Outpatients' and Treatment Providers' Cultural Model(s) of Mental Illness in Northern Illinois

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ABSTRACT

OUTPATIENTS’ AND TREATMENT PROVIDERS’ CULTURAL MODELS OF MENTAL ILLNESS IN NORTHERN ILLINOIS

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Northern Illinois University, 2019
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For this thesis, I interviewed outpatients and clinicians from mental health treatment providers in the DeKalb, Illinois, area to investigate the cultural models of mental illness held by both groups. I employed ethnographic methods of semi-structured interviews with cognitive tasks (free listing, and pile sorting) to research similarities and differences between the outpatients’ and mental health treatment providers’ cultural models of “mental illness.” Both mental health clinicians and outpatients have experience with disorders commonly termed “mental illness.” I found differences of experience and identity seemed to more strongly influence one’s cultural model of mental illness than one’s level or type of education.

Among mental health treatment providers, there were explicitly and implicitly expressed biomedical organizations of mental health disorders. A more complex psycho-social understanding of mental illness was explained by outpatients in terms of a mental illness’s symptoms, specifically “trauma.” This included explanations of how symptoms of mental illness contribute to personal identity and social expression. Pile sort tasks wherein participants organized different mental illnesses into groups served to elucidate these mental models and the differences between clinicians and outpatients. From this, I conclude that outpatients’ intimate, personal experiences with mental health disorders contribute to mold a different cultural model
of mental illness than that held by mental health treatment providers (and, by extension, the public at large without any experience of mental health treatment).
OUTPATIENTS’ AND TREATMENT PROVIDERS’ CULTURAL MODELS OF MENTAL ILLNESS IN NORTHERN ILLINOIS

BY

EMILY J. STEPHEN
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A THESIS SUBMITTED TO THE GRADUATE SCHOOL IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE
MASTER OF ARTS

DEPARTMENT OF ANTHROPOLOGY

Thesis Director:
Giovanni Bennardo
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INTRODUCTION

For this thesis, I wish to elucidate a US American cultural model of mental illness held by people who experienced receiving as well as those involved in providing outpatient mental health treatment in DeKalb, Illinois. A cultural model is a mental representation shared by members of a culture, utilized to represent some aspect of the world and reason about it (Bennardo and DeMunck, 2014:6; Fryberg and Rhys, 2009:1). Cultural models contribute to the generation of social behaviors and interact with individual values and emotions in determining or minimally suggesting courses of action (Bennardo and DeMunck, 2014:55). Looking for shared ideas and perceptions, i.e., cultural models, I investigated the expression of causation, social interactions, and identity by seeking out meaningful and salient aspects of conceiving mental illness in my target population.

I investigate if outpatients have their own culture, or subculture (discussed below), by seeing if they have shared understanding of “mental illness.” If outpatients share specific ways of conceiving mental illness that are not shared by treatment providers, then, I argue, they have their own culture (or share a subculture). The way I have chosen to try and uncover a cultural model among mental health outpatients is to investigate linguistic behavior, i.e., speech production, and cognitive organization. I expect to find cultural models expressed through shared conventional discourses and metaphors in interviews with outpatients and mental health treatment providers. I further expect cognitive data collected through cognitive tasks such as free listing and pile sorting to support the cultural models expressed in these interviews.
I argue a cultural model unique to outpatients will be further expressed through their language use regarding illness identities—either as an individual in outpatient treatment or as an individual with a mental illness. Similarly, if treatment providers share conventional discourses and metaphors or a certain cognitive organizational system with outpatients, they will be part of the same culture—partially realized in a cultural model—as the outpatients. If mental health treatment providers have different discourses, metaphors, and linguistic ideologies, then we can say that the mental health treatment providers have a separate culture from outpatients, and vice versa.

Cultural models, as cognitive structures used to understand the outside world, affect how an individual perceives and makes sense of literally everything encountered in one’s internal and external worlds. So, if treatment providers in a geographic area hold a specific cultural model of mental illness, this will undoubtedly affect their methods of practice and their patients will be exposed, though not explicitly, to this cultural model. In terms of talk therapy, the goal is to change a person’s mental model of some behavior or event. This is typically done through a conversational style called motivational questioning, allowing the therapist to linguistically share beliefs and aphorisms (indexing cultural models) about mental illness with the patient. Compliance is achieved when the patient accepts that they need to adapt certain aspects of their mental models and behaviors in the way their therapist says they should and works to change them.

I believe that there is something unique about the experience of mental illness that makes those with personal knowledge of it explain it in more social terms than psychiatrists and other medical doctors. Outpatients, due to the very nature of outpatient treatment, will spend more time discussing their mental illness, its symptoms, and its effect on their lives with
psychotherapists and counselors than they will discuss such issues with their psychiatrists. If psychotherapists do not usually have as much in-depth medical training as psychiatrists, then it would not be unlikely to assume they hold a different view of mental illness than medical doctors. It is reasonable, then, to wonder if therapists’ cultural models of mental illness are transferred to their patients simply due to the nature of their specialized forms of treatment.

I argue that the unique shared experience of mental illness may allow outpatients to form a “subculture” as defined by Dick Hebdige in his 1979 analysis of working-class British youth fashion, *Subculture: The Meaning of Style*. Hebdige argues that subcultures are a natural product of groups facing shared condemnation from dominant or hegemonic forces in society (1979:77). Subcultures grow out of resistance to dominant or paternalistic social forces, which in turn see these groups as “radical,” or extreme. Thus, social responses to subcultures lead to skepticism, anxiety, and even fear (Hebdige, 1979:106).

The goal of my research is to investigate if there is a shared culture, a subculture, of outpatients in the northern Illinois/DeKalb area. I explore what makes cultural models of mental illness (essential components of their culture) held by outpatients similar or different from cultural models of mental illness espoused in academic literature and by mental health treatment providers. I examine language use and cognitive data to find unconscious cognitive organization regarding common and salient mental illnesses. Organizations of knowledge found in shared language use will be similarly demonstrated in the results of cognitive tasks such as free listing and pile sorting.

In the following chapter, I review common conceptions of mental illness in Western and US American society and introduce the theoretical positions I have adopted. I also discuss conceptions of mental illness along with cultural model theory, its methodology, and
justifications for language use and cognitive data collected through administered tasks as investigatory tools.
CHAPTER 1
THEORETICAL POSITION

With this research, I investigate if there is a shared culture between mental health outpatients in the DeKalb, Illinois, area. To find a shared culture, I look for similarities and differences between cultural models of mental illness held by outpatients and cultural models of mental illness explained by mental health treatment providers and medical literature. In this chapter, I review common perceptions and concepts of mental illness in US American society. I introduce and explain cultural model theory, its methodology, and its justification of language use as a means of uncovering implicitly held assumptions – particularly regarding mental illness and its treatment.

In the following sections, I review common conceptions of mental illness in Western and US American society and introduce the theoretical positions I have adopted. I also discuss conceptions of mental illness along with cultural model theory, its methodology, and justifications for language use as an investigatory tool.

In Search of a Cultural Model of Mental Illness: Conceptualizing Mental Illness

Historically, interest in studying culture and mental illness lies in investigating the culture of the hospitalized “mental patient,” serious mental illnesses such as schizophrenia, people adjusting to de-institutionalization, and “culture-bound illnesses” (see American Psychiatric Association, 2000; Estroff, 1985; Goffman, 1963). Psychiatric institutions are an intriguing
world because they can provide a physically separate space wherein the mentally ill are free (somewhat) to create their own culture and social roles (Goffman, 1963). In 2019 in the USA, psychiatric institutions are not as common, but mental illness is now a more common occurrence, as one in five adults has a mental illness of some kind (National Alliance on Mental Illness, 2019). People who receive treatment for mental health issues and who are not being kept in hospitals are receiving what is known as outpatient treatment—the opposite of which is inpatient. Regarding studies of mental illness in US American cultures, it is only recently that outpatients have been the focus of research—even then, it is mostly in clinically evaluative environments conducted by people in professional positions of authority (either doctors or academics).

In more contemporary studies in US American and European societies, minority perceptions and conceptualization of mental illness are often compared to a biomedical standard (Arthur et al., 2010; Cabassa, Lester, and Zayas, 2006; Karasz, 2005; Lawrence et al., 2006; Patel, 2001; Skelton and Croyle, 1991). The implication is often that non-minority populations, particularly those who have mental health issues, hold a biomedical understanding of mental illness. By comparing the minority or “other” to biomedical standards, researchers are unconsciously arguing biomedical views to be the understandings “we” (the majority culture) have of mental illness. This is not only an unsubstantiated claim, but it is also questionable in terms of stigmatization of the mentally ill.

When reading more recent academic literature about mental illness in the US and Europe, one notices that from the 1990s onward, mental illness has come to be seen as less unusual than it once was. Whether this change in perception is due to the advent and popularity of more effective psychiatric medications for more conditions or from a better scientific understanding of the human brain, mental illness has come to be explained by medical professionals as the same
as “any other medical illness” (Malla, Joober, and Garcia, 2015). Consequently, the biomedical aspects and treatments for mental health issues have become strongly emphasized among the population at large.

A strictly biomedical conception of the mind is incorrect for understanding mental illness, as one’s real “self” or identity does not actually change while receiving medical treatment for mental health issues. If one considers the mind to be purely a biomedical entity, one would expect biomedical interventions to consistently improve mental health – which is not the case. Those in the medical community do not necessarily view biomedical interventions in this way. But the ineffable nature of the mind induces overly simplistic conceptions among the general populace.

Completely medicalized views of mental illness are incongruent with the way the medical community views mental illness and describes it in literature. So, even calling these socially held conceptions of mental illness “medicalized” is somewhat misleading. Academic and medical literature suggest that health professionals do not all hold a biomedical model of mental illness, and most are beginning to embrace a psychosocial model, or at the very least, there is much literature on psychosocial models of mental illness and their biomedical treatment (Alankrita, 2009; Anderson and Hope, 2008; Armstrong, Birnie-Lefcovitch, and Ungar, 2005; Dixit and Alankrita, 2008; Papageorgiou and Wells, 2003; Slavich and Irwin, 2014). A psychosocial model of mental illness combines aspects of a biomedical model with other psychological and social aspects, arguing that categories of illness are not fixed entities, but instead depend on societal norms (Alankrita, 2009:2). Categories of illness, and what defines illness, are embedded within the psychological, interpersonal, and cultural contexts of one’s society (Armstrong, Birnie-Lefcovitch, and Ungar, 2005).
Anthony Marsella and Geoffrey White note that two concepts of illness (one attributed to theories of disease and medicinal intervention – biomedical – and one attributed to social factors – psychosocial) can exist “side by side” (both in the minds of doctors and in the minds of patients) and are not distinct or compartmentalized differently than other aspects of folk knowledge of illness (1982:86). In this sense, conceptions of mental illness articulate with cultural conceptions of personhood and social reality, and how illness is viewed within a group depends as much on ideas about personhood and social behavior as it depends on ideas regarding disease (Marsella and White, 1982:152). If these two conceptions exist side by side, in patient and doctor, then it’s likely incorrect to view the mind or mental illness as strictly biomedical or strictly psychosocial.

Culture and Cultural Models

Guiding my research is the concept of culture as shared, common and repeated experiences “mediated by humanly created products and learned practices that lead them [people] to develop a set of similar schemas” (Strauss and Quinn, 1997:7). These schemas are representative of cultural models, mental frameworks made up of culturally, socially, and intersubjectively derived ideas and practices involving knowledge of certain cultural domains which then become embodied and instituted in everyday life (Bennardo and DeMunck, 2014). The content of cultural models includes “information about how to be a person, what is good, what is right and [...] what is not right” (Fryberg and Rhys; 2009:2).

If culture is defined as an organization of knowledge that is shared within a community, then cultural models are appropriate units for analyzing culture. Cultural models, as mental organizations of knowledge, exist within the minds of the members of a society as culture does.
Therefore, cultural models are mental representations, components of a given culture, and the discovery of these mental representations within a community can lead to a better understanding of what characterizes the culture of that specific community.

Our human capacity to “read” other people’s minds and act as if others have mental models of acceptable social behavior similar to our own is known as our “theory of mind” (Bennardo and DeMunck, 2014:28; Wassmann et al., 2011:51). However, we do not know for certain that others hold the same models of acceptable behavior as we do, but we act as if they do. This “as if” nature of what we construct as culture is key to our social behaviors – it is what allows us to conceive of others as similar to ourselves and believe other people as capable of holding the same motivations and controls for their behavior as we do.

This as if nature of culture generates an intersubjectively shared idea of what is and what is not socially acceptable behavior, all rooted in an unconscious and unspoken presupposition that we can correctly understand other people’s behaviors and motivations being sufficiently the same as our own. Those whom we understand to be similar to ourselves, we consider as having the same “culture” and internal states (beliefs, emotions, knowledge, etc.) as we do. These shared assumptions, understandings, and beliefs in common similarities as if they were true are what makes up one’s culture.

We assume and act as if others behave and think similarly to us and this is a fundamental cultural action, a commitment of the individual to the group. Cultural models are units of culture because they organize domains of knowledge shared by people within a social group. Furthermore, cultural models represent and contribute to generate properties of this group’s ideas of themselves and others.
Cultural Models as Analytical Units

In order to justify cultural models as analytic units of a society, one needs a theory of culture that allows for individual thought and agency, but also for group beliefs. Durkheim argued “the social” existed outside of the individual and had characteristics that went beyond and outside the life of the individual (Durkheim; 1952:54). So, culture is seen as a set of collective beliefs and practices shared between social groups. Goodenough (1957) later suggested to think of culture as made up of cognitive elements, all of which do not exist materially in the group but in the minds of individuals.

Gilbert (2013:20) built upon Durkheim’s theory of culture by arguing for a plural subject theory which posits that all members of a society “jointly commit” to being members of the society. This joint commitment allows for the group to coerce the individual into behaving in ways perceived as good for the group through inhibiting individual agency and making members feel compelled to act in ways considered appropriate by the group. This commitment rests on members of the group behaving in accordance with the social rules denoted by their joint commitment.

Joint commitment generates a plural subject in the minds of agents, wherein members of the social group think in terms of “we,” and “us,” with “our” values, goals, beliefs and behaviors and rules (Gilbert, 2013:22). As already pointed out, it appears that all individuals in a society recognize that everyone is operating “as if” this commitment and subject were facts. So, culture – the joint commitment of social groups under which agents operate – cannot exist in the objective, external world. Culture is, therefore, a set of concepts shared between the people of a
group. Since concepts are mental phenomena, we can conclude culture is a mental phenomenon, as well.

If one views socially acceptable behaviors as those which follow an unconscious mental model shared between individuals, we may define culture itself as a series of mental models held by members of a given group – i.e., a set of cultural models. Thus, cultural models can help us to better understand intersubjective experiences by viewing culture as a set of shared knowledge and associated mental activities. This view of culture requires the investigation of culture through the discovery of cultural models, instances of a group’s shared knowledge in specific domains. Given that culture is comprised of things one should know and that these items are transmitted through social interactions, cultural models are conceptually sound units of culture to analyze.

Finding Cultural Models

The shared and communal aspects of cultural models entail using anthropological methods such as ethnography to obtain information regarding a specific community holding a cultural model. The nature of cultural models’ organized knowledge requires methods used in both linguistics and cognitive science. Methods used in linguistics and cognitive science tend to utilize more quantitative data collection and analyses, whereas anthropological methods tend to be more qualitative in their nature. Consequently, three types of data need to be collected and analyzed for cultural model research: ethnographic, linguistic, and cognitive.
Ethnographic research is used to document the behaviors of members of a community. Thus, it represents the context of language production and its appropriate interpretation. If one wishes to learn about a cultural model, it is necessary to learn and know about the community life and its members. I have lived in Dekalb, Illinois, most of my life. I used my native knowledge of this community that I acquired from 15 years of experience with the mental health system in DeKalb to select a sample from a local semi-public mental health clinic. Along with sampling outpatients from DeKalb County, I also sampled professionals from the two types of mental health treatment available in the area: therapists and psychiatrists.

By virtue of being a member of the mental health outpatient population of DeKalb, I know that the psychiatrists at this location work both at the public and private health clinics in town. I also know that half the therapists or psychologists work in other locations in town; they have different days of availability at each location they work at, and they disclosed this during interviews. So, in effect, I sampled mental health treatment providers representative of all three layers of mental healthcare available in the area—public, semi-public (state funded, but affiliated with a private healthcare group), and private non-profit.

Outpatient participants are mostly patients at the semi-public mental health facility, but many have previously seen other treatment providers in the area. The sampling of these two groups (treatment providers and outpatients) allows me to compare the cultural models of mental illness held by mental health treatment providers and how this may differ from the cultural models held by outpatients in the mental health community of DeKalb. This may have important implications for relations between patients and treatment providers in the area, as it is common
for therapists and doctors/psychiatrists to discuss with each other the best possible route of treatment for each individual patient.

If different kinds of treatment providers conceive of mental illness in drastically different ways, there could be a gap in understanding or disagreement regarding kinds of treatment, leading to worsened care for the patient. If different treatment providers conceive of mental illness in similar ways, there may be higher agreement upon treatment, and this may lead to better care for the patient. If there are high similarities between both sample populations, this suggests a strong level of agreement regarding appropriate treatment. This strong agreement could also indicate that an outpatient has either adopted the cultural models of their psychiatrist and therapist or that they have found treatment providers with whom they agree on causes and treatments of mental health issues. A topic for further investigation would be to see if these similarities between treatment providers and outpatients continued or changed depending on the location at which the treatment providers were working on a given day.

Language and Cultural Models

Linguistic data is the most necessary for conducting cultural model research. This is because language is the most typical way in which we, as humans, externalize our representations of the world and share our internal states with others. As such, it has an inherent potential to index a speaker’s mental representations or models of the world. To express representations of the world, we need to have a method of re-representing them that is similar enough to that of other members of the community to be understood and shared; language performs such a function.
Linguistic data is collected through semi-structured interviews. This is because I am researching a cultural model that is, by its very definition, shared among people. Utilizing semi-structured interviews in cultural model research is ideal as it allows the researcher to ask the same questions of everyone in a sample. Since cultural models are generally out of an individual awareness, when trying to discover them by collecting language data, the main strategy is to ask questions which activate the cultural model under investigation without asking directly about the model itself.

Once linguistic data is collected, analysis is conducted on them at three levels: words, sentences, and discourse. These three levels of linguistic analysis are necessary because they provide the data necessary to construct the cultural model one is after. Analysis at the word level focuses on words most commonly used by interviewees that are central to their answers. This is also called keyword analysis. Keyword analysis includes conducting word frequencies. This involves counting all words and focusing on those most frequently used and topically salient, i.e., about mental illness, in the transcripts of the interviews.

Examples of analyses at the sentence level include semantic role analysis (regarding agent and patient roles), analysis of proverbs, and metaphor analysis (Bennardo and DeMunck, 2014:66). Semantic role analysis provides insight into how agency is conceived when speaking about the investigated topic. An analysis of proverbs (adages) also may provide understanding of cultural models used in thinking and speaking about the topic on which investigation is focused. A metaphor implies the projection of the structure of a source domain onto a target domain to better explain the target (Bennardo and DeMunck, 2014:66). For example, the sentence, “I am filled with despair;” represents a container metaphor in which “I” is the target domain, whose state is being explained through the source domain of “container” that can consequently be
“filled with something” (Bennardo and DeMunck, 2014:67). The types of metaphors used and the source-target relationships discovered provide further insight into the activations of cultural models expressed in the linguistic data collected.

Discourse analysis is the third type of linguistic data analysis one can use. There are two types that are commonly conducted: reasoning discourse and narrative discourse analysis. Reasoning discourse analysis occurs when investigating pieces of discourse wherein specific inferences/conclusions are drawn from some assumptions. Often, assumptions or less frequently conclusions are left out of the reasoning passage for the audience to interpret. The idea is that an analysis of reasoning used in speech can provide a privileged view into mental organizations of knowledge.

Narratives are types of discourse that are affected greatly by the cultural models taken for granted within a community. Narrative analysis is typically used to demonstrate the existence of cultural models since interpreting narratives always requires information not present in the interpreted texts. Full meaning and content of the narrative is provided by the interpreters based on a shared and unspoken cultural model (Bennardo and DeMunck, 2014:69).

Cognitive Data

Cognitive data is similar to the types of data collected by cognitive scientists through memory and cognitive tasks. However, instead of looking for differences in data results, cognitive anthropologists and cultural model researchers look for overall patterns (Bennardo and DeMunck, 2014:73). Since all human knowledge is organized and stored in our memories, administering tasks which engage one’s memory provides insight and activates the targeted organizations of knowledge, e.g., cultural models. As ethnographic knowledge informs how
sampling is conducted and the selection of type and content of interviews, similarly, it also informs the collection of cognitive data. For example, ethnographic data provides one with the insight needed to select what salient topics are appropriate for investigation within a given group. Since ethnographic data help to understand the context of speech events (Bennardo and DeMunck, 2014:63), they can also help one devise techniques to collect cognitive data.

The collection of cognitive data often refers to controlled situations wherein researchers use “obtrusive and systematic” methods for data collection, with the intent of “obtaining data from members of a defined group that can be aggregated and compared within and across groups” (Bennardo and DeMunck, 2014: 73). Cognitive data collection consists of tasks. These tasks are administered to find shared patterns indicative of cultural models within a community. This methodology is used to discover, describe, and also verify cultural models. Examples of cognitive tasks include free listing or memory tasks, sorting tasks, drawing tasks, and frame elicitation (Bennardo and DeMunck, 2014: 74).

Free listing tasks are used to discover the content of specific knowledge domains (Bennardo and DeMunck, 2014:79). The task requires the researcher to ask the subject about a specific domain of knowledge, and have participants list all the words they know that belong to the domain in question. This allows the researcher to get at the content of the domain and also obtain an insight about the most salient features of it. In fact, in free lists, the first remembered words are considered the most salient. These lists provide basic units—similar to those obtained by the keyword analysis of the interviews—out of which the relevant cultural model can be constructed.

Sorting tasks/pile sorting are conducted because the mind categorizes everything and represents categories over instances. Pile sorting tasks require participants to categorize a
specific set of items. These latter are those that have been obtained by the free listing tasks. Thus, categories that are potentially present in a cultural model are obtained. That is to say, these types of tasks give researchers salient categories with which to continue constructing cultural models (Bennardo and DeMunck, 2014).

Metaphors and Conventional Discourse

Metaphors allow us to understand and express one thing we do not know in terms of another thing we do know, which gives us the ability to express concepts unknown to our conversational partners (Lakoff and Johnson, 1980:5). Lakoff and Johnson argue that since language is rooted in our embodied conceptual systems, and because we understand and generate new concepts as they are in relation to other simpler and already known ones, it is only natural for us to communicate our internal states via metaphors (1980: 6). Metaphors provide us with ways of expressing our mental representations to others.

Developmental studies suggest that metaphor comprehension begins at a young age and is governed largely by the child’s knowledge about the world and about objects and concepts referred to in metaphorical terms (Kirmayer, 1992:334). As children grow and learn more about the world around them, the better they become at comprehending metaphors. Metaphors express situational knowledge we understand as culture, so metaphors are also grounded in one’s social context. Cultural models share some features with metaphors; both are based on shared experiences—including human bodily experience—and both are representative of aspects of cognitive structures used to make sense of the external world and acquire knowledge about it (Lakoff and Johnson, 1980; Wassmann et al., 2011:52).
Metaphors and cultural models may be used for similar purposes (i.e., making sense of the external world), but they differ in substance. Cultural models are shared representations of knowledge and behavior, whereas metaphors involve how relationships between sets of these representations are established and stored in one's mind. Metaphors allow us a way of gaining new knowledge, and cultural models are representations of this knowledge. Metaphors and cultural models allow us to learn and reinforce that learning while guiding action. Metaphorical language is representative of fundamental mental processes, as the human conceptual system functions partially through understanding new “things” in relation to known others. So, it is useful to analyze linguistic metaphors since they are employed to help others understand our personal internal states (Lakoff and Johnson, 1980:3). Thus, metaphors provide insight into the cultural models possibly present in a community.

For the analysis of interviews at the discourse level, I also employ the concept of a conventional discourse. When analyzing the content of transcripts of interviews, one notices patterns of opinion. The ways in which these patterns of opinion are expressed are known as “conventional discourses” (Strauss, 2012:60; Strauss and Quinn, 1997:36). Such patterns of speaking and thinking are indexical of cultural models regarding a certain topic (Strauss, 2012:66).

Conventional discourses are “oft-repeated shared schemas” (Strauss, 2012:60). These discourses are “conventional” in that they are expressions of cultural models through language; these discourses are learned and shared with others in the same opinion communities, that is, groups in which opinions are formed, discussed, and maintained (Strauss, 2012:62). Cultural models help shape conventional discourses by simplifying or magnifying specific issues regarding the topic (Strauss, 2012:62).
Cultural models, as generic and unconscious knowledge structures, are shaped by experiences that we use to make sense of the world around us (Strauss and Quinn, 1997:37). These cultural models are rarely explicitly expressed through language, but by using discourse analysis one can find patterns across what different people say to discover shared ways of reasoning – generated by a cultural model – about certain topics (Strauss and Quinn, 1997:61).

Conventional discourse analysis is meant to be “intertextual analysis,” that is, analysis of how other conversations speakers have heard are incorporated into their personal opinions (Strauss, 2012:66). So, insofar as people have heard about or had shared conversations about the same topics, they have access to shared cultural models which are expressed linguistically through conventional discourses (Strauss, 2012:20). If one has multiple exposures to many different conventional discourses, they may likely hold what are called “nonconforming discourses” (Strauss, 2012:20). This means they may hold conflicting cultural models which produce different discourses in a given context (Strauss, 2012:21). People tend to agree with discourses based on the cultural model the discourse represents, not necessarily on how it relates to the content of other discourses they may employ and believe (Strauss, 2012:23).

Conventional discourses are “accepted ways of thinking and talking” that people are not generally aware of using (Strauss, 2012:61). These discourses express ideas that we take for granted and do not need to discuss with people from our opinion communities but may be obscure to people from different opinion communities. An example of such shared wording and reasoning that Strauss (2012) gives is what she terms the “Foreigners Taking our Jobs Discourse” (142). This discourse is immediately recognizable in an American context, and it refers to how some people worry about competition from immigrants for employment opportunities. If you are reading this and are a US American, you probably knew that, and that is
precisely what makes it indicative of a cultural model (Strauss, 2012:142). Whether or not one fears their job will be taken from immigrants or that this is a credible fear to have is irrelevant – what matters is that we know what “foreigners taking our jobs” means; it means a set of ideas and opinions which espouse foreign immigration as an employment threat.

When analyzing interviews for shared metaphors and conventional discourse use, the goal is to find the underlying concepts/mental structures for which these linguistic devices stand (Quinn, 2005:49). As the topic of investigation is cultural models of mental illness, I use metaphor and conventional discourse analysis to investigate connotations of “mental illness” that are implicitly held by my sample population.

These two types of analysis (metaphor and discourse analyses) are useful tools for uncovering cultural models through linguistic production. These shared understandings, i.e., models, are often expressed without the speaker’s explicit intent of espousing a shared idea. When shared understandings are repeatedly expressed linguistically, even if in different ways, by a good number of people, it provides evidence of these unspoken models’ salience for cognizing about a given cultural domain within a community (Quinn, 2005:47). If one can reconstruct similar ways of reasoning—either by using the same metaphors or the same conventional discourses—from linguistic production by different people from the same culture, this would provide evidence and insight into a cultural model (Quinn, 2005:45).

Concluding Remarks on Cognitive Model Theory

Our human capacity to hold a theory of mind makes it possible for us to act “as if” we know others’ internal worlds function similarly to our own. However, we are also aware that this knowledge is also an assumption and it is simply our joint commitment to society which compels
us to believe and act as such. Mental illness interferes with theory of mind and therefore is seen as threatening to society itself, as people with mental health issues often cannot act as if their internal worlds are like everyone else’s.

This is often the very problem that makes one seek professional mental health treatment; one is acutely aware that how one feels is not “normal” nor congruent with their socially defined conceptions of selfhood. They cannot make themselves feel normal enough to act ‘as if’ they are experiencing the world the same way as the rest of their community. From preliminary research and personal experience, such ego-dystonia causes outpatients to feel disconnected from accessing, or even understanding, the interiority of neurotypicals. This has led me to argue that mental health (out)patients understand mental illness differently than the population at large due to their personal experiences with it.

Bruna Zani argues in her study of social representations of mental illness that, generally, “health beliefs involve an active interplay between dominant and dominated systems of meaning” (1995:148). Similarly, in US American and Western societies, there are dominant systems of meaning surrounding mental illness (see Foucault, 1976). Psychiatry and psychology have pathologized certain behavioral expressions of mental experiences and dominate the expression of outpatients’ mental health states while some social stigma attempts to repress certain ways of expressing these mental health states. So, it is entirely possible that there are different social representations of mental illness within the same population.

There are certain ways of reacting to events that are not considered socially appropriate, resulting in behaviors we consider as deviating from the norm enough to constitute illness. I argue that an outpatient subculture exists due to the shared experience of facing dominant social forces that wish to define certain emotional responses as illnesses and hence keep such responses
muted. This is similar to the term “subculture” as it is employed to describe punk fashion by Hebdige (1979), but it is mostly unconsciously held. By comparing mental health issues to fashion, I only mean that there is a collection of traits that outpatients tend to share and that outpatients tend to socialize with other outpatients based partially on these shared traits.

As discussed in Strauss (2012), cultural models, as intersubjectively shared instantiations of knowledge, are transmitted in social context through language use via repetition of words and phrases that people internalize and then mimic as their own reasoning, otherwise known as a conventional discourse (Strauss, 2012:15). Conventional discourses are made up of patterns of opinion as shared through similar language, including metaphor use, within a given opinion community (Quinn, 2005:25). People can apply multiple cultural models on a topic, which would be evident if conflicting discourses or metaphors are noticed throughout transcripts of outpatients and treatment providers.

If culture is understood as a set of shared knowledge and mental activities, then cultural models can help to better understand intersubjective experiences. Instances of a group’s shared knowledge in specific domains provide evidence for a cultural model. As culturally influenced organizations of knowledge are shared with others in the community, they recreate and reinforce a particular cultural model. I aim to uncover the cultural models of mental illness held by outpatients and mental health treatment providers in DeKalb County through linguistic and cognitive data elicitation by using ethnographic knowledge (literature, participant observation, and firsthand personal knowledge/experience), semi-structured interviews, analyses of transcripts of these interviews (at the three levels of keywords, metaphor, and discourse), and the results of cognitive tasks (free listing and pile sorting).
At the core of this research is a question of identity, not just of semantic categorizations. I am not just researching what a phrase, “mental illness,” means to some people, but I am asking people who have been affected by mental illness in meaningful ways to express the connotations they attach to it. This gives what Wendy Luttrell calls “narrative urgency” (in Quinn, 2005:247) to my participants’ insights and answers. In her analysis of US American, working-class women’s educational experiences, Luttrell explains the “emotional salience” and importance of such experiences in these women’s lives regarding their self-understandings and identities (Quinn, 2005:247). Most mental health issues affect one’s sense of self, and as such, mental illness is as an emotionally salient topic for outpatients as it is for mental healthcare providers (albeit for different reasons).
CHAPTER 2
DESCRIPTION OF FIELD SITE

DeKalb county, Illinois, is a mostly rural area in north-central Illinois, USA (see Figure 2.1). Located approximately 60 miles west of Chicago, DeKalb County is technically part of the Greater Chicago Metropolitan Statistical Area (otherwise known as “Chicagoland”). To be more precise, DeKalb county is in the hinterland of Chicago. Railways and highways are the main lines of exchange between the city of Chicago and DeKalb County itself. Interstate roads and freight railroads intersect near and in the cities of DeKalb and Sycamore, providing residents in the area with easy access to major cities around the state and elsewhere in the country (see Figure 2.2). Both towns had a combined population of 61,381 people in 2010 (DeKalb: 43,862; Sycamore: 17,519), representing over half the population of the entire county (104,733 people); (US Census Bureau, 2018). The location of highways and interstates has made the cities of DeKalb and Sycamore the most populous towns in DeKalb County, with a special appeal to work commuters. Many DeKalb and Sycamore residents who work in larger cities choose to live in DeKalb County precisely because of its distance from Chicago, attempting to avoid issues associated with living in urban areas (places with population densities of over 1,000 people per square mile).

The population of DeKalb county was 104,733 in 2018 (US Census Bureau, 2018). About 87% of the county’s residents are White (including Latinx), and 11% of the county’s residents are Black (US Census Bureau, 2018). There is nothing particularly unusual about
DeKalb County as far as suburban and rural areas go, except its proximity to Chicagoland. The cities of DeKalb and Sycamore themselves are more suburban than rural, with Northern Illinois University (NIU) being one of the main employers of their residents. The university draws in people from all over the world (and state) for their studies, allowing for a modicum of diversity in the area. NIU also plays an active role in the community, for example the department of counseling services provides psychotherapy to DeKalb city residents for free, and university researchers are working with the town government and local public health providers to implement mental health and crisis response training within the city’s police department (Board of Trustees of Northern Illinois University and City Council of the City of DeKalb [2018] Resolution 2018-072§1).

Figure 2.1: Location of DeKalb County in Illinois, USA (World Atlas, 2016). Note: DeKalb county is in yellow; blue star represents Chicago, IL
Figure 2.2. Map of DeKalb County, Illinois (DeKalb County Government, 2019).
This research focuses on mental health outpatients and treatment providers in the areas of the towns of DeKalb County, including DeKalb. DeKalb is the geographic and commercial center of the county, with the town of Sycamore as the neighboring county seat (see Figure 2.2). I refer to my geographic area of focus as “the DeKalb area” because it cannot just be called “DeKalb.” This is because the border between the towns of DeKalb and Sycamore is basically invisible in the larger business district, where most of the county’s medical and mental health services are located. The towns of Sycamore and DeKalb are divided north-south by a state road: The north side of the road is the town of Sycamore, and the south side of the road is DeKalb (see Figure 2.3). On both the north and the south sides of the dividing road are located several mental health treatment providers (including the county public mental health treatment center), separating mental (and other) healthcare resources between the two towns (see Figure 2.3).

Despite being part of a “metropolitan area,” there is a distinctly rural aspect to living in DeKalb county. The cities of DeKalb and Sycamore themselves are surrounded by agricultural land. Many of the county’s residents live “in the country” – on farmland nestled between fields of corn and soybean. There are also commercial hog farms just beyond the town limits of Sycamore and DeKalb, giving the area plenty of what is known as “country-fresh air.” Smaller communities and townships in the county are along state roads, with old agricultural structures such as grain elevators being the only signs of established towns beyond post offices.

With very few options for entertainment, shopping, and dining in these small towns, most of the county’s residents often drive to the DeKalb/Sycamore area for work, leisure, or just to buy groceries. The same is true for healthcare – most of the medical practitioners in the county are in either DeKalb or Sycamore (same for the county’s hospital). This means that people who
do not live in either town often must travel to the DeKalb area (or out of county) to receive medical care.

Figure 2.3 DeKalb-Sycamore area mental healthcare providers and locations (edited to show mental healthcare providers and major locations [court, university, hospital]).

Note: Difference in dots size does not correspond to difference in providers.
DeKalb-Area Mental Health Treatment Providers

Determining the exact number of mental health treatment providers in DeKalb County is almost impossible because the definition of “mental health treatment provider” is incredibly flexible. If a “mental treatment provider” is defined generally as anyone working in the mental health sector, then DeKalb County has 231 mental healthcare providers (University of Wisconsin Population Health Institute, 2019). This gives the county a resident-to-mental healthcare provider ratio of 450:1 – lower than the national average of 491:1 (see Figure 2.4). The University of Wisconsin Population Health Institute’s figures are likely inaccurate for the area because the ratio includes part-time employees such as support and administrative staff and people who do not even work in a mental healthcare practice but in areas such as administrative planning and funding of services (Dr. Melvin, private communication, 2019).

![Ratio of Mental Health Providers to Population 2016](image)

Figure 2.4 Ratio of mental health providers to population, 2016 (DeKalb County Community Health Improvement Plan, 2018).

The methodological guidelines regarding the data used in County Health Rankings, include coding for organizations (practices, offices, clinics) and “other mental healthcare
providers.” This means that providers are counted on individual and group levels that is, both the practice and the mental healthcare providers who work there are listed as two separate treatment providers (Centers for Medicare and Medicaid Services, 2013). In these studies, a psychiatric nurse who provides psychotherapy can be counted as both a psychiatric nurse and a counselor/therapist (one person as providing two different kinds of treatment), even if they are no longer either. Further confusing matters, in the County Health Rankings dataset gathered from the Centers for Medicare and Medicaid Services, there are psychologists and psychiatrists listed who no longer practice in the area (or are retired) counted in with mental health professionals who are currently practicing in the DeKalb/Sycamore area (Centers for Medicare and Medicaid Services, 2013).

The University of Wisconsin’s County Health Rankings ratio of residents to mental healthcare treatment providers for DeKalb County is quite low compared to other estimates, including those for surrounding counties (DeKalb County Community Mental Health Board, 2019; University of Wisconsin Population Health Institute, 2019). The DeKalb County Health Department’s Community Health Status Assessment of 2018 for DeKalb County reports a ratio of 676 residents for every one mental healthcare provider (see Figure 2.4). According to discussions with long-time mental health practitioners in the area, a ratio of 676:1 is a more realistic figure than 450:1.

At the time of research, there were approximately 33 mental healthcare practices in the DeKalb/Sycamore area (see Figure 2.3). These practices vary from private (privately funded) to public (public grant and tax funded), with the majority being private practices with part-time staff (Dr. Melvin, private communication, 2019; see Figure 2.3). It is difficult to say which practices actually provide treatment in DeKalb County. Some practices only provide telemetric
psychotherapy and psychiatry, and therefore treatment is technically not provided in those physical locations (Dr. Melvin, private communication, 2019). However, there is simply no way of discerning in-person treatment providers from strictly telemetric treatment providers through publicly available information.

There are only five psychiatrists currently physically practicing in DeKalb County. Four of them are part time, practicing only one or two days a week, and the only full-time psychiatrist in the county spends his week divided between three or four practices (depending on where he is needed). There are exactly two psychologists who work full time in the DeKalb area, and many Licensed Counselor and Social Workers (LCSWs), Advanced Practice Nurses (APNs), along with many psychotherapists with nursing degrees/training. Unfortunately, to reiterate, it was impossible for me to obtain an exact number of all mental healthcare practitioners who directly provide mental health treatment in the DeKalb area (e.g., part-time psychologists, LCSWs, therapists, and APNs).

Many mental health treatment providers who advertise their services in the area do not work in the DeKalb community full time, and some of those who do work in practices within the community full time may not advertise their services at all. Of those practitioners who do work in the community full time, most work in practices owned (in part) by Northwestern Memorial Medical Care, a corporate entity of Northwestern University and Northwestern University’s Feinberg School of Medicine. Northwestern Memorial Medical Care has bought many practices and clinics in counties west of Chicago (Northwestern University is located in Evanston, just north of Chicago) to “provide the area’s premier integrated academic health system” (Northwestern Medicine, 2019).
For long-term residents of the DeKalb area, this is a change. The area’s medical services were once under the umbrella of the Kishwaukee Community Health System. The DeKalb-area clinic and its satellite practices (such as physical therapists and behavioral health services) have all changed names several times since the Kishwaukee Community Health System was bought by various private entities in the early 2000s. The majority of healthcare services (including mental healthcare) available in the DeKalb area are now part of the Northwestern Medicine Kishwaukee Community health system. Many of these services are provided by the same doctors who have been in the area for decades, working at the same physical locations. These locations are now mostly united under the Northwestern Memorial Medicine HealthCare name. This includes long-standing community treatment fixtures such as the public mental health clinic, the private non-profit physician’s group of multiple specialists, and the semi-public behavioral (mental) health clinic.

**DeKalb County Community Mental Health Board**

While DeKalb County may not have the *best* resident to mental healthcare provider ratios in the state, they are far from the *worst* in the areas west of Chicagoland. Even by the generous measures of the University of Wisconsin’s County Health Rankings (2019), counties to the south and the west of DeKalb County are virtually mental healthcare deserts. The neighboring counties of Ogle, LaSalle, and Kendall (see Figure 2.1) have resident to mental healthcare provider ratios of 720:1, 1160:1, and 1130:1 respectively (University of Wisconsin Population Health Initiative, 2019). The high ratios of residents to mental healthcare professionals in surrounding counties help to illustrate a point: it is relatively unusual for a rural county to have a community mental health board, and DeKalb County has a comparatively sufficiently sized mental healthcare
system in place. There are many resources available to people with mental health issues in the county, even if many of them are unknown to the populations which they aim to serve.

The robustness of the mental healthcare system in DeKalb largely rests upon the continued existence of the Community Mental Health Board for the past 50 years. Most rural counties have public health departments, but many do not have departments specifically dedicated to mental health. The DeKalb County Community Mental Health Board (DCCMHB) works to “fund services in the county for residents who suffer from, or are at risk of developing, mental or substance use disorders, or developmental disabilities” (DCCMHB, 2019).

The DCCMHB was established in DeKalb County by referendum in 1967 (in accordance with the state-wide Community Mental Health Act [Illinois Compiled Statutes, 1967]). It was initially used for management of mental health services in coordination with the psychiatric ward of the DeKalb County community hospital. At that time, the DeKalb County hospital psychiatric ward was the only psychiatric in-patient facility in northern Illinois west of the counties which now make up Chicagoland (Dr. Tek private communication, 2018). However, the psychiatric ward was closed in 2009 amongst much controversy after the community hospital was bought out by private shareholders (Schraeder, 2009). Now, people must be transported to other hospitals (in different counties) if they are having a mental health crisis and require hospitalization.

The Community Mental Health Board funds various important mental health programs in the community, many of which are in DeKalb but are unknown to residents. Beyond funding the majority of the Ben Gordon Center (the area’s longest-established public mental healthcare clinic), they also fund lesser known services such as the Consumer Advocacy Center, which helps needy adults pay for psychiatric medications. These services are mostly located in the
DeKalb/Sycamore area. Currently, the DCCMHB is focusing on building a trauma-informed community (DCCMHB, 2019). This is a community wherein the early symptoms and causes of mental health issues, particularly those of children, can be identified as early as possible and handled properly. This is done by educating people who work with children about how to identify signs of trauma and trauma-induced behavioral problems.

The DCCMHB also funds the DeKalb County drug court’s treatment assistance plan. The DeKalb County drug court allows people with substance abuse issues to avoid jail time, convictions, and/or heavy fines for drug-related charges by working with resources within the community (schools, therapists, employers, etc.). Ideally, drug court works to get an individual off drugs instead of going to jail. This is done through constant monitoring, assistance in obtaining further education and job skills, and attending drug education courses or mandatory therapy (DeKalb County Drug/DUI Court Program 2013:6). All of this may partially explain the preponderance of substance abuse counselors and other therapists within the vicinity of the county courthouse (see Figure 2.3).

**Mental Health in DeKalb County**

Nearly 18% (17.9%) of DeKalb County citizens are considered to have some type of mental illness; this is close to the national rate of 18.5% (DeKalb County Community Mental Health Board, 2019; Illinois Department of Public Health, 2016). “Any mental illness” includes a period greater than seven days in a month during which one’s mental health is “not good” (Illinois Department of Public Health, 2016). Around 11% of residents have anxiety disorders (e.g.: panic disorder, social anxiety disorder, etc.), nearly 7% have mood disorders (e.g.: major depressive disorder, bipolar disorder, etc.), and about 1% of the county has severe mental
illnesses overlapped with anxiety and mood disorders (e.g.: schizophrenia, psychotic depression, etc.; DCCMHB, private communication, 2018).

Experience and Participation

I have lived over 30 years in this community and have been receiving some sort of mental health treatment off-and-on since grade school. I have only ever seen one mental health professional who was not in either DeKalb or Sycamore, and that was specifically because I could not find a treatment provider accepting new patients in the area. As someone with lifelong mental health issues, I have found myself often wondering how hard it would be to obtain the same level of care in another location. This is because there simply are not many locations that offer the same amount of mental health services for smaller populations such as that of DeKalb County. The Mental Health Board alone funds 52 different programs in 22 different agencies, including the domestic violence shelter, the halfway house, elder care services, epilepsy services, adventure therapy for at-risk youth, and even vocational farming projects through the DeKalb County Community Gardens (DCCMHB, 2019).

I could not perform participant observation with my population simply by joining a therapy group and reporting on it with traditional ethnographic methods. But I did, in the summer of 2018, join a therapy group for dialectic behavioral therapy (DBT) at the Northwestern Medicine Kishwaukee Behavioral Health clinic (see Figure 2.3, intersection of state Routes 23 and 34). I recruited many participants for my research through this group, but this is not why I went to group therapy. I would have been going to group DBT for my own mental health issues even if I were not conducting research. However, an overall side effect of group therapy is gaining a larger social network of people who are experiencing similar mental health issues.
While I cannot speak for other techniques of group therapy or group therapy for different mental health issues, it was not uncommon for individuals in DBT group therapy to share contact information or at least become friends on Facebook. This is due both to the nature of group therapy and the nature of being in a group. When in a group, one wants to bond with others. “Friends” from group therapy are gained in a completely different manner than one normally makes friends.

In the context of group therapy, bonding is done by sharing intensely personal information such as traumatic events and how they are currently affecting one’s life. The voluntariness of overall friendship in group therapy for people who happen to be in treatment together is questionable. After all, one does not normally explain their psychiatric diagnoses or childhood traumas upon first meeting strangers, so everyone in a group therapy setting has a bit of insight on one another that they would not have had in any other circumstance. This causes a fast and strong bond, and it can make one to feel as if other group members are friends despite a lack of any other commonality besides mental health status. Perhaps, due to the nature of mental health issues treated with DBT, this sense of friendship can be either real or merely perceived (depending on the individual). However, from discussions with other people who have been in group therapy, this sense of deep, yet superficial, friendship is not unique to DBT groups.

Group therapy not only helped me get more participants, it gave me an environment in which I could become reacquainted with how to communicate with people about whom I knew very little except their mental health status. While legally I cannot give detailed reports with identifying information on group therapy, I can report on my own experiences with it as it pertains to this research, and this is as close to participant observation as one can get without
going through a number of necessary permission-seeking steps and needing specialized
certifications in fields other than anthropology.

Concluding Remarks on Field Site Description

While some outpatient participants no longer live in DeKalb County, I consider their utilization of mental health services in the DeKalb area as indicative of the lack of services in their home towns/counties. I drew many of my participants from a semi-public practice, plus my professional participants (except for one) all worked in public mental health services to some degree (either currently or in the past). This caused my research focus to turn toward more publicly funded mental health services than private services.

The majority of mental health services in the area are private, but these are not the services which are most often reported to have been used by participants. Many participants cited a lack of financial resources in their history of searching for treatment, suggesting there is indeed a great need for public mental health services – including local law enforcement’s need for a better understanding of mental health crises.

Arguably, a better understanding of mental health outpatients’ cultural models of mental illness could contribute to better mental healthcare services, if even on a small scale. If, as I hypothesize, outpatients view mental illness as a mostly psycho-social issue (as opposed to a medical one), then mental health services that help integrate people into social aspects of the surrounding community (e.g., community gardening and volunteering programs) may be seen as more beneficial than psychotherapeutic treatment for mental health on its own. If socially oriented psychotherapeutic treatment services are seen as more beneficial, then perhaps more resources should be allocated to them (or at least to advertising their existence in the
community). If outpatient participants hold a biomedical understanding of mental illness, then it may suggest that funding and attention should be allocated to more psychiatric and psychotherapeutic resources (as questionably possible as that may be).

Further understanding of mental health outpatients’ and treatment providers’ cultural models of mental illness will be useful to facilitate conversations about how to best approach treatment options with potential outpatients in the DeKalb area. Understanding where and how treatment providers’ cultural models of mental illness differ from outpatients’ cultural models may illuminate where increased communication between patients and treatment providers would be useful. If treatment providers better understand where their patients’ understandings of mental illness are likely to differ from their own, they may be better equipped to see from their patients’ points of view, which could facilitate more appropriate and effective treatment.
CHAPTER 3

METHODOLOGY

My methodology has been informed by cultural model theory which necessitates the collection of three data types: ethnographic, linguistic, and cognitive. I focused my investigation on the mental health outpatient community in DeKalb, Illinois, along with mental health treatment providers in the area. To gather data necessary to construct an outpatient cultural model of mental illness in DeKalb County, I first collected ethnographic data through researching the mental health system in the area. Being a member of the DeKalb mental health outpatient community myself, opportunities for ethnographic data collection (through informal conversations and communication) presented themselves often throughout my daily life and are discussed in more detail both below and in Chapter 2: “Description of Field Site.”

Data Collection

To collect linguistic data, I conducted 18 semi-structured interviews and free list tasks with people from DeKalb, Illinois and neighboring towns who agreed to participate in my research. These interviews were conducted with 11 outpatients, two psychiatrists, four therapists/counselors, and a member of the DeKalb County Mental Health Board. Interviews were conducted in private settings and digitally recorded for ease of transcription. Participants who agreed to the interview and recording signed informed consent papers approved by the IRB with contact information for potential follow-up (see Appendices A and B).
To collect cognitive data, I first administered free-list or memory tasks. The results of these tasks were analyzed quantitatively for frequency and salience, then the 20 most salient free listed mental illnesses were used for a pile sort task. I conducted pile-sorting tasks with 12 participants from my initial sample population (including four mental health treatment providers and eight outpatients) to look for patterns of categorization of mental illness.

The limited number of participants did not allow me to conduct extensive statistical analysis of the data collected, so I chose a mostly qualitative approach in my analyses. Interviews were transcribed and then coded in MaxQDA to extract general themes. I also conducted keyword analysis and obtained gists of the transcriptions whose contents I analyzed in search of metaphors and conventional discourses about mental illness used by outpatients and mental health treatment providers.

**Ethnographic Data Collection**

Ethnographic data regarding DeKalb County’s mental healthcare system was collected from discussions, emails, texts, and general socialization with people involved in the mental healthcare of the community, including doctors (psychiatric and other), members of grant boards (for treatment facilities), nurses, therapists, outpatients, acquaintances, and friends. I attended public fundraisers for the mental healthcare services in DeKalb, networked with funding board members, and informally talked to doctors and nurses in addition to formally interviewing them to get a more robust picture of the mental health treatment system in DeKalb county.

At the time of research, there were approximately 33 practices in the DeKalb/Sycamore area. These practices varied from private (privately funded) to public (public grant and tax funded), with majority being private practices with part-time staff (Dr. Melvin, private
communication, 2019). I attempted to recruit outpatient participants from three mental health treatment providers within DeKalb County along with medical and staff informants from these same providers by simply asking if they were willing to participate in this study and if I may leave calls for participants in their lobbies.

To gather data necessary to construct a cultural model of mental illness, I looked to interview 27 people from DeKalb County whom I would get to agree to participate in my research: nine (three from each of three different practices) who were in outpatient treatment for mental health issues, nine (three from each of the same three practices) who worked in mental health clinics or practices as staff (secretaries, janitors, etc.), and nine (again, from the same three practices) who worked with patients as mental health treatment providers (psychiatrists, counselors, nurse; see Table 3.1).

Table 3.1 Initial Sampling Frame

<table>
<thead>
<tr>
<th>Participant Group</th>
<th>Clinic X</th>
<th>Clinic Y</th>
<th>Clinic Z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Providers</td>
<td>N = 3</td>
<td>N = 3</td>
<td>N = 3</td>
</tr>
<tr>
<td>Staff (administrative, janitorial, etc.)</td>
<td>N = 3</td>
<td>N = 3</td>
<td>N = 3</td>
</tr>
<tr>
<td>Outpatients</td>
<td>N = 3</td>
<td>N = 3</td>
<td>N = 3</td>
</tr>
</tbody>
</table>

I chose this sampling frame because it would provide data from three distinct groups in three different locations and allow me to draw comparisons. This was important to find if and how cultural models of mental illness varied from practice to practice. I wanted to investigate if staff had a different view of mental illness than either patients or mental health treatment providers. This is because I am convinced that understanding the cultural model of mental illness held by people who live in the area, but who are not involved in directly providing treatment, could be considered as a dominant cultural model of mental illness. This impersonal cultural
model of mental illness, I reasoned, could be something against which to measure outpatients’
and mental health treatment providers’ cultural models.

Since there are three types of mental healthcare providers in this area (public, semi-
public, and private non-profit), I chose three practices with the goal of gathering data from a
practice of each type (public, private, and semi-public) and further the goal of comparing cultural
models from each practice to investigate possible differences and help explain similarities
between types of practices and cultural models of mental illness.

As stated in Chapter 2, “Description of Field Site,” I attended group therapy at
Northwestern Medicine Kishwaukee Behavioral Health clinic for a period of time during my
research. I gained participants through this group, but it is important to emphasize for legal and
ethical purposes that this is not why I went to group therapy. I would have gone for my own
mental health even if I had not been conducting research. However, as also discussed in Chapter
2, a side effect of group therapy is interacting with a larger social network of people who are
experiencing mental health issues, and this was an opportunity to gain participants.

Further ethnographic data was gathered through informal conversations and interactions
with people whom I consider friends and acquaintances. Many people I knew came to me to
discuss their mental health issues and treatment from 2017-2018; these individuals explicitly said
I could use their experiences in my research and often sought me out to tell me about their
mental health because they knew I was researching outpatients and wanted to share their stories.

Research Sites and Sampling: Participants

As there are many mental health practices in the area, I believed sampling from one
public, one semi-public, and one private mental health practice would provide proper
representation of the composition of area mental health services. As my research focuses on the
cultural models of mental illness in outpatients and treatment providers within the DeKalb area,
my aim was to gather an equal distribution of psychiatrists/other treatment providers, staff, and
outpatients from three different practices within the DeKalb area (three treatment providers,
three other members of the locations’ staff, and three outpatients per practice). This sampling
distribution was designed to evaluate the similarities and differences between those who treated
people with mental health issues, those whose jobs put them in regular contact with people with
mental health issues, and those receiving outpatient treatment for their own mental health issues.
I wished to compare the mental healthcare professionals’ cultural models of “mental illness”
with those of their patients and those of other mental healthcare employees. Since I personally
know employees of a few practices and mental health professionals, I thought they would
potentially allow me to post calls for participants to my research project in their waiting rooms to
gather outpatient participants. However, none of the providers or treatment centers granted me
permission to do so, and I soon found my ideal sampling procedure to be unfeasible due to laws
surrounding privacy and medical ethics. I received much cooperation from mental health
professionals as participants, but they were wary to get their patients involved. Providers were
primarily concerned with not wanting to appear as they were promoting or recommending
participating in this research as something related to treatment.

Final Sample Composition

Due to legitimate ethical concerns (and bureaucracy), I had to resort to snowball
sampling within social networks to recruit participants. Anyone who wanted to participate and
was in or provided outpatient mental health treatment was welcome if they were over the age of
18 and receiving/practicing treatment in DeKalb County. This drastically changed my sample from the goal of nine treatment providers, nine staff, and nine outpatients. Instead of my ideal sample of treatment providers, staff, and outpatients, I obtained a sample population of outpatients, psychiatrists, and therapists (and one health board member). For ease of communication, this will be discussed as two groups: outpatients and mental health treatment providers. While omitting staff members may have left me with only treatment providers and outpatients, I believe there is still much to be learned from studying differences and similarities between treatment providers and outpatients.

At the end of my recruiting process, I was able to interview six female outpatients and five male outpatients, along with seven treatment providers (three female therapists and one male therapist, one female member of the county mental health board, and two male psychiatrists). My planned three groups of mental health treatment providers, support staff, and outpatients turned out to be only two groups: outpatients and treatment providers. The second group was composed of psychiatrists, therapists, and the mental health board member. This was an interesting development, as therapists serve different functions and have different training than psychiatrists (who are medical doctors). The difference in training and function led me to hypothesize that therapists may have different perceptions, discourses, and/or cultural models of mental illness than psychiatrists do.

When devising my original sampling frame (Table 3.1), I did not know the exact number of psychiatrists practicing in DeKalb County at the time. I planned to interview nine psychiatrists, but there are only five in the area – my desired sample would have never been achievable in the first place. I was only able to obtain two thirds of the participants I had initially anticipated. However, if we look at the sample that was obtained (Table 3.2) – there is an
acceptable amount of distribution across clinics and outpatients, and the groups of participants are only slightly different from those I had initially planned to obtain.

Table 3.2: Actual Sample Population

| Participant Group or Mental Health Treatment area | Northwestern Medicine Kishwaukee Behavioral Health | Northwestern Medicine Kishwaukee Physician’s Group | Other (LivingRite, Northwestern Kishwaukee Ben Gordon Center & DCCMHB) |
|-------------------------------------------------|--------------------------------------------------|---------------------------------------------------|
| Psychiatrists                                   | N=1 (male)                                        | N=1 (m)                                           | N=0                                                              |
| Therapists/Other Providers                      | N=3 (3 female)                                    | N=1 (m)                                           | N=1 (f)                                                         |
| Outpatients                                     | N=7 (4f, 3 m)                                     | N=2 (1f, 1m)                                      | N=2 (1f, 1m)                                                    |

The majority of participants came from one clinic, Northwestern Medicine Kishwaukee Behavioral Health. This is largely due to my involvement with and patronage of this treatment facility. While social networking did allow me to get participants, given the private and medical nature of my topic, I was not able to be quite as selective about my sample population as initially desired.

When interviewing mental health treatment providers, I kept in mind the training they had received in terms of how to understand and treat mental illness. If someone had had medical training, I thought it likely they would hold a biomedical model regarding illnesses and the body in general. Considering the overlap of treatment providers and their rotating placements within the area, I believed it to be possible that outpatients in the area hold viewpoints regarding treatment and causes of mental illnesses similar to their treatment providers. I hypothesized that the outpatients’ interactions with treatment providers may end up influencing their ideas and personal mental models of mental illnesses, possibly causing outpatients to hold multiple conflicting models of mental illness.
I used semi-structured interviews to gather linguistic data. This is because the shared nature of cultural models necessitates the researcher to ask the same questions of all participants (same wording, same order, same interviews). Semi-structured interviews were divided topically in two parts, and between the first and second parts I administered free listing tasks (see Appendix D). Participants who wished to continue taking part in this research gave me their contact information, allowing me to follow up with them for participation in further cognitive tasks.

Since cultural models regarding any specific cultural domain are generally outside of an individual’s awareness, it is better to ask questions that activate the use of the model than to ask questions directly about it (Bennardo and DeMunck, 2014:64; D’Andrade, 2005:90). It is ideal to not explicitly ask about the model. In this case, the model consists of the concepts related to the domain of “mental illness.” I found in my preliminary research that if one is prompted directly to discuss “mental illness” without any prior introduction, one may be more inclined to think of severe mental illnesses.

Severe mental illnesses are not the type of mental health issues affecting the most people in the USA, especially not outpatients. Severe mental illnesses are simply more visible in their symptoms and illness behaviors than more common/less severe mental illnesses of depression and anxiety, conditions for which most people receive exclusively outpatient treatment. Individuals generally receive inpatient treatment (institutionalization) because they have symptoms of severe mental illness. So, obviously, people in outpatient treatment are more likely to not have severe mental illness than people in inpatient treatment. There are undoubtedly
individuals with severe mental illness who manage their symptoms with outpatient treatment, but they are not the majority of people seeking outpatient treatment.

In order to get my participants to discuss less severe mental health conditions and their symptoms, I began with asking them to discuss their own mental health history – helping them to speak of “mental health issues” in relation to their own experiences and identity. I specifically avoided using “mental illness” for the first half of my interviews with outpatients (see Appendix C). Interviews consisted of questions regarding the informant’s personal mental health history, their thoughts about what causes mental health problems, how mental illness affects an individual, and how one’s external environment affects mental illness. These questions were asked to both sample groups, but with slight changes in wording for questions asked to mental health treatment providers (see Appendix D).

As already pointed out, the semi-structured interviews were divided into two halves separated by two free listing tasks. After the free listing task exposed my participants to the term and concept of “mental illness,” I used the term for the rest of my interview questions. This was done to determine if and how answers and language use changed when the concept of mental illness was raised in participants’ minds, as opposed to when they were being asked about their own mental health issues.

Cognitive Data Collection

Collecting cognitive data is often done through memory tasks. This is because we store knowledge organized in cognitive models in our memory. Therefore, obtaining data from
memory tasks may provide insight into the mental organizations of knowledge, i.e., mental/cultural models.

The first memory task I conducted was a free list task. This was administered during the semi-structured interviews. The interview began by asking questions about the interviewee’s background. I then administered the free list tasks by asking the participant to “name all the mental illnesses you know of” and then to “name the most common mental illnesses you know of” (see Appendices C and D). The most saliently listed mental illnesses reported by participants in the first free list task were then employed in a pile sort task which I administered to collect data about larger and more inclusive categories that characterize the domain/model of mental illness.

Free Listing

A free-listing task is a methodological tool to capture an emic description of a cultural domain by reporting knowledge (i.e., words) about this domain in participants’ memory (Bennardo and DeMunck, 2014:75). In other words, the purpose of free listing tasks is to elicit a set of terms pertaining to a specific cultural domain. For all free-listing tasks (memory tasks), the underlying primary assumption is that the first concepts or words remembered and listed will be more salient for the participant than other concepts.

To conduct free listing tasks, I asked participants to list all the mental illnesses they knew of and, consequently, the first mental illnesses mentioned were to be taken as the most salient. I hypothesized that if most of my population said “schizophrenia” first, then it means that the severe symptoms of schizophrenia (hallucination, psychosis, severe thought disturbances, etc.) are the most salient symptoms of the concept of mental illness for my population. This may be
because schizophrenia is often associated with highly “abnormal” social behaviors. Stereotypical symptoms of schizophrenia such as hallucination and auditory disturbances, talking to oneself, etc., are all “abnormal” behaviors to exhibit in public in US American society. The more abnormal the social behavior, the more the person is seen as deviating from the norms of our conceptions of personhood.

To function in social life, we resort to our theory of mind (Bennardo and DeMunck, 2014:32). Our theory of mind is culturally governed, that is, based on what are deemed socially acceptable behaviors. And actions are deviant or abnormal when we cannot rationalize another’s behavior with our internal logic – an intrinsic part of our theory of mind. Therefore, the more noticeably deviant a person’s behaviors or thoughts are, the more likely they are to be perceived of as a sign of illness (Marsella and White, 1982).

Free listing tasks further involved asking participants to list the mental illnesses they thought most commonly affect people. I anticipated conditions such as depression or anxiety to appear most often. This is because the behaviors exhibited by those with depression or anxiety versus those with schizophrenia are generally far less “deviant,” e.g., having a flat affect is more “normal” than extreme paranoia. In addition to having symptoms that more closely resemble normal behaviors and higher numbers of diagnoses, depression and anxiety tend to be considered more treatable and manageable than schizophrenia within US society.

The free listing task of common mental illnesses was an attempt to discover what is meant when the term “mental illness” is used to describe mental health issues that are common insofar as the individuals interviewed (outpatients) are maintaining some semblance of normal life and they are not institutionalized, so they are capable of interacting with other members of
their society. This was done by analyzing which terms were most often mentioned to be the most common mental illnesses.

Common mental illnesses are not necessarily less serious or severe than say, schizophrenia, and the term “mental illness” is often used to cover more than just the symbolic “crazy person” who hallucinates and talks to themselves (which are well-known symptoms of schizophrenia). To reiterate: mental health outpatients are far more common than mental health inpatients, so the “crazy person talking to themselves” is not the correct stereotype for the majority of people suffering what is labeled as a mental illness. For example, depression is considered a mental illness, but its symptoms are often seen and considered to be less severe or less likely indicative of being mentally ill, leading to less social avoidance (Townsend, 1978; Zani, 1995).

**Pile Sorting**

After the free listing tasks were administered and transcribed, I looked for the most frequently listed mental illnesses by my participants. Again, this task is based on the core assumption that those terms which come first to mind are the most salient. After this analysis, I took the 20 most salient mental illnesses from my first free list task (“what are all the mental illnesses you know of?”) and put them on note cards to be sorted into piles. I chose 20 terms because that was the number of terms with the most intergroup saliency—they were listed by more than one participant and mentioned earlier on in the task. Specific methods of determining these 20 terms are discussed below in the section titled “Analyses of Cognitive Data.”

I used unconstrained pile sorting; that is, I presented the cards and asked participants to sort them into groups based on their personal ways of classification and categorization,
emphasizing that there was no “correct” way of sorting the terms. This type of sorting can involve many uncontrollable variables. Nonetheless, it *is* capable of providing evidence of whether or not there is a “culturally dominant categorization strategy” used for sorting the terms provided (Bennardo and DeMunck, 2014:78).

This is exactly why I administered the task, that is, to see if outpatients and treatment providers sorted mental illnesses similarly to how they are categorized in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM–5), published by the American Psychiatric Association (2013). I anticipated mental health treatment providers would utilize a method of classification similar to the DSM-5 (that is, sorting disorders based on categories within the DSM-5). At the same time, I looked to find if the outpatients *also* would classify mental illnesses in this way, and if they did not, I wanted to know how they rationalized their categorizations (grouping) of the various mental illnesses presented. If outpatients sort mental illnesses differently than mental health treatment providers, I argue it may denote a different understanding and experience of mental illness.

Typically, pile sorting is used to discover categorization processes in research with high participant counts, but I was convinced that pile sorting had the potential to reveal relevant information even within my small population. This is because the items I used for sorting, while terms emically obtained from the results of the free listing tasks, are also well-known, pre-existing, medically recognized labels for specific mental health issues. There *is* a medically “correct” way to sort mental illnesses, and it is the way in which mental illnesses are categorized in the DSM-5. Medical professionals are aware of this way of sorting mental illnesses and so are outpatients, due to the nature of treatment. Understanding one’s treatment entails understanding one’s diagnoses, which often involves learning psychiatric
nomenclature, classifications, and symptomologies. If outpatient participants sorted these terms not as according to the DSM-5, I hypothesized that investigating how and why outpatients sort these terms the way they do would uncover a way of categorizing mental illness that is different from mental health treatment providers. I hypothesized outpatients’ methods of classification would be more psycho-socially based, as opposed to medically or biologically based. This is because outpatients do not learn of their symptoms or diagnoses from medical literature; we are given diagnoses for our mental health issues by a medical professional after experiencing some sort of personally troubling event or thoughts.

Analysis of Linguistic Data/Textual Analysis

To find metaphors and opinion patterns representative of shared discourses, I first transcribed all interviews for textual analysis. To preserve the original form and possible content of each participant’s thoughts, I made the choice to transcribe the interview content including pauses, laughter, “likes”s, “uh”s, “um”s, back-channel cues, and any sign of thinking processes being realized linguistically. Including such common but typically omitted types of linguistic production in my transcripts allowed me to obtain insight into the speaker’s train of thought, possibly indicating change in discourse or opinion being utilized to answer. After transcribing my interviews, I then entered these transcriptions into MaxQDA software for analysis. In MaxQDA, I coded phrases, sentences, and paragraphs in the answers of participants as belonging to the following themes: society, stress, environment, family, negative experiences, behaviors, what mental illness is, and recognizing mental illness in others. I chose to use these themes because they are similar to the themes evoked by my interview questions, but also because they appeared in all participants’ responses. I used the codes “what mental illness is”
and “behaviors” to capture segments of speech which tried to define mental illness or described behaviors of any given mental health issue. I did this in order to extract linguistic production from the data obtained about these two questions: What is mental illness? How does someone know if they are mentally ill?

**Metaphor Analysis**

Lakoff and Johnson argue that all metaphorical understanding is anchored in our nearly universal grasp of bodily experience (1980:6). Considering mental illness is not a universal state of being or experience, we already have little choice but to describe it through metaphorical terms. If someone knows what symptoms of an illness *are* but has not experienced them firsthand, the only way to convey the experience is through metaphorical language – either what the experience is like or what it’s *not* like based on a given individual’s knowledge of the content of other domains.

When we discuss our bodies, language use is immediate and easily understood, underlying the historical development of metaphors as organization of knowledge based in bodily experience (Kirmayer, 1992:335). It is argued that the psychophysiology of metaphors serves to close conceptual gaps between knowledge of one’s body and society (Kirmayer, 1992:335). Metaphors that seem to be the product of reference to simple motor acts are “rooted in affectively charged motivational schemas. This affect is in turn shaped and interpreted through culturally governed interactions with others” (Kirmayer, 1992:337). Thus, I analyzed my interview transcripts for metaphors wherein the body or reference to bodily experiences are used to describe symptoms or signs of mental illnesses.
Metaphors and their use are important when analyzing speech about illness because ill people need ways to communicate their bodily and mental states to others who cannot experience their causes of distress firsthand or to those with no experience with a given mental (or other) illness. This metaphorical rendering of one’s mental health state allows for other people, such as doctors and therapists, to possibly better understand the effects of an illness on an individual (e.g., severity of symptoms). However, a biomedical perspective of health emphasizes the biological nature of diseases often to the point of excluding illness experiences and patients’ personal descriptions of their own mental health states (subjective experiences, such as seriousness of distress; Kirmayer, 1988:59). So even if a person has a good capacity to express metaphorically their experiences with illness, they cannot always expect that metaphors will be understood in the same way as the medical terms with which they correspond.

It has been argued that “meaning emerges from the capacity to use bodily experience (including socially embodied experience) to think with metaphorically” (Kirmayer, 1992:334). I specifically wanted to investigate if participants used medical and bodily metaphors. I became interested in the frequency of bodily and medical metaphors utilized by outpatients in relation to those used by mental healthcare providers. This is because I hypothesize that there may be shared somatic (bodily) understanding of aspects of mental illness between outpatients that are not discussed by doctors. This hypothesis is based on prior knowledge of the DSM-5, wherein “somatoform symptom disorder” is a valid diagnosis. This condition is not considered so much a disorder as much as a complex presentation of symptoms representative of mental health states that cannot be explained by one mental health disorder specifically.

The main bodily metaphor of medicine is “the body as biochemical machine” (Kirmayer, 1988:57). In this metaphor, the patient is an owner of a “body machine” that is taken to the
doctor for repairs. When patients obey doctors and take their bodies in for repairs, they are understood to be rational, or “sane” (Kirmayer, 1988:57). Medicine applies this sense of rationality to illness by focusing on the bodies as a machine, and demanding that patients view, express, and understand their body similarly as part of adhering to the rules of the patient’s sick-role (that is, giving the body over to be examined and complying with doctor’s orders; Kirmayer, 1988:60). This (like other metaphors) becomes a conventional discourse when it is used across groups and individuals to make sense of their illness. I began with the hypothesis that the more exposure one has to health treatment providers, the more one may adopt the conventional (and medical) discourse/metaphor of the body as a biochemical machine in one’s language use.

I analyzed how outpatients described the experience of mental illness through metaphors and investigated how the nature of their metaphorical descriptions were similar to each other. I specifically was interested in whether or not bodily and other material experiences were used as sources of metaphors to explain the experience of mental illness (the target of metaphors). I also analyzed the language data collected to determine if and how outpatients’ metaphors were different from those used by mental healthcare providers. If outpatients and treatment providers use different metaphors in consistently different ways, then I argue that they hold different cultural models of mental illness.

Conventional Discourse Analysis

Conventional discourses are best found by looking for shared patterns of discourse (including metaphorical expressions) in transcripts of interviews (Strauss, 2012:61). By analyzing the interview transcripts for conventional discourses, I intended to identify cultural
models generating those discourses produced by my informants. Specifically, in my research I looked for conventional discourses in my sample population to determine if outpatients (the mentally ill) represent their own opinion community. I also investigated if mental healthcare providers represented a separate opinion community by expressing different conventional discourses on mental illness from those used by outpatients.

Since a conventional discourse is “an accepted way of thinking and talking in a particular opinion community,” in order to investigate discourses one needs to analyze linguistic production (Strauss, 2012:61). In fact, repeated keywords and phrases help signal conventional discourses (Strauss, 2012:63). This is because when individuals linguistically use a conventional discourse, they often repeat the way they have heard it said before, so they produce the same keywords or phrases or sentences indicative of this discourse.

Strauss’ suggested methodology to find conventional discourses involves analysis of shared keywords and common metaphors across interview transcripts. I used the same strategy – I analyzed my transcripts for shared metaphors and keywords related to the “most common” mental illnesses listed by participants (e.g., “depression” and “anxiety”), pulling out metaphors and expressions. If opinion communities share conventional discourses about mental illness, then these conventional discourses on mental illness will include shared metaphors about it.

I investigated overall patterns of explanation regarding mental health issues with the aim of uncovering cultural models of mental illness. Again, a conventional discourse is an “oft-repeated, shared schema” (Strauss, 2012:22). The ways in which outpatients talk about mental illness may change based on the context, including our surrounding audience. According to Strauss (2012), “People can choose their discourses in terms of the identities they want to assume, and their projected identity can change as they shift discourses” (73). Accordingly, I am
convinced that participants have access to both a socially normative conventional discourse of mental illness (a medical one), and a different, “outpatient” conventional discourse of mental illness due to the diversity of opinion communities we belong to (outpatients are also employees, voters, family members, etc.).

The discourses expressed by varying opinion communities may conflict with or contradict each other and are often not integrated into a singular or coherent discourse/opinion by individuals. When individuals express conflicting discourses and are not aware of the contradictions between their viewpoints, it is called “compartmentalization” (Strauss, 2012:82). When individuals are aware of the conflicts in their discourses or opinions, they may find no meaningful way to resolve the contradictions, indicating what is called “true ambivalence” (Strauss, 2012:82). When individuals are both aware of, and meaningfully resolve, their conflicting viewpoints and accompanying contradictory discourses, it is called “integration” (Strauss, 2012:82). I expected outpatients to express either true ambivalence or integration of biomedical and other viewpoints. Consequently, I hypothesized that outpatients, due to their exposure to, and participation in society, are likely to utilize both a socially normative discourse on mental illness (expressing a biomedical cultural model) and a different outpatient discourse about mental illness.

A strictly biomedical view of mental illness and health is not the only viewpoint that outpatients are expected to accept in their role as outpatients. Modern psychotherapy largely involves helping the patient to ways to personally manage their environment and life circumstances to help lessen the severity of mental health issues. This contradicts biomedical discourses—that argue mental health is strictly determined by neurochemicals—by positing that changes in life circumstances can also be determining factors of mental health and illness. As
such, I hypothesized that outpatients would express conflicting discourses on mental illness but that they would also be aware of these contradictions. Because people’s formative experiences and personal identities are often shaped by the contradictory discourses expressed in each different opinion community to which they belong (Strauss, 2012:93), I further anticipated integration of conflicting conventional discourses regarding mental illness and its treatment.

I argue that there is a socially normative conventional discourse of mental illness held by most people in US American society acquired by participating in our culture. This normative conventional discourse is largely based on a medical understanding of mental illness as “any other kind of illness.” I also argue that there are different discourses about mental illness that outpatients are aware of and utilize to make sense of their own lives and diagnoses, as people choose which discourses to use based on their identities (Strauss, 2012:87). Such conventional discourses of mental illness differ in speech patterns and the language usage that realizes them, specifically, linguistically produced metaphorical comparisons of internal states. These linguistic differences in discursive expression, I maintain, make for subtle cues of membership to a subculture (or opinion community) and are instantiations of a differently held cultural model of mental illness.

I further hypothesize that these conventional discourses are expressed in such ways by outpatients as to avoid significantly othering themselves from members of their main culture/opinion community. This is because outpatients often must use an artful blending of all kinds of reasoning (medical, social, bodily, etc.) to fully explain their conditions, limitations, and problems they present to others who may not understand their mental health issues.
Analyses of Cognitive Data

Analysis of Free List Results

Analysis of free list results was conducted to determine the saliency of particular mental illnesses as expressed by participants. To determine frequencies of listed illnesses for both free list questions (“What are all the mental illnesses you can think of?” “What are the most common mental illnesses you know of?”), a ranking of each mental illness listed per participant was determined by the formula:

\[
\frac{\text{number of illnesses listed per participant} - \text{memory rank of mental illness} \times \text{number of illnesses listed per participant}}{\text{aggregated total number of illnesses remembered per participant}} + 1
\]

This formula produces values of .01 to 1.00 for all mental illnesses listed by each participant, allowing them to be ranked (Bennardo, 2009:289). Aggregates - sums of all values - for every illness listed by participants were then calculated (totaed) by using the formula:

\[
\frac{\text{aggregate sum of mental illness}}{\text{total number of illnesses listed by all participants}}
\]

This was done to determine final rankings of each mental illness listed by participants. The lower the final ranking, the less salient (later/worst remembered) an illness is in the group of participants as a whole; a higher final ranking means the illness listed is more salient (earlier/better remembered) by the group of participants.

I reduced the results of the first free list task (“list all the mental illnesses you can think of”) to the 20 most salient terms to be used for the pile sorting tasks described. I chose these 20 terms for pile sorting because that was the amount of terms listed with aggregate values over 1 and rankings over .05, indicating intergroup saliency. I repeated this procedure on the free list
results obtained by the second question, “What are the most common mental illnesses you can think of?” to come up with a ranking of what my overall sample population considered to be “common” mental illnesses. To uncover how participants discussed these “common mental illnesses,” I investigated the use of these terms in interview transcripts.

I used the most common mental illnesses listed as keywords to search transcripts for shared metaphors and other discursive similarities. This was done to uncover how mental health issues common to outpatient treatment were described and to look for keywords and statements indicative of metaphors and conventional discourses. These keywords were further used to help me determine what to code as signs and symptoms of mental illness in interview transcripts.

**Analysis of Pile Sort Results**

Pile sorting, as a cognitive task, investigates semantic categories (categorization); that is, it obtains the relations between terms, i.e., categories, by asking participants to evaluate the similarity of particular items in relation to each other (Bennardo and DeMunck, 2014:78). The goal of the task is to have the participants group members of a cultural domain—the salient words obtained by a free list task—into smaller groups. In other words, participants need to sort the units into categories. These categories may be found to participate in the construction of a larger cultural model.

As mentioned previously, administering a sorting task requires the researcher to select the most salient items from the results of the free listing tasks, put them on index cards, and ask subjects to sort these cards into groups, without giving any guidelines—simply watching how these items are grouped and recording the groups obtained. When a researcher provides the similarity by which they want the cards sorted, the sorting task is called constrained pile sorting;
when a researcher lets participants sort the cards into whatever categories participants so choose, it is called an unconstrained sorting task. I used an unconstrained sorting task.

To keep the pile sort as unconstrained as possible, I omitted “personality disorder” and “disorder” from salient terms to be printed on cards (e.g., “narcissistic” was printed on the card instead of “narcissistic personality disorder”). This was done to avoid providing a similarity by which participants could unwittingly categorize terms. I did this except where it is impossible to understand the concept denoted by the term on the card without including the word “disorder” (e.g., eating disorders, panic disorder, adjustment disorders). To determine the salient terms to be used in my pile sort task, I looked to the aggregate scores and rankings of my free list results as determined by the formulas in the section “Analysis of Free List Results.”

After interview transcripts and free lists were analyzed, I contacted my original participants and asked if they would participate in a pile-sorting task. Some time had passed, so not all 18 participants were available for this task. I met with 12 who agreed to participate (four mental health treatment providers [two psychiatrists, two therapists] and eight outpatients) and administered them the task. I asked the 12 participants to engage in unconstrained pile sorting of the most salient mental illnesses obtained from the free-listing tasks. I asked participants to sort the cards into as small of groups as possible. Ideally, I expected groupings of four cards or less. If a participant made groupings of five or more, I did not ask them to make smaller groupings because I was most interested in immediate, first-to-mind (most salient), “snap” judgments and categorizations of mental illnesses.

My goal was to investigate if outpatients (and mental health providers) have a medicalized way of categorizing mental illnesses and if their explanations about their categorization strategies are more medical or social. For example, in the DSM-5, various mental
illnesses are categorized into groups such as “anxious disorders,” “depressive disorders,” and “personality disorders” for the purposes of medically diagnosing and treating mental illnesses. Thus, if outpatients or treatment providers classify the mental illnesses on the cards by this categorization, I would know if they held a medicalized model of mental illness.

Concluding Remarks on Methodology

I conducted semi-structured interviews and free listing tasks with 18 outpatients and mental healthcare providers to gather linguistic and cognitive data to find supporting evidence for my hypothesis based on ethnographic and firsthand experience: Outpatients have a different cultural model of mental illness than mental health treatment providers or others with no personal experience of it. To find an outpatient cultural model of mental illness and examine its similarities and differences with mental health treatment providers, I transcribed interviews to analyze for discursive patterns and metaphor use. I further investigated these patterns for signs of shared conventional discourses indexing a cultural model of mental illness, specifically looking for expressions of the body or mind as a biochemical machine. I considered those who employed metaphors and discourse of the body as a machine to be expressing a more medicalized cultural model than those who do not employ biological-mechanical metaphors for the body or mind.

Then I administered pile sort tasks using the results of my first free list task (“Would you please list all the mental illnesses you know of?”) to further investigate categorization processes of mental illnesses among and between members of my sample population. When focusing on the similarities among treatment providers, similarities among outpatients, and how these similarities differ between the two groups, I specifically looked for the existence of a medical categorization of mental health disorders similar to that in the DSM-5. The more similar pile sort
results were to medical classifications, the more I considered them to be indicative of a medicalized cultural model.

These methods gave me the opportunity to investigate the hypothesis that mental health outpatients express and possibly hold a different cultural model of mental illness than mental healthcare providers. I intend to show that those with experience of mental health issues hold multiple, sometimes irreconcilable, conventional discourses about mental illness which they use at different times, depending on audience and social context. I argue these differences may be due to the lived experience of mental illness, the experience of its medical treatment, and having to navigate life in a dominantly neurotypical society.
CHAPTER 4
ETHNOGRAPHIC DATA ANALYSIS

Outpatient Participants

Of my 18 participants, 11 were outpatients in the DeKalb area and 8 were mental health treatment providers in the area. Of the 11 outpatients, six were female and five were male. The outpatients ranged from 21 to 39 years of age, and all had some level of education beyond high school. Five (three women, two men) had either bachelor’s or associates degrees, three (all women) were working on college degrees (two bachelor’s, one masters), and three (all men) had attended college at some point in the past but stopped taking courses for various reasons. All 11 outpatient participants employed what would be considered medically correct terminology and exhibited a large degree of knowledge about various mental health conditions and their symptomologies.

At the time of interviewing, four outpatients (two men and two women) had full-time jobs, five (three women and two men) were employed part time, and two (one man and one woman) were unemployed. The ages of my participants were in keeping with national age trends (see Figure 4.1). Adults under the age of 50 make up the majority of people in the USA who have any mental illness (most of them are female), with people of two or more ethnic groups having a higher prevalence of mental illnesses than any other group. Eight out of 11 of my participants were White, and the three who were not White (two women, one man) described themselves as bi-racial.
Seven of the outpatient participants (four women, three men) were recruited from the Northwestern Medicine Kishwaukee Behavioral Health treatment center, with five of these outpatients (four women, one man) seeing psychiatrists at the location and participating in the dialectic behavioral therapy group which I attended for a short period in 2018. The other two participants (both men) from this treatment facility only saw psychiatrists and did not participate in psychotherapeutic services provided at the location. Two of the outpatient participants (one man, one woman) received treatment at the Northwestern Medicine Regional Medical Group facility. One outpatient participant woman received psychotherapeutic services at a private facility in Sycamore called LivingRite, and one man received psychotherapeutic services at the DeKalb city public mental health facility, Ben Gordon Center.
Three out of the 11 outpatients interviewed were not actually diagnosed with any mental health disorders (at the time of interviewing), but they were aware of why they were in treatment. Two of these outpatients without diagnosis (both women) were receiving psychotherapy for issues with anxiety from what they called “stress” or “issues with” past “bad relationships”:

Narissa¹, 21, F, outpatient: I was having a lot of stress about a bad relationship that had been ended for a while. Um, and I kind of noticed that every year around this time I feel kind of bad and just anxious, so I don't see her for a diagnosis, just stress.²

Zoescope, 35, F, outpatient: I was in a terrible relationship, and I just had a lot of issues with it. It could have been a good relationship, but it was very exacerbated by the group of people I was in, my family situation, just awful people doing awful things. It just ended up really traumatizing me giving me a lot of anxiety, and eventually I just saw someone about it.

The other participant without a diagnosis was introduced to the area’s psychotherapeutic services through interactions with the police department for possession of cannabis.

Seven out of 11 of my outpatient informants had had prior involvement with the police – legal troubles were a common theme expressed in interviews with outpatients. Four of my informants had involvement with the legal system which facilitated their receipt of mental health services, and another three had had past involvement with the legal system for various reasons associated with their mental health diagnoses. Five participants with anxiety issues had been arrested or fined for possession of cannabis. One participant with bipolar disorder had been arrested twice for shoplifting, had so many traffic tickets she was unsure of the number, and was once even institutionalized by the police, all in DeKalb County.

The outpatient participants’ view was that people with mental illness are more likely to have been involved with law enforcement because of their mental health issues. This theme was

¹ Participants chose their own pseudonyms – they were explicitly asked what they would like to be called when/if quoted in text.
² All excerpts in block quotes from here forward that are bolded are done so to show my emphasis of particularly discursive relevant aspects of the statements being quoted.
particularly relevant when discussing how someone would know they had a mental illness, with many saying one might not even be able to notice until they upset those around them or got into trouble.

**Duo, 28, M, outpatient:** I don’t know if they could know. A lot of times, unfortunately, it’s through the criminal quote-unquote "justice" system – it’s where you get diagnosed because you get arrested for you know, DUI because you're an alcoholic, or you know you try to commit suicide and you get hospitalized. answering “How would someone know if they had a mental illness?”

**Lucy, 30, F, outpatient:** I’ve met lots of people that had no clue they might need help until they got in like, dangerous situations, did something they really regretted – like, got in trouble with the police for reckless crap and turned out they were just manic, or went to the hospital because they thought they were dying when in reality they were having a panic attack.

From informants’ responses, the involvement of law enforcement in mental health treatment was not seen as useful at all. Police involvement in mental health services was often derided and pointed out as not only unhelpful but (often systematically) detrimental.

**Zoescope, 35, F, outpatient:** You have places like Skid Row in LA, where there’s homeless people with mental health issues who are treating it with illegal drugs, feeding them back into the criminal justice system and poverty. We arrest the homeless, who statistically, are more likely to suffer from mental illness, and who knows? Maybe that’s why they’re homeless.

Another sentiment expressed in the same vein was distrust of emergency or mental health crisis hotlines, explaining that calling them was seen as equivalent to calling the police on oneself.

**Nestor, 33, M, outpatient:** People are like, “call a hotline.” Yeah, so the police can come arrest or shoot you. Hemingway would have totally been ok if he just had a suicide hotline.

**Amethyst, 34, F, outpatient:** Ever since they committed me, it’s like the police like, profile me. Like, the cops came to my apartment when I tried that, whatever, 1-800-TALK number because I was feeling suicidal. I just wanted to talk about it, and like, the damn number says TALK, but they sent police because I was thinking about things.
Pants, 35, F, outpatient: They’re like, “call these numbers if you see the signs of suicidality.” Yeah, please call these volunteers without any experience actually treating people with mental health problems. Then, when you talk about wanting die, they’ll wind up over their head and have to call the police on you – because that’s what they’re trained to do when they can’t help. And it’s like, how the hell can they tell if they’re helping from over the phone?

Outpatient participants expressed a feeling of marginalization within society, especially when discussing their mental health with people with no professional training in treating mental health conditions. A shared sense of mental health issues being perceived as potentially criminally deviant was expressed by discussing publicly available mental health resources such as crisis hotlines as gateways to unwanted police interaction. A sense of mental health crises constituting potentially illegal behavior was shared by all participants, even if not explicitly stated as above. If participants consider mental health crises to be seen as criminally deviant, perhaps they may fear their own mental health issues as also being seen as potentially deviant or criminal. This may be why they express solidarity with, understanding of, and sympathy for those who have been more severely marginalized for mental health issues within society.

**Group Therapy**

As mentioned above, five of my outpatient participants were gathered from a therapy group I attended at Northwestern Medical System Kishwaukee Behavioral Health Center. The specific type of group therapy I attended is known as dialectic behavioral therapy, or DBT. DBT is a modified form of cognitive behavioral therapy (CBT) typically conducted in a group setting and originally designed to treat “parasuicidal women with BPD (borderline personality disorder)” (Chapman 2006:61). It is also used to treat complex PTSD (post-traumatic stress disorder) caused by multiple or repeated exposure to traumatic events. DBT has further been
shown to help in the treatment of more common mental health issues such as depression, social anxiety, self-harm, substance abuse, and bipolar disorders (Chapman 2006:61).

Personally, I first went to DBT as an early teenager to help me cope with the problems my mother’s mental health issues caused in my personal life. I continue to go to DBT off and on as an adult because it generally helps me deal with issues related to everyday life. At this location, the group is typically majority women (one or two men occasionally will join), and the group has (in my experience) always been conducted by two women therapists (not always the same therapists).

The most prevailing common trait of everyone I met in group DBT is that they have experienced something they consider horrible or traumatic in their lives that they feel disconnects them from other people. No one seems proud of whatever behavior or conflict they disclose in group – in fact, they are generally ashamed of their behavior or their past. However, there is a great deal of acceptance of these unproud moments in DBT group, and others will openly relate to them and discuss how they have dealt with similar issues.

DBT group has the goal of fostering a sense of radical acceptance towards others and encouraging one to approach all their relationships outside of therapy with that same level of acceptance. However, group members often expressed a frustration with connecting to people who have not been in DBT (or mental health treatment in general) and they contrasted the comfort they feel with group members to neurotypicals’ inability to “understand” or “get it.” The inability to find others who understand their problems leads to perceived social isolation as illustrated below.

J, 22, M, outpatient and DBT group member: I would say the people that I know the most are the people from groups and stuff like that I’ve been to. I absolutely feel comfortable talking to them, they get it, and I try to be an open book for the most part when it comes
to mental health and stuff like that. Even with total strangers, but you know, that’s really hit or miss.

Lucy, 30, F, outpatient and DBT group member: Most people I know are, you know, very much still dealing with their shit like I am. And I feel that outside of group, like, I don’t know a lot of people who are, I don’t know, as understanding of that, or even get the point of therapy. But people from group know what it’s like to be there, and I don’t have to explain it, you know? But I still try, I guess.

Duck, 28, F, outpatient and DBT group member: It’s hard to find other people that have dealt with that kind of stuff [childhood sexual abuse], but they generally get it. It’s even harder to find like, neurotypicals that will just leave it as something that happened in the past, and understand that I’ll talk about it if I want to.

Amethyst, 34, outpatient and DBT group member: I have friends that are, like you know, quote-unquote “normal” or whatever asking very brutal stuff [about my childhood]. So, even just my, you know, normal friends from outside group sometimes cause flashbacks and crying – I mean, I get they don’t mean to, but they just don’t, can’t understand like people who’ve been in group can.

Group therapy outpatient participants seem to include themselves in a group separated from the rest of society by referring to other people without a history of mental health treatment as “strangers,” “normal people,” or “neurotypicals.” However, they are likely to express their own mental health circumstances in less clinical (and therefore less alienating) terms than they would be medically labelled – such as calling their trauma and mental health problems their “shit,” “issues,” and “stuff like that.”

Just as the above, non-DBT group outpatient participants included themselves in a community of the mentally ill that is vulnerable to marginalization, so did DBT group therapy participants see themselves as belonging to a different social community than those without mental health issues. They find others in “normal” society hard to make connections with and so choose to express a different social identity than “neurotypicals” express. This can be most easily seen in the normalized language use regarding their personal mental health conditions, along with the abnormalized language use regarding others who have not used mental health services.
Whether or not this has to do with literally belonging to a (treatment) group of people with mental health issues, it is hard to say. What is obvious, however, is a definite sense of feeling different or othered within society in general.

**Outpatients’ Descriptions of Mental Illness**

Mental illness was explained mostly in terms of anxiety and depression (with depression, anxiety, PTSD, and bipolar being the most listed “common mental illnesses.” When discussing mental illnesses, these latter and their symptoms were described as “stuff,” or “things going on in” one’s head.

**Pants, 35, F, outpatient:** So, you’re – you’re making poor decisions, you know? **Because you just can’t deal with, uh... what you have going on in your head.** You know, it’s like, it’s just easier to just drown it out.

**Narissa, 21, F, outpatient:** If there's **anything going on in their head** it could be because of something that happened in their life or just something that they’ve felt forever, or something that came on out of nowhere…

Often, the “stuff” and thoughts in one’s “head,” “brain,” or “mind” were considered adversaries, saboteurs, or at the very least, distractions.

**Duo, 28, M, outpatient:** It's difficult to balance having to function in the real world and **be fighting against your own mind.**

**Lucy, 30, F, outpatient:** […] **If you’re used to your brain beating you up,** it’s gonna seem normal until you’re too tired to get out of bed for a month […] I know what it’s like **to want your brain to just stop sabotaging everything.**

**Nestor, 33, M, outpatient:** [Anxiety and depression are like being] **very distracted by thoughts** on something in particular, and it could be you know like, something you do, or like something you did, or something you need, want, desire… but they’re definitely **negative thoughts.**

**Amethyst, 34, F, outpatient:** I would start **ruminating.** And then I’d feel bad and I’d tell myself to stop ruminating. And then I’d eventually wind up going back to the rumination. **I would be fighting it** all day.
While experiencing trauma was considered to lead to increased chances of developing a mental illness over one’s lifetime, the chemical or structural properties of the brain were directly explained to be what was responsible for mental illness. Brain structure and chemistry were believed to affect one’s mental health over time, and trauma was explained as the main factor in “changing,” “rewiring,” or “shaping” one’s brain structure or chemistry.

Shinji, 31, M, outpatient: Because of how our brain tries to cope with traumatic events and emotions that are brought out, it could maybe end up changing brain chemistry incorrectly to some extent so that you don’t lose those chemical changes or imbalances.

Lucy, 30, F, outpatient: There’s this weird thing that happens with PTSD where you just get like, rewired to evaluate every situation as a threat.

The most widely expressed explanation of what makes a mental health issue a problem requiring treatment was a chemical imbalance.

Zoescope, 35, F, outpatient: There are receptors in your brain, along with synapses – and some people’s brains don’t work quite right. Their brain receptors and synapses are off and they don’t get enough serotonin, or dopamine, or whatever brain chemical is causing the problem.

An external event was considered necessary to “trigger” a mental health disorder to which one may be predisposed due to a trauma-affected brain structure. Brain structure was explained as more negatively affected by trauma if the traumatic events were left unaddressed, or not “dealt with.”

Duo, 28, M, outpatient: Childhood trauma is ... maybe a little different, because your brain is so plastic that severe trauma can significantly shape the way that you develop. [...] So, an event in isolation in certain circumstances absolutely would be a trigger for mental illness. But there's nothing that, I don't think there's an event that absolutely would be the cause - it has to do with how we deal with that trauma.

Even when discussing mental health conditions directly linked to trauma (such as PTSD), it was explained that all trauma can have a detrimental effect upon an individual which may
present itself as symptoms of various other mental illnesses if left untreated, particularly if one experiences another traumatic event later on in life.

J, 22, M, outpatient: I think it’s definitely going through some sort of trauma. That can be part of it, or increase the likelihood of any of it [mental illness], or you know, there’s also – I believe you can be born with some predispositions, maybe, possibly. (In response to “What makes a person mentally ill?”)

Narissa, 21, F, outpatient: PTSD is something that is definitely triggered by something happening in your life, and I feel like that’s something - like I said, more people than they know are suffering from it. They might be diagnosed as depressed, but it’s like, did something happen to make them feel that depressed?

Shinji, 31, M, outpatient: I think things like that [trauma], they can help create a new brain chemistry. That’s the whole PTSD thing, to an extent. [...] That’s because of the stress of someone dying. It’s a traumatic event in the same sense that verbal abuse can hurt, physical abuse – just one experience can make someone have – like rape, one time is enough to have post-traumatic stress from rape. A lot of other things can be triggered later on.

Mental illness was further expressed as the result of mental events making one unable to “live their life like normal,” or an inability to deal with stress or life events “like normal,” or having a negative effect on one’s “well-being.” Stress and anxiety were discussed by outpatients as normal events within the human condition, with mental illness being dependent on how well one subjectively feels they can handle or “cope” with stressful or anxiety-provoking situations.

Lucy, 30, F, outpatient: I guess it’s dependent on how they handle stress and what kind of stress or anxiety and if it feels normal to them. (Answering: “How would someone know if they had a mental illness?”)

Narissa, 21, F, outpatient: I just think that if they feel bad enough that they want to die, or they feel bad enough that they can't live their life like normal - what's normal - but they can't go out and do normal things, like going to the grocery store without planning out how to get out of it, can't go out and socialize [then they may have mental illness].

Duck, 28, F, outpatient: You’d have to know that the anxiety or whatever was just reaching an irrational level -like, personally, and be discomforted by the changes and forces in your life to the extent it like, affects your well-being.
The presence of stress was also thought to alter brain chemistry in a similar manner to trauma (discussed above). However, stress was not discussed in detail by many outpatients separately from the concept of trauma. When stress was discussed, it was expressed to be something people should *not* always have to deal with, and something largely out of one’s control. Stress was seen (by the few outpatients who addressed it) as a product of society that we (members of society) are not taught how to deal with. Even when stress was discussed as a typical element of human existence, the presence of *overwhelming* levels of stress was attributed to our “culture,” “society,” or one’s “environment.”

*Shinji, 31, M, outpatient:* *Our culture is a very high stress culture,* and because of that – and by high stress, I mean *we get let less vacation days than most other developed nations. Things like that can add up,* and no one seems to care.

*Zoescope, 35, F, outpatient:* There can be a lot of triggers and stressors in an environment. Some places are easier to be. *Some environments are more conducive to mental health, and some seem more conducive to stress.*

*Razadem, 37, M, outpatient:* I think we just don’t have coping mechanisms and they get diagnosed as mental illnesses when *really, we’re just so overly stressed from society, the way life is, that we end up having these, like, conditions.*

**Treatment Providers**

As discussed in Chapter 3, “Field Site Description,” anyone working in the mental health sector can be called a “mental health treatment provider.” I focused my attention on people who have played a direct role in providing mental health treatment, such as psychiatrists and psychotherapists/counselors. Unlike most of the people with any mental illness in the USA, the treatment providers I interviewed all identified as White, with all but two being over the age of 49. Four of the treatment providers were women, three were men. Two of the men were
psychiatrists older than 60 (one 64, the other 77), and the other one was a social worker in his mid-50s.

Mental health treatment providers also expressed a feeling of otherness (particularly the LCSWs/therapists). All but one mental health treatment provider interviewed expressed being judged, labeled, or asked questions by family or friends for choosing to work in the mental health sector.

Kit, 55, M, LCSW: People think, you know, psychiatrists, social workers, psychologists, they’re associated as "those nut doctors" or those "crazy" doctors, you know, and I think everybody gets a bad rap.

Dna, 49, F, DCCMHB member: A lot of people don’t really care about mental health. They don’t. Until it affects you, you don’t really think about it. So, I have people [asking] like, “why are you working for something people don’t really care about that much?” except that, unless there’s those who care about it, who else is going to do it?

Pimento, 56, F, LCSW and APN: I have an aunt that’s an OB nurse that told my mom that if I went into psychiatric nursing that I would be crazy myself. Like, I would develop my own mental illness, I think that’s what she meant.

S, 35, F, LCSW: I get people who want to hear war stories, you know… Oh, and I was warned by one of my coworkers that when my oldest daughter got to school age, to not necessarily let teachers know what I do for a living – especially not the fact that I work with at-risk youth. Because they said that every time they signed up to help with a field trip, they got all the ‘at-risk,’ difficult kids.

Molly, 41, F, LCSW: My mom consistently judges me for going into mental healthcare because she doesn’t understand it. I don’t talk to her about my job because of that, because she just doesn’t get it. She thinks that people cause their own problems, and I think it’s a generational thing to some extent.

The psychiatrists, however, did not express having experienced quite as negative a judgment towards their career choices from people in their personal lives. One expressed judgment by other doctors; the other did not recall any such issues.

Dr. Melvin, 64, M, psychiatrist: Other doctors – when I was in residency, they were always trying to persuade me: "don’t waste your time in mental health or
psychiatry, or pediatrics,” that kind of thing. Mostly because they were trying to get me to go into their field like internal medicine, instead.

Dr. Tek, 77, M, psychiatrist: I haven't run into any real problems with that [feeling different or treated differently for working in mental healthcare]. I think it's more of a stigma for patients. I mean, at one time, you know, years ago there was uh, prejudice against the providers, but not by the time I got into it so much.

The level of judgment therapists felt was expressed more intensely than it was expressed by psychiatrists, maybe because psychiatrists are medical doctors, and being an MD is considered a respectable profession almost everywhere.

All four therapists I interviewed stated that they do not even like to tell strangers what they do for a living. This was for various reasons, including ethical and legal boundaries about discussing patients.

Molly, 41, F, LCSW: If they know I’m a therapist, they want to talk to me about their problems or get advice about someone they know, and it’s just not really appropriate for me to do that when I’m not here [in the practice]. So, I try not to do that. It does happen a lot. It happens enough that I try not to always say what I do for a living. But if I say I’m a social worker, then their default thought is that I must work for DCFS. Sometimes just saying I’m a social worker is better.

S, 35, F, LCSW: To be completely honest, it depends on the person I’m talking to on how I say what I do. People, I’ve learned, have varied reactions when I tell people I’m a therapist. You get some people who want to hear the “horror stories”, and you have some that like, freak out – like, “Oh my god, you’re psychoanalyzing me?!” So, depending on the situation or where I’m at I might say I’m a counselor, a social worker or a therapist.

Pimento, 56, F, LCSW and APN: Sometimes when I meet a new person and they ask ‘Oh, what do you do for a living?’ and I tell them I’m a therapist, they usually think I’m going to try to analyze them. So, I try to make a joke out of it like, "Oh, don’t worry, I'm off duty."

Kit, 55, M, LCSW: I really never discuss my work. I would never, ever... I don't even generally talk about clients. In fact, when my kids were young, they really never even knew what I did. Not until, you know much later, they all know I'm a social worker and a therapist - but they don't really know what I do because I don't talk about clients. It's just not okay, in my opinion.
Treatment providers’ desire to *not* discuss their profession was stated as mostly to assuage others’ potential fears of being “analyzed,” or to keep people from asking them to analyze others. Often, if they *do* tell others about their professions, they de-emphasize their involvement with mental health treatment.

Treatment providers discussed what mental illness was in mostly hereditary and biological terms, frequently echoing the outpatients’ views that while one may be *predisposed* to a mental illness, it takes an external event to “trigger” it. Unlike outpatients’ explanations of traumatic events as predisposing factors, however, treatment providers more often explained predispositions to mental illness through primarily biological concepts such as genetics and neurochemistry.

**Dr. Melvin, 64, M, psychiatrist:** *Something has to trigger it, there's genetics, there's brain tumors, there's all sorts of physical conditions that can cause craziness, or the appearance of craziness.* Is there one set cause for craziness? No, because there’s different kinds of crazy, right?

Providers typically cited schizophrenia first in a list of mental illnesses when discussing causation of mental illness, using its hereditary nature to contrast it with other mental illnesses (i.e.; anxiety or depression). When explained as a hereditary or biologically-caused mental illness, schizophrenia was used as an example of a disorder which needs little to no external “trigger.”

**Pimento, 56, F, LCSW and APN:** I feel it's always more than one factor. There's never just one thing - *maybe in the case of someone with schizophrenia, it's somewhat more genetic...* and I think some of the studies like, bear that kind of thing out, but *what you tend to inherit is a predisposition. What you don't necessarily inherit is the trigger that sets off that predisposition, so I think there's some environmental pieces of that.*

**Dna, 49, F, DCCMHB member:** Many different reasons someone could end up having a mental illness; *there’s lot of new research coming out that outlines actual physical changes in the brain if someone has schizophrenia or someone has bipolar disorder.*
They’re finding out that there’s differences in cells in the brain, things that are in DNA.

S, 35, F, LCSW: There are genetic components we find, too. Schizophrenia has a genetic component. Anxiety and depression have a genetic component, too. So, depending on those aspects, genetically, you may just have a predisposition to it, it doesn’t mean you’re gonna have it, but it means you’re more likely to.

The second most frequently cited causal factor for mental illness (after hereditary and biological factors) mentioned by treatment providers was one’s upbringing or childhood.

Dr. Tek, 77, M, Psychiatrist: Heredity and environment basically. I think there's more and more information on genetics and how that effects things and also, they do a lot of brain imaging and things like that now. But, there's also good studies that show that you know problems or abuse in childhood um... could cause brain changes later on. So, it's a combination of what people inherit what genes their parents have given them, plus what happens to them when they grow up. (answering: “What makes someone mentally ill?”)

Molly, 41, F, LCSW: Sometimes modeling [can cause a mental illness to come about]. I’d say some of the more personality stuff and some of the anxiety stuff can be modeling behaviors that are picked up at home.

What is interesting to note in treatment providers and outpatients is how they differed in their views of the role of trauma in mental illness. Outpatients viewed trauma as a predisposing factor for mental illness, whereas treatment providers explained it as a trigger, or causal factor, for mental illness. One treatment provider was hesitant to name any one causal factor over another, stating that there’s simply too much variation in people to name a predominant variable they might share – besides “stressors.”

Kit, 55, M, LCSW: It depends on the variables, it depends on the stressors, it depends on ... all the variables. It's so complicated. No easy answer. Every person who has problems is different.

However, this followed a pattern in treatment providers: External events considered to trigger mental illness in (biologically) predisposed individuals were generally referred to as “stressors,” or “stress.”
Dr. Tek, 77, M, psychiatrist: You know, *stresses of everyday life* - I mean, a person losing their job... I mean that can be a real *stress* for them, *certainly loss of a spouse or loved one* can go beyond *grief*, *can lead to depression*. Um... *Also, stresses can lead to alcoholism, drug use.* – Dr. Tek (answering “What makes someone mentally ill?”)

Dr. Melvin, 64, M, psychiatrist: *Nature, nurture,* and um, well *anything that can stress you can make you feel like you're mentally ill,* I would say. (Answering “What makes someone mentally ill?”)

Kit, 55, M, LCSW: *Someone who faces different stressors, depending on the stressor,* you know depending on the illness, you know - you look at again, again the factors of two people who go do the same job and one has a home life which is bad versus another who has a home life that’s great, and those factors affect if their job impacts mental health.

The concepts of stress and trauma were not always clearly differentiated by providers. Some said stress can come from trauma, some said that stress can cause trauma, and some said that simply the way one deals with trauma and/or stress could present itself as mental illness.

Dna, 49, F, DCCMHB member: When *you have trauma,* *your body comes up with a way to survive that trauma,* and *these stress reactions can often look like a mental health issue.*

Stress was occasionally stated to be a biological factor itself, with discussions of stress-induced models of inflammation used for explanation, to explain *symptoms* of mental illness such as feelings of depression and anxiety and effects on one’s “energy levels.”

Molly, 41, F, LCSW: *I think just living in that day to day constant stress,* I can see *that bringing on some depression, bringing on some anxiety.* We know that *when your body is constantly stressed,* *that you’re releasing more cortisol,* which is a *stress hormone,* it causes some issues. We know *that stress impacts our physical health.*

Pimento, 56, F, LCSW and APN: *I think just your stress levels,* I guess. Or if you’re doing something that you really don’t like doing, *I think that would affect things.*... One of the things that they have done some studies on are people that work rotating shifts or night shifts and stuff, that *it has some effect on your stress level - your cortisol levels and stuff,* which in general is not the greatest thing for you or your energy levels.
One provider even reported an anecdote explaining how stress can have visibly physical manifestations in areas other than the brain.

Kit, 55, M, LCSW: The dermatologist we had here would send me a client and say "the patient has a rash" and I'd be like "well that's more biological", and she'd say "no, it's stress-related, it's more psychological - the way I see it, so let me know what you think." So you know, she would give them a cream to help with the you know, substantive - the uh, rash, but eventually getting rid of the stress is what helped get rid of the rash.

The basic idea behind providers explaining stressors as causal factors in mental illness is to show that stress can cause all sorts of problems in the human brain and body. While the experience of stress is often discussed as psychological phenomena by laypeople, providers’ overwhelmingly biological explanations for (and examples of) stress’s effects on people suggest that perhaps treatment providers see stress more as a physiological phenomenon that can be expressed as both physically and mentally unwanted/unhealthy states.

Shared Discourses on Mental Illness

While outpatients and treatment providers did not express the same causal chain of events leading to mental illness in terms of trauma and brain chemistry, both groups did discuss the importance of each concept to understanding the causes of mental illness. This complex statement by Molly (a therapist) combines the explanatory model expressed by outpatients that “brain chemistry altered by trauma can predispose one to mental illness” with the providers’ expressed explanatory model that “childhood events and genetics can predispose one to mental illness”:

Molly, 41, F, LCSW: Chemistry… Just not having things firing the right way or whatever, not having enough of certain chemicals or too much of others. If somebody’s in a traumatic situation, it [chemical imbalances] can definitely develop as a response to that. Not that everyone who’s had trauma develops PTSD, but it’s
normally a thing that happens. **Individuals can develop personality disorders as a reaction to their childhood.** (Answering “What makes someone mentally ill?”)

This response most adequately mirrors outpatients’ responses to causes of mental illness because it explains that neurochemistry can be changed by *trauma*, not just “stress.” Considering this provider also explained chemical imbalances as caused by stress (see above), it appears that believing that stress can cause chemical imbalances is *not* mutually exclusive to believing that trauma can cause similar chemical imbalances or structural changes within the human brain.

What outpatients and treatment providers directly defined as mental illness was often was either indicated by, or included an inability to function in everyday life. Specifically cited as a barrier to everyday functions was one’s desire to “stay in bed” or their inability to “get out of bed.”

**Duck, 28, F, outpatient:** Like, *if you can’t get out of bed for a month, you might have depression* – that’s pretty well known.

**J, 22, M, outpatient:** There were days – Thank God, not anymore, *days that I would lay in bed and not get out.* I would wake up at like six or seven at night and I was like, “I haven’t done anything with my day, I’ve laid in bed, I haven’t moved, I haven’t eaten, I haven’t drank anything…” (Answering “How does mental illness physically feel?”)

**Lucy, 30, F, outpatient:** […] If you’re used to your brain beating you up, *it’s gonna seem normal until you’re too tired to get out of bed for a month.*

**Narissa, 21, F, outpatient:** Maybe when you're depressed and it's like, “Yes I'm going to stay in bed forever and that's where I wanna be and I'll never have to deal with people again and it'll be awesome.” […] Then you might need to talk to someone or get some help. (answering “How would someone know if they had a mental illness?”)

**Kit, 55, M, LCSW:** *Someone with severe depression can't get out of bed,* versus someone with mild depression who wakes up and get out of bed, but they really feel lethargic. (Answering “How does mental illness physically feel?”)

**S, 35, F, LCSW:** I think you have the symptoms that impact you – like physically, when you’re feeling exhausted like *with depression, it’s gonna be extremely hard for you to get out of bed.*
Dr. Tek, 77, M, psychiatrist: They can become irritable angry nasty or withdrawn, just stay at home and in bed all the time, you know? (answering “Can mental illness disrupt social relationships?”)

Dna, 49, F, DCMMHB member: So mental illness is ‘okay you have depression’ and it starts to affect all the qualities of life – you can’t get out of bed, you can’t eat, you can’t stop crying, you can’t think about anything but your own depression. (answering “What makes a person mentally ill?”)

A similar thought expressed as a hindrance to everyday functioning was feeling “really tired” or wanting to “sleep all the time” as potential signs of mental health issues – again, particularly depression.

Molly, 41, F, LCSW: It was pretty depressing when it was going on, I say depressing because you feel really tired, like sleeping all the time, lack of motivation.

Pants, 35, F, outpatient: You know, like, before I even had access to drinking, I was shoving food in my face for depression. If it wasn’t nailed down, I’d eat it. Yeah, all I could do was basically eat, sleep, and pee.

Along with the concept of sleeping too much or staying in bed as a sign of mental illness, the contradictory symptom of difficulty sleeping was cited as another factor indicating potential mental health issues:

Amethyst, 34, F, Outpatient: I think my depression is getting worse – I just got to the point where I’m drinking myself to sleep because my sleep problems are that bad.

Another similarity between outpatient participants and treatment providers’ discourses on mental illness is that all respondents initially claimed people with mental illness “look just like everybody else” and “sound just like anyone else” and that they would not be able to tell if someone had a mental illness without their disclosure. But when pressured further with more questions about how people with mental illness sound or look, the same patterns of traits appeared in both groups’ (outpatients and treatment providers) responses. These traits were
explained as differences in speed of behavior and speech (i.e., depression means “slow,” anxious or manic means “fast”), “energies,” “patterns,” and specific types of body and verbal language.

While both treatment providers and outpatients initially insisted one cannot tell a person has a mental illness by how they talk or look, providers then proceeded to give examples of when one can tell a person has a mental illness based on certain illnesses’ symptomologies (most often, depression).

Molly, 41, F, LCSW: If somebody is depressed, they may talk a little slower. Someone with depression just may not feel energetic enough to really talk, someone with anxiety may talk too fast. Somebody who’s manic may talk too fast – but I mean… if you just generalize looking at ‘how does a person with mental illness talk’ I’d say just like anyone else.

Pimento, 56, F, LCSW: Like, if your depression is severe enough that it’s gotten to that point [that you need medication], like, people have slow psychomotor skills when they’re depressed a lot of times, and that usually gets better.

Dr. Tek, 77, M, psychiatrist: There are certain symptoms that you look for so you can make the diagnoses - people that are more muted or talk extremely quiet, people whose affect is blunted can be very depressed. So, I mean there's symptoms of the disorders that people have, but in general you can't say "people that are mentally ill talk this way."

S, 35, F, LCSW: I think you can say “how do particular diagnoses symptom-wise appear,” I don’t like that question. I think with certain diagnoses and certain conditions, there are themes typically that you’re gonna see. Someone with depression, you’re gonna notice their body weight seems a little heavier, and they’re gonna move slower because of the depression. (answering “How does a person with mental illness look?”)

Outpatients also stated that people with mental illness look like anyone else and then proceeded to list social cues that would perhaps indicate to someone that another was dealing with a mental health issue. The difference between outpatients’ and providers’ examples was that providers linked the traits they listed to specific illnesses’ symptomologies, whereas outpatients generally did not attempt to link the traits to any specific mental illnesses’ symptoms, but instead tended to
link the behaviors to emotions or thought processes (things going on in their “minds” or “heads”).

Zoescope, 35, F, outpatient: Fidgeting could probably be seen as anxious – like shaking your leg, or tapping your foot. And that’s normal, but if someone’s constantly moving around, that just seems like you’re very uncomfortable and probably freaking out on the inside.

Razadem, 37, M, outpatient: I mean, it [anxiety] can manifest itself as just like, “they seem antisocial” but really they just have a bunch of anxieties in their head, or some other internal thing, that you can’t really presume. So, once again, you’d have to like, talk to the person.

Amethyst, 34, F, outpatient: Generally like, lack of eye contact, withdrawing from the group – if you have a cluster of people, not really standing in that cluster of people.

J, 22, M, outpatient: You kinda see it in patterns of behavior. Just like a huge lack of confidence has been a pattern in some of those people that I work with. […] I’m trying to figure out how to phrase this correctly. The patterns of behavior I would say, is definitely what leads me to suspect you know, something might be going on.

Duck, 28, F, outpatient: Well, I mean, they can look like everyone else, but there might be some patterns or something one could like pick up on, I think. Like if I see someone by themselves or like as a part of a group but still not sitting with that group, like, maybe a little bit further away than everyone else to the center of the conversation – I mean, I generally interpret that kind of stand-offish energy to people dealing with their own stuff in their minds.

Both outpatients and providers said they would be able to tell if someone had been in treatment for mental health issues through their verbal language use – notably, if concepts and terminology from treatment were incorporated into their everyday speech. Some outpatients did not know how to explain the type of language use they were referencing, stating it was just something they could “tell.”

Duck, 28, F, outpatient: Therapy gives you like, a way to talk about your emotions, because that is what the problem is usually, you have emotions about unresolved something that needs to be addressed. It gives you a way of explaining things that uh, ‘normal’ people just don’t do. I don’t even know how to explain it.
Duo, 28, M, outpatient: Part of the fact of treatment is you know, sort of learning a certain vocabulary and language around like, mental health and treatment and recovery. So, you know, being able to sort of verbalize things and then talk about things, and have concepts for emotions and you know, coping mechanisms, because that’s part of I think, how you internalize the treatment.

Nestor, 33, M, outpatient: It’s something you can tell, but not like straight off the bat, but with certain verbal things that I can’t think of specific examples of… just but yeah, and maybe the way they talk about certain things. They use those terms… that you learn in counseling and therapy groups, etcetera. Just the way of expressing emotions. I don’t even – I can’t even think of one off the top of my head right now.

The majority of outpatient participants stated they “can just tell” if someone has been in treatment or has a mental health problem from the language they use about emotions. Only one treatment provider (S, 35, F, therapist) mentioned this as a unique way that people with mental illness may speak, but all treatment providers discussed ways that people may speak after receiving treatment. Generally, a better/more effective way of expressing emotions and thoughts was considered to be indicative of mental health by treatment providers. Outpatient Duo (28, M) mentioned that using the emotional vocabulary learned in therapy can be considered a way of internalizing one’s treatment, and this may be why outpatients were so confused or unable to exactly describe the types of speech patterns and language use they said would tip them off to another’s mental health status.

Discussion: Providers’ and Outpatients’ Cultural Models of Mental Illness

Outpatients fear being seen as deviant or criminal when discussing their problems outside of treatment settings. Outpatients expressed feeling stigmatized and judged by others, which prevents them from making connections with people, particularly those they consider to be neurotypicals. Group therapy and other outpatient participants expressed having had a hard time making neurotypical friends because they feel they cannot be as open with them as they can with
other group members and their neuroatypical friends. These results dovetail with my suggestion in Chapter 1, “Theoretical Position,” that people with mental illnesses have difficulty accessing the interiority of “mentally healthy” individuals. If individuals with mental health issues have shared difficulties relating to and understanding neurotypicals, it helps support the suggestion they hold a different cultural model of mental illness than those without any experience of mental health problems.

I found that not only do outpatients feel significantly othered among neurotypicals but also that treatment providers feel othered in general society. Providers often gloss over what they do for a living in discussions with non-providers. Unlike DBT group outpatients’ feelings of shame regarding life events and the potential stigma of disclosing one’s mental health status, providers do not feel ashamed of their jobs. All mental health treatment providers interviewed emphatically expressed enjoying their work and having a genuine desire to help people. But this professional contentment does not shield them from the judgment they feel from others who do not necessarily know the boundaries of what mental health professionals can and cannot discuss.

In order to avoid awkward and potentially unethical situations, treatment providers may omit information about their careers or simply choose not to disclose their profession. This is similar to how outpatient participants expressed choosing to disclose their mental health issues with others based on their audience’s experiences with mental illness. I argue a shared feeling of difference and abnormality in the view of society at large helps explain linguistically instantiated similarities between mental health treatment providers’ cultural models of mental illness and the cultural models of mental illness held by outpatients.

These results illustrate differences and similarities between people with mental health issues and those who treat them. As discussed earlier, it seems unlikely that the cultural models
held by mental health treatment providers would not be shared with or instilled in their clients and patients. I have argued that people with mental illness constitute their own subculture, but I failed to consider that this subculture may include mental health treatment providers. Further evidence that mental health treatment providers and outpatients may be members of the same subculture was shown in outpatients’ expressions of being able to tell if a person has mental health issues from the use of language learned in treatment settings (taught by treatment providers).

Similarities in cultural models of mental illness between outpatients and providers include a core concept of “not getting out of bed” as a symptom of mental illness and the utilization of language used in therapy/effective ways of expressing emotions as a sign of having been in treatment or having a mental health issue. The social cues of withdrawing from a group, having a monotonous voice, not wanting to make friends, fidgeting, etc., were used by outpatients as ways of describing persons with possible mental health conditions in everyday settings. The settings and behaviors used to describe those with mental illness by treatment providers held a more clinical or treatment-oriented context. This could be because treatment providers work in treatment settings and outpatients work in and inhabit the world outside of treatment settings.

Outpatients largely described mental illness as something “going on” in their (or someone else’s) head or mind. For outpatients, traumatic life experiences were believed to predispose one to mental illness (which was “triggered” by some sort of event or emotion). Outpatients explained trauma as capable of significantly changing brain structure and chemistry, resulting in a predisposition to mental health problems that can be triggered later on in life. For outpatients, mental illness means being unable to function in daily life as “normal,” due to the things or
thoughts inside one’s mind. For providers, mental illness is considered to be largely the same problem, but with different predisposing factors and causal triggers.

Providers explained genetics and neurochemistry as predisposing factors to mental illness and gave the example of trauma or “stress” as the triggering event that would actually make one have a mental illness. Neither group is incorrect; trauma, stress, and mental illness are known to have a very strong relationship, but whether mental illness predisposes one to be more sensitive to stress and trauma or a life of stress and trauma predisposes one to have mental illness is a topic of popular psychological investigation. The relationship between the two (mental illness and trauma) may be well known, but the direction of this relationship in terms of causation is not as well known or documented.

While there were differences in causal explanations of mental illness for providers and outpatients, it seems both ideas of causation could belong to the same cultural model of mental illness. Mental illness was expressed by all participants as something that is both biologically instantiated and environmentally/socially influenced. Not even the medical doctors (psychiatrists) gave only biomedical explanations of mental illness, suggesting that mental illness is not seen by this sample as a strictly biomedical experience nor a condition that can only be treated by medicine. This raises issues with looking for a biomedical model of mental illness – even the medical professionals’ models of mental illness were not strictly biomedical.

While emphasis is placed on stress in explanations given by mental health treatment providers, stress does not play a similar role in outpatients’ explanations. I am inclined to believe stress was not mentioned by outpatients as much because they do not seem to know of the stress-induced model of inflammation. In fact, I was surprised to find providers so readily offering this explanation for the problems of stress (as it related to depression and mental illness); the
relationship between elevated cortisol levels and illness behaviors (that tend to look like symptoms of mental illness) has only very recently been discovered and accepted as part of medical knowledge (see Slavich and Irwin, 2014).

Even though the social transduction theory of stress and inflammation is not knowledge outpatients were perhaps privy to, they nevertheless understood the relationship between psychological duress and neurochemicals. These espoused beliefs in the neurochemical and neurological instantiation of mental illness are exactly what doctors and therapists explain as causes and signs of mental illness. This supports my hypothesis that outpatients and providers, while holding different cultural models of mental illness, may share a large amount of their content. This knowledge is likely shared between patients and their therapists due to the socially and epistemically hierarchical nature of their relationship (i.e., you are mentally ill because of the reasons your therapist or doctor says you are mentally ill).
CHAPTER 5
RESULTS OF METAPHOR ANALYSIS

Types of Metaphors

It is argued that human understanding is expressed through conceptual metaphors that are anchored by bodily experiences shared by all humans (Lakoff and Johnson, 1980:6). Conceptual metaphors are based in general motor acts of the human body, “rooted in affectively charged motivational schemas” which are further understood through cultural norms and social interactions (Kirmayer, 1992:337). In addition to constituting aspects of conventional discourses, conceptual metaphors are linguistically instantiated aspects of cultural models regarding a specific topic. Metaphorical language use is important for investigating illness experiences because the ill person may have to explain their sickness to someone with no firsthand experience of it, particularly in medical settings. Therefore, it is helpful to analyze the metaphors used by participants to gain knowledge of their cultural models of mental illness.

Conceptual metaphors work by allowing us to understand one thing in terms of another. In this sense, conceptual metaphors are mental shortcuts for communication and thought. It is very hard to explain our internal mental states to others, so we often employ linguistic examples of physical objects to explain or communicate immaterial concepts. Ontologically speaking, this means we use physical objects (such as our bodies) and states (such as positions or locations of objects) to explain aspects of human existence for which we have no other means of description.
Again, a conventional discourse is “an oft-repeated, shared schema,” and one may wonder how schemas are shared so as to compose discourses (Strauss, 2012:15). Schemas are shared linguistically through the repeated use of metaphors. Strauss and Quinn argue that metaphors serve as tools of clarification for nonmetaphorical concepts precisely because they draw from knowledge domains that are widely accepted to be exemplars of human experience (1997:145). For the purpose of ontological conceptual metaphors, the human body is considered to be an exemplar of human experience. How we interpret and express aspects of having a human body is largely affected by our culture or society, and so in order to effectively communicate, we use metaphors that are intersubjectively shared and understood by members of our society (Strauss and Quinn, 1997:150).

Cultural models are mental representations that are shared between members of a culture that inform their communicative and behavioral interactions with other people (Bennardo and DeMunck, 2014:5). If a conventional discourse is an oft-repeated and shared mental representation (schema), then a cultural model is the underlying structure of knowledge or experience that is experientially shared between speakers. Metaphors in speech are linguistic instantiations of how one perceives and explains internal states that are necessarily governed by shared, cultural norms of what is understood. Therefore, metaphor usage indicates the existence of an underlying cultural model that helps us understand which metaphors will be understood by others.

Adopting the position that the main metaphor of medicine is “the body as biochemical machine,” I argue that complying with medical professional health treatment necessarily means accepting the metaphor of the patient as an owner of a “body machine” that one takes to health professionals for repairs (Kirmayer, 1988:59). In medical and mental health treatment, patients
are only understood to be rational or sane if they accept and follow the orders of health professionals. This requires patients to conceptually commit to the notion that if something seems wrong with their bodies, they need to see a health professional for “repairs.”

Current biological and medical understanding explains mental activity as a property of the human nervous system, requiring the notion of the body as a biochemical machine to be extended to problems of the mind (Kirmayer, 1988:57). Considering the human nervous system is contained within the human body, people experiencing problems with mental activities are thus expected to take their body-machines to a health professional for repairs as much as people with bodily ailments and problems.

I suggested that both outpatients and treatment providers would express an understanding of the body as a biochemical machine. I believe outpatients have access to the concept of the body as a biochemical machine due to their interactions with treatment providers and the necessity of adopting this metaphor for the body as part of psychiatric and psychotherapeutic treatment. I further suggested that treatment providers would also use the metaphor of body as a biochemical machine simply because it is the dominant concept in Western/US American medicine. Biomedical explanations and terminology used by outpatients and treatment providers were taken to be representative of this understanding during the following textual analysis.

In Chapter 3, “Methodology,” I hypothesized that, as part of their shared cultural model of mental illness, outpatients would use bodily metaphors when discussing their experiences with mental health issues. Outpatients would express bodily metaphors because they have had more immediate and personal experiences with mental health issues than treatment providers. I argued that bodily metaphors would be used by outpatients because it is outpatients who take themselves (their bodies) in for repairs and therapies, not treatment providers. To investigate these
hypotheses, I looked at the use of bodily metaphors in transcripts to find any differences between the outpatient and the treatment provider populations.

I analyzed interview transcripts for metaphors using the *Master Metaphor List* (1991) by George Lakoff, Jane Espenson, and Alan Schwartz. Segments of speech were coded in MaxQDA as specific metaphors, themselves representative of categories such as event structures, mental states, and emotions (Lakoff, Espenson, and Schwartz, 1991:2). I read through transcripts to see if statements were representations of *any* metaphor on the list. It should be noted that the subjective nature of this method of analysis may have been influenced by my own cultural models and biases; I decided whose and which statements were metaphors and which metaphors they were. However, since I fit my own criteria for inclusion in my sample population of outpatients, I believe this approach is still sufficiently emic in nature as opposed to biased.

**Body as a Biochemical Machine**

I found that both outpatients and treatment providers heavily relied on a metaphorical understanding of the body as a biochemical machine insofar as the mind was considered an entity to be treated by health professionals. All participants stated that a person requires evaluation by a mental health professional to know if they have a mental illness. I found further evidence of understanding the body as a type of biochemical machine in need of external repairs in discussions of medication, prior treatment, and investigating what participants thought made individuals mentally ill. Even individuals who expressed skepticism with mental health services also expressed a belief that mental health professionals are needed to evaluate whether a person needs treatment (and is therefore mentally ill).
Zoescope, 35, F, outpatient: I have problems with psychiatry but there are trained professionals who have a better sense of what may or may not merit medication. There are sometimes when people are just an immediate danger to themselves and others and [they] need to be medicated or hospitalized because there’s an imminent threat.

This is indicative of a belief that health lies in taking oneself to medical professionals to determine if they need repairs and submitting to treatment plans. The authority given to mental health professionals by outpatients includes the power to define what is and is not mental illness, to define what requires treatment, and gives them the power to involuntarily compel people to behave according to these definitions (under certain circumstances).

Further ways of understanding the body as a biochemical machine included reference to the Diagnostic and Statistical Manual, which clinicians use as a guide to make psychiatric and psychological diagnoses. Even the phrasing of this guide as a “manual” is reminiscent of machinery – mechanics use manuals to repair things.

Nestor, 33, M, Outpatient: If someone is mentally ill, to me, it sort of means they meet a set of diagnostic criteria set by some groups of standards that are set up by, you know, psychologists. And whether they have been diagnosed or not, if they meet these criteria or enough of them, that I kinda agree with the general DSM [Diagnostic and Statistical Manual] guidelines on psychological, psychiatric stuff.

Other language used by outpatients that indicates the conceptual metaphor of the body as a biochemical machine involves discussing specific chemicals (such as serotonin) and biological factors (such as genetics and brain structure) in mental illness causation and instantiation.

Pants, 35, F, Outpatient: You know, if you already have an unbalanced brain as it is… like it’s adapted so far into this type of deal, you know, like, my brain doesn’t work that way, […] my brain isn’t at those levels of serotonin and if you put it at those levels, it may not have the same effect as it does on neurotypicals.

This expresses both an uncertainty in psychiatric concepts regarding levels of certain chemicals (e.g., lack of serotonin is responsible for depression) but also a belief in the psychological concept that brain chemistry adapts and changes to make up for differences in levels of certain
neurochemicals, depending on one’s experiences. This view of neurochemistry was also espoused by mental health treatment providers.

**Molly, 41, F, LCSW:** I think brain chemistry can cause it [mental illness] to some extent, um, exposure to – experiences, exposure to trauma, reactions to trauma, you adapt to that. Um, sometimes modeling, too, can all affect the, um, brain’s levels of certain chemicals and we see it in some disorders – not in all of them [disorders], but enough to have *some* idea.

Other language illustrative of the metaphor of the body as a biochemical machine included discussions of how certain kinds of treatment can change the biological functioning of one’s brain. Biomedical statements by outpatients expressed acceptance of biomedical models and explanations of mental illness. These concepts were not just expressed by outpatients as being held by the medical establishment at large; they were also expressed by mental health treatment providers. Both outpatients and treatment providers expressed that the way to help someone with mental illness involved taking oneself into a treatment environment to fix issues caused by one’s brain structure.

I found that regardless of profession or mental health diagnoses, outpatients and providers generally considered medication to be less effective than therapy for helping with mental health issues (insofar as help involved changes in one’s brain structure). Many suggested therapy specifically as a way to change one’s brain structure.

**Melvin, 64, M, psychiatrist:** CBT [cognitive behavioral therapy] can actually change the brain structure. The opposite of CBT would be a negative coping strategy that can alter the brain in a negative way. Like if you’re repeating negative thoughts to yourself, if it’s correctable with CBT - the whole basis is correcting self-myths, things you learned as a kid growing up about yourself and messages you’ve given yourself that they’re altering your brain in a negative way, whereas CBT teaches you to reframe things and to make different messages.

I took expressions of support for CBT (cognitive behavioral therapy) as examples of how the “body as biochemical machine” metaphor requires one to believe that compliance with suggested
treatment is necessary to improve one’s condition. This is because CBT requires the individual seeking treatment to make many minor changes in their own life, including changes to how they think. The individual is then seen as responsible for their condition based on how successfully they have incorporated into their everyday life behaviors suggested to them in therapy.

Razadem, 37, M, Outpatient: Unless you’re in like, cognitive therapy, medication might not always be what you need. CBT actually changes your brain structure, so you stop these negative myths, and you gain control back over your mind rather than your subconscious sort of feeding you things based sorta, like, on past experiences.

While the emphasis is on the individual taking control over one’s own thoughts and mind, one needs to see a mental health professional on a regular basis to engage in CBT, further necessitating the process of taking oneself in for repairs. Therapy was overwhelmingly seen as a more effective way to change brain structure and alter neurochemicals than medication, suggesting that methods of treatment with higher levels of interaction between treatment provider and outpatient are more helpful for mental illness.

Conceptual Metaphors

People in general heavily employ conceptual metaphors in speech, but I found that neither group in my sample (outpatients nor treatment providers) used many conceptual metaphors. Again, a conceptual metaphor is when one cognitive domain is used to describe a different cognitive domain. Conceptual metaphors occur when information (both content and relation) is “transformed from the physical to a non-physical, mental, domain” (Wassman, et al., 2011:53). Ontological conceptual metaphors allow us to understand our experiences and emotions (states of being) in terms of physical objects and substances (Lakoff and Johnson, 1980:25). This is a mental shortcut that makes it easier for us (as humans) to conceptualize and
express aspects of human states as being discrete entities or subjects to be examined (Lakoff and Johnson, 1980:25). The metaphor “the body is a container” is a classic example – we might say that we are “filled with rage” or “filled with despair,” but one’s body is not actually being occupied (or “filled”) by physical “rage” or “despair.” We say we are “filled” with a given emotion when we are experiencing the mental state that accompanies said emotion. Speaking of our bodies as containers allows us to verbally express (and conceptually grapple with) otherwise inexpressible internal states.

While outpatients did, overall, used far more metaphors (465 coded segments of speech labeled as metaphors) than treatment providers (184 coded segments), participants in both groups often combined multiple metaphors. This resulted in some statements being counted as up to four different metaphors. The greater use of metaphors by outpatient participants than treatment providers supports my suggestion that outpatients are often forced to use metaphors because there is simply no other way to communicate their internal states. I had thought that the abstract and internal nature of topics regarding mental illness would necessitate a good deal of metaphorical language use.

Within the metaphorical language I analyzed, I will briefly discuss here the most often used conceptual metaphors I found across the transcripts, including: “psychological forces are physical forces” (specifically “support” and “pressure”), “ideas are objects,” “states are locations,” “good is up/bad is down,” and “the mind is a body” (expressed through the metaphors “the mind is a fighter” and “the mind is a container for objects”; Lakoff, Espenson, and Schwartz, 1991).
Psychological Forces Are Physical Forces

Shared bodily experience constitutes the cognitive basis for conceptual metaphors. Ontological conceptual metaphors for entities and substances are based on our physical experiences of encountering objects and substances, allowing us to identify, categorize, and express our internal experiences as discrete objects (Lakoff and Johnson, 1980: 25). This allows us to readily discuss otherwise hard to describe mental events in language based on body part relationships, physicality and movement, and the shared understanding we have of them (Lakoff and Johnson, 1980:28).

The ontological conceptual metaphor I found most commonly used by both groups for mental events is “psychological forces are physical forces” (Lakoff, Espenson, and Schwartz, 1991:131). This metaphor expresses psychological activities as having the same properties as physical forces. For example, one can be said to engage in the physical process of exertion when using the psychological force of “influence” (Lakoff, Espenson, and Schwartz, 1991:131). We often speak of how one can exert their influence upon others. This metaphor shows that we often express the use of psychological activities the same as we express the use of physical forces.

The metaphor “psychological forces are physical forces” was expressed 113 times in my interview transcripts – 73 times by outpatients and 40 times by treatment providers, equaling 17.41% of all metaphor use. These expressions are not usually recognized as metaphors. For example:

Amethyst, 34, F. outpatient: I think social and emotional support plays a huge role in the how mentally healthy the more privileged are, and how mentally healthy people are in general.
The psychological force here is emotional support, but “support” itself is a physical force. We support something when we help hold it up (a physical act understood through bodily motion and orientation). The same idea of supporting a physical object by helping hold it up is at play with the concept of emotional support, too. By helping “support” or “hold up” a person emotionally, we give that person better chances of mental health.

Molly, 41, F, LCSW: If a partner’s not supportive of the one who is going through treatment, I think that that’s that can cause a problem. Because when you’re going through treatment, you need that support. It’s really helpful to have a good support system.

Here, again, we see expression of the psychological force of “support” expressed as physical force to be used by others to help with one’s mental health.

“Support” was the most commonly used example of the metaphor “psychological forces are physical forces.” “Support” was mentioned 26 times in interview transcripts (11 times by treatment providers and 15 by outpatients), usually in the context of a “support network” (24 times): friends and family present in one’s life to “support” their decisions (psychologically holding one’s choices up or preventing them from being pulled down), which ultimately is seen as helping one make mentally healthy life choices.

“Pressure” was the second most common example of the ontological conceptual metaphor “psychological forces are physical forces.” Both outpatients and treatment providers mentioned “pressure” as a psychological force expressed as a physical force. “Pressure” understood as a psychological activity expressed as a physical force was found 16 times in transcripts (nine times by outpatients, seven by treatment providers), always in reference to social or environmental expectations that negatively affect a person’s mental health.

Zoescope, 35, F, outpatient: There’s enormous pressure on us to succeed. Many external pressures are placed upon people regarding who to be and what to do.
Note that no one is literally physically applying pressure on people to do and be certain things; there is no actual physical force to this kind of “pressure.” When she says “pressure,” she is referring to psychological phenomena: stress and worries about how one chooses to live one’s life in relation to how other people think one’s life should be lived. Discussing how one’s job may be detrimental to one’s mental health, the concept of “pressure” was used in a similar manner.

Melvin, 64, M, psychiatrist: I think the more pressure-packed it [your job] is, the more exposure to trauma that you see, the more social um, appraisal of what you do for example... psychological, social and stress level... the more it’ll affect your mental health poorly.

Again, no one is physically “packing” pressure into certain professions. “Pressure-packed” here refers to careers which require many duties and responsibilities likely to put an individual under a good deal of psychological stress.

Ideas Are Objects

The second most common ontological conceptual metaphor used by participants was “ideas are objects” (Lakoff, Espenson, and Schwartz, 1991: 94). To reiterate, an ontological conceptual metaphor is a metaphor based on shared aspects of human experience and embodiment. I found this conceptual metaphor used 44 times in transcripts (33 times by outpatients, 11 times by treatment providers). “Ideas are objects” was expanded to include thoughts as ideas (and thus as objects) when the term “thought” was being used to refer to mental actions being described in a physical manner.

Razadem, 37, M, outpatient: We don’t pay attention to all these thoughts that are like crossing our mind, or like, where they come from.
Here, thoughts are referred to as things that can “cross” our mind but “come from” somewhere else. This is also an example of the special subcase of ideas as objects: “ideas are moving objects” (Lakoff, Espenson, and Schwartz, 1991:96). This is because Razadem is discussing thoughts as coming from somewhere and crossing “our mind” (like physically crossing a path).

Another statement that also exemplifies ideas as objects and expresses ideas as moving objects was given.

S, 35, F, LCSW: Instead of being like, "I just can't sleep," they'll [patients will] be like, "My thoughts were racing last night," because “racing thoughts” is you know, a symptom.

Here, ideas as objects are expressed as “racing thoughts.” This refers to the mental and emotional experience when one’s mind will not focus on only one idea but focuses on many ideas in quick succession. “Racing thoughts” are generally negative thoughts about oneself or one’s worries about the future, and it is their movement of racing (through one’s mind) that makes the thoughts particularly distressing and symptomatic of anxiety (both the emotion and the disorder).

When Lucy (30, F, outpatient) talked of being in treatment for anxiety, she said, “The thoughts can still race but maybe they're harder to follow.” Lucy is not saying that her thoughts or ideas are physically moving nor that she is physically moving after them. She is saying that even with treatment, anxious thoughts are still present and may “race” in her mind. However, with treatment she finds the thoughts are harder to “follow,” meaning they are less distressing to her because she does not feel the need to give these thoughts as much psychological attention as they previously demanded.
The ontological conceptual metaphor “states are locations” is expressed in event-structure metaphors referring to a person’s or thing’s location in, at, or near a certain state of being (Lakoff, Espenson, and Schwartz, 1991:8). This conceptual metaphor was employed 40 times by participants: 27 times by outpatients and 13 by treatment providers. The concept of being emotionally and mentally healthy was often expressed as being in a certain place.

J, 22, M, Outpatient: You know if you’re trying to date someone who isn’t in a good place in their life you’re gonna have some problems.

J means that if one tries to date someone who is not emotionally/mentally healthy, there will likely be some problems in the relationship. “Being in a good place” was often used to refer to being mentally healthy, or at least at a point where they can handle life’s stresses without resorting to harmful thoughts and accompanying behaviors.

Narissa, 21, F, Outpatient: Like, you see yourself doing things or saying things that are like, you that like, if you were in a good state of mind, you wouldn’t be saying or doing those things.

This example is particularly illustrative. We (in English) outright say a person has (or is in) a specific “state of mind,” this is obviously a metaphoric understanding of mental activities. Nevertheless, if one is said to be in a specific state, then that state is a location. Therefore, if one is in “a good state of mind;” then they are in a metaphorical location that is “good” for their “mind.” In Narissa’s case the location is defined by a) being mentally located, and b) being a set of mental activities leading to the absence of specific behaviors.

At other times, the concept of states as locations arose out of not knowing where to delineate mental illness from regular human behaviors. Outpatients spoke of there being an invisible demarcation between mental illness and not mental illness, but they also said they
didn’t know where it was. This was not brought up by any providers, but six outpatients used the metaphor.

**Zoescope, 35, F, Outpatient:** If there wasn’t such a harsh line between like, sane people and crazy people, those who felt like they could use help might be more inclined to seek it.

Again, no one is drawing physical boundaries between sane and crazy people; these are metaphorical and conceptual lines based in shared cultural assumptions about what is considered “sane” and “crazy” in the context of two people in mental health treatment. Unfortunately, this kind of divisive language use can indicate a feeling of disconnection from “sane” people, depending on how one views the term “crazy.”

**Good Is Up/Bad Is Down**

I found the usage of the ontological metaphor of states as locations overlapped with the orientational metaphor “good is up/bad is down” (Lakoff and Johnson, 1980:16-17). Good is up/bad is down was used 26 times by participants, 13 times each by outpatients and treatment providers. Orientational metaphors, according to Lakoff and Johnson, give concepts spatial orientations, generally based on bodily experience of spatial orientation (1980:14). This is for ease of communication and thinking. Many orientational metaphors are based in social understandings (Lakoff and Johnson, 1980:16). For example, in English we often might say we are feeling “up” if we feel good, and we may say we are feeling “down” if we feel bad (Lakoff and Johnson, 1980:16). This is apparent in an explanation of rumination given by this participant:

**Razadem, 37, M, Outpatient:** You have these shitty thoughts that cycle over and over, so you start beating yourself up and that brings you to like, this super low state.
In this example, mental states are locations one can be “brought to” from ideas as moving objects (“thoughts that cycle over and over”) that cause one to mentally berate oneself (“beating up” is not a location in this statement) which takes one to a poor emotional or mental state (represented as “low”). Going or getting somewhere low involves a downward motion. This metaphor was employed by six outpatients to describe mental states, but only by one mental health treatment provider used it to describe a mental or emotional state.

Kit, 55, M, LCSW: Physically - they feel shame, and then go into self-loathing and then they physically feel depressed and down because they're different.

Kit’s description does not explain “down” as a location, however. Instead, it is a physical feeling. Nevertheless, it is contextually obvious that he uses the word “down” as a negative descriptor.

The Mind Is a Body: The Mind Is a Fighter and the Mind Is a Container for Objects

Under the overarching conceptual metaphor of “the mind as a body” are two other more specific metaphors for the mind: “the mind as a fighter,” and “the mind as a container for objects” (Lakoff, Espenson, and Schwartz, 1991:94). The mind as a fighter was the third most often-employed conceptual metaphor by my participants, with 34 coded segments (24 outpatients and 10 treatment providers), followed by the mind as a container for objects, which was employed 33 times (28 times by outpatients and only five times by treatment providers).

Consider this statement given by a participant conceptualizing the mind as a fighter:

Duo, 28, M, outpatient: I feel like most people suffer from some degree of you know, I mean... I feel like most people have unresolved like, traumas and you know, issues and conflicts within themselves and with the world.
Here, the words “suffer” and “conflict” are worth noting – he locates conflict within oneself as a state which causes suffering in the person overall. Often someone in a fight will suffer injuries, and one will typically struggle with their adversary to win. For this reason, I included uses of both terms “suffering” and “struggling” as examples of the “the mind as a fighter” conceptual metaphor. If we consider the self to be a product of the mind, then Duo’s statement further implies use of the conceptual metaphor of the “mind as a container” (discussed below), as conflicts and issues are located by him to be within oneself. While this is an exemplar of the conceptual metaphor of the mind as a fighter – the idea of mental illness as something that causes “suffering” or being something that causes “struggles” within one’s mind was a common theme throughout the interviews.

Suffering and struggling were often associated with having symptoms of mental illness – “suffering” was used 12 times and “struggling” used 16 times. The concept of mental illness as something that one “suffers” was employed a total of 12 times: eight times by four outpatients and four times by two providers. “Struggling” was used nine times by two providers, but eight of them were by the same treatment provider (indicating low intergroup saliency). Four outpatients employed the concept of mental illness as something like a “struggle” a total of seven times.

The conceptual metaphor of the mind as a container for objects was employed 33 times: 28 times by outpatient participants and only five times by four treatment providers. An outpatient said of being in treatment for mental health problems:

J, 22, M, outpatient: When I finally came out on the other side, I feel like I’m a much stronger person, I don’t carry as much shame with it anymore, and I’m much more okay with being open about it and sharing it with people – what I’ve been through.

J is saying that, now that he is in treatment, he feels comfortable opening his mind/self to others and sharing his experiences with mental illness contained therein with others. Experiences
cannot be shared like physical objects; one cannot lend another half of their experiences in therapy. But in this case, verbally telling others one’s story is considered giving them an object—it is giving others knowledge about oneself. If we compare how often the metaphor “the mind is a container” was used by outpatient participants (28 times) to how often it was used by treatment providers (five times), I believe it illustrates that a different understanding of the mind is held by outpatients than treatment providers. These differing understandings of the mind may participate in the construction of differing cultural models of mental illness.

Concluding Remarks on Results of Metaphor Analysis

All participants readily used medical terminology that I did not interpret as metaphors. While medical concepts were employed by both mental health treatment providers and outpatients to explain topics related to mental illness, they were not used metaphorically. Both outpatients and providers used language indicating a perception of the body (including the mind) as a biochemical entity requiring repairs from professionals. This shared understanding of the body as a biochemical machine leads to considering the mind as something that may need repairs from professionals. This should not be surprising, since outpatients are people who have conceded that their mental health needs repairing enough to seek out professional help and follow treatment plans.

I believe it is relevant to point out that mental health treatment providers expressed conceptual metaphors far less often than outpatient participants. I had hypothesized that outpatient participants would use more bodily metaphors than treatment providers due to the physically and personally immediate experiences with mental illness that outpatients have had. I interpret the fact that outpatients used more metaphors as support of this hypothesis. The
physical and bodily basis for the ontological conceptual metaphors found and discussed shows that outpatients think of mental illness differently than treatment providers.

When considering direct bodily metaphors such as “the mind as a container,” we note the scarcity of its use among treatment providers (by whom it was used only five times) as an example of how much more frequently outpatients (who used it 28 times) perceive and explain concepts related to mental illness in physical terms. The difference in perception and discussion of mental illness as a series of physical objects to be examined, I argue, shows that although mental illness is expressed by outpatients and treatment providers similarly in many other ways, it is understood differently by outpatients.

Explaining symptoms of mental illness involves describing internal states in ways that other people can understand in relation to other things they have experienced – metaphors. My hypothesis was that outpatients, due to their firsthand experience with mental illness and its treatment, would use more metaphors to describe mental illnesses. My findings show that more outpatients than treatment providers frequently use bodily metaphors when describing mental illnesses. These differences in overall frequencies of use of conceptual metaphors by outpatients and providers index possible underlying differences in the cultural models of mental illness held by outpatients and treatment providers.
CHAPTER 6

COGNITIVE DATA RESULTS

Collection of cognitive data was achieved through the administration of what are known as memory tasks and categorization tasks. Memory tasks are used for this end because we, as humans, store knowledge organized into categories as cognitive models in our memory. The aim of collecting cognitive data through memory and categorization tasks then; is to gain insight into mental organizations of knowledge shared between people in groups – their cultural models. Cognitive data were collected via the administration of a memory task (a free-listing task) and a categorization task (a pile sorting task). I collected these two types of cognitive data to investigate if participants’ mental classifications of mental illnesses, especially in their memory, corresponded with their linguistic classifications. That is, I wanted to see if participants thought about mental illness in the same way they spoke of it.

Free Listing and Pile Sorting Analyses

As described in Chapter 3, “Methodology,” free listing tasks are used to gather lists of terms pertaining to a particular cultural domain (Bennardo and DeMunck, 2014:75). The free list tasks I conducted during interviews consisted of two questions: “What are all the mental illnesses you know of?” and “What are the most common mental illnesses you know of?” The first question (“What are all the mental illnesses you know of?”) was used to find a range of items and
terms participants considered to be mental illnesses. These items were taken to (partially) constitute the cultural domain of “mental illness.” The second question (“What are the most common mental illnesses you know of?”) was asked to determine if participants differentiated certain mental health disorders as more common than others.

I also administered a pile sorting task to collect data regarding participants’ categorizations of specific mental illnesses. While pile sorting data does not definitively show mental organization of a cultural domain, it can, most notably, show if a “culturally dominant algorithm” is used in mental categorization and sorting (Bennardo and DeMunck, 2014:79). It is with this specific view that the pile sorts were conducted. I investigated participants’ organizations of mental illnesses to find if they were sorted according to the culturally dominant algorithms of medical classifications of mental illnesses as used in the Diagnostic and Statistical Manual IV-TR (DSM-IV), the book used by doctors to define and diagnose mental disorders in patients (American Psychiatric Association, 2000). If participants organized mental illnesses similarly to how they are organized in the DSM-IV, I took it as supporting evidence of a medicalized cultural model of mental illness.

Results of Free list Task 1: “All the Mental Illnesses You Know Of”

To conduct the first free listing task, I asked participants to list all the mental illnesses they knew of and considered the illnesses mentioned first to be the most salient. I had hypothesized that if most of my population indicated “schizophrenia” or other severe mental illnesses first, then it would mean that stereotypically noticeable and socially disruptive symptoms of schizophrenia (hallucination, psychosis, severe thought disturbances, etc.) were the most salient symptoms of mental illness for my population. The salience of more visible mental
illnesses was investigated by asking, “What are all the mental illnesses you know of?” and finding rank scores for the most salient (first-to-mind) mental illnesses listed by participants.

Using the formulas presented in Chapter 3, “Methodology,” I found aggregates and ranking scores for the mental illnesses listed by my participants. While I obtained 47 unique terms, many were only listed by one person. Here I have focused attention on the 20 most salient listed illnesses mentioned by more than one person (see Table 6.1). I focused on these 20 terms because they are terms listed with aggregate values over 1 (with the exception of “psychopathy”) and saliency rankings over .05. Further reasons for and explanations of condensing this list are discussed below in “Pile Sorting Results.”

Table 6.1: Free List #1 (“What are all the mental illnesses you know of?”)
Eight participants stated “depression” first, making it the most salient mental illness listed by all participants. Anxiety was the second most salient mental illness listed by participants. Anxiety was listed by 16 out of 18 participants as a mental illness (two people mentioned it first in the list), with most of them mentioning it early in their lists (indicating higher saliency). The third most salient mental illness listed in this free list task was bipolar (disorder), with 15 out of 18 participants stating it relatively early in their lists. The fourth most salient mental illness was schizophrenia which was mentioned by 16 out of 18 participants, but later in their lists than “anxiety” or “depression.” The fifth most salient term, “borderline personality disorder,” was only mentioned by 10 out of 18 participants.

My hypothesis that participants overall would list “schizophrenia” first was not supported; in fact, only four participants mentioned it as their first response. Instead, the most salient mental illness listed was depression. Depression is rather common; we often see advertisements for treatment options, and over half of my outpatient participants were in (or had been in) treatment for depression. Anxiety was the second most salient mental illness, again with over half of outpatient participants expressing problems with, being in, or having been in treatment for it. Anxiety disorders are very common in US American society; they are the most commonly diagnosed mental illnesses, and there is a great deal of knowledge in the public realm about each of these disorders (National Alliance on Mental Illness, 2019).

Instead of listing mental illnesses based on the visibility of their symptoms, it is possible that the two most salient mental illnesses of depression and anxiety were mentioned first because they were most personally relevant to participants. Most outpatient participants had expressed a history of treatment for either depression or anxiety (or both), and two treatment providers had
sought treatment themselves for anxious and (or) depressive issues. Depression and anxiety were also among the disorders that providers said they most often saw in patients and clients.

The listing of “bipolar” and “schizophrenia” as the third and fourth most salient mental illnesses, after “depression” and “anxiety,” was surprising to me. I cannot reason that these mental illnesses are more personally relevant and therefore salient to my population, as only four people mentioned being in treatment or having been in treatment for bipolar disorders, and no one was in treatment (or had been) for schizophrenia. While bipolar (like anxiety and depression) was listed as a common mental illness, schizophrenia was not (see “Free List Results: Common Mental Illnesses” below).

The ranking of bipolar (.58) is close to that of schizophrenia (.57), indicating that (as a group) bipolar disorder was mentioned as a mental illness before schizophrenia. The proximity of bipolar disorder and schizophrenia in the list is perhaps telling of similarities between the two that differentiate either disorder from anxiety and/or depression. It was expressed in interviews that both bipolar disorders and schizophrenia require medication, both involve a (perceived) lack of control over behaviors, and people with either disorder may experience psychosis because of it. We can contrast these similarities with similarities between anxiety and depression expressed in interviews: both conditions do not (always) require medication, both generally involve increased inhibition of one’s behaviors, and both depression and anxiety do not (typically) involve a risk for psychosis. It is plausible that the listing of “bipolar” and “schizophrenia” after “depression” and “anxiety” indicates a break in thought or change in mental models, separating conditions of depression and anxiety from the rest of the disorders listed.

The ranking (fifth most salient) of borderline personality disorder (BPD) raised many questions for me, primarily about sampling. Having gathered outpatient participants from a
dialectic behavioral therapy (DBT) group, I feared I had skewed the population towards people to whom BPD would be more personally relevant. DBT was originally aimed at people with BPD, and DBT patients know this – the history of the therapy’s development is discussed in the first meeting, along with the symptoms of BPD. However, DBT is not used just for people with BPD anymore, and no outpatient participants said they had BPD (but they could have simply not disclosed it).

The idea of personal relevancy via DBT also does not explain the saliency of BPD among people who were not from the DBT group. Considering media coverage of BPD, however, it is entirely possible participants just knew of it from movies or television. BPD’s position in the free list ranking could be due to the fact that mental illnesses with socially disruptive behaviors may be sufficiently salient in the group’s mind, but only after mental illnesses with which individuals have had personal experience.

I believe BPD’s intergroup saliency in relation to that of schizophrenia and bipolar disorder illustrate that these three mental illnesses are being conceptually grouped differently than other mental illnesses. Commonly expressed traits of BPD by participants found in interview transcripts included emotional instability and impulsive behavior (only four participants discussed the disorder other than listing it). Compare this to the sentiment expressed by participants that both people with bipolar disorders and those with schizophrenia do not always have control over their behavior or emotions (discussed by 13 participants). What is “impulsive” or “unstable” to one person may be perceived as a “lack of control” to another. In both cases, though, motives for the behaviors are unknown to the observer.
The goal of the free listing task of “common” mental illnesses was to discover what is meant when the term “mental illness” is used to describe mental health issues with behavioral symptoms that are generally not seen as socially disruptive or severe. This was investigated with the free listing task, “What are the most common mental illnesses you know of?” and the results of the analysis of which terms were most often listed as “common mental illnesses.” I calculated aggregate and ranked scores for the results of this free listing task to find what my overall sample population considered to be “common” mental illnesses (Table 6.2).

### Table 6.2: Free List #2 (“What are the most common mental illnesses you know of?”)

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I discovered four “common” mental health conditions with high levels of intergroup saliency: “depression,” “anxiety,” “PTSD (posttraumatic stress disorder)” and “bipolar” (Table 6.2). To determine how participants discussed these common mental illnesses, I investigated the use of these terms in interview transcripts. These four mental illnesses were used as keywords to search transcripts for shared metaphors and other discursive similarities about mental illness and treatment. I wanted to investigate what is meant when the term “mental illness” is used to describe mental health issues that are considered common in my sample population (outpatients and mental health treatment providers). I used these four most common mental illnesses to
uncover how mental health issues typical in outpatient treatment were described, and to look for
discursive similarities between them (and mental illness in general) which are already discussed
in Chapters 4 (“Results of Ethnographic Data Analysis”) and 5 (“Results of Metaphor
Analysis”).

I expected either anxiety or depression to be listed as the most salient common mental
illnesses and had anticipated both to be the two most salient common mental illnesses. I had
hypothesized that “anxiety” would be listed before “depression” because more of my participants
reported having issues with anxiety than reported having issues with depression. This was based
on the idea of personal relevancy; since more people had personal experience with anxiety, I
thought anxiety would be more salient than depression. Two thirds (12) of my entire participant
population (outpatients and treatment providers) expressed having been in treatment for anxiety-
related issues, and over half of my entire participant population (10), again, both outpatients and
providers reported having been in treatment for depression. However, the ranking of depression
(1) is not much higher than anxiety (.9), suggesting near-equal salience.

These findings are not entirely out of line with national statistics. Around 18% of US
American adults have had an anxiety disorder at some point in their lives, and at least 6.9% of
US American adults reported having had a major depressive episode in the past year (National
Alliance on Mental Illness, 2019). Considering that more than twice as many people nationally
have had issues with anxiety than have had recent problems with depression, participants’
saliency of depression and anxiety did not match up with national statistics. Nevertheless,
participants were aware that depression and anxiety were considered very common mental health
problems.
The third most salient common mental illness listed by participants was posttraumatic stress disorder (PTSD). PTSD is a difficult condition to classify or compare to national statistics, as most statistics for mental health disorders consider it an anxiety disorder and include it in their statistics for anxiety disorders (for example, National Alliance on Mental Illness, 2019). However, the National Institute of Mental Health estimated 3.6% of adult US Americans had PTSD in 2017 (National Institute of Mental Health, 2017). It is not clear from data available if this excludes people with mental health issues comorbid with their PTSD, but all participants who discussed PTSD (14) expressed knowledge that PTSD often presented itself through symptoms that look like anxiety.

Seven outpatient participants and one treatment provider discussed being or having been treated for PTSD or problems with stress related to traumatic events. The two outpatient participants who had no official diagnoses were in therapy for “stress” related to prior “bad” relationships. I did not press on what kinds of stress they experienced or what made their relationships bad; whatever they experienced was obviously bad enough to cause them to go to therapy. While these two women may not have had the diagnosis of PTSD, they were in treatment for posttraumatic stress. People very often seek mental health treatment for stress related to traumatic events to prevent problems associated with PTSD from developing.

The fourth most salient common mental illness listed by participants was bipolar. Four outpatients discussed having been in treatment for bipolar disorders, making it the fourth most common mental illness among my participants. The group’s saliency ranking for bipolar as the fourth most common mental illness was also in line with national statistics – 2.6% of US American adults have bipolar disorder (National Alliance on Mental Illness, 2019). If we compare the national statistics of 3.6% of Americans with PTSD, 6.9% with depressive episodes,
and 18% with anxiety disorders, bipolar is fourth when added to that list at 2.6% (National Alliance on Mental Illness, 2019; National Institute of Mental Health, 2017). Bipolar disorder was also the fourth most common mental health disorder for which outpatients received treatment, as well as being fourth within group rankings.

I did not do this free list task with the purpose of comparing the results to national statistics, and it was not a quiz to see the knowledge level of my participants. These results were just immediately noticeable during research. I argue that this ranking emerged because outpatients and mental health treatment providers are by virtue jobs and associations more knowledgeable about trends of mental health disorders than neurotypical people. Participants’ ability to rank mental illnesses in line with national prevalence rates was not a topic I had intended to investigate. If I asked participants to explicitly list common mental disorders as they thought they ranked among the US American population, I may have gotten different results. But this also may not be the case, as outpatients’ saliency rankings show they thought of depression as first in their lists more often, thus ranking it out of line with national statistics. The matching trends in treatment numbers (among participants), national statistics, and saliency rankings could simply be because these illnesses are what participants were in treatment for (or were treating) at the time, or other idiosyncratic reasons.

Pile Sort Results

Pile sorting tasks are conducted to find how participants categorize salient items (gained through free list tasks) belonging to a given cultural domain. Since mental illness is the cultural domain I am investigating, the salient items to be categorized were specific mental illnesses. Items used for pile sorting were obtained from the results of my free list task, “What are all the
mental illnesses you know of?” My aim, then, was to determine how my participants categorized mental illnesses obtained from this free list task. I hypothesized that if participants categorized these mental illnesses similarly to treatment providers, then they likely shared a similar cultural model of mental illness. I further hypothesized that mental health treatment providers would have a medicalized categorization of mental illnesses which would be shown by their grouping illnesses as according to guidelines in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013).

Pile Sorting is a cognitive task that investigates semantic categorization through obtaining relations between terms by asking participants to classify particular items based on their similarities (Bennardo and DeMunck, 2014:78). The goal is to have participants group items (salient terms gathered through a free listing task) of a cultural domain into smaller groups. Participants are, in other words, asked to sort these items as members of categories. These resulting categories may be understood to participate in the construction of a larger cultural model.

As previously discussed, free list results from the task, “What are all the mental illnesses you know of?” were to be used for the cognitive pile sorting task to see how outpatients and mental health providers categorized mental illnesses (see Table 6.1). To determine which items obtained through free list tasks are salient enough to include in a pile sort, analysis must first be performed on the free list results (Bennardo and DeMunck, 2014:79). Saliency gradings and rankings were used to determine which terms elicited in free lists should be included in the pile sort task. These rankings were determined by the formulas presented in Chapter 3 “Methodology” (in the section “Analysis of Free List Results”).
Since the list of “common mental illnesses” had only 10 unique terms, I used the most salient terms in the list of “all the mental illnesses you know of” for pile sorting. After gathering 47 unique terms from the free list task, I excluded any term with an aggregate lower than 1 and a saliency ranking lower than .05. Any term listed by only one participant was not considered salient within the group, and consequently left out of the pile sorting process. I omitted “personality disorders” from my list of pile sorting terms because most participants listed at least one personality disorder already, and the term “personality disorders” had an aggregate and ranking significantly lower than those for specific personality disorders (indicating less intergroup saliency).

The term “fictitious conversion disorders” was also omitted from the pile sort task. This is because it was the first listed mental illness of only one participant (no one else mentioned this term) (see Table 6.1). This gave the term an aggregate of 1 and a ranking of over .05, but I excluded it from the pile sort terms since only one person mentioned it and as such it had no actual intergroup saliency. The more people list a term, the more salient it is to the group, and as “psychopathy” was listed by two people, I considered it to be a more salient term than “fictitious conversion disorders” and therefore included it in the terms for my pile sort task. “Psychopathy” only has an aggregate of .933 – but it was the last term mentioned by more than one person, so I used it in the pile sort. This selection process yielded 20 salient terms (mental illnesses) to be sorted. Pile sorting the 20 different mental health disorders that participants most readily listed revealed categories of mental illnesses, that is, potential components of the cultural model of illness.

To reiterate, the pile sort task was specifically used to investigate how treatment providers categorized various mental illnesses and to compare these categorizations to those of
outpatient participants. If treatment providers utilized diagnostic classifications for the pile sort task, then they were thought to have a medicalized cultural model of mental illness. If treatment providers categorized mental illnesses based on diagnostic criteria and outpatient participants used similar categorizations to treatment providers, then I hypothesized both groups’ pile sort results were representative of a medicalized cultural model of mental illness shared by treatment providers and outpatients. If it was only treatment providers who utilized clinical diagnostic categories, then I theorized it was only treatment providers who had a medicalized cultural model of mental illness.

Mental health treatment providers overwhelmingly categorized the 20 mental illness according to criteria in the DSM-IV. Outpatients showed less obvious patterns in their groupings of mental illnesses in the pile sort task. Table 6.3 shows the results of the pile sort tasks for both treatment providers and outpatient participants. The categorizations of mental illnesses shown in the columns for treatment providers are similar to categorization of disorders in the most well-known version of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV). For purposes of this research, I compare the categorizations of mental illnesses to those in the DSM-IV, as the specific categories used in that edition were given as reasoning for certain categorizations, and treatment providers expressed not having strong knowledge of DSM-5 categorizations (the DSM-5 is the most current version of the Diagnostic and Statistical Manual for Mental Disorders).

Treatment Providers’ Pile Sort Results

The first grouping of mental illnesses by treatment providers of note is the grouping of “depression” and “bipolar” into their own group by all four providers, separate from any other
Mental illnesses (see table 6.3). In the *Diagnostic and Statistical Manual of Mental Disorders IV*, bipolar and depressive disorders are both classified as “Mood Disorders” (American Psychiatric Association, 2000:20). The second grouping of note includes “anxiety,” “panic disorder,” “social phobia,” and “obsessive compulsive disorder (OCD),” which all treatment providers grouped together (Table 7.3). Three of the four treatment providers grouped “PTSD (post-traumatic stress disorder)” together with these disorders. One way to explain this is because in the DSM-IV, panic disorder, OCD, PTSD, general anxiety disorder, and social phobia are included in the diagnostic category of “Anxiety Disorders” (American Psychiatric Association, 2000:20).

Molly, 41, F, LCSW: I put these together like that because they’re the anxiety disorders. So, it was kinda cut and dry for me. That’s my specialty: PTSD, panic, and anxiety, that’s where I live, so it was the easiest for me to group.

**Table 6.3: Results of Pile Sort Task**

<table>
<thead>
<tr>
<th>Mental Health Treatment Providers</th>
<th>Outpatients</th>
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<td>Bipolar depression bipolar bipolar</td>
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<td>Anxiety PTSD anxiety PTSD</td>
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<td>OCD anxiety panic disorder anxiety Bipolar ADD OCD</td>
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<td>Social phobia Bipolar ADD PTSD ED</td>
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One treatment provider grouped dissociative identity disorder (DID) along with anxiety disorders (see Table 6.3), even though DID belongs to the separate category of “Dissociative Disorders” in the DSM-IV (American Psychiatric Association, 2000:21). He justified this classification by explaining DID (in his experience) was often brought on by a traumatic experience or anxiety around life events, making it similar to PTSD. The psychiatrist Melvin (64, M) explained, “DID used to be totally classified as anxious, but now it’s its own thing. A lot of times it’s got PTS (posttraumatic stress).”

DID was grouped separately from the other 19 mental illnesses in the pile sort task by two out of four treatment providers (one psychiatrist and one therapist), and it was sorted with schizophrenia by one provider (see Table 6.3). Molly, a therapist who grouped schizophrenia and DID together, explained, “I put those together because they’re dissociative disorders.” This way of categorizing schizophrenia and DID is not immediately explainable by clinical or diagnostic reasoning; according to the DSM-IV (and DSM-5), DID is a dissociative disorder, and schizophrenia is included under the separate category of “Schizophrenic and Other Psychotic Disorders” (American Psychiatric Association, 2000:19; American Psychiatric Association, 2013: xv, xx).

“Borderline personality disorder (BPD),” “narcissistic personality disorder (NPD),” and “sociopathy” were grouped together in the pile sort task by three out of four treatment providers (two psychiatrists, one therapist) (see Table 6.3). While “sociopathy” is no longer a diagnosis used by clinicians, the term is often employed in everyday language as a placeholder for what is now known as antisocial personality disorder (ASPD). This way of grouping the three disorders also matches DSM-IV criteria in that NPD, BPD, and sociopathy (as ASPD) are classified under the diagnostic category of “Personality Disorders” (American Psychiatric Association, 2000:23).
Three of the four treatment providers (two psychiatrists and one therapist) also grouped BPD, NPD, and schizoaffective disorder (SD) together. This does not go along with DSM-IV categorization, as BPD and NPD are personality disorders and SD is classified under “Schizophrenia and Other Psychotic Disorders” (American Psychiatric Association, 2000:19). However, upon looking at the symptomology of SD (which has three forms: bipolar, depressed, and unspecified), it shares characteristics with BPD and NPD (American Psychiatric Association, 2000:19). All three disorders share the characteristic of disordered thoughts, leading to grandiosity in NPD and bipolar SD, but leading to a distortion of sense of self in BPD and depressed SD. One participant had sorted SD into a group with bipolar and depression initially but later moved the cards to include SD with NPD, BPD, ODD, sociopathy and psychopathy.

**Melvin, 64, M, psychiatrist:** “Schizoaffective” is kind of a garbage-can category. You can have schizoaffective disorder bipolar, schizoaffective disorder depressed, or schizoaffective disorder unspecified… but it’s all got psychosis, which is the “schizo-” part that both schizophrenia and schizoaffective share.

An example of how mental health diagnoses can be interpreted in different ways by different people is well-illustrated by the lack of similarities between treatment providers’ groupings of “psychopathy.” Two treatment providers included “psychopathy” in their groupings of BPD, NPD, and sociopathy (see Table 6.3). Psychopathy is not a clinical or diagnostic term, and its exact meaning is the subject of debate, yet psychopathy is often considered to be more akin to a series of personality traits than any one specifically diagnosable mental health disorder (Patrick, Fowles, and Krueger, 2009). Melvin’s explanation for his grouping of BPD, NPD, sociopathy, psychopathy, oppositional defiant disorder (ODD), and SD together was simply that “these all involve personality issues.” Tek’s explanation for this grouping included that
sociopathy and psychopathy often both refer to ASPD, so he grouped them together “because they’re all personality disorders.”

Molly and S (both therapists) grouped psychopathy and sociopathy quite differently than the psychiatrists Melvin and Tek. Molly separated sociopathy and psychopathy into their own group, stating, “These aren’t DSM terms, so that’s why I put them together.” S grouped schizophrenia, SD, and psychopathy together, explaining, “These all have psychosis.” Psychosis (while a symptom of schizophrenia and SD) is not a symptom of psychopathy, but both terms (psychopathy and psychosis) share the linguistic prefix of “psycho-,” which may explain why she thought psychopathy included psychosis.

Three out of four treatment providers (two psychiatrists, one therapist) listed “adjustment disorder” as separate from all other mental illnesses (see Table 6.3). This matches DSM-IV categorization, as “Adjustment Disorders” is its own diagnostic category in the manual (American Psychiatric Association, 2000:23). The one treatment provider (S, a therapist) who did not group adjustment disorder as separate from all other mental illnesses grouped it with PTSD, explaining that “these are both trauma based.” This is more or less in line with clinical categorizations, as both adjustment disorders and PTSD are considered to occur due to stress related to a life event (Bisson and Sakhuja, 2006).

Treatment providers also tended to group autism spectrum disorders (AS) and attention deficit disorder (ADD) together, separate from other mental illnesses. One treatment provider grouped ADD and oppositional defiant disorder (ODD) together but grouped AS separately; a second grouped ADD, AS, and ODD into their own category (see Table 6.3). Autistic disorders (which are now called “Autism Spectrum Disorders” in the DSM-5 [American Psychiatric

ADD and ODD share the diagnostic category of “Attention Deficit And Disruptive Behavior Disorders” (American Psychiatric Association, 2000:14). The reason given for grouping ADD and AS together is often that they are diagnosed in children, which is the same reason given by one provider for including ODD with their grouping of AS and ADD. Molly, the single treatment provider who grouped AS into its own category, after the pile sort task, explained in this way her reasoning for this categorization:

Molly, 41, F, LCSW: I didn’t know what else to put it with. I thought about sorting like things that I think more of the kids’ therapists do, put together, so it’d be “AS, ODD, ADD” but then I was like ‘where do I put eating disorders?’

Even though Molly initially perceived AS as initially belonging to a separate group, she then explained she believed she should have put it with ODD and ADD (which would have matched the other three treatment providers’ categorizations).

**Outpatient Participants’ Pile Sort Results**

Outpatient participants’ groupings had little in common with treatment providers, and while their reasons for grouping mental illnesses the ways they did is interesting, they simply were unrelated to both the piles and categorizations made by the treatment providers. Looking at the right-hand side of Table 6.3 (under “Outpatients”), we can see that “depression” was often (but not always) grouped along with what are clinically considered anxiety disorders. This was not done because outpatients viewed them as symptomatically similar, but because they viewed these disorders as more “common.”
Zoescope, 35, F, outpatient: Depression, anxiety, social phobia, and panic disorder – these all seem pretty common, maybe invisible, and you might expect more random people pulled off the street to have them.

An interesting pattern was found in the grouping of “sociopathy,” “psychopathy,” and “narcissistic” together by four out of eight outpatient participants. These conditions were grouped together in the pile sort task with the explanation that they either were not very common or participants simply did not know that much about them. Nevertheless, there was an understanding expressed that being labelled any of the three (sociopathic, psychopathic, or narcissistic) was equivalent to a negative character assessment.

Pants, 34, F, Outpatient: I know there’s a difference between sociopath and psychopath, but I don’t know what it is. Sociopathy, psychopathy, narcissistic – I don’t know much at all about these, but they’re never used in a good way. I’m sure there’s good people with sociopathy or narcissism, but you always hear them used as sort of blanket labels for people who’ve done bad or violent things.

Those who sorted “sociopathy” and “psychopathy” into a pile separate from other mental illnesses (three out of eight outpatient participants) explained their grouping by stating they knew that sociopathy and psychopathy were no longer considered “real” mental illnesses. As Lucy explained, “Sociopathy and psychopathy both don’t really exist anymore. They’re sorta just scary pop psychology terms used on television.”

The outpatient participant who did not group psychopathy and sociopathy together (either on their own or with other illnesses), grouped sociopathy, borderline personality disorder (BPD), and narcissistic personality disorder (NPD) together.

Duo, 28, M, Outpatient: I know sociopathy isn’t really a diagnosis anymore, but I’m pretty sure it’s related to antisocial personality disorder. And borderline and narcissistic are both personality disorders, too, so… they just fit together like that. They’re personality disorders.
Duck’s reasoning for grouping sociopathy, psychopathy, BPD, and NPD together (the only outpatient to have this grouping) mimics the understanding expressed by Duo above. While recognizing that sociopathy and psychopathy are no longer clinically recognized diagnoses, she knew that they were commonly associated with personality disorders:

**Duck, 28, F, outpatient:** Borderline and narcissistic, well, people can still have these and maybe it causes them to do things other people don’t like. And I know people aren’t diagnosed with psychopathy or sociopathy anymore, but like, I do know that they were, well, I think those terms used to refer to people with antisocial personality disorder. I think. But now, they just refer to serial killers or whatever … but yeah, I think they were all at some point personality disorder words.

These were the only two significant patterns I found in outpatient participants’ pile sort results. Outpatients expressed an understanding that some mental illnesses are more common than others (depression, PTSD, panic disorder, and anxiety disorders being more or less “common”), and they expressed that sociopathy and psychopathy are (or were) considered to be related to personality disorders. Over half of outpatient participants in the pile sort task (five out of eight) explained that sociopathy, psychopathy, or both are no longer clinically relevant diagnoses.

**Concluding Remarks on Free List and Pile Sort Results**

The first free list task, “What are all the mental illnesses you know of?” did not support my hypothesis that mental illnesses often thought to have noticeably disruptive behavioral symptoms would be most salient to participants. Instead, depression was the most saliently ranked mental illness listed by all participants. Depression is not a mental illness with incredibly disruptive behavioral symptoms. Anxiety was the second most salient mental illness listed by the group of participants, followed by “bipolar,” “schizophrenia,” and “borderline” personality
disorder (BPD). I suggest that the rankings of the first two mental illnesses for the first free list task are based on personal relevancy, as most participants disclosed being (or having been) in treatment for either depression, anxiety, or both.

I feared that BPD had a high level of salience in the group’s free list due to the fact that some of my participants were recruited from a therapy group originally designed to treat BPD. However, as BPD was also listed by outpatients who were not in a dialectic behavioral therapy group (and no one said they had BPD), I am inclined to believe its high intergroup salience is due to discussions of BPD in various forms of media.

I found the listing of depression and anxiety as highly salient to be interesting in relation to the three mental illnesses that were ranked directly below them (bipolar, schizophrenia, and BPD). It is possible that the proximity of anxiety and depression in the free list task represents a conceptual grouping of these disorders as “different” from the mental illnesses that followed in the free list task. Bipolar disorders, schizophrenia, and BPD all share characteristics in interview transcripts which serve to distinguish them from the conditions of depression and anxiety. Commonly expressed traits of BPD by participants found in interview transcripts include emotional instability and impulsive behavior, and commonly discussed traits of schizophrenia and bipolar disorders are lack of control over one’s behavior and emotions. While linguistically there is a difference between instability, impulsiveness, and a lack of control, these traits can present themselves similarly. It is not impossible to tell from mere visual observation if a person is just impulsive and emotionally unstable, or if one genuinely has no control over their behaviors and feelings.

For the second free list task “What are the most common mental illnesses you know of?” I found that (as a group) participants generally listed mental illnesses in order of their prevalence
within the US American adult population. The only difference was that participants listed depression as the most common mental illness, followed by anxiety. This was different from national statistics which listed anxiety and depression (in this order) as the most common mental illnesses. It is possible that they listed depression first because they found their experiences with that disorder more relevant or memorable, as opposed to their experiences with anxiety. But the fact that when asked “What are the most common mental illnesses you know of?” the participant group listed the top four most common mental illnesses in the USA (and almost in order of prevalence) is surprising. I take this as evidence that outpatients and treatment providers have a large degree of knowledge about mental illnesses and their prevalence (possibly more than neurotypical people), most likely due to their personal experiences with mental illnesses and their professions.

My hypothesis that treatment providers would be likely to use a medicalized method of sorting mental illnesses (that is, following guidelines as established in the *Diagnostic and Statistical Manual of Mental Disorders, 4th ed.*) was supported by the results of the pile sort task. Not only did treatment providers overwhelmingly categorize mental illnesses based on diagnostic criteria and categories, but outpatient participants did not utilize this same method for the pile sort task. This illustrates a difference in the conceptual organization of mental illnesses utilized by mental health treatment providers and outpatients. This difference in conceptual organization helps support my hypothesis that treatment providers and outpatient participants have different cultural models of mental illness.
CHAPTER 7
CONCLUSION

Treatment Providers’ Cultural Model of Mental Illness

During this research I found that mental health treatment providers’ cultural model of mental illness was highly medicalized and based upon an understanding of stress as detrimental to one’s mental health. It was consistently expressed by mental health treatment providers that people with mental illness look just like everybody else. Furthermore, there was a shared understanding that not many people care about mental health, and mental health treatment providers feel like most people view them as “crazy” themselves. As explained in Chapter 6, organization of mental illnesses into diagnostic categories was unique to treatment providers, indicating different methods of mental organization of mental illness between outpatients and treatment providers. For the sake of simplicity, treatment providers’ cultural model of mental illness will be illustrated by a list of propositional statements. These statements make up pertinent parts of the structure of this cultural model. These aspects of their cultural model will be supported by statements gathered from interview transcripts which were discursively shared between treatment providers.
Stress was widely explained as contributing to physical and mental illnesses by treatment providers.

a. **Kit, 55, M, LCSW**: Someone who faces different stressors depending on the stressor, you know depending on the business, you know - you look at again, again the factors of two people who go do the same job and one has a home life which is bad versus another who has a home life that's great, and those factors affect [...] their problems.

b. **Melvin, 64, M, psychiatrist**: [What determines mental illness is] how you deal with stress, coping strategies. that's why psychotherapy can be helpful in a lot of different illnesses, CBT (cognitive behavioral therapy) can actually change the brain structure.

c. **Dna, 49, F, DCCMHB**: When you have trauma, your body comes up with a way to survive that trauma, and trauma can often look like a mental health issue.

d. **Molly, 41, LCSW**: I think just living in day to day constant stress, I can see that bringing on some depression, bringing on some anxiety. We know that when your body is constantly stressed, that you’re releasing more cortisol, which is a stress hormone, it causes some issues. We know that stress impacts our physical health.

While “stress” itself was not explicitly defined by treatment providers, stress’s contribution to mental illness included the concept that whatever life stressor one experiences is affected by the overall environment in which one lives (such as a good home life helping one deal with a stressful job). It was further expressed by treatment providers that stress can change a person’s brain. Providers connect trauma to health, but not directly to mental illness (other than PTSD), as well. Stress is discussed as a physical phenomenon, both affected by and affecting one’s bodily health. The relationship between stress and mental illness is very strongly expressed.
by mental health treatment providers, having the effect of making mental illnesses sound like conditions wherein one just cannot handle the external stresses of everyday life.

The content of treatment providers’ cultural model of mental illness strongly discourages the use of visual (or other) stereotypes to describe people with mental illness. This was expressed by treatment providers through quick repetitive stock phrases, such as people with mental illness look “like anybody” or “there is no face to mental illness.”

a. **Melvin, 65, psychiatrist:** They [people with mental illness] look like you and me. They look like anybody - you can't tell somebody has a mental illness from looking at them.

b. **Dna, 49, F, DCCMH:** <Q: What does someone with mental illness look like?> Like anybody.
   <Q: What does someone in treatment for mental illness look like?> Like anybody.
   <Q: What does someone with mental illness sound like?> Like anybody.
   <Q: What does someone in treatment for mental illness sound like?> Like anybody – the fascinating thing about mental illness is you can’t look at somebody and know.

c. **Pimento, 56, F, LCSW:** [people with mental illness look] like anybody else, I think

d. **Kit, 55, M, LCSW:** They [people with mental illness] look like anyone else. There is no face to mental illness.

e. **S, 35, F, LCSW:** <Q: What does someone with mental illness look like?> I don’t like that question. I feel that’s very judgmental. I think you can say “how do particular diagnoses symptom-wise appear” versus what does a person with mental illness look like. I don’t like that question.

This cultural model further expresses the concept that schizophrenia and bipolar disorder are primarily biological disorders which occur when the brain is not structured correctly. In the case of schizophrenia and bipolar disorder, the brain is not structured properly due to genetics. This improper brain structure does not produce enough of certain chemicals, leading to behaviors and thoughts symptomatic of bipolar and schizophrenic disorders. This belief is conducive to reasoning in favor of medication in some cases of mental illness but not others.
a. **Kit, 55, M, LCSW:** I would say 100% of bipolar clients need to be on medication because that is a medical disorder that requires medication. But someone with depression doesn't necessarily require medication.

b. **Melvin, 64, M, psychiatrist:** There are some families where it's really strong - like certain kinds of schizophrenia. They've done studies where it's every generation - it's definitely a more dominant gene that's involved there somehow.

c. **Dna, 49, F, DCCMHB:** There’s lot of new research coming out that outlines actual physical changes in the brain if someone has schizophrenia or someone has bipolar disorder.

A particularly interesting aspect of treatment providers’ cultural model of mental illness was explained as a tendency for people to view mental health treatment providers as always judging or psychoanalyzing the person to whom they are speaking and to be downright hostile at times. This sentiment that mental health treatment providers are not to be trusted was expressed as a hindrance to friendships. On the contrary, while outpatients also expressed frustrations with making and maintaining friendships, it was for reasons other than feeling personally judged or distrusted.

a. **Molly, 41, F, LCSW:** I have had people make comments like we’re witch doctors and we don’t really do anything helpful. It’s not that common hearing it as a therapist, I think I heard it more at the hospital when people were angry.

b. **Pimento, 56, F, LCSW:** Sometimes when I meet a new person and explain oh ‘what do you do for a living’ and I tell them I’m a therapist, they usually think you're going to try to analyze them. So I try to make a joke out of it, like “oh I’m off duty”.

c. **S, 35, F, LCSW:** You have some that like, freak out, like “oh my god, you’re psychoanalyzing me?!”. So, depending on the situation or where I’m at I might, say I’m a counselor, a social worker or a therapist.

**Outpatients’ Cultural Model of Mental Illness**

Instead of the causal relationship between “stress” and mental illness found in treatment providers, outpatients expressed a causal relationship between trauma and mental illness. Trauma is further explained to alter brain chemistry and structure. Mental illness is expressed as an
imbalance of brain chemicals or an improperly structured brain. Outpatients heavily utilize the conceptual metaphor “mind as a container for objects” (discussed in Chapter 5) when explaining mental illness as something “going on” in one’s “head.” Outpatients said they are often able to tell if someone is dealing with mental health issues through subtle body language and vocal intonation or just a peculiar sense of “knowing.”

<table>
<thead>
<tr>
<th>Outpatients’ Cultural Model of Mental Illness</th>
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<tbody>
<tr>
<td>Trauma can lead to mental illness.</td>
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<tr>
<td>Mental illness is the biological result of an improperly structured brain or lack of certain neurochemicals.</td>
</tr>
<tr>
<td>The mind is a container for objects (such as mental illnesses).</td>
</tr>
<tr>
<td>If you look close enough, you can tell if a person has a mental health problem.</td>
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</table>

a. J, 22, M, outpatient: I think it’s definitely going through some sort of trauma. That can be part of it or increase the likelihood of any of it [mental illness].
b. Duo, 28, M, outpatient: I don't think there's an event that absolutely would be the cause [of mental illness] - it has to do with how we deal with that trauma. Whether it becomes a permanent part of our psyche and our lives. Or if it's just an event that we deal with and move past.
c. Zoescope, 35, F, outpatient: People can experience really traumatic events and suffer from mental illnesses as a result of that. They perhaps otherwise wouldn’t have had any issues with mental health if not for such events.

The concept that trauma can cause mental illness was explained rather explicitly by outpatients: traumatic experiences affect the brain (its structure and chemicals), which causes mental illness. Traumatic experiences were understood as changing the structure of or chemicals in the brain, further affecting one’s thoughts and moods. This went along with outpatient participants’ understanding of mental illness as, on average, being the biological result of an
improperly structured brain or abnormal levels of neurochemicals, as expressed by outpatient participants.

a. **Razadem, 37, M, outpatient**: CBT (cognitive behavioral therapy) actually changes your brain structure, so you stop these negative myths, and then you gain control back over your mind rather than your subconscious sort of feeding you things based sort of like on past experiences.

b. **Shinji, 31, M, outpatient**: Because of how our brain tries to cope with stressful events and emotions that are brought out, it could maybe end up changing brain chemistry incorrectly to some extent so that you don’t lose those chemical changes or imbalances. Because you’re not really seeing it as biological: post-traumatic stress disorder is one of those things that can actually be cured by various forms of therapy.

c. **Lucy, 30, F, outpatient**: There are receptors in your brain, along with synapses – and some people’s brains don’t work quite right. Their brain receptors and synapses are off and they don’t get enough serotonin, or dopamine, or whatever brain chemical is causing the problem [the mental illness].

The conceptual metaphor of minds as bodies was expressed by outpatient participants referring to immaterial concepts (e.g.: thoughts or mental illnesses) as discrete objects existing in one’s mind (for an earlier discussion of this conceptual metaphor, refer to Chapter 5, “Results of Metaphor Analysis”).

a. **Duck, 28, F, outpatient**: I guess they would have to know that whatever they had going on in their heads wasn’t normal. Which is gonna be hard sometimes, like, uh… if someone has like, absent or neglectful parents and is depressed, they’re not going to have a healthy role model to compare themselves to. (answering “How would someone know if they had a mental illness?”)

b. **Pants, 35, F, outpatient**: So, you’re – you’re making poor decisions, you know? Because you just can’t deal with, uh… what you have going on in your head. You know, it’s like, it’s just easier to just drown it out. (On mentally ill behavior)

c. **Zoescope, 35, F, outpatient**: mental illness is um, when someone reaches a point where they … can’t really do the things they need to do in their life to be healthy and happy and take care of themselves. Baseline function, like they can’t function at baseline because of stuff that’s going on in their minds.

Outpatient participants expressed an ability to tell if a person is experiencing a mental health problem as a sense, a type of “radar,” or an energy. Other times this ability to notice fellow neuroatypical people is expressed as something that happens if you just “pay attention.”
a. Nestor, 33, M, outpatient: I can generally tell when people talk about certain things in their lives that they have some things – it just has to do with the way they speak of events that unfold within their lives and their reactions to them generally speaking. And their reactions to largely negative things or stressful things seem to be what indicate that they might not – because they talk about how they wanna deal with it, and it doesn’t really seem logical or … a good, healthy way to deal with it. That sort of thing.

b. J, 22, M, outpatient: I suspected that maybe this guy’s dealing with anxiety or depression or something deep down and they’ve just been rooted there for years and years, so yeah, um. I think once – and like once you’ve lived it you can honestly, you have that kind of radar in a sense, you can pick up “oh this person might have something going on” but again I’m not a professional, I don’t have any degrees, but you kinda figure out when something’s going on.

c. Narissa, 21, F, outpatient: If you pay attention - it depends on the kind of mental illness that the person has, like if you pay attention there are definitely trademark signs of people with problems like that. Just withdrawn a lot of the time, antsy, sometimes - not all the time, people get antsy, but some people are antsy all the time and that tends to be an anxiety thing.

Outpatient Subculture

One of the topics of my investigation was whether or not outpatients made up their own subculture. I hypothesized this would be expressed through metaphors, conventional discourses, and other discursive instantiations of cultural models. If outpatients expressed other than medical models when discussing mental illness, I hypothesized they held their own subculture. I further hypothesized there are different discourses about mental illness and that people with mental health problems utilize them to help make sense of their own diagnoses and identities. I believed instantiations of outpatients’ differing cultural models from medical models of mental illness (those expressed by treatment providers) would be further illustrated through a difference of categorization of mental illnesses during memory tasks (pile sorting).

I argued that there exists a socially normative discourse on mental illness which is largely based on medical understandings but that outpatients would describe mental illness differently
than with medical terminology. I hypothesized that if outpatients and treatment providers were found to use similar metaphors and discourses on mental illness, then the cultural models of treatment providers had suppressed any other cultural models of mental illness outpatients may have held. I found that not only did outpatients use more bodily metaphors to describe mental illness experiences (as opposed to medical terminology), but they also described different factors of causation. Outpatients described “trauma” as a causal factor in mental illness, whereas treatment providers said “stress” contributed to mental illness. Outpatients also used more bodily (ontological) conceptual metaphors than treatment providers when discussing mental illness, suggesting that the physically personal experience of mental illness affects the way one chooses to explain its symptomology to an outside audience.

While outpatients were aware of medical models of mental illness, many expressed skepticism of strictly medical and biological explanations of mental illness. Instead, outpatients often referred to one’s upbringing and social life as important factors affecting one’s mental health state. Treatment providers shunned the idea of being able to notice (visibly) if another person has mental illness. Outpatients simply listed behaviors they would interpret as symptomatic of mental illness while acknowledging that people may have mental illness and not exhibit these behaviors (or that the behaviors could be unrelated to one’s mental health state).

The use of the term “neurotypical” and “normie” were particularly interesting to find (nine out of 11 outpatients used one or the other term). These terms are used to normalize people with mental illnesses and to label people without mental health problems as “other.” Perhaps this is the most telling example of an outpatient (or mental illness) subculture; no one would need a word to describe people who have not experienced mental health issues unless they were communicating with other people who had experienced such issues.
A normalization of some mental health disorders (but not all) was also found in the pile sort task administered to outpatients. Outpatients (unlike treatment providers) did not utilize a medical categorization of mental illnesses. Instead, outpatients categorized some mental illnesses separately from others based on whether or not they considered it likely to find someone “on the street” with a given disorder. Outpatients classified mental illnesses based on their understandings of them as commonly occurring, whereas treatment providers categorized mental illnesses based on diagnostic criteria and groups (as discussed in Chapter 6 “Cognitive Data Results”). Based on these results, I am inclined to believe my hypothesis was correct and that outpatients do share a subtle subculture. This subculture is mainly characterized by othering neurotypicals and readily reading other people’s body language for cues of internal strife.

Issues of Possible Importance

The key differences in the cultural models of outpatients and treatment providers that is relevant for mental health practitioners and the mental health community in the DeKalb, Illinois area involved the linguistic expression of their perception of mental illness as caused by “trauma” and “stress.” Not everything that is stressful is traumatic, not all instances of emotional turmoil over stress are symptomatic of mental illness. Treatment providers verbally expressed damaging psychological events as “stress” (opposed to outpatients’ explanations of “trauma”). However, treatment providers also expressed “stress” as nearly equivalent to trauma, or at the very least, as similarly psychologically damaging phenomena.

Both treatment providers and outpatient participants expressed knowledge that traumatic and/or stressful events have the ability to change one’s brain structure (and/or neurochemistry), however. This shared understanding of stress and trauma as damaging to mental health does not
seem as though it would be logically difficult to adopt in one’s pre-existing cultural models of mental illness. Treatment providers and outpatients also shared an explanation of mental illness as when one is unable to get out of bed for an extended period of time due to a bad emotional state.

The DeKalb County Community Mental Health Board’s initiatives to spread awareness of trauma do not have to address mental health outpatients, as they seem to be keenly aware of the link between trauma and mental illness. Mental health treatment providers however, are more interested in the relationship between stress and mental illness. Outpatients expressed no real problems with stress. They mentioned that our society is very stressful, that they have to go to therapy to learn coping mechanisms for stressful mental states, and that their stressful society simply does not contribute to mental well-being. The difference to note between mental health treatment providers and outpatients is the linguistic difference between the causal role of “trauma” expressed by outpatients and how this causal role might differ from the role of “stress” that mental health treatment providers expressed. It suggests that “trauma” would not be so salient to my outpatient participants if they had not experienced or known others who had experienced traumatic events.

Outpatients know they have experienced trauma but do not know how to deal with the results of the traumatic event. However, they also know that if they do not want the trauma to dominate their thoughts, they need to seek mental health treatment. If outpatients are able to easily accept the relationship between things that happened in the past and how they feel currently, the efforts of the county’s community mental health board to foster a trauma-informed community will likely be easily accepted by people in the area. These goals are in line with what
outpatients think is important and therefore probably in line with the feelings or understandings of people in the community who need mental health treatment because of traumatic experiences.

I believe this research is relevant in the field of cognitive anthropology because very few studies focus on the mental organizations and knowledge structures of the mentally ill. Even fewer studies focus on people with mental illness who are not hospitalized or are not conducted in clinical settings – which I believe raises some uncomfortable questions of ethical research conduct regarding power dynamics. The underrepresentation of outpatients in anthropological literature regarding mental illness is not reflective of the reality of mental illness in the 21st century. Sue Estroff’s *Making it Crazy* is an excellent ethnographic study of mentally ill people who lived in a mental institution in the 1970s and 1980s. We no longer have mental institutions of the type Estroff studied 30 years ago, the majority of people with mental health disorders today are on medications and attempting to contribute to society or continue living in the “real world.”

For those of us who are receiving outpatient treatment for mental health concerns, representation is very important. People with mental illness are constantly vilified in our media. Mass killers or people who go on shooting sprees are immediately identified as mentally ill – and that is simply unfair to those of us with mental illness who have no intentions of ever hurting another human being. There is no normalized image of mental illness in US American culture, even though there are a great many of people who have serious mental health issues who can function in society perfectly well. For a field of study as culturally open minded as anthropology, it seems necessary and crucial to ask that our experiences as outpatients be investigated seriously and understood to be relevant to the societies in which we live. Outpatient treatment has become
incredibly common in US American society, and as such, I believe it needs to be academically investigated as a relevant aspect of the human experience.
REFERENCES


APPENDIX A

INFORMED CONSENT FOR OUTPATIENTS
Informed Consent Document – Outpatient Participants

This research investigates perceptions and beliefs regarding mental health issues held by persons receiving outpatient psychological, psychotherapeutic, and/or psychiatric treatment within the DeKalb, Illinois area. The purpose of this investigation is to uncover the most widely or commonly held beliefs and views about mental health issues in the area amongst people who have and treat them.

Interviews for this research will be held at a time and place mutually agreed upon by the researcher and participant. I will be asking questions regarding your personal mental health history and your opinions on mental health issues in general. The interview will last roughly 45 minutes – 1.5 hours.

Your participation is voluntary. You may stop participating in this research at any time, without prejudice or suspicion, penalty or loss of possible benefit. If you choose to stop participation, I will not use your data nor will I contact you for any follow up questions.

Benefits: I cannot guarantee any benefits, but your participation in this research will allow you to confidentially voice opinions of mental health problems and their treatment within the DeKalb area. Your participation will help further an understanding of mental health and mental health problems amongst an overlooked population.

Risks to participation are minimal. However, this is a sensitive topic and I cannot guarantee that my questions will not be triggering (emotionally or otherwise). If this occurs at any point in the interview, please tell me, and we can end the interview with no risk of loss of benefit.

As I cannot offer medical advice: If you feel as though you need to talk to someone after the interview, please make use of the information regarding emergency mental health services attached to this consent form.

All recorded interviews will be destroyed after transcription. Transcriptions and excerpts used in findings will not include personally identifying information.

Feel free to contact me if you have questions about this research, its methods, its purpose, or for a copy of findings. I will be communicating findings in my master’s thesis, of which you may also request a copy. My e-mail is ejstephen@niu.edu.

By signing this form below, you agree that you have read and understood this document, and have been given a copy of it for your records.

Signature: ________________________________
Date: ____________________

By signing below, you consent to the audiotaping of our interview. All audio files obtained will be stored in a secure, encrypted location and deleted upon completion of transcription.

Signature: ________________________________
Date: ____________________

If you would like further information regarding your rights and participation in this research, you may contact the Office of Research Compliance at Northern Illinois University at (815) 753-8588
APPENDIX B

INFORMED CONSENT FOR MENTAL HEALTHCARE PROVIDERS
Research project: Cultural Models of Mental Health Issues  
Emily Stephen, Anthropology Master’s student  
Northern Illinois University  
Email: ejstephen@niu.edu

**Informed Consent Document – Mental Health Professionals**

This research investigates perceptions and beliefs regarding mental health issues held by persons receiving outpatient psychological, psychotherapeutic, and/or psychiatric treatment within the DeKalb, Illinois area. The purpose of this investigation is to uncover the most widely or commonly held beliefs and views about mental health issues in the area amongst people who have and treat them.

Interviews for this research will be held at a time and place mutually agreed upon by the researcher and participant. I will be asking questions regarding your personal mental health history and your opinions on mental health issues in general. The interview will last roughly 45 minutes – 1.5 hours.

Your participation is voluntary. You may stop participating in this research at any time, without prejudice or suspicion, penalty or loss of possible benefit. If you choose to stop participation, I will not use your data nor will I contact you for any follow up questions.

Benefits: I cannot guarantee any benefits, but your participation in this research will allow you to confidentially voice opinions of mental health problems and their treatment within the DeKalb area. Your participation will help further an understanding of mental health and mental health problems amongst an overlooked population.

Risks to participation are minimal. However, this is a sensitive topic and I cannot guarantee that my questions will not be triggering (emotionally or otherwise). If this occurs at any point in the interview, please tell me, and we can end the interview with no risk of loss of benefit.

As I cannot offer medical advice: If you feel as though you need to talk to someone after the interview, please make use of the information regarding emergency mental health services attached to this consent form.

All recorded interviews will be destroyed after transcription. Transcriptions and excerpts used in findings will not include personally identifying information.

Feel free to contact me if you have questions about this research, its methods, its purpose, or for a copy of findings. I will be communicating findings in my master’s thesis, of which you may also request a copy. My e-mail is ejstephen@niu.edu.

By signing this form below, you agree that you have read and understood this document, and have been given a copy of it for your records.

Signature: __________________________________________________________

Date: __________________

By signing below, you consent to the audiotaping of our interview. All audio files obtained will be stored in a secure, encrypted location and deleted upon completion of transcription.

Signature: __________________________________________________________

Date: __________________

If you would like further information regarding your rights and participation in this research, you may contact the Office of Research Compliance at Northern Illinois University at (815) 753-8588
APPENDIX C

INTERVIEW SCHEDULE FOR OUTPATIENTS
Interview Questions – Patient

Demographic & Background Questions

Questions I will need to remember to ask as their topics organically arise in the interview process:

- How old are you?
- What is your race/ethnicity?
- What gender pronouns do you prefer I use?
- Where are you from?
- What do you do for a living?

What made you decide to participate in this research?

Where did you get the information from (presuming it’s a clinic)?

What do you go there (place above) for?
  - Do you find (the place above) helpful (for it - whatever the participant goes to a mental healthcare professional for)?

Semi-Structured Interview

Have you undergone other kinds of treatment for (interviewee’s specific mental health issues)?
  - If yes: What treatments?
  - If no: Move on to next question.

Have you ever been on medication for your mental health issues?
  - If yes: Would you mind telling me about your experience with medication?
  - If no: Move on to next question.

Do you know any other people with similar diagnoses/mental health issues?
  - If yes: Do you feel comfortable talking to them about your mental health?
  - If no: Do you wish you did? Why/why not?

Has there even been a time you may have been put down or felt like someone was insulting you for having mental health issues?
  - If yes: Would you mind sharing that with me?
  - If no: Have you ever been in a situation where you felt you had to conceal your illness (or mental health issues) to prevent ridicule?

Is there any time you feel like you were stigmatized for your mental health issues?
  - If yes: Would you mind sharing that with me?
  - If no: Move on to next question.

Do you have any other health conditions?
  - If yes: Does it/do they effect your mental health?
    - If yes: How so?
    - If no: Move on to next question.
If no: Do you think other medical problems besides mental illness can affect a person’s mental health? Why/why not?

**Free-Listing**
Would you please list all the mental illnesses you know of?

Would you please list the most common mental illnesses you know of?

**Return to Semi-Structured Interview**
What does a person with mental illness look like?
   What does a person with *treated* mental illness look like?

How does a person with mental illness talk?
   How does a person with *treated* mental illness talk?

How would someone know if they had a mental illness?
   How would you be able to tell if someone else had a mental illness?
   How would you be able to tell if someone else had a *treated* mental illness?

How does mental illness physically feel?

What makes a person mentally ill?

Do you think that there are biological causes behind mental illness?
   If yes: Which do you consider the most prevalent?
   If no: Move on to next question.

Can a person’s physical environment contribute to mental illness? *(Note: participants in previous research found this question confusing and often needed examples)*
   If yes: How so?
      If confused: Could someone’s neighborhood, house, or even geographic area of residence make them mentally ill?
      If yes: How so?
         If still confused, move on to next question and return to this question at later point in interview.
         If no: Move on to next question.
   If no: Move on to next question.

Are there any social factors which can contribute to mental illness?
   If yes: Such as…?
   If no: Move on to next question.

Are there individual or personal causes of mental illness?
   If yes: Such as?
   If no: Move on to next question.

Can events happen in a person’s life to cause them to have mental illness?
   If yes: What kinds of events?
If no: Move on to next question.

Can a person’s social standing or public image be disrupted by mental illness?
   If yes: How so?
   If no: Move on to next question.

Can one’s professional or work environment effect their mental health?
Can a person’s job cause mental illness?
   If yes: How so?
   If no: Move on to next question.

Can factors in a person’s upbringing (such as adverse childhood experiences) effect their chances of having a mental illness?
   If yes: What kinds of factors?
   If no: Move on to next question.

What do you think about fulfilling your personal responsibilities (going to school/work/taking care of your children/caring for your parents/etc.) while dealing with mental illness?

Can people’s personal relationships be disrupted by mental illness?
   If yes: how so?
   If no: move on

Can people’s social relationships be disrupted by mental illness?
   If yes: How so?
   If no: End.
APPENDIX D

INTERVIEW SCHEDULE FOR MENTAL HEALTH TREATMENT PROVIDERS
Interview Questions – Mental healthcare providers/Staff

Demographic & Background Questions
*Questions I will need to remember to ask as their topics organically arise in the interview process:*

- How old are you?
- What is your race/ethnicity?
- What gender pronouns do you prefer I use?
- Where are you from?
- What do you do for a living?

What made you want to go into psychiatry/psychology/therapy?
How did you end up as a secretary/janitor/administrator/staff at a mental health facility?

What made you want to work here, at this facility?
What made you decide to practice in DeKalb/Sycamore?

What do most of your clients/patients come here for?
  - Do your clients have a high rate of success in treatment?
  - What treatments do you offer?
Tell me about your medication policy as a doctor (if staff: tell me about this clinic’s medication policies).

Semi-Structured Interview
In your experience, does medication often help persons with mental illnesses?
  - If yes: Would you please give me an example?
  - If no: Move on to next question.

Have you ever struggled with mental illness?
  - If yes: Could you please tell me a bit about that?
  - If no: Move on to next question.

Does anyone in your personal life deal with mental illness?
  - If yes: Do you feel comfortable with them telling you about their issues outside of a treatment setting?
  - If no: Do you wish you knew anyone who did? Why/why not?

Do you have any health conditions?
  - If yes: Does it affect your mental health?
    - If yes: How so?
    - If no: Move on to next question.
  - If no: Do you think other health problems besides mental illness can affect a person’s mental health? Why/why not?

Can you tell me about a time where you felt like someone was judging you for choosing to go into mental healthcare?
Have you ever felt uncomfortable discussing your profession/place of work with your friends or family?
**Free-Listing**
Would you please list all the mental illnesses you know of?

Would you please list the most common mental illnesses you know of?

**Return to Semi-Structured Interview**
Can you recall a time wherein you witnessed a person being stigmatized for their mental health issues?
- If yes: Would you mind sharing that with me?
- If no: Move on to next question.

What does a person with mental illness look like?
- What does a person with *treated* mental illness look like?

How does a person with mental illness talk?
- How does a person with *treated* mental illness talk?

How would a person know if they had a mental illness?
- How would you be able to tell if someone else had a mental illness, without seeing them as a patient? (in everyday settings outside of work)
- How would you be able to tell if someone was in treatment for a mental illness, without seeing them as a patient? (in everyday settings outside of work)

How does mental illness physically feel?

What makes a person mentally ill?

Do you think that there are biological causes behind mental illness?
- If yes: Which do you consider the most prevalent?
- If no: Move on to next question.

Can a person’s physical environment contribute to mental illness? *(Note: participants in previous research found this question confusing and often needed examples)*
- If yes: How so?
  - If confused: Could someone’s neighborhood, house, or even geographic area of residence make them mentally ill?
  - If yes: How so?
  - *If still confused, move on to next question and return to this question at later point in interview.*
  - *If no: Move on to next question.*
- If no: Move on to next question.

Are there any social factors which can contribute to mental illness?
- If yes: Such as…?
- If no: Move on to next question.

Are there individual or personal causes of mental illness?
- If yes: Such as?
If no: Move on to next question.

Can events happen in a person’s life to cause them to have mental illness?
If yes: What kinds of events?
If no: Move on to next question.

Can a person’s social standing or public image be disrupted by mental illness?
If yes: How so?
If no: Move on to next question.

Can one’s professional or work environment effect their mental health?
Can a person’s job cause mental illness?
If yes: How so?
If no: Move on to next question.

Can factors in a person’s upbringing (such as adverse childhood experiences) effect their chances of having a mental illness?
If yes: What kinds of factors?
If no: Move on to next question.

What do you think about patients fulfilling their personal responsibilities (going to school/work/taking care of your children/caring for your parents/etc.) while dealing with mental illness?

Can people’s personal relationships be disrupted by mental illness?
If yes: How so?
If no: Move on to next question.

Can people’s social relationships be disrupted by mental illness?
If yes: How so?
If no: End.