

Getting Our Own House in Order:
Stigma in the Mental Health System

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Introduction

In 1963, Erving Goffman published his landmark volume, Stigma: Notes on the Management of Spoiled Identity¹. In it, he explored the phenomena of stigma, which he defined as, "...an attribute that is deeply discrediting..." (p. 3). Such attributes included physical deformities, "blemishes of individual character," or "tribal stigma of race, nation, and religion" (p. 4). Goffman was especially interested in the effects of stigma on interactions between stigmatized persons and those he termed "normals." The consequence of possessing a stigmatizing attribute, he wrote, was that "...an individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us" (p. 5). In other words, persons with stigmatizing characteristics might be denied acceptance, respect and regard from others whom they encountered.

Since that time, in the field of mental health alone, numerous books, articles, and research projects have continued the exploration of stigma. Scholars in a number of disciplines - sociology, psychology, history, anthropology - have contributed to an understanding of the causes and effects of stigma. For example, Link²⁻⁸ and others have done considerable research in the area of public attitudes and the effects of labeling.

Wahl⁹⁻¹² has also focused on public attitudes and, in particular, on the impact of television on public attitudes. Fabrega^{13,14} has conducted extensive reviews of the literature on psychiatric stigma from the Classical to the Modern period in Western Societies.

Deegan ¹⁵ has written on the environmental barriers confronting people with psychiatric disabilities - stigma being one of those - and on the impact of such barriers on people's lives. Herman ¹⁶ followed 285 former psychiatric patients living in Canadian society in order to understand how they made sense of their experiences with stigma and what coping strategies they developed.

In addition to the research and theoretical work on stigma, consumer/survivor, family, and professional advocates have mounted campaigns to "stamp out stigma." Task forces, public forums and conferences have been convened on the topic of stigma.

Despite the many efforts to explore this phenomenon, conversations with consumers/survivors within the mental health field indicate that the topic has not been sufficiently addressed. Stories from stigmatized persons tell of painful experiences of being excluded, rejected and discriminated against, transacted by hundreds of subtle day-to-day interactions and experiences. Further, people's experiences indicate that many stigmatizing occurrences are related to attitudes and practices occurring within the mental health system itself. While people talk about being stigmatized by family, neighbors, friends, employers, and others, many of their stories point to the mental health service system as a primary source of stigma. Yet little appears in the literature on this topic and virtually no work in the field exists regarding the subjective experience of stigma and stigmatizing practices in mental health services.

Because of this discrepancy between the stories of service users and the focus of research, writing and practice intended to address stigma, a small research project was initiated to identify what people with psychiatric disabilities and their families considered to be the main sources of stigma. Also examined were participants' views

on the effects of stigma in their lives, as well as their ideas about how stigma might be addressed.

The project was conceptualized, probe questions developed and potential informants identified with the assistance of an advisory committee comprised of representatives from academia, practitioners, consumers/survivors and family members from across the country. Forty-six people were interviewed, most by phone. While no systematic attempt was made to secure a representative sample, there was an effort to target people from varied geographic areas across the United States as well as to talk with people from different racial and ethnic backgrounds. In addition, an effort was made to interview both current and former service users, as well as people with an array of political and ideological orientations.

Of the forty-six people interviewed, thirty-four identified themselves as current or former consumers/survivors. Some of these individuals were also mental health practitioners or professional advocates. Ten participants were family members or professionals who did not identify themselves as consumers/survivors.

The interviews were open-ended. A small number of probe questions were used to generate responses: 1.) Please tell me a little about your background and, in particular, your experiences with the mental health system. 2.) Have you ever experienced stigma? In what areas of your life? 3.) Do mental health services contribute to stigma? In what ways? 4.) What are the effects of stigma in your life?

All participants were very willing to be interviewed and most readily agreed to have their statements attributed to them in print*. Some participants even called a second time or sent articles, letters, and cassette tapes. A number of people noted that

no one had ever asked them about stigma. While some respondents initially found it difficult to articulate their thoughts, once they started talking about their experiences it was sometimes difficult to end the conversation.

A draft of the report was circulated to all respondents for comment and correction on quotes. It was also shared with the advisory committee for their review, which produced considerable changes. The final report was circulated in December of 1993, and has been broadly (although informally) circulated, used for training and presentations by a variety of people, and excerpted in various places.

Mental health practitioners interested in reducing stigma will be both heartened and challenged by the many possibilities for reducing stigma that are within their purview. This article will briefly describe some of the attitudes and practices of mental health services considered to be stigmatizing by respondents. It will then describe possible implications for practice.

The Dynamics of Stigmatization

Recent efforts to describe the dynamics of stigmatization suggest that it is a set of responses to what Coleman¹⁷ terms "the dilemma of difference." This dilemma can be stated as follows: It is a fact that all human beings differ from one another in a multitude of ways. Age, gender, skin color, intellectual and social characteristics are but a few of these differences. Although it is a fact of human existence that no two people are exactly alike, certain of these characteristics or attributes become defined as undesired differences or stigmas¹. Which differences become defined as undesired are, to a certain extent arbitrary. In other words, virtually any difference is potentially a stigma. The particular differences which become defined as undesired are highly

* Those who did not agree are identified as "a participant," or "anonymous."

dependent upon the social context. Coleman ¹⁷ and others ^{1,18,19,20,21} assert that stigmas reflect the value judgments of a dominant group, i.e., those possessing power within a given culture. In North America, such values reflect an emphasis on wealth, material prosperity, health and physical beauty, youth, competence, independence, productivity, and achievement ²¹. People not seen as reflecting such values are consequently stigmatized.

Ainlay and Crosby ¹⁸ write, "It is shared negative evaluations of human differences that are central to stigma. Individually held biases do not carry the weight of socially designated (hence shared) negative evaluations...societal devaluations are powerful because they cannot be dismissed as the ravings of some idiosyncratic bigot. Instead, they form part of a socially shared sense of 'reality.' This characteristic of devaluation is essential for one's very humanness to be questioned (by stigmatizer and stigmatized alike), and as such, these devaluations can be passed on to succeeding generations and woven into the institutional fabric of society" (p. 31).

Wolfensberger and Thomas ²⁰ assert that stigma is conveyed through the often unconscious process of image association. They state that the symbols and images historically associated with devalued persons are strongly negative and convey messages of illness and death, criminality, worthlessness, incapacity, and others. While these image associations are often made unconsciously, they "nevertheless strongly influence people's role expectancies and the social valuation of the persons so imaged" (p. 27). They describe six service elements ("media") through which images and other messages are conveyed to and about a person or group: physical environments; social contexts, including the people associated with or near a person or group; activities,

behaviors, uses of time and rhythms; language; personal presentation; and miscellaneous aspects (e.g., funding sources, laws and regulations).

The remainder of this paper will describe features of mental health programs considered to be stigmatizing by people with psychiatric disabilities and their families. These observations are remarkably consistent with the majority of service elements or “media” through which stigma is conveyed, as described by Wolfensberger & Thomas, and will thus be used to organize the findings in this article.

Practices of Mental Health Programs Found to be Stigmatizing Physical Environments

Very few respondents commented specifically on the physical environment as being stigmatizing. Where aspects of the environment were mentioned, it was usually as evidence of an attitude on the part of staff that was thought to be stigmatizing. For example, in talking about the status differences between staff and clients, some people commented on symbols or images within the physical environment which conveyed this message. One respondent said, "You're shit and I'm not. Why? Because I've got the keys." Other people commented on the presence of separate and more attractive accommodations, such as staff bathrooms and dining rooms, as symbolic of the difference in status.

A couple of people commented on the location of programs in poor neighborhoods or rundown environments as being reflective of the view that service recipients are considered to be second hand or second rate. One respondent observed that there were cues in the physical environment inherited from the asylum era. These cues included both service practices, such as locking up knives and padlocking

refrigerators or medication closets, as well as physical features, such as covered radiators, etc.

Social Contexts, Including Grouping with Other People and Programs

A number of respondents described the practice of separating people with psychiatric disabilities from ordinary community life as stigmatizing. Several people also commented on the practice of congregating or grouping people with similar labels. Carmen Meek described an event she had experienced as very stigmatizing when she was in a group living situation: "One day we were loaded in the van, they packed lunch for us, and carted us off to a movie. The social worker bought tickets for our group, handed them to the ticket taker and we all trailed in like some group of mental patients."

Another person, critiquing the practices of mental health centers with which he was familiar, said, "Mental health centers group people, isolate them, and set up an artificial pseudo-environment. They do things outside society, actively set up a segregated society. It is harder for people to improve their quality of life if they can't make it in the society where the rewards come from. Mental health centers reinforce the tendency for people to drop out, stay out, to disengage....The system turns people into monsters. Mental health centers are zoos in the community where mental monsters hang out all day."

Bill Butler referred to segregated housing as the "housing with meals mentality" and said, "segregated housing is the killer."

Activities, Behaviors, Uses of Time and Rhythms

This category of media was, by far, most often mentioned as stigmatizing. However, to merely term these as *activities* or *behaviors* is to minimize the emotional

content associated with them. Respondents clearly deciphered what they believed were underlying messages about people with psychiatric disabilities embedded in many service practices, even though the practices themselves were often informal or even unconscious. In order to accurately reflect participants' observations, this section will be divided into five sub-sections relating to the perceived messages communicated by certain activities, practices, or behaviors.

Power issues.

Program practices relating to power and control were most often mentioned as stigmatizing. Respondents observed that power and control permeated the practices of the mental health system. Ron Thompson considered involuntary treatment* to be the practice which "alone guarantees the existence and perpetuation of 'stigma'" (Personal communication, January 10, 1993). He said, "Anybody who advocates power over others - forced treatment - is for stigma and discrimination."

Comments from other respondents were consistent with this observation. A number of people indicated that the practice of "forced" anything - medication, treatment, hospitalization, activities - was particularly stigmatizing. One person said, "When there's no coercion, there's no stigma."

In addition to overt coercion, some people mentioned threats - of forced treatment, or no treatment - as a strategy to keep people in line. For example, one respondent, who was a voluntary inpatient in a psychiatric hospital, was told that involuntary procedures would be instituted if she left the hospital.

* "Involuntary treatment" can also be considered under the media of miscellaneous service practices since it is a law which spawns various service practices. For the sake of this article, however, it will be considered here.

Mentioned several times were issues relating to the "ownership" of a person's treatment plan. One person said, "They set a series of goals that the program devises for other people. If the person doesn't like the goals, or if they have goals of their own, they're called 'non-compliant,' or 'rebellious,' or 'unresponsive to treatment'."

Other people described the following practices of programs as stigmatizing: restrictions on freedom to come and go, being told when to do things, lack of choice about life decisions, being "placed" in a house or apartment, staff speaking for people served, having one's preferences, insights, self-knowledge and perspectives ignored. Bill Butler summed it up by saying, "You're not given a choice, you're given a sentence. You're placed in a house, you're placed in an apartment. If you don't have choices that are regular community choices, that is stigmatizing."

Status difference between staff and service users.

Respondents found the fact that people with psychiatric disabilities are perceived and treated as having lower status than staff within the mental health system to be very stigmatizing.

Many examples illustrated the ways in which interpersonal interactions and beliefs reinforced this difference. For example, David Hanlin told the following story: "I think it (stigma) is worse within the delivery system than it is in the public. For example, a friend went to a five day seminar on mental health issues. Three people stayed in a hotel room: my friend, a therapist, and a social worker. When they found out she was a consumer, they had her reassigned. They said, 'We're here to learn about mental illness, to get away. We don't want to be burdened down'" - not only implying that she

would be a burden, but also that they, the professionals, were “supposed to” care for her, even though they had no official role or responsibility in that regard.

Respondents gave examples of the status differential as it played out in therapeutic interactions. For example, interactions in which staff treated consumers as children were cited, as were the use of techniques one might employ with children.

Status differences embedded in program policies and procedures were also described. Stephen Holochuck described an experience where he phoned a mental health center to request a copy of their brochure. The receptionist asked, "Have you received services here?" He responded, "I don't care to answer. Why do you need to know?" The answer was, "Because if you're a professional, we'll mail it to you. If you're a consumer, you have to come in and pick it up."

Tokenism was also cited, on both an individual and an organizational level. Some people mentioned the experience of having their input solicited and then not used.

There were numerous examples of the status differential between people with psychiatric disabilities hired to work in mental health programs and other workers. Again, this was reflected in personal interactions, as well as embedded within program policy and practice. While a full elaboration of the numerous examples is not possible here, Pat Risser's anecdote captures the experience of many people. Pat, who worked as a consumer case management aide, said, "I was trained as a professional, I worked as a professional, but I was always one rung below on the ladder. We're held to higher standards." He also said, "We had a hard time transitioning into the role as a professional because we were excluded from the social activities of the 'normal' staff.

We were not treated as social equals. They would go out on Friday nights. When we were finally invited to join the others at their weekly TGIF outings, the barrier of stigma from our co-workers finally broke down, we did socialize when given the opportunity and proved ourselves to be equally, fully, human. There still remained huge differences in salary and economic status. There remains a long way to go to achieve 'equal pay for equal work.' But, breaking down the social barrier was certainly a step in the right direction."

Regimentation and deindividualization.

Some practices appear to merely contribute to the stigma that already exists. However, other practices not only perpetuate stigma, but they actively serve to strip a person of their nonstigmatized identity and replace it with the stigmatized identity of a "mental patient." Regimented and deindividualizing practices of both institutional and community programs are powerful examples. Herman ¹⁶ cites her own and other research^{1,22} on the prime source of stigma within the mental health system- -the institutional processing that is a dominant feature of mental hospitalization. Specifically, these include being brought to a hospital against one's will in an ambulance, being treated like an inanimate object, being subjected to an embarrassing physical examination, having one's possessions taken away, staff enforcement of rules and regulations, having intimate information about one's life gathered in the form of case histories (which are then available to all staff), and having enforced interactions with other patients. These processes "...serve to strip the individuals of their prior non-deviant self-conceptions. In its place, the institution offers such persons an alternative

conception of self as 'mental patient' -- a deviant identity and status which the persons gradually begin to accept" (Herman, p. 171).

Respondents in this study gave examples of their experience of regimentation and deindividualization within programs, both institution and community. Specifically, they cited the following:

- Dehumanizing admitting procedures - "During my first hospitalization...the first time I was medicated it was very mortifying. They said I could take it by mouth or injection. I refused, they grabbed me and held me down and injected...Then they took my clothes away. I do not minimize the impact of taking my clothes away. I never got them back. I still remember those - a yellow shirt with green stripes and green pants...During the first month they didn't allow family, friends and my outpatient psychiatrist...they cut my hair." (Dan Fisher).
- Regimented activities - One respondent described a community day treatment program in which he participated where consumers were not allowed to use the bathroom during the entire hour of "group." Other respondents described having to take part in activities (arts and crafts, group therapy) whether they wanted to or not, at fixed times.
- Having to wait for appointments - One respondent commented on the practice of making people wait for appointments or scheduling appointments during the day as if people had nothing better to do. While one interpretation of this phenomena might be that highly valued professionals routinely overbook their appointments, it has a more

insidious function of reinforcing messages about consumers that are a consistent theme throughout the entire system - messages that people are not important, are certainly less important than staff, and that their lives are meaningless.

- Being forced to accept a psychiatric diagnosis - "When you go into a psych setting, they get you to admit you're mentally ill and if you don't, they say it's a symptom of your illness. They make you helpless, they break you down. If you're strong and fight back, they'll crush you with drugs and shock treatment and cause further brain damage"

(Anonymous).

Non-developmental approach.

The absence of challenge or orientation to personal development within the mental health system was also commonly described as stigmatizing. Respondents commented on this feature in the system at large, as well as within programs and individual staff interactions. One respondent said, "There has been, for most of my experience with private and public psychiatry, no rehabilitative approach. I was expected to amount to no more than a clerk even though I have a PhD." Several people commented on the underlying beliefs about people with psychiatric disabilities which they felt contributed to a non-developmental approach. For example, Janet Foner felt that the belief in mental illness as a permanent, chronic, and deteriorating condition was a major factor. Carmen Meek said, "The system reminds you of what you can't do: how disabled you are, how ill you are. It doesn't focus on wellness, capability, potential of people."

When describing specific program practices, people often referred to their experiences in psychiatric hospitals and in day or vocational programs. Several people mentioned the types of activities they found stigmatizing: arts and crafts, children's games, and practice with activities of daily living (ADL) instead of developing work and social skills. For example, one person said, "The activities in mental health centers were no more than baby sitting - arts and crafts, ADL skills. They were not empowering, a waste of time. They should have vocational services during the day and building socialization skills for after hours." Pat Risser, who referred to rehabilitation programs which placed people in menial jobs as "food or filth," said, "People are plugged into one or a few slots. They don't really train people to do what they want to do, or find what their potential is." He went on to say, "I went through a severe depression, was in a lot of pain. I said I wanted to do something with my life. Instead of sending me to school as a paralegal, they sent me to a sheltered workshop. I was standing next to someone who was severely retarded and we were counting fish hooks. I was class president in college, I was a law school drop out. If I wasn't depressed going in, that sure did it. I thought, 'God, have I sunk that low? Is this what everybody thinks?'"

Other respondents described interactions with staff that reinforced low expectations and the view of people as having limited potential. One person said, "One case manager spent most of our time together convincing me that I should accept my devalued status and that I should accept part-time janitorial work as a future...accept my disabled and unabledness." This same person is now working full-time in mental health administration at a state level.

"Life in a fishbowl".

The lack of respect for privacy was seen as stigmatizing by a number of respondents. In fact, more than once, people referred to this experience as "life in a fishbowl." This sense of always being observed was mentioned by several different people.

Combined with the experience of always being observed by staff was the sense that one's behavior was "overinterpreted" - in other words, that any normal feelings or behavior were interpreted as pathology or symptoms of one's illness. Pam Goodman, director of a state-wide advocacy organization, said, "Once I took this job, I experienced a lot of stigma. It was a token organization, barely funded. I started attending meetings. I was discounted, condescended to, treated as a consumer. People talked down to me. I served on a committee which had to do with evaluation and measurement. I have a PhD in that field. I was putting out state-of-the-art ideas but I must have gotten too enthusiastic. I actually got patted down."

Amy, who coined the term "overinterpreted behavior," described her experience during a hospitalization. She related that during her time in the hospital, she chose to be very quiet ("I didn't trust them. I wasn't going to tell them life's deepest secrets because I didn't know how it would be twisted, used against me.") However, she was much more animated when she made phone calls to her friends and family. Consequently, in her case record was written: "Question manipulative affect. Brighter when on phone."

Other examples:

Regarding people who spoke up for themselves: "Maybe we should increase your medications."

Regarding someone who was very tired: "Are you sure you're not toxic on Lithium?"

One consequence of this was the stifling of ordinary emotions. Janice Herring said, "'Calm down, calm down': When I get mad my contributions aren't taken seriously." Carmen Meek, in speaking about her personal relationships, reported, "If you get angry, irritated, have feelings, there's a question of 'Did you take your pill?' You're not allowed to express your feelings, or to have normal human reactions."

Language and labels.

Respondents' comments about language and labeling fell into seven categories:

1. Objections to language separating the phenomena of stigma from the larger dynamics of oppression: Some respondents were adamant about using words such as "prejudice," "oppression" or "discrimination" to describe the phenomena being addressed, rather than using the word "stigma." Judi Chamberlin said, "Even the word 'stigma' is a bad word. The concept of stigma, itself, implies that there's something wrong and we have to hide. We need to talk about discrimination and prejudice. It's a civil rights protection problem."
2. Objections to offensive slang: Words such as "twisted," "nut," "cripple," "moron" were seen as stigmatizing.
3. Objections to patronizing or condescending language: Some people commented on the practice of referring to people as "our" mentally ill or "the" mentally ill.

Other people talked about patronizing tones of voices, or those which might be used in talking to children.

4. Objections to euphemistic language: One person said, "Psycho-babble like 'We're waiting for the therapeutic effect' bothers me." Another person felt the word 'consumer' was euphemistic: "They changed the language, but they didn't change the practice. It's a lie. There's no market research, the products aren't changed."
5. Objections to language with a medical orientation: Words such as "patients," "mental illness," "sick," were seen as stigmatizing by some respondents, along with the "language regarding symptomology that makes it sound like people have mold growing out of their ears," as one person said. "Decompensating" is one example.
6. Objections to language with the implicit assumption of the power to judge: Terms such as "treatment resistant," "high or low functioning," "non-compliant," "rebellious," "unresponsive to treatment," and similar terms, which tended to pass judgment, were considered stigmatizing by a number of people.
7. Objections to dehumanizing language: Very few people commented specifically on the use of dehumanizing language. One respondent said he felt the term "placing people" was stigmatizing people because it was as if the people were rocks - inanimate objects.

Personal presentation.

A small number of people mentioned various personal characteristics of service recipients which were stigmatizing. For instance, one person commented that effects of

drugs cause funny movements which draw undue attention to the person. Another person wrote, "Treatment with drugs often makes invisible suffering visible."

A couple of people referred to the clothing and behavior of consumers ("For four and a half years I was institutionalized, right down to the clothes I wore. It set me apart.") Although program staff may not be directly responsible for causing these stigmatizing aspects of a person's identity, they do have a responsibility to support individuals who wish to address them. In addition, staff have the responsibility to offer feedback to people when aspects of their behavior and/or appearance get in the way of achieving other goals they may have, such as employment, personal relationships, being accepted in the community, etc.

Implications for Practice: Organizing a Response

Given the myriad of practices felt to be stigmatizing by service users, it is no wonder current efforts to "stamp out stigma" are inadequate. Even addressing one aspect is likely to require long term, significant effort and link with other areas which must also be addressed.

While many possibilities for change are suggested by this project--perhaps too many--the first challenge is to organize a response which is likely to lead to some success, and which in turn can suggest other actions to be taken. Otherwise, even those who agree with the descriptions of stigmatizing practices are likely to become overwhelmed. Below are some suggestions for first steps, which in turn will help point out additional actions which can be initiated by service providers and consumers/survivors:

Consciousness-raising on the part of service providers about what contributes to stigma and what its effects can be is a fundamental element of the “destigmatization process.” This will require honest dialogue with consumers/survivors and a willingness to take their perspective seriously, even if it is not the only perspective considered.

Conducting a Stigma Inventory, a process which systematically examines service practices for elements which promote or reinforce stigma (even if unconsciously) can be an important first step in formulating a strategy for change. Such an effort would be most beneficial if it included both staff and consumer/survivors. It could be carried out as either an internal or an external assessment, depending on circumstances within the organization. See Table 1 for sample questions.

Consciousness-raising on the part of consumers/survivors is another important step in the destigmatization process. Respondents interviewed for the study recommended self help and peer support as a response to stigma. In fact, Judi Chamberlin attributed her minimal experience with stigma to being open about her identity and active in the movement. She said, "My experience has been pretty unusual because I've been so open about it. I got to write a book, travel and speak. Why was my experience different? Being part of a movement, part of a group...seeing it as a rights issue from the very beginning."

As part of the consciousness-raising effort, it is important to fully recognize the powerful effects of stigma. Respondents described these and other effects: Lowered self-esteem; anger; depression; sense of heightened vulnerability; a mindset of degradation; stifling of growth, productivity and initiative; social isolation; and “social death.” Although services are not the only sources of stigmatizing experiences

contributing to the above effects, respondents did consider services to be a primary source of stigma. Interventions aimed at diminishing stigmatizing practices could actually reduce some of the “symptoms” (e.g., depression, anger, lack of motivation or initiative) often attributed to the psychiatric disability itself.

The perceptions of consumers/survivors regarding what is stigmatizing within the services they receive must be taken seriously even if such practices are never seen by the “general public.” There are powerful effects on the individuals themselves (and on staff) which create a feedback loop or a self-fulfilling prophesy. For example, if various practices convey low expectations about service recipients, as some respondents reported, those expectations will be internalized by the individuals and are likely to influence how they view themselves and how they behave. They are also likely to influence the attitudes of staff and thus their behavior toward people receiving services.

Develop a Systematic Strategy for Reducing Stigmatizing Program Practices: Stigma is initiated and maintained on a number of levels: Intrapersonal, interpersonal, organizational, and systemic. There are stigmatizing aspects woven into the entire mental health system, its ideology and practice. Some of these aspects also have legitimate functions, others did once. Even the most zealous change agents will quickly become overwhelmed at how deeply embedded stigmatizing attitudes and practice are and may be tempted to give up, or may alienate themselves from others to the point of ineffectiveness. It is important to adopt a long term perspective and approach the destigmatization process thoughtfully and systematically.

Because many respondents in this study indicated that the interpersonal aspects of stigma were the most personally damaging, especially those related to the status

difference between staff and consumer and those having to do with power and control, it might be fruitful to begin by finding ways of reducing stigma in those areas. Some specific suggestions made by respondents included:

Building rapport with people served: Having relationships based on trust and responsiveness were mentioned by a number of people as effective responses to stigma. Feeling "heard" by staff was an important experience to people. Some participants suggested giving people more chances to talk, and focusing on building rapport with a single person rather than feeling like one had to treat all people served identically. Also mentioned was one of the most basic strategies to respond to stigma: Treat people as human beings.

While these recommendations contribute to valuing the person and treating them with respect and dignity, they do not address the social control aspect of stigma since it is possible to treat one's subordinates with respect and dignity. In fact, as Supeene²³ writes, people who are treated with dignity while remaining in a subordinate position can experience great conflict: "The conflict lay between the staff's friendliness on the one hand, and their authority on the other. Because they could be supportive listeners I felt respected and cared for. But they were also the 'experts' and they were in authority; therefore they had the final say on what my problems really were and what would be done about them, so I felt diminished and helpless" (p.34).

Cultivate a sense of mutuality: Some people recommended that staff share their own challenges and difficulties in order to relate to people on a more equal level.

More choices, more control: Providing opportunities to have more control over one's life was a commonly mentioned way of reducing stigma. Respondents recommended that

this be adopted in a number of ways, including attitudes and roles of staff, more choice and control for consumers within existing programs, and fundamental change that focused on eliminating coercive treatment.

In terms of attitudes and roles of staff, one respondent recommended that providers ask service recipients, "How can I help?" People suggested that consumers be assisted to play a greater part in determining their own services and staff see themselves as consultants to that process.

In terms of greater control within existing programs, a number of recommendations were made. Specific areas included trusting people to take their own medication, affording opportunities to establish a schedule that fits one's own life, and providing more choices in activities. In addition, consumer perspectives on case notes and reports were mentioned. At the systemic level, consumer participation in individual, program, and system decisions was recommended as an antidote to stigma.

More fundamentally, some participants advocated the elimination of coercion within mental health services as a way of eliminating stigma. One participant said, "No coercion = no stigma." Ron Thompson, who believes that "forced treatment" is a contradiction in terms, recommended that the two be separated conceptually. He said, "...two things are tied together that shouldn't: force - involuntarism - and the practice of medicine...When I say I'm against forced treatment, people hear me saying two things I didn't say: (That) I'm against treatment and (that) I'm against coercion."

Conclusion

While we are unlikely to eradicate stigma completely--within the mental health system or the wider society--there is a great deal that can be done to create services

and supports which help in the recovery process and minimally contribute to stigma. The first step, however, is to recognize the ways in which services have contributed to stigma, albeit inadvertently, and then to acknowledge the damaging effects of those practices on service recipients. Rather than focus energy on addressing stigma in the general public, mental health practitioners could make significant strides in the elimination of stigma by concentrating on “getting our own house in order.” Judging from the stories of people interviewed for this study, that effort alone would pay off enormously.

Table 1: Sample Questions for a Stigma Inventory

Physical Environments	<ul style="list-style-type: none"> • Are there symbols or images in the environment which communicate status differences between people served and staff? What are they? What is their purpose? • Are there features that reinforce the perception of service users as dangerous, childlike, animal-like, needing protection, brutish, physical unwell, etc.? • Is the environment attractive, well maintained? Is it a desirable place to be? Would I choose to spend time there? 	
Social Contexts	<ul style="list-style-type: none"> • Are service users separated from ordinary community life? How much support is available to people to participate actively in community life? • Are people congregated together (esp. involuntarily)? • Do people do activities in groups? 	
Activities, Behaviors, Uses of Time	Power	<ul style="list-style-type: none"> • To what extent is involuntary treatment a part of the program? • Is there coercion (overt or covert) occurring? • Are threats (unconscious or conscious) used to “keep people in line”? • To what extent do consumers feel ownership of treatment plans? • In what areas do consumers have real choice, decision-making opportunities? Where are there restrictions? Why?
	Status Difference	<ul style="list-style-type: none"> • Are staff & consumers treated differently? In what ways? (Look at interactions, program policies, procedures, systemic) • Are expatient staff treated differently than other staff? In what ways? What are the reasons?
	Regimentation	<ul style="list-style-type: none"> • Are there dehumanizing or unnecessarily regimented practices? • Would it be possible to personalize program practices to a greater extent?
	Developmental Orientation	<ul style="list-style-type: none"> • Do programs promote growth & development? • What underlying beliefs exist about the developmental possibilities of people served?
	Privacy	<ul style="list-style-type: none"> • How attentive is the program to consumers’ privacy? • To what extent is the behavior of consumers attributed solely to their disability?
Language	<ul style="list-style-type: none"> • What language is used to describe people & programs which might be stigmatizing? • Are there alternate forms of language or labels? • What do people themselves prefer? 	
Personal Presentation	<ul style="list-style-type: none"> • To what degree does the program support individuals who wish to pay attention to behavior or personal appearance which might be stigmatizing? 	

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