

## **Stigma and Mental Health: Exploring Potential Models to Enhance Opportunities for a Parity of Participation**

Dr Ewen Speed  
Senior Lecturer Medical Sociology  
School of Health and Social Care  
University of Essex  
Wivenhoe Park, Colchester, UK

Dr Danny Taggart  
Lecturer in Clinical Psychology  
School of Health and Social Care  
University of Essex  
Wivenhoe Park, Colchester, UK

### **Abstract**

Over the past two decades, stigma in mental health has become an increasing concern for researchers, practitioners, service users, and policymakers. This has led to a number of international government funded campaigns to reduce stigma and discrimination against people with mental health problems. In this paper, we examine the theoretical and conceptual foundations of these stigma campaigns in order to critically examine what version of mental health is being presented and what the implications are of the campaign messages for people with mental health problems and wider society. We present two models, one which deals with the stigma of mental illness, and another that deals with a stigma in mental health. We propose these models underpin much anti-stigma work in mental health, and that they are respectively predicated on individual or social aetiology models. Both of these models present problems for anti-stigma campaigns that must be addressed if opportunities for an ethics of inclusion for people with emotional distress are to be advanced. In connecting this paper to the themes of the special edition we argue that Mad Studies and associated forms of 'epistemic resistance' need to be incorporated into anti-stigma campaigns in order to truly represent the plurality of perspectives from survivor movements.

## Stigma and Mental Health

That people with a psychiatric diagnosis are stigmatized is beyond doubt. There is a clear body of evidence that demonstrates the link between psychiatric diagnoses and stigmatization. Much of this survey based research can be traced back to two 1950's Sociological studies in the United States (Woodward, 1951; Star, 1955) which demonstrated that for both the 'mentally ill' and for wider society there was significant resistance to disclosing having a mental health problem and pronounced public misunderstanding of what this label might signify. Research in this area has continued to focus on the changing shift in public attitudes towards 'mental illness' since then (for an overview see Pescosolido, 2013). The consequences of stigma are considerable; the end point of the stigma cycle of active discrimination has significant consequences for the diagnosed person with social exclusion in both leisure and vocational arenas, as well as people not accessing treatment and suffering significant health and social problems as a result (Peterson, Pere, Sheehan, & Surgenor, 2007; Beales, 2001; Read & Baker, 1996). For the purposes of clarity, in this paper we will refer to a threefold chain model of stigma developed by Thornicroft and colleagues (2007). They argue that stigma consists of problems of ignorance (knowledge), attitudes (prejudice) and behaviour (discrimination).

In response to the evidence for population level problems with stigma and the deleterious effects that it has, over the past twenty years a number of mental health anti-stigma campaigns have been launched in high-income countries. High profile examples have been rolled out in countries including Australia "Beyond Blue" (Morgan & Jorm, 2007), New Zealand "Like minds, like mine" (Thornicroft, Wyllie, Thornicroft, & Mehta, 2014), the UK "Time to Change" (Smith, 2013), and Sweden "Hjärnkoll" (Hansson, Stjernswärd, & Svensson, 2016). Many of these draw from similar models of delivery, relying on social marketing, celebrity, and service user testimonies of their 'mental illness' and interactive events that utilise principles of social contact theory (Gronholm, Henderson, Deb, & Thornicroft, 2017). These campaigns have enjoyed political support and government funding, and in the UK have been connected to some high level policy changes, such as the 2011 Mental Health Strategy for England and Wales (titled *No Health Without Mental Health*, DH, 2011), which insisted upon parity of esteem between physical and mental health service provision (albeit with no actual statutory process for ensuring this parity). Given this international convergence of stigma campaigns and policies we suggest these campaigns can be regarded as a form of new social movement

(Crossley, 2002).

While the evidence for the existence of stigma and its effects are clear (for the purpose of this paper, we regard discrimination as a negative consequence (material or perceived) that impacts upon a person as a result of a stigmatizing judgement, based on an ascription of that person being 'mentally ill'). What is less clear is how the relation between the diagnosis and the stigmatization might be best understood. This has important implications for how we characterise mental health and stigma, as well as the possible solutions we might develop to address discrimination and stigma in terms of developing an ethics of inclusion that will allow meaningful and consistent social, political, economic, and cultural participation. In moving to understand this relation between diagnosis and stigma, an important first step is to work through how we might characterise what is being stigmatized. Is it the individual with the diagnosis who is stigmatized or is it the process of being labelled as 'psychiatric' that is stigmatizing? This has implications for the context in which we will look to develop an ethics of inclusion, for example, raising a question of do we need to address issues of individual or collective inclusion? Furthermore, does the responsibility for addressing the prejudice and stigma reside at the level of the stigmatized individual, the stigmatizing public, or the stigmatizing institutions? The answer, in part, to these questions might lie in how understandings of emotional distress are understood in terms of their social and political aetiology.

In order to address this, and to inform an ethics of inclusion, we propose two models of aetiology in relation to stigma and mental health, predicated upon either 'stigma of mental illness' or 'stigma in mental health'. The former tends to be based upon an individual aetiology model where the focus of analysis and intervention is an identified person who is regarded as being mentally ill, and all interventions (and stigma) relate to their individualised mental illness. Anti-stigma campaigns, in this context, would tend to invoke strategies aimed at normalizing mental illness as just another form of illness. The latter (stigma in mental health), conversely, draws from a social aetiology model, whereby the co-constitutive effects of poverty, inequality, and trauma can be held to be central to any emotional distress that a person may be experiencing. Anti-stigma campaigns in this context would involve addressing a range of contributory and stigmatizing factors (such as poverty, unemployment, and/or a history of trauma), which might be seen to ascribe a set of negative characteristics upon a person. Anti-stigma campaigns predicated upon a stigma of mental illness (i.e. individual aetiology model), function to background the influence and significance of other social factors by prioritizing medical

model explanations. Conversely, it might be argued that social aetiology models background or cover over issues of individual or personal biography by prioritizing a more social model of madness. So both positions are potentially problematic for different reasons. The core problematisation we unpack in this paper is how these aetiological models can be seen to underpin anti-stigma campaigns and to explore what is gained and lost in terms of an ethics of inclusion, and in the different problematizations that these different models raise for both the stigmatized and the stigmatizing. In turn, this reflection can also feed into current thinking about anti-stigma campaigns, allowing us to consider the appropriateness and applicability of uniform anti-stigma campaigns in the context of a diversity of causes and effects of severe emotional distress.

After Fraser (2003), we can conceive of the individual aetiology model as being predominantly constructed around questions of identity, (even spoiled identity, cf. Goffman, 1963), where a dominant concern is with the politics of recognition. Conversely, we conceive of the social aetiology model as being predominantly concerned with questions around the social, political, cultural, and economic processes that contribute to mental health problems. This is predicated upon questions of structural inequality, or a politics of redistribution, characterised by the coalescence of poverty, trauma, inequality, and social exclusion. Obviously, there is significant overlap between these categories (they are not binary) but both approaches are predominantly informed by frameworks predicated upon notions of recognition or redistribution, which in themselves are underpinned by divergent epistemological positions.

For example, we take as a point of departure a question of whether these two explanations of stigma operate on two fundamentally different aetiological models of emotional distress. Furthermore, we ask whether they function to create or construct a very different psychiatric subject, presenting distinct potential constraints and opportunities for those psychiatric subjects to draw from when making sense of their own (and others) situations.

We do this in order to raise questions about whether mainstream anti-stigma campaigns contain an inherent assumption whereby the primary emphasis is placed on the notion of the stigma of mental illness. In part, this might be regarded as pragmatic; it is far easier to identify and target discrimination against a person because they are ill. In this context, a medical illness frame is used to legitimize difference, such that it becomes possible to acknowledge difference whilst also explaining it (yes, Anne is different, but that's because Anne is ill). This process would involve a series of

engagements whereby the non-ill majority would be educated that those individuals in the affected minority were in fact ill, (not Mad), and therefore were not to be discriminated against because of mental health stigma. This works along the principles of the sick role (Parsons, 1954), which considers the social processes involved whereby people are regarded as being 'legitimately' ill (or not). Furthermore, drawing from another study in classical sociology, this model, predicated upon *stigma of mental illness*, moves to claim back the idea of someone with mental illness as being someone with a spoiled identity (cf. Goffman, 1963). Rather, they are to be seen as someone who is medically ill (i.e. not spoiled). But medicalising the effects of structural inequalities does not make those inequalities go away, it simply provides another explanatory framework for them, one which (re) locates the problem at the level of an individual illness.

Conversely, it is far harder to address stigma *in* mental health, which tends to be predicated upon a series of social, political, economic, or cultural judgments which are not as easily justified by a medical illness explanation. There may be far more pejorative judgements made, which associate madness with badness or laziness (if the person is unable to access the labour market). So whilst a stigma in mental health social aetiology model might be better for someone experiencing emotional distress, in that it enables them to draw attention to the range of social factors contributing to their situation, conversely (even perversely) it may make it harder for them to counter the enduring stigma they experience as part of their difficult social situation. This can be seen in the ongoing struggle in the UK of people with a mental health problem claiming social security for illness and disability. In contrast with the rhetoric of 'an illness like any other', there is evidence that the Work Capability Assessment used to assess welfare eligibility does not take sufficient account of the particular features of mental health problems and so discriminates against this population (Barr et al., 2015). Therefore, an individual level diagnosis being destigmatized through an increased focus on social factors actually contains an attendant risk that their distress will simultaneously be de-legitimized.

Perhaps this conundrum goes some way to explaining the dominance of the individual aetiology (stigma of mental illness) model. However, a problem arises when one explanatory frame achieves dominance in any field, because it actively works to background alternative ones. Stigma campaigns, focusing on the stigma of mental illness, emphasize educating 'the public' and simultaneously reify the idea of (un) spoiled identities. This functions to limit the capacity for developing a public discourse that points to processes and practices of redistributive justice around stigma in

mental health in ways which might allow us all, much more actively, to identify and address pejorative judgements about the role of social inequality, poverty, and the attendant effects of trauma and distress.

### **Individual Aetiology Model**

Within the context of the individual aetiology model, there is a need for an explanatory frame which separates the illness out from the person, in much the way that the medical model of illness locates pathology as a property of individual physical bodies, rather than a reflection of social, political, economic, or cultural conditions

In the English context, the most prominent anti-stigma campaign in mental health has been the Time to Change campaign (TTC). Initiated in 2009, TTC was tasked with coordinating local and national interventions to reduce discrimination against people stigmatized because of their mental health (Henderson et al., 2012). According to Henderson et al., the two mental health charities tasked with delivering TTC set an initial target of a 5% reduction in discrimination experienced by people with mental health problems. Whilst laudable, this aspiration is incredibly difficult to operationalize as it seeks to separate mental health from discrimination. In order to problematize discrimination without problematizing the person's mental health, it is necessary to separate them, and to locate the origin and aetiology of mental illness as something separate to, apart from, who that person is, as a person. In this sense, the framing of mental health stigma in this way implicitly functions to reify a medical model of mental illness,

Consider the work involved in establishing and maintaining a separation between mental health and mental health stigma. A model proposed by Thornicroft et al., (2016) demonstrates, quite rightly, that stigmatization is a particular concern for people with mental health problems and that it can have worse consequences for the sufferer than the original mental health problem itself. They present mental health stigma as constituted around problems of knowledge, attitudes, and behavior (Thornicroft et al., 2016). Problems of knowledge are said to refer to levels of public ignorance regarding mental health problems (i.e. mental health literacy). They go on to argue that these problems of knowledge give rise to the second part of the stigmatization chain; attitudes, or problems of prejudice. Prejudice in this context is defined as negative attitudes held towards people with a

diagnosis of a mental health problem. This chain of prejudice is influenced by Allport's (1954) work which examined racial prejudice in the United States, developing a set of psychological explanations in the form of social attitudes. This corresponds to an individual aetiology model by locating the problem in the mind of the discriminating individual. The solution therefore becomes to correct the 'faulty thinking' of those who hold prejudicial social attitudes. In terms of the 'stigma in mental health' model this means educating the public about common myths around "mental illness" and presenting a more humane face of the "mentally ill" through testimonials, including some from celebrities. While there is undoubted value in this approach and evidence to suggest it can have a positive effect on public attitudes (Thornicroft et al., 2016) at least in the short term, we would argue that by identifying and locating the difficulties primarily at the levels of the individual misses an important wider problem.

Prejudice in an individual aetiology model has both cognitive and affective components, such as the negative appraisals of people with mental health problems often coupled to reactions of fear or disgust (this resonates with Goffman's 1963 idea of a spoiled identity). Problems of knowledge and attitude combine to present the third component of the model, whereby stigma is constituted through problems of behavior. The behavioral consequence of stigmatization is one of discrimination against people with a diagnosis of a mental health problem. So a lack of knowledge leads to prejudicial negative judgements that result in people actively discriminating against people with a psychiatric diagnosis. At all three levels the focus of the intervention is the wider public, not the person with a diagnosis. In this context, the target of the intervention looks to be correct, as a case is clearly made for stigmatizers, (not the stigmatized) to be educated, such that they change their attitudes and behaviors. However, this model of intervention is contingent upon the person with the diagnosis accepting they have an 'illness' – the model does not work unless it is possible to legitimize emotional distress as a medical illness. Unless the person accepts that the set of material conditions they are experiencing are an illness (and therefore not the combined effect of a range of structural inequalities) it is impossible to resist the pejorative stigma attached to unemployment, poverty, and so forth.

Whilst there is nothing ostensibly wrong with the processes outlined in this model, the key point we want to draw attention to is where this model leaves us in terms of possible action it is possible for the stigmatized person to take. This characterization means that the logical response is to educate the 'normal' population, to disavow them of prejudice and change their behavior. This model assumes that the only source of stigma that the 'affected' person might experience is drawn from a 'discredited'

social identity based on the presence of a psychiatric diagnosis, thus ignoring the stigma of poverty, unemployment, sexual abuse, or any other number of contributory factors. Furthermore, it does not allow these co-constitutive factors to be considered as things that need to be addressed. This primary focus on spoiled identity corresponds with the politics of recognition, where it is the identity of the mental health patient that is problematized.

A more recent development of the Time to Change campaign has been to engage people with lived experience in writing 'Personal Stories', narratives designed to be shared with people in similar circumstances and to educate others in what it is like to suffer from a mental health problem (for examples see the website <https://www.time-to-change.org.uk/personal-stories>). The use of personal testimonies by people with lived experience represents an attempt to redress what Fricker (2007) refers to as epistemic injustice, where the lived experiences of people are devalued as a form of knowledge. However, once we look more closely at the contexts in which these stories get used by large charities like the ones behind Time to Change, a more problematic relationship emerges. The use of expert by experience testimonies as part of campaigns have been critiqued as a form of 'patient porn' or 'disability tourism' whereby people's stories are solicited and then edited to fit with a particular, often recovery-based agenda (Costa et al., 2012). This can risk using narratives to fit the interests of the campaign, which in the case of Time to Change is the promotion of an individual aetiological model characterized by a psychocentrism (Rimke, 2003) which functions to background wider social contexts. So while an individual testimony can be an important act of epistemic justice on behalf of the individual person who writes it and, indeed, the person who reads it, the wider structural problem of hermeneutical injustice (Fricker, 2007), e.g. knowledge forms generated, owned, and controlled by people with mental health problems, continue to be marginalized.

### **Social Aetiology Model**

In contrast to the individual aetiology model, a social aetiology model emphasises the social, economic, cultural, political, and historical context in which the mental health problem occurs. Therefore, in this conceptualisation, the construct of 'mental illness' is rejected as presenting an atomised, separate, and identity-based subject position. Instead, 'mental health' is situated in relation to the multiple forms of intersectional disadvantage and structural discrimination that co-constitute it.

This distinction is important because 'mental illness', in an individual aetiology model stigma framework, is presented as an 'illness like any other', whereas in a social aetiology model 'mental health' is seen as occurring primarily in a context of social and relational harm. This shift in emphasis moves the issue of stigma away from a focus on the 'mental illness' as fundamentally external to the person and their context. Rather, it considers how people are 'driven mad' by context, circumstance, and relationships. As well as taking a more pluralistic perspective on mental health (i.e. of mental health being an intrinsic part of who we all are), there is considerable empirical support for these more social aetiologies. The high levels of trauma in the mental health population provides stark evidence for the causal link between child maltreatment and adult mental health problems (Read, Bentall, & Fosse, 2009). Considering adversity and disadvantage in childhood, the Adverse Child Experiences (ACE) studies contribute evidence to an argument of a social aetiology of mental health. The original ACE study (Felitti et al., 1998) examined the relationships between health in adulthood and exposure to childhood physical, emotional, and sexual abuse. It found a strong 'dose responsive' relationship between childhood harm and a number of health problems including substance misuse, depression, and suicide attempts alongside stress related physical health problems. What this, and subsequent ACE studies (Edwards, Holden, Felitti & Anda, 2003), demonstrate, is that 'mental illness' is a problematic construct unless understood in context and that a social model of aetiology goes much further in explaining the wider context of mental health. It is our concern that in this context, anti-stigma campaigns that adhere to an individual aetiology model risk inadvertently masking the harm that underlies a 'mental illness' diagnosis and, by separating it out for other contextual factors, risks adding to other forms of stigma.

A similar process can be seen when we consider wider social determinants of population level mental health problems. As the epidemiological research of Marmot et al., (2010) and others (World Health Organization & Calouste Gulbenkian Foundation, 2014; Friedli & World Health Organization, 2009; Murali & Oyeboode, 2004) demonstrates, rates of mental health problems in society can be linked to levels of income inequality both in terms of the relative frequency of problems occurring at different levels of the income hierarchy but also with higher levels of mental health problems occurring in more unequal societies (Pickett & Wilkinson, 2009). In other words, in relatively wealthy societies like the UK and US, (which have high levels of income inequality), levels of mental health problems are significantly higher than in countries with lower levels of inequality such as many Northern European countries. This relationship also follows a 'social gradient' of health whereby those at the bottom of

the income ladder have higher rates of mental health diagnoses than those immediately above them, who in turn are more vulnerable than those above them and so on and so forth across the trajectory (Marmot, 2010). In this regard, consider how anti-stigma campaigns attempt to normalise 'mental illness' by talking about how frequently it occurs in the population, (the example of 1 in 4 from Time to Change being an example here, see Gronholm et al., 2017). From a social aetiology model perspective, this needs to be challenged; there is little positive benefit in talking about how frequently a population gets unwell because of toxic social environments. Instead, within a social aetiology model the emphasis needs to be on highlighting how the maldistribution of wealth and other forms of structural disadvantage co-constitute mental health problems to create passive subjects that are forced into a sick role. Here, the idea of illness functions to prevent a counter-claim that it is poverty that is the problem, rather than a 'sick individual'. Being socially marginalized and disadvantaged carries multiple forms of discrimination such as reduced social mobility (Social Mobility Commission, 2016), limited access to housing (Dorling, 2015), racism (Fernando, 2014) and quality of health (Marmot, 2010). Therefore, rather than being a consequence of having a mental illness diagnosis, stigma here acts as a co-constituent feature of mental health problems that interact in a circular, complex, and co-morbid way. This stands in contrast to an individual aetiological model that privileges a sequential approach to stigma and discrimination, viewing social disadvantage primarily as a consequence of diagnosis.

In returning to Allport's original work on prejudice (work that is still hugely influential in the world of anti-stigma campaigns today), Henriques (1984) critiqued the work from a post-colonial, critical perspective and examined how this focus on the social attitudes of the autonomous individual allowed wider, structural prejudice and discrimination to go unchallenged. Furthermore, a focus on the social and economic discrimination that a social aetiology model promotes would offer up the possibility of transcending the identity politics of "mental illness." This, in turn, could allow for connections to be made with other groups of disabled peoples, thereby establishing what Laclau (2000) refers to as a "chain of equivalences", where the interests of different groups can coalesce to form a movement to agitate for reduced discrimination which is predicated not upon an acceptance of the medical model, but rather that acknowledges the intersectional stigmatising nature of poverty, disability, trauma, and marginalisation, and which call for a fundamental redistribution of wealth as a means of combatting the effects of poverty, and so on.

A final aspect of a social aetiology model approach to stigma in mental health concerns a move away from the essentialism inherent in many current individual aetiology model stigma campaigns whereby “mental illness” is normalized through a process of reification that perversely emphasizes the differences between those with it and those without. The messages refer to how common “mental illness” is, in the UK context currently affecting 1 in 4 of the population. This figure is based on epidemiological figures from the Psychiatric Morbidity Study (National Centre for Social Research, 2007) which reports that in that survey year, 23% of the sampled adult population had at least one form of psychiatric disorder. However, there is a problem with the methodology of categorization. The ICD-10 Classification of Mental and Behavioral disorders was used in the survey to provide working definitions of the psychiatric disorders assessed. There is a well-rehearsed and comprehensive critique of this framework (see Bentall, 2004), specifically in terms of issues of reliability and validity. This critique emphasizes the limitations of assessing psychiatric symptoms in the absence of objective bio-markers, asserting this undermines the ICD-10’s credibility as a meaningful way to discriminate between those who have and those who do not have mental health problems. Furthermore, in trying to emphasize how frequent it is for mental health problems to occur by saying 1 in 4 of the population will suffer at any one time, it still leaves those diagnosed in a minority in comparison to the 3 in 4 people who will have no problem at all. A more dimensional view of mental health would instead be to argue that some people suffer more extreme forms of distress at different times depending on a range of environmental factors (British Psychological Society, 2017). A social aetiology approach to stigma facilitates a more dimensional approach, which in turn emphasises that mental health problems, whilst they are extreme forms of human experience, they are not qualitatively different from other, more common experiences such as anger, fear, despair, sadness, and shame. So whilst normalising (this has to be an inherent feature of any anti-stigma campaign), it seeks to normalise not based on the medical model, i.e. not on the condition that a person has to accept they are ill, before they can be ‘de-stigmatised’. This breaking down of categorical distinctions echoes Voronka’s, (2016) critical reading of the ‘strategic essentialism’ endemic in viewing people with mental health problems as representing a cohesive, homogenous group. As she argues, taking up an identity position of “mentally ill” even in the pursuit of emancipatory politics risks solidifying difference from the margins and is itself a form of identity politics that obscures the problematic formation of these distinctions. This also intersects neatly with a Politics of Redistribution which likewise argues for the transcendence of atomising group identity formations (Fraser, 2003).

### Politics of recognition, distribution and emotional distress

A previous application of Frasers work to the mental health context identified the ways issues of identity and disparity played out in relation to social justice models of mental health and recovery, (Harper & Speed, 2013). In this instance, we take the core theoretical concept at the heart of Fraser's model of social justice and apply it to the individual and social aetiology models we have identified. This is the idea of 'parity of participation' (Fraser, 2003), in which prevailing social arrangements must 'permit all (adult) members of society to interact with one another as peers', (Fraser, 2003, p.36). Notions of parity of participation underpin *stigma of mental illness* approaches, whereby (re)classification of mental health as an illness is seen as a prerequisite to create parity of participation. In this context, parity of participation seems quite straightforward. But, we argue that this model is overly simplistic, as it fails to address the inherent difficulties in asserting parity. For example, Armstrong and Thompson (2009) draw out the role of 'status order' in this complexity. This is the pattern within any given society that marks some groups out as more culturally recognised than others. The individual aetiology model functions to ascribe status for people who are mentally ill, on the basis of an argument that they are ill, not Mad. Whilst not in itself problematic, this is an overly singular view of both the problem and the solution. Armstrong and Thompson (2009) characterise a number of problems with status order. Pertinent to our argument is their idea of 'institutional differentiation', which highlights the lack of currency in thinking about a singular status order. They give the examples of a heterosexual woman who may be able to compete with a heterosexual man in education, but not at the workplace. There are multiple status orders that combine to enhance or disadvantage the same person in different ways in different contexts. The same principle holds true in relation to a stigma of mental illness model. It only holds true in one status order and, even then, requires the person to accept a certain (medically delineated) status that they may not wish to accept. This links with Faulkner's, (2017) critique of the social contact approach used by many anti-stigma campaigns. She argues that while you can ensure parity of participation in the controlled and regulated forum where the social contact occurs between someone with mental illness diagnosis and a member of the public, this contact may have multiple other, hidden forms of hierarchical difference that can influence relative status and subsequent power relations, to say nothing of what might happen in a similar contact in another context.

The second issue we address in terms of parity of participation is the distinction between

affirmative and transformative political strategies (Fraser, 1997). The transformative struggles set out to challenge 'root causes', such as the root causes that underpin what we have labelled the social aetiology model. Affirmative strategies tackle 'end-state outcomes', much like the stigma of being identified as someone who is mentally ill (in an individual aetiology model). According to Armstrong and Thompson (2009), "a transformative strategy would engage in 'deconstruction': to critique and undermine existing patterns of cultural value in order to create a field of multiple differences" (p.116). It is this type of complexity that we feel anti-stigma campaigns, predicated upon a '*stigma of mental illness*', fail to address. In this sense, they are more affirmative than transformative, to the extent that their failure to address transformative issues may actually be more stigmatising. Fraser herself is characterised as having moved away from a proclivity for transformative approaches to cultural difference and economic issues. However, we feel there is still something of value in these approaches. The potential of any anti-stigma campaign to either affirm or transform particular views or outcomes has to be central to how we make sense of such campaigns. The differences between them offers a clear delineation between different subject positions that the person may or may not be able to take, and speak to wider social projects to transform status orders, which are multiple in their complexity. Whilst there may be numerous obstacles to instituting a parity of participation in practice, the need to think through and theorise these difficulties in relation to concrete, real world examples, can only help to elucidate some of this difficulty.

## Conclusion

As we have set them up in the preceding paper, there are significant differences between an individual and a social aetiology model of stigma in mental health. They are established in the paper as antithetical binary positions. At this point, we want to assert that this was an intentional act on our part, in order to make the case for them as specific positions in the stigma field. Of course, we readily acknowledge that there is much more complexity to this field than our crude model suggests. Indeed, rather than regarding them as models, we would be more comfortable to shift analytical focus and to describe them as different sets of discursive practices, which overlap, sometimes coalescing, other times contradicting, around the complex ways in which people experiencing emotional distress are treated and regarded by those people not experiencing emotional distress. Unfortunately, whilst this world of subtlety and nuance is essential for the social scientists seeking to make sense of this field,

this is not necessarily true for citizens, policy makers, and even service users. As such, perhaps this is the true challenge for anti-stigma campaigns, that is, they need to bring more complexity (and subtlety and nuance) into our understanding of mental health stigma, and indeed mental health itself. As such, an ethics of inclusion must seek to identify and address multiple sources of exclusion if stigma is meaningfully to be identified and tackled. Otherwise, those anti-stigma campaigns risk being underpinned by an ethics of exclusion, i.e. the 1 in 4 rhetoric.

In linking this paper to the themes of the special edition, we ask what is it about mental health that each model attempts to normalise? By focusing upon a 'stigma of mental illness', the individual aetiological model places epistemological limits on what can be considered sane or mad. This binary distinction sits in contrast with the emerging discipline of Mad Studies which promotes a plurality of knowledge forms in the area of mental health and rejects "the hegemony of sanism, psychocentrism and psy discourses" (LeBlanc & Kinsella, 2016). In contrast, the social aetiological model, in promoting a dimensional view of mental health as opposed to mental illness, seeks to avoid these polarities and attempts to open up the possibility of a genuine ethics of inclusion whereby the epistemic credibility of people with "experiential knowledge" (Beresford, 2005) can begin to be normalised. Furthermore, by insisting mental health is considered in context, the social aetiological model links mental health up to wider concerns of social justice which evinces the need for this 'epistemic resistance' (Medina, 2012) to lead on to other forms of social change.

So where does this leave the field in regard to the dominant approaches to anti-stigma campaigns? While we are realistic in our appraisal of the political expediency of such approaches and recognise their value, we would argue that a shift in emphasis is needed. A more pluralistic approach to categorising emotional distress would resolve the reified distinction between those with and those without a mental health problem, indeed this has already been addressed by UK based 'Only Us' campaign, which calls for the dissolution of the 1 in 4 distinction. Likewise, closer attendance to aetiology could demystify mental health by locating it in a more psychosocial context, which some research has suggested can also reduce public stigma (Longdon & Read, 2017). More than anything, however, the current tendency towards individualised, affirmative anti-stigma campaigns means that anti-stigma efforts merely tinker at the edges of mental health and can be read as a relatively cheap policy initiative that can present a society as caring in times of austerity policy formation that endangers the lives of the most marginalised. Seen from this perspective, current campaigns risk not only falling short of transformation but of being inadvertently complicit with the status quo by providing cover for

a less visible, economically based attack on people with mental health problems, their families, and communities.

## References

- Allport, G. W. (1954). *The nature of prejudice*. Reading: Addison-Wesley.
- Armstrong, C., & Thompson, S. (2009). Parity of participation and the politics of status. *European Journal of Political Theory*, 8(1), 109-122.
- Barr, B., Taylor-Robinson, D., Stuckler, D., Loopstra, R., Reeves, A., & Whitehead, M. (2015). First, do no harm': are disability assessments associated with adverse trends in mental health? A longitudinal ecological study. *Journal of Epidemiology and Community Health*, 70(4), 339-345.
- Beales, D. (2001). Continuing stigmatisation by psychiatrists. *British Journal of Psychiatry*, 178(5), 475.
- Bentall, R. (2004). *Madness explained: Psychosis and human nature*. London: Penguin.
- Beresford, P. (2005). Developing the theoretical basis for service user/survivor led research and equal involvement in research, *Epidemiology and Psychiatric Sciences*, 14, 1, 4-9.
- British Psychological Society. (2017). *Understanding psychosis and schizophrenia: Revised edition*. Retrieved from <https://shop.bps.org.uk/understanding-psychosis-and-schizophrenia.html>
- Costa, L., Voronka, J., Landry, D., Reid, J., Mcfarlane, B., Reville, D., & Church, K. (2012). Recovering our stories: A small act of resistance. *Studies in Social Justice*, 6(1), 85-101.
- Crossley, N. (2002). *Making sense of social movements*. London: McGraw-Hill Education.
- Department of Health. (2011). *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*. Department of Health, London.
- Dorling, D. (2015). *Injustice: Why social inequality still persists*. Bristol: Policy Press.
- Edwards, V. J., Holden, G. W., Felitti, V. J., & Anda, R. F. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: Results

from the adverse childhood experiences study. *American Journal of Psychiatry*, 160(8), 1453-1460.

- Faulkner, A. (2017). Radical change or warm sentiments: A commentary on Gronholm et al. (2017) Interventions to reduce discrimination and stigma: the state of the art. *Social Psychiatry and Psychiatric Epidemiology*, 52(7), 777-779.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, 14(4), 245-258.
- Fernando, S. (2014). *Race and culture in psychiatry (Psychology Revivals)*. London: Routledge.
- Fraser, N. (1997). *Justice interruptus: Critical reflections on the 'postsocialist' condition*. London: Routledge.
- Fraser, N. (2003). Social justice in the age of identity politics: Redistribution, recognition, and participation. In N. Fraser & A. Honneth (Eds.), *Redistribution or recognition? A political-philosophical exchange*, (pp. 7-110). London: Verso.
- Fricker, M. (2007) *Epistemic injustice: Power and the ethics of knowing*. Oxford: Oxford University Press.
- Friedli, L., & World Health Organisation. (2009). Mental health, resilience and inequalities [PDF file]. Retrieved from <http://www.euro.who.int/document/e92227.pdf>
- Goffman, E. (1963). *Stigma: Notes on a spoiled identity*. Jenkins, J. H. & Carpenter.
- Gronholm, P. C., Henderson, C., Deb, T., & Thornicroft, G. (2017). Interventions to reduce discrimination and stigma: The state of the art. *Social Psychiatry and Psychiatric Epidemiology*, 52(3), 249-258.
- Hansson, L., Stjernswärd, S., & Svensson, B. (2016). Changes in attitudes, intended behaviour, and mental health literacy in the Swedish population 2009–2014: An evaluation of a national antistigma programme. *Acta Psychiatrica Scandinavica*, 134(S446), 71-79.
- Harper, D., & Speed, E. (2013). Uncovering recovery: The resistible rise of recovery and resilience. *Studies in Social Justice*, 6(1), 9-26.

- Henderson, C., Corker, E., Lewis-Holmes, E., Hamilton, S., Flach, C., Rose, D., Thornicroft, G. (2012). England's time to change antistigma campaign: one-year outcomes of service user-rated experiences of discrimination. *Psychiatric Services*, 63(5), 451-457.
- Henriques, J. (1984). *Changing the subject: Psychology, social regulation, and subjectivity*: Psychology Press.
- Laclau, E. (2000). Constructing Universality. In J. P. Butler, E. Laclau, & S. Žižek (Eds.), *Contingency, Hegemony, Universality: Contemporary Dialogues on the Left*, (pp. 281-307). London: Verso.
- LeBlanc, S & Kinsella, E. (2016) Toward epistemic justice: A critically reflective examination of 'sanism' and implications for knowledge generation. *Studies in Social Justice*, 10(1) 59-78.
- Longdon, E., & Read, J. (2017). 'People with problems, not patients with illnesses': Using psychosocial frameworks to reduce the stigma of psychosis. *The Israel Journal of Psychiatry and Related Sciences*, 54(1), 24-28.
- Marmot, M. G., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair society, healthy lives: Strategic review of health inequalities in England post-2010* [PDF file]. London: The Marmot Review. Retrieved from <https://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf>
- Medina, J. (2012). *The epistemology of resistance: Gender and racial oppression, epistemic injustice, and the social imagination*. Oxford: Oxford University Press.
- Morgan, A., & Jorm, A. (2007). Awareness of beyondblue: The national depression initiative in Australian young people. *Australasian Psychiatry*, 15(4), 329-333.
- Murali, V., & Oyebode, F. (2004). Poverty, social inequality and mental health. *Advances in Psychiatric Treatment*, 10(3), 216-224.
- National Centre for Social Research, (2017) *Adult psychiatric morbidity survey, 2007*. Retrieved from: <http://doi.org/10.5255/UKDA-SN-6379-2>
- Parsons, T. (1954). *Essays in sociological theory (Revised edition)*. New York: The Free Press.

- Pescosolido, B. A. (2013). The public stigma of mental illness: What do we think; what do we know; what can we prove? *Journal of Health and Social Behavior*, 54(1), 1-21.
- Peterson, D., Pere, L., Sheehan, N., & Surgenor, G. (2007). Experiences of mental health discrimination in New Zealand. *Health & Social Care in the Community*, 15(1), 18-25.
- Pickett, K., & Wilkinson, R. (2009). *The spirit level: Why more equal societies almost always do better*. London: Allen Lane.
- Read, J., & Baker, S. (1996). *Not just sticks & stones: A survey of the stigma, taboos and discrimination experienced by people with mental health problems*. London: Mind Publications.
- Read, J., Bentall, R. P., & Fosse, R. (2009). Time to abandon the bio-bio-bio model of psychosis: Exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms. *Epidemiology and Psychiatric Sciences*, 18(4), 299-310.
- Rimke, H. (2003). Constituting transgressive interiorities: 19th-century psychiatric readings of morally mad bodies. In A. Arturo (Ed.), *Violence and the body: Race, gender and the State* (pp. 403-28). Bloomington, Indiana: Indiana University Press.
- Smith, M. (2013). Anti-stigma campaigns: time to change. *The British Journal of Psychiatry*, 202(55), 49-50.
- Social Mobility Commission, (2016). *State of the nation 2016: Social mobility in Great Britain*. London, UK: UK Government.
- Star, S. A. (1955). *The public's ideas about mental illness*. National Association for Mental Health. Chicago: National Opinion Research Center Library.
- Thorncroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., . . . Henderson, C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet*, 387(10023), 1123-1132.
- Thorncroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: Ignorance, prejudice or discrimination? *British Journal of Psychiatry*, 190(3), 192-193.

Thornicroft, C., Wyllie, A., Thornicroft, G., & Mehta, N. (2014). Impact of the “Like Minds, Like Mine” anti-stigma and discrimination campaign in New Zealand on anticipated and experienced discrimination. *Australian & New Zealand Journal of Psychiatry*, 48(4), 360-370.

Voronka, J. (2016). The politics of 'people with lived experience': Experiential authority and the risks of strategic essentialism. *Philosophy, Psychiatry, & Psychology*, 23(3), 189-201.

Woodward, J. L. (1951). Changing ideas on mental illness and its treatment. *American Sociological Review*, 16(4), 443-454.

World Health Organization & Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health*. Geneva: World Health Organisation.

**Acknowledgements:** none

**Competing Interests:** none

**Addresses for Correspondence:**

Dr Ewen Speed: [esspeed@essex.ac.uk](mailto:esspeed@essex.ac.uk)

Dr Danny Taggart: [dtaggart@essex.ac.uk](mailto:dtaggart@essex.ac.uk)

**Publication Date:** July 15, 2019