Abstract

Negative beliefs and stereotypes associated with individuals with mental illness continue to influence mainstream society and popular thought despite the high prevalence of mental illness in North America. According to current labelling theories, the stigma and discriminatory behaviour associated with having a label of mental illness is more damaging than the illness itself. Western medical models of illness, labelling theories, gender, and public versus self stigma are discussed in this paper. Research study results of a small exploratory study are included. The study asked the question: What are the experiences of labelling and stigma for adult mental health consumers? Using a qualitative, social constructivist approach, I examine the experiences of diagnosis, labelling, public stigma and self stigma from the perspective of five adult mental health consumers diagnosed with depression. The interviews revealed the strong presence of public and self stigma, despite the availability of common sources of support: family/friends and healthcare practitioners. Suggestions for ethical social work practice within the mental health system to address stigma are included.


Introduction

Despite the wealth of research available on mental health and mental illness, it is still a “well known fact that mental health service users often suffer from discrimination, stigma and the negative attitudes of others” (Green, Hayes, Dickinson, Whittaker, & Gilheany, 2003, p. 223). There continues to be significant lack of acceptance of the mentally ill (Bright, 1997) and mental illness was noted as “one of the most stigmatized conditions in our society” (Alexander & Link, 2003, p. 271). To shed more light on this topic, this paper will address the issue of stigma associated with adults who have been diagnosed and labelled with a mental illness. I will begin by examining the western medical model and its conception of mental illness. Past and current labelling theories and their views on the link between labelling and stigma will be discussed. I have also included the results from a study I conducted for a research course which involved adult mental health consumers describing personal experiences of being diagnosed with depression. After conducting this study in which participants were largely male, I became interested in and decided to include the additional aspect of gender. From the experiences described, male participants experienced unique barriers that were largely ascribed to stereotypes related to their gender.

My overall purpose is to add to the existing literature available on mental illness, from the rarely voiced perspective of the mental health consumer, to address stigma associated with labelling. As well, discussion on implications for future practice will hopefully offer some direction and suggestions as to how social workers in the mental health system can work at different levels to empower clients and to raise awareness of the stigma associated with mental illness labels on a public scale.
The medical model is described as a “dominant worldview” based on the “concept of disease process and a deficit-based understanding of human behaviour as exemplified by psychopathology and the DSM” (Graybeal, 2001). The rise of the medical model in the late nineteenth century (Todd, 2006) has had significant effects within the realm of healthcare, as well as in influencing public and private conceptions of what constitutes illness. Western society’s embrace of the medical model has dictated the isolative method in which both physical and mental illness is currently perceived and has defined healthcare as a process of diagnosis and treatment. This medical model of diagnosis and treatment requires classification, categorization and emphasizes individual pathology of illness.

Western medical models of healthcare have resulted not only in a system of classification but in an entire mode of viewing illness as a deficit and the result of individual flaws. As Peter Dunn wrote, “the medical paradigm…views disability as a sickness and focuses on limitations of individuals…The paradigm focuses on policy principles of medicalization, categorizing people, and functional limitations” (Dunn, 2003). The shortcomings of the medical model have been recognized as “charged with diagnosing and “labelling” people (Rothman, 2003). Outside the realm of healthcare however, the social effects of labelling have also been acknowledged as having a significant effect on individuals, where “disability labels drawn from the medical model generally have a negative connotation and can have a powerful negative effect. Stereotyping, discrimination and prejudice often accompany medical labelling” (Rothman, 2003).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is currently the standard reference used by healthcare practitioners for diagnosing psychopathology (Ishibashi, 2005). In practice, the traditional model for mental health assessments includes: “a thorough
history of client’s current and past functioning, symptoms and problems, historical milestones, current and past treatment, and concludes with diagnostic impressions and treatment recommendations. Axes IV of the DSM-IV (psychosocial and environmental problems) and V (global assessment of functioning scale) are often not used, or when used, receive scant attention” (Graybeal, 2001). These assessment tools are often required from all healthcare practitioners, including social workers, who find that the structure of the assessment forms “lead inexorably toward problem lists, pathology, and psychiatric diagnoses” and that “while some of these forms include attention to strengths, they often do so as an aside, or as an afterthought.” (Graybeal, 2001).

Although meant to be “a simple catalogue of illness without any theoretical bias” (Ishibashi, 2005, p. 67), the connotations associated with psychiatric labels have both perceived and real consequences for the individual being labelled ‘mentally ill.’ Noriko Ishibashi spoke of the power of language, particularly within mental health, when she said, “an issue arises when the diagnosis is given greater meaning, and hence, greater power in the minds of those who use it.” (Ishibashi, 2005, p. 66) The strength of a diagnostic label is in its resiliency, in that “once attached, [they] are difficult to shake off” (Ishibashi, 2005, p. 66).

Labelling Theory

Sarah Rosenfield described labelling as a continuum which opened individuals up to varying degrees of both stigma and services (Rosenfield, 1997). Although some studies have indicated positive consequences of labelling, the overwhelming majority of participant responses have indicated negative personal experiences of living with a label of mental illness, due to the associated effects of stigmatization (Rosenfield, 1997). The central problem of labelling is the inextricable stigma that is attached to mental illness labels (Rosenfield, 1997). As objective as a
diagnosis may claim to be, any label causes automatic responses (Ishibashi, 2005). Clinicians are not immune to the effects, as specific diagnoses in the form of a label have been shown to impact the way clinicians treat clients (Ishibashi, 2005). Rosenfield states that when a psychiatric label is given, it sets into action “cultural stereotypes and negative images about mental illness that are applied to the person by others and by the person to himself or herself” (Rosenfield, 1997, p. 660).

Recognizing the powerful effects of diagnosis, labelling theory developed out of sociological theories of deviance (Bright, 1997). From this perspective, labelling was seen as a destructive process. The idea was that the label of mental illness, rather than the mental illness itself, was more damaging to an individual. Labelling theorists claimed that mental illness was actually perpetuated by the expectations attached to the label (Rosenfield, 1997). Bright described Scheff’s original labelling theory as a cyclical, self-fulfilling process, in which “having a label caused others to behave differently towards that person, creating further deviant behavior” (Bright, 1997, p. 2).

Link’s modified labelling theory later proposed that the label of mental illness was not the key causal factor in perpetuating illness (Bright, 1997). Stigma decreased self esteem and social interaction, which resulted in unhealthy patterns of coping (Bright, 1997). Unlike original theories of labelling, modified theories held that the consequences of the stigma of labelling were the more destructive causal forces. “Devaluation and discrimination created by the label interfere with a broad range of areas, including access to social and economic resources and general feelings of well being” (Rosenfield, 1997, p. 660).
Although specific definitions vary across studies, there is general consensus that stigma is a negative process that involves widely held beliefs and/or stereotypes, and results in discriminatory behaviour toward a particular group. Stigma is also described as an effect of labelling, as a label may be associated, or elicit a negative reaction from others. Broader definitions included “negative effects of a label placed on any group” (Bright, 1997, p. 1) as well as “a complex term” which “represents the overall stereotypical and prejudicial process” (Corrigan & Wassel, 2008, p. 43). In relation to mental illness specifically, Ishibashi described stigma as “the general public’s negative attitudes and stereotypes about how people with psychiatric illness perceive and experience these negative attitudes and actions” (Ishibashi, 2005, p. 343). Key features of the stigma process included tagging, where a person was identified and a label affixed to the person, being set apart and connected to undesirable characteristics, and being broadly discriminated against as a result (Alexander & Link, 2003). In the field of mental health, the stigma associated with medical labels is particularly negative, with possible negative consequences such as rejection, exclusion, and discrimination in accessing to social, economic, and political resources (Link, & Phelan, 2001). It is these experiences of marginalization from stigma associated with labelling that I focus on, as the basis of this paper and in my research study.

Public Stigma

Avoidant behaviours and external rejection of affiliation with individuals and groups who have been labelled ‘mentally ill’ are manifestations of public stigma. Corrigan and Wassel (2008) define public stigma as a representation of “what the public does to people who are marked with a mental illness” (p. 43) by “endorsing and implementing the stereotypes, prejudice, and discrimination that comprise mental illness stigma” (Corrigan & Wassel, 2008, p. 44). Knight,
Wykes and Hayward (2003) describe public stigma simply as “the reaction to mental health consumers by the community (p. 209). A more operational definition of stigma is offered by Green, Hayes, Dickinson, Whittaker, and Gelheany, who state that stigma is a two-way process involving interactions and clear distinctions between the ‘normal’ and the ‘stigmatized’, or the ‘self’ and the ‘other’ (Green et. al., 2003, p. 225). Common media images portray individuals with mental illness in overwhelmingly negative and inaccurate ways, such as violent, dangerous, unpredictable, incompetent and unlikeable (Alexander & Link, 2003). These images contribute to stereotypes held by the general population that individuals with mental illness are dangerous and unpredictable (Alexander & Link, 2003), that individuals with mental illness are somehow responsible for their symptoms and therefore subject to blame (Corrigan & Wassel, 2008), and that individuals with mental illness are incapable of acting independently and need parental like figures to make decisions for them (Corrigan & Wassel, 2008). Negative attitudes and beliefs held by the general public regarding individuals with mental illness were found to be “deeply held and irrational” (Ishibashi, 2005, p. 344), and individuals with schizophrenia were particularly rejected (Ishibashi, 2005). These overwhelmingly negative beliefs held by the general public have obvious detrimental effects on the psychological wellbeing of individuals with mental illness who are exposed to public stigma.

Self Stigma

In Prince and Prince’s (2002) study, psychiatric self labelling was found to be negatively related to quality of life. This self stigma refers to what people who belong to a particular group do to themselves (Corrigan & Wassel, 2008). In relation to mental illness, self stigma is a mental health consumers’ response to themselves, taking into account their personal experiences of mental illness and/or public stigma (Knight et. al., 2003). Self stigma involves internalization of
public stigma (Corrigan & Wassel, 2008) and cultural standards held by wider society (Knight et. al., 2003). The negative effects of self stigma on an individual with mental illness are deeply damaging. In a study by Corrigan and Wassel (2008), questions were posed to mental health consumers regarding levels of awareness of stereotypes, levels of agreement with stereotypes, applications of stereotypes to themselves, and the effects of internalized stereotypes on their self esteem and self efficacy. Individuals who were found to have internalized public stigma risked “harming themselves both cognitively and behaviourally” (Corrigan & Wassel, 2008, p. 43). Other studies have shown negative effects of self stigma on individuals with mental illness. Individuals who have experienced self stigma discredit themselves, feel self hatred and shame, and negatively evaluate themselves (Green et. al., 2003). It seems apparent that self stigma greatly impacts an individual’s self concept as well as their sense of self identity. Knight et al.’s study identified the struggle for individuals who felt as if their identity had been overpowered by the identity of a diagnosis (Knight et al., 2003). Internally, there is a battle to maintain a positive sense of self and to keep a sense hope for recovery (Knight et al, 2003). In Green et al.’s study, the concept of identity was explored as a function of two types of stigma: felt or perceived stigma, and enacted or discriminatory stigma (Green et al., 2003). Researchers found that an individual’s self concept presented as a self-fulfilling prophecy when measuring for experiences of self stigma (Green et al, 2003). As well, perceived stigma was more prevalent than enacted, and predisposed stigmatized individuals to “conceal conditions to protect against possible discrimination” (Green et al, 2003, p. 225), similar to behaviours of label avoidance. This desire to conceal aspects of the self poses a significant element for practitioners to be aware of, when working with individuals who may have internalized negative stereotypes of mental illness.
It is important to note, however, that the nature and degree of perceived stigma may vary dramatically from one individual to the next (Ishibashi, 2005). Consequently, some individuals have the ability to shrug off, ignore, or even counter stigmatizing views held by wider society (Ishibashi, 2005).

*Gender*

Studies show that men visit their doctors less frequently than their female counterparts and ask fewer questions per visit, but are overrepresented in hospital emergency rooms (Addis & Mahalik, 2003). In terms of accessing health services, unique barriers exist for men which likely contribute to a deliberate avoidance of the mental health system altogether. Several studies show that men are less likely than women to seek help from healthcare professionals (Galdas, Cheater & Marshall, 2005) (Tudiver & Talbot, 1999), (Addis & Mahalik, 2003), and that men tended to “underuse primary care health services despite their susceptibility to particular types of illness” (Tudiver & Talbot, 1999, p.47). This behaviour is also present when addressing issues of mental health. In their 2005 study, Paul Galdas, Francine Cheater & Paul Marshall revealed that men were “less likely than women to seek help from health professionals for problems as diverse as depression, substance abuse, physical disabilities and stressful life events.” This point was echoed by other researchers, who noted that men sought medical, mental health and substance abuse services less frequently than women, despite reporting higher levels of substance abuse, and higher likelihoods of psychosocial problems related to drug use (Addis & Mahalik, 2003). In mental health specifically, men were found to seek out and utilize psychiatric services, psychotherapy, and counseling less often than women (Addis & Mahalik, 2003). In most studies, the source of male reluctance to seek treatment has been strongly linked to ideas of traditional masculinised self concepts which do not support help seeking attitudes or behaviours as positive male traits.
From a standpoint feminist perspective and based on much of the literature, gender is implicated in the construction of mental disorders, but the relationship is “indirect, mediated through conceptions of properly male and female behaviour” (Lunbeck, 1998, p.19). Larger society maintains these conceptions through encouraging gendered behaviours and activities. As a result, specific characteristics and traits in individuals are either masculinised or feminized. In a patriarchal society and within a patriarchal system such as healthcare, masculinised traits such as rationality and objectivity have been more valued throughout history. In assessments of mental illness, “this process of embedding gender in diagnostic categories is most evident in the neuroses and behaviour disorders, but the general principle that sees rationality and autonomy as male, and emotionality and passivity as female, holds across the diagnoses” (Lunbeck, 1998, p.19). The direct contrast between masculine and feminine qualities serves to increase the reluctance for men to access mental health services, when such a choice would be deemed ‘un-manly’.

Symptoms of mental illness are closely linked and regarded as ‘feminine’ in nature even when displayed by men. This connection has contributed to the overwhelming public view that mental health is somehow a ‘women’s issue’. Women are thought of as naturally “better at empathizing than men, who are prone to emotional inarticulacy and self-withdrawal while excelling at systematizing, control, and organization” (Schoene, 2008, p.379). Men are often stereotyped as “unreconstructed” and “emotionally impaired” (Schoene, 2008, p.379). Boys are socialized to “to identify against the feminine” by molding them into “emotionally & cognitively impaired monads” (Schoene, 2008, p.379). Our patriarchal society has stereotyped the male and female into diametrically opposing counterparts and pitted them against one another. Men and women are defined in relation to their differences from one other. Male ‘reason’ is opposed to female ‘insanity’, (379),
men are “oppressive and violent (in) self-assertion” (Schoene, 2008, p.380)”, whereas women are “hysterical” and depicted as a type of “feminine falling apart of the self” (Schoene, 2008, p.380). However, the view of ‘women as expressive’ described by Gove & Tudor, found that women were not naturally more prone to psychiatric illness (Gove & Tudor, 1973). “Women’s higher rates of psychiatric disturbance is not due to ‘real sex differences of disturbance but rather to man’s greater reluctance to admit certain unpleasurable feelings and sensations since men believe such behaviour is not masculine” (Gove & Tudor, 1973, p.830). Their reasoning for the overrepresentation of women utilizing psychiatric services was, “…it is more culturally appropriate and acceptable for women to be more expressive about their difficulties” (Gove & Tudor, 1973, p.830). In this manner, typical mental health treatment involving voluntarily treatment seeking attitudes, expression, talking and sharing emotions has thus become equated with the traditional female and tend to exclude men “…scholars have noted that the culture of psychotherapy, with its emphasis on stereotypically feminine behaviours—such as emotional expression, introspection, and acknowledgment of vulnerability—opposes masculine norms of self-reliance and self-restraint” (Hoyer et. al., 2005, p.190).

**Stigma for males**

For men, the stigma of having a label of mental illness may also be combined with the stigma of being a male, when accessing services that have been deemed ‘feminine’ by society. The stigma may be felt both internally and from others. Personally, men with mental illness may face crises of self confidence and identity in seeking mental health services. Seeking help goes against the basic, traditional gendered norm that “man has to show himself to be in command” (Schoene, 2008, p.387). Publicly, research has shown
that “people tend to punish gender deviance” and “behaving in a gender-atypical way may itself be a source of stigmatization, and backlash may ensue” (Bodenhausen, Galen & Wirth, 2009, p.170). In this case, “individuals who display gender-atypical mental illness symptoms may be stigmatized to a greater extent than persons who display gender-typical symptoms” (Bodenhausen, et. al., 2009, p.170). As for the link between gendered expectations and stigma, the authors concluded that, “Stigmatizing individuals for gender deviance is certainly a real phenomenon; gender does appear to be a factor in mental-illness stigma...” (Bodenhausen, et. al., 2009, p.172). In fact, the stigma of mental illness has been found to negatively impact men more than women. As Gove and Tudor found, “Even though women may be diagnosed and treated for mental illness at higher rates, stigma for men may be higher. ...there is fairly strong evidence that if both men and women perform acts indicative of mental illness, men are much more likely to be perceived and reacted to as mentally ill. ...men were rejected more strongly than women even though the behaviour in each case was the same” (Gove & Tudor, 1973, p.829).

A detrimental consequence from this perceived stigma and deviance from gendered norms has been negative help seeking behaviours from males. In a study by the National Institute of Mental Health (NIMH), researchers found that “men are less likely than women to recognize, acknowledge, and seek treatment for their depression” (Hoyer et. al., 2005, p.186), and “men who express depressive symptoms and report negative help-seeking attitudes tend to conform to restrictive gender role norms” (Hoyer et. al., 2005, p.186). The more rigid the gender roles, the more difficult it is to seek outside treatment, as this act may be perceived as emasculating and a loss of control over oneself. Many authors have made the link between negative help seeking behaviours with traditional notions of masculinity. “...authors have suggested that men in need of
treatment commonly refuse to pursue it, and that this is in part due to a belief that asking for help is a sign of weakness and thus counter to the rules that govern traditional masculinity” (Hoyer et. al., 2005, p.186). This “historical aversion to psychological treatment” stems from the view that psychotherapy and help seeking is a “stereotypically feminine process”, versus “traditional masculine norms and values” (Hoyer et. al., 2005, p.186). Specific features that deterred men from seeking help included “stereotypes about masculinity and ethnic identity” (Hoyer et. al., 2005, p.188). Admitting weakness and asking for help is “threatening to the masculine ideals of occupational, social, and physical prowess. The need to appear potent and accomplished in the eyes of others has historically made admitting to emotional distress difficult for men” (Hoyer et. al., 2005, p.191). The relationship between men and psychotherapy was described as tenuous at best, where men will “do almost anything to avoid a therapist’s office,” and that they often seek help with an interest not in achieving personal growth, but in the hopes of ridding themselves of a specific problem” (Hoyer et. al., 2005, p.190).

In a campaign entitled “Real Men Real Depression” by the National Institute for Mental Health (NIMH), gendered norms were targeted as the primary significant factor, with the aim of increasing help seeking attitudes in men. The “heavy emphasis on masculinity makes the campaign particularly relevant to those male audience members who conform most strenuously to rigid gender roles...considering that men who conform to rigid gender roles also report negative help-seeking attitudes” (Hoyer et. al., 2005, p.190).

A clear dichotomy exists between feminine and masculine traits and many males’ reluctance to seek treatment for a ‘feminine issue’. In terms of stigma, gender creates an additional barrier for men, resulting in unique challenges to accessing services. My original research study did not involve aspects of gender; however, the gender factor naturally arose during
interviews as a source of stigma for particular male participants. The research study I’ve included looks at the connection between mental illness labels and experienced stigma. My original study was conducted for a qualitative research course, and was approved by the UBC ethics board. My initial purpose was to identify and give voice to lived experiences of stigma from the perspective of mental health consumers. Gender had not been an original consideration when preparing focus questions, but the semi structured interviews and broad questions allowed participants the freedom to often elaborate more on issues of personal interest. The majority of participants were male, and some identified their gender as a source of stigma. Their experiences piqued my own interest. As a result, this paper examines both diagnostic labelling as well as gender as sources of stigma within the realm of mental illness.

In my literature review, I found that previous studies had sought to answer questions of the impacts of stigma of mental illness labels through quantitative research. These quantitative methods, often in the form of surveys and structured interviews, did not allow much room for elaboration or deviation from predetermined questions. These methods often utilized larger sample sizes and yielded generalizable results. However, participants of the study, mental health consumers themselves, had little to no say in the process of what areas or experiences were deemed significant. The few qualitative studies available followed a less structured path of questioning which yielded richer, more detailed stories, at the expense of having smaller sample sizes. Unlike previous research which has utilized mainly quantitative methods, I used semi-structured interviews. In doing so, I am hoping to give voice to the lived experiences of individuals with mental illness, who are often left out of the research process entirely, in a disempowering process.
Methods

Participants

Participants for the research study were recruited on a voluntary basis from mental health consumer organizations in Richmond and Vancouver. A poster with the project and researcher contact information was posted on various community boards at these organizations. Interested individuals contacted me for a brief pre-screening via telephone and to determine a meeting place of their choice. Eligibility criteria included: being over 18 years of age, being a resident of British Columbia, being fluent in English, having a diagnosis of depression for at least one year, and being a member of a mental health consumer organization. The rationale behind a minimum one year diagnosis was the idea that individuals had at least one year to process the experience of having a label of mental illness, in which case certain relevant experiences and opinions may have formed. Five participants contacted me and were interviewed in total. Participants were members of either of two consumer-run organizations: the BC Mood Disorders Association or Pathways Clubhouse. Four of the participants were male and one was female. All interviews were conducted in rooms at one of the two organizations. For purposes of confidentiality, I have altered the names of participants, to Gary, Ben, Liz, Nick, and Omar. At the same time, I have attempted to preserve as much authenticity to the story as possible, by using the participants’ own words to describe their experiences. It was my hope that in re-telling their stories, participants might gain further insight into their own situations, and be able to identify positive aspects, personal strengths, or lessons learned from each experience, so that the interview was a mutually beneficial process.
for both researcher and participant. To give some context to the interviews, I’ve included a brief description of each participant below:

*Gary*

Gary was first diagnosed in 1989 at age 22, with major depression and dysthymia. Gary described the experience as not a complete surprise, and he did not struggle with having a label of mental illness. The challenge Gary described, was in years of mistreatment and disrespect, some from friends and family, but most often from healthcare professionals. The biggest source of support for Gary has always been in pets, namely his cats and dogs. It wasn’t until Gary turned 39 that he finally found a psychiatrist whom he felt respected him and treated him considerately. He currently works as a manager at the BC Mood Disorders Association, where he attends and co-facilitates peer support groups.

*Ben*

Ben was first diagnosed in 2000 when he was in his early twenties. He was working graveyard shifts as a security guard at the time and described feeling like a ‘hermit’, with ‘no life’. After several weeks, he told his parents about his difficulties eating, sleeping, and hallucinations he had begun having, and they accompanied him to the hospital. After an inpatient stay at the psychiatric ward, Ben continued taking medication but had difficulty sustaining work. Within the span of one year, he lost his sister, father and grandfather, and ended a five year relationship with a partner whom he felt did not understand or support his mental illness.

Ben currently has a great relationship with his psychiatrist. He lives with his mother who he considers his ‘best friend’, and who works at the UBC psychiatric ward. Prior to Pathways, Ben used to drink nightly at his local pub, in order to gain some social contact. Since coming to
Pathways, Ben says he no longer has the desire to drink because of the new social network he has built there.

*Liz.*

Liz said she had suffered from anxiety, manic depression and obsessive compulsive disorder since she was three years old. She had been hospitalized many times over the course of her life, and always told that it was a nervous breakdown. She was not formally diagnosed and put on medication until 2001 at age 58, when she was once again hospitalized and finally diagnosed with manic depression (bipolar affective disorder). During the time between her frequent hospitalizations and first diagnosis, Lynn described living a double life, in which any mention of mental illness was hidden from her contacts. At work, she was the competent supervisor, and at home, her personal life was in shambles.

Lynn described abuse, particularly alcohol abuse as a large part of the household she grew up in. There was no mention of mental illness at the time, she explained. People just didn’t talk about it then. Alcohol abuse continued to be a factor in her life with later partners, until her relationship with her ex-husband ended. She has a daughter and two grandchildren, and has been an active board member of Pathways for several years now. Although Lynn says she still has problems with isolating, she has found a great source of support from friends who are aware of her diagnosis, her mental health team, and her work at Pathways.

*Nick*

Nick grew up in a small, rural town in Nova Scotia with a population of less than 10,000. Growing up, Nick described his childhood as ‘tough’, but had a vast network of family and friends, who encouraged his many achievements. He had little exposure to mental illness. He
explained that in his hometown, everyone knew about a particular gentleman who talked to birds and was considered odd but generally harmless, and that had been his only exposure to mental illness, prior to his own self described breakdown and hospitalization.

Nick moved to Richmond after university and worked as a bartender for several years. He described the move from his hometown to Richmond as a huge culture shock, and a terrifying experience. Although Nick said that he had always known even as a young child that he was somehow ‘different’, he believed that many of the symptoms of his mental illness were triggered mainly by the changes that occurred during this period of culture shock in his twenties. To cope with his overwhelming feelings, Nick increasingly turned to alcohol. He considered himself lucky, in that he had a huge support system of friends and family to turn to when he needed help. He eventually stopped drinking completely, has chosen to stop taking all medications (although he still has a diagnosis of mental illness), and currently works as a staff member at Pathways.

Nick’s younger brother also has severe depression, but has no desire to seek treatment and continues to self medicate with alcohol. Nick describes him as a highly functioning alcoholic, whose depression is generally not recognized.

**Omar**

Omar grew up in a deeply religious Catholic household where he and his siblings were often severely punished by their parents for minor infractions. He described the punishments not as abusive, but as highly unusual, and often publicly humiliating. Omar’s family had a history of mental illness. He described being familiar with siblings, aunts and uncles who had Alzheimer’s disease, depression, schizophrenia, and bipolar affective disorder.
Omar was first diagnosed with depression in 1989. He was a student at the time, and had days where he would be unable to get out of bed to attend classes. He eventually stopped going to school altogether and saw his GP, who referred him to a psychiatrist who put him on antidepressant medication. Omar then worked for a number of years in residential buildings as a concierge, got married, and had a child. He began turning to alcohol as a means to cope with his depression. In 2003, Omar was diagnosed with cancer, which he says triggered a deep depression, and he began to have suicidal thoughts. His psychiatrist diagnosed him with anxiety and depression. Omar’s drinking had begun to get out of control and his marriage had ended. Five years ago, he joined AA and he has not had any alcohol since. He lives with his second wife and daughter, and hopes to enter the workforce again at some point. When I met Omar, he had only been at Pathways for two weeks.

Data Analysis

In keeping with the essence of qualitative research and honouring individuals as experts in their own lives and active participants in the construction of personal realities, I adopted a social constructivist approach. Individual perceptions and constructions of reality in relation to experiences of stigma and labelling were examined. By using in-depth, qualitative interviews with focus questions as a general guideline rather than a structured format, I gave participants the flexibility to alter and tailor the course of each interview (see appendix I). Open ended questions such as, “What was your first experience of diagnosis?”, “What does mental illness mean to you?” “What does stigma mean to you”, and “How do you feel your life has been impacted by having a label of mental illness?” allowed for a great deal of personal interpretation and narrative responses. In doing so, the unique story of each mental health consumer had the opportunity to be told, and I
gained a more comprehensive insight into the experiences of labelling and stigma from a mental health consumer’s individual perspective.

Interviews were then transcribed and analyzed for significant themes, as mentioned below.

**Results**

Individual stories and perceptions of diagnosis, public stigma and self stigma were explored from the five interviews. While responses varied in the degree, perception, and source of stigma, all participants nonetheless described discriminatory experiences which had occurred in association with their mental illness.

*Diagnosis and Labelling*

For participants, the experience of diagnosis was surprisingly not unanimously described in negative terms. In accordance to Link’s modified labelling theory (Bright, 1997), having the label of mental illness itself did not seem to be the primary source of distress for participants of this study. What both Link and study participants described as most damaging, were consequences of the stigma that was inextricably tied to labelling (Rosenfield, 1997).

The range of responses was varied, when I asked participants about their first experiences with formal diagnosis and having the label of a mental illness. For Gary and Ben, although both participants described experiences of stigma and discrimination, both felt that the actual words ‘mental illness’ and ‘depression’ were merely words, without any inherent value or judgment. For Ben, “the words (depression and mental illness) don’t affect me because I know I am, and I know who I am and I know I’m a nice person so it’s just- it doesn’t bother me much. They’re words.”
In Gary’s experience, “It was what I expected for the most part. I already knew I had depression, so that wasn’t- they didn’t need to tell me any of that. I didn’t find those stigmatizing. I had no problems with those labels. I felt the way I was treated was kind of stigmatizing, you know what I mean. Just not being treated considerately and respectfully.”

In Liz’s case, as a 65 year old woman who wasn’t diagnosed until she was 58, the experience in hindsight was described almost as a relief, after years of breakdowns and struggles at home and in the workplace:

“I was so glad I finally got diagnosed. I was grateful that, at least I knew what was wrong and I knew that there was help and I gradually got the help. When I was diagnosed and went through the therapy and everything, I realized the pitfalls that I had been falling into and everything in my life.”

Nick and Omar on the other hand, both expressed negative experiences or thoughts at the time of diagnosis. Although their distress was no doubt very real, their stories still revealed that their negative experiences were more closely tied to assumptions or perceptions of what each believed having a diagnosis entailed, rather than the process of being labelled itself.

For instance, for Nick, although the experience of first diagnosis was traumatic, it was not the label itself, but the implications of the label which he considered most damaging:

“You learn the sort of implications of what people are telling you, right? Diagnosed with mental illness- probably across the gamut, is depressing, because the implications of what you’re being told for your future, is kind of toxic, or devastating… ‘cause when someone tells you that, you’re going, okay, you know, in a couple of sentences, you’ve just killed all my dreams for the future.”
In Omar’s case, having grown up with several close family members who had been diagnosed with schizophrenia and bipolar affective disorder, he had witnessed firsthand the challenges that his own brothers and sisters faced. These past experiences were likely negative and no doubt influenced his own perceptions of mental illness, as his response to his own diagnosis was:

“It (diagnosis) made me feel there was something wrong with me, and I didn’t wanna talk about it because I thought - I was afraid that the people would misjudge me and - because I couldn’t understand the illness, I didn’t understand nothing, so I just blamed myself for everything.”

His primary worry lay in the (mis)treatment and stigma he believed he would receive from others as a result of his label, and he reacted by feeling guilt and self blame.

**Public Stigma**

All participants described experiences of public stigma, as defined by “negative attitudes and stereotypes about how people with psychiatric illness perceive and experience these negative attitudes and actions” (Ishibashi, 2005, p. 343). Although not always recognized or identified explicitly as stigmatizing behaviour, the stories that were shared revealed that all participants had been discriminated against at some point in their lives, as a consequence of others knowing about their mental illness. Participants described what they felt were the general attitudes of society in terms of perceived stigma.

Ben: “I think people might look down on me just from word of mouth. Like, people in my neighbourhood. My neighbourhood saying, oh he’s been in the psych ward, he has mental health issues, or he’s crazy or whatever.”
Nick: “We’re the modern day lepers. In society, it’s still very much stigmatized. There’s almost this thing, that people are afraid they’re gonna be contaminated or catch something from you. It’s funny, right, but that’s the mentality. It’s there, and people are afraid of what they don’t understand. You can’t even really blame people... People make comments about being afraid of me...”

Omar: “I almost feel that people are judging me, you know. I know in general, people don’t believe that depression is a big thing. Some people believe that if people are depressed, get up, dust yourself off, you know, keep going. But it’s not that easy. There’s nothing more that I would like than for me to pick up myself but it’s very, very hard. Yeah, and I accept that people generally are not knowledgeable in these things either, and if they judge me, I understand. I can only do what I can. I can only control my feelings. I can’t go and make somebody feel anything, you know. The stigma of the illness is that people don’t understand you know. They don’t understand. They think depression is not a big deal, but it is. It is.”

Although most participants believed that the larger society still held stigmatizing views toward individuals with mental illness, many personal experiences of felt stigma stemmed from people who also offered support; family members, friends, and healthcare practitioners. This source of stigma seemed to be more subtle and indirect than stigma felt from strangers or larger society, in that some participants only offered the following stories in relation to discussions of sources of support. Much like a double edged sword, the same sources participants identified as their strongest means of support, at times also acted in ways which served to further isolate and stigmatize participants. The complexity of close relationships is such that those closest to a person
often have the most influence over them, and can consequently wind up either helping or harming them the most.

For Gary, any support he felt from his family and friends paled in comparison to the mistreatment he described, from family, friends, and particularly the healthcare profession:

“They (family) really didn’t understand. And - I don’t know, friends tend not to be super supportive, I find. That’s what I found. I mean, some of them are, but they’re a minority. So I guess I have got some stigma from friends as well, and I’ve felt sometimes kind of looked down upon too, because I have this illness... I did feel it with friends and family, that they’d kind of look upon me as lazy - mostly that, or mostly weak. By friends and of course, you know, the professionals with doctors and some psychiatrists- psychiatric nurses... I found the most harmful stigmatizing has come from health professionals. Not just mental health professionals, GPs too. And that’s the most damaging too.”

Similarly, although Omar named his wife as his strongest supporter, he also acknowledged tensions and judgmental attitudes in his own home, at times from his wife and more often from his daughter.

“I married again and I have one daughter and they don’t understand very much. My daughter sometimes yells at me. She yells because she doesn’t understand. I think she has a little bit of denial because she doesn’t want me to be ‘that person’ you know, she wants me to be in control and she’s afraid of getting depressed too. She’s afraid of getting the same problems. It’s really difficult to talk with her because she’s not open to it. She doesn’t wanna talk about it. She’s afraid. But she shows her fear in different ways. Like, not talking to me, or not including me for family decisions.”
In my interview with Liz, she initially described her relationship with her daughter as strong, and cited her as a primary source of support. However, when asked further as to how her daughter responded to her mother having a mental illness, she said,

“My daughter doesn’t really - she won’t let me talk to her about it (mental illness), so I feel that she is not quite accepting of the fact that it’s okay… She’s supportive, kind of - but not as far as Clubhouse and stuff like that is concerned… she never asks me any questions about it… My daughter had 2 more children, E. and K. E. is 8 and K. is 6 and she won’t let me bring them here because she feels that other people- like there’s people that talk to themselves and do different things- and so she won’t let them come. Other than that, I’m mom and I’m grandma. Just don’t talk about it. Just don’t talk about what’s going on with me… I can’t talk about my mental health with her.”

**Self Stigma**

The question of self stigma was not always answered explicitly. One participant, Omar, clearly identified with feelings of self stigma and blame when he said, “I do feel bad when somebody doesn’t understand. I start to play the old tapes, maybe my family was right, maybe there is something wrong with me.”

Nick, on the other hand, seemed truly genuine when he stated that he did not experience self stigma, stating the reason that, “I always kind of thought that I really didn’t bring this on myself, that I really didn’t deserve this. I mean I certainly didn’t want to feel that way, right, so I don’t think I blamed myself too much.”

For the other participants, experiences associated with self stigma were discussed more indirectly. All participants, being mental health consumers, had received some form of treatment
and peer support in the past. All participants, including Omar, acknowledged from their treatment that their mental illness was not due to an inherent ‘fault’, and that they should not blame themselves. However, when surrounding issues such as being on disability benefits arose, participants spoke of feeling guilt, disappointment in themselves, and attempts to change in order to better fit into mainstream society. To feel undeserving of particular services, or to deny or hide a part of oneself, speaks of discontent with the self, and perhaps feelings of shame and lowered self value. These aspects are integral parts in developing or breaking down self esteem, and very likely contribute to increases in self stigma.

For Ben, the realization that his life path did not necessarily follow society’s expectations was disappointing and a cause for some anxiety. “I mean, I’m 34. I should have it together but I’ve had a few stops, along the way right, but I mean, I should be in a career or something. I should be, but I’m just confused with where life will take me now...”

Nick talked at length about his constant desire to ‘fit in’ by hiding the fact that he had a mental illness, but still always feeling like an outsider-

As a kid, I felt different. I felt- you know, something’s wrong here, I don’t seem to be like other people. And you grow up with that kinda thing... It’s a question of how well you’re able to cloak yourself to look like the flock... I guess I’m afraid of people alright, so I’ll do these kinds of things, you know, I’ll be who I think people want me to be... it’s very important that I do my happy mode. Obviously I have depression, still have it, so people who see through my role, see that I’m still sad.

The stigma associated with receiving income assistance, such as disability cheques, was an issue that two participants brought up. Although Ben spoke of disability benefits more in terms of
public stigma and animosity (“I think people are actually jealous in a way, to see that I’m collecting disability when they have to go to work every day”), Omar’s experience of receiving disability has been extremely damaging to his self esteem. The issue of employment and receiving financial assistance clearly troubled Omar a great deal, and was a large contributor to feelings of guilt and self blame. In his own words,

“I went on disability and I’ve been on disability now for maybe a year. But I don’t like it, you know. I don’t like disability. Because I don’t feel worth it. It feels to me that I should be able to work because I have two legs and two hands and two eyes you know, and I see people out there with more disabilities and they are working you know. They are working. So, that’s why I feel bad sometimes. Because I should be able to work, you know - I like to be out there, working, but I lost the last few jobs because I couldn’t handle it. I was crying, I was just having problems... I feel that I should be working, paying my taxes and instead I’m draining the system being on disability. So I feel bad, because of that. I feel that I shouldn’t be taking disability. I feel I should be working, paying my own way and supporting my family in every way. It makes me feel guilty that I can’t, and I put myself down.”

The major differences in the perception of the two men seemed to be in their feelings of being either deserving or undeserving recipients of financial assistance. Even though both participants acknowledged that they were currently unable to partake in full time work to the same extent that they had before, Omar continued to feel somehow less deserving of receiving disability than someone with a physical, visible impairment. Gary’s experiences reminded me of the credibility and sympathy our society places on medical and physical illness, compared to the much more stigmatized and less funded, mental illness.
Gender

The additional aspect of gender occurred to me during the research process more as an afterthought, when I noticed that the majority of participants were male. As a result, the question of gender was posed only in the final two interviews, to Omar and Gary. Their responses were extremely insightful and I wish I had had the opportunity to pose the question of gender to all participants. Although none of the participants vocally identified gender as significant to their perceptions of stigma, the question did not surprise either participant. In fact, both participants responded immediately, as if they had pondered the question themselves before. In both instances, participants felt that their gender presented an additional barrier, in that seeking help was seen as ‘un-masculine.’

For Omar, having grown up in a traditional household with strict gender roles, seeking treatment was the challenge. “When I was little, my family taught me that boys don’t speak about their problems. They don’t express their feelings. Now I find myself, I have to express myself, I have to find help, and that’s why it’s difficult you know. I have this mindset that when I was little, my family told me that men don’t cry and the man is in control of the marriage, which I found out is not so.” To receive help, Omar had to change his previous conceptions of what being a ‘man’ meant.

In Gary’s situation, the barrier was in the type of treatment he felt he received from professionals. “I found it (depression) wasn’t taken really seriously, and maybe it’s because I’m male that it wasn’t the seriousness that it should have been. I did think that women were treated a bit more compassionately than men. That it really wasn’t taken seriously enough and I think partly because I am male.” Gary’s experience seemed to speak of the public view and stereotypes that continue to surround mainstream ideas of mental illness being a ‘woman’s issue’.
Discussion, Limitations and Implications for Social Work Practice

Discussion

All participants expressed awareness that society was not fully informed about or supportive of individuals with mental illness. Even when participants believed they had experienced little stigma, they nonetheless were all able to identify people in their lives who had either treated them in a discriminating manner, or with whom they did not feel their mental illness was fully accepted. For individuals like Lynn, Omar and Gary, public stigma was felt from their closest circles, from their daughters, wives and other family members and friends. For individuals like Nick and Ben, public stigma was felt from larger social groups outside of their immediate circle, such as from the community and larger society. In terms of self stigma, feelings of shame related to having a mental illness were evident in Omar. While not explicitly stated among the other participants, aspects of self worth appeared as significant when discussing feelings of being ‘deserving’ or ‘undeserving’ of financial assistance. These overt and subtle experiences of stigma speak to the continued strength of the negative impacts of psychiatric labels. As social workers, it is an issue that must be addressed when working with clients.

Limitations

The results of the study are not meant to be generalizable to the broader population. My study is illustrative (Mason, 2002), in that a particular set of individuals and their subjective experiences are brought to light. This form of sampling illustrates significant themes of labels and stigma from the perspective of individual mental health consumers,
rather than directly representing a general view that is common to all consumers. More diverse views are allowed with this form of sampling.

Because my study looked at the experiences of labelling and stigma from a mental health consumers’ perspective, I needed to be aware that their experiences may share commonalities that differ from other individuals with mental illness who are not consumers (actively using services), or who do not identify with mental illness. My participants, being agreeable to participation and actively identifying as having a mental illness and engaging in a particular mental health consumer based group, may have experiences that are more common among this group (i.e., increased feelings of self empowerment, self esteem, having a voice, etc). In addition, I feel the limited number of participants from the limited number of organizations does not accurately represent the experiences and beliefs held by the majority of mental health consumers. Finally, mental illness itself is a broad and complex term, whose definitions vary across cultures and audiences. A specific diagnosis was required to obtain UBC ethics approval; however, experiences of stigma and labelling likely vary widely across the spectrum that we call mental illness.

My primary purpose of this study was to explore the experiences of stigma for adults with formal diagnoses of depression, and to increase the qualitative body of knowledge available on mental illness. In addition, my hope is to increase awareness of the discriminating effects that stigmatized individuals with a label of mental illness face on a daily basis.

*Implications for Practice: Working within the Medical Model*

Although making changes to address oppressive structures of the medical model in practice may appear a very intimidating task, positive change is still possible without necessarily taking a radical approach. The flexibility of roles as social workers allows for a number of different
approaches, perspectives and styles, all of which could potentially positively impact a situation. An area where a social worker may be able to utilize and make the most impact is through incorporating strengths based and narrative approaches within the medically based Mental Status Exam (MSE) assessments. Keeping an assessment tool such as the MSE with its important information would be wholly appropriate at mental health facilities. The process of assessment however, could be adapted to include empowerment and/or strengths based questions.

Empowerment based practice, as defined by Gilbert J. Greene and Mo-Yee Lee, involves “both a process and an outcome. It involves intervening with clients to develop a greater sense of power over their lives.” (Greene & Lee, 2002). Specific techniques include:

- developing a collaborative, mutually participatory relationship with clients
- engaging in mutual problem-solving and decision making with the client
- working with problems and goals as defined by clients
- supporting clients’ self-determination
- de emphasizing the social worker’s role as professional expert
- identifying and building on client strengths (recognize and validate skills and competencies)

(Greene & Lee, 2002)

The fundamental premise of strengths based practice is that individuals show better long term achievement when they are able to identify, recognize and use their own strengths and community resources. (Graybeal, 2001). In relation to medical practice, strengths based approaches do not necessarily work against the medical model. Graybeal states, “The strengths perspective does not ignore or minimize diagnoses or diagnostic skills, but does assert that they
must be seen as contextual and part of a larger process. Having assessed the damage, the social worker needs to ensure that diagnosis does not become a cornerstone of identity” (Graybeal, 2001). One method of achieving this, is to be aware of the use of language, both written and spoken, as being potentially oppressive in connotation. Graybeal gives the example of saying/writing, “She’s a borderline” versus “She has borderline personality disorder” versus “Sometimes she’s very kind, sometimes she’s very critical.” (Graybeal, 2001) Using a label or diagnosis only when necessary and separating the individual from the behavior are all ways show respect and recognition of client dignity.

As well, strengths based questions and responses that come from a place of exception, hope, and possibility seek to bring focus back to the client’s own sense of competency (Graybeal, 2001). As such, clients are more likely to have a sense of control and a vested interest in their own ability to make decisions regarding their own wellness. In this manner, social workers can support clients in ultimately making their own, hopefully informed, decisions.

Implications for Practice: Addressing Stigma

Social workers in the field of mental health possess a privilege that comes with their professionalization, which can be used to further their support of clients by acting as a liaison between client and agency. To address issues of labelling and stigma, social workers may work to increase awareness and change through a variety of avenues at different levels. Whether it is working with individuals, groups, agencies, governments and larger society, practitioners have a role in reducing the effects of stigma associated with mental illness.

Public stigma by definition involves not only the individual, but the perceptions and influences of other people. As such, any anti-stigma work which addresses public stigma needs to
involve public education. Front line social workers can address issues of public stigma by raising awareness at the individual level. Social workers can discuss the influence of mainstream media in shaping public perceptions of mental illness with clients who may have internalized public stigma without necessarily realizing it. Sources of low self esteem and negative self concept should be brought up and linked to society’s negative, stereotyped image of mental illness as necessary. These types of conversations can also be discussed among clients through the development of peer groups. Social workers can assist in developing, maintaining and/or facilitating such educational groups.

At the macro level, systems involving the media, policy, public education and research are all avenues through which social workers can be involved to address mental illness stigma. In terms of media, anti-stigma campaigns such as “Real Men Real Depression” commercials can make a huge impact on mainstream society by reaching a broad audience, some of whom might not have had any exposure to mental illness. Social workers can open up the lines of communication between client(s) and agency, or advocate for issues of stigma awareness at the policy level.

*Implications for Practice: Addressing Gender*

“Research suggests that women are generally subjected to less mental-illness stigma than men” (Bodenhausen et. al., 2009, p.169). Despite or perhaps because of the fact that men are less represented as mental health consumers, the mental illness stigma for men has been stronger than for women. The challenge for men with mental illness, particularly mood disorders, has been avoidance of mental health services altogether. In addition to addressing the stigma of mental illness itself, there needs to be change in public attitudes towards mental health treatment as gendered. The idea “that mental health service utilization reflects feminized values of self-care
and emotional disclosure” (Hoyer et. al., 2005, p.191) needs to end. Instead, a productive change would be to “devise an alternative model of help seeking that is characterized by traditionally masculine qualities, including courage, strength, and purposeful action” as “a promising tactic for addressing highly traditional men’s underutilization of mental healthcare” (Hoyer et. al., 2005, p.191).

Anti-stigma campaigns and treatment need to be available which appeal to both genders. One way of addressing this may include increased media campaigns such as Real Men Real Depression, which portray men with traditional masculinised roles comfortable talking about seeking professional help for depression. Another method that involves a more subtle, but prevalent means of shifting attitudes from mental illness as solely a woman’s issue, is language. By discussing and advertising treatment in more gender neutral terms, men may be more willing to attend. For example, by changing the language of ‘support group’, which may imply feminized qualities of sharing feelings, a ‘workshop’ may appeal more to men in traditional gender roles, who may be more interested in skill-based learning than open ended discussion.

Implications for Practice: Collaboration

An essential component of social work within the mental health system is the process of collaboration. Many individuals from marginalized populations such as mental health consumers face oppression in the form of power imbalances, where they are more often in the position of less power. For social workers wanting to empower their clients, the process must be a truly collaborative one, where the client’s needs, experience and knowledge are valued as equally as the social worker’s expertise.

This does not deny or ignore the power social workers hold in the eyes of larger society, in comparison to their clients. Recognizing and acknowledging power imbalances is part of the
process- it is the starting point from which worker and client can begin their collaboration. The recognized power from professionalization that the social worker holds can be used for the benefit of the client, by facilitating discussions between client and agency, as well as increasing validity of client concerns, in the eyes of general society. Mainstream society values skilled professionals. One need only look at current advertisements, where professionals of a genre (sports, medicine, theatre, to name a few) are paid exorbitant amounts of money to endorse a product, to see this. Social work in this sense is not that different. By having a so-called ‘expert’ such as a social worker supporting a ‘non-expert’ (i.e. client’s) issue, social workers are using their power to further strengthen their client’s voice.

Conclusion

The mental health system and its practitioners are far from providing treatment which is gender sensitive in regards to recognizing the gendered history of healthcare, as well as appreciating the changing socio-politico context in which mental illness is defined. When considering mental illness, “mental disorder, too often considered monolithically, should be seen as referring to a number of discrete conditions, some of which are linked to women (depression, anxiety, anorexia nervosa), some to men (alcohol-related disorders, antisocial personality), and some to neither (schizophrenia, mania)” (Lunbeck, 1998, p.19). In terms of treatment, “Psychosocial treatments need to be sensitive to gender differences in symptom perception and illness concept, in coping, and illness- and help-seeking behaviour. Thus, such treatments must recognize the importance of current social and professional roles (partnership, motherhood, etc), social status, social stress and social support, as well as the influence of gender-specific socialization and ‘gendered’ role behaviour” (Armstrong et. al., 2009, p.107).
The complex issue of stigma can be attributed to many factors, including negative public views of mental illness, internalized versions of these views, and gendered socialization, to name a few. Practitioners working in the field of mental health need to be aware of these factors and appreciate their complexities. Stigmatized support is a reminder to practitioners that an individual’s support system is not necessarily without its drawbacks. Loved ones, despite good intentions, may continue to believe and treat family members in a manner that perpetuates stereotypes and is ultimately damaging to one’s self concept. There is still need for increased public awareness, and anti-stigma campaigns and training not only for members of the public, but for practitioners as well. There are sources of support and treatment, but not a universal solution that ‘fits’ everyone.

As such, practitioners need to be aware of clients’ past experiences, and have a sensitive ear to the unique needs of each individual. Whether it is working with individuals, groups, or at the policy level, social workers have a significant role to play in raising awareness of the stigma associated with mental illness labels. As facilitators, counsellors, educators and advocates, there are many ways that social workers can raise the level of individual and societal consciousness to shed light on issues such as stigma.
References


Appendix I

Focus Questions:

What was your first experience of diagnosis?

What does ‘depression’ mean to you?

When I say the words ‘mental illness’, what does that mean to you?

What has mental illness meant in your life?

Do you consider any of your experiences of having a mental illness positive? How so?

When I say word the ‘stigma’, what does that mean to you?

What has stigma meant in your life?

Do you consider any of your experiences of stigma positive? How so?

Is there a message (about depression/mental illness/labeling/stigma) that you would like other people to hear?