

# Chapter 18

## Erving Goffman: The Moral Career of Stigma and Mental Illness

*Bernice A. Pescosolido*

Observing patients and providers at St. Elizabeth's Hospital in Washington DC, Goffman began the development of his basic concepts about how culturally and socially defined 'difference' shapes the status, roles, rewards and penalties of mental illness. His first set of articles and the book *Asylums* offered an overall analysis of the organisations that deal with the positive or negative reorientation of the self as monk, naval officer or physician in the first case, and mental patient, prisoner or labour camp worker in the second. Goffman outlines the pathways, rhythms, social processes and accommodations possible in the moral career of individuals who enter these organisations. And, he considers the critical role of context in shaping entrances, processes and outcomes. The follow-up, *Stigma*, focused directly on the aftermath of occupying a negatively valued status, where Goffman elaborated the many types, dynamics and effects of the devaluation of identities marked by social circumstances as damaged. In this chapter, the basic framework of Goffman's ideas about the (1) organisational and community processes affecting identity that follow from mental hospitalisation, and (2) stigma that attaches and often remains after socially devalued labels are attached to mental illness are presented.

Only those specifics that are still relevant in contemporary society, where long-term hospitalisation is rare, will be discussed. Yet the insights that remain relevant are many and remarkably durable. Though, even as Goffman himself was 'uninvolved' in the public discussion, his work became a centrepiece of the social and political movement to deinstitutionalise the treatment of mental illness in the United States and across the globe (Grob 1994:272). How ironic, then, that many of the sociological phenomena that he observed continue to describe the social psychological ramifications of being diagnosed with mental illness. His work on how providers, families, patients and even strangers together enact the treatment of mental illness and the longer-term ramifications on social life hold a central place in the understanding of stigmatised illnesses, writ large, laying the groundwork for later theoretical and empirical investigations from obesity to HIV/AIDS.

## The intellectual history

Freund (in chapter 10 of this volume) provides a brief biographic history for Goffman; there is no need to repeat it here. Rather, the relationship of his ideas to his research positions puts the work in context and provides a platform for understanding the germination of his theorising. Unlike the present-day US National Institute of Mental Health (NIMH), the NIMH of the early post-Second World War period was one in which the general development of social science theory was supported. As Goffman noted in the Preface to *Asylums*, John Clausen, founding director of the Laboratory of Socio-environmental Studies at NIMH, provided logistical, fiscal and intellectual support, encouraging Goffman 'to look at the hospital with sociology in mind, not junior psychiatry' (Goffman 1961:xi).

In his time in the Lab, specifically from fall of 1954 to the end of 1957, Goffman had done some 'brief studies', as he called them (1961:ix), at the NIH Clinical Center. But it was the year-long ethnography (1955–1956) at St. Elizabeth's Hospital, the enormous federal psychiatric hospital in Washington DC housing thousands of 'mental patients', that provided the data for his early articles (for example, Goffman 1959) and for the two books that followed (Goffman 1961, 1963). While Goffman did not limit his observation to mental illness or even illness (for example, the subtitle of the 1961 book is *Essays on the Social Situation of Mental Patients and Other Inmates*), his theoretical insights on identity were sharpened by employing the common sociological concept of 'deviance', a concept central to the labelling theory of mental illness that was to come later (Scheff 1966). But they also may have been fuelled by personal life experiences. Goffman's first wife, Angelica Choate, was diagnosed with serious mental illness and committed suicide in 1964 (Fine and Manning 2003).

Earlier, Goffman had laid out his thesis about individual action, public reaction and identity in *The Presentation of Self in Everyday Life* (1959). But training his sociological lens on mental hospitals, prisons, convents and the military provided an organisational focal point to sharpen his views of identity, interaction and context under extreme conditions. While Goffman supplemented his original observations by weaving in cases from other contemporary research (for example, Biderman's 1960 *Sociometry* piece on police interrogation; Stouffer's 1945 classic, (1949) *The American Soldier*) and even from literature (for example, Hulme's 1956 biographical book, *A Nun's Story*; Melville's 1850 novel, *White Jacket*) in the sociological style of the day, Goffman's real contribution comes from ethnographic insights.

Yet, there are contentious debates about the nature of Goffman's contributions and his intellectual influences. The prominent German medical sociologist Uta Gerhardt (2003:14) argues that Georg Simmel's ideas, cited in

Goffman's early writings but absent in his later ones, led Goffman to hold a common view of the 'basic forms of social order'. This observation is in line with Fine and Manning's (2003) conclusion that Goffman never directly engaged other theorists in discussion. Yet, clear influences of early anthropological, sociological and psychoanalytic theory are evident in his work, especially those of his mentor at the University of Chicago, Everett C Hughes (Burns 2002).

### The seminal statement

In his essay 'The Insanity of Place', Goffman (1969:357) summed up and laid out his assessment of the major form of treatment of the day, long-term hospitalisation:

Patients recover more often than not, at least temporarily, but this seems in spite of the mental hospital, not because of it. Upon examination, many of these establishments have proven to be hopeless storage dumps trimmed in psychiatric paper. They have served to remove the patient from the scene of his symptomatic behaviour, which in itself can be constructive, but this function has been performed by fences, not doctors. And the price that the patient has had to pay for this service has been considerable: dislocation from civic life, alienation from loved ones who arranged the commitment, mortification due to hospital regimentation and surveillance, permanent post-hospital stigmatisation. This has been not merely a bad deal; it has been a grotesque one.

This statement came after the publication of his two major works on mental illness and its treatment in the United States prior to deinstitutionalisation. While he acknowledged some of the changes that occurred by the end of the 1960s (for example, tightened involuntary commitment laws, a shift to community-based care), Goffman remained steadfast in his conclusion that the situation of mental illness raised critical social issues of identity, place and social interaction for individuals, families or providers that were neither understood nor considered even as the dominant logic on the nature and societal response to mental illness was shifting.

To this day, Goffman's fundamental insights on the nature of treatment continue to spark discussion and recommendations across the societal landscape. Perhaps this is because he 'put a face on the sociological subject', as Denzin (2003:128) claims, or as Scheff points out, shattered 'the calm surface of everyday life ... [proposing] not a political/economic revolution but a revolution in culture' (2003:61). For those diagnosed or treated in the mental health system, there are frequent mentions of how Goffman's work transformed their

understanding of their experiences, helping to give rise to the notion of the 'consumer' (in Australia, *Our Consumer Movement*; in Germany, *The Runaway-House*; in Hungary, *Voice of Soul*; *Mind Freedom International*), coalition (for example, the National Alliance for the Mentally III in the United States) and 'psychiatric survivors' movements (for example, *World Network of Users and Survivors of Psychiatry*; see McLean 1995; Morrison 2005 on histories) and most recently to 'mad studies' (LeFrancois et al. 2013).

For psychiatrists, Byrne (1997) reminds us that while stigma existed long before psychiatry, the profession has done little to reduce stereotyping and prejudice, and sometimes added to it (for example, the schizophrenogenic or 'refrigerator' mother theory of mental illness, particularly for schizophrenia and autism). Only in recent history has psychiatry taken on this topic wholeheartedly, led by Norman Sartorius, who in 1993 as president of the World Psychiatric Association, chose stigma as the focus on the global meeting. There have always been 'radical' mental health providers at the forefront of efforts to improve and change (for example, RD Laing, Thomas Szasz). As Crossley (2006) documents for the 'anti-psychiatry movement' in the United Kingdom, psychiatrists were often on the frontlines of the challenge to traditional psychiatry, finding support from social scientists and other groups.

Yet, as a profession, the quest for the best diagnostic scheme among warring factions (the Emil Kraepelin's vs Sigmund Freud's followers) was the significant pressing social and professional issue of the nineteenth and twentieth centuries, and even today (for example, DSM-5 vs. RDoC debate, Insel 2013).

Today professional, private and public efforts to reduce stigma vary tremendously cross-nationally. The UK and New Zealand governments heavily fund national reduction initiatives (*Time to Change*; *Like Minds, Like Mine*), but the United States relies almost entirely on private efforts for stigma change (though see SAMSHA's efforts as an exception), while research funding focuses increasingly on the molecular level and away from community-based issues.

### ***The Basics – Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (1961)***

Goffman's fundamental concern in *Asylums* lay in understanding meaning and identity, which Freund (chapter 10, this volume) correctly characterises as his focus. Yet, it was the constricted structural roles of those in 'total institutions' that enabled him to see how even such restricted situations allow for, even require, the establishment of meaning, both 'reasonable' and 'normal' as he notes (see Table 18.1). Goffman saw the primary role of structural contexts where 'an organisation can therefore be viewed as a place for generating assumptions about identity' (1961:186). Thus, Goffman may not have embraced the national or historical sweep of the institution of medicine that others, like Foucault (1988) for example, did, yet he understood the inevitable

Table 18.1 Goffman's typologies in *Asylums* (1961) and *Stigma* (1963)

Phenomenon	Types	Examples
Total Institutions	Established for those labelled in capable and harmless	Nursing homes, orphanages, poor houses
	Established for those labelled incapable and an unintentional threat	TB sanatoria, mental hospitals
	Established to protect the community from 'intentional' dangers and threats	Jails, P.O.W. camps, concentration camps
	Established to pursue an instrumental task	Army barracks, boarding schools, work camps
	Established as retreats and training stations	Monasteries, convents
Inmate Responses to Mortification and Reorganisation Efforts	Situational withdrawal	Curtailment in social involvement
	Intransigent line	Challenging the institution with flagrant refusal to cooperate
	Colonisation	Acceptance of institutional conditions as preferable to those outside with satisfaction from procurement of inside resources
	Conversion	Adoption of institution view of self with corresponding behaviours to be the 'perfect' inmate, patient, soldier to identifying with the staff and acting in their behalf
	'Playing it Cool'	Opportunistic use of all other strategies to maximise physical and psychological damage to self
Types of Stigma	Abominations of the body	Physical deformities
	Blemishes of individual character	Mental illness, Alcoholism, Obesity, Criminality, Homosexuality
	Tribal stigma	Race, Religion, National Identities
Public Knowledge of Stigma (recognition)	Discredited	An obvious 'mark' that is easily perceived or already known
	Discreditable	Concealable 'mark'

Table 18.1 (Continued)

Phenomenon	Types	Examples
Coping with Stigma	Acceptance with isolation	Withdrawal from society, accompanied by bitterness, sadness
	Acceptance with actions	Incorporation into identity, e.g., Advocacy, Support Groups
	Passing	Attempt to normalise or hide stigmatising condition
	Correction	Addressing to negate, e.g., Treatment
	Compensation	Performing normal tasks in a different/extraordinary way, e.g., Special Olympics
	Hostile bravado	Flaunting, usually with a component of anger, e.g., protest
	Victimhood	Seeking secondary gains, e.g., sympathy and roles release
	Blessing in disguise	Attaching special meaning, e.g., gift

connection of culture and structure of the personal and the public. As he noted on the 'two-sided' concept of careers:

One side is linked to internal matters held dearly and closely, such as image of self and felt identity; the other side concerns official position, jural relations, and style of life, and is part of a publicly accessible institutional complex (Goffman 1961:127).

Thus, like those structural identity theorists who followed (for example, Stryker and Burke 2000), it was the 'structure of the self' (1961:xiii) that Goffman sought to understand. Fundamentally, *Asylums* is about the power of social institutions to shape the life chances and lifestyles of individuals who live and work in 'total institutions'. These institutions 'are encompassing to a degree discontinuously greater than the ones next in line ... symbolised by the barrier to social intercourse to the outside and to departure that is often built right into the physical plant' (Goffman 1961:4). Yet, their influence extends far beyond their walls, moulding both patient and provider, jailor and jailed, novice and veteran, when or if they are allowed to re-enter the community. While Goffman often reminded us that it is social *interaction* through which the structure of the self is formed, he also clearly stated that his sensibilities lay squarely with the 'inmates', as he called them, with the goal of learning about their subjective experiences (Goffman 1961:xii).

In *Asylums*, Goffman sought to define, describe and understand the moral career which is 'composed of progressive changes that occur in the beliefs that he has concerning himself and significant others' (1961:14). A total institution does not aim to 'support' an individual's identity; rather, the goal is

to 'constitute it'. Radically, Goffman saw the self not as a property of the person but of the 'prevailing social arrangements' and in particular, in total institutions, of the social control system that routinely compels both the individual and others to act. While the situation is fundamentally different for those who enter a total organisation voluntarily (for example, those who enlist in the military, medical school) versus those who are 'sentenced' to it (for example, those who are drafted, involuntarily hospitalised, sent to jail; Pescosolido 1986), social experiences are likely similar, if less intense in role assimilation. The process begins with a challenge to the self, ultimately reconstituting it, to one degree or another, in line with the organisation's aims. The *mortification of the self* in total institutions is achieved through clear lines of interaction between the few staff and the many inmates and through 'stripping' the physical symbols of the outside world (for example, clothing, hair styles, possessions). Once completed, the *privilege system* offers the foundation for the reorganisation of the self through house rules, rewarding those who follow them and punishing transgressions.

These structures and processes result in narrow and hostile stereotypes whereby, for example, patients come to see themselves as 'inferior, weak, blameworthy, and guilty' (Goffman 1961:7), though the staff hold the power to lessen stigma by offering a 'clean bill of health' (1961:73) upon discharge. Further, because the strategies, or what Goffman called 'secondary accommodations', to the status of 'mental patient' tend to be varied and flexibly employed (Table 18.1), he believed that neither the breaking down nor the rebuilding process could have lasting effects. Yet, he also noted that an individual's 'social position on the outside will never again be quite what it was prior to entrance', since 'the total institution bestows an unfavourable status' (Goffman 1961:72) where stigmatisation produces 'a cool reception in the wider world' (1961:73). Institutional psychiatry, with involuntary admission and lengthy treatment, translated into alienation from society both by and for the individual who receives treatment:

Once he has a record of having been in a mental hospital, the public at large, both formally, in terms of employment restrictions, and informally, in terms of day-to-day social treatment, considers him to be set apart; they place a stigma on him (Goffman 1961:355).

It was this phenomena, the prejudice and discrimination that followed from both the label and the hospitalisation experience, which his next book explicated.

#### **The Basics – *Stigma: Notes on the Management of Spoiled Identity* (1963)**

In *Stigma*, Goffman provided the now standard definition of the concept, an accounting of basic types, and the theoretical fundamentals widely used in

research and practice (Hinshaw 2006; Scambler 2011; Pescosolido 2013). Stigma is a 'mark' that signals to others that an individual possesses an attribute which reduces them from 'whole and usual' to 'tainted and discounted' (Goffman 1963:3). As he notes (1963:5, chapter 1):

... an individual who might have been received easily in social intercourse possesses a trait that can obtrude upon itself attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us. He possesses a stigma, an undesired differentness from what we had anticipated . . . . By definition, of course, we believe that the person with a stigma is not quite human. On this assumption we exercise a varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances.

The central issue or question that follows is *acceptance* (Goffman 1963:13):

Those who have dealings with him fail to accord him the respect and regard which the uncontaminated aspects of his social identity have led them to anticipate extending, and have led him to anticipate receiving; he echoes this denial by finding some of his own attributes warrant it.

Stigma, then, is fundamentally a social phenomenon rooted in social relationships and shaped by the culture and structure of society. While arising from an attribute marking difference, stigma can only be enacted in social interaction and is typified by exclusion from key participation in society. Individuals who face stigma are disqualified from full social citizenship.

As in *Asylums*, Goffman focused on a wide range of identities, rejecting the notion of status as an imprecise and overly broad concept. He considered the situation of being an orphan, facing hearing impairment or a wide spectrum of disabilities, engaging in criminal behaviour and holding identities from prostitute to revolutionary, in addition to having a mental illness. He saw the nature and effects of stigma not as static but as having an ebb and flow in concert with other aspects of an individual's 'moral career' and the larger societal context.

Goffman distinguished different types of stigma that categorised both the 'differences' that societies separate out, the influence of public knowledge and the various responses that individuals can take (Table 18.1). Importantly, the issue of disclosure becomes critical for those who have a concealable stigma and whose coping strategy is 'passing' (1963:84ff). However, individuals could expect support from two groups of individuals in society – others that share the stigma and the 'wise', those who do not bear the mark but are nonetheless sympathetic and including (1963:26).



In sum, difference can create a 'spoiled identity' that has ramifications for prejudice, discrimination and ultimately both lifestyle and life chances.

### The continuing relevance of Goffman's ideas on mental illness

Sociological attention to stigma has been uneven (Pescosolido and Martin 2007). It nearly disappeared from research entirely in the late 1980s; however, a resurgence at the end of the twentieth century marked renewed sociological attention and greater collaboration with other social scientists and other disciplines, including psychiatry (Pescosolido 2013). In fact, this resurgence found voice in the United States' first Surgeon General's *Report on Mental Illness*. By the time of that publication, the new wave of research had documented that psychiatry's claims of the 'dissipation' of stigma were unequivocally wrong (Martin et al. 2000; Link and Phelan 2001), not only in the United States but in other Western nations (Crisp et al. 2000; Jorm 2000; Angermeyer and Dietrich 2006). The evidence clearly showed the continued existence of stigma and its impact on the lives of people with mental illness, on their families, and on the lower levels of support for research, treatment facilities and providers, and programmatic efforts (Pescosolido 2013).

Perhaps most damning are recent studies documenting the morbidity and premature mortality levels for those diagnosed with mental illness. In the United Kingdom, individuals with serious mental illness (SMI) are at a greater risk for mortality from cardiovascular disease, a risk not attributable to medications or smoking (Osborn et al. 2007). In Sweden, 'excess deaths' were attributed to suicide for men and cardiovascular disease for women (Osby et al. 2000). Further, individuals with SMI in the United States experience poorer medical care (for example, lower rates of cardiovascular procedures, substandard diabetes care, Desai et al. 2002; Druss et al. 2002). All in all, years of life lost are estimated to be, on average, 20 years for men and 15 years for women (Thornicroft 2011).

In fact, in some areas, the data reveal that the social and cultural climate appeared to have worsened (for example, assessments of dangerousness, Phelan et al. 2000). This led the Surgeon General to declare stigma as the 'greatest obstacle' to the recovery of persons with mental illness and to follow-up with the *President's New Freedom Commission on Mental Health* (2003). Other nations, notably Australia and New Zealand, seemed to be ahead in their research and programmatic efforts, and during this time, the United Kingdom formulated its national efforts (see special issue of the *British Journal of Psychiatry*, April 2013, for a recent report on progress).

Goffman's legacy has found a wider voice across a range of medical and behavioural issues, including HIV/AIDS (Pryor et al. 1999; Bos et al. 2008), obesity (Hebl and Mannix 2003), sexual orientation (Herek 2009), smoking (Link

and Phelan 2009) and autism (Mak and Kowk 2010). Finally, while there has been more cross-fertilisation across substantive and theoretical traditions in understanding the advances in Goffman's concept, a promising route to further advances remains in taking stock and integrating insights across disciplines.

### Where from here?

With Goffman's foundation intact, both theoretical developments and empirical research since his time have built a foundation to elaborate the social processes underlying stigma, helping to define the path to a new generation of research. Figure 18.1 provides the graphical representation of a modern, trans-disciplinary approach that starts with Goffman's notion that understanding stigma requires a language of social relationships. However, it acknowledges the role of *complexity* that Nobel Laureate Elinor Ostrom (2009), a social scientist herself, argued that we must acknowledge and build into our research. The notion of complexity should not be confused with the idea that social life is complicated; sociologists have always known that. Rather, it acknowledges that large, interacting systems are at work in any social process. Thus, as Figure 18.1 indicates, individuals do not come to social interaction devoid of psychological issues of affect and motivation; they have a history (or lack thereof) of lived experiences with mental health problems or with the lived experiences of others; they also live in contexts in which organisations, media and larger cultures structure normative expectations for stigma. Labelling theory, social network theory, the limited capacity model of media influence, the social psychology of prejudice and discrimination, and theories of the welfare state, all have the potential to contribute to an understanding of the complex web of expectations and structure, shaping what individuals in a particular social time and a particular social place see as 'different', 'undesirable' or 'dangerous' (Pescosolido et al. 2008).

In sum, while Goffman's contributions remain the fundamental base and continued reference point for stigma (Keusch et al. 2006), they have been complemented by other lines of research. Current theory and research have fleshed out the subtle and not-so subtle nature of stigma (Dovidio et al. 2000) and its current levels at the national (Martin et al. 2000; Pescosolido et al. 2008) and global levels (Pescosolido 2013; Pescosolido et al. 2013). More recent research has looked to change (Pescosolido et al. 2010) and the effect of stigmatising context on stigmatising experiences and the use of treatment (Mojtabai 2010; Evans-Lacko et al. 2011). Importantly, the issue of power has become more visible in understanding the roots of stigma, its relationship to population health and the potential for change (Link and Phelan 2001; Stuart et al. 2012; Evans-Lacko et al. 2013; Hatzenbuehler et al. 2013; Pescosolido et al. 2013).

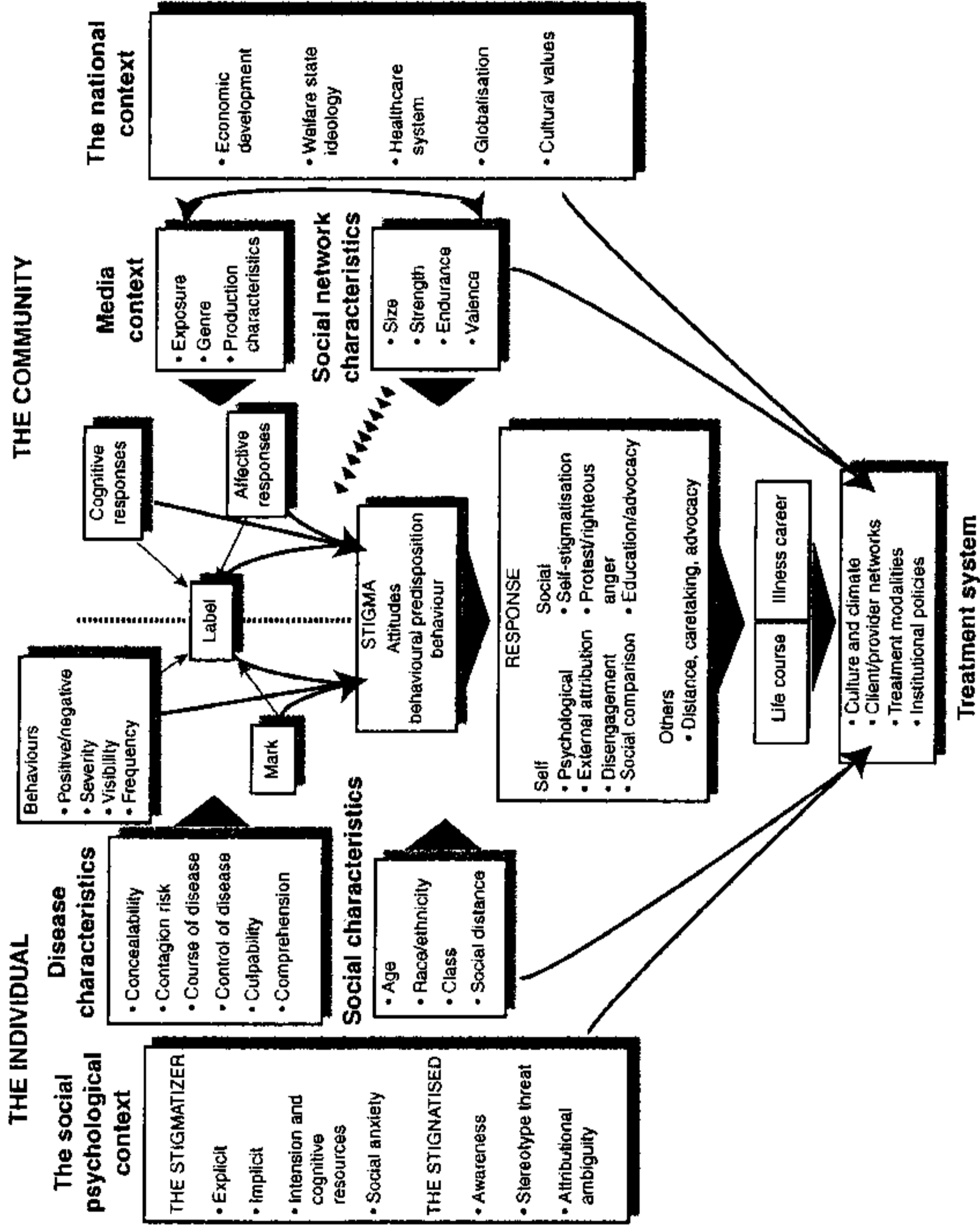


Figure 18.1 Framework Integrating Normative Influences on Stigma (FINIS) Model

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It is important to continue to monitor levels of stigma for individuals, organisations and societies, especially since claims of change are made by those who do not study culture. Yet, it is time to return to some of Goffman's basic ideas, all the while going beyond them, collecting data that benefit from our contemporary toolbox of ideas and approaches. We have the intellectual tools to provide a scientific foundation for efforts to decrease stigma. To date, few efforts do so (see the United States' *Bring Change 2 Mind* as an exception). However, as Figure 18.1 indicates, and sociologists know so well, unintended consequences can arise from a focus on one small part of a complex social system. Just as research advances the need to become more sophisticated, so too do policy and programme efforts to reduce prejudice and discrimination towards mental illness. Sociologists, even in their role as basic researchers like Goffman, can have an immense impact on institutional social change.

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