

THESIS

FINDING A STORY FOR ENDING MENTAL HEALTH STIGMA

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## ABSTRACT

### FINDING A STORY FOR ENDING MENTAL HEALTH STIGMA

There is a discursive collision between the individual and the social models of disability, and mental health is at its focal point. Understanding this collision might help scholars and communication practitioners to better address one of the most troublesome public health issues—mental health stigma. There are multitudes of issues that exist at the heart of this discursive collision, and many are closely connected to mental health stigma. This thesis examines the issue of mental health stigma in a communications context. The study uses a qualitative focus group method to help elucidate how both mental health practitioners and non-professionals with expressed interests in reducing mental health stigma form their discourses about mental health conditions, the media, and society. The study seeks to identify practical narrative tools that communications practitioners could use for helping to de-marginalize people with mental health conditions. The study concludes with a call for communications practitioners to think more critically and creatively about how to approach reducing mental health stigma. Recommendations for practice and for future research are offered.

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## INTRODUCTION

People with mental health conditions are highly stigmatized and frequently rejected from society. This rejection through discrimination results in many different problems for these people that go well beyond their mental health conditions. People with mental health conditions often do not receive adequate physical healthcare in part due to stigma, which results in major health disparities and shorter lifespans (Iezzoni, Ramanan, & Lee, 2006; Ross & Goldner, 2009; Stuber, Meyer, & Link, 2008; Hinshaw & Stier, 2008; Corrigan et al., 2014). Other issues include job discrimination, housing discrimination, and policy discrimination that are based on false or overgeneralized stereotypes (Hinshaw & Stier, 2008; Stuber, et al., 2008). In a qualitative research study, people with schizophrenia (arguably one of the most stigmatized mental health conditions) reported that they were more concerned with external social prejudices than they were troubled by their mental health conditions (Gunnmo & Bergman, 2010; Hocking, 2003). The stigma and subsequent discrimination that results from the identification of a mental health condition are major barriers to this population's ability to achieve wellness and to participate fully in society (Perlick et al., 2001). Mental health stigma is an important health concern that should be addressed using public health messaging.

For communications professionals, it can be vexing to run a campaign designed to get public and private support for mental health services. For various reasons, audiences are often dismissive of mental health issues. This might be partially due to the fact that mental health conditions often present as invisible disabilities, so they may need justification to be considered legitimate (Samuels, 2003). It is important for public health communicators to actively make non-disabled audiences understand the legitimacy of these invisible disabilities. Even when



communicators are able to do this, however, many people actively avoid the topic altogether as distasteful or uncomfortable. These problems are even more difficult when communicators try to reduce mental health stigma because addressing stigma might often seem secondary to providing quality services. It is, however, at least equally important to eliminate the stigmatization of this population.

A powerful antidote to marginalization might be to increase the self-esteem and self-efficacy of people who have mental health conditions through empowerment and protest. But, as will be discussed, ending mental health stigma through empowerment messaging may also create resistance to treatment (Hinshaw & Stier, 2008), and it may even result in public opinion polarization about this issue (Rüsch, Angermeyer, & Corrigan, 2005; Boysen & Vogel, 2008).

As the previous discussion illustrates, there are many tensions involved in reducing mental health stigma. This is not to say, however, that these tensions have gone without attempts to address them. Campaign developers have tried to normalize mental health conditions while also maintaining the issue's saliency. They have attempted to do this by problematizing these disabilities using a biopsychological medical discourse. This discourse constructs disabilities as problems that can be addressed (and possibly eventually cured) given the proper resources. Recent and ongoing research has shown that this tactic is not effective in reducing mental health stigma (Read et al., 2006; Schomerus et al., 2012; Angermeyer, Holzinger, Carta, & Schomerus, 2011; Schlier, Schmick, & Lincoln, 2014). Addressing stigma under a biopsychological medical discourse has not helped to destigmatize mental health conditions (Pattyn, Verhaeghe, Sercu, & Bracke, 2013). Some campaigns have had various degrees of success in reducing different kinds of stigma like blame stigma (see: Rüsch et al., 2005), but the dangerousness and helplessness stigmas persist.

The major complication behind the stigma discussion is this: normalizing and destigmatizing mental health conditions might help the situation, but it might also hurt by creating an environment where mental health conditions are trivialized or overlooked. The medical problematization of mental health conditions in itself may increase – or at least perpetuate – mental health stigma (Schomerus et al., 2012; Boysen & Vogel, 2008; Schlier et al., 2014), but without this problematization people may not view mental health conditions as serious (Hinshaw & Stier, 2008). Furthermore, research has shown that by reducing one form of stigma (blame stigma) current practices have actually strengthened stigma that results in social rejection (dangerousness stigma) (Read, Haslam, Sayce, & Davies, 2006; Kvaale, Gottdiener, & Haslam, 2013). How can this complex situation be navigated to address the major problem of mental health stigma? Given these tensions, how should public health professionals approach communications about mental health conditions? To help answer these questions, formative qualitative research was conducted.

First, terms will be defined and some context provided for understanding the concepts of disability and disability discourses. Then, some of the most relevant literature on this topic will be discussed in greater detail. Next, narrative typologies about disability that might be useful in understanding mental health experiences will be outlined. The following section is about the methods used to promote reflexivity and thoroughness. The results and the discussion sections are combined in the next section, followed by recommendations and a conclusion.

## LITERATURE REVIEW PART I: CONCEPTS

### Models of Understanding Disability

Is the person disabled or is the environment disabling? This question is very important because the answer might determine where resources are allocated to address disability-related issues, including issues related to mental health. It might have a major influence on how the ‘problem’ of disability is defined. In this section, various models of understanding disability are overviewed in order to provide context to the reader.

*Individual model.* Proponents of the individual model of disability argue that the responsibility is largely on the individual with a disability to adjust to society’s ability expectations (Oliver, 2004). A benefit of this model is that resources are often used most efficiently at the individual level. The primary problem with the individual model is that when overstated it places the burden to adjust on only the individual, which can disadvantage disabled people who are then required to spend extra resources on solutions that might never be fully achievable. Another problem is that the individual model fails to recognize barriers to full life participation that are socially constructed (like prejudice) as needing to change within the environment. In this model, it is the individual who needs to change, not the environment.

One of the most dominant sub-models of the individualistic paradigm is the *medical model* of disability. This model seeks to ‘cure’ or otherwise ‘correct’ disabilities from a biological standpoint, an idea that is quite controversial in many disability communities (Hahn & Belt, 2004; Crow, 1996). This model often seems to objectify disabled people as merely biologically different, viewing them as passive patients in a health context. People with

disabilities are seen as being ‘personal tragedies’ who are bad and who should be eliminated (Crow, 1996). As one disability activist stated:

Within this framework... a person’s functional limitations (impairments) are the root cause of any disadvantages experienced and these disadvantages can therefore only be rectified by treatment or cure. (Crow, 1996, p. 3)

For some, focusing only on ‘curing’ and objectifying disability devalues the positive lived experiences of people who have disabilities. As a marginalized population, disabled people have a valuable perspective, meaningful narratives, and important memberships in disabled social communities as a result of their shared experiences in the social process of disablement. To many, the medical model does not appear to consider disability culture and identity.

*Social model.* The social model of disability was constructed in direct response to the individual model (Oliver, 2004), and has been used to resist the objectification of the medical model in particular (Crow, 1996; Koch, 2001; O’Malley-Keighran & Coleman, 2014; Mulvany, 2000). According to one of the founders of the social model, it was

[A]n attempt to switch the focus away from the functional limitations of individuals with an impairment on to the problems caused by disabling environments, barriers, and cultures. (Oliver, 2004, p. 4)

A social model focusing on mental health “redirects analysis from the individual to processes of social oppression, discrimination and exclusion” (Mulvany, 2000, p. 582). Originally, the social model was constructed as a tool for practitioners from various disciplines to use while considering how to better the lives of people with all forms of disabilities from a sociopolitical and institutional perspective (Oliver, 2004; Oliver, 2013). However, within the past decade, more criticisms of the social model have surfaced than there have been studies on how best to implement its socio-environmental focus (Oliver, 2013). These criticisms have primarily come from medical philosophers and medical sociologists (Anastasiou & Kauffman, 2013;

Shakespeare 2008, Hahn & Belt, 2004; Anastasiou & Kauffman, 2013), but some criticisms come from the advocates of the social model itself (e.g. Crow, 1996). The result has been an unfortunate under-utilization of the social model as a script for social and environmental change (Oliver, 2013).

In the *social model*, health conditions have two aspects: (1) The *impairment* is the actual biological or psychological difference and/or loss, and (2) the *disability* is caused by social and environmental factors that limit people with impairments from performing socially expected roles (Oliver, 2004; Anastasiou & Kauffman, 2013). In this paper, the term ‘health condition’ is used instead of illness to incorporate both aspects of mental health.

*Disability* (as opposed to *impairment*) is more of a social identity like race, class, gender, ethnicity, and so forth. For most health professionals the *impairment* is the problematic object or ‘biological condition’ that we should focus on correcting. For disabled people the *impairment* can also be seen as a problem (Crow, 1996), but for many it might not be seen as the problem at all (Hahn & Belt, 2004). For other disabled people, both *disability* and *impairment* are problems with varying degrees of impact on their lives. For this reason, “neither model is considered adequate, although both are partially valid,” for understanding the experience of disability (O’Malley-Keighran & Coleman, 2014, p. 176). However, most academics agree that the *medical model* is dominant in society. Some argue that this imbalance leads to an unhealthy fixation on illness, which can be disempowering for people with disabilities (Jenkins, 2013; Mulvany, 2000).

Some communities of people with mental health conditions may well take a social model approach that is not in opposition to medical model tenets. Rather, they might define medical institutions as providing resources for dealing with the negative effects of their impairments.

This population may not feel reduced through the ‘biological reductionism’ of the medical model. They may be instead empowered through the language of illness and liberated by the understanding that their impairment is real, and that it can be overcome (Weinberg, 1997).<sup>1</sup>

However, this does not mean that the medical model is always the best lens to understand mental health. An overemphasis on an overly ‘objectifying’ model may prevent society from ever seeing any potential positives that can come from the experience of having a mental health condition. An overemphasis on concepts like ‘personal responsibility’ might distract from environmental factors like the availability of drugs. An overemphasis on symptoms might also result in an under emphasis on living well in the moment.

*Political/relational model.* Recently, disability scholars have attempted to reconcile the individual/medical model and the social model of disability. In her book *Feminist, Queer, Crip*, Alison Kafer (2013) proposed a *political/relational model*, which she said recognizes all of the political interest of disabled people. Under this model, both *disabilities* and the *impairments* are seen as connected to legitimate political and social identities (Kafer, 2013). Kafer (2013) argues that the *political/relational model* does not reject *medical model* ideologies; people are allowed to desire a ‘cure,’ for example. She also argues that the *political/relational model* departs from the *social model* because it readily recognizes that *impairments* can be disabling beyond just the social (Kafer, 2013). Kafer said that by placing “disability squarely in the realm of the political,” the *political/relational model* recognizes the interests of all disabled people no matter their personal outlooks on the value of having an impairment/disability (p. 9).

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<sup>1</sup> It is important to note that the medical model is itself a response to the religious sin model of disability (Arboleda-Flórez & Stuart, 2012; Weiner, 1993), which accused people with disabilities of being morally corrupt. In this old model people with mental health conditions were either possessed by evil spirits or cursed by God. The medical model was an improvement.

This political perspective is well in line with the approach taken in this paper, but this paper will still discuss disability primarily from the individual/medical and social models of disability. While the *political/relational model* might be more inclusive of disabled people's political interests, which of these interests get more attention (the social focused or the individual focused) might well be politically disproportionate. An overemphasis on interests related to the individual model might still result in a 'false consciousness' that makes it difficult for disabled people to even recognize, let alone act on, their social model interests.

The *political/relational model* of disability might be an example of what happens in the kind of discursive collision that will be discussed in the next section. It is useful to look at mental health in the light of the *political/relational model*, but it is more informative in this paper to also look at the individual and social model dichotomy.

#### The Disability Discursive Collision

A discourse is not simply about structures of language as in semiotics (Hall, 1997; Foucault, 1980). A discourse is also about relations of power and knowledge production (Foucault, 1980). A discourse,

[D]efines the objects of our knowledge. It governs the ways that an object can be meaningfully talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others. (Hall, 1997, p. 44)

People have particular interests, and based on these interests, they perpetuate and transform discourses. These people are "bricoleurs" who necessarily borrow "one's concepts from the text of a heritage which is more or less coherent or ruined..." to build new discourses (Derrida, 1993, p. 231). Using the 'bricolage' or in English, the 'knick-knacks' (forms of language) of old discursive structures, people create meaning with each other around objects and events in such a way that their interests are forwarded. These people, intentionally or

unintentionally, then forward their meanings to others. Others can observe and adopt these meanings. Still others might have these meanings imposed upon them in a power struggle (Foucault, 1980). In this way, discourses grow, spread, and are maintained.

Discourses are hard for people to define because it is often the case that their own discourses seem so obvious that they define themselves.

Discourses... can be so ingrained that subjects are unaware of their presence. What an outsider can see as a discourse, an insider will often take for granted as the natural order of things. (Dryzek, 2007, p. 46)

People's definitions and assumptions about the world cannot exist outside of discourse (Hall, 1997; Foucault, 1972). Objects can exist outside of discourse, but humans can only understand objects from within (Hall, 1997; Foucault, 1972). Everything that people think they know as fact or 'truth' is connected to an ongoing production of knowledge (Foucault, 1972; Foucault, 1980). This production is not independent of *invested and biased interests*— what Foucault (1972) called “a will to knowledge” and “the will to truth” (p. 355-357). These invested interests motivate the *will* that powers the production of knowledge (Foucault, 1972). People seek knowledge based on these interests and they reproduce 'truth' in ways that support these interests (Foucault, 1972).

Discourses change as people with new interests come into power, and as they are able to convince (within contexts and limitations) populations to accept new assumptions about 'reality' that serve the new interest (Bates, 1975). Discursive change is similar to the process of hegemonic change as discussed by Italian political activist Antonio Gramsci near the end of his life (Bates, 1975).

Hegemonic change is an example of discursive change where the dominant discourses are linguistically co-opted and/or replaced by new powerful interests. Those asserting their power to



define reality often already see their positions as ‘obviously’ true within a particular discourse. In times of political and hegemonic change within a discourse, “A social class cannot convince others of the validity of its world view until it is fully convinced itself” (Bates, 1975, p. 355). This quote means that discourses must be fully formed before they can become dominant. People assert their assumptions by trying to convince others that the assumptions are legitimate, often by appealing to their interests. Because people have interests in accepting the assumptions of the powerful, they might enter into a kind of ‘false consciousness’ where their assumptions about the world do not necessarily and completely serve their highest interests (Bates, 1975, p. 360). It may even come to pass that people actively rearrange their primary interests to legitimize the elite in a kind of social contract, which is not intrinsically bad and may be necessary for political stability (Bates, 1975). If the people with power are ultimately successful, new and/or competing discourses can become dominant. As people’s invested interests and power to assert their assumptions change or are replaced through time, discourses also change. These changes occur within a discursive collision— within a war that exists among the gods of our collective minds (Foucault, 1980; Teubner, 1997).

*Discourses and paradigms.* In the academic literature, paradigms and discourses are not always seen as separate concepts (for what I would consider to be an example see: Colby, 1991). For the purposes of this paper, I take the perspective that paradigms are somewhat different from discourses, though they are not mutually exclusive. I believe that paradigms are more formally established ways of thinking that can be found in places like academic and political institutions (Dryzek, 2007). At the center of *most* discourses are what Foucault (1972) called “disciplines” (p. 295-296), which I see as producing paradigmatic thinking.

Paradigms have their origins in academic disciplines, and are oriented in the first instance to generating explanations of aspects of the natural or social world. Paradigms structure

the world and, in particular, its problems or aspects requiring explanation. (Dryzek, 2007, p. 45)

Discourses, on the other hand,

[E]stablish meanings, identify agents in contrast to those who can only be the object of action, confirm relations between actors and other entities, set the boundaries for what is legitimate knowledge, and generate what is accepted as common sense. (Dryzek, 2007, p. 46)

People who rigorously and systematically create meaning construct paradigms to explain their observations. These people like myself and other scholars attempt to suspend or ignore their primary invested interests in favor of an imperfect ‘objectivity.’ Even academics understand their realities within discourses, but they try to go beyond ‘common sense’ in order to describe (through defining) aspects of the world with systematic intention. Those who are not within the paradigm often misunderstand what is produced within a paradigm, yet the languages and basic ideas created by and used by academics are often co-opted and reshaped within discourses. People from different disciplines can also cherry pick from each other in a way that either push paradigms further apart through the misuse of ideas (sociology and psychology) or pulls them together through their appropriate use (social psychology) all within larger overall discourses.

Paradigms are assumptions about what make things problems and they are learned, presented, and named. Discourses exist more broadly and may include elements of paradigms. Discourses are “judgments, assumptions, capabilities, dispositions, and intentions, establishing the foundations for analysis, debates, agreements, and disagreements” (Dryzek, 2007, p. 46). Paradigms can become so ingrained into culture that they become taken for granted within a discourse, and blend with discourse where there are “analysis, debates, agreements, and disagreements” (Dryzek, 2007, p. 46) that include both discourse and paradigm. A discourse

goes beyond the paradigm. A person does not need to be formally taught his or her discourses. Discourses are socialized into his or her life from birth.

The medical discourse is not simply about the paradigms of human biomedical and biopsychological study. Unlike the antipsychiatry academics from the 20<sup>th</sup> century, my interest is not to completely undermine the valuable disciplines that can exist under the biopsychological paradigm (for a review of the anti-psychiatry movement see: Rissmiller & Rissmiller, 2006). The biopsychological discourse that exists throughout global society might have originated as academic paradigms, but they have since been adopted and transformed by entire civilizations of people who might have different (though, not likely completely different) discursive interests.

It is too simple to say that the people who produce a specific discourse only have unethical interests. People hold many interests, and these interests all help to inform them in constructing their ‘realities.’

While many of the interests that exist within a discourse are very ethical and reasonable, it is important to recognize that there are also interests that are not ethical or reasonable. Furthermore, people often overstate their reality assumptions in order to justify their interests. No institution is immune to overstating their positions, including every discipline that exists within the various paradigms of academia.

*The discourses of disability.* As discussed in the previous section, the social model of disability started as a practical tool for addressing disability issues within academia and political institutions. In this way, the social model is at one level a paradigm that can be challenged from an academic point of view. The *social model*, however, has been extended past the paradigm and into the discourse of disability (for examples of people who have *social model* disability identities see: Crow, 1996). This has occurred to such an extent that having a *social model*

identity is accepted as legitimate, which is more difficult to challenge. A challenge to a person's valued identity might lead to a tautological and pointless argument. For example, if someone told me that I do not have a legitimate disability identity founded in the *social model*, he/she would likely receive a very educational response. It would be like someone telling a black person who advocates for racial justice in America that he/she does not have a racial identity—insulting and very incorrect. The *social model of disability* recognizes disabled people as a minority group. Many disabled people who see themselves as having a minority perspective might not even know that the *social model of disability* originated within a paradigm of thought. The *social model* discourse includes the paradigm, but it goes beyond the paradigm as well. The elevation of the *social model* from a paradigm to a broader discourse has been a fairly recent development.

Unlike the *social model*, the *individual model of disability*, especially its *medical model* components, has long been a part of the global discourse of disability. To explain the nature of discourse in more detail, the following is a *potential* explanation as to how the *individual model discourse* might work. This example is founded in my studies of disability, in my experiences with my peers in disability, and in my studies of discourse. It is only intended as a *possible* and elucidating explanation of how and why people perpetuate the *individual model* as the hegemonic discourse around disability. It is italic to set it apart from the rest of the text.

*The first order of business for dealing with someone with a disability might be based on an initial assumption. In the individual model, the assumption might be that the best place to start in maximizing a person's autonomy is to change the individual, as that is the most direct and easiest place to start. The interest behind this assumption might be that people in dominant society often do not want to change themselves, which means that changing society is undesirable. People might not want to invest in changing the environment, especially when they*

*do not have any accessibility difficulties. It might be within the biased interests of many nondisabled people to take on the language that makes disability someone else's responsibility. Nonprofessionals in this discourse, without any kind of actual knowledge of neurobiology, might talk of having a 'delayed neurological process' instead of merely thinking slowly. They might think of depression as a 'chemical imbalance' without the foggiest idea about which 'chemicals,' and how they can even become 'imbalanced.' These words might connect to the medical model discourse that places the responsibility to define disability squarely in the purview of those who have a financial interest in having that responsibility: doctors, psychiatrists, pharmacists, and biomedical researchers. These professionals might in turn encourage this discourse by promoting their own understanding of reality, which others who have both different and similar interests can then recycle back into the discourse in such a way that their understanding of reality benefits their interests.*

In this example, I am not implying that 'others' are unethical for forwarding their interests in how they might define the world. We all are equally guilty of constructing our discourses to benefit our interests; this is the nature of all discourses. The ethical question depends on which interests we are forwarding and how overstated our assumptions are. Doctors, psychiatrists, pharmacists, and biomedical researchers may well have various interests that motivate them to define reality the way that they do. These interests may be more or less ethical. I believe, however, that simply having the interest of not wanting to change to include others as equals is ethically questionable. I might see people who have an interest in promoting the health of a community as generally more ethical, but I do not think their understanding of reality would stem from only (or even primarily) an *individual model discourse*.

The *medical* and *social models* of disability represent two separate discourses. Each connects to a larger discourse of modernity (medical) and postmodernity (social) (J. Champ, personal communication, October 2, 2014). Currently, there is a discursive collision occurring around the concept of disability. What the word ‘disability’ means to a person depends in large part on which discourse he or she ascribes to. Different definitions of disability that seem contrary may still be completely legitimate, and yet they may simultaneously be seen as illegitimate from the perspectives of those who ascribe to different discourses. Everything anyone thinks they know about disability can be challenged from one perspective or the other. In short, this discursive collision, along with the wide diversity of impairments, makes the topic of disability particularly interesting and complicated. Subsequently, the study of mental health conditions and stigma may turn out to be similarly interesting and complicated. The following literature review illustrates the complexity of this collision.

#### Linguistic Components of Discourse

The concept of discourse incorporates language, and language is informed by discourse. There are many forms of language that can be looked at in order to understand discourse, and some academics define these forms differently from others (for an example see: Foucault, 1972; Williams & Champ, in press). These forms are all variations on the same ideas, however. The three forms of language that are of interest for this discourse analysis are signs, strips, and narratives (Williams & Champ, in press). By looking at these three forms of language, it is easier to see and identify discourses, where discourses collide, and where they overlap.

Signs are words and symbolic objects (like national flags) that people use to communicate definitions and implicit meaning to each other (Williams & Champ, in press). By examining signs, people can see discourses in two ways. 1) Signs can be put together to create

ideas and themes that can then be associated with an overarching discourse. In other words, signs can be used to create other forms that exist at a more intricate level of language. 2) Signs can be clustered into a language script, or a group of words that are all defined with the same basic assumptions in mind. A script is a cluster of signs unique to particular discourses and/or paradigms. This is similar to a reading list for a specific area of study; it is a list of signs that are specific to a discourse. Signs can be connected to discourses by looking at the assumptions underlying their implicit meanings and their definitions (J. Champ, personal communication, October 9, 2014).

When someone insists on redefining a sign, that act might be seen as an instance of a discursive collision. When a person uses his/her own script to redefine a word (or sign) of another person's script it is in essence an assertion of one discourse over another. For example, when a psychiatrist uses the word *recovery*, he or she might think it means that there was an

[A]melioration of symptoms and other deficits associated with the disorder to a sufficient degree that they no longer interfere with daily functioning, allowing the person to resume personal, social, and vocational activities within what is considered a normal range. (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005, p. 480)

The 'recovery' used in this context might be categorized under an individual model discourse. *Recovery* could mean something else altogether, however. Some might seek to redefine *recovery* under the social model discourse, which does not focus on the individual's symptoms but instead focuses on other socially caused factors.

Recovery in this sense refers instead to overcoming the effects of being a mental patient—including poverty, substandard housing, isolation, unemployment, loss of valued social roles and identity, loss of sense of self and purpose in life, and iatrogenic effects of involuntary treatment and hospitalization—in order to retain or resume some degree of control over their own lives. Given the traumatic nature of being treated as a mental patient, advocates consider a return to a pre-illness state impossible, emphasizing instead the gains the person has had to make to manage and overcome the disorder. (Davidson et al., 2005, p. 481)

There may also be times when a sign used by someone in a discourse means roughly the same thing as a different sign in a different discourse. It is not uncommon for people to suddenly come to the understanding that what they are disagreeing about is actually the same thing being described with different discursive languages. In these instances, discourses might be seen as overlapping.

Strips are threaded signs. Strips are ideas that have a start and an end, but they do not rise to the level of a story. Strips do not have plots, but they are pieces of plots. Strips make signs complex, and they serve as the cornerstones and as the building blocks of narratives. The ways that strips can be constructed can change the meanings of signs, contextualize the meanings of signs, and/or amplify the meanings of signs. Strips are used in the definitions of signs (e.g. words). Strips can be metaphors born through the juxtapositions and comparisons of signs. People use strips to start extending their symbolic resources (or their language) around objects in order to incorporate the objects into their discursive understanding. It is important to understand how strips are constructed because they show us how phenomenological constructions are achieved. Strips might also help us to identify the core assumptions that exist under every discourse by helping us to see how ‘reality’ is ordered (J. Champ, personal communication, October 9, 2014). An example of a strip is, ‘as broke as an English major.’

Narratives are perhaps the greatest form of language that can be actually physically observed. Narratives are stories with plots that have beginnings, middles, and endings. Linguistically, a narrative is comprised of sets of two or more linked clauses that are placed in a recognizable time order (Green, 2006; Banerjee & Greene, 2012; Watson, 1973; Labov, 2006; Barwell, 2009). There can be stories within stories, so narratives can exist at many different levels of language. Narratives are the most useful to use when identifying discourses because



they can reveal relations of power and people's invested interests in addition to containing both strips and signs. Narratives might help researchers to identify the core assumptions that exist under every discourse by revealing the progression of actors within 'reality' (J. Champ, personal communication, October 9, 2014). Narratives can span across different discourses, and people can use narratives to both deconstruct discourses and tie them together.

To change a discourse is to change people's core understanding of how 'reality' is defined, how 'reality' is ordered, and how people can act within 'reality.' A discursive collision can be seen as a conversation among assumptions and an argument among interests. This conversation must take place through the use of signs, strips, and narratives. The best way to understand how to end stigma is to ask those people who have an interest in ending the stigma. We need to understand what the other competing interests are in this population, how they define the problem, and how they might approach finding a solution. A discourse analysis is key to figuring out where the best place is to start for changing the discourse of mental health stigma.

### Defining Mental Health Conditions

One of the biggest difficulties with researching mental health conditions in a social capacity is the lack of an agreed upon understanding of what mental health conditions are. This section will briefly examine several different ways mental health conditions have been understood in the past few decades. It will conclude with a normalizing understanding of mental health conditions as occurring on different spectrums of experience and severity. For communications social scientists, this conceptualization may be particularly useful for destigmatizing mental health conditions.

*Common definition.* Many researchers use the term 'mental illness' as a single all-encompassing term. One researcher defines mental illness as a mental health state that "disrupts

well-being, hindering an individual's ability to achieve, deal with the everyday, and participate fully in society" (Thompson, 2012). This definition is about as useful as saying 'physically sick' to describe the entire range of physical impairments that the human race experiences; that is to say, it is not very useful when researching how people make meaning of their identities. It might be somewhat useful when looking at 'mental illness' as a very broad social identity, but not every community with mental disorders will identify with their disorders in the same way. Some of these disorders are on very different spectrums of experience (for example depression vs. psychosis), and academics need to be better at recognizing these differences. If there is a shared experience of 'mental illness' then it needs to emerge from studying clusters of individual communities who themselves share common identities.

'Mental illness' is a common singular concept often used in academic communications research. Much of the research on media depictions of mental health conditions reflects the tendency of journalists and other media practitioners to group all mental health conditions into one category. "Specific diagnoses of mental health conditions are commonly omitted when the media present a description of an individual or fictional character" (Edney, 2004, p. 6). While coding, many researchers might be primarily interested in terms like 'mentally ill' and 'crazy' (Edney, 2004), which is useful to the extent that the terms inform people about the prejudicial positions of media producers. However, these terms oversimplify mental disorders in such a way that it becomes difficult to research more specific identities and lived experiences. In short, for communications research, using an all-encompassing term like 'mental illness' is not always bad, but it is very limiting.

*Severe mental illness.* Aside from the problems that were already associated with using the term 'mental illness,' the term 'severe mental illness' adds another layer of issues.

Researchers use the term ‘severe mental illness’ to describe only the population of people who are significantly affected by their mental impairments (e.g. McGinty, Webster, Jarlenski, & Barry, 2014). Unfortunately, what these researchers consider ‘severe’ is also not well explained in the literature. Even when researchers attempt to explain this term in more detail, the discussion usually serves to merely emphasize how disabilities fall on a spectrum of impact in people’s lives. The term ‘severe mental illness’ oversimplifies what is potentially a very complex concept. ‘Severe mental illness’ is not consistent and often too arbitrarily assigned to participants in research. Severity may well be a factor in mental health condition research, but it usually needs to be better defined.

*Social constructivist definition.* Some might be tempted to argue that without limiting environmental and social factors, disability as a human condition would not practically exist. From this perspective, disabilities only exist as a result of people socially constructing human conditions as deviant and *other*.

In contrast to the *medical model*, which assumes that diseases are universal and invariant to time or place, social constructionists emphasize how the meaning and experience of illness is shaped by cultural and social systems. (Conrad & Barker, 2010, p. S67)

This is an important perspective because it challenges dominant constructions of disability by refocusing on factors that are external to the individual. When overstated, however, this perspective might also be somewhat impractical, and it might even misrepresent the actual experience of having an impairment (Kafer, 2013).

It is important to view most mental health conditions as ‘real’ (or as having to some extent their own meaning), not merely social constructions (Crow, 1996). At the very least, it is important to understand that for most people with disabilities, the experience is very ‘real’ to them; it might even have serious impacts on their survival. As one critic of the social

constructivist perspective stated, “if we ignore the existence of [impairments] or pretend that they do not exist, then we are in danger of leaving critical humans’ needs untreated” (Anastasiou & Kauffman, 2013). If people ignore the negative effects of some of these impairments, they would also be leaving these populations’ lived experiences invalidated (Crow, 1996). As one disability scholar states, “People whose reality is denied can remain recipients of treatments and services, but they cannot be participants in empathic relations of care” (Frank, 1995, p. 109). For example, it would be wrong to deny a person’s lived experience with pain. While we can see that pain is itself a social construction to a large extent, it is not particularly useful in most cases to deny the actual experience of feeling pain (Kafer, 2013).

*Medical definition.* Most psychiatric professionals define mental disorders by using the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Published by the American Psychiatric Association (2013), this manual is an efficient and practical/clinical tool for assigning funding in the bureaucratic governing structure of United States politics. Researchers use this manual because it helps to justify their funding (Seligman, 2014). The use of this manual is also problematic, however. As Seligman (2014) states:

This funding strategy suborned two entire generations of scientists, prodding them in the direction of trying to find some reality behind the diagnostic categories, rather than discovering the basic processes of real mental disorders. (p. 2)

While DSM-5 categories might be better at explaining the individual differences among various mental disorders, they are also too rigid for a social understanding of disability. Not everyone with the diagnosis of schizophrenia has the same experience with their impairments, and few people *fit* completely into one category. The use of this manual to justify funding may also create somewhat of a self-fulfilling prophecy. Evidence justifying a category in the DSM might be ‘found’ primarily because the evidence justifying that category is all that is noticed.

*My definition: on different spectrums of experience.* Lumping all disorders into one category of ‘mental illness’ is too simplistic, although sometimes useful while examining simplistic media messages and stereotypical lay audience perceptions. Strictly categorizing these disabilities is also problematic because everyone experiences their impairments differently. Therefore, communications researchers need to understand mental disabilities as existing on different (yet often related) spectrums of severity and experience. Impairments related to emotions, like depression, fall on a spectrum that is different from the spectrum of ‘reality perception’ like psychosis. Everyone constructs their own realities differently, but some do so to the extent that they are considered *psychotic* or ‘delusional.’

These different spectrums of experience should also not be assessed independent of the social context of the people who are assessed. For example, a discussion of psychosis needs to take into account the person’s cultural discourses, lest the discussion misses its mark and becomes a cultural critique. A person who ‘hears God’ might be seen as having psychosis or as merely religious (Evans & Steslow, 2010). This is why a definition of psychoses like the one used by the National Alliance on Mental Illness (NAMI) is more appropriate. The NAMI (2014) defines psychosis as “the experience of loss of contact with reality [that] is not part of the person’s cultural group belief system or experience.” The second part of this definition is important because without looking at the person’s culture, a delusion may be mistaken as intentional meaning construction when it is not. The reverse can also be true; a person who intentionally constructs meaning may be mistaken as delusional.

Severity is a factor when it comes to defining mental health conditions. It can be assessed as the extent to which a person’s mental health condition interferes with his or her daily living. As discussed earlier, however, this definition of severity is too simplistic. Severity is both on a

spectrum and contextual. Consider a person who has a long-term mental health condition, but who also experiences fairly mild symptoms. In some research contexts, this person may be seen as having a more severe condition than someone who experiences extreme symptoms less frequently. Both people may experience major adverse effects on their lives; yet, both might also only experience minimal adverse effects. Beyond frequency and intensity of symptoms, other contextual factors should be involved in an assessment of severity, such as the impact of the impairment on employability and other factors related to a person's social participation.

Mental condition spectrums are not mutually exclusive but can coexist (for example, a person with psychoses can also be severely depressed). Studying how people make meaning of their intersectional identities might be a fruitful area of future social inquiry for health communications researchers.

The *spectrum of experience* definition of mental impairments is a normalizing one because it recognizes that even people who are 'outliers' are still a part of the typical human condition. In a series of focus group interviews, military professionals preferred the term 'Combat Stress' to the medical DSM-5 definition of 'Post-Traumatic Stress Disorder' in part because they said it normalized the disability as on a spectrum (Clark-Hitt, Smith, & Broderick, 2012).

This is a dynamic understanding of mental health conditions that has the potential to give health communication professionals a useful foundation for creating effective messages. This *spectrum of different types of experiences* definition of mental health condition also highlights the need for communications professionals to *generally* understand the nature of the mental health conditions they wish to address. This does not require a PhD in psychology, but it does require a little more awareness.

## Mental Health Stigma

Stigma is a powerful social force. Stigma is often characterized as a ‘mark’ that people use to distinguish difference in a negative and stereotypical manner (Pescosolido, Martin, Lang, & Olafsdottir, 2008). This conceptualization is good, but is also somewhat restrictive. Stigma is better understood as a particular type of defined situation where there is a temporary ‘mark’ that only exists in so long as its social definition is considered to be strong and ‘real.’ Stigma can be changed socially, not simply removed or hidden.

Goffman (1963) believed that stigma comes into existence when an individual is viewed as having, “an attribute that links [him or her] to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one” (p. 3). Thus, different types of stigma vary given different attributes, the strength of the link between the attribute and the stereotype, the stereotype, and the negative valence associated with the stereotype. It is important to remember that Goffman (1963) thought of stigma as a matter of social relationships. While Goffman (1963) did talk a lot about the consequences stigma can have on individuals, he was more interested in how stigma came into being in social situations.

Stigma varies with different disabilities. This is why it is imperative that public health researchers who are interested in reducing health-related stigma do not overgeneralize disabilities using all-encompassing terms like ‘mental illness.’ As discussed previously, it makes little sense to group all of these disabilities together when conditions like depression and schizophrenia are so different both biologically and socially. While many disabilities share common traits, it is not very useful for message creators to focus only on ending the stigma of ‘mental illness.’ Every disability has a different social meaning depending on the social context of the bearer. Disabilities like dyslexia may be connected with stigmas related to ‘lazy,’ and

‘stupid.’ Some physical disabilities may carry stigmas related to ‘disgusting’ and ‘unattractiveness.’ Each form of stigma represents a unique challenge for disability advocates and public health communicators. Any communications effort to address stigma must include a plan to target the specific stigmas that are related to the disability at hand.

*Self-stigma.* Stigma can have highly negative effects on a person’s self-concept. This is especially problematic for people with mental illness because,

[A] history of mental disorder is usually concealable, and stigmatized conditions that can be hidden (as opposed to those that are visible) yield considerable anxiety and stress for those who have them. (Hinshaw & Stier, 2008, p. 374)

Studies have shown that the effects of identity concealment can be both psychologically and socially stressful. As one study reported:

[A]lthough individuals living with concealable stigmatized identities report a preference for hiding (vs. revealing) the identity during social interactions, hiding in fact reduces feelings of belonging—an effect that is mediated by felt inauthenticity and reduced general self-disclosure.... Furthermore, the detrimental interpersonal effects of hiding (vs. revealing) a stigmatized identity are detected by external observers and non-stigmatized interaction partners. (Newheiser & Barreto, 2014, p. 58)

This has the effect of internal stigmatization and may lead to feelings of social isolation and loneliness. This internalization is unintentionally communicated to others, which can lead to actual social rejection (Newheiser & Barreto, 2014). It harms people’s sense of authenticity, and it fosters shame that limits this population’s potential for life success (Newheiser & Barreto, 2014; Goffman, 1963).

### Influence of Media

It has been shown that news accounts involving people with mental health conditions are highly influential in the perpetuation of the ‘violence’ (dangerousness) stigma (Klin & Lemish, 2008; Paterson, 2006). Journalism is a business that must make a profit, and journalists might well “purposefully strive to frame stories in ways that resonate with what journalists perceive to



be the largest segment of their audience” (Hallahan, 1999, p. 228). The ‘scary, crazy, cursed, psychokiller’ character has been present in various historical narratives for centuries (Arboleda-Flórez & Stuart, 2012). It is deeply rooted in the discourse of western and global culture, and the “popular psychokiller plot has long been exploited by the cinematographic industry” (Arboleda-Flórez & Stuart, 2012, p. 460). These stories resonate strongly with audiences, so media producers might often exaggerate, invent, and/or non-representatively select them with a profit bias in mind. Both news producers (McGinty et al., 2014; Slopen, Watson, Gracia, & Corrigan, 2007; Klin & Lemish, 2008; Paterson, 2006; Wahl, 2003a) and entertainment producers (Pirkis, Blood, Francis, & McCallum, 2006; Diefenbach & West, 2007) have a role in this perpetuation of negative ‘violence-centered’ stereotypes about people with mental health conditions. In fact, this narrative is so entrenched into various historical discourses that it has been shown to be present in entertainment media targeted for children (Wilson, Nairn, Coverdale, & Panapa, 2000; Wahl, 2003b), and it exists internationally with only slight variations among nations (Murphy, Fatoye, & Wibberley, 2013; Nawková et al., 2012; Bilic & Georgaca, 2007). This issue permeates the mental health communications literature with almost every credible research article about this topic referencing the negative influences of mass media.

To compound these problems, people with mental health conditions rarely have the opportunity to speak from their own lived experiences in news media (Wahl, 2003a). Medical professionals overwhelmingly represent the experiences of people with mental health conditions by taking an ‘expert’ pathological approach to explaining mental health conditions (Wahl, Wood, & Richards, 2002). This increases the vulnerability of this group because they are not privileged with the opportunity to subjectively assert their identities.

## Is the Stigma Justified?

The actual dangerousness of people with mental health conditions is a controversial topic. Not all mental health conditions are associated with a dangerousness stigma, but one stands out—schizophrenia. In the interest of brevity, this section will focus primarily on the research done on people diagnosed with schizophrenia.

A great deal of research has been dedicated to determining to what extent people with schizophrenia are actually dangerous as a result of their disability. One of the problems with this question is that researchers usually try to answer it using positivist methods that cannot control for all of the variables involved in violence. Consequently, there seems to be a fair amount of disagreement stemming from methodological inconsistencies. This being said, this issue still needs to be addressed in this paper using the available research.

Most of the research on this topic seems to indicate that the presence of a mental health condition like schizophrenia is a limited but statistically significant risk factor of violence, especially during and following symptoms. Researchers Van Dorn, Volavka, and Johnson (2012) attempted to show that people who were diagnosed with a severe mental health condition recently (within the previous twelve months) were significantly more likely than the rest of the population to commit a violent act against another person. However, it is not clear in the study if the violence resulted in a psychiatric evaluation that culminated in a diagnosis or if the mental health condition actually caused the violence. In fact, a causal link from psychosis to violence seems to have eluded positivist researchers in this area (e.g. Witt, Van Dorn, & Fazel, 2013). This finding also leaves open the possibility that people who have schizophrenia diagnosed further in the past (more than twelve months back) may not be as violent due to remission or some other factors that reduce violent tendencies (Van Dorn et al., 2012).

According to Van Dorn et al. (2012), the population that is most at risk for committing violence in the mental health community includes people with a recent diagnosis of schizophrenia, a childhood history of abuse, and comorbidity with substance abuse (particularly alcohol). This is consistent with other research; although a myriad of other risk factors are often included by other researchers (Fazel, Langström, Hjern, Grann, & Lichtenstein, 2009; Hodgins, Cree, Alderton, & Mak, 2008; Mullen, 2006).

As Van Dorn et al. (2012) also argue, people with recent (within twelve months) severe (as in strong symptoms) mental health conditions are more likely to commit violence, even when controlling for factors like substance abuse. However, a different 2009 study that conducted a meta-analysis of available research and that focused on psychosis and violence found that,

[I]ndividuals with substance use disorders may be more dangerous than individuals with schizophrenia and other psychoses, and that the psychoses comorbid with substance abuse may confer no additional risk over and above the risk associated with the substance abuse. (Fazel, Gulati, Linsell, Geddes, & Grann, 2009, p. 12)

In other words, one study reported that disabilities like schizophrenia do predict violence independent of drug abuse while the other reported that it is actually drug abuse only that significantly predicts violence, albeit more so for people with schizophrenia because they tend to abuse drugs more. These contradictions only serve to make this issue more controversial and difficult, yet drug use is clearly a problem for this population in particular.

Positivist researchers have identified many other risk factors in this population like nonadherence to medication, a history of violent victimization, criminal history, and other demographics like gender and homelessness (Witt et al., 2013; Mullen, 2006). While some argue strongly for the use of risk assessments to improve mental health care (see: Mullen, 2006), others call into question the usefulness of looking at schizophrenia as a risk factor for suicide or violence (Large, Ryan, Singh, Paton, & Nielssen, 2011). As Large, et al. (2011) argued,

A large proportion of patients classified as being at high risk will not, in fact, cause or suffer any harm. Unintended consequences of inaccurate risk categorization include unwarranted detention for some patients, failure to treat others, misallocation of scarce health resources, and the stigma arising from patients being labeled as dangerous. (p. 25)

Just because someone is in a category with increased risk factors that does not mean he or she will become violent. Measuring risk factors may actually contribute to the problem of overgeneralization and stigma.

Simply because the violence stigma is overgeneralized to a vulnerable population, the stigma is not justified. According to positivists, only a small subset of the population with symptoms of psychosis becomes violent (18.5% was the heist estimate), and it is not clear how much of their violence is attributable to their psychosis (Witt et al., 2013).

In fact, some of their violence may be contributed to the stigma itself. Some research has actually demonstrated causation between social rejection and subsequent feelings of aggression towards the rejecting group (Gaertner, Iuzzini, & O'Mara, 2008).

When a rejecter's group membership is salient during an act of rejection, the rejectee ostensibly associates the rejecter's group with rejection and retaliates against the group. (Gaertner, et al., 2008, p. 958)

When a person is stigmatized, he or she may experience social rejection from many different groups in society. This may foster enmity towards others in general, and is a possible explanation for a higher rate of violence in this group that is not extensively studied in mental health literature. Stigma itself may be a major risk factor for violence that this group experiences at a very acute level, although this possible relationship is not well studied.

Ultimately, the stereotype that people with schizophrenia are inherently unpredictable, violent, and dangerous can be difficult to refute, mainly because it carries with it a grain of truth. While the available research is not particularly good at indicating what extent violence occurs while people are experiencing psychosis, we know that it has happened before, and that these

true stories sometimes follow the ‘psychokiller’ narrative all too well. For example, a recent CNN article tells the story of Will Bruce, a man who murdered his mother while in a paranoid schizophrenic episode (Drash, 2014). He apparently killed her with a hatchet because he thought she was an al Qaeda agent out to get him (Drash, 2014). This story is credible, and it demonstrates how this ‘grain of truth’ can make the destigmatization of schizophrenia difficult to promote. While the real ‘psychokiller’ character appears to be extremely rare, it certainly carries a lot of weight for media producers and media audiences.<sup>2</sup>

In summary, the stigma of schizophrenia is largely not justified. But, the grains of postulated truth present within the narrative of some media-spotlighted stories thoroughly nail the stigma into public consciousness. The solution to this is to view each individual person on a case-by-case basis, to treat him or her as a valuable human being, and to include him or her in day-to-day life as an equal. These people and their experiences are worth something to us and to our society, and stigmatizing attitudes are unethical.

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<sup>2</sup> To be fair, this CNN story does include a dynamic profile of Will Bruce as a person who is doing well in recovery.

## LITERATURE REVIEW PART II: UNDERSTANDING THE PROBLEM

With the possible exception of mood disorder stigmas (see: Kelly & Jorm, 2007; Lazowski, Koller, Stuart, & Milev, 2012), the stigmas placed on people with mental health conditions like schizophrenia have remained nearly unchanged or become worse for decades despite efforts to address the problem. Between 1950 and 1996 “perceptions that mentally ill people are violent or frightening substantially increased” especially when it came to people who experience psychosis (Phelan, Link, Stueve, & Pescosolido, 2000, p. 188). This has remained a consistent trend over time and internationally (Schomerus et al., 2012; Angermeyer, & Matschinger, 2005).

One of the dominant efforts to reduce stigma is to increase the mental health literacy of people who do not have mental health conditions. Over the past two decades, health literacy has been based on the idea that the more people know about the biopsychiatric aspects of mental health conditions, the less likely they will overgeneralize stereotypes to the population with that mental health condition (Read et al., 2006; Phelan, 2002). This, however, is a questionable tactic. One German study found that while the health literacy of the German population increased between 1993 and 2001, the “desire for social distance from people with major depression and schizophrenia remained unchanged or even increased” (Angermeyer, Holzinger, & Matschinger, 2009, p. 225). This implies that teaching people about mental health conditions from a medical ‘health literacy’ framework is not actually that effective at reducing rejection and prejudice. Another group of researchers found that the “mental illness is an illness like any other” approach

to ending stigma is not effective when it comes to dangerousness stigma (Read et al., 2006, p. 303). As they stated,

[B]iogenetic causal theories and diagnostic labeling as ‘illness’, are both positively related to perceptions of dangerousness and unpredictability, and to fear and desire for social distance. (Read et al., 2006, p. 303)

This finding has been supported by more recent research as well (see: Schomerus et al., 2012; Angermeyer, Holzinger, Carta, & Schomerus, 2011; Kvaale et al, 2013; Schlier et al., 2014), which illustrates the need for health communicators to step well beyond biological and psychiatric explanations to reduce stigma. Biopsychiatric explanations reduce blame stigma and may increase help seeking, but at the cost of lowering people’s beliefs in these individual’s ability to have control over their own lives (Read et al., 2006; Kvaale et al., 2013; Schlier et al., 2014).

Simply creating messages that try to separate the person from the ‘illness’ is insufficient to reduce stigma. As one study stated,

[E]vidence suggests that while such an approach reduces blame for mental illness, it may unintentionally exacerbate other components of stigma, particularly the benevolence and dangerousness stigmas’ (Corrigan & Watson, 2004, p. 477)

It is not revolutionary to conceptualize mental health conditions as merely biological attributes that exist separately from the person. In fact, medical this approach to disability is not all that different from the old *sin model* of disability (Arboleda-Flórez & Stuart, 2012; Weiner, 1993). In the *sin model*, people with mental health conditions like psychosis were seen as being “possessed by the devil,” as a result of some sin. Unlike the *sin model*, a *medical model* of disability does not blame people for their mental health conditions, yet the *medical model* also does not address the social stigma (Arboleda-Flórez & Stuart, 2012; Weiner, 1993). The idea of ‘*illness*’ as an alien biological process merely replaced the idea of a ‘*demon*’ (Arboleda-Flórez &

Stuart, 2012; Weiner, 1993). Under both models people are free to remain scared of those who are possessed (or become ‘ill’) and who subsequently lose the capacity for moral reason.

Some advocates are so devoted to getting people to think about mental health in medical terms that they often compare these conditions to things like cancer and diabetes (Borelius, Lindhardt, & Schalling 2014; Phelan, 2002). Such comparisons might help people to better understand the nature of mental health as a biological process, but they do not reduce dangerousness stigma (Phelan, 2002). People’s mental health conditions are irrevocably tied to their behaviors. The ‘object’ to fear (the mental health condition) is *within* the person, and it can best be observed as it *comes out* through their (potentially unpredictable) behavior. The stigma around cancer is not the same as the stigma around mental health (Phelan, 2002).

Increasing the health literacy of mental health conditions also often involves educating people about how these conditions are *curable* (Phelan, 2002). A ‘cure’ is not always possible, and even if it were, this tactic is still not likely to help reduce the stigma of those who are in recovery or regularly experiencing symptoms. This tactic also misses the mark because it does not address the stigma issue. Is the search for a biological cure motivated by empathy at recognizing person’s pain, or is it motivated by stigma? The search for a ‘cure’ may be itself a way of buying into the stigma.

The stigma discussion might need to move into sociopolitical discourses that are further outside of the realm of the biological sciences. The biopsychiatric discourse is not effective at reducing stigma (Schlier et al., 2014).

### Interests Concerning Mental Health

The institutions that exist around mental health issues have their own interests that might be ethical, unethical, understated, and/or overstated. Some argue that many of these interests do



not always align with client needs (Jenkins, 2013; Crossley, 2004). For example, communicators in the field of psychiatry might benefit from dangerousness stigma by allowing it to create a kind of *generalized fear appeal* and by promoting a *biopsychiatric understanding* of mental health. Psychiatrists have a lot of authority to define what it means to have a mental health condition. They can use this authority to increase their political, economic, and cultural power.<sup>3</sup>

People's stigmatizing fears of mental health conditions have motivated public policy and resource distribution for centuries (McGinty et al., 2014; Wahl, 2003a). Stigmatizing fear appeals can influence publics to give mental health institutions the authority and the resources they want and need to survive. Some people might be motivated to fund mental health institutions as a way of passing off the responsibility to others. Some campaigns have even sought to play on people's fears and feelings of helplessness when dealing with mental health populations to encourage funding to 'professional' services (for example see: Kaufman, 2007, December 14). Despite the efforts of many mental health organizations to reduce stigma, psychiatric institutions might actually still benefit from stigma at some level. The stigma of mental health might not threaten institutional legitimacy directly, so it might not be within the interests of all psychiatrists to actually destigmatize the population.

Psychiatrists might also be motivated to take a biopsychiatric approach, which may do little to reduce certain types of stigma, because they have an interest in being seen as more

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<sup>3</sup> Researchers have shown that fear appeals in health messaging are powerful at changing behavior when the fear they provoke is somewhat strong and coupled with messages that impart high levels of self-efficacy in audiences (Witte & Allen, 2000). Fear messages might increase dangerousness stigma, while also increasing other's efficacy to 'do something about those people' (perhaps not worded so strongly, but you get the idea). For audiences with mental health conditions the opposite might be true: their self-efficacy might decrease while their self-stigma might increase. If true, this could be a very powerful form of social marginalization, which is common in the process of hegemonic perpetuation (Bates, 1975). This relationship should be studied in more detail.

legitimate within healthcare (Pilgrim & Rogers, 2005). Psychiatric institutions might try to appeal to those who are already in power in healthcare by emphasizing the physical (biological) nature of mental health. Making mental healthcare as legitimate as physical healthcare might be a good idea from a services perspective. Many psychiatrists have altruistic professional interests and personal economic interests in bringing mental healthcare closer to primary care. This move might increase the legitimacy of mental health services, which might lead to better service overall. It might also make it easier to justify funding for mental healthcare, which is good for psychiatrists' long-term job security. However, from a communications perspective, biological messaging does not help to reduce fear and social distance. Thus, strictly biopsychological language should probably be avoided in messaging intended to reduce social distance and dangerousness stigma.

The *individual model* discourse might also serve psychiatrists interests' because 'treating individuals' is what they know how to do. However, many psychiatrists have far overstated the individual approach, especially when trying to reduce socially situated stigma as defined by Goffman (1963). Psychiatrists might have even redefined stigma to serve their interests by citing papers that cherry-picked Goffman's work on stigma to make it seem more of an individual issue (Pilgrim & Rogers, 2005). By restructuring "knowledge about asocial phenomenon in clinical terms" the idea of stigma can be "re-framed as a part of psychiatric (not sociological) knowledge" (Pilgrim & Rogers, 2005, p. 2552).

Given the choice, medical and psychological professionals are just as likely as anyone to privilege what they think is important to justify their existence (Jenkins, 2013; Pilgrim & Rogers, 2005). If the choice is between *reducing stigma while possibly losing funding* and *maintaining stigma to keep funding*, these institutions are likely to pick the latter as more pressing. These

professionals might also be a little too quick to, “think of stigma as inconsequential compared to the positive effects of treatment and receiving high quality services” (Rosenfield, 1997, p. 668). These interests come out in how psychiatrists define the issue of stigma within their paradigm.

Psychiatrists know that it is important to reduce stigma because their clients and other research have informed them that the stigma is a barrier to living well and to getting treatment (Gunnmo & Bergman, 2010; Hocking, 2003; Gary, 2005; Schomerus & Angermeyer, 2008). Psychiatrists also know stigma is bad because research has shown the negative psychological effects of stigma (Newheiser & Barreto, 2014). Yet, without even realizing it, *psychiatrists might routinely define their reality in such a way that the stigma benefits their political and economic interests without actually helping them to fulfill their purpose*. Mental health practitioners need to move away from this contradiction, especially when it comes to their communications. Stigma might help to justify their assumptions and services today, but in the long term, stigma is a larger barrier to their success. Many mental health organizations realize results are what matter, not merely institutional survival. It might be the case that only the mental health professionals who do not have an expressed interest in destigmatizing mental health take this position, and research indicates that mental health practitioners often have stigmatizing attitudes towards their clients (Hansson, Jormfeldt, Svedberg, & Svensson, 2013; Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013; Nordt, Rössler, & Lauber, 2006; Lauber, Nordt, Braunschweig, & Rössler, 2006; Mårtensson, Jacobsson, & Engström, 2014).

Sociology, and the study of discourse in particular, can be useful for addressing the problem of stigma. Recognizing the power positions held by psychiatric institutions to define mental health can only help psychiatrists to be more reflexive about their roles in reducing mental health stigma. Communicators must reduce social stigma in a way that will also increase

the urgency of this issue without using fear to motivate public action. Reducing stigma might make it easier for people to seek help from mental health services. These goals will require a deep understanding of discourse and a focused effort to change the discourse.

### The Language of Psychiatry

Psychiatrists are often the first people to introduce clients to established structures of meaning around mental health conditions. This can start a process of identity formation that is sympathetic to the psychiatric paradigm. People who consistently find themselves within “local moral worlds” (see: Kleinman, 1988; Katz & Alegría, 2009) that are centered on a language of psychiatry eventually grow to adopt the base assumptions of that world. ‘Local moral worlds’ are defined realities and situations where people struggle for power but where they are also educated in, and agree upon, ethics, cultural practices, and definitions about reality (Kleinman, 1988; Katz & Alegría, 2009). They do this by learning “the *range of symbolic* [sic] resources that they feel they can comfortably incorporate into their identities” (Shaw, 1994, p. 85). People grow attached “to a common body of symbols” (Cohen, 1985, p. 16) that limit, yet are also necessary for, the construction of their identities. This process frequently occurs in mental health contexts where people with newly acquired disabilities go to specialists who then help their clients to make sense of their experiences (for example see: Katz & Alegría, 2009). Psychiatrists and doctors do this by defining their client’s experiences using language that is unique to the psychiatrists’ and doctors’ respective disciplines. Much of these languages can be categorized under overarching individual and medical model discourses.

In short, “the distinctions that mark subject position are reproduced rather than transcended” (Shaw, 1994, p. 85). Even if people with mental health conditions decided to become involved in an empowerment movement, many of them would likely privilege a

psychiatric understanding of their identities. This can be problematic if it results in narratives and language that reinforces or perpetuates stigma.

This transfer of base assumptions is not inherently bad, however. In fact, sharing a local moral world might actually help clinicians to build positive relationships with clients (Katz & Alegría, 2009). These positive relationships with psychiatrists are highly desirable. Many clients with mental health conditions have indicated that better relationships with their psychiatrists can directly reduce symptoms of psychosis (Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2014). Sharing a social script is important in building psychiatrist-to-client relationships; thus, introducing clients to identity scripts that can help them understand and take control of their lives is essential. But, it is also important for psychiatrists to be critical of their own language and to reinvent it if necessary. As Roberts (2009) stated,

[T]he challenge, as well as the opportunity, that confronts mental health nurses is to facilitate greater, more active user participation by practicing in a manner that elicits the resources, capabilities and potential that service users possess, thereby challenging the prevailing and restrictive sense of the diagnostic categories by which people are identified, and by which they come to identify themselves. (p. 290)

The language of psychiatry is problem-orientated and has “vocabulary characterized by lack, deficiency and deficit” (Roberts, 2009, p. 292). This deficit-orientated language might perpetuate self-stigma, shame, and social stigma. It might even limit clients’ ability to actively engage in their own treatment by creating a power dynamic where the clinician has an overwhelming weight of influence over the interaction. As Roberts (2009) also stated,

[I]n so far as an individual is conceptualized in terms of lack and deficiency, as suffering from a degenerative condition from which they are unlikely to recover – then that individual is subject to a variety of restrictive interventions from numerous mental health professionals such that the existential possibilities of service users, and the possibility of actively participating in mental health services in particular, is inhibited or closed down. (Roberts, 2009, p. 291)

This problem-oriented language might also limit this population's willingness to openly participate in the public sphere, which is a barrier to reducing stigma. From a health communications perspective, this can hinder the recruitment of people with mental health conditions who are willing to speak from their experiences in health messaging. It can also influence the type of narrative (described later in this paper) that producers can ethically create. If it is unethical to misrepresent people's self-described lived experiences, and if the way they want to be portrayed is stigmatizing, then producers who want to reduce stigma will have even more trouble succeeding in their goals.

Problem-oriented language scripts might also inhibit people from seeking help from healthcare agencies. In a stigmatizing culture, no one wants to have a mental 'problem,' so they might deny its existence. People in denial do not get help. If we define mental impairments as unproblematic or as at least having some kind of social value (e.g. diversity is valuable at the very least), it might lead to the empowerment of many of these populations. Yet, as the next section will demonstrate, through empowerment, people with mental health conditions might come to resist dominant discourses.

### Empowerment and Resistance

As stated before, health campaigns that seek to address the issue of mental health stigma can focus on eliminating self-stigma through empowerment. While some argue that this type of 'protest' is not effective at reducing social stigma (Rüsch et al., 2005), it still has the potential to decrease self-stigma (Thoits, 2011). This empowerment might also lead to more participation and increased social contact of publics with people who have mental health conditions. Personal contact with people who have mental health conditions has been shown to reduce stigma (Rüsch et al., 2005; Magliano et al., 2014). Reclaiming mental health identities might be useful for the

empowerment of these populations. For example, Sandy Jeffs (1998), a self-proclaimed 'madwoman' with schizophrenia took steps to reclaim her identity through empowerment.

I call myself mad and write about my madness as a way of reinventing my life. This is not to glorify being mad, indeed, being mad is like having a living Hell in one's mind, and is an experience I would not recommend to anyone, nor would I wish it upon anyone else, including my worst enemies! However, through poetry, I seek to subvert the dominant paradigm, which has been dismissive of madness, and give the experience validity. I seek to order the disordered through the use of ordered language; to connect with other mad people and celebrate our difference. I am not afraid to claim my madness. And being the madwoman, I declare war on a society that vilifies and stigmatizes those it chooses to marginalize. I seek to be nonconformist in talking about madness, which has been buried beneath the rubble of society's inability to cope with that which it has perceived to be anti-social and renegade. (Jeffs, 1998, p. 38)

While Jeffs (1998) clearly does not like her mental health condition, she also does not dismiss the experience of her impairment as worthless. Jeffs (1998) has a sense of empowerment around her reclaimed identity, but others may not feel the same way about their mental health identities. Instead, many of these people may simply opt to deflect the potentially harmful messages that are directed at their identities (Thoits, 2011). Where reclaiming identity and challenging dominant discourse "involves pushing back with a force of one's own," in deflecting, "one guards or hardens the self rather than engaging in conflict" (Thoits, 2011, p. 11). While challenging might increase a person's self-esteem, deflecting might merely maintain a person's self-esteem at its current (and likely negative) level (Thoits, 2011).

If people with mental health conditions cannot bring themselves to see their health conditions as giving them a valuable identity, they might be able to at least reclaim the identity of being *othered* as a form of diversity. Reclaiming this element of their marginalized identities might reduce self-stigmatization and shame (Thoits, 2011). This would be a valuable goal for any health campaign. It may improve the lives of those with a history of mental health conditions by helping to buffer them against the stigma in the environment. It might also encourage more

people with mental health conditions to ‘come out,’ which might in turn help to reduce stigma through this population’s open participation in society (Corrigan, Kosyluk, & Rüscher, 2013).

One potential problem with this, however, is that reclaiming identities often occurs when resisting dominant social discourse (for examples of resistance to dominant discourse see: Jeffs, 1998; Crossley, 2004; Saguy & Ward, 2011). If a community views medical and psychiatric paradigms (like the medical model) as oppressive, then that group may reject mental healthcare as a resource. As some scholars and petitioners worry,

Without foresight, it is possible that forms of activism and different types of destigmatizing messages could well yield significant clinical problems in the arena of mental health. (Hinshaw & Stier, 2008, p. 383)

Yet, the ability to resist dominant stigmatizing messages from news and entertainment media could be extremely valuable (Corrigan, et al., 2013).

#### Illness Narratives

As discussed, very little seems to have worked to help address the issues involved in dealing with mental health stigma. For this reason, it is important to start almost from scratch. Since narratives are rich in discursive meaning, and since they can span across different discourses, introducing people to disability narrative typologies could be a good first step in informing a different perspective on this problem. Narratives inform about relations of power and about the agency of things and actors. Narratives make clear the perceived causes and effects of events and actions. By using narratives to describe change, readers can see how actors cross among, connect to, justify, and invent discourses.

Frank (1995) outlined three different disability narratives that might be useful for helping people with mental health conditions to describe their experiences. Frank (1995) calls these three narrative typologies *chaos* narratives, *restitution* narratives, and *quest* narratives.



In *chaos narratives*, the speaker is without hope of a better life— wellness is not and cannot be achieved (Frank, 1995; O’Malley-Keighran & Coleman, 2014). These are narratives of loss, grief, pain, suffering, and negative change. Chaos narratives “reveal vulnerability, futility and powerlessness” over a person’s ability to be a subjective agent in defining the world (O’Malley-Keighran & Coleman, 2014, p. 177). It can be hard to listen to these narratives, but it is important to do so because it is a part of respecting the lived experiences of those who have impairments (O’Malley-Keighran & Coleman, 2014). Chaos narratives occur most frequently in times of change that are perceived as negative and that cause physical and/or emotional pain. While these narratives should be respected, it is also important to find ways to move out of chaos.

In *restitution* narratives “hope is a way of life” (O’Malley-Keighran & Coleman, 2014, p. 182). These are the stories about people who lost something, but who are (usually) ‘cured’ through medical intervention. The speaker is (or hopes to be) ‘restored’ to his or her original state. The speaker hopes for a ‘return’ to wellness. An issue with this narrative is that when a cure is unobtainable, people tend to get stuck living in a state of fragile hope that may frequently recycle into chaos. This can prevent people who have incurable disabilities from obtaining a meaningful state of wellness. Dominant and objectifying medicalized language scripts tend to be prominent within this narrative. As negative as this may seem, this narrative can be good for encouraging people to take personal responsibility for their social and physical health. It might also help to motivate people to push for more autonomy in their lives.

*Quest* narratives are stories about people who seek to find something new and positive in their disability identities (O’Malley-Keighran & Coleman, 2014; Frank, 1995). In these narratives, “[w]hat is searched for may never become entirely clear, but the quest is defined by

the ill person's belief that something is to be gained through the experience" (O'Malley-Keighran & Coleman, 2014, p. 177). Wellness is 'discovered' through living in the moment, and through celebrating life's diversities. If a person has acquired a disability, then quest narratives mark a departure from his or her past identity in favor of reaching for a new and positive self. A positive element about these narratives is that they keep people from cycling exclusively through restitution and chaos narratives. They also allow people with incurable disabilities to 'discover' meaningful and longer-term wellness. These narratives also often include reclaiming language and challenging dominant ideas of what is 'normal.' They are highly empowering, which is good for reducing self-stigmatization. The problem with these narratives is that they can often seem 'sappy' and unrealistic. People can also use them to resist the potentially useful medical paradigm that is so prevalent in the restitution narrative.

People with disabilities can move through all of these narratives within a single day. These narratives do not have to be seen as mutually exclusive; in fact, they may be better understood as continuous. How each narrative is connected to the others can be complex. An example of a narrative that includes all three typologies can be found in Jeffs' (1998) essay about her identity as a 'madwoman,' as previously discussed. The quote from her paper that is included in the previous section has elements of a *chaos* narrative and a *quest* narrative, but the rest of Jeffs' (1998) paper also includes elements of *restitution* when she talks about using asylums as safe and protected places where she can recover from episodes of her psychosis. These are the typologies I will explore in this research study in order to find ways to destigmatize mental health conditions.

## Research Questions

The research questions were:

- 1) How do people who have an interest in destigmatizing mental health conditions understand the problem of mental health stigma from a communications perspective?
- 2) How do these people address this issue after discussing the tensions between empowerment (which might cause resistance to treatment) and the biopsychological approach to destigmatization (which might cause fear stigma and rejection, but also decrease blame stigma)?
- 3) Do people who have an interest in destigmatizing mental health conditions think that Frank's (1995) illness narrative typologies are applicable to the experiences of having mental health conditions?
- 4) What kinds of narratives do members of a mental health community think media producers should use to reduce stigma? This is assuming, of course, that the participants think producers should or can do anything.
- 5) How do these people think Frank's (1995) narratives might be useful for destigmatizing mental health conditions?

The first and second questions represent the primary focus of this study.

### The Construction of this Literature Review

The research and the writing of a literature review is in itself a form of qualitative knowledge production. Therefore, it is important to reflexively outline my motivations behind writing this literature review the way I have. A major element of being reflexive is to be honest and to be held accountable.

Whether or not accountability is fully expressed in every research report, it is a quality that can be called on at any point, when we should then be able to tell the story of the story. (Markham, 2009, p. 196)

The following story of how I wrote my literature review involves my identity, my culture, my interests, and my assumptions. It should demonstrate how I realize that even I am bound within discourses of meaning.

I am a graduate student with a strong background in sociology and disability studies. As a person with a learning disability, I consider myself to be an advocate for what I see as my common disability community. I am an advocate of the social model of disability, but I do not dismiss the individual model as useless. I like the political/relational model, too. While I do not currently have an identifiable mental health condition, I believe that I can identify with this group to an extent. Like them, I have to manage my invisible identity in socially stigmatizing situations. I believe that everyone with a disability has to somehow make sense of his or her identity while experiencing the discursive collision that is occurring around the concept of *disability*.

I chose this topic in part because of my connection with disability communities at my university. I also chose this topic because I have been close to many people with mental health conditions. Some of these people have been indispensable role models to me, instilling in me a strong sense of personal responsibility and emotional maturity. Some of these people were also very destructive in my life, and some even committed deadly violence to others while on drugs or while experiencing crisis episodes. I have a strong interest in reducing mental health stigma because I care a great deal for the people in my life who experience social rejection as a result of their impairments.

When I first started this research, I approached it from a perspective that was very skeptical of the institution of psychiatry. My initial inclination was to be critical of psychiatry because I perceived that mental health institutions were not doing enough to reduce stigma. My

assumption that the institution of psychiatry was bad also likely stemmed from my interest in promoting sociology, as that is where my education was grounded. Yet, as I was exposed to more research, and as I spoke with more people who had mental health conditions, I realized that my initial approach was simplistic. I became more reflexive about my own life experiences, and I eventually realized how psychiatry had been helpful, not helpful, and somewhere in between for the people I cared about.

Another one of my interests that came up while writing this review was financial in nature. I realized that if I ever wanted a job in the area of mental health, I should probably strive to see psychiatry in a more productive and less pointlessly critical light. I wanted to eventually publish this article as well, and I did not believe that an anti-psychiatry article would be accepted into a quality journal given the extreme nature of the anti-psychiatry movement.

In writing this section of my literature review, I primarily wanted to demonstrate that my discussion of discourse is legitimate. I assumed that my reader would be able to see how my interests and assumptions about the world informed my research, and how they informed my construction of how I think my 'reality' works. By going back through the literature review, I have little doubt that my reader will be able to identify how the signs, strips, and narratives that I have used connect to an overall discourse of disability. I also wrote this section because I wanted to be reflexive and to hold myself accountable throughout the writing process.

## METHODS

### Rigorousness of Approach

This study used a constructivist methodology. In this methodology, validity can be assessed by looking at how accurately researchers are able to describe the shifting subjective realities of the people they study in relation to their own shifting subjective realities (Pouliot, 2007). Falsifiability is not really possible in this methodology (Pouliot, 2007). Rather, it is “academic debate and reinterpretation” that place checks against weaker explanations of social phenomena (Pouliot, 2007, p. 378). Finally, generalizability is not possible, but comparability is possible (Pouliot, 2007). Researchers who use this methodology understand that ideas and ways of viewing the world that are generated in one context can be used and tested in other contexts without needing to be immediately generalizable (Pouliot, 2007).

In qualitative research, systematic reflexivity is key to quality. The following quote illustrates the core of what it means to be reflexive:

We should not be in the business of promising that other people will see exactly the same things we did should they return to our field sites; indeed, they should expect change. But we should be in the business of convincing readers that had they been there when we were, looking at the things we looked at using the analytic perspectives we used, then they would have seen things that were extremely close to what we saw. (Baym, 2009, p. 186)

There are many ways to be reflexive, but a primary way has to do with constantly challenging our own perceptions and assumptions about how the world works. Part of being reflexive is to be transparent about our own processes, perceptions, and assumptions. This requires documentation of thoughts and actions to be ongoing, self-critical, and thorough (Baym, 2009). Other ways include building checks into our studies so that we have no choice but to be reflexive.

Achieving a high degree of reflexivity is one of my primary goals for this study, but it is not the only way to strive for rigorous observations, analysis, and reporting.

In qualitative inquiry, we achieve validation by evaluating multiple forms of evidence... by looking at (and for) evidence that disconfirms an interpretation... and by checking out some of our hunches, claims, and explanations with the participants themselves.... (Lindlof & Taylor, 2011, p. 274)

This study exemplifies each of these forms of validation.

There is always some level of subjectivity involved in research, however. This is why qualitative data analysis does not exclude the researchers' own biases from the project (J. Champ, personal communication, April 2014). The only time a qualitative researcher's bias becomes a problem is when it is not openly discussed in the write-up. By knowing the backgrounds and motivations of those conducting the research, readers can triangulate their own interpretations of the analysis. Readers can *see where the researcher is coming from*, which may enable them to understand the researcher's findings in a way that goes beyond the text (J. Champ, personal communication, April 2014). This can help the reader to relate to the research on a deeper level.

### Community-Based Participatory Research

Community-based participatory research (CBPR) may be the best way to approach conducting this study. As an outsider coming into a community that I did not know a lot about, I needed to be very open to the perspectives forwarded by this community. It was important for my research to include opportunities for the communities I studied to resist and add to my observations and conclusions. This helped to increase my study's reflexivity, which I believed would be essential for my qualitative research. Without this kind of member-checking reflexivity, my observations would not have been as systematic and thoughtful as they should

have been for academic study (Lindlof & Taylor, 2011). Involving members of the community directly helped me to think in ways that I never considered.

According to Israel, Schulz, Parker, and Becker (2001):

[CBPR] in public health focuses on social, structural, and physical environmental inequities through active involvement of community members, organizational representatives, and researchers in all aspects of the research process. Partners contribute their expertise to enhance understanding of a given phenomenon and integrate the knowledge gained with action to benefit the community involved. (p. 182)

People who have genuine interests in reducing mental health stigma do not always have the opportunity to assert their sociopolitical positions on this topic in research. CBPR is a uniquely ethical approach for understanding this population because it allows participants to craft “other narratives linked to alternative discourses” (J. Champ, personal communication, September 2, 2014). Community members should have the freedom to subjectively define their identities, experiences, and perspectives somewhere within the situation of academic research. CBPR is also useful because it provides those who are being studied with opportunities to directly correct misunderstandings as they arise. CBPR can help researchers to be more critical of their assumptions and to check this social privilege at the door (Wallerstein & Duran, 2006). The requirements for true CBPR research are as follow:

1. recognizes community as a unit of identity;
  2. builds on strengths and resources within the community;
  3. facilitates collaborative, equitable involvement of all partners in all phases of the research;
  4. integrates knowledge and action for mutual benefit of all partners;
  5. promotes a co-learning and empowering process that attends to social inequalities;
  6. involves a cyclical and iterative process;
  7. addresses health from both positive and ecological perspectives;
  8. disseminates findings and knowledge gained to all partners; and
  9. involves a long-term commitment by all partners.
- (Israel, Schulz, Parker, Becker, Allen, & Guzman, 2003, p. 184)



CBPR is not without its weaknesses. Research has shown that despite the efforts of many well-intended academics, power dynamics, social privilege, and community representativeness still tarnish the ethical and reflexive quality of CBPR (Wallerstein & Duran, 2006). Issues of race, ethnicity, class, language barriers, and other dividing social influences tend to persist (Wallerstein & Duran, 2006), and many of these will likely be challenges for me as well. However, it is still important as a guiding framework for this study as the quality of my results is dependent on my ability to allow participants to subjectively define their own lived experiences, perspectives, and identities.

My attempts to conduct CBPR were limited in part because of my status as a student, and my subsequent lack of access to the community. Involving the whole community in the analysis of the data was difficult because few participants were willing to reply to the emails I sent to their anonymous accounts. It also took a long time to transcribe the focus groups, and many participants may have lost interest.

#### Qualitative Methodology: Focus Group and Interviews

*Focus groups.* Meaning is created within socially situated communications (Lunt & Livingstone, 1996), so it made sense to conduct focus groups. The focus group method

[I]s a useful social laboratory for studying the diversity of opinion on a topic, the collaborative process of meaning construction, and the cultural performance of communication. (Lindlof & Taylor, 2011, p. 183)

Instead of only seeing how one person places an object within a discourse of meaning, more can be seen with a focus group.

The method takes advantage of the fact that, in both ordinary conversations and guided discussions, people draw upon a shared fund of experiences. What occurs in this context is a kind of “chaining” or “cascading” effect in which each person’s turn of the conversation links to, or tumbles out of, the topics and expressions that came before it. (Lindlof & Taylor, 2011, p. 183)

The focus group method is good for showing how people with shared experiences negotiate to create entire narratives that add to, and partially reflect, the overall discourse around destigmatizing mental health. Discourses are created in communities with shared interests, so observing a community as a unit in a focus group made the most sense. I wanted to know how participants would create and share meaning with each other, and not just with me as in an interview. Participants helped each other have deeper and more complete insights while in the focus groups. Contradictory perspectives were also easier to discuss as they arose within the focus group.

According to Ryan, Gandha, Culbertson, & Carlson (2014) I conducted a Type B focus group. The Type B focus group is founded in a social constructivist ontology (Ryan et al., 2014).

In the Type B focus group,

It is through the stories participants tell themselves and each other that multiple meanings and the richness of their social world emerge, sometimes in surprising ways. Under these circumstances, knowledge or information is constructed from shared ideas, opinions, beliefs, experiences, and actions. (Ryan et al., 2014, p. 331)

These Type B focus groups were particularly useful for studying the production of discourse.

They helped me to see relationships and ideas that were implicit and not obvious.

The group dynamics, social interactions, and social relations that emerge during the focus group help to clarify and reveal what is hidden but often understood by participants and sometimes by researchers (Ryan et al., 2014, p. 331)

Since discourses are not always apparent, gaining an implicit understanding of the group was helpful in the analysis stage.

*Interviews.* Focus groups come with their own particular issues. Confidentiality cannot be assured in a focus group (Morgan, 1997; Morgan, 1996), and many of the participants likely had identities, opinions, and perspectives that they did not want to share due to social desirability and safety factors. Thus, participants were not required to disclose if they had mental health

conditions. Participants were specifically encouraged to avoid disclosing their mental health statuses in order to ensure that no one was outed by default. Disclosure was not completely prohibited, however. It was the right of each participant to disclose his/her potentially stigmatized identity. Participants had full autonomy in what they wanted to share about themselves, and many of them decided to talk openly about their mental health conditions. Participants were encouraged to speak only from their own perspectives. The ground rules for the focus group included an explanation of the ethics of ‘outing’ others, which was prohibited.

Social research can be used in part “as a vehicle for giving voice to socially marginalized and invisible populations” (Willis, 2011, p. 150). Socially marginalized populations should have opportunities to speak out safely about their experiences. Therefore, optional follow-up anonymous interviews were available to all participants in order to catch perspectives that were not recorded during the focus groups. As of yet, no one has participated in a follow-up interview; however, they will continue to be pursued after the submission of this thesis.

The follow up interviews might help add reflexivity to this study by triangulating the researcher’s observations with the observations of participants made during the interview (Lindlof & Taylor, 2011). Some participants might also be more comfortable in discussing their identities and perspectives in a text-only virtual interview, especially if those perspectives and identities are contrary to those of other participants in the group. Even if participants take issue with some of the things discussed in the interview,

[D]ifferent contexts of data collection do not invalidate each other, but rather they illustrate the truism that different contexts generate different kinds of data with different meanings. (Lunt & Livingstone, 1996, p. 91)

It is true that focus groups and qualitative interviews do not produce generalizable data, but they can inform questions in other valuable ways (Lunt & Livingstone, 1996). Even post

positivist researchers cannot create a survey without first being exposed to the discourse that exists around their topics of study. As non-generalizable as this research is, it can provide some direction for future research. This is formative research, meaning that it might form the foundation of other research, qualitative and quantitative, about this topic.

All of this being said, “[a]ll studies will be bounded, to some extent, by what the researcher can practically achieve” (Hine, 2009, p. 18). Not everything of importance will be discussed from the focus groups in this study, and the focus groups were not perfect.

#### Dual Focus Group Study Design

In order to avoid intimidation and/or deferment to experts in the focus groups, I had two different focus groups: one with mental health professionals and the other with non-professionals in mental health. Common problems with focus groups have to do with issues including “individuals dominating within the groups, constructing the Other, tendencies towards normative discourses, and conflicts and arguments within focus groups” (Smithson, 2000, p. 103). As discussed, experts in the mental health profession have a great deal of influence over how mental health issues are talked about. Thus, it was important to allow a diversity of opinions to arise, largely independent of dominant assertions of reality. I wanted to construct focus group situations where participants would not simply defer to experts, but rather create their own narratives without the guiding influence of professional interests in healthcare. This was achieved to some extent, but some professionals did end up coming to the non-professional focus group. There was some constructing of the Other and some domination from these individuals, but not so much that the information collected was too degraded.

It is important to see how practitioners approach talking about this issue independent of the influences of non-practitioners. As experts it is expected that they would have different

perspectives and insights than non-experts. For example: when researching perspectives about neuroanatomy, it would be logical to interview professors in neuroanatomy separately from their freshmen undergraduate students. Mental healthcare practitioners might have completely different ideas about how to reduce mental health stigma. It is important to provide practitioners with the opportunity to speak more or less freely without having to constantly educate the others in the group.

The issue of gender domination was addressed in this study (Lunt & Livingstone, 1996; Morgan, 1997; Morgan, 1996). In the ground rules of the focus group, all participants were reminded not to dominate the conversation. It was also made clear to the co-facilitator that it was important to keep people from dominating the conversation. The co-facilitator was specifically selected for her skills in preventing participants from dominating.

#### Participants and Recruitment

People create discourses based on their interests. Therefore, participants who had an interest in reducing mental health stigma were recruited for this study. This population involved a wide range of people, including but not limited to: mental health professionals, family members of people with mental health conditions, people with mental health conditions, and concerned citizens. People who had mental health conditions were strongly encouraged to participate, but a diagnosis was not a requirement to attend. People with mental health conditions attended both focus groups, but an exact count was not possible due to the confidentiality ground rules. For the purpose of this study, *mental health professionals* were defined as people who performed essential duties for a mental health organization. These duties needed to be related to mental health, and these people should have had some degree of mental health training.

A purposive sample of participants was recruited from a medium sized city in the Midwest of the United States, where several community meetings about mental health had recently (within the past year) taken place. The point of this purposive sample was to get at the heart of the community by involving those who were most relevant to the conversation, and who already knew a lot about the local discourse.

A local community mental health service organization agreed to help with this research. This organization was responsible for coordinating the local community meetings about mental health, so they had a lot of community connections. Since this was a CBPR study, this organization was asked for feedback about the study design, procedures, and incentives. This helped to clarify the methods and procedures. This community mental health organization also offered to help with recruitment by using their email lists from community meetings to disseminate the recruitment letter. They offered to use a list of internal professionals who work for THP in order to get professionals to participate.

Just before the non-professional focus group, it became apparent that the community mental health organization's non-professional contacts would not be sufficient to recruit enough participants. Consequently, the university's disability resources center was approached, and they agreed to disseminate the recruitment letter to all the students who were registered with their office.

The community mental health organization proved to be the best source for recruiting professionals. Five out of the seven professionals in the professional focus group were people who worked for the mental health organization. The other two professional participants heard about the focus group through their connections with the mental health organization. It was not completely clear where the participants in the non-professional focus group had heard about the

study, but it was clear that at least five of the twelve in that group were students, and three heard about the group from the community organization. The others were apparently recruited through an unintentional snowball effect where they received forwarded information about the focus groups from people these organizations directly contacted.

A sampling procedure may be defined as snowball sampling when the researcher accesses informants through contact information that is provided by other informants. This process is, by necessity, repetitive: informants refer the researcher to other informants, who are contacted by the researcher and then refer her or him to yet other informants, and so on. (Noy, 2008, p. 330)

While some may malign snowball sampling as a ‘last resort,’ others have argued that it is particularly useful from a constructivist’s epistemological perspective (Noy, 2008). This is because the way a sample is taken itself a form of knowledge production (Noy, 2008). When we sample using a snowball method, we allow ourselves to move with the flow of where participants are currently socially situated, and this can help us to unpretentiously join into the *organic* knowledge production of these social groups (Noy, 2008).

Using these organizations for recruitment resulted in both strengths and limitations for this study. Both of these organizations had connections with precisely the populations most relevant to the issue. Both organizations had access to many opinion leaders who were both practitioners and non-practitioners in the community. Many of these people had real and invested interests in reducing mental health stigma, which was the primary qualification to attend.

There are some problems with using gatekeepers like these organizations in focus group research. The first is that “the gatekeeper may screen potential participants” (Kitzinger & Barbour, 1999, p. 10). This could lead to a lack of diversity in the focus group, which in turn has the potential to yield uninteresting or homogeneous conversation (Kitzinger & Barbour, 1999). Gatekeepers may also only recruit participants who agree with their perspectives (Kitzinger &

Barbour, 1999). While this can be an issue when the gatekeeper is left as the soul agent who is recruiting participants, it can easily be addressed with the active participation of the researcher in the recruitment process. However, the primary researchers did not have access to the emailing lists of participants for confidentiality reasons. The researchers had to trust that both organizations would make an effort to recruit participants with a diversity of ideas and perspectives. Each focus group turned out to have people with vary diverse perspectives about the issue. However, only three out of the twelve people in the non-professional focus group appeared to be male, and only two out of the seven people in the professional focus group appeared to be male. This gender difference might have had something to do with the recruitment pool, but it might also be due to other sociological factors or just randomness.

“The second issue for focus group recruitment is an ethical one: far from denying access, an enthusiastic group contact may facilitate access without passing on all relevant information” (Kitzinger & Barbour, 1999, p. 10). To address this issue, a recruitment letter explaining all the qualifications for attending, risks, and logistical information was used. This letter remained the same throughout the recruitment stage, and it was approved by IRB before dissemination. Confidentiality and informed consent were also discussed at the beginning of the focus group meeting.

Each of the focus groups had exactly the right number of participants, falling on or between the recommended six to twelve participants (Lindlof & Taylor, 2011, p. 184). Too many people can result in voices and topics being overlooked, and too few people can result in a lack of diversity in the conversation (Lindlof & Taylor, 2011, p. 184).



The participants were all adults who were 18 years old or older. It would likely be better to study children in a separate study, as a very different study design would have to be made for minors.

#### Incentive

The incentive for participating was a \$10 gift card to a local restaurant, Participants committed a lot of time to these focus groups, and it was only ethical to provide them with a meal.

#### Focus Group Setting

The professional focus group was held in a conference room at the main office of the community mental health organization that helped with the study. This was convenient because most of the participants in this focus group were familiar with this location through their work. The non-professional focus group took place in a classroom at a local university. It was decided that it would have been ethically questionable to require non-professional participants to go to their doctor's office for this focus group. Both groups were held on separate weekends at the end of January 2015.

#### Safety Net

Some of the participants were members of an emotionally and socially vulnerable mental health population. People trained in mental health first aid attended each focus group just in case someone had been triggered by the sensitive conversation. This concern turned out not to be a problem, however.

#### Data Collection and Reporting

*Focus groups.* The focus groups were recorded with audio only. Video was not used as to reduce the risk of a confidentiality breach. Each participant was given a number, and the order in

which they spoke was written down. The multiple recorders were used to cover the whole room and to insure against equipment failures. Two facilitators took detailed notes during the focus group.

All the participant's names were changed in the transcript. As suggested by Morgan (1997), all access of the recordings was limited to those researchers who were involved in the project. Both of the focus group interviews were transcribed as soon as possible after collection, though this process took some time.

*Interviews.* Even though the emailed interviews will not be analyzed as part of this thesis, it is still important to include a description of how they will be conducted, collected, and reported. Unlike the focus group data, all interviews will be confidential and completely stripped of identifiable markers upon collection. I will conduct these interviews over email. I will set up and provide each participant with an email account, password, and email address that they can use for an interview and that they (or I) can then delete following the interview.

This virtual form of communication might be particularly good for participants who are marginalized and who do not want their identities known (Willis, 2011). Many participants might also be more comfortable communicating over email instead of in a face-to-face interaction like a focus group (Salmons, 2015). The asynchronous nature of emailed communications might pose a challenge for completing interviews, but the deadline for completing all interviews was made clear to all participants. During these nonverbal interviews, casual and easily understood language will be used that matches the form of language used by the participants to develop rapport (for examples of this see: Barratt, 2012; Willis, 2011).

If there is an instance where a person's identity cannot be confidential, his or her data will be reported as if it were an observation made by a facilitator. For example, if there is only

one woman in the focus group, and she wanted to talk about how patriarchal the group behaved during the focus group, I would report that perspective as one made by the facilitator as not to identify the participant by default. If there is no way to avoid identifying a participant when reporting interview data that he or she wants to remain confidential, then I will not report that data. Even in such an instance, such data is important to know. Insights gained from that kind of data might still serve to inform this research a great deal.

*Data organization and protection.* There was a system of organization throughout the data collection process. As Lindlof and Taylor (2011) stated, “Without tools for categorizing, sorting, and retrieving data, the job of finding one’s way around the research evidence would be a forbidding prospect indeed” (p. 243).

First, all of the ‘data’ was put on two different external hard drives. One of the hard drives was a master backup that was locked in a secure location. The master hard drive had all the raw recordings and a copy of the transcripts. The other hard drive has only de-identified transcripts of the focus groups. For security reasons, these hard drives were used only on computers that are completely disconnected from any network.

Folders organize the hard drives. In the master backup, one of the folders has all of the raw recordings. This folder was divided into more folders dedicated to each focus group meeting. These folders were labeled with the focus group number. For example, focus group one was labeled FG1. Each recording was labeled with the corresponding audio recording number. For example, an audio file from focus group one, audio recorder three was labeled FG1.AR3.

Upon collection, all of the email interviews will be copied and pasted into word documents directly. These documents will be saved in the same folder as the raw recordings, and

they will not be copied until I make sure they are completely de-identified. Each interview will be labeled in the order completed. For example, the third interview will be labeled as In3.

Another folder contains all of the raw transcripts, which are saved as Word documents. This folder is setup almost identically to the recordings folder, with each transcript having the same document title as their corresponding folder. The only exception was that recordings from the same meeting were all compiled into one document for that meeting.

The next folder contained the annotated data. This was a copy of the transcript folder, but the transcripts in this folder had the researcher's descriptions, comments, and thoughts about the discussion. This data was annotated using the *comment tool* and the *highlight tool* in Word.

#### Moderation

There were two facilitators for each focus group because, "*multiple researchers* [sic] can be used to overcome the biases or other shortcomings of a lone investigator" (Lindlof & Taylor, 2011, p. 275). I was one of the facilitators, and the other facilitator was a fellow graduate student in communications. As the main researcher collecting the data, I wanted to have more of an opportunity to observe the group. However, I also needed to have the authority to interject when the conversation started to deviate too much and when there was something that needed to be explored further for theoretical reasons.

Both facilitators took extensive notes during each focus group because, "[k]eeping copious notes makes it far easier to articulate our process to others so that they have grounds on which to make... judgments" about our reflexivity and analytic processes (Baym, 2009, p. 186).

Right after the focus groups, I sat down with the other facilitator to go over what we observed. This increased the study's reflexivity by helping us to triangulate and enriching our observations (for a similar use of this method see: Russell & Potter, 2002).

By design, the other facilitator was female, which hopefully offset my male perspective. Men often dominate focus groups, and I wanted to be reflexive about whose voices were contributing to the discourse and whose were not.

If the fieldnotes of two or more researchers differ, it may be evidence of the sometimes subtle, sometimes powerful, ways in which the gender, age, race, or other qualities of researchers influence their observations. (Lindlof & Taylor, 2011, p. 276)

In addition, since I spent so much time researching this topic, I was afraid that I would be too prescriptive in my interjections, so the facilitator also had the job of letting me know when she thought I was dominating the conversation.

Throughout each focus group, both facilitators adjusted to the flow of the conversation as participants asserted their individual positions on the topic and built common ground. We encouraged all participants to speak by reading nonverbal cues and opening space for them to talk. Later, we allowed the conversation to flow more naturally, and we only encouraged different participants to speak if there was a noticeable deviation from the topic at hand. Both facilitators took an empathic approach to the group, meaning that we attempted to connect with participants by reflecting their concerns and by adding our own tentative ideas where appropriate (Ryan et al., 2014). We took the role of the *inquisitive researchers* who come to the situation with some *tentative* new knowledge that is by no means absolute, but that might have been useful for addressing the problem.

We guided the “discussion with a list of questions and probes” in order to actually get to the root of the theoretical inquiry (Lindlof & Taylor, 2011, p. 185). While in this role, we helped each other walk the fine lines,

...between encouraging each person to speak and promoting a positive group feeling; between promoting a robust, uninhibited discussion and gently tamping down a domineering group member; between ensuring that all key questions are asked and not inserting oneself too forcefully in the discussion. (Lindlof & Taylor, 2011, p. 185)

We worked “within a broadly standardized format with a schedule of topics or issues that, for the purposes of group comparability and coverage of theoretical concerns, [had to be] addressed” (Lunt & Livingstone, 1996, p. 84). Stewart, Shamdasani, and Rook (2007) also have a list of additional issues that a good moderator needs to consider, such as how to deal with self-appointed ‘experts’ and hostile members of the group. We took this list into consideration.

### Research Procedure

When all participants sat down, four filter questions were asked. Originally these questions were going to be asked by someone at the door, but too many people showed up at once, and some even came in a little late in both groups. It was just more practical to ask once everyone was situated. The questions were: (1) are you here for the focus group about mental health stigma, (2) are you interested in finding ways to end mental health stigma, (3) are you a mental health professional or non-professional and, (4) are you 18 years old or older? The facilitators attempted to make it clear to all participants that the word *professional* in this study meant that the participant fulfilled essential duties for a mental health organization as a volunteer or employee with mental health training. Everyone answered apparently correctly for these questions, but later some professionals identified themselves in the non-professional focus group.

Once everyone was settled, the facilitators introduced themselves as graduate students. Following this, the ground rules and other documents were gone over thoroughly, and all the participants gave their consent. All of the participants were thanked for agreeing to be in the focus group. The introduction was a little difficult and disjointed at first, but the essential information was communicated.

A *funneling* approach was used where the facilitators started by asking broad questions, and then moved to narrower theoretical questions (Schlesinger, Dobash, Dobash, & Weaver,

1992; Morgan, 1997). The facilitators started with the general *get to know you type* questions like “where are you from?” and “what do you like to do in your free time?” in order to break the ice. The facilitator then introduced the general issue of mental health stigma as an *object* that the group attempted to define. Next, to narrow the topic, the facilitator asked how the group would address the issue of stigma using communications messaging. Participants had the opportunity to use their own symbolic resources to define this problem in a setting that strove “for *complementary interactions* [sic],” where “the group members attain[ed] consensus on the topics under discussion and [went] on to add their own observations and subtle shades of meaning” (Lindlof & Taylor, 2011, p. 183). Each focus group started with general agreement with each other about the problem, even though it was not completely clear to the facilitators at the time about how the problem was actually being understood by the group. As one researcher stated, “if the goal is to learn something new from the participants, then it is best to let them speak for themselves” (Morgan, 1997, p. 13). Sometimes the most profound interpretations of qualitative information arise when the researcher’s assumptions about the most general understanding of the problem are contradicted or refined. This is why it was so valuable to use the funneling approach in this research.

A 10-minute break was offered at one hour, but everyone remained seated.

The next question was supposed to focus on what participants thought had and had not worked to reduce stigma using communication messaging. After discussing this for a few minutes, I interjected with some information about how the ‘illness like any other illness’ approach has not worked to reduce dangerousness stigma and social distance. The reason for presenting this information was to encourage participants to come up with *new* ideas about how to destigmatize mental health from a communications messaging perspective.

The next segment of the focus group was about the concerns that approaching this issue with empowerment and protest messaging could create resistance to mental health services. The facilitators handed out an example of a resistance narrative from Jeffs' (1998) paper in order to help participants understand what an empowerment and resistance narrative might look like. The facilitator then asked what role empowerment messages might have in communications about mental health.

A 10-minute break was offered at two hours, but everyone remained seated again.

In the next section, the three narrative typologies as discussed by Frank (1995) were presented. All participants were presented with a copy of Frank's (1995) narrative model as a discussion stimulus. After these narratives were presented, the facilitator asked participants if they thought the narrative typologies were realistic representations of the experience of having a mental health condition. The point of presenting these narratives was to help participants think about mental health in ways that might give them new symbolic resources to address the problem, and to help them challenge, or at least see, the boundaries of their discourse. The model certainly stimulated some interesting conversation, and probing was not very necessary.

Once the group addressed some of their concerns about these narrative typologies, the facilitators asked how they thought (or if they thought) the typologies could be useful in constructing destigmatizing communications messages. Participants were first asked to write down their ideas. Participants were also asked to think about some of the issues discussed previously in the focus group. This strategy seemed to work better in the professional focus group. The non-professional focus group seemed to fragment towards the end. Participants in the non-professional focus group seemed more interested in pulling the narratives apart to criticize or support particular aspects instead of applying them to the issues discussed before.



As expected, participants disagreed with each other, and with the facilitators, more in the second and last parts of the procedure. This might be in part because these sections indirectly challenged the participants to be critical of their own discourses, which might have created some confusion and some tensions. There were not a lot of identifiable emotional tensions among participants in either group, and the emotional tensions that did occur seemed to work themselves out quickly.

Each focus group resulted in rich discussions that might add important insights to the overall discourse around mental health stigma.

### Analysis

The first step in the analysis process was to come to a deep and fundamental understanding of each focus group discussion. At first, neither focus group seemed to hold much promise, but it seemed likely this was due to interpretive confusion, not because the focus groups had nothing to offer. Patterson and Williams (2002) advocated for a multiple rereading of transcripts, including a rereading for comparison across groups. This was done, but instead of just rereading the transcripts, I listened to them. As a person with a reading disability, spending too much time rereading the transcribed text would have likely made the information more difficult to process. In addition, “[o]ral communication is vastly different than written communication, and the transcriber has had to make difficult and sometimes critical, decisions” (Patterson & Williams, 2002, p. 46). Instead of relying mostly on imperfect transcripts, I primarily relied on the actual recordings of each focus group. I re-listened to each focus group recording in full more than five times, and in part countless other times, while taking walks. While not walking, I was transcribing, and I rarely had more than 12 hours without engaging with the data over several weeks. The goal while listening was to hear and understand the exact

meaning of what participants were saying. The recordings were listened to so many times that the researcher could remember exactly how the conversation would develop next, and no new significant meaning seemed apparent without a considerable stretch of the imagination. When the time came for the second step of the analysis process, the researcher was able to navigate the final written transcript with very little uncertainty.

The second step in this constructivist analysis was to reduce the data. According to Lindlof and Taylor (2011),

[D]ata reduction means that the use value of evidence is prioritized according to emerging schemes of interpretation. This does not mean that data should be thrown away like chaff; you never know when chaff, or unused data, might become wheat in another work context. Instead, data are ‘reduced’ by categories and signs that put you in touch with those parts of the material that can be used to construct claims. (p. 243)

An analysis technique learned from J. Champ (personal communication, April 2014; see also Williams & Champ, in press) was used to systematically organize the data. Champ’s technique forces qualitative researchers to be disciplined in how they analyze transcripts. It is a way of thinking about the data from the smallest forms of language up to whole discourses. The following is a visual interpretation of the method:

Discourse  
Narratives  
Strips  
Signs

The usefulness of this model was that it forced me to be very systematic and discerning about what I pulled out of the transcripts. While it can be hard sometimes to see where one level begins and another level ends, it was important to look at every piece of information critically, closely, in detail, and from a distance. At this data reduction stage, I looked for individual signs, strips, and narratives, and I decided which of those signs, strips, and narratives were relevant to the emerging patterns and the theoretical inquiry. I was interested in reoccurring ideas because

reoccurrence might have indicated that the group placed a greater level of importance on those ideas.

The actual writing process also contributed a lot to the analysis. The discussion section of this paper was rewritten completely several times. Every draft was a little more discerning, reflexive, and connected to discursive observations than the previous drafts. The focus group recordings were re-listened to before each draft was rewritten.

### Conceptual Development

At this stage of analysis, I wanted to “provide focus and shape to the body of material gathered during [the] project” (Lindlof & Taylor, 2011, p. 244). I looked at how participants constructed the problem and how they came up with possible solutions through their stories and descriptions. This was a narrative stage of analysis, which I thought could be important because people’s bias interests are not always the most interesting elements of their discourses. Sometimes the journey itself is more important than the motivations behind how it is told. The discussion often chained together, with participants adding complexity and depth to ideas that seemed at first very simple but which turned out to be actually very complex.

The analysis included power relations and other elements of a critical discourse analysis (see: Van Dijk, 1993), but the goal was not to simply criticize mental health institutions. Sometimes solutions and good conclusions come from different discourses that disagree on some level. Often these solutions and conclusions are similar among people coming from different discourses. At the very least, people with dominant interests in different discourses can certainly agree with each other about the nature of ‘reality’ based similar, and even different, interests.

## RESULTS AND DISCUSSIONS

### Group Representation

*Non-professional.* It is important to make several observations before discussing the information gained from these focus groups. First, despite all efforts, some of the people who came to the non-professional focus group were what this study would consider professionals in mental health. Hanna was a communications professional for the community mental health organization that helped support the study. Hanna left early, but she still contributed in defining the initial situation and in defining the problem. Jack was the coordinator for mental health first aid training for the same organization. Jack stayed throughout the whole focus group, and he played a significant role in the discussion. This led to some interesting observations while it was also a limitation of this study. Kate identified herself as a peer specialist who worked for the same organization. Of the three, Kate was probably the most qualified to be in the non-professional group since her education about mental health was largely gained from her direct experience as a person who worked through the system as a client. Kate only mentioned her role working with the mental health organization once, and, unlike Jake, she did not attempt to educate the rest of the group about the services that were available from the mental health organization. Peer specialists were people who went through recovery successfully, and who served as mentors to others in the system.

*Professional.* No non-professionals attended the professional focus group. However, one of the members in the professional focus group identified himself as a peer specialist. This participant, Evin, was a very prominent member of the mental health community who had several years of experience with advocating for mental health causes. Like Kate, Evin had a

strong interest in speaking from a perspective of someone who had experienced recovery first-hand. This also led to some interesting power dynamics in the professional focus group.

### Defining the Problem as More Than Stigma

Goffman (1963) thought of stigma as a matter of social relationships within social situations where ‘normals’ identify and discredit people’s specific attributes. Despite this sociological definition, however, Goffman (1963) often used narratives about how the stigmatized dealt with their shame, which he said is a result of stigmatization, to illustrate his points about the power of social stigma. It is not surprising, therefore, that people who have interests in reducing mental health stigma also have interests in reducing people’s individual shame. Participants in both focus groups defined the actual problem in a way that bridged discourses. The problem was not simply about reducing stigma; it was about psychological and sociological de-marginalization.

*Non-professionals.* The first question asked participants in the non-professional focus group to define the term stigma, but the conversation went far beyond stigma. It quickly became apparent that participants were actually defining what they saw as the overall problem, which was much more complex than just stigma. The participants often seemed either hesitant or unable to see stigma as separate from its psychological consequences like individual shame and the development of other people’s negative attitudes towards them. They also discussed other social consequences like prejudice, stereotyping, and discrimination. Despite this, they still seemed to have a general understanding of stigma that was consistent with Goffman’s (1963) definition. Stigma associated with disabilities, they said, could be powerfully discrediting:

(Jane)- When you are in any way considered disabled you’re less than competent, entirely, no matter what that might be.

(Sue)- And less than.

(Jane)- Yeah. Definitely not a human being.

The discussion included sociological concepts like harmful micro aggressions, bullying, gender, and generational differences. The conversation did not turn to a more individually focused perspective until a couple of the professionals brought up shame. As Hanna stated, “I think people can also feel bad about themselves if they have a mental illness... like having a mental illness can make them feel less about themselves.” Many in the group quickly and naturally incorporated this individual perspective by defining the problem as largely existing within the individual:

(Tom)- I think it is about shame. Like, there is a lot of self-shame people don't want to seek the help, people don't want to see a shrink. It exploits their weakness as a human being. If you don't think it is truly a problem for you you think 'I can live day-to-day without the occurrence of the daily problem,' then they don't get help.

Hanna's professional perspective strongly influenced the definition of the problem, but no one seemed to disagree with the individual perspective. Many, however, were intent on not limiting the definition to the individual.

In an attempt to make the problem more complex, Liz made it clear that not getting help is not just a psychological issue, however. For Liz, avoiding treatment could also be seen as a rational choice because of the real social risks of being identified with a mental health condition. As she said, “When you go to a psychiatrist you risk getting a label. You risk being more vulnerable to alternatives like the hospital. Do something and get thrown in jail.”

While Jane agreed that part of the issue exists at an individual level, she also emphasized the situational nature of stigma and its individual consequences.

(Jane)- I don't know, I see that self-esteem is a problem in a lot of things. It's, I don't feel bad about myself generally until I have to deal with another person who either goes out of their way and flippantly does it. Like, it's very—I am mostly okay until I have to deal with someone who is mostly a prick.

For the non-professional focus group, the problem appeared to bridge both the individual and social discourses of disability. Furthermore, the problem appeared to be both situational and systematic. In short, the problem was defined as very big and very complex.

*Professionals.* The professional focus group defined the problem in a very similar way as the nonprofessional group.

The discussion started with a retired psychiatric RN, Shelly, who stated that she saw the problem as existing at a very individualistic level.

(Shelly)- [Stigma is] the inability to be honest with yourself, because you are afraid if you are honest with yourself you will have to admit that there is something wrong, and if there is something wrong you will have to admit to your partner, your family. So, that's step one. Then the biggest thing is that if you sense there's something wrong, and you want to have help then that's admitting that you have to go out to the public to find an answer for what is going on with you.

Shelly described a process that had to do primarily with individual shame and individual social anxiety, not really with the actual existence of other social factors like stigma and prejudice.

Immediately after Shelly's statement, however, another participant asserted her belief that the problem existed at both the social and the individual levels.

(Willow)- I think stigma is a macro issue and a micro issue. It's, I, I see it as a stereotype, preconceived, umm, notions that we have in this society about persons with mental health and addiction disorders. But, um, and it's based on fear as a group-think and down to an individual level where we have, like you were saying, where we have fears of looking at what's really going on, and it is a negative. It's a, ah um, painted with a black brush that if you have a mental illness you're marked, and it makes it really hard to get treatment.

Willow defined the issue as existing at both individual and social levels. Others followed with similar statements, even Shelly, who extended her original statement to include a social element. However, It is important to take note that Willow's statement concluded by implying that the main goal should be focused on treatment, which might be seen as an individual model approach to addressing the problem of mental health. This was a trend discussed more in this paper.

*Summation of the problem as understood by the groups.* Stigma, as defined by Goffman (1963), appeared to be very relevant. However, the problem that has been conflated with the ‘stigma’ concept is actually a very complex issue that goes well beyond the situation where stigmatization occurs. The issue is comprised of a myriad of potential causes and consequences. According to these groups, the goal should not be destigmatization; rather, the actual goal might be understood better as de-marginalization. De-marginalization would include reducing instances where social stigmatization occurs, reducing instances where self- stigmatization occurs, addressing systematic social barriers to full participation in society, and addressing systematic psychological barriers to full participation in society.

*Theoretical and practical interpretations.* The discursive collision happening around mental health is likely due in part because of the complexity of this issue. Communications practitioners need to take this complexity into account when constructing messages to de-marginalize people with mental health conditions.

The idea that the issue is more complicated beyond the ‘stigma’ concept is not new. Yet, researchers have only just started to really understand how the individual and social sides of this problem interconnect to have undesirable results, and how this connectedness can be used to reverse the process. While much has been done to try to address stigma, it appears that, “evaluating stigma is not sufficient; absence of stereotypes does not promote social inclusion,” (Corrigan, Powell, & Michaels, 2014, p. 466). There are many variables involved that must be understood, and research is headed in that direction (see: Corrigan, et al., 2014). Marginalization happens at both an individual and social level, and other factors that connect these levels together must be taken into account. One of these possible factors is the subject of the next section—normalization.



## Normalization

*Non-professional.* When participants were first asked how they would address the problem using communications, one of the most consistent replies had to do with normalization. They did not seem to emphasize the normalization of mental health specifically, however. Rather, they emphasized more the normalization of the populations with mental health conditions. The message here was not ‘mental health conditions are normal, accept them.’ The message appeared to be more like, ‘people with mental health conditions are more normal than they are different.’ For example, Tom expressed his belief that many people often do not think that individuals with mental health conditions can assimilate into ‘normal culture.’

(Tom)- I think there should be a national wide recognition that people with these health conditions are functional and can assimilate into normal culture.... I have a lot of veteran friends, and I'd say probably about 90% of them have [posttraumatic stress].... And they are all functioning... one of my friends sells cars—they all know how to assimilate into normal culture.

For Tom, stigma is reduced when the individual can assimilate into society. Typically, this is an individual model perspective because it places the burden to change on the individual with the disability. However, in this case it is also a social model perspective because it places the burden on society to recognize that people with mental health conditions are not that deviant.

Tom also argued that normalizing perspectives of people with mental health conditions are undermined when their differences are overemphasized.

(Tom)- The only time you ever hear about [mental health] is when stuff goes catiewonkers and that's not the right way to approach it. It's like, look at all the things Robin Williams did for a very long time before unfortunately his end-of-life decision. It's really heartbreaking for the mentally ill community that this stuff happens, but we need to put a better light on the people who are actually assimilating into society.

Others agreed with Tom that a more normalizing perspective was needed, but they added that there also needed to be a better understanding of differences. For them, the issue is that the

opportunities to educate others about their differences are often constrained by how and when mental health can be talked about.

(Jane)- It's like, the only time it actually becomes possible to talk about it—like I actually took [Robin William's] suicide as an opportunity to talk about depression because people don't want to hear about it until someone famous dies. So, if that's the only thing that allows you to talk about it, that's pretty bad.

Communications research about sexual health is full of evidence that suggests people use media content to help them talk seriously about socially awkward or stigmatizing issues (Collins, Elliott, Berry, Kanouse, & Hunter, 2003; Helme, et al., 2011). Similarly, by using media events as the impetus for risky conversations, stigmatized people might feel more efficacious in coming out to talk about their identities in social situations. However, when media events about mental health are talked about negatively, they might lead to overly negative and overgeneralized perceptions of mental health, even when people with mental health conditions decide to use them as the impetus for serious conversations. It might also be more difficult for people to talk about their identities using media events when the event is seen as extremely deviant, like a school shooting. Thus, it might be important to find new ways to construct messages and stories that can help people with mental health conditions talk about their differences with others in more positive social contexts.

Opportunities for people to use media content as impetuses for conversations about mental health extend to online content. Generations who have grown up with the Internet might find it easier to talk about mental health because of how easy it is to find positive mental health representations online. Sam, a younger participant who identified with a mental health condition, said that she thought her generation approaches mental health differently partly because they see mental health as adding a 'cool factor' to mental health social identities. The development of this

‘cool factor’ she said, might be partly due to her generation’s parasocial interpersonal relationships with online-famous people.

(Sam)- One thing that’s really cool about the media social circles that I watch—and hang out with, is that, um, there’s a lot of famous people on the internet... who are open with, that they have, or have been dealing with mental illness.... A lot of people my age are being, um, exposed to mental illness and are functioning. A lot of YouTubers that are the most famous people on the Internet have, like, a lot of issues. And people are like, ‘they are doing stuff, and they’re screwed up in the head, and I am screwed up in the head, and I can do stuff too.’

Online stories of people with mental health conditions can provide both positive and negative opportunities for people to identify with and to talk about mental health (Ziebland & Wyke, 2012). Famous people can be both role models for how to live with mental health conditions and cautionary examples of when things go wrong. However, specific anti-stigma social movements can be created online where people emphasize their social individuality and redefine their stigmatized traits as adding to positive yet still marginalized diversity (Saguy & Ward, 2011). Famous YouTubers who have large social media followings, for example, might ‘come out’ as having stigmatized identities to appeal to socially diverse younger audiences. Others with stigmatized identities who come out might also be characterized as ‘brave’ and on the cutting edge of social change. Thus, deviant social identities, if not deviant activities, might be eventually defined as ‘cool factors.’

*Professionals.* The professional group seems to have agreed that normalization for people with mental health conditions is important in communication. As Lacy said,

(Lacy)- I think putting positive images out in the media of folks who have mental health issues who are willing to share their stories; to see that they’re no different than anyone else in the population.

While Lacy said that people with mental health conditions were, "...no different than anyone else in the population," participants still seemed to acknowledge a need for the general population to understand mental health differences.

Like the professional group, the non-professional group also acknowledged how difficult it can be to educate people about mental health differences when dominant messaging promotes social marginalization. For example, Lacy, who said she works mainly with substance users, talked about one example in particular. She said that The Meth Project's advertisement campaign, which is designed to scare people away from using meth (for a review see: Anderson & Elsea, 2014), actually makes the issue worse for people trying to recover by stigmatizing meth users.

(Willow)- We are starting to see that trickle down into other areas where folks who have used meth or who have a meth related charge are now being scrutinized more closely for housing, are now being scrutinized more for other things because the image out there of somebody who uses methamphetamine is very graphic and horrific. So, it in some ways attempts to prevent something but increases the stigma around specific substances.

The Meth Project, which is still active in several Western states, actually has the goal of stigmatizing meth use (Linnemann, Hanson, & Williams, 2013). One of the consequences of stigmatizing the use, however, likely involves creating highly negative and stereotypical views about the population. The social situations created by such divisive messaging do not lend themselves to positive group acceptance, and they also create impetuses for people with stereotypical beliefs to talk about mental health in divisive ways. Of course, meth use is a public health problem, which was not lost on Lacy. However, Lacy later added that messages designed to discourage drug use need to include positive images of former users in recovery. Making recovery seem more achievable might be an important approach to the normalization of mental health populations who have histories of substance abuse.

The professional group appeared to agree with the non-professional group that stories about people with mental health conditions create opportunities for others to talk about their identities. They also agreed that famous people coming out could help encourage and provide the opportunities for others with mental health conditions to educate their communities. As Lauren stated, “I think [when famous people come out,] it opens up at least an avenue for people to talk about it in social places.”

Unlike the non-professional focus group, the professionals also seemed to emphasize the need to normalize and promote mental health treatment. As Willow stated, “If you can make it okay to get help, maybe the trickle down from that is [less stigma].” Treatment seemed to have been a big part of the professionals’ interests in reducing marginalization. Treatment, as an individually oriented practice, connects to an individual level discourse. From Willow’s perspective, social normalization of individual treatment might lead to more people who get treated, which in turn might lead to less marginalization by helping the individual to better assimilate into society. Normalizing treatment is a sociological approach to promoting an individually centered solution to the ‘problem’ of all mental health, not just the social marginalization of people with mental health conditions.

*Theoretical and practical interpretations.* In order for the normalization approach to work towards de-marginalization, people with mental health conditions need to be recognized as more or less assimilating into general culture. This requires both that people with mental health conditions work towards assimilation (through treatment and identity management) and that others in society recognize when that assimilation has been more or less achieved. People in society can make their recognition of assimilation more achievable by redefining what they see as ‘typical’ behavior or ‘acceptable’ identities to include people who have been traditionally

defined as outside of the norm. Communications practitioners can thus focus on both helping people appear to be assimilating and by helping others redefine what is considered to be acceptable behaviors and/or acceptable social identities.

Communications practitioners who aim to help in the de-marginalization of mental health should consider creating messaging in ways that allow people to talk about mental health differences in less distressing and more positive contexts. Using famous people in messaging about mental health might make the normalization of people with mental health conditions seem more achievable. Practitioners should avoid stigmatizing fearful messaging about mental health unless they also include positive, efficacious, and believable endings.

While normalization is important, both focus groups talked about the need for people to understand mental health differences. The messaging here might be something such as, ‘people are more alike than they are different, but it is important to understand the differences so no one’s needs are left out.’ How these ‘differences’ are defined, however, can vary dramatically, and these definitions are not necessarily de-marginalizing. One way people have defined these differences has been through the use of the ‘illness like any other illness’ approach.

#### Illness Like Any Other Illness

Examples of the ‘illness like any other illness’ metaphor were used throughout both focus groups. Mental health was frequently compared to physical conditions like cancer. These comparisons were naturally accepted into both group discussions. Both groups ceased to use this metaphor after it was specifically talked about, but neither group dismissed its use entirely. Both groups were asked to consider the validity of the ‘illness like any other illness’ approach and its usefulness in destigmatizing mental health. Part way through answering this question, each group was given a summary of its effectiveness that was based on the research discussed in this paper.

*Non-professional.* When participants in the non-professional group were asked to react to the ‘illness like any other illness’ idea, they initially came up with a mixed response. Kate said that she liked the approach because, “[i]t takes the fear and certain emotions out of it and you tend to, at least in my opinion, tend to go more towards the, ‘ok, how do we fix it’ Not fix it, ‘how do we take care of it?’” Jane, however, responded by picking apart the metaphor,

(Jane)- [I]t’s not like any other illness.... It’s one thing to get is so it seems normal but at some point if you treat it like a broken leg, you know what to do about a broken leg. There is one fix.... [Mental health is] not curable for most people—it’s manageable, which is a different thing. You don’t generally manage, like, a sprained ankle.

Jane argued that mental health is not like *any* other illness because most other illnesses are curable, whereas mental health is usually just manageable. Another student who was open about having a mental health condition quickly added that any comparison would have to be to one made to a chronic illness. She said,

(Alison)- Because it’s not fair to be like, ‘it’s like having a broken leg’— I wish I had a broken leg.... If we are going to say it is an illness like any other illness we gotta pick the right other illnesses we are comparing it to.

Liz made the comparison even more specific by pinpointing mental health as biologically different because it is in the brain.

Recognizing anatomy, and that you have a brain included with, you know, your heart your lungs, and your bones.... That we are a physical being and... it’s a neurological and physiological malady. It’s different than other illnesses because it is of the brain.... It’s an illness; it’s based in your anatomy, we can do what we can do at this point in time and we are learning more every day.

Liz had a strong belief that the nature of the difference of mental health was at its core biologically based. However, chaining from the comments that came before, Alison provided more insight into the interests in why the participants like to describe mental health conditions as illnesses.

I almost feel like it's physiological, but every illness is an illness like any other illness, like I think there's a difference. Like, it's biologically based, but that's where the illness comparison ends. So, I guess I struggle with 'it's an illness like any other illness'— it's comparing it to other things where it's—I don't know, it's the same but not the same? Like, I feel like maybe it's not a fair comparison. Like, I would like people to know it's not my fault. Like, I feel like if it is physiological it takes some of the blame away, but I would not compare it too much to other things. I think [the comparison] takes away some of the struggle. Like, this is really really hard, and it's a different kind of hard and I don't want to minimize the different kind of hard it is. But it's not my fault, like my brain is messed up, like my brain is sick.

Allison likes the way that the blame seems lessened when mental health is compared to other illnesses. She sees these other illnesses as being understood as typically blameless, but she also expresses a desire for people to better understand the 'real' difficulty that makes mental health different from other illnesses. In other words, the 'illness like any other illness' approach did not go far enough for Allison in helping her to communicate how her mental health condition makes her different from other people.

The discussion turned to be about how understanding the biological 'object' of mental health could help to reduce stigma. Several participants seemed to imply that they believed mental health conditions (not just the people with mental health conditions) could be normalized within a medical understanding of the human condition. However, they admitted that the biological science behind mental health, while improving, is still not quite sufficient for this normalization to be complete using a biological framework. When Sue asked what exactly happens in the brain, the other participants answered with an almost simultaneous "we don't actually know." However, an incomplete biological normalization of this difference did seem possible for some participants. Allison proposed that it might be useful to at least understand that the brain is biologically complicated.

(Allison)- I think understanding the brain, I like that, because if you don't get how complicated the brain is—Parkinson's is in the brain, and all these other things are brain



illnesses, I'd almost rather go that direction, because yeah you know, is it ion channels, is it chemicals, is it electrical signaling?

(Jane)- How much and which chemical? (stated sarcastically, group laughed)

(Allison)- But if people can understand this is a system that can go so wrong so easily.

Even with this imperfect and increasingly barebones understanding of the biological nature of mental health, Sue again emphasized that she still saw it as helping to reduce blame.

(Sue)- I think it takes the personal out of it as in, in the sense that you didn't choose this, and, it happens. And, I think that so much with how people feel about mental illness right now is that 'well, if you had made some different choices' or 'well, if you had done this.'

Sue saw this approach as addressing what she thought as society's judgmental attitude towards people with mental health conditions. Sam agreed, stating that what should be added to the metaphor was a clear statement about how these conditions are 'real.'

(Sam)- Yeah, I think that if we just added that it's 'real just like any other illness,' it's—

(group makes several statements of agreement)

(Sam)- Yeah, cause a lot of people are like, 'it can't happen to me.' 'I can't imagine it.' I can imagine a broken ankle, I can imagine what it is to be hurt, but I can't imagine being somebody with a mental health issue not mine. If we just taught everyone it is real, it's not something that the 1% of the population got together on a Saturday night and was just like 'guys, lets, let's play a prank.' (group laughs)

Sam's statement seems to get to the actual crux of the matter. It is not so much that mental health is like other illnesses; rather, the need is for people to understand that mental health conditions are 'real,' unavoidable, and a part of the human condition.

Liz added to the idea that mental health conditions are 'real' by talking about them as being obviously and objectively present.

(Liz)- So, um, the more neutral the view the more objective you can see every individual. And, um, neutral meaning it's not good or bad, it 'just is,' and you've got to work with what is.

When Liz stated that mental health ‘just is’ and that this perspective ‘neutralizes’ mental health in a ‘objective’ way, she was talking about seeing mental health conditions as ‘objects’ with some extent their own meaning within physical reality. For this group, mental health conditions appear to be ‘objects’ like forests and volcanoes are ‘objects.’ People do not have to understand volcanoes and forests perfectly to agree that they are ‘real.’

‘Objects’ are not mere social constructions; objects demand defining. A volcano exploding could symbolically mean any number of things, but it cannot be ignored. The same appears to be true for the participants with mental health conditions—they must define their conditions. Yet, the symbolic resources that people have to define these bodily ‘objects’ may be limited to mere functional and biological language scripts.

While it might bring some peace to think about ‘objects’ as ‘just existing,’ without any kind of judgment as to what they mean for people’s lives, it also might not be sustainable in actual social situations where people want to act on and improve their worlds as they see them. Seeing an ‘object’ as dysfunctional, for example, might imply a certain judgment that turns the so called ‘neutral’ thing into a problem that needs correcting. Furthermore, by defining the ‘object’ in clinical and individual terms it becomes clear where the problem actually exists—within the individual. The difference between people who are seen as ‘normal’ and those with mental health stigmas might therefore be seen solely as an individual difference, and not also as a social identity difference that has been used to justify group marginalization for centuries.

Like several of the participants, many people with mental health conditions prefer to be talked about using person-first language. Many of these people take offense when they are referred to as ‘the mentally ill.’ The illness metaphor for mental health might make it easier for people to isolate, diminish, and ‘neutralize’ the ‘objects’ that are their mental health conditions.

Through this process, mental health conditions might be more easily disconnected from the individual's self-concept. What might have been a stigmatized and shameful master identity might therefore be relegated to an incidental 'object' that 'just is' like a pebble with little meaningful consequence. Like a rock in a shoe, a pebble identity must still be managed, however. When 'objects' make themselves known, they demand defining—and thus the pebble in the shoe becomes a problem that must be addressed. In so long as the pebble is seen as just a pebble (assuming that would ever really be possible), it is blameless. But, as soon as the pebble becomes known as a problem, it is vulnerable to any number of negative definitions. Without someone who is willing to defend the value of the pebble in the shoe, or at least defend the valuable perspectives gained from such a painful experience, both the pebble and its suffering bearer may be subject to other people's pitying or scornful judgments. After all, these particular pebbles cannot just be taken out of the shoe, a concept that might be beyond many people's comprehension having never experienced something similar.

Of course, it might seem odd to want to defend the value of such an inconsequential thing as a pebble, which might be one of the problems of the objectifying process and a limitation of this metaphor. Mental health conditions are not inconsequential in stigmatizing contexts. Mental health conditions probably shouldn't be seen as mere pebble identities in marginalizing social contexts that prevent people from getting treatment, housing, physical healthcare, voting rights, jobs, and from participating in community generally. How can identities so insignificant stand up to social issues that are so huge? A pebble in a shoe will likely not result in major health disparities, but having mental health conditions do. This is not to advocate a militant approach to facing social issues. This is to advocate for taking pride in at least some aspect of the experience while also civilly defending that experience as valuable.

The pebbleization of identity is more than just objectification. The word is meant to imply a certain shrinking or reducing of an identity from something large and oppressive to something small and simple. The word is also supposed to avoid the negative connotations that have been associated with the word 'objectify.' Pebbleization may be a politically limiting identity, but it might also be essential in the empowerment of people with mental health conditions (for a similar conception see: Curtis, 2000). Therefore, it should not be seen as a negative and dehumanizing process.

*Professional.* The professionals seemed to think that the 'illness like any other illness' approach made it easier for them to empathize with clients.

(Shelly)- Empathy for someone who has cancer, uh, within a hospital staff is something that is, is—you can identify that with each other. But [when] a hospital staff says, 'person A is a borderline personality disorder,' then that stance empathy changes and their reaction to that person. That's a human part of any of us, whether we are professional or not a professional. It changes, and that's probably part of human nature. We just need to have an awareness when our empathy button is switching over and we are reacting differently. It's easier to talk about a person with diabetes and possibly depression or a chemical imbalance, but it's very difficult with certain disorders. Chemical imbalances are—we can cope with them better than personality disorders.

For Shelly, viewing mental health as an involuntary illness made it easier to empathize with her clients. It made it more comfortable for her because she felt less judgmental, and perhaps more needed. People with 'chemical imbalances' were easier to help because they were not as morally responsible for their life situations. Shelly might have also had an interest in feeling virtuous, which might result in situations that could be taken positively and/or taken negatively by mental health clients. It is important to note that this perspective could be interpreted as encouraging both an empathetic approach and a pity, 'oh, let me help you, poor soul' model approach to mental health services.

Willow added clarity to Shelly's argument by saying that the illness construction helps to reduce the blame associated with mental health.

(Willow)- I think that implies if you have, um, um, a chemical imbalance, it's something that your brain is doing, it has nothing to do with you. But when it, personality disorders does have to do with you, but if it's diabetes or cancer, you didn't do anything, it's not your fault. But, when it comes to mental health issues, back to the stigma of, 'it's your fault, it's something you did, you're weak,' something like that.

The professionals emphasized how the metaphor reduced blame, but they did not discuss how it might increase the 'realness' of mental health conditions like the non-professional group.

Another member, Jim, brought up how other illnesses can also invoke judgments. He asked the group to think about a person with lung cancer who keeps smoking. Some in the group agreed that there could be blame assigned in that case, too. However, for the most part, the group thought the illness metaphor was a fairly good rhetorical tool for understanding mental health as blameless and not simply character flaws.

Only Evin, the peer specialist, pushed against the limitations of this metaphor, stating that he believed there was more to mental health than just biological difference.

(Evin)- You know, there's some value in looking at these things as just chemical things in the brain, um, but there's also things people need to talk about. You know? Their not, you know-- there's more of an emotional aspect to things too. Um, which, I mean, certainly there's emotional aspects to cancer, but that's not what you go to the doctor for. Um, whereas when you go in for mental health treatment, the emotional part is a huge factor, so, um. So yeah, I think it is a little different than just your basic physical malady.

According to Evin, what makes people with mental health conditions different involves emotions, whether inside or outside of an individual biological context.

While the 'illness like any other illness' approach was seen as valuable, when the group was asked if it was a sufficient message for addressing stigma, no one said yes completely.

Everyone agreed that it was a good message, but they all agreed that the message did not go far enough in helping people understand the stigma.

As discussed, the mental health professionals might have had other reasons for why they want people to think about mental health as physical. One of these reasons might have had to do with creating better services, and another reason might be a financial resources interest as implied in the following exchange:

(Shelly)- [P]hysicians tend to separate the head from the body. And that has gone on for as long as I've been in the psychiatry area. And it's still going on. It's still pervasive.... But how sad that we still separate the head from the body in 2015.

(Mary)- I mean, insurance has been up to very, very recently, and not fully even now, have only paid for neck down only.

In this exchange, Shelly maligned what she saw as a problem with physical healthcare. Mary immediately took up the thread of the conversation and connected it to a problem with insurance coverage. The main factor that connected these two statements had to do with what they saw as the 'disconnect' that primary physical healthcare has with mental health.

As discussed in the literature review, it might be within psychiatrists' professional and economic interests to connect mental health more to physical healthcare. A deep analysis of the 'illness like any other illness' metaphor may not have been very important to the professional group because the metaphor already clearly served their financial and professional interests. Why complicate what is already so obviously beneficial?

Of course, non-professionals also likely have strong interests in having insurance pay for mental health services, but their justification for why insurance should pay might not be as strongly tied to the physical nature of mental health. Rather, the non-professionals' motivation to deconstruct the 'illness like any other illness' approach might have been powered mainly by their interests in actually understanding their conditions. For non-professionals, insurance should pay because mental health is 'real,' treatment helps, and they want to be functional in society. For

professionals, mental health is ‘as legitimate and prestigious’ as physical healthcare, it should be funded like physical healthcare, and this funding would make their jobs (to help their clients become and remain functional) easier. The most relevant question here might be: how can communications practitioners get people to see mental healthcare as more legitimate using other communications messages that go beyond the pathologizing of mental health? Answering this question might go some ways towards the de-marginalization of mental health populations.

The professionals did not discuss as deeply about assessing the validity of the metaphor as the non-professionals also likely in part because we did not stay on this question as long. The professional group also moved off topic a couple times, which distracted the conversation.

*Theoretical and practical interpretations.* For both focus groups, the ‘illness like any other illness’ metaphor seems to have been at least somewhat useful in defining mental health differences. However, it is important to realize that this approach also has limitations. Ultimately, the illness metaphor is just one of many possible metaphors. There is no reason for why communications practitioners would have to keep using this particular metaphor as apposed to other metaphors or other language altogether to make similar points. For example, LGBTQ advocates might argue that their gender identities ‘are not a choice’ for similar reasons why mental health advocates use illness metaphors—to impress upon others that their identities are ‘real.’ At some level, everything is bounded within a physical ‘reality,’ what actually matters is how people make meaning of physical ‘objects’ within their socially constructed ‘commonsense’ worlds. The possibilities for doing so are endless.

## Diversity

Another way to view mental health differences is a positive perspective: as another form of valuable human diversity. This perspective was not specifically addressed in these focus groups, but it arose anyway, and it bears mentioning. Evin stated this perspective most clearly:

(Evin)- There's... people with mental health issues that are very different from everybody else in a lot of television, um, and that's a valuable thing. Um, so, ah, I don't know, if ah, we could maybe celebrate a new kind of diversity, perhaps not just racial, you know?

This kind of understanding difference through seeing diversity was compared to the LGBT movement in both focus groups. This was especially true when the discussion was about identity reclamation, which is primarily about reframing language to view an identity more positively.

(Sue)- And I kinda liken this to the movement that's come out of the LGBT, the Queer movement, and reclaiming that word. My generation that was a word that was stigma—it had a lot of stigma, a lot of prejudice, a lot of negative things associated to it. [In] the younger generations, that's a badge of honor.

Reclaiming identity through language fundamentally reframes the identity from something negative to something positive. People can still be given diagnoses, but instead of it becoming discrediting attributes, they become badges of honor.

*Theoretical and practical interpretations.* Corrigan, et al., (2014) argue that variables like self-determination, empowerment, and attitudes must also be assessed when looking at stigma. According to them, interpersonal affirmation is what's often missing in the normalization process. By defining mental health conditions as non-problematic and as valuable in diversity, it might make it easier for publics to be affirming about people coming out. Communications practitioners might benefit from seeking out people with mental health conditions who want to reclaim and reframe mental health to inform their messaging appropriately.



## Empowerment

For the discussion about empowerment, every group member was handed a copy of a quote from Sandy Jeff's (1998) essay about reclaiming her identity. Following the reading of this narrative, they were told about how there was some concern in the literature about whether or not identity empowerment could cause resistance to mental healthcare. They were then asked to take a position on empowerment messaging in terms of its usefulness in de-marginalizing mental health.

*Non-professional.* The non-professional group took a generally positive, yet somewhat still skeptical, approach to the idea of empowerment messaging. It almost seems like the group saw Jeff's (1998) identity empowerment approach as the opposite to the normalization approach. Instead of normalizing people with mental health conditions, Jeff's (1998) approach seems to forward a desire to celebrate people's mental health differences. Alison was the most vocal in expressing her concerns about this kind of messaging, especially when it might be targeted towards those who are not yet willing to see themselves as having profound social identity differences.

(Alison)- I would say this isn't for a general audience. I don't think I would stand up and be like 'everyone should hear this.' Like, I feel like people that have sought help and people that are tired of being stigmatized, they need to hear this. But the person that's maybe depressed and 'I don't know if I want to get help,' this isn't for them. Like, I almost feel like this is a selective audience.

When first thinking about seeking treatment, many people might find it hard enough to admit that they need help, let alone that they actually have a stigmatized identity. Such an admission, even when encouraged in a positive light, might constitute an "identity threat" which is "the harm that occurs when one's sense of self is challenged by association with a stigmatized group" (Corrigan, et al., 2013, p. 794). Alison was concerned that pushing an identity empowerment

message would be too much for people who are not ready to engage openly with others about their mental health conditions. And yet, there are many benefits to being open about mental health experiences that might help to de-marginalize the population (for overview of these benefits see Corrigan, et al., 2013).

For Jane, it made complete sense that empowerment would involve a certain degree of choice about whether or not to get treatment. For Jane, a certain level of resistance to treatment should be acceptable in an empowering world.

(Jane)- I think another thing when you talk about, um, not seeking help. That is a choice that is valid as well. Like, if someone chooses not to take medication and stay talking to things they can't see or they choose not to take medication and be catatonic as their situation allows, or not to see a therapist because they don't want to discuss it, it's also a valid choice. So, um, you talk about reducing something like [resistance], it's assuming that someone is mentally ill than they have to go after treating it, and they really have no obligation to do that if they don't want to.

Jane's argument could be interpreted in two ways: (1) it might be viewed as proving the point that empowerment can indeed create resistance, or (2) it might be viewed as an argument that other people need to be more accepting of some 'deviant' behavior. It could be a positive and honest rebuttal to the very idea that mental health treatment is essential to the wellbeing of all people with mental health conditions. Of course, Jane's argument can only really be applied to people who are not actually legally or morally (in the case of someone who really can be dangerous) obligated to seek and abide by treatment. Jane's points might hold some validity, validity that people who work in mental health fields might be reluctant to encourage. Friends and family members of people with mental health conditions might also be reluctant to encourage this perspective.

While some seemed to agree with Jane, Allison was still skeptical. It is important to note that Allison was a student studying occupational therapy, and she had experience working in a

disability treatment center. As a person with a mental health condition as well, Allison likely had a diverse range of interests in arguing for her position on empowerment. Therefore, it makes sense that Allison would both promote treatment and empowerment. Allison was eventually successful in bringing up one of the most difficult tensions when it comes to empowerment messaging. In a population where marginalization can be both psychological and social in nature, when can someone's resistance to treatment be seen as empowered choice, and when is resistance to treatment just another symptom of marginalization? The main tension was this: what if someone's mental health condition, or even his or her self-stigma, prevents him or her from getting treatment, then how could we say that he or she is actually empowered in his or her choice not to get the treatment?

The group agreed that the social and psychological barriers to treatment have to be addressed before the conversation about whether or not treatment was a choice could really be had. *The group said that treatment has to be available, and its benefits understood by the individual, before it can be convincingly proven that that individual had made an empowered choice not to seek treatment.* This argument spanned across both the social and the individual discourses by involving both social barriers (finances, treatment availability, social stigma) and psychological barriers (shame, mental health, and self-stigma) to treatment. Notably, everyone in the group who identified themselves as having a mental health condition said that they had at some point gone through treatment; thus, dissenting voices to this perspective may have been largely absent.

It was more or less agreed that to have a 'legitimately' empowered identity, one has to be seen as at least trying treatment first. Once this was discussed, Allison seemed placated and more willing to champion an empowerment approach. When asked if empowerment can help to reduce

the stigma, Allison eventually conceded that individual empowerment is important for helping people to represent themselves in a social context.

(Allison)- I think [empowerment is] a huge part of things. I think if people with mental illness are not willing and able to speak up for themselves, I don't think the message is as clear. If I'm expecting a psychiatrist to tell other people about my experience and somehow communicate what mental illness is, they don't get it.... And I can educate better than a healthcare worker.... I think that there is something incredibly powerful about someone speaking out for themselves... I always hate the 'voice for the voiceless' because I feel like you need to help those people have a voice.

For Alison, empowerment helps people with mental health conditions to feel comfortable with realistically educating others about their experiences, perspectives, and needs. The rest of the group also seemed to think that through individual empowerment, people with mental health conditions might find it easier to address social issues through self-advocacy. Some even argued that identity empowerment might lead to people being more open about their diagnoses, a perspective that is supported in the literature (see: Corrigan, et al., 2013). At the very least, it seems that “coming out proud” can help people address their self-stigma (Corrigan, et al., 2013, p. 794). Research has shown interpersonal contact with people who have mental health conditions, “will diminish stigma—providing the community welcomes disclosure” (Corrigan, et al., 2013, p. 798). However, convincing people to come out about their stigmatized identities is one of the biggest difficulties (Corrigan, et al., 2013), which might be something that targeted communications can help to encourage. For those who are ready, the group agreed, empowerment messaging seems to be indispensable to de-marginalization. Like Jane said, “Having people being able to stand up for themselves is almost never a bad thing.”

Many mental health institutions have already recognized the value of empowerment. Directly following Allison's statement, a professional in the group brought up how his organization was doing more to incorporate empowerment into their treatment services.

(Jake)- I mean, from a treatment standpoint, that's becoming a huge part of the treatment pie, is something called certified peer specialists, so not only are people working with a clinician or a therapist, but they are also working with a certified peer specialist.... There is a big big empowerment piece to those individuals.

When people are grouped together in treatment-centered contexts, they can collaborate, share meaning, and educate each other about their common social identities. As various scholars and practitioners believe,

Peer support programs provide a range of services: encouragement for those who are just coming out; shared experiences, which foster a sense of community within a surrounding hostile culture; and advocacy efforts to further promote group pride. (Corrigan, et al., 2013, p. 797)

In this way, identity empowerment might eventually lead to stronger sociopolitical representation of the mental health minority group. However, this empowerment is limited without a political outlet, which might be a need that communications practitioners can fulfill.

It seems like empowerment as a tool for de-marginalization was largely grounded within the individual model discourse. The group's focus on individual empowerment (as opposed to community empowerment) within a treatment context makes this a relatively defensible argument. However, they also said that individual empowerment can lead to de-marginalization within the social discourse of disability. Through individual empowerment, groups can come together and form social perspectives.

The group was hesitant to recommend using identity empowerment messaging partly because they were concerned that for some people it might actually aggravate their mental health symptoms. For example, it might not be a good idea to 'over-empower' people who experience bipolar manic episodes, which are very positive feelings that can lead to thoughts about invulnerability and unavoidable success. In this case, strongly worded empowerment messages might be more enabling and problematic than de-marginalizing. However, identity empowerment

messaging does not have to be unsophisticatedly positive. Messages about taking personal responsibility for appropriate social functioning need not be separated from other empowering messages. As Sam stated:

(Sam)- [I]f people do talk about these things, um, in a wider message, it should also come with the message that you could be proud of whoever you are and still recognize the fact that you still need help with things and that it doesn't make you weak, it makes you strong and it should make you proud to be strong while dealing with other issues.

Messages about taking pride in a mental health social identity do not have to be separated from messages where people ask for help. A message using this perspective might look something like this: "I can be proud about who I am as a disabled person while I ask others for help."

Practitioners might want to consider using communications to promote identity empowerment, but only when targeting audiences who are 'ready' for such messages. These audiences might include those who have spent some time in recovery, and who have already developed relatively positive social identities around mental health. To some extent, communications might help people who are on the verge of identity empowerment to finally achieve that empowerment. However, the main purpose for communications when it comes to mental health empowerment might not be to encourage people with mental health conditions to see themselves positively. Rather, practitioners can help by bringing to light the political and social issues that already empowered individuals care about.

*Professional.* As mentioned in the non-professional group, the mental health organization that helped with this study has a strong commitment to promoting empowerment. Many of the reasons why they encourage empowerment reflect the same reasons forwarded by the non-professional focus group. What made the professional's responses to this section of the focus group interesting was not what they thought about the role of empowerment in de-

marginalization. Rather, their responses were interesting because of how they reacted to the idea of empowered resistance to treatment.

The professional's initial reaction was strongly against the idea that empowerment would cause resistance to treatment. Evin said he felt particularly strongly about this, stating that he saw the very idea as a vestige of prejudice. For him, empowering people does not mean they would simply resist treatment.

(Evin)- It really seems like, um, the the, reaction against empowerment is almost like a vestige of the, the, kinda horrible way mental illness has been approached by the mental health professionals in the past... Like. Yeah, empowerment should be part of what we are trying to do. The fact that anyone thinks that... empowering people is going to, like, make them untreatable. It should actually be part of the treatment and there should be more like, ah, teamwork thing going on instead of this, ah, butting heads.

As a peer specialist, Evin likely has a strong interest in keeping empowerment as a part of treatment services. He believed treatment and empowerment were best when approached together. Evin did not second-guess empowerment or treatment even when presented with the argument that empowerment might cause some resistance to treatment.

When faced with the idea of empowered resistance to treatment, some of the mental health professionals began to question empowerment separate from treatment.

(Willow)- But is that empowerment with treatment or is that empowerment without treatment? Like you said, if the idea is empowerment might make people more resistant to treatment, I think empowerment is so important, but if you can't function because you're not getting treatment, how is that empowering you? But if you—somebody's in treatment, and you empower them or help them feel empowered through treatment, that's different.

Like the non-professional group, Willow seemed to be hesitant to accept empowerment as legitimate unless treatment was also involved. If someone needs treatment but does not get treatment, then how can they be seen as empowered in their resistance to treatment? In Willow's

statement, treatment is characterized as the catalyst for legitimate empowerment, with other forms of empowerment seeming problematic in their potential to result in resistance to treatment.

The group returned to the value of treatment several times throughout this part of the conversation. The credit for the clients' successful empowerment was largely attributed to the mental health treatment.

(Shelly)- There's a young man, and acquaintance that I have known over the, um, years, and whoever his therapist is is doing a remarkable job because this young man has tardive dyskinesia, so he does a lot of walking, you know, marching, and he says to everyone he meets, within a very short period of time, 'I have schizophrenia, I'm on medication, and it makes me walk differently.' And I think, what a—and I told him, I said, 'that is amazing that you can be right up front.' He looks at you right in the eye and so his background with his mental health providers, since he's on medication, is a good one. And wouldn't it be a nice thing if more young people could be right up front with that, because no one I know has had any problem with that, once they understand why he walks.

In this narrative, Shelly gives the credit for this man's success to his therapist's efforts. It is important to note, however, that Shelly was speaking for this person. Shelly might be completely incorrect in her assertion that this man had a good relationship with his therapist. It might be that this man has done well in spite of his therapist, and that he decided to be open about his identity independently of any empowerment treatment. In this narrative, the most power was given to the therapist, not to the client's own free will. Yet, in Shelly's story, the man's presentation of his social identity to others was still normalizing and open in a way that many in the group saw as desirable.

Immediately after Shelly's narrative, Mary brought up an interesting point about stigmatized resistance generally.

(Mary)- And so his presentation of himself while he is interacting with somebody else has nothing to do with declaring war and has nothing to do with resistance.... If I'm going to declare war, if it's me against them, there isn't them room for a lack of resistance, if we just assume there will be resistance.



Mary's concern was that if people begin to present their identities in divisive ways, than the marginalization could become worse; each side would become resistant to each other. In short, Mary was making the argument that hostel resistance is not desirable in the de-marginalization process. This is similar to Goffman's (1963) assertion that when the stigmatized become militant society becomes more divided and eventually lose out on the opportunity to be seen as the normal people they actually are.

Empowered but also hostel and uncivil messaging will likely not work to de-marginalize mental health. However, it is important to encourage hegemonic groups to be self-reflexive and self-critical about how they see people with mental health conditions. Willow exemplified this self-reflexivity in the following narrative about her friend with depression:

(Willow)- I have a really close friend that, um, has severe depression, and there was a period of time where she consented, 'okay, I'm going to go and see if I can get help for this.' And, um, she was put on medication. And her attitude was, 'medication is just to make me more palatable for the rest of the population. I have the right to be depressed; I have the right to be who I am. But, when you put me on medication, then I'm not so weird to you, and you can deal with me better.' So, she went off the medication. She says, 'it's your problem, not my problem.' She prefers not to be on medication, even though, wow, I thought, 'she was so much better on the medication,' but was that my perception, it made me more comfortable to see her on medication? I mean, to me that was a little bit of a, um, claiming more on, you know, the general population. 'You just want me to look better for you, not for me.'

Willow's reflexivity is exactly the kind of thinking that can be promoted by communications professionals who want to encourage society to be more accepting of mental health differences. In Willow's narrative, her friend statement reframed the 'problem' as outside of herself in a way that took Willow aback. Instead of arguing, however, Willow was reflexive and accepted that the problem really could be with her perception. In Willow's story, her friend's position had legitimacy and the power to change Willow's mind. In part, Willow told her friend's story in order to tell her own. This might be an interesting approach for communications practitioners.

Instead of using stories that are only from those who have mental health conditions, communicators could also tell a de-stigmatizing story from the perspective of a non-disable other. Stories about mental health could be told from both perspectives in normalizing ways in order to help de-stigmatize mental health within the defines situation of the narrative.

Evin agreed that sometimes treatment is undesirable, and he said that resistance might not always be an unacceptable decision. He made this point by telling a little bit of his own story:

(Evin)- I have not been on my ADD medication for a couple years now (laughs). Partly it's, you know, getting on top of that situation. But also, partly it's that I like the way I think, you know. And I think differently when I am on the medication. It's useful in it's own way and stuff. Actually, it's useful for dealing with other people mostly (laughs, group laughs). Um, you know? But, um, there's used for, for thinking the way I do I think. So, um, to me it's like a balance, like you know, it's like, I want to interact and be productive, and that's what treatment is for, but when I don't want that I don't want it crammed down my throat either.

Evin later agreed that legitimate identity empowerment could exist separate from treatment. He was the only person in the professional group who expressed his agreement with this perspective. However, he also agreed with Lauren that identity empowerment and treatment should inform each other. As a person with a mental health condition, Evin had an interest in seeing independent agency in his empowerment for a positive social identity. As mental health practitioners, the others in the group had an interest in seeing empowerment being irrevocably tied to treatment. Both sides recognized the importance of both treatment and empowerment, regardless of how these approaches were blended together within the discussion or within their practice.

*Theoretical and practical interpretations.* Positive and effective empowerment is possible outside of mental health treatment. However, both focus groups said that mental health treatment was very important. It can help people become more functional in society. This helps them to assimilate better, and makes it easier for them to 'come out' about their identities. This in turn

contributes to the normalization of mental health. However, this method for normalization depends on the individual changing to fit society and not the other way around. That means this discussion was grounded in an individual model discourse. Becoming militant may not be desirable, but there has to be some way to address the social acceptance of mental health that goes beyond normalizing it in a biomedical language script. One way might be to use narratives that are designed specifically to promote reflexive and normalizing thinking about mental health.

### Dangerousness and Empowerment for a Moral Identity

When people are a danger to themselves or others, resistance to treatment was seen as problematic. Similarly to the non-professional focus group, the professionals also expressed concern over empowering people who have manic episodes as a result of bipolar disorder.

(Shelly)- And there's an issue. A good friend whose son right now is in a manic episode. He likes it, he's off his medication and drinking is part of it, and now the situation is he's driving drunk. His choices present a danger to others. And, she's at a loss at what to do right now. He lives in another state, and the police are not going to do anything to help. So there's empowerment on her son's part, he's very happy, and he's in denial, and he thinks 'hey, I'm capable of driving when I drink.' So, what do we do in society with that kind of empowerment?

The group agreed that when people are actually dangerous, empowering them is not desirable. Therefore, in messaging it might be beneficial to make the distinction between positive identity empowerment and negative behaviors. While people in society should be accepting of a wider range of behaviors, they cannot accept behaviors and choices that present real danger.

While the mental health 'object' is 'real,' a person with a mental health condition can still get treatment to better assimilate into society. As Allison from the non-professional group said, "I feel bad for healthcare workers sometimes because it's this delicate balance of, 'it's not your fault, but you've got to do something about it.'" There is a personal responsibility element specific to mental health that is not really present in other marginalized groups.

While people in society should be more accepting of deviance, people who can be dangerous might still have a social and moral obligation to follow through with treatment. Even Jane, who has been the most vocal about people's rights to choose not to get treatment, agreed about dangerousness. She made it a point, however, that dangerousness should not be overgeneralized to the entire population of people with mental health conditions.

(Jane)- There needs to be a clear differentiation between being on the spectrum and actually being harmful. Cause a lot of behavior is not tolerated even though it is causing literally no one harm, even though it might be somewhat annoying to someone else. And it's treated as if it is going to devolve into chaos and destruction, and that's not even close to mostly true... If someone thinks you're dangerous, fine, but why do they think you're dangerous? Because it's been told to you that this is a sign of danger and any deviation is a sign of something wrong. Not something different, but something wrong.... If you want to say something is wrong, then it has to be correlated with harm. If you want to say something is different, then it has to end there, it can't be correlated, or connected, even accidentally.

Such a 'clear distinction' might be difficult, however. People might fear the unpredictability and uncertainty of those who are in crisis.

(Hanna)- It's like you don't know how to react. It's like—well fear really, you want to protect yourself, you want to help but then. And then you don't want to step over your boundaries either because what's your place? I mean, he's living his life.

(Kate)- And then my lack of education on it, I don't know what would trigger the person. I don't know what they are going through.

The uncertainty expressed even in this relatively educated group reveals the need to communicate better about how people can react to those who seem unpredictable. Educating people about how they can utilize services like mental health mobile units and 24-hour treatment offices might help to give people more confidence that they can actually do something to help. They need to know that approaching people who look confused calmly and sympathetically will usually not result in sudden acts of violence. However, communications practitioners should not only be interested in educating people about what to do while in these precarious situations. Such

situations are pretty rare, but they have an extreme impact on perceptions of people with mental health conditions generally. Addressing these long-term perceptions is arguably more important than teaching people how to deal with uncertain situations.

People need to know that it is okay to have a reaction for self-preservation in seemingly dangerous situations. They also need to know, however, that when someone tells them that he/she has a mental health condition (like schizophrenia) it is not okay to assume that person is automatically dangerous. Even people who might be dangerous can ‘recover,’ meaning that with treatment, and if they make the effort, these people can assimilate into society. People need the chance to prove themselves to society, and society needs to provide those opportunities—within reason. According to Liz, the more communications practitioners can promote people’s stories about successful recovery, the more accepting society will become.

(Liz)- The more we represent, or the more the mentally ill represent, themselves on the spectrum—the continuum of wellness, the more, um, society will be able to see, ‘oh, the treatments are working. We have a certain contingent out there that are maybe dangerous, but we also have a contingent that are diligent about taking their medicine, doing what they can to not be a harm to themselves or others.’

The best way to de-marginalize mental health conditions connected to dangerousness might be to prove to others that the fear is largely unfounded. Liz’s representation approach might be normalizing in a way that is not dissimilar to the normalizing perspective already discussed.

*Theoretical and practical interpretations.* Empowerment for a social identity is important, and getting society to be more accepting of mental health differences is also important. But there are moral limitations to this balance that cannot be avoided. Therefore, empowerment messaging that includes moral (but not accusatory) elements might be useful. The goal is to empower people to have positive and moral mental health social identities. For other marginalized groups, the moral element to empowerment largely goes unsaid. For some people

with mental health conditions, however, to be moral means that they actually have to go out of their way and get treatment. This can be very difficult in a culture where mental health conditions are stigmatized, the people marginalized, the resources are scarce, and people have every reason to remain in denial of their ethical obligations.

It is very important to emphasize that not everyone who has a mental health condition needs to hear messages about having a moral obligation to get treatment. In fact, for many such an assertion would likely be somewhat insulting. Disability advocates have long criticized the moral model of disability, largely because it puts too much blame on the individual. However, these critics have never stated that moral perspectives on disability are altogether bad. It is unavoidable to ascribe a moral responsibility to some people with behavioral disabilities that contribute to their violent decisions. It is important to approach people in these situations empathetically and with an encouraging attitude that they can do something about their behaviors if they are willing to work on treatment.

It would probably not be a good idea to broadcast moral responsibility messages to a general audience. Large audiences might be too prone to overgeneralize moral responsibility messages to people who they see as problematic but who are really just unusual. The moral responsibility message is also likely a hard message to both communicate and to accept. The situation necessary for a conversation about taking moral responsibility for something the person did not choose might be too sensitive for a generally applicable message.

When dangerousness is a concern, the discourse about mental health becomes heavily individualistic. This might explain to some extent why the discourses around mental health seem to lean towards the individual discourse instead of a social perspective. Social discourses about interpersonal acceptance, environmental resources, and political change are no less important;

however, they might be overshadowed when the problem is often discussed in the light of violent and negative events.

### Narratives

The narrative typologies discussed in the literature review were characterized as ‘narratives that span discourse.’ The participants in both focus groups seemed to take a different direction, however. They mostly talked about the narratives as individual’s stories, but in ways that might be theoretically important for understanding narrative messaging about mental health.

*Non-professional.* People’s attitudes might well have something to do with how they view the narratives, as exemplified by Tom’s skeptical perspective about all three narratives.

(Tom)- My initial response is that it makes it sound like a fairytale. I hate saying that, like. I read this and I was like, ‘what, you open a book and you read about people with mental health conditions,’ that’s not the reality of it. The reality is, you run into these people from day to day, it’s if you want to interact with them, if you want to acknowledge that there’s something different about them. But—very fantasy like, and I hate using that.

Tom did not see the narratives as representing the experience of interacting with people who have mental health conditions. To Tom, the narratives seemed fanciful, and detached from what is usually a pretty hard thing to deal with on a day-to-day basis. Others agreed with Tom, but they also were quick to point out the value of the narratives.

(Liz)- I found it making it very approachable. Very, um, kinda at arm’s length, the fairytale part, but at the same time very human, very, um, something I can enter into that captured my interest and at the same time was very real, very real part of experiences throughout life. (Pause) And it, well, like you said, it was kind of removed and that made it more approachable. It wasn’t threatening.

Liz makes an important point here. The narrative typologies, discussed as abstract ideas, are not threatening. For Liz, they are ‘real’ and ‘human’ as if they put life in some kind of generalized and positive perspective. The narratives’ effectiveness to destigmatize mental health might

depend on the readers' willingness and their ability to think *abstractly* about mental health. This will need to be researched in future studies.

Jane expressed her extreme skepticism about the chaos narrative. According to her, it was never a good idea to use the chaos narrative. Jane deeply distrusted the public's ability to accept that some people experience chaos in mental health.

(Jane)- I think in America this kind of thing should just be avoided because—or has to be really carefully handled—because the way that we communicate anything that isn't super happy is generally not handled well.

For Jane, in a culture that only wants to accept happiness, chaos narratives have a great deal of potential to result in marginalization. Yet others liked the chaos narrative for its honesty.

(Allison)- I found that originally I thought people really wanted me to be happy, but then honestly it made me unapproachable. It made me 'other.' People were like, 'do you ever have a bad day? I have a bad day.' I guess I have bad days too, but I never showed them. So, I think there is a need for that, like the reality of it, so I think there is some benefit to the chaos section of things. But, you can't stay there. Like, I think emotionally you might want to, like on a bad day you would just see the chaos, but, um, also on a good day you might just see the discovery. So much of it is mood dependent.... Strangely enough, people with mental illness often struggle a lot with a lot of emotion, so like, depending on where they are emotionally is the story you are going to hear.

For Allison, people with mental health conditions cannot stay in the 'story telling mode' of chaos narratives— they need to move on. But, all of the narratives had a place depending on the mood or 'status' of the storyteller. Several members of the group agreed that the same person could tell all three of the narratives every day, and that all three of the narrative should be seen as blending together.

At this point, Kate decided to push against the idea of 'wellness' as it was discussed in each narrative.

(Kate)- Don't compare yourself to this ideal of this sort of 'wellness.' ... There's some kind of disconnect, when I read those narratives I see disconnect.... I don't know, coming from a yoga standpoint there's a connectedness between your mind and body and being



in the present moment, not being future, past, or being separate from yourself—in the moment.

For Kate, wellness can be achieved by accepting yourself in whatever state of mind you are experiencing. In chaos, wellness is accepting the chaos as a part of the experience of living.

Allison agreed with this perspective.

(Allison)- I like that. I feel like there's a lot of expectation. Like, what you expect to be good or bad or normal. . . . That's what makes Christmas hard for me, like if I don't feel well. It's like, 'oh, it's supposed to be lovely and there's cookies,' and like, you're supposed to be happy and it makes it so much worse when you're not.

For these participants, wellness is not a state of mind; rather, wellness is a state of acceptance.

Acceptance can be achieved in all three 'narrative storytelling modes' (the mindsets people might be in while creating or 'living' each narrative for the first time). Through acceptance, the burdensome social expectation of positivity, which Jane thought was problematic, might be alleviated. People with mental illness can shift between a focus on wellness and a focus on illness (Paterson, 2001). This focusing is not binary; it occurs on a spectrum (Paterson, 2003).

Wellness, defined as a general state of *life* wellbeing, is an outcome to complex processes in the discourse of disability. Wellness is ongoing and can be a part of the whole experience even when it is a struggle to think positively. It is important to communicate this idea to people who want to and need to learn about what having mental health conditions can be like when acceptance of the condition is achieved. Most mental health conditions can at best be managed, and communications practitioners can help people understand how it is not necessarily hard to live with (as opposed to despite or against) the condition. People live in recovery, but they do not recover. People can live in healing, but they are never simply healed. Wellness is never 'achieved,' only maintained. Audiences need to understand that wellness and mental health are ongoing processes for many people in life. The resolution in the quest narrative is the acceptance

of the process; it is the acceptance that the whole narrative has been and will be lived through, albeit in different ways, again, and that that is okay. Communications practitioners can help audiences to see how that is a good perspective of living with a mental health condition, and how people can ‘get better’ over time with this kind of life wellness gained through acceptance.

This might be an interesting way to approach messaging about mental health, and this approach does not have to focus on only people with mental health conditions. More research needs to be done on the concepts of psychological acceptance in social situations, and how this kind of acceptance might be used in communications about mental health. During the chaotic uncertainty of dealing with people who have mental health conditions, would acceptance of the person’s mental health condition in the situation help people react in less stigmatizing ways? Campaigns that encourage everyone to be more accepting of social situations where people are experiencing mental health symptoms might be very powerful.

When asked which narratives the participants thought were the most dominant, Kate, the peer specialist, identified a possible financial interest for healthcare workers to forward restitution narratives.

(Kate)- Healthcare, [restitution] for sure, because it is definitely across the board very medical centered stories because they need those studies and they need that black and white printed ‘proof’ that this is going to work... because that is what is going to give you the funds.

This perspective is important. If mental health professionals have an interest in being accepted more in physical healthcare, then restitution narratives might become more prevalent. This might not be a good thing, however, because the restitution narrative seems to reinforce false individualistic notions about mental health like it is ‘curable’ and that ‘cures’ are always desirable.

When asked which narratives or which narrative combinations they thought would be destigmatizing, the participants replied with a complex set of perspectives. Some rejected all of the narratives based on their stances about wellness, but others tried to make the narratives work. Jane's perspective in particular stands out. She said that she would only see the quest narrative as useful for destigmatizing mental health.

(Jane)- These [chaos narratives] are fairly exploitative, these [restitution narratives] require... someone else's evaluation of you. I'd say the only one is the empowerment, reclaiming identity [the quest narratives]. But that's still assuming that they get to do it from their own viewpoint.

Others in the group agreed with Jane that the quest narrative needs more attention, but they were not as willing to exclude the 'realness' of the chaos narratives. Others still thought all of the narratives were problematic. Liz seemed to sum up the controversy when she said, "all three of them can be stigmatizing and all three of them can be empowering depending on how you look at it."

*Professionals.* The professionals took a generally positive approach to the narrative typologies. The facilitators had been using the word 'recovery' to describe the 'restitution' narrative, which resulted in some controversy. Once the facilitators made it clear that they had not been using the word 'recovery' in the same sense that it is used in the Recovery Movement (to learn about the multiple uses of the word 'recovery' see: Davidson & Roe, 2007; Davidson et al., 2005), the group seemed to think more positively about the narratives than the nonprofessional group. The group also saw the quest narrative as what they would typically describe as living in recovery as opposed to recovering from the disability (Davidson & Roe, 2007; Davidson et al., 2005). This redefining of the word 'recovery' as being more of a 'quest' narrative represents a discursive collision. Living in recovery is still an individual model perspective, but recognizing the definition that came from the Recovery Movement (a social

movement) might have increased the perceived legitimacy of these particular mental health professionals. They were 'socially in touch,' whereas the facilitators seemed out of touch. The facilitators were using the word in its most basic form (i.e. to regain the thing that was missing), which might actually be more of a medical model use. The word, 'recovery' still seems to focus on the individual's living and not social living, however. The discursive collision was between the medical model and what might be seen as a behavioral model of mental health, which both exist under an individual model.

The professionals strongly pushed against the idea of 'cure' that was in the restitution narrative, though they recognized that many people see 'illness' in terms of 'getting better.' In fact, Jim said he thought that the restitution narrative might be the best at reducing stigma because it is the least abstract while still being encouraging:

(Jim)- Well, I think the middle narrative is the one that is most likely to diminish the stigma. I think news media will emphasize the chaos, and only very specialized media sources, journals and so on, are going to talk about empowerment and discovery and transcendence and all that. Most people won't have time for that to commit. But then the center story... I might pick up a magazine and go to an article that talks about the move from chaos to recovery, and go home feeling like, well, 'there's hope for the world.' People can get over the worst part of depression or whatever.

Later, others seemed to agree with Jim that the restitution narrative is important, but also because it adds an element of individual responsibility to the story.

Evin agreed that recovery was a part of the quest narrative, but he saw the quest narrative a little differently. He said he liked the quest narrative, but he did not exclude the chaos that is inherent in the quest.

(Evin)- Chaos happens, that's what we're dealing with, and the disturbing realizations are often true, which is part of the problem (laughs). But, also, um, they need to be made, those realizations too. That's why it is this quest of self-discovery, and then it's like, once you've gone through some recovery you can see it that way. So these are not separate stories.

For Evin, the stories are all connected, but a person has to go through all of them to know that it is a quest. Furthermore, for Evin, the occasion for the quest of self-discovery was not the disability; rather, the chaos itself was the occasion for a journey of self-discovery. The quest narrative in mental health might therefore be somewhat of a retrospective narrative, not just one about living in the moment, even if living in the moment is identified in the narrative as important.

Interestingly, no one in the professional focus group dismissed the chaos narrative. They all thought it played a role in imparting the seriousness of mental health, but they also agreed that the story should not only focus on chaos. Lacy brought up the Meth Project again as an example of a chaos narrative that could be improved upon:

(Lacy)- So, going back to that ‘Not Even Once’ campaign again for substance use disorders. They really focus on the chaos of it all. I wonder how much more powerful that would have been if, okay, we see the chaos, and then we see the recovery?

(Lauren)- Yeah, like, what if you put all of these pieces into one message? Rather than just one [piece].

(Lacy)- Right. That girl in the bathroom suddenly becomes that girl sitting next to you in class. Or suddenly becomes that girl who is, um, your friend. And that, I wonder if that would make that marketing strategy much more powerful; seeing that people do get better.

Everyone agreed that it would be better to include all of the narratives in a message to make it realistic, but they disagreed somewhat on where the emphasis should be.

Evin did not think the restitution narrative was all that important to include in messaging designed to destigmatize mental health specifically. Speaking as the only person in the room who was open about experiencing treatment first-hand, and as a peer advocate, Evin said he thought the restitution narrative was not for everyone.

(Evin)- I think the [restitution] part doesn't make a great story a lot of times. It's like, a lot of aphorisms (laughs). Once, um, I talk to people in AA and it's like, you know, the whole program, if you don't really need it it's actually kinda really boring (laughs, group laughs).

Later in the discussion, Evin repeated his position about how the restitution narrative is not that important. Evin said, "Um, the center narrative is kinda like the work that you do. I don't think it's essential to the story. It's like, well I did the work you know? You can sum it up." This time others were quick to push back on Evin's position, saying that they do not want people to think that recovery, which seemed to include an element of the restitution narrative, happens like, "magic." The other participants were concerned that without the restitution narrative, people might not see how important and beneficial treatment can be in helping to address people's mental health conditions. Evin agreed, but he also stayed with his original position. As he said, "Yeah, well yeah, you have to definitely say it takes effort, it takes work. But I mean, that's the boring part."

At this point, other participants argued that maybe education about different treatments or approaches to recovery would be useful. This position very much serves the interests of professionals in mental health because it focuses on getting people treatment. However, the treatment approach to education and communication does not necessarily directly have anything to do with destigmatization. Recognizing this, Evin stayed firm on his position that the restitution narrative is not good for messaging to reduce stigma.

(Jim)- And maybe that's where the education comes in. 'This' might be useful, and 'that' might be useful.

(Lauren)- I think the tools are useful, they might not work for the—the tools you use might not work for somebody else, but maybe one of the five you use will.

(Evin)- That's the thing. Each approach is really specific to each, you know, each individual illness, to each individual that has that illness, so, so, you would have to do too much tailoring (laughs) for that to be useful. Cause this is for, like, the general public, message. So I mean, um, yeah the important part is to get across the, you know, where it came from, how it ended up. And definitely mention how it was a struggle to get there, like, you know, you don't have to go into the specifics.

While Jim had earlier in the focus group said that he liked the restitution narrative's simplicity, Evin seems to have disagreed on the grounds that actually, the 'restitution' process is too specific to each individual to make for effective messaging. Furthermore, Evin saw the restitution narrative as important to mention, but he also saw it as boring and unhelpful to reducing stigma generally.

Think about Evin's position like a movie. Everyone knows that the movie took a lot of time and physical work behind the scenes, and some might even be interested in that element of the story. But at the end of the day, all people really care to see is the movie's quest—the *struggle* and its *resolution*. Not seeing the resolution as possible means that the production of the positive 'movie' (the quest) may never be attempted. But, if people can *believe* that the resolution is possible, the 'production' (restitution work) might seem worthwhile, and the quest might then become a desirable 'reality' in the minds of viewers. The restitution is the actual production of the movie, boring to most of those who are not directly involved. What matters in reducing stigma is the struggle and resolution story that shows up on the screen.

*Theoretical and practical interpretations.* When Evin's perspective on the narrative typologies is combined with the idea of the 'pebble identity' discussed earlier in this paper, an interesting theoretical perspective on identity emerges. Imagine that at the start of the chaos narrative the stigmatized identity is dominant. Now, imagine that through hard work a person is able to erase and reduce that stigmatized master identity through objectifying it to its physical 'reality.' Finally, imagine that a person is somehow empowered, motivated, and able to rewrite

their identity around the object to be something else. This is not to say the ‘chaos’ of having a self-stigmatized identity is invalid, only that through this process other valid, and potentially more helpful, identities (the ‘neutral’ and the ‘empowered’) can be formed. Once all of the identities are written and are known, it might be possible for them to return to each depending on their psychological dispositions and their social situations. This might be the story of mental health identity, but perhaps not the whole story of de-marginalization.

While neither focus group reached a consensus about which narratives to use for destigmatizing mental health, it appears that the most frequent recommendation was to use a chaos-quest combination. It should also be communicated that recovery requires a lot of hard work, but should not be the main focus in messages designed to destigmatize mental health.



## RECOMMENDATIONS AND CONCLUSION

### Recommendations For Practitioners

An important way to help de-marginalize people with mental health conditions might be to get more people into treatment, but that would be a different kind of campaign than one about stigma, and the de-marginalization effect would not be as directly a result of communications. Rather, treatment, which participants viewed as very important, would have an effect on empowerment, individual assimilation, and ultimately de-marginalization. Communications practitioners can do a lot, however, to make it easier for people with mental health conditions to be normalized and accepted into society. The following suggestions are designed for the de-marginalization of mental health using communications, specifically addressing social rejection and stigma.

Communication practitioners would do well to include normalizing messaging told from the perspectives of both stigmatized people and self-reflexive others. For example, a scene in a show might be something like: a reflexively thinking doctor decides to admit his/her own prejudice, and he/she subsequently forms a better relationship with a depressed client. Another example might be: a teacher who realizes that he/she might have been insensitive, and who thus apologizes to a student who then finds the motivation and resources to complete the class.

It is recommended that communications practitioners think more creatively (e.g. beyond biological metaphors) about how to convince publics that mental health conditions are both ‘real’ and not a choice. Other metaphors could be linked to things that exist in nature. Mental health is ‘real’ like a mountain/a tree/the weather/a rock is ‘real.’ A mental health condition is not a choice, like how sleep is not a choice, and how the rain is not a choice. There might be ways to

manage, and even sometimes change objects (if that is desirable, which is not always the case), but blaming a person for not being able to control something like a sunrise is unproductive, which is an important observation to impart to audiences (like policy makers and others). Biological metaphors are useful because they are established, and because they might be connected to mental health practitioners' professional and economic interests, but they are still limited. They might also be somewhat overused, and a fresh approach might be desirable.

Practitioners should encourage people with mental health conditions to be open about their identities by creating messages that help them to talk about their conditions in more positive social situations. Getting celebrities to talk about their mental health conditions as positively adding to their worldviews, and as informing their arts, might be particularly effective. For example: a photographer with anxiety is motivated to always be ready to take a picture, resulting in many amazing images. Another example might be: a fantasy writer with psychosis uses his experiences with his symptoms to inform his writing. A final example might be: a person who has bipolar teaches others how to be emotionally self-aware, helping them deal with their grief. Negative descriptions of mental health conditions need not be excluded, but positive descriptions might help people connect other de-marginalizing definitions to the object of mental health. This positive approach might do a lot for changing the overall discourse.

Practitioners should consider using chaos-quest narratives about mental health to help reduce stigma. The emphasis should be on the quest, and care should be taken to make these narratives engaging but also realistic. Mentioning the work that goes into recovery is important, but it is not the main goal. The chaos narrative adds to the serious and often painful experiences of having mental health conditions, and chaos narratives should be portrayed empathetically. The resolution of the quest narrative is not absolute; wellness is a process, and it requires an

acceptance of mental health experiences in every part of the overall narrative. The resolution of the narrative is that the story (with its struggles and with its joys) is never completely over, and that is a good thing.

Practitioners should continue to include advocates who have mental health conditions in every step of the production process. In recruitment, however, it is important to find people who can speak to experiencing all three (chaos, restitution, quest) narratives. Practitioners' might consider seeking out people who can think beyond the 'neutralized' pebble identity to include positive mental health identities that carry a sense of pride.

#### Recommendations For Future Research

Not only was this study not generalizable, it was also very culturally specific. Participants were all people with interests in reducing mental health stigma, so other definitions of the object of mental health were not examined. This was on purpose; part of the goal of this study was to create a guide on how to understand mental health in de-stigmatizing ways. For this reason, only those who might be expected to have enlightened perspectives on the issue were invited. However, this is a limitation of the study as well. This study involved professionals from a progressive community mental health organization. Community mental health organizations do not always have the same kinds of cultures that exist in other places like hospitals, for example. Both focus groups were conducted in the United States. Studies conducted with different people, in different cultures, and in different social contexts will possibly result in very different observations about mental health. It is therefore important for future research about mental health communications to expand inquiry into different social contexts. It is important to conduct more generalizable research, and to conduct more qualitative research with key communities who deal with communications and mental health. For example, hospital staff might connect mental health

definitions more to a medical model discourse due to their proximity to the medical paradigm, which might pose some different challenges for communicating about mental health in physical healthcare settings. It would also be interesting to see if people who have less of an interest in reducing mental health stigma connect more or less to the discourses around mental health.

Thinking about narratives abstractly before and after reading them should be researched as a tool that might be useful in interventions to reduce stigma. More research needs to be done on how to communicate about dangerousness in ways that will not result in overgeneralizations about mental health. In the future of the mental health movement, can we and should we separate people who are dangerous as a result of their mental health conditions from those who are not? More research also needs to be conducted on how to talk about individual responsibility in ways that do not underemphasize or dismiss social issues. Finally, it should be a subject of further inquiry to see how preconceived attitudes about mental health affect what people think of various mental health narratives. Frank's (1995) narrative might have some potential to help destigmatize mental health, and effects need to be assessed.

### Conclusion

The problems outlined at the beginning of this paper might have some resolutions. First, empowerment for a social identity need not be seen as creating resistance to healthcare. As long as people with mental health conditions understand that they have to honestly try treatment before they can be seen as legitimately empowered in their resistance to treatment, mental healthcare will likely prevail. Communications practitioners can promote this perspective, but it might be useful to do so with the mindset that treatment is fundamental to psychosocial de-marginalization, which is more of a political interests approach than just a health approach. Next, normalization and empowerment will not necessarily trivialize mental health services to the point

where funding is decreased. As long as people in the mental health movement uphold access to treatment as a fundamental right to de-marginalization, mental healthcare will likely retain, or even increase, funding for treatment. Mental health institutions should consider becoming the leading advocates for mental health social identities, and having good communications would be key to taking that position.

From the participant's perspective, the problem of mental health stigma was understood as more complex than just 'stigma.' The problem with communications was that media practitioners seem to perpetuate stigma, and that they were underrepresented in media content. The groups liked the biopsychological approach because it made mental health conditions seem more 'objectively real,' but they seemed willing to use different language to describe the realness of mental health. Participants pushed against the idea that empowerment would cause resistance to treatment; some even characterized the idea of 'resistance' as being a part of the stigma. There were mixed responses to the 'legitimacy' of Frank's (1995) narrative typologies, but participants identified some potentially important ideas related to the narratives that might help inform messaging about mental health. Participants seem to think that at the very least more emphasis needs to be put on quest narratives, but they also largely agreed that the chaos narratives added realism to the story. The discursive collision around mental health seems to lean towards an individual model perspective, but with more positive and political social representation of people with mental health conditions, this discourse has the potential to change dramatically.

There were dozens of other important ideas that arose from the rich discussions that occurred in each focus group. There are many opportunities for both scholars and media practitioners to gain better insights into how to communicate about mental health. The story of how to end mental health stigma has yet to be told, but the opportunity to write it is there.

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