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Introduction

As Slack, Miller, and Doak state “because professional communicators contribute to the process of articulating meaning . . . they must be able to analyze critically the ethical implications of the meanings they contribute to” (95). This fact is what has brought me to my research question for this investigative report: what agency do technical communicators have in the representation of people with mental illness? In this report, I analyze how the representation of mental illness by technical communicators affects people with mental illness and how technical communicators can counteract the negative impacts. I present research on identity, disability, and authority in technical communication in order to articulate the technical communicator’s agency.

I use the Diagnostic and Statistical Manual of Mental Disorders IV as an example of a piece of technical communication that serves to represent people with mental illness for social, financial, medical, therapeutic, and other purposes. This piece of technical communication demonstrates the complexity and power of the technical communicator’s agency in representing people with mental illness because it is “a major interpretive code of the mental health profession” (Berkenkotter 146). Analyzing the ways this piece of technical communication represents others and impacts lives helps to determine ways technical communicators can be more ethical in their communication.

Technical Communication’s Affect on People with Mental Illness

Technical communicators are in a powerful position in representing individuals, communities, and cultures. A technical writer has at least partial control over the words that are used in every medical, historical, or scientific text. These words and how they are framed by a specific cultural rhetorical background determine the impact they have on the people being represented: “In the Western humanist tradition, wherever the body is placed in a hierarchical system of value (almost always subordinated to the mind), disability is carried along but assigned to an even lower rung as ‘defective body’” (Wilson and Lewiecki-Wilson 6). And this valuing of the body over the mind has also increased the stigma against disability associated with the mind: “The mind body split . . . persists in popular thinking and has several negative effects: It reinforces the deep prejudices against disabled people with mental illness and cognitive impairments . . .” (Wilson and Lewiecki-Wilson 10).

Since mental illness has been stigmatized throughout history, the representation of people with mental illness is a sensitive and complicated issue. It is important to be fair and respectful in any form of representation, especially when the people being represented have been marginalized throughout history (e.g. those who are traditionally referred to as physically disabled and mentally disordered).

Technical communicators, which includes anyone writing/communicating in the scientific and medical fields, must understand that the words they use to represent people with mental illness have a direct and indirect impact on the ways the mentally ill are seen by society. The methods used to develop texts, like the DSM IV, can leave people out of their own representation and build on assumptions about who is valued and devalued in society. The words they use do more than state facts (that the scientific community has defined as facts), they perpetuate assumptions and

stereotypes about what it means to be *disordered* or *ill*, which makes assumptions about what is normal.

DSM IV

The DSM is a perfect example of a piece of technical communication that serves the purpose of representing people with mental illness. As a “technology of identity,” the DSM has the power to assign identity to those with mental illnesses (Slack and Wise 150). It is used in almost every aspect of the diagnosing, therapy, and billing in the mental health field. It has the power to affect not only how people with mental illness are *literally* represented but how they are treated, both in the “treatment” of mental illness and in how they are treated by society. The DSM IV is just like any other technology, it was “created in a cultural context” which means that it is “shaped by the values and conflicts of that culture” (Slack and Wise 151). And it is also important to remember that the DSM is “constructed by individuals upholding particular values and forwarding particular arrangements of power” and not “the reflection of unassailable truths generated by objective methods” (McCarthy and Gerring 186).

Mullins-Sweatt and Widiger explain the purpose of the DSM as a complex relationship between “a matter of addressing a scientific interest in understanding and explaining psychopathology” and “to facilitate the practice of clinicians administering clinical care” (310). And Catherine Prendergast calls the DSM an “illness-constructing document of incredible rhetorical power” (Wilson and Lewiecki-Wilson 48). Some of the impacts the DSM IV can have include pathologizing the patient and “thereby reducing the complex, multidimensional problems that clients present . . . to a one-dimensional typification, a presenting mental disorder,” normalizing specific behavior that is socially constructed and dependent on the culture surrounding it, and taking this (largely) socially constructed “disorder” and using it for the purposes of health insurance companies, courts, and medical clinics that can profoundly impact lives (Berkenkotter 148).

Although the authors of the DSM are often concerned with the issue of stigmatization, it is not the primary concern when constructing the DSM. This, however, is most likely the primary concern of people with mental illness because of its impact on their lives. How people with mental illness can take part in trying to alleviate this stigma will be discussed further in an upcoming section, but it is important to note that the concerns of people with mental illness should have equally vital roles in their representation as scientific and medical professionals “expertise” has because it brings humanity to the attention of scientific, medical, and technical professionals, who are seen as “experts” and given authority over people with mental illness.

Normalcy Rhetoric

In understanding how the DSM can affect people with mental illness, it is important to consider issues of identity that impact the representation of people with mental illness. We must ask, how does the DSM represent people with mental illness as abnormal and how does this affect their identity? One of the ways the DSM represents people with mental illness is based on the prevalence of the belief in some behavior or values being “normal” or “universal”: “Concepts of universality and the norm . . . are deeply embedded in how a society defines, talks, and writes about disability . . .” (Wilson and Lewiecki-Wilson 6). James C. Wilson and Cynthia Lewiecki-Wilson state in their article “Disability, Rhetoric, and the Body,”: “since Aristotle, the idea of the norm has legitimated exclusion of the disabled . . .” (12). The labeling of some behavior or abilities as “normal” and others “abnormal” has the impact of excluding the “abnormal” by determining access to medical treatments or educational services, defining their agency in legal discourse, and denying access to

various areas in society. The DSM and the communicators behind it wield a great deal of power over the lives of people with mental illness.

The DSM is a reference manual for people who diagnose and treat people with mental illnesses to determine what their *disorder* is. The definitions of mental disorders in the DSM IV, therefore, state how people with disorders are not correctly ordered in one way or another. For example, a common mental illness is depression. In the DSM, there is “Criteria for Major Depressive Episode” that clinicians evaluate to determine whether or not their patients have a “depressive episode.” Clinicians are directed that if “five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning,” along with four more categories that determine that the patient is *not* suffering from a different kind of disorder, that the patient can be diagnosed as having depression (327). This process *literally* defines the patient’s behavior/symptoms as abnormal because it departs from “normal” behavior (i.e. not having those five characteristics in a 2-week period, etc.).

Defining “normal” by defining “abnormal” is problematic because it represents those with the following symptoms as having a “disorder” (temporarily or otherwise). This emphasis on what is considered “disordered” is all part of what Jason Palmeri calls “technical communication’s regime of normalization” (49). Palmeri argues that “technical communication participates in the discursive process of normalization” by “marking bodies as normal or deviant” (49). This process is evident in the DSM IV. The authors of the text set forth definitions of disorders and clinicians diagnose the people who manifest the behaviors/symptoms described by the definitions.

Mullins-Sweatt and Widiger suggest that “[i]t is perhaps the assumption that only a small minority of the population suffers from psychopathology that is contributing to a negative outgroup perception” (308). The fact that many in the public think that mental illness is rarer than it is may contribute to the stigma of mental illness: Believing that mental illness is something that few people deal with “others” those with mental illness by labeling mental illness as abnormal. This could cause people with mental illness to feel that they are alone, different, and abnormal, thereby being identified by society and themselves as disordered. Defining people as disordered impacts the way others see people with mental illnesses as abnormal and the way people with mental disorders see themselves as abnormal. They are forced to define their identity by the ways the medical and scientific fields as well as the social world define them: as disordered, abnormal. Having a mental illness is only part of someone’s identity; it should not define them as a person. However, this can be increasingly complex in the “Information Age” because of how a diagnosis of mental illness can change someone’s life both socially and financially through stigma, insurance, and other areas of society.

Constructing identity and normalcy through representing people with mental illness as being defined by these diagnoses also contributes to how (and if) people with mental illness participate in this representation and how the individual is lost in these labels by the systems that uphold them.

Participation, Agency, and Insurance

The participation of people with mental illness in how they are represented is almost wholly limited to the observations of physicians. There isn’t much research specifically suggesting that people with mental illness take a more influential role in how they are represented. However, when considering the research done by professionals in the field of disability studies, there have been many insights into how researchers should assure people who are differently-abled “a place at the table in making decisions regarding technological delegation” (Slack and Wise 160). Wilson and Lewiecki-Wilson

explain that “disability studies seeks to advance the cause of the disabled and promote social change by analyzing the present social formation that contributes to maintain the walls of exclusion” (9). Analyzing the present social formation that contribute to exclusion and marginalization plays an important role in the impact technical communicators have in representing people who are differently-abled, like people with mental illness, because this analysis is vital to technical communicators’ understanding of how they contribute or counteract that social formation. It is simply not enough for technical communicators to *assume* that they are keeping people who are differently-abled (or ordered) in mind when developing technologies, as that can be problematic on its own.

Jason Palmeri argues that “although participatory design can be great model for reconceiving of usability in ways that value the perspectives of people with disabilities, a disability studies cultural critique demands that we (at times) challenge the assumptions of users in normalized contexts” (57). In other words, involving people who are differently-abled or differently-ordered in the usability testing of technologies (such as reference manuals on mental disorders) without critical understanding of how this usability might reinforce normalizing rhetoric does not effectively solve the issues inherent in representation. Without a critical analysis of “normalcy,” technical communicators might “create a usable yet exclusionary technology” (Palmeri 57). This means that an analysis of the language used as well as the dominating ideology (“ableist”) under which the technology was developed is necessary to developing a fair and respectful involvement of people with mental illnesses.

The human element of mental illness must be incorporated into the process of creating the DSM by involving people with mental illness in the representation of these mental illnesses. This is important not only for research and development of technical communication documents on mental illness (everything from pamphlets in a doctor’s office to the DSM IV), but also because the human element needs to be a focus of the systems that reinforce the normalizing effects of those documents through bureaucratic means and economic purposes. This can be done through developing the rhetoricity of people with mental illness. While the majority of people with mental illness could easily participate in this rhetoricity because of their ability to demonstrate their individual agency, people with severe mental disabilities are often left out because “they do not fit liberalism’s model of independence, productivity, and rhetorical agency” (Lewiecki-Wilson 159). The fact is that “people with secret cognitive and psychiatric disabilities still suffer the worst forms of discrimination and stigma, lack adequate and caring communities and support services, and too often live isolated from social interaction and suffer in sometimes abusive and restrictive settings,” (Lewiecki-Wilson 159). Lewiecki-Wilson suggests, in her article “Rethinking Rhetoric through Mental Disabilities,” that a “revised understanding of rhetoricity as a potential” and utilizing “collaborative and mediated rhetoric, co-constructed by the disabled and their advocates through a reading of bodily rhetoric” can help make including the severely mental disabled in this shaping of their representation possible.

Further complications arise from not having a responsible and critical involvement of people with mental illness in their representation in the DSM because it becomes the basis for the ways insurance companies and the business side of the mental health industry determines who gets help and who doesn’t. In an interview with Keith Brotheridge, a supervisor in the field of mental health, he related his experience as someone who regularly treats patients: “I treat symptoms, not so much a specific diagnosis, but it is the diagnosis number that drives the business side of mental health.” This demonstrates one of the direct effects of the DSM IV on people with mental illness. He also stated

that he did not agree with the labeling aspect of the manual partly because “these diagnoses follow folks around for the rest of their life and become ‘preconditions’ for the next insurance carrier.” Brotheridge explained that what medication a person can receive (and be paid for by insurance), as well as other kinds of treatment, are based solely on the diagnosis the patient receives. And this diagnosis affects whether or not patients can continue medical treatment if they switch to another insurance carrier based on it being a pre-existing condition.

Carol Berkenkotter, in her article “Psychotherapist as Author,” explains that the way psychotherapists diagnose patients involves constructing a written narrative of the patient’s history: the case history. She also explains that this narrative is translated “into a set of meanings compatible with the classifications of psychopathology of the fourth edition of the DSM IV” (146). She points out the resulting impact of that translation is often a pathologizing of the patient as the diagnosis, rather than the narrative that was initially constructed. It also fails “to serve another important purpose for many therapists, which is helping the therapist guide the therapy process by providing a record of the client’s perspective of his or her lifeworld” (146). In the description of the symptoms of depression that was stated earlier, the “criteria” (symptoms) are the basis of such clinician’s diagnosis, but they are often more complex and socially, culturally situated than something as simple as a diagnosis of “Depression.” This suggests that something needs to be done in order to make the DSM more useful and helpful both for clinicians and patients, rather than a document used to determine insurance coverage.

How people with mental illnesses are represented in the DSM IV impacts their ability to be part of that representation. And a direct effect of this representation on their day-to-day lives demonstrates how technical communicators have a complex job in front of them. The ultimate question is how technical communicators can be aware of their power and use their agency to create ethical representations of people with mental illness.

Counteracting the Negative Impact

The analysis of the technical communicator’s agency in representing people with mental illness is tied to the issues of meaning, power, and authority: What’s the meaning? Who has the power to decide that meaning? Who has authority over what meanings? And how these issues can be dealt with ethically (Slack, Miller and Doak). Palmeri argues that technical communication advances a “social constructionist view of science and technology—a view that emphasizes the need to interrogate the ethical, social, and political effects of scientific and technical discourse” (51). This interrogation is imperative to any technical communicator who wishes to ethically represent people with mental illnesses.

Challenge Normalcy Rhetoric

Palmeri states that one of the most important aspects of this interrogation is the issue of normalization. Normalcy in regard to mental illness is more complex than whether or not a person has a mental disorder. Because this diagnosis in Western culture is based in Western ideas of what is “normal,” cultural complexities must be acknowledged. One way to counteract these negative effects of this Westernization would be to develop the DSM IV to be more critical of normalcy rhetoric. Brotheridge stated that one of the ways this could be done is to provide cultural and social contexts for the diagnoses, which he suggests would help clinicians use the text cross-culturally, thereby making the text more usable and moving the basis away from the “very westernized medical approach” that is now the basis of the DSM IV. This westernizing approach inherently others

people from non-western cultures and normalizes western notions of "normal" over others; it needs to be interrogated by everyone from researchers to clinicians in order to be counteracted.

As Slack and Wise explain, “[o]ne of the legacies of the eighteenth-century European Enlightenment was that modern science was rational, ordered, and morally superior” (160). Normalcy rhetoric is based on a binary that was created by scientists when trying to define who is normal by defining the abnormal (the *disordered*). Slack and Wise also explain that “[c]ultural and medical technologies of normalization . . . work against that continuum and on the general population to identify, characterize, and reinforce discrete categories of physical characteristics and behavior” (161). Scientists, researchers, and technical communicators have a powerful role in society because they are historically situated as experts who know the “truth.” They must be able to work against the scientific and medical views of people with mental illness that can label them as abnormal or “special.”

Critically Analyze “Assistive Technology/Usability”

As Palmeri explains, so-called “assistive” technology and usability testing may work to make technologies more usable and representative, but they can have complex repercussions when they reinforce normalcy rhetoric that differentiates between those that need “special” technologies and those who are “normal” users. He states that “[w]e must begin to trouble the binary between normal and assistive technologies” (Palmeri 58). This binary can continue to make people who are differently-abled and differently-ordered seem like a small minority that needs to be “accommodated,” rather than an equal participant in the process of creating technologies that ethically represent their interests.

Involve People with Mental Illness in their Representation

Since Palmeri argues that “assistive” technologies and usability can be problematic, technical communicators need to find a new way to involve people with mental illness in the discourse that serves to represent them: “[w]e technical communication scholars must also critically intervene in broader usability discourses in which people with disabilities are often absent or marginalized” (Palmeri 59). I would argue that this is more than a job for scholars, it is a job for all technical communicators. Prendergast asks, “I wonder if there will be a rhetoric of mental disability that the mentally disabled themselves have the greatest part in crafting” (59)? A positive answer to this question can be created by technical communicators taking their role as advocate for their audience, which people with mental illness as well as therapists, clinicians, and others who utilize the DSM should be a part of, and understand that an ethically responsible text can only be created by involving the voices of those who are impacted by the text.

Because the stigma that goes with mental illness is “the most debilitating handicap faced by former mental patients” (Granello and Pauley 162), involving people with mental illness in the usability testing and creation of the texts that represent them would serve both the technical communicators’ interests (more complex and ethical documents) and the people with mental illnesses’ interests because it would give them a voice that could stand up to the stigma that has existed for so long. If people with mental illness are most affected by the stigma, but also by the diagnosis itself as Brotheridge explained, it is vital for them to have a voice to speak to the scientific, technical, medical communities and, most important, the public about the misinformation and ignorance that exists about mental illness. And this voice must not come solely from those with mental illness who fit into the traditional ideal of a rhetorical individual. As Lewiecki-Wilson argues, using collaborative strategies that involve the person with the disability and their care-giver is vitally important to

incorporating these voices into the representation of people with mental illness. The main role of technical communicators, with mental illnesses and without, needs to be to encourage and infuse these voices into any and all communication that serves to represent people who are *differently*-ordered.

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