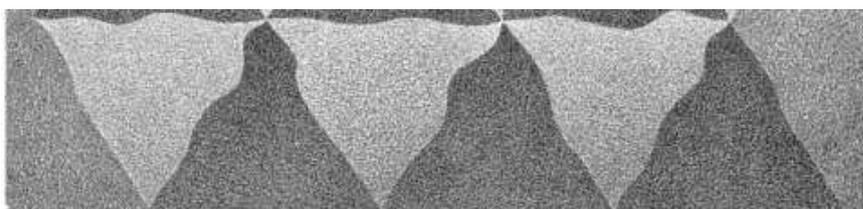


Chapter Two

Placing my research in context: the key issues



Research process:

Within a review of the key issues, with respect to mental health and stigma, I begin to unravel possible linguistic research approaches that will enable me to take my own research forward. I also highlight limited research within the field of adolescent mental health related to management of stigma in mainstream schools.

Young people's perspectives:

I begin to reveal the complex issues related to adolescents experiencing mental health problems returning to mainstream schools. However, even while thinking of young people as belonging to the homogenous groups of 'normal' and 'stigmatised' I introduce the idea that within this concept of in and out groups there may well be difference as well as sameness. The triangular shapes that are becoming slightly irregular show this change in thinking.

Voice of the developing researcher:

Although I begin to have a realisation of the complexities embedded within the concept of the stigma of mental health I give the reader an insight into a personal need, at the start of my research journey, to follow my line of investigation within the containment and tightness of definitions, variables and homogenous groups.

I now present an overview of the key issues that relate to young people experiencing mental health problems, which provided the theoretical framework upon which I initially based my research project. I selected literature that enabled me to locate the field of mental health within that of mainstream education; namely to place the subjects of my research within the context of a stigmatised group in mainstream education with respect to language used. I also introduce others' research into the issues of mental health and stigmatisation.

The issues I deal with in this chapter are:

- adolescence and mental health
- stigma, prejudice and discrimination
- language embedded within the culture of mental health and stigma
- effects of stigma on those with mental health problems
- changing stereotypes
- combating stigma and discrimination and the issues of 'coming out' or 'passing' (Goffman 1963: 92) with respect to having received psychiatric treatment.

I have drawn on a range of texts with partial relevance such as reference to adult rather than adolescent mental health, employment rather than education, and make relevant links to adolescents and their perceptions of mental health issues particularly within the context of mainstream schools. I return to this issue in Chapter Ten when I offer certain critiques with respect to methodology employed by others whose work I reference with respect to being influential in my own selection of measures within my own research process.

In Chapters Four and Seven I present additional literature that I drew on in order to underpin the development of my methodological approach.

2.1 Adolescence and mental health issues

2.1.1 Adolescence

I begin by sharing a quote attributed to Socrates in the 5th century B.C (Figure 2.1), and one which I often read to my pupils as a reminder to be mindful that, in many respects, they are the same as adolescents have always been and probably will be for a long time to come.

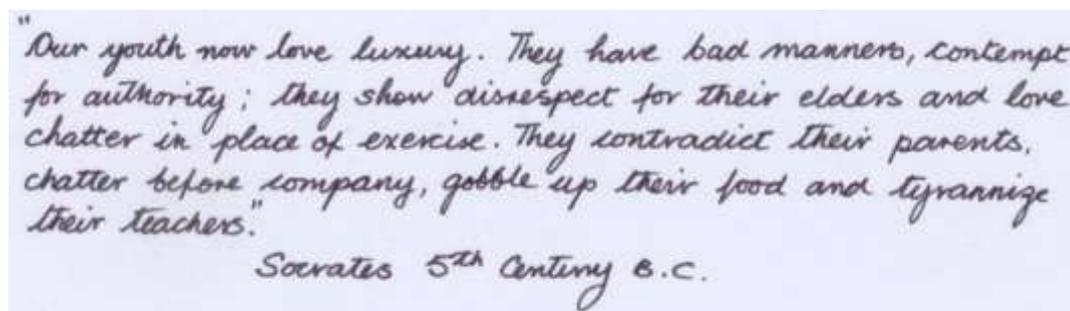


Figure 2.1 A reading from the School assembly book

Adolescence is a period in the lives of young people which brings its very own complexities and which for the 21st century adolescent, within our own society, seems to be forever extending (Aggleton et al 2000). It describes the transition from childhood to adulthood and is characterised by important developments in personal relationships and pronounced physical, cognitive and emotional changes (Hughes et al 2002). Adolescence is a time when young people may become sexually active, when they can learn to drive a car and when some may exhibit experimental behaviours such as the use of drugs and alcohol. It is also a time when young people are expected to become educated, study for important exams, make choices and become less dependent on family members by starting to rely more on their peers for development and support (Mackerell and Lavender 2004). It is at this stage that it seems important to be the same as everyone else, even down to the vocabulary used, perhaps in order to experience a sense of group identity before eventually establishing a unique identity in adulthood (Marshall 2004).

Although adolescence can be a time full of excitement and opportunities, for some it can also be a time full of turmoil, disturbances, anxiety and uncertainty (Hughes et al 2002, Peterson and Leffert 1995) and when the incidence of a range of mental health problems is seen to increase dramatically (Aggleton et al 2000).

2.1.2 Mental health

The term ‘mental health ... [can be] used positively to indicate a state of psychological well being ...’ (Pilgrim 2005: 3) while, that of ‘mental health problems’ reflects the breakdown of emotional order (Long and Fogell 1999). However, Marshall (2004) explained that mental illness is an extremely controversial topic and Corrigan and Kleinlein stated that ‘understanding the nosology and aetiology of mental illness is a complex and ever-evolving enterprise,’ (2005: 12). Marshall (2004) went on to ask:

‘What is mental illness?’ Does it really exist? Are we referring to something that is of the mind, of the brain, or of the whole person? Is it an illness? What is an illness anyway? Or is it a cluster of random symptoms and behaviours? Or one point on a wide continuum of possible human experiences?’ (2004: 137)

There are those who believe that there is no such thing as mental illness as distinct from social deviance (Campbell and Heginbotham 1991, Szasz 1974). But, there are also those who, although accepting the existence of mental illness, also recognise that its boundaries are not well defined and that the kind of duality that a person is either mentally ill or sane is false. This then implies the boundary between mental illness and ‘normal’ as being quite blurred (Corrigan and Matthews 2003). Campbell and Heginbotham (1991) attempted to make clear distinctions between mental illness, learning disabilities or difficulties (mentally handicapped), personality disorders and dementias all of which they put under the heading of mental disorders. Accepting their distinctions on which to build my own framework, in Figure 2.2 I present the main elements of their classification.

Given this confusion within the literature with respect to the nature and definition of mental health, to help my readers establish a sense of the category of young people who are the focus of my research, in Chapter One I conceptualised and presented a simplistic and bounded definition of mental health. I remind the reader that I defined mental health problems as involving a breakdown in the cognitive, perceptual or emotional functioning of a

person to such a degree that prevents them from being able to adequately manage their everyday lives. Although in section (2.4) I discuss the desire to avoid labelling categories of young people I also acknowledge that such avoidance can lead ‘to a tendency to refer to ... [young people] with very different needs as if they were all the ‘same’ ...’ (Warnock 2005: 19) rather than acknowledging, that they are all different and celebrating their differences. I explore the ideas of prejudice of those exhibiting differences in section (2.2.5).

Mental disorders (Dotted lines indicate indistinct boundaries with some overlapping)			
Learning disabilities/difficulties	Mental Illness	Personality Disorders	Dementias
<p>Low or very low intellectual capacity.</p> <p>Present from an early age.</p> <p>Usually congenital and effectively irreversible.</p>	<p>Often transient and highly variable.</p> <p>Involves some breakdown in the cognitive, perceptual or emotional functioning of intellectually normal people.</p> <p>Prevents people coping adequately with everyday aspects of life.</p> <p>Treatment may alleviate symptoms or contribute to a cure.</p> <p>Can be defined as psychotic or neurotic conditions.</p>	<p>Abnormalities of personality.</p> <p>Respond to certain forms of treatment such as behaviour therapy.</p> <p>Include a wide range of patterned characteristics: paranoid, narcissistic, anti-social and harmful.</p>	<p>Deterioration of intellectual functions, particularly memory.</p> <p>Usually happens in old age.</p> <p>Essentially irreversible.</p>

Figure 2.2 Classification of mental disorders based on the ideas of Campbell and Heginbotham (1991: 30-37)

2.1.3 Adolescent mental health

‘... I’m so mixed up and lonely
 Can’t even make friends with my brain
 I’m too young to where I’m going
 But I’m too old to go back again.’

(5)

Although periods of emotional disturbance can perhaps be considered as part of going through ‘normal’ adolescence, for some young people there appears to be a fine line between these acceptable teenage moods, which could be described as young people just ‘moving in

and out of different *cultures* and *contexts* of health' (Warwick et al 2000: 136) and problems with mental health.

For some young people however, it appears that the everyday expectations of adolescent life with added factors, such as illness, bereavement, drug abuse, family breakdown, a learning difficulty or bullying all act as extra stressors and can lead to the onset of mental health problems (Long and Fogell 1999). However, it is important to be aware that, although outside stressors may contribute to the aetiology, genetic predisposition may also be an important factor in causing mental health problems in adolescents.

The turmoil and the difficulties experienced during this potentially troubled time, of enduring mental health problems, can become of such severity that the young person is unable to carry on with everyday life and will need the help of specialist treatment (Hughes et al 2002). For some young people this can be provided in the community (CAMHS Outreach team and clinics) while others will need the support of an in-patient placement such as an adolescent psychiatric unit.

It is important to make the point that because of the complexity of adolescence and of mental health issues, professionals often have difficulties in diagnosing and thus labelling young people's problems within the standard psychiatric diagnostic categories used for adults. As a result psychiatrists may often resort to the term 'emerging personality disorder' in an attempt to give some order and meaning to an otherwise chaotic and complex presentation of behaviours (Lilley 2000). I have even heard one adolescent consultant psychiatrist reflect on the idea that:

'... the older I become the fuzzier my definition of a mental health problem becomes. I would now say it is [perhaps] a lack of mental health rather than having ...'

Phelan et al (2000) who carried out a study to compare public conceptions of adult mental illness in 1950 with those in 1996 also asked the question 'What is mental illness ...?' They suggested that it is only in recent years that definitions of mental illness have broadened to include non-psychotic disorders. This could perhaps explain how although emotional and conduct disorders are common but psychotic states quite rare amongst young people, it was claimed, in 2002, that as many as approximately 20% of adolescents were said to be experiencing psychiatric problems (Hughes et al 2002).

Although I have shown the difficulties in making psychiatric diagnoses within the adolescent group I shall mention here some of those perhaps more generally recognised as mental health labels by the public. I consider that this is important to the development of my research with respect to relating to and uncovering the depth of mainstream pupils' understanding of mental health problems (Chapters Eight and Nine). I include in my list of labels:

- Emotional disorders, including anxiety and depressive disorders that can lead to deliberate acts of self-harm, and suicide.
- Psychotic states which, although relatively infrequent amongst young people, are among those most likely to be hospitalised. They include schizophrenia, drug-induced psychoses with clinical features such as delusional beliefs, hallucinations, and bizarre behaviours.
- Bipolar affective disorder in which the adolescent is seen to be in an elevated mood (manic) and at other times severely depressed.

- Eating disorders including anorexia nervosa involving self-induced weight loss through refusal to eat, and bulimia nervosa which shares the same psychopathology as anorexia but is characterised by bouts of bingeing followed by induced vomiting.
- Obsessive-compulsive disorder (OCD) which is characterised by recurrent obsessional thoughts and/or compulsive acts. It is important to recognise that OCD features are often present in neurobiological disorders such as Tourette's. (Hughes et al 2002)

As I have explained I had intended to explore attitudes only towards those who would come under the headings of experiencing mental illness or emerging personality disorders (Figure 2.2) and who had received psychiatric in-patient treatment, that is, those who may carry the label of (ex) psychiatric patient. However, I show that as my research developed I recognised certain difficulties in this approach.

2.2 Stigma, prejudice and discrimination

In Chapter One, I defined stigma as social disapproval and devaluation associated with unsympathetic connotations of moral judgements of responsibility (Weiner 1995), prejudice and discrimination. Here I explore stigma in more detail and how it relates to prejudice and discrimination. The word stigma is derived from the Ancient Greek practice of cutting and burning people so that they bore a visible sign of shame known as stigmata (Hinshaw 2007, Goffman 1963). Although I use the word to describe the underlying disgrace (Goffman 1963) and shame of experiencing mental health problems rather than visible bodily scars I acknowledge, through my practice-based knowledge, that 'stigma's impact on a [young] person's life may be as harmful as the direct effects of the ... [problem]' (Corrigan & Penn 1999: 765).

Goffman helps to create a picture of stigma in his studies of situations where those he called the 'normals' and those who possess 'a stigma, an undesired differentness from what we had anticipated' (1963: 15) come together in social encounters. I relate to the work of Goffman as I consider the interactions of mainstream pupils and ex-mental health patients in the social context of a mainstream school.

Stigma refers to the social consequences of negative attributions about a person who is perceived stereotypically as belonging to a group rather than being regarded as an individual (Pilgrim 2005). People, and here I include adolescents, are in general more comfortable amongst those with whom they share common characteristics, likes and dislikes. Those who appear different from this sense of commonality may not be so easy to be around and can find themselves being isolated. So, perhaps it is the desire to belong to a group, mentioned earlier as an adolescent characteristic, that makes people regard anyone who is different as an 'outsider', 'one of them' and to stigmatise them (Marshall 2004).

Stigma can fall into three categories: enacted overt public-stigma, internalised self-stigma and perceived stigma (Figures 2.3 and 2.4), all of which are enmeshed and at times difficult to separate (Corrigan and Kleinlein 2005, Green et al 2003).

2.2.1 Signals of experiencing mental health problems

In this section I explain the relationship between signals and stigma of mental health. The fact that people experiencing mental health problems are considered as belonging to a stigmatised group is well documented within the literature, '[with] ... the traditional stereotypes of mental disorder ... [being] solidly entrenched in the population because they are learned early in childhood and are continuously reaffirmed in the mass media and in everyday conversation' (Scheff 1984: 63). But, the fact that someone is experiencing a mental health problem cannot be directly seen and must therefore be inferred from what Corrigan and Kleinlein called 'signals' (2005: 13). They referred to the four signals (Figure 2.3) of:

- symptoms such as bizarre behaviours and talking aloud to oneself
- poor social skills
- appearance such as poor personal hygiene and physical disabilities
- labels of a psychiatric diagnosis.

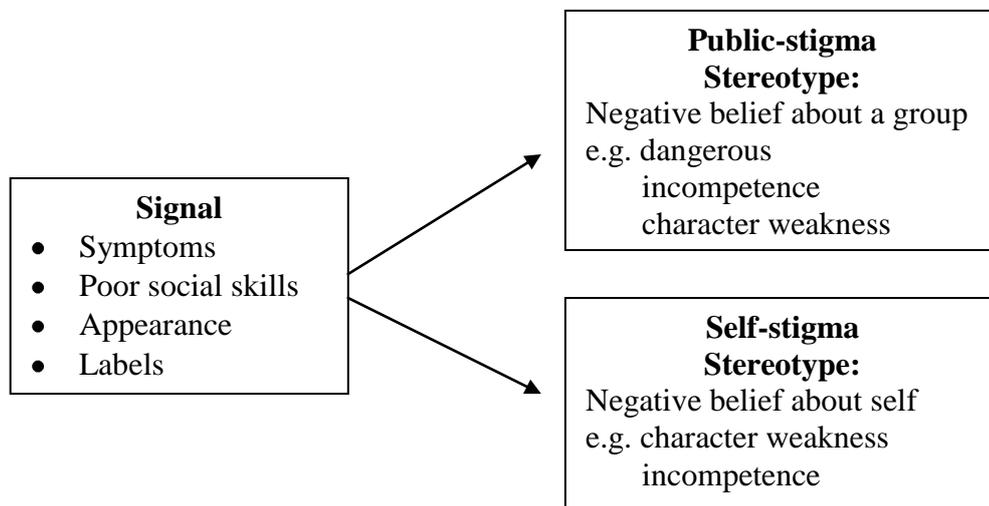


Figure 2.3 Relationship of signals to stigma, based on the ideas of Corrigan and Kleinlein (2005)

The first three signals are aspects of the presentation of self and extremely susceptible to producing false inferences with respect to mental health (Chapters Eight, Nine and Ten) and such misattribution can go either way. A young person who is unkempt and displays 'strange' or 'different' behaviours may not necessarily be experiencing mental health problems but yet could be discredited and carry the stigma of one that does. Another, who has learned to hide his or her experiences with mental health, may not present such signals and as such not be openly stigmatised, but will be what Goffman (1963) described as 'discreditable'. But on the other hand, the fourth signal of labels can be externally generated and research (Link et al 1987, Scheff 1984) has suggested that even in the absence of the first three signals labelling can have negative affects. I return to the issue of labelling in section (2.4). It seems that it may be those with the most marked problems that signal others about their mental health and as such 'these signals yield stereotypes about persons with mental illness [as being] "crazy" and "dangerous" ...' (Corrigan and Kleinlein 2005: 13). In

Chapter Five I show how this idea of signals that may lead to stigmatisation was very important in the early development of my research questionnaire.

I believe that it is worth noting at this point that it is not only those who experience mental health problems that are considered as being stigmatised but also their families and those that care for them (Larson and Corrigan 2008, Hinshaw 2007, Corrigan and Kleinlein 2005, Goffman 1963) and as Faulks, the novelist, said ‘but mad-doctors ... everyone knows they are the hopeless ones ... it was not a proper branch of medicine’ (2005: 106).

Green et al (2003) who explored the nature and impact of stigma from the perspective of the lived experience of adult mental health service users gave a clear description of self and perceived stigma which I shall now turn to in order to describe how, although they may both differ from overt public-stigma, they may all impact in such a way as to increase the sense of being different and of otherness.

2.2.2 Public-stigma

Having described how certain signals such as symptoms, appearance, behaviours and labels can lead to social stereotypes (Corrigan and Kleinlein 2005) I now consider those signals that may lead the general public to believe that people experiencing mental health problems lack intelligibility, social competence and are dangerous (Pilgrim 2005). I also question whether mainstream pupils may believe this of their peers returning to school after in-patient psychiatric treatment and if so what signals would relate to such beliefs. It is true that some people experiencing mental health problems may at some time exhibit one or all of the afore mentioned signals, but not all people with mental health problems will portray all or any of these signals all the time. It could be that it is the symptoms of severe mental illness that manifest beliefs of bizarre and dangerous behaviours and frighten the public which may then produce the overt stigmatising reactions to all those experiencing mental health problems (Goffman 1963). As a result, ‘members of the general public who endorse the stigma of mental illness are perhaps likely to avoid these people and rob them of their opportunities’ (Corrigan 2005: 3). For this reason it appears that many people may hide, even from their peers, the fact that they experience or have experienced a mental health problem. I consider this issue in more detail in section (2.6) when I talk about disclosing and ‘passing’ (Goffman 1963).

2.2.3 Self-stigma

Young people with mental health problems are part of a society that is believed to stigmatise those with such problems and in turn they absorb and internalise the cultural standards held by that group. This process of internalising public-stigma can result in the stigmatised person feeling spoiled and worthless and having a very negative view of him or herself (Green et al 2003, Link et al 2001). Therefore dislike does not only come from others, but may also come from the negative feelings that those experiencing mental health problems have towards themselves, although the origins of that negativity may be the views of the other. It also seems that once stigma has been internalised then the person’s sensitivity to it increases and sometimes to such an extent that many of the behaviours of those belonging to the ‘normal others’ may be misinterpreted as stigmatising (Green et al 2003). This then

forms a vicious circle of perceived stigma, lowered self-esteem and increased sensitivity to social intercourse that may be interpreted as conveying further stigma.

2.2.4 Perceived stigma

Perceived stigma relates to feelings of shame and an oppressive fear of, rather than experience of, overt public-stigma. A person experiencing mental health problems may distort the feelings of social restriction and discrimination to such an extent that it results in self-withdrawal from society. They may also exhibit an overwhelming desire not to disclose their problems to prevent exposure of what they perceive to be the ‘stigmatising attribute and which may spoil their identity’ (Green et al 2003: 228).

I now consider these three types of stigma in relation to prejudice and discrimination.

2.2.5 Prejudice and discrimination

‘No corner of the world is free from group scorn. Being fettered to our respective cultures we are bundles of prejudice.’ (Allport 1954: 20)

When negative emotions towards those experiencing mental health problems, such as dislike, anger, fear, disgust, discomfort and even hatred become involved and are in excess of what would be considered as appropriate then stereotypes tend to lead to prejudice and ultimately acts of discrimination such as avoidance and withholding support (Corrigan and Kleinlein 2005, Stangor 2000, Scheff 1984). I outline this relationship between stigma, prejudice and discrimination in Figure 2.4.

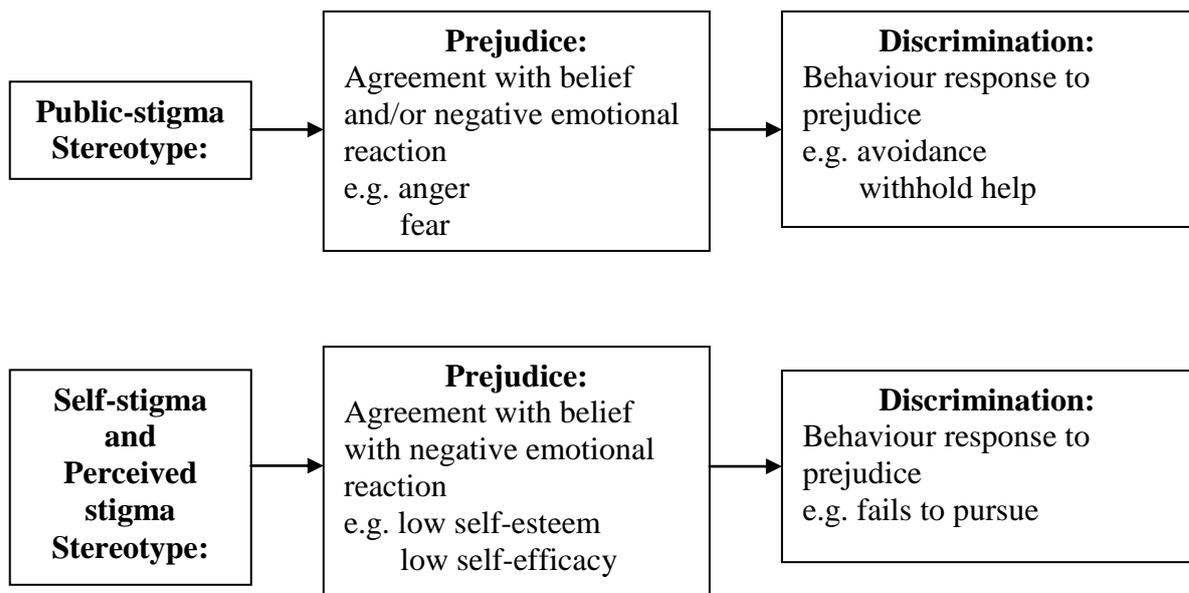


Figure 2.4 Distinction between public stigma, self-stigma and perceived stigma, based on the ideas of Corrigan and Kleinlein (2005)

Marshall (2004) suggested that even if people could be discouraged from engaging in overt expressions of prejudices and discrimination this may do nothing to remove the underlying beliefs, thoughts and feelings that motivate such expressions.

In section (2.3.4) I consider, by reflecting on a selective review of historical perspectives of mental health and stigma, how the early treatment of those seen as exhibiting ‘atypical behaviour patterns’ (Hinshaw 2007: 53) has influenced these preconceptions of those experiencing mental health problems today.

2.3 A linguistic perspective

2.3.1 Language embedded in the culture of mental health and stigma

‘Dad says I’m mental ... He doesn’t know the difference between a lunatic and someone in hospital to work on issues.’

(Quotation from a young person who attended the Unit School)

Rasinski et al (2005), who considered methods for studying stigma and mental illness including that of linguistic analysis, suggested that the stigma of mental health may well be reflected in the language used and that many of the words used to describe those experiencing mental health problems are inappropriate and used in a derogatory and damaging way, perhaps to make feelings of negative attitudes known. But although ‘we [may] use specific stigma terms ... in our daily discourse as a source of metaphor and imagery, typically without giving thought to the original meaning’ (Goffman 1963: 15), this type of language may feed into the already mistaken views that all people experiencing mental health problems are mad or dangerous or both. As Campbell and Heginbotham (1991) suggested, stigmatisation and discrimination have been fuelled for years by jokes about madness. I also believe that the media, by the way it treats mental illness such as associating sadistic killings with ‘madness’ involving a ‘psycho’, influences such attitudes and in Chapter Five I return to the ways in which mental health issues are dealt with in popular television soap operas and how I made use of them in my research design.

In this review of key issues I have already acknowledged the considerable controversy regarding the definition of mental disorders, but even amongst those accepting its existence there appears to be yet further confusion about which terms should be used to describe such problems. Within what at first seems acceptable language to describe those experiencing mental health problems, there are again differences of opinion. Leon (1999) suggested that, as the subject of mental health is so sensitive, particularly in relation to stigma and negative stereotyping, the Mental Health Foundation would focus and talk about having difficulties rather than experiencing mental health problems, while Campbell and Heginbotham (1991) even went so far as to suggest that the word ‘illness’ within the context of mental health could be regarded as a stigmatising term.

So in this dissertation I find myself asking if I should refer to mental health problems or difficulties, mental illness or psychiatric problems. Which would be least hurtful and damaging to the young people experiencing in-patient psychiatric treatment, who are the focus of my research, and which in turn is most accurate? In the writing of this review I have and will continue to adhere, as closely as possible to the original terms used by other

authors, but in the reporting of my own research I shall refer to the young people as experiencing mental health problems and to mental health issues in an attempt to avoid causing any further distress through exacerbating an already fragile and uncertain situation.

I now consider an intergroup context by looking at the work of Maass et al (1989). Basing their work on Semin and Fiedler's linguistic categories (1988) Maass et al showed that the usage of differential categorisations of language could contribute to the development of negative stereotypes and resulting stigmatisation.

2.3.2 An intergroup context

Even though advances in 'biological/genetic models' (Hinshaw 2007: 91) have provided grounds for a less moral and judgemental stance towards the behaviours of those experiencing mental health problems, stigma still appears to exist. Prejudice and discrimination appears to create an 'us' in-group, the 'normals', and a 'them' out-group, the 'stigmatized' (Goffman 1963), a situation that appears highly resistant to change and to have persisted across generations (Allport 1954). The mere categorization of people into groups may lead to favouritism towards the in-group and discrimination against the out-group. So, although such intergroup biases can be important, particularly to adolescents with regards to the maintenance of self-esteem, they can also appear to contribute to the perpetuation of existing stereotypic beliefs even, as in the case of mental illness, these beliefs can often be shown to be misrepresentative of all members of the group.

Although the work of Maass et al (1989) was not in the field of mental health it offered methodologies and methods valuable in beginning to open up an understanding into the language used in the context of young people experiencing mental health problems. Here I look at their theoretical model, the Linguistic Intergroup Bias, and then in Chapters Three, Four and Five I discuss how I employed it in the development of my own study.

Maass et al (1989) carried out experiments that provided evidence for biased language use in such intergroup contexts. They examined the type of language used to describe in-group and out-group behaviours and how it might contribute to the transmission and persistence of social stereotypes. They believed that people described desirable in-group behaviours and undesirable out-group behaviours in more abstract terms than undesirable in-group and desirable out-group behaviours. In their experiments they employed a response scale developed from Semin and Fiedler's (1988) linguistic categories, which outlined a four-level classification, distinguishing between verbs and adjectives used in describing people's behaviours (Appendix 2a). Before describing this underpinning theoretical model in more detail I acknowledge young people's ability to communicate linguistic intergroup bias (Werkman et al 1999). I return to this issue in Chapter Five when considering my own research approach.

In their linguistic category model Semin and Fiedler suggested that the sentence 'A is aggressive' is abstract and implies that person A 'could and probably would behave similarly in the future, in different situations, and with other people ... [and perhaps could even] be expected to show related aggressive behaviours such as kicking, spitting or pulling hair'. However, they put forward that no such inferences could be drawn from the sentence 'A is punching B' which they described as concrete (Maass et al 1989: 982). Through their research Semin and Fiedler (1988) generally confirmed that with increasing level of

abstraction the amount of information about the actor and the expectancies of a repetition of the behaviours increase in a linear fashion. They also confirmed that abstract descriptions are considered less verifiable than concrete ones and that the lack of verifiability implies that behaviours described in abstract remarks maintain stereotypic beliefs.

Maass et al (1989) provided support for Semin and Fiedler's contention in that the more negatively an out-group action is perceived, the higher the level of abstraction at which it appears to be described. They also supported the idea that a biased language is much more pronounced for out-group than for in-group actions, which in the context of a young person experiencing a mental health problem in a mainstream school could be demonstrated by the use of adjectives such as 'crazy', 'mad', 'dangerous' or 'insane'.

At the onset of my own study I proposed that if it is the desire for a positive social identity that is at the basis of the Linguistic Intergroup Bias, then such bias should perhaps emerge in the intergroup setting in which the mentally ill versus 'normal' categorization is important and the 'individual's social identity is at stake' (Maass et al 1989: 991). For young people, I suggested that one of the most public places that this situation could arise would be in a mainstream school setting.

Although language used in describing another's behaviours has been seen to play a large part in maintaining stereotypes, it is also believed that the signal of a mental health label, such as 'schizophrenia' or 'psychosis' or that of 'ex-mental health patient', may also lead to stigma and discrimination and be present regardless of the person's behaviour (Corrigan and Kleinlein 2005). But before looking at the effect of labelling it is important to remind the reader that, because of the complexity of adolescence, professionals often have difficulties in diagnosing and thus labelling their problems within the standard psychiatric diagnostic categories for adults.

2.3.3 Labelling

Whilst Hayward and Bright (1997), who reviewed research on the extent and nature of psychiatric stigma, found support for the view that a psychiatric label is stigmatising, Rosenfield (1997) showed that both stigma and services received may have opposing effects on the quality of life for adults with a mental health label. Although these texts focused on adult mental health they provide useful information regarding stigma and discrimination caused by receiving a mental health label and which seems relevant to young people in mainstream schools.

During the 1960s, it was questioned whether disabilities associated with mental health problems were caused completely by the disorder or whether those with the mental health label continued to behave in such a way as to fit the given 'tag'. It is this split in thinking that appears to divide many mental health providers and researchers into those supporting the medical model and those preferring the labelling theory (Corrigan and Kleinlein 2005).

I now consider both theories but as my research focuses on the language used within the context of mental health, for the purpose of this study I concentrate more specifically on the labelling theory. The medical model of mental illness concentrates on the problem within the individual and usually ignores the social causes. As such the medical model has clear limitations with respect to mental health problems and among these are the lack of

appreciation of the social and cultural aspects with an over-reliance on categories, ideals, and objectivity. This in turn can result in the young person experiencing mental health issues as 'being the problem,' and being expected to 'adapt ... to fit into the world as it is' (6). I now consider the labelling theory in more detail.

Scheff (1984) made clear that the paradigm of the labelling theory does not replace that of the medical model but that it in fact complements it, in suggesting that mental health problems are not caused solely by medical but also social factors. He explained the labelling theory of mental illness as being embedded in the idea that the symptoms of mental illness can be thought of as breaking a set of social rules and being maintained by the reactions of others:

'Labeling [sic] ... is one particular aspect of the process of the segregation of deviants: prisons, asylums ... By virtue of special procedures of segregation the offender receives an official label (... schizophrenic, mental patient ...). These labels or status names are also related to stigmatization [sic], however, since they always carry a heavy weight of moral condemnation ... A deviant is that person whose normative violations have aroused strong emotions in the members of society. In the process of labeling [sic], this moral opprobrium somehow becomes attached to the deviant; he or she is stigmatised.'

(Scheff 1984: 30)

Although the labelling theory claims that the stigma of a label interferes with people having access to certain social and economic resources (Link et al 1987), critics of the theory claim that any stigma encountered by people experiencing mental health problems is relatively inconsequential because labelling may result in them receiving needed services and thus provides significant benefits. However, Rosenfield (1997) who examined these views in relation to adults with chronic mental illness showed that both stigma and received services can have independent and opposite effects on the quality of life through opposing influences on self-concept. Also, before considering how labelling may bring about stigma and discrimination within mainstream schools I explain that it could be argued that without the appropriate label young people may not receive appropriate care or education (Warnock 2005, Dyson 2001). So, by being able to label people as experiencing mental health problems they are perhaps better able to receive the assistance and care they need to improve the qualities of their lives. But then if:

'... services are geared to the label not the individual; ... the label ... [can] become a stereotype which feeds irrational fears in the general public. A deep and genuine fear about mental illness ... [can then be] compounded by frightening and unintelligible labels - schizophrenia, manic depression - and the humanity behind the label is lost.'

Campbell and Heginbotham (1991: 199)

I return to the concept of labelling with respect to education in Chapter Ten (10.2.2 and 10.2.4).

Scheff (1984) had referred to the labelling of individuals by the professionals but it may be that labelling by the general public can be equally as damaging, and perhaps even more so as they, unlike the professionals, will not have a diagnostic framework on which to depend (Campbell and Heginbotham 1991). It is perhaps because of the damaging effects of name calling by pupils such as 'psycho', 'nutter', 'freak', that many young people, on return to mainstream schools, may choose not to disclose the fact that they have been in a psychiatric

hospital. In fact Penn and Wykes recognised that ‘there is evidence that negative attitudes are present in the young even when they do not have a full understanding of mental illness with some reporting them in children as young as 8’ (2003: 205).

However, it has been suggested that if perhaps those who have received psychiatric treatment could behave relatively normal then they probably could shed their label and live a normal life (Link et al 1987). With this notion in mind I now give examples of studies carried out to investigate stigma shown towards those carrying a mental health label that demonstrate how the consequences of labelling still remain unclear:

- Link et al (1987) carried out empirical analyses, which included a measure of how dangerous mental patients are believed to be and whether labelling information activates those beliefs. Their research indicated that a simple assessment of labelling has little effect on social distance, but when a measure of perceived dangerousness of those experiencing mental health problems is introduced then strong effects emerge.
- Harris et al (1990), whose study addressed expectancy effects among children, demonstrated that the knowledge of a person’s psychiatric history does predict social rejection and that these tendencies can start in childhood.
- Alexander and Link (2003), who investigated the relationships between various types of contact, perceived dangerousness and desired social distance, demonstrated that the fear of violence and the need to keep a social distance from people with psychiatric diagnosis diminishes with increasing contact. However, Corrigan et al (2005) did not find this to be the case in their work with adolescents.

So, it seems that although there may be a move towards acceptance of many forms of mental illness as something that could happen to any of us, it still appears from the literature that those diagnosed and labelled with a psychosis may remain ‘one of them’ and, according to Phelan et al (2000), be more feared than they were fifty years ago (Chapter Five). This is an interesting point as mental health problems appear, in current times, more prevalent or if not more prevalent then perhaps more readily recognised as an illness to be treated rather than a condition to be hidden away in asylums. However, I suggest that it should also be acknowledged that through modern forms of communication, including television, the public are perhaps more aware of the different forms of mental health problems and some of the more extreme behaviours and language associated with them. So it seems that those who are experiencing or have experienced mental health problems may continue to suffer considerably from stigmatisation and direct and indirect discrimination, because of the label they carry, even though they show no outward signals that could tend to lead to stereotyping.

I discuss further in Chapter Five, ‘Developing the questionnaire’, the ways in which I consider the label of psychosis and television, particularly the portrayal of mental health issues in popular soaps, within my research approach and data-gathering tool design.

I now reflect on a selective review of historical perspectives of mental health and stigma with specific consideration to language.

2.3.4 A historical perspective

Mental health is enmeshed in the world and embedded in a historical culture. I now consider how the past can be seen to influence the understanding of the meaning of language used

with respect to mental health problems today. This consideration of historical influences also highlights why those young people experiencing mental health problems may be sensitive to some of the language used by their peers.

The treatment of young people experiencing mental health problems today is very different from that of those incarcerated as ‘mad’ up to the middle of the 20th century and unlike those experiencing mental health problems, before ‘madness’ became medicalised in the 19th century. They are now neither regarded as being possessed by the devil nor, as in some cultures, seen to be blessed by a supernatural gift and sainted. Nevertheless they do appear, from the literature, to carry much of the stigma and prejudice inherited from those early beliefs that the ‘mad’ were dangerous and needed to be locked away (Pilgrim 2005). A study of the history of mental health and the early days of psychiatry revealed some of the underlying beliefs and an understanding of the way mental health problems are perceived today.

Faulks in his novel ‘Human Traces’ (2005) gave a concise and yet powerfully descriptive account of what at times appears to be a very cruel history of those believed to be suffering mental disorders:

‘The history of the subject was shameful and brief. There had been the dark ages, when wandering idiots were mocked or pilloried; there had been the superstitious centuries when people spoke of ‘possession’ and other devilish nonsense; then there had been the era of cruelty, of imprisonment and taunting, when the idle sane paid to make faces at the lunatics. This had turned into the era of ‘restraint’, earlier in the century, when the gathering of many mentally afflicted people in one place for the first time had necessitated the use of manacles, irons and straitwaistcoats ... the first medicine was not a herbal preparation or a surgical procedure, but simple kindness; odd, because the struggle of the pioneering mad-doctors had always been to establish that illness of the mind was organic, a physical malfunction to be treated in the same way as an illness of the liver or the foot ...’ (Faulks 2005: 101)

In writing about the history of mental health and psychiatry Pilgrim (2005) referred to such words as ‘insanity’, ‘madness’, ‘foolish’; words often associated with being used today as derogatory terms against those experiencing mental health problems. They are perhaps used today without their original meanings and full implications being fully appreciated and understood. Unsure as to how these terms would fit with psychiatric thinking of the late 20th and early 21st century, I now look at the use of language to describe people experiencing mental health problems.

2.3.5 Language to describe those experiencing mental health problems

‘It’s just a word ... just a blasted word. And what’s more it is a word that will be used, whether we like it or not ... as though the world depended on the choice of a single word ... It doesn’t.’ (Faulks 2005: 136)

The English language is full of words used to describe those as considered ‘mad’ or ‘insane’; such as ‘crazy’, ‘bonkers’, ‘bananas’, ‘psycho’, ‘wacky’, ‘dangerous’, ‘dirty’, ‘bad’, ‘weak’, ‘ignorant’ or just ‘mental’ (Pilgrim 2005). Many of these words are used today to describe those experiencing mental health problems, but as I have already discussed there are many

different views held on what constitutes a mental illness and I now ask are madness, mental illness and insanity the same thing under different descriptive labels? Although Campbell and Heginbotham (1991) argued that they are not the same, they did admit that they couldn't be easily separated by distinct boundaries (Figure 2.5); with people able to cross from each category either through behaviours displayed or diagnoses made by the professionals.

Madness	Mental illness	Insanity
<p>Folk term.</p> <p>Everyday conceptions of what it is to be literally 'mad', 'crazy' 'out of your mind'.</p> <p>'Mad' people are believed to have incomprehensible thought patterns, behave in a ridiculous way, are frightening and sometimes harmful.</p> <p>Carries the stigma of being different, licences a degree of ridicule, [fear], and sometimes pity.</p>	<p>Diagnostic and treatment concept.</p> <p>Clinical concept that refers to syndromes of signs and symptoms professionally recognized as designating mental and emotional conditions.</p> <p>Appropriate to treat in order to effect a cure, prevent deterioration or enable the individual to cope with their condition.</p> <p>Characteristically episodic, with an origin and development which can be set against the normal functioning of that individual. May involve reduced intellectual capacity.</p>	<p>A traditional term used to cover the legal perspective on the general phenomenon of mental abnormality.</p> <p>Primarily to do with legal 'competence'.</p> <p>A condition, which excuses the individual from criminal liability.</p> <p>Frequently confused with mental illness, thus fuelling the tendency to equate mental illness with non-competence.</p>

Figure 2.5 The boundaries of 'mental illness' based on the ideas of Campbell and Heginbotham (1991: 33-37)

I suggest that it is perhaps a complex combination of misunderstanding and misuse of language and difficulty of labelling a difference, as well as historical and cultural influences, that endorse incidents of stigma of those experiencing mental health problems. I return to the issues raised in section (2.3) in Chapters Ten and Eleven.

2.4 Effects of stigma on those with mental health problems

Although the public's conceptualisation of mental illness appears to have broadened the perception that mentally ill people are violent or frightening may have actually increased

(Phelan et al 2000). ‘The former mental patient, although he is urged to rehabilitate himself in the community finds himself discriminated against in seeking to return to his old status and on trying to find a new one in the occupational, ... [mainstream educational], and other spheres’ (Scheff 1984: 66). The belief that mentally ill people are violent or frightening has perhaps been the cause of stigma attached to mental illness, which has led to the increased preferred social distance from them (Corrigan and Kleinlein 2005). This increase in stigma and discrimination could also be partly due to the media or the de-institutionalisation of those with mental illness. Both will have led to a greater exposure of others to mentally ill people who may be perceived as frightening and thus resulted in increased perceptions of dangerousness (Phelan et al 2000).

Because of this perceived increase in fear, many people with mental health problems may experience incidents of rejection, unfriendliness and abuse. It is perhaps the dread of such stigmatising reactions towards them that leads many to be secretive about their mental health problems. Some may even hide from seeking the help they need or fail to comply with treatment once they have been admitted to hospital (Corrigan and Kleinlein 2005). If on the other hand they have received treatment they may avoid disclosing to others the fact that they have experienced mental health problems and been in a psychiatric hospital or the fact they are experiencing ongoing and perhaps long-term problems. As I have already described, being aware of belonging to such a stereotyped social group can lead to feelings of shame and negative behaviours towards him or herself and others in their group, resulting in self-stigma. In section (2.6) I consider in more detail the dilemmas faced by people in deciding whether to disclose or ‘pass’ (Goffman 1963) with respect to having received psychiatric treatment.

Belonging to the stigmatised group of those experiencing mental health problems may also result in the insulting deprivations of being given only simple tasks to perform and being spoken to in a patronising manner. Such insults can be particularly damaging and it is in this way that discrimination can be regarded as a process, which produces and sustains humiliating disadvantages (Campbell and Heginbotham 1991). It has also been my personal experience that people often believe adolescents attending a school attached to an adolescent psychiatric unit will, in general, have learning difficulties or developmental disorders and to be performing at a very low academic level.

However, it has also been seen that not all people with mental health problems have the same bad experiences. Recent reviews of the research evidence has identified a core set of interventions that help persons with a mental illness be better able to accomplish life goals (Drake et al 2001). So for some receiving a diagnosis of mental illness means allowing them access to treatment, which results in relief from troubling symptoms and a positive experience of being a psychiatric patient (Gregoire 1990). Others, belonging to the same stigmatised group may even go one step further and rather than experiencing diminished self-esteem and self-efficacy have in fact managed to oppose the negative evaluation and are able to think of themselves in a positive way and even manage to express righteous anger (Corrigan and Calabrese 2005, Corrigan and Kleinlein 2005).

2.5 Changing stereotypes: combating stigma and discrimination

Having established, from the literature, that there are those who believe that stigma towards people experiencing mental health problems exists, I now turn to look at how such stigma

may be combated. But, as I have also shown, stigma can take the form of public, self, or perceived stigma and so perhaps different approaches may be needed if they are all to be combated.

In this section I include the work of Corrigan et al (2005) and Mackerell and Lavender (2004) who looked at adolescent peer relationships of those experiencing mental health problems. Mackerell and Lavender however limited their study to older adolescents with a first psychosis who had not necessarily returned to education. They claimed that although psychosis may emerge in adolescence limited research had investigated its effect on peer relationships.

2.5.1 Public-stigma

It is believed that to change stereotypes and prejudice shown towards those young people experiencing mental health problems might prove to be very difficult, as the change would need to overcome all social biased beliefs regarding mental illness (Stangor 2000). Rosenfield (1997: 670) suggested that ‘only interventions that reduce stigma within communities and provide high quality treatment can truly improve the life chances and quality of life of people living with mental illness.’ The three most evident and tried ways of changing stereotypes (Corrigan and Penn 1999) include:

- Protest strategies that highlight the injustice of specific stigmas.
- Education strategies, which largely focus on replacing the emotionally charged myths of mental illness, such as ‘mentally ill people are dangerous’. Such strategies include the campaign ‘Changing Minds: Every Family in the Land’, which aims to highlight the high prevalence of mental illness in order to demonstrate that far from being ‘different’ (Marshall 2004) the mentally ill are much like ‘us’ and that very few families are never affected by mental illness (Green et al 2003). In fact, Mackerell and Lavender concluded from their research that ‘early intervention programmes aimed at increasing resilience may enable young people to manage negative peer relationships in ... adolescents ... recovering from a first episode of psychosis,’ (2004: 467) and as such provides a strategy for supporting those young people experiencing mental health problems. Pinfold et al (2003), in their paper into the reduction of psychiatric stigma and discrimination, reported that, although educational workshops in UK secondary schools can produce positive changes in participants’ attitudes towards people with mental health problems, they may not represent lasting behavioural changes.
- Contact strategies, which attempt to challenge the stigma of mental health problems through openness and contact. In some cases such strategies have been found to yield the best changes in stereotypes, prejudice and discriminating behaviours by members of the general public. However, although Alexander and Link (2003) showed that increased contact decreased desired social distance in adults research by Corrigan et al (2005) into how adolescents perceive the stigma of mental illness indicated that contact in fact led to increased discrimination.

I acknowledge that the latter two strategies, both of which relate to my own research, do in fact appear to have had limited effect on changing stereotypes and as such stigmatisation towards those with mental health problems.

2.5.2 Self-stigma

Previous ways to combat stigma appear to have challenged public-stigma by aiming to change the way in which people who do not have mental health problems think about and behave towards those who do. But, Green et al (2003) claimed that less attention has been given to the role of people with mental health problems in the construction of the stigma towards themselves (self-stigma) or the impact that it has upon them. Being part of a stigmatised group can harm the self-esteem of a person and therefore an important consequence of reducing stigma would be to concentrate on improving the self-esteem of people who themselves have or have had mental illnesses (Link et al 2001). Therefore perhaps it would be more beneficial to explore how young people themselves perceive and experience stigma to help them structure their interactions positively (Bagley and King 2005). In Chapter Eleven I consider a young person's ability to change his or her personal constructs through which they perceive their own world.

It seems therefore that perhaps self-stigma, and to some extent perceived stigma, could prove to be a greater barrier than actual overt public-stigma to young people making a successful re-integration back to mainstream education. Therefore, at the time of planning the young person's transition programme, discussion around self, perceived and public-stigma would appear to be important for both reassurance and developing coping strategies. But, any attempt to combat stigmatisation and discrimination, in order to support young people make a successful re-integration to mainstream education, may acknowledge a 'them' and 'us' situation, which could in turn highlight the prevalence of hostile attitudes and perpetuate a stigmatised stereotype (Green et al 2003). Such acts could ultimately reinforce the sense of perceived stigma and 'otherness' and further prevent young people from making a disclosure as to having received psychiatric treatment or what Goffman (1963: 92) refers to as 'passing'.

In the next section I draw on a literature base around the issues of the young gay and lesbian community and relate to disclosing having received in-patient psychiatric treatment.

2.6 'Coming out' or 'passing'

Pupils often ask advice before returning to mainstream education as to what or how much they need to tell people about where they have been during their long absence from school. It would be good to have the confidence to say to them 'tell the truth, it will be okay,' but there does not seem to be any firm evidence that this is the case. Would disclosure or 'coming out', regarding their psychiatric treatment, at the time of transition be beneficial to young people returning to mainstream education?

Advocates and researchers holding the belief that contact does reduce stigma and discrimination have, in several cases, compared the experiences of those experiencing mental health problems to those of the gay and lesbian community. I now turn to the work of Corrigan and Matthews (2003) who looked at the costs and benefits for people with psychiatric disorders to publicly disclose their psychiatric labels, and compared these tensions with the gay and lesbian community. They explained that some clinicians claim that a necessary part of recovery from mental illness is to be able to identify the role that the experience of having had a mental illness plays in defining the self and suggested that models of identity development relevant to gays and lesbians (Cass 1979) may also be

beneficial to those experiencing mental health problems; such that the person's identity as mentally ill becomes only one aspect of their identity.

2.6.1 A time for transition

It may legitimately be assumed that a school transfer can be difficult, but for pupils with any type of special needs, the transfer can be regarded as involving an increased level of 'culture shock' (Smith and Goldthorpe 1988). Recent case studies have shown that young people who have experienced hospitalisation become extremely worried about education; with their main concerns being that they have fallen behind and therefore either need to catch up or accept a reduction in academic qualifications. This can cause great distress, particularly if on return to a mainstream school they find themselves working with pupils younger or less able than themselves (Closs 2000, Larcombe 1995). As I described in Chapter One, preparing to leave a unit school is something that may seem to preoccupy many young people for weeks prior to the actual event. It may become a time of great stress with behaviours such as self-harm, being disruptive and unhealthy eating patterns re-emerging. As such the young people appear to become overwhelmed with anxiety and unable to maintain their newly found higher levels of functioning and communication (Lole 2003). For many pupils their time at the special school will have been successful, as they will have developed socially and emotionally as part of a small group. At the start of the transition process they may begin to focus on their last experiences of mainstream school, which for many may have been unsuccessful. So, whilst they want to be able to re-engage with all the opportunities that mainstream education can offer, they will fear the repeat of past difficulties, which may include experiences of stigmatisation and prejudice.

However, a young person who decides, at the time of their transition back into mainstream education, to disclose and make known that they have been a psychiatric patient become what Goffman (1963: 14) called 'discredited' and must consider the advantages and disadvantages of their action. They must be allowed to decide for themselves if, when or how they will make their disclosure. If they do decide to disclose they may believe that they could experience ridicule or isolation, from their peers, yet on the other hand they could benefit from a decrease in the stress levels caused by keeping a secret and constant questioning regarding their whereabouts when they had not been in school (Corrigan and Mathews 2003). Those who decide to 'pass' and not reveal where they have been Goffman called the 'discreditable' (1963: 14) and went on to explain that although their differentness is neither known about nor perceivable there is the potential that they become discredited or rejected if the stigmatising attribute is found out.

Although the ultimate aim of my research is to share my findings with young people attending the Unit School in order to empower them to be able to make more informed decisions regarding whether to disclose a period of psychiatric treatment at an adolescent unit or to 'pass' I will need to be careful how I decide to impart this knowledge. I will need to decide if I intend to support them to increase their resilience to negative peer relationships (Makerell and Lavender 2004) by construing alternative personal constructions (Butt and Burr 2004) in that stigmatising attitudes are not as dominant as they believed or trusting that contact could change stereotypes, prejudice and discriminating behaviours. Using my research results could even mean that I will need to suggest that perhaps it is their own self-stigma that is the main barrier to their relationships with their peers. Or, maybe from my

findings I will conclude that for a successful re-integration a combination of all the above approaches will be required.

2.7 Summary

Although research indicates the importance of considering the issue of stigma for any group who have experienced mental health problems (Rusch et al 2005, Hayward and Bright 1997) there appears to have been limited research into the stigma experienced by young people returning to mainstream education after experiencing in-patient psychiatric treatment. However in this review of the key issues I have shown several interconnected strands of theory and practice on which I was able to draw in my own research.

Young people experiencing mental health problems will become aware of finding themselves in the middle of what appears to be an extremely complex and multifaceted situation. Not only are they going through the turmoil of adolescence but they are also experiencing 'something' that perhaps even the professionals are not always able to diagnose and label, yet which renders a 'normal' life in the community impossible. On admission to an adolescent unit they become a 'psychiatric patient', but are they 'mentally ill' or experiencing problems? Then, once 'better' they are expected to return to their mainstream school, something difficult for any young person having experienced a long absence for whatever reason, but for them a place where they may face the injustice of stigmatising reactions from their peers.

It could be argued that, unless research identifies the exact source of these unfortunate stereotypes and advocacy manages to change them, the lives of these young people may continue to be complicated by the prejudicial effects of stigma and rejection. It seems that in order to enable these young people to deal with stigma on return to mainstream school it is first necessary to establish the presence and form of the stigma they may experience.