

Sanism, 'Mental Health', and Social Work/Education: A Review and Call to Action

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Abstract

Sanism is a devastating form of oppression, often leading to negative stereotyping or arguments that individuals with 'mental health' histories are not fit to study social work. However, the term *sanism* is rarely used, understood, or interrogated in the social work academy, even in anti-oppressive spaces. Indeed, social work has been so loyal to the medical model that sanist aggressions, such as pathologizing, labelling, exclusion, and dismissal have become a 'normal' part of professional practice and education. We query the moral integrity of a profession that at its foundational core could play a role in such a discriminatory tactic as sanism. We wonder what the effect of this has been on social work and its education. We ask, who has been excluded, what has been silenced or denied because of the privileging of medical conceptualizations of madness, and how can we work toward anti-sanist social work today? In this paper we provide an overview of sanism. We offer a more critical review of the literature on 'mental health' and social work. We report on our anti-sanist participatory pilot research, and aligned with current Canadian rights work, we call for action with respect to how social workers theorize, research, and respond to madness now.

Keywords: mental health, sanism, Mad studies, oppression, rights, social work, social work education

Social work has long been known for its anti-oppressive scholarship on issues such as racism, heterosexism, and ableism (see, for example, Adams, Dominelli, & Payne, 2002; Baines, 2007; Ben-Ari, 2001; Butler, Elliott, & Stopard, 2003; Hicks, 2008; Krieglstein, 2004; Macey & Moxon, 1986; McPhail, 2010; Trolander, 1997; Trotter, Brogatzki, Duggan, Foster, & Levie, 2006). Yet another form of oppression has received comparatively little attention—namely, 'sanism' (Perlin, 1992, 2003, 2006).

Also called 'mentalism' by the late American activist Judi Chamberlin (1979, 1990, 2005), sanism describes the systematic subjugation of people who have received 'mental health'¹ diagnoses or treatment. Like racism, sanism may result in

¹ Throughout this paper, we use language that differentiates between a medicalized or pathologized approach and an anti-sanist one. To this end, we use 'mental health' to refer to medicalized or pathologized conceptualizations and Mad or madness to refer to anti-sanist approaches.

blatant discrimination, but will be most commonly expressed in “multiple, small insults and indignities” known as “microaggressions” (Kalinowski & Risser, 2005, p. 1). Sanist microaggressions will include low expectations and professional judgments that individuals with such diagnoses are “incompetent, not able to do things for themselves, constantly in need of supervision and assistance, unpredictable, violent and irrational” (Chamberlin, 1990, p. 2).

Although they have not referenced sanism, a handful of scholars have begun to explore ‘mental health’ stigma in social work (Gormley & Quinn, 2009; Larson, 2008; Morley, 2003; Scheyett, 2005). They have reminded us of Goffman’s description of stigma as an “attribute that is deeply discrediting” (1963, cited in Gormley & Quinn, 2009, p. 259). They have also cited Link and Phelan (2001) who broke the process of stigmatization down into “labelling, stereotyping ... and practices such as disapproval” (cited in Gormley & Quinn, 2009, p. 259). In addition, other authors have drawn our attention to the dangers of *internalized stigma* which makes individuals fearful of seeking help and support (Hinshaw, 2007), the notion of *public stigma* “which occurs when large segments of the general public agree with negative stereotypes” (Corrigan & Shapiro, 2010 p. 909) and the impact on families when ‘helpful’ professionals exacerbate stigmatization by focusing on pathology (Lefley, 1992).

However, Thornicroft (2003, 2006) and Sayce (1998) argued that a focus on ‘stigma’ is still too limiting. We agree, for not only does it perpetuate medical conceptions and language around ‘mental health’, but it minimizes the jagged reality of widespread rights abuse and oppression (or sanism) experienced by individuals with such ‘mental health’ histories. With two notable exceptions (see LeFrançois, 2011a, 2011b), it follows that rare is the acknowledgement of sanism in social work scholarship. It also follows that social work’s subscription to a medicalizing discourse that pathologizes madness is so dominant that “offensive and injurious practices are integrated into everyday procedures to the point where we no longer recognize them as discrimination” (Kalinowski & Risser, 2005, p. 2).

With respect to social work and its education, the results of this ‘integration’ are pervasive. The Central Council for Education and Training in Social Work in the United Kingdom has argued “social work needs to be protected from damaging and dangerous practices” by social work students with “mental health difficulties” (Collins, 2006, p. 453). Morrow (2000) suggested that acceptance to social work programs be delayed in these instances. Royse (2000) argued that social work educators should not allow students with these ‘impairments’ to graduate at all, and in Canada, national debates continue around (un)suitability, ‘mental health’ disability and social work education (Watkinson & Chalmers, 2008, p. 505). Yet, despite the potential for rights violations and recent findings that more than 40% of university students in North America may be experiencing “mental health disorders” (Kim, Coumar, Lober, & Kim, 2011)², the issues have often been kept quiet. This suggests

² This is a recent American study that used an online self-screening tool with a sample of 1,000 university students.

that a system of oppression around madness—or, rather sanism—may be, regrettably, alive and well in social work education.

We query the moral integrity of a profession that at its foundational core could play a role in such a discriminatory tactic as sanism. We wonder what the effect of this has been on social work and its education. We ask, who has been excluded, what has been silenced or denied because of the privileging of medical conceptualizations of madness, and how can we work toward a deeper understanding and practice of anti-sanism now?

Taking up these questions, in this paper we provide an overview of sanism. Setting ourselves apart from a traditional, pathologizing orientation to 'mental health and illness', our paper is informed by anti-oppressive practice, intersectionality, and the social model of disability. After describing this theoretical approach, we offer a review³ of literature on 'mental health', madness, social work, and its education as well as details of our own anti-sanist participatory pilot research. Drawing on current Canadian rights work, we conclude with a call for action with respect to how social workers theorize, research, and respond to madness now.

Rethorizing Madness: Using Anti-Oppressive Practice, Intersectionality, and the Social Model of Disability

Given that sanism can be traced to a pathological view of madness, retheorizing begins with recognition of how the predominant use of the medical model has pushed other approaches to the periphery. Although the medical model has been and will continue to be effective for many, it is not the only possible orientation for social work educators and students thinking about madness. Consequently, we approach the issues through three other, but connected, theoretical lenses—anti-oppressive practice (AOP), intersectionality, and the social model of disability.

According to Healy (2005), AOP is the latest iteration of critical social work, an approach that includes but is not limited to feminist, structural, and anti-racist social work. Starting in the United Kingdom in the late 1980s (Martin, 2003) and as part of a move beyond class, AOP has been defined by Dominelli (2002) as addressing “social divisions and structural inequalities in the work that is done with clients or workers ... [that] embodies a person-centred philosophy, an egalitarian value system and a focus on process and outcome” (p.6). An AOP stance assumes that there are multiple forms of oppression, that oppression is tied to unequal power relations, and that critical reflection on these matters is paramount (Healy, 2005). In addition, with AOP the focus must be on creating spaces that promote service users' empowerment and working in partnership with those users in practice, pedagogical, and research settings.

³ To find this literature, we used search engines such as Social Service Abstracts, Academic Search Premier, Social Work Abstracts, and Proquest Research Library. We also used our networks and our peers as well as Google and Google Scholar to find reports, narratives, and pieces that were not peer reviewed.

Tied to this approach is ‘intersectionality’, which has been recently described (CGSM, 2010) as a theoretical framework and tool for achieving social justice (Hancock, 2007; Hankivsky & Cormier, 2009; Shultz & Mullings, 2006; Symington, 2004; Weber & Parra-Medina, 2003). Intersectionality is concerned with how aspects of social identity—such as race, gender, and health status—intersect with oppressions such as sexism and heterosexism to produce and exacerbate suffering. Within the context of ‘mental health’, it has been argued that “intersectionality can be thought of as the social, political, and economic processes through which oppression and privilege are experienced by individuals who have the added stigma and discrimination associated with having a mental illness diagnosis” (CGSM, 2010, p.2). This means we must attend to diversity within social categories, interrogate how the categories depend on one another for meaning, and look “for commonalities cutting across categories often viewed as deeply different” (Cole, 2009, cited in LeFrançois, 2011a, p. 2).

Despite the increasing use of intersectionality and AOP, social work may (unwittingly) contribute to a pathologizing view of people who live with ‘mental health’ issues. This view has been fed by loyalty to medicalizing discourses (Carey, 2003), discourses that frame ‘Mad’⁴ folk as “in need of ... treatment, cure or regulation” (Meekosha & Dowse, 2007, p. 170). As we have already argued, it has also been fed by social work’s related focus on stigma and reluctance to embrace or educate around sanism. However, the social model of disability makes possible a discourse and practice of anti-sanism. It locates the difficulties that Mad folk face not only in their ‘conditions’ but also in our pathologizing, sanist, and “disabling society” permeated by oppressive power relations (Dossa, 2006; Race, Boxall, & Carson, 2005). Depending on social location, gender, race, class, and sexual orientation (Humphrey, 1999), these power relations make it possible for individuals acting ‘differently’ to be taken against their will to the hospital; for workers to be denied employment because of ‘mental health’ histories; or, for Mad students to be excluded from social work programs.

A Review of ‘Mental Health’, Madness, and Sanism in Social Work/Education

Relevant literature informing our work on sanism in social work/education can be classified as scholarship on ‘mental health’ in (a) social work, (b) the psychiatric patient/survivor and Mad movements⁵, (c) ‘mental health recovery’, (d) anti-

⁴ Usage of the term “Mad” by psychiatrized people (who may also identify as patients, clients, users, survivors, and consumers of mental health services) is political; we reappropriate some of the very language that has been used in a derogative manner to oppress us (see Reid, 2008, for more).

⁵ There is considerable debate in the community about these movements. Some see the two as separate, and some believe that the Mad movement is a more recent extension of, and owes its existence to, the work of former patients and consumer/survivors in the 1960s, 1970s, and 1980s.

oppressive practice (AOP), and (e) critical disability. That literature is also a response to the dominance of the biomedical model of 'mental illness'.

Through such a biomedical lens, an expert diagnoses problems and prescribes treatment, thereby directing assessment toward pathology and viewing patients when symptomatic (Stromwall, 2002). Although driven by good intentions, such medicalizing practices have had a profound impact on the way social work has approached madness. On the positive side, social workers now play a pivotal role in the provision of invaluable care and treatment for individuals with a wide variety of 'mental health' issues (see, for example, Heinonen & Metteri, 2005). On the negative side, social work discourses have become rife with references to diagnosis, classification, and 'inappropriate behaviour' (Watkinson & Chalmers, 2008), and are heavily influenced by positivist, traditional forms of research that regularly exclude service users from the production of knowledge (Razack, 1999; Wilson & Beresford, 2000). In our experience with the academy, most 'mental health' courses are organized around pathology, intervention, and working with clients to 'stay on their meds', and most researchers approach madness from a clinical rather than a critical or anti-oppressive stance. Such practices have often led to a divisive 'us' and 'them' mentality in social work where 'we', the rational, well, social work practitioners decide on and distance ourselves from 'them', the irrational, 'ill' users of 'mental health' and social work services (who may also want to be social work students).

This divisiveness has contributed to a long history of medically sympathetic and sanist literature concerned with student competence, 'fitness', and suitability for the profession (Cole, 1991; Cole, Christ, & Light, 1995; Cole & Lewis, 1993; Gibbs, 1994; Hepler & Noble, 1990; Miller & Koerin, 1998; Sin, 2009). According to Buckles et al. (2008), the effect of this ongoing relationship between medicine and social work has resulted in "an unwillingness to learn about or adopt terms such as consumer, survivor or Mad, a refusal to include professionals with psychiatric disabilities and finally, complacency with regard to advocacy and responsibility for public education" (p. 259). Not surprisingly, there have been many reactions to this long-standing relationship, including those voiced by members of the psychiatric patient/survivor and Mad movements.

As Chamberlin (1990) has noted, "like other liberation struggles of oppressed people, the activism of former psychiatric patients has been frequently ignored and discredited" (p. 1), even in social work. And yet, beginning in the late 1960s, 'mental patients' started banding together to question medical treatments, rights abuses, and forced institutionalization (Rheaume, 2002). The founding of this patient/survivor movement saw the formation of organizations such as the Insane Liberation Front in Oregon (Mackay, 2005), publications such as the *Cuckoo's Nest* as well as the development of local peer-driven social alternatives. The founding of the movement also saw the coining of the terms mentalism⁶ (Chamberlin, 1979) and sanism (Perlin 1992, 2003, 2006).

⁶ These two terms are often used interchangeably as they both seek to identify mental health oppression. However, as sanism appears to have more currency in the Mad and survivor movements at present, our project has become an anti-sanist as opposed to anti-mentalist one.

The Coalition Against Sanist Attitudes (CASA, 2011) has credited the late American attorney Morton Birnbaum with coining the term sanism. However, it is Michael Perlin, Director of the Mental Disability Law Studies Program at New York Law School, who is best known for introducing and elucidating the concept of sanism in scholarly articles and books. Summarizing Perlin's arguments, CASA (2011) has explained:

Sanism is a prejudice that closely parallels racism or sexism. Sanist attitudes are built upon a foundation of beliefs that are:

- 1) Insupportable of valid research and evidence to the contrary.
- 2) Based on "gut feelings" or intuition.
- 3) Supported by hyper-unusual anecdotes portrayed by the media.
- 4) Based on how we segregate ourselves (emotions, thoughts, behaviors) from those labeled with a mental disability.

CASA (2011) has also made a clear distinction between stigma and sanism. In line with our earlier arguments, the organization outlines how stigma (be it individual, public, or internalized, for example), is only possible because of "sanist beliefs, attitudes, and practices." In short, the over-arching, prevalent, and often ignored oppression known as sanism is to blame for 'breeding' stigma and our continued interest in it as educators, researchers, and practitioners.

Kalinowski and Risser (2005) detailed that this breeding will separate people into a 'power-up' group and a 'power-down' group. The power-up group is assumed to be normal, healthy, and capable. The power-down group is assumed to be sick, disabled, unreliable, and possibly violent. This factional splitting ensures a lower standard of service for the power-down group, and it promotes the unjust attitude that any medication, residence, job, or education that is substandard for 'us' (the power-up) is fine for 'them' (the power-down). Such splitting also allows the power-up group to judge and reframe behaviours of the power-down group in pathological terms (i.e., as "crazy," "sick," "unsuitable," or "mentally ill").

Grounded in hope, personal responsibility, and self-care, the literature on 'mental health recovery' has detailed the real-life experience of many power-down people as they accept and overcome the challenge of what is perceived (and often pathologized) as their 'mental health' issues (Deegan, 1988; Harding, Brooks, Ashikaga, Strauss, & Breier, 1986a, 1986b). In a departure from the medical model, the central claim is that recovery from 'illness', labelling, and exclusion is not only possible but probable (Mead & Copeland, 2000) with supports and, significantly, access to higher education (Carpenter 2002; Deegan, 2005; Jimenez, 1988). Although flawed (Poole, 2011), recovery has become so popular (Jacobson & Curtis, 2000) that mental health workers are now expected to adopt recovery concepts in their work (Ministry of Health and Long-Term Care, 2009). In the name of redressing oppression, building capacity, and improving employment prospects, they are also expected to open the doors of their Bachelor of Social Work and Master of Social Work programs to Mad individuals (Stromwall, 2002; Deegan, 2005).

This approach to inclusion through education is one that is, in essence, anti-oppressive. Through its concern with the use and abuses of power, anti-oppressive practice (AOP) is a space-making and change-creating initiative (Poole, 2010). Indeed, Mullaly (2001) argued that AOP “depathologizes” seemingly “psychotic behaviours on the part of members of subordinate groups by understanding that such behaviours are often defence and coping mechanisms” (p. 313). However, as argued by the late writer and activist Audre Lorde, the focus of change must be “that piece of the oppressor which is planted deep within each of us” (cited in McDonald & Coleman, 1999, p. 24). So, if we want to improve anti-oppressive pedagogy, we must turn the lens on ourselves and examine that ‘piece within’ (Brookfield, 2006; Rossiter, 2007). If we want to identify and respond to sanism, we must also ask what damage that particular piece—one tied up with normalized aggressions, diagnostic criteria, and fear—may have already done in our social work classrooms.

Others have posed similar questions. Like Kumsa (2008), disability scholars Wilson and Beresford (2000) have argued that, although AOP is committed to social justice and empowerment, the continued reliance on the medical model of madness in many progressive schools of social work is not only inconsistent with this ethos but also exclusionary. Some have suggested (Sin, 2009; Tew, 1999) that the next step must be to address sanism by involving the Mad community in social work research and education. To that end, Reynolds and Read (1999) reported tokenism, invalidation, and dismissal of their efforts toward this goal. However Khoo, McVicar, and Brandon (2004) had pedagogical success in the United Kingdom, as did Matsuoka and Thompson (2009) with their anti-stigma module for Canadian social work programs. Indeed social work education appears to be shifting, but like Stromwall (2002), we wonder if social work’s door is really open to Mad students now? And is their reality, even in anti-oppressive spaces, decidedly different from that of ‘normal’ students?

A Call to Action: Research and Rights Work for Anti-Sanism

The short answer to the latter question is a resounding yes, for the realities experienced by Mad social work students can be exceptionally difficult. As noted previously, various authors have explored issues around ‘mental health’ stigma (Gormley & Quinn, 2009; Larson, 2008; Scheyett, 2005), but a focus on and use of the term *stigma* does not accurately reflect the jagged reality of widespread rights abuse and oppression experienced by Mad individuals. We believe research also needs to target the presence and impact of sanism.

In response, we have begun our own longitudinal community-based research program (CBR) on sanism in social work. With a focus on the development of critical consciousness and aim of breaking down the lines between ‘researchers’ and ‘researched’ (Gaventa, 1993), CBR places what Flicker named as “emancipatory social-justice agendas over positivist notions of objectivity” (2005, p.2). Connected to a history of user-led research in the Mad community (Rose, 2003), CBR builds on the strengths and resources within the community, promotes co-learning, emphasizes the local relevance of ‘problems’, and is always iterative in its process (Israel, Schulz, Parker, & Becker, 2001). CBR also assumes that members of the research

team are peers with personal experience of the issue at hand. Essentially, such a research process is an anti-sanist social work practice.

Our CBR program began with a pilot study⁷ on the experiences of Mad students at a Canadian university (Poole, Barnoff, & Reid, 2009). Speaking to the silences, gaps, and microaggressions that may characterize sanism, the pilot identified a dearth of alternative or non-medical course options on mental health in social work. It revealed ongoing institutional resistance to requested accommodations such as extended time to complete assignments. It revealed issues with how madness has been languaged in the classroom, such as the indiscriminate use of the term *crazy*. It also revealed fears that Mad students may be a danger to the school and/or others. For example, when presenting some of the initial findings at a major social work conference, a senior social work administrator from another university asked, “So you want us to let any old psychopath into our programs?”

Informed by AOP, intersectionality, and the social model of disability, our anti-sanist research process and program now seeks to shift the discourse swirling around mental health in social work from ‘danger’ to discrimination; from fears of a threat to awareness of a benefit to the ‘profession’ and from talk of physical and chemical restraints to one of rights and accommodations. Indeed, we seek to remind social work practitioners and educators that a Mad individual may be living with a long-term challenge, but that challenge may not only improve his/her/hir⁸ feel for the work but by law, must be accommodated.

This brings us to our call for rights work at the local, national, and international levels. As an example, the Ontario Human Rights Commission (OHRC, 2000) has made clear that a ‘mental health issue’ constitutes a non-evident form of disability, and persons with such disabilities face “a high degree of stigmatization” (OHRC, 2000, p. 8). Importantly, the OHRC also distinguishes between stigma, discrimination, and sanism, arguing that stigma and discrimination are part of “a larger belief system” that is not only ableist but sanist (OHRC 2009a, p. 3). Citing Perlin’s work, OHRC has detailed that this larger belief system “can be conscious or unconscious, is embedded in structures and institutions” and underpins and makes possible acts of prejudice and discrimination (OHRC, 2009a, p. 3). In addition, the Supreme Court of Canada has recognized the “distinct disadvantage and negative stereotyping faced by persons with mental disabilities, and has held that discrimination against individuals with mental disabilities is unlawful” (OHRC, 2000, p.8). This extends to a failure to accommodate or fully integrate people with disabilities through the inclusive design of both goods and services. According to the Accessibility for Ontarians with Disabilities Act, such services include schools and universities (OHRC, 2005, p. 5).

⁷This work is also theoretically oriented to anti-oppressive practice and the social model of disability.

⁸ Hir is a gender neutral pronoun, and like Ze (as in “Ze went to the store for hir milk”) speaks to those who do not identify with the pronouns *him* or *her*. Born of organizing and writing in the trans and queer communities, the pronoun has appeared in scholarly work since the 1980s.

As outlined by the OHRC, discrimination in a university can occur when an “education provider adopts a rule that, on its face, discriminates against persons with disabilities” (OHRC, 2005, p. 6). We suggest an example of this may be the common practice of mandatory social work student placements on specific days and at specific times of the weekdays that may conflict with the early morning affects of certain medications. The OHRC has added that discrimination can “take place through another person or means” (OHRC, 2005, p. 6). We suggest an example of this may be when social work administrators suggest to their peers at national conferences that Mad students are ‘psychopaths’. The OHRC has also argued discrimination can take place when “policies, procedures, requirements, eligibility criteria, or qualifications may appear neutral but may nonetheless amount to constructive or ‘adverse effect’ discrimination” (OHRC, 2005, p. 6). According to the OHRC, an example of this may be the common practice of “awarding scholarships only to students in full-time attendance,” effectively excluding those students who may only attend on a part-time basis (OHRC, 2005, p. 7).

Although it has long fielded rights complaints from Mad individuals, the OHRC recently launched a full-scale inquiry into these and other forms of discrimination, finding that they “have contributed to experiences of systemic inequality, including poverty, lack of access to appropriate treatment and support services, and difficulties obtaining employment and housing” (OHRC, 2009b, p.3). The commission also makes clear that people with ‘mental health issues’ often experience a “domino effect,” whereby barriers in one area (such as education), lead to barriers in other areas (such as housing; OHRC, 2009b, p.7). Specific areas of concern going forward include a lack of awareness about Mad people’s rights to be free of discrimination, a lack of anti-discrimination campaigns, and significantly, a prevalence of discriminatory attitudes in higher education (OHRC, 2009b).

Toward an Anti-Oppressive, Anti-Sanist Social Work/Education

Indeed, in their consultation report on achieving barrier-free education for students with disabilities, the OHRC (2003, p. 74) outlined 12 actions that with respect to ‘mental health’ are “required” of post-secondary institutions. These actions include: “review[ing] their policies with respect to part-time students, with a view to identifying and removing barriers to students with disabilities”; “tak[ing] steps to develop and implement appropriate education strategies for faculty and staff with respect to disability-related issues”; and “working together to develop and share best practices for service delivery and supports for students with disabilities.”

We heartily agree, for unless we work together to revisit our own ‘larger belief system’, critical voices will continue to be drowned out by those that feel the profession should be ‘protected’ from Mad individuals. In keeping with what is taking place in the Mad and patient/survivor movements and in rights work across the country, we argue that social work must consider sanism now.

This means the time has come to teach all social work students about the history of the Mad and patient/survivor movements; to offer alternatives to courses that privilege medicalized ‘mental health’ practices; to consider the language in the

classroom and the fear that governs our tendency to segregate ourselves from service users and Mad people wanting to study social work. In practical terms, we suggest that departments conduct an immediate review of their social work courses to determine how Mad histories can be incorporated into foundational classes; for example, how anti-sanist practices and language can be incorporated into individual counselling and group skill building sessions and how taking a course in Mad Studies (Church, in press; Reville, in press) might better educate social workers to the realities faced by service users, community members, and many of their peers.

With respect to research, it is time to do this in a way that includes and is directed by the Mad folk we proclaim to want to ‘know’ and help. It is time not only to study the effects and extent of ‘mental health’ in our daily social work practices but also to revisit and reconsider what sanism actually means *in* social work. It may be that we need to come up with our own understanding and practice of (anti)sanism for social work, one that acknowledges that what we always hoped was ‘mental health care’ can also be an oppressive form of control (Chambon, 1999). It is imperative that we admit how our loyalty to a medicalizing discourse may have blinded us to acts of exclusion, derision, and denial; and it is imperative that we realize refusal or reluctance to explore these issues may actually be unlawful.

If stigma and discrimination flow from and are made possible by the ‘larger belief system’ known as sanism, there really is no way forward except to educate around and work to eradicate sanism from social work. We cannot sensitize our students to oppressions such as heterosexism and racism, for example, and continue to shy away from the stark reality of sanism. Indeed, we must teach an intersectionality that assumes that such oppressions have been and will always be inseparable.

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