter-patient group dynamics and their impact on recovery experiences. These insights can inform more effective approaches to mental health care that acknowledge and address the complex social realities of psychiatric treatment settings.

Conflict of Interest

The author does not report any conflict of interest in the preparation of this manuscript.

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