

THE ABSENCE OF PSYCHIATRIC C/S/X PERSPECTIVES IN ACADEMIC
DISCOURSE:
CONSEQUENCES AND IMPLICATIONS

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ABSTRACT

There is growing recognition that psychiatric consumer, survivor or ex-patient perspectives are not well-integrated into disability studies work and academic discourse, more generally. While debate centers around whether the preferred next step is an independent ‘mad studies’ discourse or a disability studies framework more inclusive of c/s/x voices, the broader consequences of this absence have been largely overlooked. The purpose of this review is to highlight three major consequences of the absence of c/s/x voices in research in the US: The (1) relatively greater biomedicalization and (2) clinical professionalization of psychiatric disability compared with other forms of disability, and (3) barriers and obstacles to training and advancement in academia for doctoral students and faculty with psychiatric disabilities.

THE ABSENCE OF PSYCHIATRIC C/S/X PERSPECTIVES IN ACADEMIC DISCOURSE: CONSEQUENCES AND IMPLICATION

Introduction

Over the past decade, there has been growing recognition that the perspectives of people with psychiatric disabilities have not been well-integrated into academic discourse. This recognition has been prominent in disability studies (e.g. Donaldson & Prendergast, 2011; Sykes et al., 2007) and, in recent years, attention has been devoted to the question of whether c/s/x perspectives should be integrated into the disability studies framework or developed as a stand-alone discipline (Beresford, 2000; Coyle, 2012; Hewett, 2006; Lewis, 2009; Price, 2011; Reaume, 2006). However, this discussion has also highlighted the fact that issues concerning psychiatric diversity/disorder have received significantly less theoretical and empirical attention within disability studies than topics related to physical (and, to a lesser extent, developmental) disability and health. As Beresford (2000) notes, it is often not even clear “whether or not madness, distress and psychiatric system survivors are part of the [disability rights] discussion” (p. 168) (cf Donaldson & Prendergast, 2011; Lester & Tritter, 2005; Mulvany, 2000; Prendergast, 2003; Sykes et al., 2007). Such an omission is particularly striking given the focus of recent disability studies research on other forms of diversity and intersectionality in the experience of disability, including that occasioned by race/ethnicity, gender and sexual orientation (Dyck, 1995; Erevelles & Minear, 2010; McRuer, 2008; Meyer, Schwartz & Frost, 2008; Sherry, 2004).

Many factors undoubtedly contribute to the underinclusion of ‘mad’ discourse

within disability studies. As Lewis (2006) notes, the historical and sub-cultural trajectories of the consumer/survivor/ex-patient (c/s/x) and disability rights movements have diverged significantly, and individuals involved with both movements have at times accused each other of latent ableism or saneism (Donaldson & Prendergast; 2011; McNamara, 1996; Wiener, Ribeiro & Warner, 2009)..Additionally, although some Centers for Independent Living (CILs) are fully cross-disability, for the most part both peer and professional services for mental health, on the one hand, and physical or developmental disabilities, on the other, have developed independently of one another, draw on different private and federal funding sources, and employ clinicians and providers with divergent training and disciplinary backgrounds (Mulvany, 2000; Pilgrim et al., 1997). With certain exceptions, mental health and disability activists are thus dealing with largely autonomous systems, infrastructures, and policy issues.

At a more academic level, psychiatric viewpoints have tended to play a more tenuous role within disability studies than perspectives from other social and behavioral sciences, and tensions have persisted over the tendency of psychiatrists and psychologists to view physical and developmental disabilities as abnormal, deficient or deviant (Asch, 1984; Barnes, 2003; Gleeson, 1997; Olkin & Pledger, 2003; Thorne & Paterson, 1998). Further, when psychiatric disability or “poor mental health” more generally is discussed in the context of disabilities, it is nearly always cited as a worst-case outcome of physical disability or disability-based discrimination. This approach fails to distinguish psychological distress from psychological diversity (including experiences of voices, visions, and other extreme states) and may further strengthen the framing of psychiatric disabilities/mental struggles as entirely negative outcomes of the ableist social

environment, rather than equivalent instances of human variation.

In spite of these differences, there is also clearly overlap in many of the goals and values of the disability rights and c/s/x movements. Incontrovertibly, there is no single guiding ideology for all extant c/s/x or disability rights groups and advocates. Certain common themes, however, link c/s/x advocates, including strong critiques of involuntary inpatient and outpatient commitment, drug-centered or compliance-focused treatment programs, and reductionist biomedical and cognitivist models of “mental illness.” The broader concerns that these issues raise are embraced across disability rights advocacy groups – for example, concerns surrounding the issue of involuntary treatment are consistent with the tenets of the independent living movement and its emphasis on freedom and self-determination (Deegan, 1992; Williams, 1983). Similarly, criticisms of biomedical and cognitivist models of mental illness are consistent with the repudiation of medical and moral models of disability in favor of broadly social models that acknowledge social, cultural and structural forces (Beresford, 2002, 2009a; Beresford, Nettle & Perring, 2010; Lester & Tritter, 2005; Mulvany, 2000) as well as the value of physical, mental and neurodiversity (Intervoice, n.d.,; Roberston, 2010; Roberston & Ne’eman, 2008).

Along these lines, several scholars have reviewed commonalities between the disability rights and c/s/x movements (for example, Beresford, 2000 or Lewis, 2006) and there is a small but growing literature concerned with applying disability studies frameworks to the study of mental health (Fabris, 2011; Ingram, 2007a, 2007b; Lester & Tritter, 2005; Mulvany, 2000; Price, 2011). This growing body of research highlights that (a) disability studies can clearly provide a forum for discussing issues concerning

psychiatric disability or diversity, regardless of whether or not it should provide ‘the’ academic home for c/s/x perspectives; and (b) the non-biomedical academic exploration of c/s/x perspectives is in its infancy.

Our goal in this review is to highlight three reasons why c/s/x perspectives might be further developed in academic discourse by discussing the consequences of this underinclusion. These are: the relative lack of critical theoretical scholarship, exemplified by (1) the relatively greater biomedicalization and (2) clinical professionalization of discourse about psychiatric disabilities; and (3) negative impacts with respect to the training and support of students and juniors researchers with psychiatric disabilities. It is worth underscoring that these three impact areas are admittedly not symmetrical. While it is possible to draw on a variety of empirical sources concerning the biomedicalization of psychiatric disability, for example, relatively little work investigates the distinct implications of clinicalization, particularly with respect to research and academic discourse about mental health, and almost no empirical research has directly assessed the level of exclusion/inclusion or challenges of doctoral students and faculty with significant psychiatric disabilities¹. This circumstance, of course, reinforces the central theme guiding this review – that further development of c/s/x perspectives in academic discourse is needed.

Biomedicalization

¹ As Price (2011) notes, there is little consensus as to the best or most emancipatory term with which to reference “mental illness,” “disorder,” disability or madness. In the context of this paper, we generally use the term “individuals with psychiatric disabilities”—currently the “progressive” standard in psychiatric rehabilitation research—but recognize that some may prefer other terms or even explicitly object to our use of “disability” inasmuch as such a move arguably reduces madness to a form of disability.

It is first useful to compare responses to the increased scientific legitimacy of medical approaches to physical and mental health issues in the 20th century. The considerable advances in physical rehabilitation technologies made throughout the twentieth century to the present (Braddock & Parish, 2003; Longmore, 2003) have often been accompanied by increased expectations that medicine can “cure” poor health (Freund & McGuire, 1995; Goldstein, 1999). However, since the late 1970s, physical disability rights groups and advocates have emphatically and effectively questioned the medical field’s practical limits. They have promoted an understanding that new technologies are not to be considered a silver bullet ‘cure’ for physical limitations, shifting attention to the prevention of illness rather than the restoration of normative health and holistic approaches to well-being that promote personal efficacy and stress management (Albrecht & Verbrugge, 2000; Braddock & Parish, 2003). These views are well-integrated in both the disability studies discourse and the fields from which disability studies derives (sociology, anthropology, etc.).

In contrast, the 20th century was largely marked by decreased confidence in psychosocial psychiatric services, in particular psychotherapy, as it increasingly became clear that early psychoanalytically-derived therapeutic approaches to treatment were largely ineffective in improving mental health (Busfield, 1996; Dowdall, 1999; Horwitz, 2003). In addition, little consensus could be reached concerning what constitutes mental disorder and diagnostic systems varied dramatically between nations (Andreasen, 2007; Kendall et al., 1971). Responding to some of these concerns, psychiatric disease models that emerged in the 1950s (e.g., Lewis, 1953) and were further consolidated in the 70s paved the way for more uniform diagnostic criteria such as that provided by the non-

psychoanalytically grounded DSM-III (American Psychiatric Association, 1980). Additionally, the emergence in the 1970s and 80s of new technologies that made it possible to study the brain for the first time (e.g., CT, MRI, and PET technologies) and accompanying psychopharmacological developments swiftly shifted the focus among researchers and practitioners from psychological explanations of mental illness such as developmental contingencies and personality traits to biological explanations (Castel, 1992; Cohen, 1993; Luhrmann, 2000; Rose, 1998, 2007). The biomedical perspective that has emerged is rooted in an understanding of mental illness as a brain disorder caused by genetic vulnerabilities, early childhood illnesses, or other traumas that change the chemistry of the brain (Read, 2005; Sharfstein, 2005, 2006). This perspective emphasizes that mental illness is a medical illness akin to cancer or diabetes for which the front-line treatment should be drug therapy (Hermson, 2011; Moncrieff, 2008; Schwartz & Corcoran, 2010; Rose, 2007).

Although this perspective has served to legitimize the field of psychiatry (Mechanic, 1978), it is not entirely without its critics and social histories of mental health care often characterize the ascendancy of the biomedical model as therapeutically inefficient. For example, Grob (1966) observed that, “psychiatrists tended to engage in a vast holding operation by confining mentally ill patients until that distant day when specific cures for specific disease entities would become available” (p. 357). Many c/s/x advocates have been particularly vocal in their opposition to biomedical models of disability and distress and have emphasized the disconnect between their experiences and journeys of recovery and traditional biologically-based theories, treatment strategies and expectations (Coleman, 2009; Fabris, 2011; Morrison, 2009; Sweeney et al., 2009). In

particular, the refusal of many US psychiatrists to recognize and implement empirically documented “med minimalist” treatment approaches such as Soteria House, Finnish Open Dialogue and Hearing Voices Movement approaches in favor of drug centered treatment (Calton et al., 2008; Corstens, Escher & Romme, 2008; Romme, Honig, Noorthoorn & Escher, 1992; Seikkula et al., 2003, 2006) have led many to question the political and financial motivations of researchers and clinical leaders (Ban, 2006; Choudhry, Stelfox, & Detsky, 2002; Lexchin, 2012; Moncrieff, 2007, 2009; Moncrieff, Hopker & Thomas, 2005).²

Nonetheless, since it has become the dominant paradigm for understanding psychiatric disability, the low degree of scientific confirmation of many psychiatric disorders (particularly compared to physical disorders) has not been well recognized publicly. Additionally, there is little appreciation for the social constructionist nature of diagnostic criteria within scientific discourse, which is evidenced by the lack of specificity and changes in specificity within diagnostic criteria. White (1970), for example, long ago demonstrated that between one-quarter and one-half of patients receiving ambulatory psychiatric care were not able to be diagnosed based upon existing criteria and such ambiguity persists. While there is persisting concern about the broadening of diagnostic criteria and public acceptance of alarmist research citing the growing number of people who have a psychiatric or neurodevelopmental disorder (as a result of this broadened criteria), these discussions rarely critically question either the

² It is worth emphasizing that we are in no way claiming that psychiatric disability has no neurological basis; all psychological phenomena are clearly connected to neural events. Nevertheless, as in other areas of human experience such as love, empathy, and creativity, this does not mean that these experiences can or should simply be reduced to neurological events, divorced from the interplay between the brain, the individual the sociocultural environment and so forth.

etiology or ontology of disorder itself, especially for more serious diagnoses such as psychosis. Thus, while the forthcoming DSM-5 has been criticized for medicalizing “expectable” grief following bereavement (Kleinman, 2012, Lancet, 2012), debates over a proposed new diagnosis for “attenuated” (prodromal) psychosis have instead focused on issues of predictive power and the risks and benefits of labeling and potentially unnecessary antipsychotic treatment rather than the questionable biopathological status of extreme and unusual but non-psychotic mental states (Corcoran, First & Cornblatt, 2010; Fusar-Poli & Yung, 2012; Shrivastava et al., 2011) .

The nature of the discourse among those opposed to mainstream psychiatry has also been influenced by the dominance of the biomedical perspective. This is evident in that science or biomedicine has become the driving point of confrontation between mainstream psychiatry and a significant number of critical consumer/survivor groups. As an illustration, even the critical U.S. c/s/x movement’s most prominent line of critique tends to adopt what Brad Lewis (2009) calls a “critical realist” epistemology—an epistemology, that is, that targets mainstream psychiatry as an exemplar of “bad science” while nevertheless continuing to affirm the basic tenets of positivist or empiricist scientific discourse (rather than generating substantive alternative epistemologies).

Furthermore, the implications of a biomedical conceptual framework for those with psychiatric disabilities have not been thoroughly investigated. There is growing evidence that simplistic biological and genetic attributions of “mental illness,” particularly of schizophrenia, have in fact led (contrary to early researchers’ and family advocacy groups’ predictions), to an exacerbation of public stigma (including greater perceived seriousness, permanence and dangerousness) (Pescosolido et al., 2010; Phelan,

2005; Schnittker, 2008; Schomerus et al., 2012). As an illustration, public opinion research suggests decreased interest, compared to 50 years ago, in marrying someone with a serious mental illness because of possible genetic causes (Pescosolido et al., 2010). In addition, exploratory qualitative research among individuals with depression suggests a mixed picture even for this ostensibly less-stigmatized disability: although it may be common for depressed individuals to adopt a biomedical model, and even use this model to mitigate self-blame, “unintended” negative consequences also follow, including the objectification and somatization of the “illness,” and the “shifting of ownership” and “responsibility for managing” the problem away from the individual, with a consequent disinvestment in self-directed behavioral change (Schreiber & Hartrick, 2002, p. 99-100).

Our primary purpose in rehearsing the current state of affairs with respect to biomedicalization is to underscore the extent to which the absence of an academic and empirical discourse guided by *c/s/x* experiences has allowed a strongly biomedical and pathologizing approach to and conceptualization of “mental illness” to proceed largely uncontested within academia (and, hence, given the power and status of academic discourse—in the eyes of the general public). We now consider the implications of clinicalization in greater detail.

Greater Professionalization/Clinicalization

A second key consequence of the absence of an academic branch of the *c/s/x* movement can be located in the greater professionalization and clinicalization of psychiatric disability and the absence of more substantively cross- or transdisciplinary work. By professionalization and clinicalization, as distinguished from medicalization, we mean to describe the process whereby the power to generate knowledge about

particular phenomena is allotted not just to credentialed academics, but academics that have specifically been trained to treat individual abnormality or pathology.³ While disability studies researchers herald from a wide variety of clinical *and* non-clinical disciplinary homes (including sociology, anthropology, English, communication, public health and education, as well as occupational and physical therapy and medicine), mental health research in the US remains almost wholly dominated by clinically trained investigators.

Consequently, while much work in disability studies celebrates and explores such themes as disability culture, disability history, disability and the arts, disability identity and disability theory, the literature on psychiatric disability tends to revolve around clinical treatment and rehabilitation. Even those non-clinically oriented US sociology and anthropology texts that attempt to address broader sociopolitical issues (e.g. Coleman, 2008; Estroff, 1981, 1993; Luhrmann, 2007; Morrison, 2005) nevertheless tend to ultimately focus on conflicts between consumer/survivors and the psychiatric (treatment) system as opposed to, for example, explorations of the connections between psychosis or mania and spirituality, art or cultural critique. This trend arguably also extends to work on consumer-run organizations and mutual support groups, which tend to be investigated in terms of their impact on clinically-relevant outcomes rather than, for example, their effects on identity and artistic expression or their contribution to the development of shared (sub-)cultural narratives (Brown & Wituk, 2010).

³ Biomedicalization and clinicalization are nevertheless certainly closely linked; a recent review and metaanalysis by Schomerus and colleagues (2012), for example, demonstrates a strong positive correlation between population-level increases in biomedical causal attributions for mental illness and belief in the value or necessity of engagement with psychiatric professionals.

Another consequence of clinicalization lies in the instantiation and reinforcement of the belief that only individuals with highly-specialized training can help, support or understand individuals with psychiatric disabilities. Several reviews of the rehabilitation literature (e.g., Anthony, 1993; Young & Ensing, 2010) suggest that this orientation may be problematic because it can create rehabilitation models that are inconsistent with the actual experiences or desires of people with psychiatric disabilities. For example, qualitative work among people with psychiatric disabilities emphasizes the importance of self-care for many, which Young and Ensing (2010) find is largely absent from the recovery literature, perhaps because, as they note, “self-care is simply not perceived as very interesting or informative” from a clinical standpoint (p. 24).

This orientation may additionally be problematic because it encourages patients to embrace the language of clinical diagnosis and semantic delimitations of psychiatric symptoms. As Rose (2001) notes, this clinical or therapeutic discourse is inherently positive in the sense that it produces new possibilities of experience and selfhood. A patient, for example, might be taught to distinguish between “normal” and “delusional” thoughts—the former properly his or hers, the latter the consequence of cognitive or neural dysfunction—potentially leading to an experiential dis-integration of the connection between agency and mental processes. While clinical control of diagnostic language may not be wholly negative or destructive, socioethnographic work documents the danger of “engulfment” in a clinically-delimited ‘chronic patient’ role (Estroff, 1989, 1993; Link, 1982, 1987; Schur, 1971).

Moreover, there is little acknowledgment in the clinical rehabilitation literature that the relationship between clinicians and patients is also a relationship almost

irreducibly marked by asymmetrical power relations, which is troublesome to many people with psychiatric disabilities (Rose, 1996): clinicalization, that is, reinforces not only the belief that only sanctioned clinicians can understand and attend to psychiatric disability but also that this assistance can only be accomplished through a very specific and in most cases intrinsically hierarchical relationship. On the one hand, the clinician—whether biomedical, behaviorist or psychodynamic in orientation—remains neutral, objective, and aloof, while the patient “confesses” his or her emotional (subjective, raw, naive) problems (cf Butchart, 1997; Foucault, 1978; Hook, 2007). Through processes of guided subjectivization—the patient’s identification both as the subject that speaks and the (psychopathological) subject of speech—his or her self-experience is brought in line with the “language and norms of psychological expertise” (Rose, 1996, p. 96). Both quantitative and qualitative work in the clinical disciplines makes this relationship even more explicit: the consenting research subject at once symbolically concedes the scientific hermeneutics of his or her disorder to the academic researcher while at the same time reifying his or her position as an informant or provider of data that will only become externally valid once it has been combined with dozens of other narratives, reports or data points and finally scientifically ‘processed’ (Rose, 2009; Turner & Beresford, 2005).

The authority of the clinician has been further naturalized in both clinical practice and the psychiatric research literature through the elaboration of the construct of “lack of insight” or anosognosia (Amador & David, 1998). In this discourse, mere disagreement with a psychiatric label and/or the legitimacy of a past or current hospitalization is often recast as a neuropsychiatric deficit or further exemplar of underlying psychopathology. An example of this can be found in the Beck Cognitive Insight Scale (Beck et al., 2004),

which counts disagreement with the statement “other people can understand the cause of my unusual experiences better than I can” as an example of a *deficit* of “insight.” In order to prove his or her mental health, the patient must learn to accept the clinicians’ semantic, diagnostic, and psychological authority.

To the extent that scholarship on psychiatric disability continues to be controlled by researchers whose expertise is defined in part by virtue of their neutral and objective *second-hand* observational knowledge, coupled with strong cultural messages regarding the potential danger of non-professional engagements with ‘mentally disordered’ individuals, it is not difficult to appreciate some of the barriers to the inclusion of both psychiatrically disabled academics and academic or “scientific” perspectives that are explicitly informed by *first-person* experience.

In disability studies, conversely, the importance of first-person experience, and the importance of the integration of disability with other aspects of identity, including academic identity, is well-accepted. Indeed, disability studies has been characterized as a place from where “crips strike back” (1999) – as an illustration, Zola’s (e.g., 1981, 1982) often autobiographical and cross-disciplinary writings revolutionized our understanding of the sociopolitical and personal aspects of the lived experience of physical disability. However, the equivalent to this type of work in American psychiatric disability research is largely absent; what is more, the prevailing research environment, as we explore in more depth below, may inhibit the emergence of such scholarship.

Consumer/Survivor Researcher Academic Climate

Ultimately, the greater biomedicalization and clinicalization of psychiatric disability/disorder reviewed above has resulted in an academic environment that many cite as inhospitable to scholars with psychiatric disabilities (Jamison, 2010; Karp, 2002; Saks, 2007). Evidence indicates that the academic environment is problematic throughout the typical academic career trajectory, from graduate training through tenure. While part of this inhospitability may stem from a general discomfort with disease and disability of all types (Goodwin & Morgan, 2012), much empirical research documents the high prevalence of profoundly negative and yet widely socially accepted stereotypes regarding individuals with significant psychiatric disabilities (Corrigan, Markowitz & Watson, 2004; Pescosolido et al., 2010; Schomerus et al., 2012). Hinshaw (2008) explores some of the reasons why such stigma may actually be particularly pronounced within clinical mental health disciplines, leading to a culture of silence and non-disclosure. As Price (2011) and Reiss (2010) discuss, the consequences of stereotypes centered around dangerousness and unpredictability have recently become particularly salient in the wake of a series of widely-publicized school shootings as well as more general acts of violence in which students or faculty with some form of psychiatric disability were implicated. These include the Virginia Tech, NIU and Jared Loughner shootings, and the recent murder of a graduate student by a faculty member with bipolar disorder at the University of Idaho. While legitimately motivated by concerns for both student safety and legal liability, academic institutions, as Reiss (2010) notes, have responded to the danger posed by disordered community members through an array of initiatives designed to screen, redirect and/or monitor “risky” individuals. This discourse of risk, in turn, may reify the

legitimacy of the public's fear of mental illness, and further objectifies psychiatrically disabled students and faculty.

In addition to such general stereotypes, stereotypes more explicitly directed at the mental or cognitive (in)capacity of individuals with psychiatric disabilities are undoubtedly equally problematic. Price (2011), for instance, discusses a myriad of ways in which individuals with mental disabilities—disabilities that affect intellectual energy and socio-academic relationships in addition to intellectual function—are stigmatized in the context of academic work and their perceived mismatch with the “ideal” (able-bodied and, most importantly, able-minded) academic. Although no existing empirical work has directly assayed the prevalence of academic stereotypes amongst faculty and within doctoral training programs, one study reported that among a sample of postsecondary students with psychiatric disabilities who sought academic accommodations, a full 56% reported feelings of embarrassment or shame about disclosing their disability to faculty, the same number (56%) reported a fear of being stigmatized by faculty, and almost half (42%) reported actual negative experiences such as a lack of faculty cooperation (Salzer, Wick & Rogers, 2008). In addition to the negative consequences of perceived academic stigma among members of the university community, recent research has documented the damaging effects of psychiatric-specific stereotype threat on academic performance: college students subtly primed with their psychiatric status, that is, were found to significantly underperform on academic tests relative to un-primed controls (Quinn, Kahng & Crocker, 2011). These academic forms of stigma are perhaps mostly likely to negatively impact doctoral students, pre-tenured and adjunct faculty, whose success depends so strongly on successfully projecting an image of academic competence.

In the context of higher education, stigma and stereotyping may also constitute a threat to perceptions of the quality of one's research. Thus even if an individual with a psychiatric disability makes it through a doctoral program and obtains an academic appointment, his or her research may be suspect due to assumptions of additional bias, subjectivity, personal overinvolvement, weak boundaries, or a lack of rigor (Rose, D., 2003, 2008, 2009; Saks, 2007, 2009; Sweeney et al., 2009). Arguably, such stereotypes, as suggested above, follow from both the medicalization and clinicalization of mental health discourse to the extent that these discourses tend to privilege neutrality, emotional distance, and second-hand observation. Further, in fields in which explicit activist scholarship is rare, researchers' commitment to the advocacy community runs the risk of being viewed as compromised science.

In addition to concerns about the social consequences of requesting accommodations, there is also concern surrounding the fact that accommodations specific to psychiatric issues are often inadequate, particularly among graduate students and faculty, for a variety of practical and legal reasons (Jones, Harrison, Aguiar & Munro, in press). Thus, although students with psychiatric disabilities now represent the single largest disability sub-group receiving campus disability services (General Accountability Office, 2009), many disability services offices are far better equipped to deal with cognitive and physical disabilities than psychiatric issues (Collins, 2000). Additionally, to these immediate institutional barriers, legal research suggests that individuals with psychiatric disabilities are often significantly less well protected by key legislation such as the ADA, compared to other disability groups, particularly in the contexts of education and employment (Stefan 2000, 2001; Swanson et al., 2006). In a comparative paper,

Sahlin (2009) even more specifically examines a number of the difficulties of obtaining *faculty* accommodations for psychosocial impairments in the US given the legal deference granted academic institutions regarding determinations of “unfair advantage,” “undue [institutional] burden” and constitutively exclusive definitions of the “essential functions” of academic work.

As an illustration of several of these issues, Saks (2007), in her autobiography about her experiences completing graduate work after being diagnosed with schizophrenia, details the lack of accommodations offered by the university where she studied and open discomfort exhibited by faculty whenever she acknowledged symptoms (exemplified in a tendency to simply suggest she go directly to a mental hospital). As a consequence, and to avoid being viewed as incompetent, she overcompensated in her graduate work to such an extent that her thesis was deemed by her examiners to be of a quality equal to what is typically expected in a doctoral dissertation –also notable is that it was completed while, unbeknownst to others, she was experiencing auditory hallucinations so severe they led to her hospitalization (Saks 2007).

Inadequate accommodations and stigma also pose a threat to many faculty members with psychiatric disabilities, as other personal histories demonstrate (Jamison 2010; Karp 2002). Jamison (2010), for example, highlights the vulnerability of junior faculty who choose not to disclose a psychiatric disability in her depiction of a chancellor’s garden party she attended in the midst of a manic episode: While she thought herself to be having “a fabulous, bubbly, seductive, assured time” (p. 26), it was later pointed out to her that she was dressed provocatively, wearing much more makeup than usual and seemed hysterical. Karp (2002) additionally describes the profound sense of

loneliness that was occasioned by his vulnerability as a junior faculty member pre-tenure, depicting sleepless nights accompanied by the knowledge that the rigors of his teaching load could not be assuaged simply because he was experiencing clinically-significant symptoms.

While such personal accounts highlight the barriers and challenges of succeeding academically as a research with psychiatric disabilities, it is noteworthy that this issue is largely absent from the research literature. Our review indicates that the only published discussions of this issue in the U.S. have been limited to select reflections on the inclusion and exclusion of students with psychiatric disabilities from undergraduate and master's level social work programs (GlenMaye & Bolin, 2007; Stromwall, 2002) and, to a lesser extent, doctoral programs in psychology (Jones et al., in press), as well as reflections from tenured faculty (Jamison 2010; Karp 2002; Saks 2007). Even in texts in which the plight of academics and students with disabilities is discussed more generally, issues specific to psychiatric issues are often not mentioned. For example, while Olkin (2002) very helpfully unpacks the potential difficulties of doctoral students with disabilities enrolled in clinical psychology training programs, she makes no mention of any issues or concerns—particularly pronounced in such contexts—regarding the particular challenges that arise in the context of psychiatric disability.

Mentoring is another area in which individuals with psychiatric disabilities may be disadvantaged. While the value of mentoring of minority doctoral students and junior faculty has been well-documented and discussed (Jeste et al., 2009; Shavers et al., 2005; Smith, Smith & Warkin, 2000; Waitzkin, Yager & Parker, 2006), discussion of the mentorship of junior colleagues with psychiatric disabilities is virtually non-existent.

One implication of this lack of discussion is that people with psychiatric disabilities may face not only many of the same challenges as other visible minority groups but also the additional burden of sorting through complex issues of disclosure and identity (particularly in the face, as discussed above, of substantial *socially acceptable* stigma) (cf Goodwin & Morgan, 2012; Saks, 2009). Although it would be problematic to suggest that non-disabled senior faculty cannot appropriately mentor junior colleagues, given the frequency with which “like me” faculty are often sought as mentors (Rockquemore, 2011), the double invisibility of many researchers—invisible due both to the nature of their disability and their decisions not to publicly disclose—arguably decreases the pool of recognizable mentors even as it reinforces an academic culture of silence. It is, therefore, perhaps not surprising that even a figure as prominent as Marsha Linehan, the esteemed developer of dialectical behavioral therapy (DBT), waited until the very end of her career to publicly disclose her own struggles with borderline personality disorder (Carey, 2011, June 23).

Although we have thus far discussed many of the challenges that face graduate students and faculty in academia, this discussion has excluded the arguably more basic issues of graduate *admission*. In addition to abundant (but anecdotal) stories of discrimination in the doctoral admissions process, a recent survey of psychology graduate admissions directors led to the categorization of disclosures of personal mental health issues as a “kiss of death” (KOD) in the admissions process (Applby & Applby, 2006). The authors explain:

The discussion of a personal mental health problem is likely to decrease an applicant’s chances of acceptance into a program. Examples of this particular

KOD in a personal statement included comments such as “showing evidence of untreated mental illness,” “emotional instability,” and seeking graduate training “to better understand one’s own problems or problems in one’s family.” More specifically, one respondent stated that a KOD may occur “when students highlight how they were drawn to graduate study because of significant personal problems or trauma. Graduate school is an academic/career path, not a personal treatment or intervention for problems.”

The authors further warn prospective graduate students to “avoid references to...mental health [because] such statements could create the impression you may be unable to function as a successful graduate student” (Applby & Applby, 2006, p. 23). Psychiatric disability, these authors suggest, may more or less directly imply some level of academic incompetence or risk regardless of one’s academic record, at least for some admissions directors.

Clearly enough, graduate students and faculty with a range of different (physical and mental) disabilities and chronic illnesses face significant barriers and an often inhospitable climate in higher education. The development of disability studies programs and curricula, on the other hand, has clearly led to at least pockets of support and acceptance and perhaps even advantage. To the extent that both psychiatric diversity as a research area and students and faculty representing the full spectrum of psychiatric disability are significantly under-represented in disability studies and academia more generally, however, academics with psychiatric disabilities are arguably at even more of a disadvantage.

Conclusion

The narrative of the consequences of the absence of c/s/x perspectives in academic discourse presented here paints a disquieting picture: While there is increased interest in bringing c/s/x perspectives into the academic fold, biomedical models of psychiatric disability dominate, cross-disciplinary research remains rare, scholarship largely revolves around clinical interests and goals, and the aspirations of academics with psychiatric disabilities may be thwarted by the current academic environment. Given the increased attention being paid to issues concerning psychiatric disability and diversity in the disability studies literature, specifically, it is worth highlighting two potential courses of action for scholars within this discipline.

As alluded to in our introduction, the differences between disability and c/s/x discourse are not insignificant and, thus, the question of how best to address some of these negative consequences—whether to work toward an independent ‘mad studies’ discourse, encourage the disability studies establishment to more fully include psychiatric issues, advocate for the expansion of critical and interdisciplinary approaches within traditional disciplines such as sociology and psychology, or attempt several of these—is unclear. Developments outside the US, for instance in Canada, where ‘mad studies’ has made more significant inroads in disability studies (e.g. Reaume, 2006), or in the UK, which has seen the emergence of a strong social science user/survivor researcher movement over the past decade and a half (Beresford, 2002, 2009a, 2009b; Chandler, 2009; Sweeney et al., 2009; Rose, 2008, 2009; Rose, Thornicroft & Slade, 2006) suggest the viability of several different paths.

If c/s/x perspectives are to be more fully considered in the context of existing academic disciplines (disability studies or other), meaningful critical self-reflection seems a necessary prerequisite. Departments, that is, including disability studies programs, need to honestly examine the extent to which they currently employ researchers (with or without personal experience) who approach psychiatric disability from a holistic, non-pathologizing perspective. Hiring faculty with such interests, in turn, would help create a pipeline encouraging applications from students both with and without psychiatric disabilities invested in these issues. Likewise efforts might be made to fund and organize mad or psychiatric disability focused symposia, conferences, and research initiatives, as well as targeted special issues of journals, in order to promote and encourage progressive psychiatric disability specific scholarship.

Even in the absence of the formation of a full-fledged mad studies discipline, steps can also be taken to address some of the issues specific to the often stigmatizing academic climate, and lack of targeted supports for doctoral students and junior faculty with psychiatric disabilities. With modification, programs already in place aimed at promoting the success of students of other historically disadvantaged groups (including special summer institutes, research fellowships, and additional mentoring opportunities) might be implemented for students with psychiatric disabilities. In addition, steps could be taken to empirically investigate and then make available effective academic accommodations specific *to* doctoral students and faculty—i.e. accommodations involving not only coursework, but modifications to duties and expectations in the areas of teaching and research. The absence of any such research in our review highlights the need for further attention to this matter, and that such efforts and initiatives might be

limited if they do not openly acknowledge and support the full range of psychiatric disabilities, including more highly stigmatized and potentially complex disabilities such as schizophrenia.

As Cook (2000) notes, “some have argued that institutionalized discrimination against people with mental illness” is in fact “one of the last socially-acceptable, government-sanctioned threats to the rights of a large class of vulnerable individuals” (p. 199). In this review, we hope to have made the case that the c/s/x community also remains one of the last large sociopolitical groups to be excluded from academic discourse in the US. Open acknowledgement of this underinclusion and its causes and consequences is the necessary condition for change.

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