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Pathologizing poverty: New forms of diagnosis, disability, and structural stigma under welfare reform



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ABSTRACT

In 1996 the U.S. severely restricted public support for low income people, ending “welfare as we know it.” This led to dramatic increases in medicalized forms of support for indigent people, who increasingly rely on disability benefits justified by psychiatric diagnoses of chronic mental illness. We present case studies drawn from ethnographic data involving daily participant-observation between 2005 and 2012 in public clinics and impoverished neighborhoods in New York City, to describe the subjective experience of structural stigma imposed by the increasing medicalization of public support for the poor through a diagnosis of permanent mental disability. In some cases, disability benefits enable recipients to fulfill important social roles (sustaining a vulnerable household and promoting stable parenting). The status of family members who receive a monthly disability check improves within their kin and neighborhood-based networks, counterbalancing the felt stigma of being identified by doctors as “crazy”. When a diagnosis of mental pathology becomes a valuable survival strategy constituting the basis for fulfillment of household responsibilities, stigmatizing processes are structurally altered. Through the decades, the stigmatized labels applied to the poor have shifted: from being a symptom of racial weakness, to the culture of poverty, and now to permanent medical pathology. The neoliberal bureaucratic requirement that the poor must repeatedly prove their “disabled” status through therapy and psychotropic medication appears to be generating a national and policy-maker discourse condemning SSI malingerers, resurrecting the 16th century specter of the “unworthy poor”.

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Introduction

The past two decades have witnessed dramatic changes in the structure of public aid for the poor in the United States. In 1996, President Clinton signed the Personal Responsibility and Work Opportunity Act, ending “welfare as we know it” and causing a sea change in poverty law – a redefinition and restriction of the basis of public support for our poorest citizens. The dismantling of traditional welfare transfer payments has shifted indigent populations to a form of financial support that is increasingly medicalized – requiring a medical or psychiatric diagnosis to qualify a patient for disability payments. This represents a new approach to the historically ambivalent public responsibility for poverty in the United

States, altering it in ways that we must learn to understand and address at the level of public policy and clinical practice.

Welfare, formerly known as Aid to Families with Dependent Children (AFDC), was renamed Temporary Assistance for Needy Families (TANF), capped at a five year lifetime limit for benefits, and given stricter eligibility criteria, including requirements for workforce participation. This shift prompted a crisis at state and city levels as the 5 years limits were reached. Social service bureaucracies scrambled for new ways to provide support for the still very poor and unemployed populations. Social security insurance (SSI) emerged as one of the primary strategies of poverty relief, with a four-fold increase in the annual growth of SSI beneficiaries between 1996 and 1998 and a 50–100% growth in the number of young adult SSI beneficiaries (30–59 years old) by 2000 (Jans, Stoddard & Kraus, 2004; Wiseman & Wamhoff, 2005/2006). Young adults have become the fastest growing group with disability due to chronic conditions (Joffe-Walt 2013; Lakdawalla, Bhattacharya, & Goldman, 2004).

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Mental health diagnoses have now become the major drivers of the increase in Social Security beneficiaries. By 1999 over a third of Social Security Insurance (SSI) benefit awards were based on psychiatric diagnoses, making it the largest diagnostic category qualifying awardees for benefits, and this percentage continues to rise (Drake, Skinner, Bond & Goldman, 2009). Furthermore, alcoholism and addiction were eliminated as a qualifying diagnosis in 1996, contributing to an increase in mental health-related dual diagnoses (i.e. substance dependence plus another psychiatric diagnosis) (Davies, Iams, & Rupp, 2000). The proportion of SSI awards based on chronic pain conditions such as musculoskeletal conditions also grew substantially after welfare reform - by 25% between 1996 and 2005 (Deyo, Mirza, Turner & Martin, 2009).

Mental health and chronic pain claims have now become virtually the only avenues available for access to relatively stable benefits. Marcia Angell, former editor of the *New England Journal of Medicine*, pointed out, “as low-income families experience growing economic hardship, many are finding that applying for Supplemental Security Income (SSI) payments on the basis of mental disability is the only way to survive” (Angell, 2011). Angell raises the question of whether this relationship between structural stressors and bureaucratic pressures to qualify for psychiatric diagnoses foments subjectivities of disability among the poor; that is, to what extent does their receipt of a psychiatric diagnosis shape their personal identities and capacities?

SSI claims based on mental health or chronic pain diagnoses themselves are likely to have serious health consequences because they have been accompanied by a significant rise in the number of Americans prescribed psychotropic medications. These medications rose from 13% of the U.S. population in 1997 to 19% in 2007 (Mark, Kassed, Levi & Vandivort-Warren, 2012) – antidepressant prescriptions increased by 400% between 2005 and 2008 alone (Pratt, Brody & Gu, 2011). Antipsychotic medications are now the third best selling pharmaceuticals as a class, at \$13.1 billion in sales for 2007 in the U.S. alone (Crystal, Olfson, Huang, Pincus & Gerhard, 2009). Consumption of antipsychotics is frequently a requirement for continued receipt of SSI benefits, despite the fact that they carry the risk of serious side effects, including obesity, diabetes, and elevated cholesterol (Hudepohl & Nasrallah 2012). The expanded prescription of these drugs also increases the likelihood of diversion to street markets, where pharmaceuticals can generate much needed cash (Maxwell, 2011).

Political and moral economies of stigma

Our research draws on the theoretical approaches of political economy and moral economy to help conceptualize the interaction between macro and micro level policy shifts and associated phenomena; e.g. relationships between social structures and stigma. Political economy, for the purposes of this paper, refers to the macropolitics of influence within political, legal, and economic institutions of a society, including labor markets, capital flows, and institutional and policy level decision-making strategies and negotiations that shape access to political power and financial resources. The relationship of political economy to health is well documented in the literature on social determinants of health (CDC, 2011; Marmot, 2005). Some theorists posit that political economic inequalities not only increase health risks of disadvantaged populations, but predetermine the very mechanisms of risk and causation across populations; they identify social inequalities as the fundamental cause of disease; as the “risk of risks” (Link & Phelan, 1995; Rose, 2001).

Erving Goffman's (1963) foundational typology of stigma and identity management strategies is compatible with the broader

theoretical approach of moral economy, which refers to micropolitics of social value and to the interpersonal strategies that social actors use to influence it. Moral economy draws from a number of political economy influences (Scott 1976; Thompson 1971) as well as applications of Marcel Mauss' theory of gift exchange obligations among marginalized populations that reveal how dependencies stigmatized by the larger society are, in fact, the basis for respected reciprocities integral to maintaining extended families (Bourgois & Schonberg, 2009; Stack 1975). More recently sociologist Pierre Bourdieu introduced a model of exchange and reproduction of cultural capital (knowledge, education) and social capital (social contacts and social influence) (Bourdieu, 1986); conceiving of them as vital resources that are exchanged, reproduced and legitimized within local moral economies. These theoretical frames add a much-needed structural dimension to Goffman's concept of stigma, by linking local, interpersonal strategies for managing identities and social value to larger institutional processes of the state, the exercise of power, class relations, and cultural and ideological impositions of meaning and value.

As pointed out by scholars of the institutional causes of stigma, structural factors overdetermine how stigma is experienced on the ground, by politically and economically marginalized groups (Castro & Farmer, 2005; Hatzenbuehler 2011; Parker & Aggleton, 2003; Phelan, Link & Dividio, 2008). In this paper, we use the term *the pathologization of poverty* to describe the increased necessity for disability benefit-related diagnosis after Welfare Reform. It highlights the unintended negative subjectivity-and-social-network-producing effects of increasingly limited access to Federal and State social welfare benefits that have pressured the indigent to seek clinical diagnoses and accept potentially dangerous medications.

We also ask whether being identified as mentally ill is experienced as stigmatizing on the ground, when it becomes integral to stable survival strategies for poor people in the post-welfare reform era. We examine how these strategies may have important effects on their stigmatization at levels far from the direct experiences of recipients, such as in policy making, and how they may be in contradiction to their perceived experience of vulnerability. Here we draw on Pierre Bourdieu's (1993) concept of *fields*, as a system of social positions structured in terms of power relationships. People are affected by multiple overlapping fields, which are hierarchically arranged with local fields generally subordinated to the larger fields that are governed by overarching symbolic power and class relationships. In looking at Welfare Reform and disability, we ask how structures and stigma shape one another: how stigma takes on different meaning and stakes depending on the field in which it is operating (neighborhood resources versus public policy constraints on access to resources). It is the disjunction between the understanding and the rewards and hazards of stigma within and across hierarchically overlapping fields that may be at the crux of what can be conceived of as *structural* in the processual concept of stigma to elucidate the systemic vulnerability of specific population subgroups (Quesada, Hart & Bourgois, 2011).

Methods

Drawing from two long-term ethnographic field projects in two New York City sites, we present here four cases of study participants who received psychiatric diagnoses qualifying them for disability benefits. The first author (Helena), in her role as a psychiatric resident and fellow from 2005 to 2012, recorded participant-observation and interview data from patients and staff in three Manhattan-based outpatient clinics that provided a range of substance abuse, mental health, and primary care treatment services, as part of a study of the use of pharmaceuticals to treat

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