McLaughlin, Kenneth (2020) Stigmas Old and New: The changing nature of stigma in the twenty-first century. In: The Routledge International Handbook of Global Therapeutic Cultures. Routledge. ISBN 9780367110925

Publisher: Routledge

Version: Accepted Version

Stigmas Old and New: The changing nature of stigma in the twenty-first century

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Introduction

Since Goffman popularised the term, the concept of stigma and the negative effects it can produce has been subject to much debate within a variety of academic, activist and governmental fields. It permeates, in various guises or modifications, social policy, claims for social justice and the therapeutic management of social interaction.

In this chapter I discuss the concept of stigma in relation to various theoretical interpretations as Goffman's work has been critiqued and advanced in the years since the publication of his classic work *Stigma: Notes on the Management of Spoiled Identity* (Goffman, 1963). I also give consideration to the way activists, campaign groups and individuals have attempted to combat both the causes and effects of stigma. In doing so I wish to highlight the changing forms of personal and political uses and challenges to stigma by consideration of the expansion of the term and its use as a claims-making trope within contemporary political life.

As we shall see a therapeutic sensibility permeates the discourse around stigma today, a sensibility that crosses the political spectrum to a significant degree, to such an extent that often there are many shared assumptions about the fragility and political impotence of both the stigmatised and those who do the stigmatising.

Whilst the focus is on the UK context, stigma is a global issue, although the processes and forms of stigmatisation can be culturally specific. Nevertheless, my intention is to highlight theoretical and real world examples of stigmatisation that, although culturally specific, will allow international readers to consider the extent to which similar processes are at work in their geographical area.

Conceptualising Stigma

Goffman defined stigma as ‘the situation of the individual who is disqualified from full social acceptance’ (1963, p.9) The term originates from the Greeks were it referred to bodily signifiers designed to expose the flawed moral status of the signified. They were largely marked upon the body, such signs being cut or burnt into the flesh and served to advertise ‘that the bearer was a slave, a criminal, or a traitor – a blemished person, ritually polluted, to be avoided, especially in public spaces (Goffman, 1963, p.1). In Christian times stigma, or stigmata, could represent bodily signs of grace or divinity marked by eruptions of the skin. Today, it is the Greek view that holds common currency, stigma being a sign of a flawed moral status rather than a divine one.

Historically, stigma can not only lead to a loss of social standing but also to the loss of social rights and social existence. For example, the Romans denied social rights to those who were born unable to hear or speak. They were forbidden to marry and had state guardians appointed to them (Meadow, 1969). In more recent times, the mentally ill have been likened to animals. The belief that they were less than human meant that they could be treated as such:

> They are dirty, and so there are mass cleaning facilities. They are like animals, so they have to be “kept” in asylums designed for supervision. They have no aesthetic sense, so the institutions are drab. Their inability to learn means they are not allowed privacy, property, communication, relationships with each other, or individuality.
>
> (quoted in Spicker, 1984, p.161)

Whilst such views surrounding mental disorder are not so pronounced today in a time of increased awareness, sympathy and care for some groups, others can be cast as social pariahs outwith polite society, e.g. asylum seekers, ‘chavs’ and gypsies (Tyler, 2013).

For Goffman (1963) ‘stigma involves not so much a set of concrete individuals who can be separated into two piles, the stigmatized and the normal, it is rather a pervasive two-role social process in which every individual participates in both roles, at least in some connections and in some phases of life’ (pp.163-164). Of importance is that whilst stigma refers to a deeply discrediting attribute it needs to be seen as ‘a language of relationships, not attributes’ (ibid. p.3). The same behaviour can be seen as carrying no shame for one person but be something another wants to hide. This need not necessarily relate to large-scale examples of discrimination and social oppression, it can also involve relatively trivial interactions. For example, Goffman gives the example of a middle-class boy feeling no compunction in going to the library, but then quotes a professional criminal who on entering his local library would check over his shoulder to ensure no one he knew was watching.

Thornicroft et al. (2007) view stigma as referring to problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination), whilst Scrambler (2018) argues for a distinction between stigma (an ‘ontological deficit’ associated with shame) and deviance (a ‘moral deficit’ associated with blame). Link and Phelan (2001) define stigma as something that ‘exists when elements of labeling, stereotyping, separating, status loss and discrediting occur in a power situation that allows these processes to occur (p. 382). Of importance from their perspective is access to social, economic and political power.

One criticism of Link and Phelan, and indeed of many conceptualisations of stigma, is that unlike Goffman himself, they fail directly to link stigma with shame. This was Scheff’s (2014) concern, who argues that such conceptualisations ‘confound stigma and the process of stigmatization’, although he does concede that ‘status loss’ could be seen as ‘a roundabout way of referring to shame’ (p.724). This failure to discuss shame in relation to stigma is problematic for Scheff, as the two are closely entwined (indeed Scheff argues that stigma can be defined as shame). For him, discussing it more openly would not only allow researchers of both terms to learn from each other, it would also 'stop reinforcing the taboo on shame' p.725).

Perhaps in acknowledgement of such complexities, Rogers and Pilgrim (2014) suggest that multiple theorising may be necessary in order to understand the complexities of stigma such as labelling theory, social network theory, the social psychology of prejudice and discrimination, and theories of the welfare state. Interestingly, in the earlier second edition of their book, published in 1999, there is no section on stigma indicating that current sociological and psychological interest in it has risen in the intervening years.

Stigma and the process of stigmatization therefore involves a narrative of social relations: an attribute that shames bearers at one spatio-temporal juncture can pass them by at another. In other words the types of behaviours and/or markers that connote a discredited moral status can, and do, change both culturally and historically. Homosexuality is a powerful example of the importance of the cultural and historical context in which stigma is identified and experienced. Its legality and social acceptance varies enormously, being legal and celebrated in many countries in the current period, being highly socially discreditable and criminalised in others, with some seeing it as an attribute punishable by death. Its current acceptance in many countries is also relatively recent, in the UK for example it was only decriminalised in 1967.

Goffman (1963) made a conceptual distinction between people who are 'discredited' and 'discreditable', the former being conspicuous, the latter, whilst often able to be hidden, risks being exposed at any time, for example being homosexual, an ex-psychiatric patient or having a hidden disability. Strategies to avoid public opprobrium are seen as ways of 'passing'

Goffman has been criticised for implying that stigma is a personal flaw that focuses too much attention on the stigmatised and not on the people and/or processes that lead to them being stigmatised in the first place. Scrambler (2016) points out that one consequence of the early labelling theorists' focus on 'labellers', translated into an intensive medical sociological interest in 'labellees'. This more micro analysis of the stigmatising process all too often downplayed wider issues such as the way the political economy and vested interests, such as those behind medicine's construction and application of diagnostic labels in how we view mental and physical disability. This then led to researchers switching 'their attention to the "personal tragedies" such labels occasioned….The labellee thus becomes a victim with a personal tragedy to resolve' (online).

For Chamberlin, a mental health user/survivor activist the term stigma is itself stigmatising as it locates the problem with the individual (quoted in Sayce, 2000. P.15). In relation to physical disability, Oliver (1990) argues stigma is not a useful concept due to its inability to 'throw off the shackles of the individualistic approach with its focus on the discredited and the discreditable' (p.14). This is a common criticism of Goffman's work in that his focus was on the microlevel of interpersonal relationships, of how people were perceived by others and themselves rather than any wider socio-political structural analysis. Similarly, Link and Phelan (2001) draw on disability and sociological studies to define stigma as 'the co-occurrence of its components – labelling, stereotyping, separation, status loss, and discrimination' (p.36). Of importance is that for stigmatization to occur 'power must be exercised'. In this respect stigma 'is entirely dependent on social, economic and political power – it takes power to stigmatize' (ibid.). Discrimination therefore does not simply refer to interpersonal prejudice, to the mistreatment of one person by another on account of a stigmatised trait, but rather to structural or institutional discrimination that constitutes a disabling environment.

Stigma can also be experienced by virtue of social connection to a stigmatized person, what Goffman (1963) refers to as a 'courtesy stigma'. It was this form of stigma that made some physical disability activists reluctant to join together with those with mental health problems arguing that an association with the ‘irrational’ would undermine their campaign to be seen as rational subjects able to take control of their lives (Sayce, 2000).

If it takes power to stigmatise this does not mean that the stigmatised are powerless victims of social opprobrium. On the contrary, stigmatised and marginalised groups have a long history of fighting back against their treatment. Revolutions, civil unrest, mass protests, political lobbying, mobilisations, consciousness-raising etc. attest to the possibility of such groups challenging the status quo and at times instigating a change in social relations and attitudes.

Stigma as governmentality

Stigma and the processes by which some people and/or behaviours are stigmatised and others are not is not arbitrary. If it takes power to stigmatise then it should be no surprise that stigma can work in the interests of the most powerful in society. Tyler (2017) sees the profound changes to society resulting from the impact of neoliberalism as being ‘fuelled by the crafting of stigma, violence and hatred from above’ (online). She draws on the work of Georges Bataille to give an extreme example of how it can work to exclude people from mainstream society by portraying them as moral outcasts, on the margins and viewed from the ‘outside with disgust as the dregs of the people, populace and gutter’ (quoted in Tyler, 2017, online). Writing in the year following the Nazi Party’s election to power in Germany, Bataille was witness to the way such representation cast the recipients as subhuman, as vermin responsible for infecting the health of the nation and who therefore required extermination.

In her book *Revolting Subjects* Tyler (2013) uses the concept of social abjection to examine the workings of neoliberal forms of government in contemporary Britain. However, she does not portray such ‘social abjects’ as mere victims of an all-powerful neoliberal system. On the contrary she also shows how ‘abject populations’ can revolt against their treatment (for example on the protests of migrants in detention centres and facing deportation, and the riots in England in the summer of 2011 the participants of which were mostly, but not exclusively, young people). The latter example is debateable, given the lack of political direction of the rioters, nevertheless, Tyler’s aim was ‘to elaborate an account of social abjection as a vital technology of state power, detailing the forms of revolt that being treated “with disgust as the dregs of the people” gives rise to’ (Tyler, 2017, online).

Such political uses of stigma, what Scrambler (2018) calls the ‘weaponisation of stigma’ is a political strategy ‘of “heaping blame on shame”, or rendering people personally responsible for their “problems”, whatever form these might take (impoverishment, homelessness, disability and so on). Stigma weaponised in such a fashion opens the way for governments to abandon any collective responsibility for helping them, cutting benefits and so on’ (online).

The production of scapegoats to further a capitalist, or indeed any ideological or economic system, is nothing new. However, for Tyler (2013) what is new ‘are the ways in which the language of democracy, fairness and equality is invoked to *justify* the channelling of public hostilities towards vulnerable and/or disadvantaged populations’ (p.212, emphasis in original). She highlights the relationship between the governmental exercise of abjection, the forms abjection takes in different historical periods, and the changing social and economic imperatives of different systems of capitalism. This historical materialist approach allows her to show the way both the ‘abject’ and forms of abjection have changed over time.

It would be a mistake to view stigma as solely a *product* of neoliberal policies that marginalise specific groups such as asylum seekers and the unemployed, on the contrary they are *a pivotal part of neoliberal governmentality* (Waquant, 2010). As such the process of stigmatisation ‘operates as a form of governance which legitimizes the reproduction and entrenchment of inequalities and injustices which impact us all’ (Tyler, 2013, p.212). It is a process that sees the expulsion of the urban poor to the margins of society.

The process of governmentality does not simply lead to increased governance of the stigmatised and marginalised groups. The promotion of scare stories, of the threat such groups pose to society generates the desire for protection and/or a return to an idealised version of social life. Of course, the direct impact falls on those whom Tyler (2013) labels ‘social abjects’ but they also become ‘ideological conductors mobilized to do the dirty work of neoliberal governmentality’ (p.9). In other words, they become scapegoats that enable the structures of power to function. They are transformed into symbolic and material scapegoats for the social decomposition effected by market deregulation that has a negative, degrading impact upon us all (Tyler, 2013, p.211).

If stigma can be used as a form of maintaining consensus by labelling certain bodies and ways of thinking as a threat to the social fabric, and if such objects and the processes that stigmatises them change over time and are subject to the workings of power, then it is imperative to see how they operate in the contemporary socio-political field. As we will see, the stigma attached to the working classes still exists. However, whilst the more overt forms of prejudice tend to be frowned upon (in public at least), there remains a hostility towards them which often emanates from those who purport to challenge their demonization in other areas. In other words, whilst they highlight many prejudices they simultaneously betray their own. First, we take a brief look at some of the forms that challenges to stigma have taken, with a specific focus on mental health.

Challenging Stigma

There have been many challenges by stigmatised groups to their discredited social status for example around inter alia class, gender, race, sexuality and disability, with more latterly increased attention given to the intersectionality of such identities (Crenshaw, 1993; Nayak, 2014). Given this special edition is around the rise of a therapeutic sensibility I wish to focus on challenges to the stigmatisation of those deemed ‘mentallly ill’ where four key perspectives have been identified: the brain disease model; libertarian model; individual growth model; and the disability inclusion model (Sayce, 2000). In discussing these models I wish to pay particular attention to the individual growth model as it has arguably had the most influence on contemporary politics.

The brain disease model sees no fundamental difference between a diseased brain and any other diseased organ of the body. In this sense it removes any moral taint from the individual, it is not of their doing. Not only is the individual absolved of blame but the wider social system (such as the family, environmental issues, poverty, abuse, unemployment etc.) are downplayed or dismissed. The problem of course is that whilst there are organic brain diseases (for example dementia) the functional mental illnesses such as schizophrenia, mania and depression, lack any such scientific validity, being dismissed by critics such as no more than names we have given to a constellation of symptoms/behaviours. The ‘brain disease therefore no fault’ argument also comes at great cost to civil liberties. If the individual cannot help it, if they are not responsible for their actions, then this lack of moral autonomy legitimises both paternalistic and coercive interventions into their lives. If they cannot control themselves then some other source of control must be utilised.

At the other extreme from the brain disease model lies the libertarian model. If the brain disease model can be summed up as one of ‘no responsibility therefore no (or restricted) civil rights', the hard libertarian stance is one of 'full responsibility therefore full citizenship'. For these campaigners, involuntary hospital detention and forced treatment is the most blatant form of discrimination they face; they are being detained on the basis of their thoughts and/or on a risk assessment by professionals that concludes they may harm themselves or others in the future. Most of us lose our liberty based on what we do, not what others think we will do. These campaigners are requesting the same civil and legal rights that we take for granted. The flip side of course is that with full rights comes full responsibility; mitigation for a crime due to diminished responsibility is not an option within this framework. From this perspective the insanity defence should be abolished. As one activist put it: 'sure, this may mean that the handful of people who escape execution by NGRI (not guilty by reason of insanity) will die [that is through execution], but what about the many more who die in restraints and seclusion rooms, or of iatrogenically induced drug effects?' (quoted in Sayce, 2000, p.118).

The 'individual growth' model works on the basis that there is no strict dividing line between mental health and mental illness. We are all placed somewhere on the continuum and we will all, at some point, move along it, for better or worse, in one direction or another as we experience the pleasure and pain of the human condition, therefore, to classify some people as mentally ill sets up an 'us and them' situation, with 'them' being stigmatised and oppressed. This, so the argument goes, will reduce stigma as people realise that we all have emotional problems and we can all embark on a journey of personal growth. If the two paradigms discussed above are minority positions the continuum model is proving extremely popular not only within the disciplines of counselling and therapy but within wider society.

It is easy to understand where those who promote the continuum thesis are coming from, the classification and diagnosis of aspects of human experience as mental disorders is far from an exact science, and the medicalisation of distress is a relatively recent historical phenomenon. For radical critics such as Thomas Szasz, a psychiatrist himself, the very concept of mental illness is a myth, one that is used to control people who exhibit behaviours that we as a society cannot understand or tolerate. The mind, like the economy, can only be sick in a metaphorical, not literal, sense (Szasz, 1961). Mental illnesses, from this perspective, do not exist as discrete entities but are created by the psychiatric profession. Whereas you have a disease such as cancer irrespective of whether or not a doctor has diagnosed it, you do not have schizophrenia unless the psychiatrist says so. In effect, the psychiatrist creates illness by naming it. Whilst such insights are extremely useful and serve to make us aware of the dangers of medicalising human experience, there is also the danger that it fails to acknowledge the very real pain and distress that people are suffering.

However, as seductive as the individual growth model is it is not without its problems. First, the continuum argument may be valid in the sense that all mental experiences involve the emotions and also that there is no rigid, ahistorical or apolitical dividing line between what gets classed as normal or abnormal; yesterday's naughty child is today's ADHD sufferer, the shy adult now has 'avoidant personality disorder'. However, to conflate all emotional states as belonging on the same continuum, for example severe depression with life's ups and downs, is as absurd as conflating a child's sand pit with the Sahara desert; both may contain sand, but that is where the similarity ends. There may be a financial continuum between poverty and wealth, we are all somewhere along the line, but how that helps the poor is not at all clear. In a culture in which a therapeutic sensibility is increasingly common, the tendency is to pathologise more and more of the continuum (Lane, 2007).

The continuum advocates' main strength is the way in which they highlight the historical construction of contemporary psychiatric theory, diagnosis and practice, including the role of politics and social change in our understanding of the causes of, and attempts to alleviate, mental distress. However, their main weakness is a failure fully to appreciate the impact of such factors on the current mental-health debate. If the traditional concept of mental illness arose due to the interplay of wider social phenomena, so too did the current trend to view us all as on a continuum and in need of therapeutic help to maintain our equilibrium. Today, the tendency is to view us all, to a greater or lesser degree, as mentally ill, as weak and irrational subjects in need of control and guidance by government and an assorted array of therapeutic professionals. Even organisations that would in the past have emphasised the collective strength of their members, such as trade unions, are now more likely to make demands on the basis of the individual vulnerability of workers (Wainwright and Calnan, 2002).

Sayce's fourth paradigm and the one she favours is the 'disability inclusion model' the aim of which is 'to dismantle the discrimination faced by people because they have a diagnosis or record of mental illness, and to open up new opportunities. It does not matter where the discrimination occurs: in the legal system, the hospital ward, the boss's office or the TV studio' (p.129). She sees this as more progressive and empowering than both the brain disease and individual growth models which tend to focus on making it easier for people to receive help, 'the paternalistic notion that all disabled people need is "services" to "help" them has to be replaced by a broader view of people's aspirations and potential' (p.129). Whilst having much to recommend it, the broader therapeutic/continuum culture is often dismissive of people's aspirations and potential. As we will see below, challenges to representations often start from the position of vulnerability to hurt and emotional fragility.

Challenging Representation: Halloween Madness

The disability inclusion model can be seen at work in efforts to combat the way mental 'illness ' is portrayed within wider society, often around the use of language, imagery and other 'anti-stigma' campaigns. This is not to say that there is always a consensus in how groups should be addressed and/or portrayed, views over what is the correct terminology can be heated. For some, progress will be made if a ‘softer label’ is used. This was the rationale behind the New York League for the Hard of Hearing who dropped the label ‘Deaf’ and substituted terms such as ‘hard of hearing, impaired hearing, and hearing loss’ in the hope that the new vocabulary would permeate public discourse, a strategy that achieved some success (Goffman, 1963). For others, the stigmatised label, far from being excised is embraced, so for many Deaf people (with a capital D) deafness is seen not as something to be ashamed of, or even as a disability but as a marker of a cultural and linguistic minority (Jankowski, 1997). For the latter group, the term ‘Deaf’ is to be emphasised, not excised, from public discourse. However, in terms of the dominance of a therapeutic sensibility, the focus on representation is most instructive. Often, these take the form of challenging what are perceived as derogatory language or some other form of negative portrayal. I wish to illustrate this with reference to a recent event in the UK that generated a lot of media attention at the time.[i]

In 2013 the UK supermarket chains Asda and Tesco found themselves subject to much criticism following advertisements on their websites offering Halloween costumes for sale. In the case of Asda, buyers were offered a horror mask, fake blood on clothing and a plastic meat cleaver, accompanied by a photograph to illustrate the product. It was described as a ‘zombie fancy dress costume’ on the internet link to the webpage. If that description had been kept perhaps few people would have heard of it, except for some children who would have bought one and had some fun scaring their friends on Halloween. However, once the page was accessed the ‘zombie’ had become a ‘mental patient’, with the product details reading: ‘Everyone will be running away from you in fear in this mental patient fancy dress costume…. it’s a terrifying Halloween option’. Tesco offered an orange boiler suit emblazoned on the back with ‘Psycho ward’, with a plastic jaw restraint and the chance to buy a machete to ‘complete the look’ (quoted in McLaughlin, 2013, online).

Both stores came under attack from many campaigners who used social media to accuse them of promoting unhelpful stereotypes around mental illness and dangerousness, in the process increasing the stigma and fear that can blight the lives of many people suffering from mental-health problems. Those voicing their outrage included some high-profile sufferers of mental ill-health. Alastair Campbell, the former New Labour director of communications, who has written about his mental problems, tweeted: ‘Look what Asda’s selling… what possesses these people?’ Stan Collymore, a former footballer who has had several episodes of depression, also criticised the use of such a ‘stereotype’, tweeting: ‘Do you actually realise how many people are hanging themselves because of being frightened of the stigma?’ (ibid).

Mental-health charities also joined the criticism. Rethink, for example, tweeted that it was ‘stunned’, while Sue Baker of Mind told BBC Radio 5 that the worst thing about the costume was that it reinforced outdated stigma-causing stereotypes about people with mental-health problems, in particular ‘the assumption that we’re going to be dangerous, knife-wielding maniacs and that is simply not the case’ (ibid). At the time my own Twitter account had posts and retweets from a variety of service users, professionals and campaign groups almost exclusively expressing outrage over the supermarkets’ behaviour. In response to such criticism, both stores have withdrawn the product from sale, offered apologies, and Asda announced that it was to make ‘a very sizeable donation’ to Mind.

The description of the outfit as that of a mental patient was insensitive and was bound to upset some people. The companies could have saved themselves some criticism if they had stuck with the zombie tag. Nevertheless, the outraged response to the costume was not only out of proportion, it also had some extremely concerning aspects to it.

First, there was an assumption that the linking of ‘mental patient’ with the costume would increase the stigma that people with mental illness can face, a sort of ‘monkey see, monkey do’ attitude towards the general public. In addition, it is worth noting that attitudes to mental illness are improving. For example, the percentage of people who agree that ‘it is frightening to think of people with mental problems living in residential neighbourhoods’ has fallen from 26 per cent to 12 per cent between 1997 and 2014 (Time to Change, 2015).

It is also very important to note that such changes have come about at the same time that many of those who expressed outrage have had no compunction over linking mental illness with violence in the past. For example, where was Alastair Campbell’s outrage when the government of which he was a key member was amending mental-health legislation to introduce community treatment orders (CTOs) and abolish the ‘treatability clause’, measures that the government said were necessary due to the dangerousness of the mentally ill? Many government policy documents on mental healthcare implicitly linked mental illness and violence, carrying titles such as ‘Safety First’ (DoH, 2001a) and ‘Avoidable Deaths’ (DoH, 2001b). It could be argued that the Labour government invoked the spectre of the mad axe-man to far greater effect than the two supermarkets. We could return Alastair Campbell’s question and ask him what possesses such people?

Once professionals had the power to discharge patients on CTOs, they embraced it, with the number of patients subject to one being 10 times higher than the government originally forecast. In 2012, there were 4,764 people subject to such orders – 473 more than in 2011 (McLaughlin, 2010). It is not unreasonable to assume that such high usage has led to the suspicion that CTOs are being used to cover the backs of professionals in case something goes wrong, rather than for the benefit of the patient. In other words, there is a presumption of dangerousness that carries far more significance for mental patients than anything Asda or Tesco have come up with.

Similarly, many professionals and their regulatory bodies are also prone to equate mental illness with violence. Whenever one of my students disclosed that he or she had a psychiatric diagnosis, I often had to argue that the diagnosis should be considered irrelevant, it was someone’s ability to complete the course in a satisfactory and professional manner, with support if necessary, that was important. My view was frequently ignored, with medical reports being deemed necessary before such students were registered with the now disbanded General Social Care Council.

The level of distrust towards people with mental-health issues from many within government, the mental-health professions and their regulatory bodies should be more of a concern than an insensitive, but otherwise harmless Halloween costume.

Awareness Raising: Is it Time to Change?

An increasingly common tactic used by campaigners to challenge stigma today is to try and raise awareness of the problems/issues facing their particular area of concern. Here, as above I wish to concentrate on mental health in general and on the *Time to Change* (TTC) initiative in particular.

Awareness raising campaigns are not new. In one of the earliest attempts to improve community awareness of mental health issues Cumming and Cumming (1957) spent six months in the small Canadian town of Indian Head, Saskatchewan, where they provided education, visited schools, distributed leaflets and appeared on local radio conveying information to help improve public attitudes to mental health. Interestingly, the townspeople ‘normalised’ a wider range of behaviour than the researchers, although they were also of the opinion that there was a clear dividing line between mental illness and normal behaviour. It seems the initiative was not successful with the townspeople eventually turning against the researchers with the mayor telling them ‘We have had too much of this sort of thing; we are not interested in it in this town anymore. The sooner you leave, the better' (Cumming and Cumming, 1957, p.44). More recently, the effectiveness of anti-stigma campaigns remains inconclusive.

Reviewing the evidence for anti-stigma campaigns, Smith (2013) concluded that whilst some progress has been made, 'the wholesale shift in in attitudes that we all want to see has yet to occur' (p.s50). Therefore, 'we should resist the temptation to presume that "more of the same" might work in future, since the Cummings remind us that we have been trying that for 60 years' (ibid.). He concludes with the hope that 'Time to Change can live up to its name and provide a rethink not just for the public, but for anti-stigma campaigns as well' (ibid.).

There is some evidence that Time to Change's anti-stigma campaign is potentially cost-effective in that changes in public knowledge, attitudes and intended behaviour can have a positive impact on the employment rates of people with depression, although the authors themselves admit that 'it is impossible to know the impact of the TTC campaign rather than to other contemporaneous influences present in England (Evans-Lacko et al 2013a, p.s100). In addition, the same researchers also found that the TTC campaign was linked to improvements in *intended* behaviour as well as a non-significant improvement in attitudes there was no significant improvement in knowledge or *reported* behaviour' (Evans-Lacko et al. 2013b).

Other studies have found a significant overall reduction in the levels of experienced discrimination reported by people using mental health services (Henderson et al. 2012; Henderson and Thornicroft, 2013). Campbell et al.'s (2011) awareness raising intervention with teenagers found that the group that was given mental health information and also had input from a psychosis sufferer had significantly reduced levels of discriminatory attitudes than the control group immediately after the intervention. However, such an effect was not sustained at ten-week follow up.

There are other problems with anti-stigma campaigns that focus on the attitudes of the public. For example, for Teresa May, the UK Prime Minister, a key concern is the perception of mental illness. According to her, ‘If we look at the issue of mental health in this country, I think it’s more about the stigma that still attaches’ (quoted in Sparrow and Walker, 2017, online). For May, it is the attitudes of the public that require attention more so than the inadequacy of frontline mental health provision. The focus moves from the structure and funding of services or wider societal problems onto the general public. It is their lack of knowledge, their lack of awareness that gets highlighted as the barrier to the inclusion of those suffering with mental distress.

It is also possible that awareness-raising campaigns increase societal anxiety as we are constantly ‘made aware’ of myriad threats to our health and safety. So, far from being benign the cult of awareness raising can have a detrimental effect on our health, promote self-expression as opposed to public engagement and be more concerned with the prevention of death than the living of life. In order to combat such a corrosive situation perhaps we need to, somewhat paradoxically, raise awareness of the dangers of raising awareness. However, this form of awareness raising will challenge the obsession with the self and promote a climate that can reinvigorate the public and political sphere. Another concern is that those who wish to raise awareness set up a binary between themselves, ‘the aware’, and the rest of us, ‘the unaware’, who must be educated in a top-down, often moralistic fashion.

Conclusion

The ideological process of stigmatising others has not disappeared but its acceptable, mainstream face has changed. Overt racist, sexist or homophobic acts are more likely to be condemned than condoned by the mainstream political and liberal class. This is not to say that many do not still harbour such sentiments, but to make the point that such views are not as welcome in the public realm as they once would have been, or at least in such a form.

However, contemporary processes of stigmatisation that attempt to naturalise inequality and objectify the poor, can, in a roundabout way, entrench the older racial discourse due to many minority ethnic groups suffering disproportionate socioeconomic inequality. Simultaneously, the white working-class can find themselves cast as a race apart, an underclass outwith mainstream societal norms; the poor, no matter their ethnicity, made scapegoats for the failure of neoliberal economics.

Given the ideological, practical and personal implications of stigma it is important to challenge it where possible. However, as I have argued above, it is important to note that within many anti-stigma campaigns a therapeutic narrative is to the fore, one which cultivates vulnerability, and which can, as in the case of awareness-raising campaigns and the Halloween costume furore, fight stigma by paradoxically stigmatising the general public. We have a disjuncture between the ‘aware’ and the ‘unaware’ with the latter requiring guidance from the former. Indeed, such a process has the potential to be more far-reaching than a class analysis. With ‘lack of awareness’ seen as transcending social status it can open the door for processes of governmentality to be applied to a wider demographic who must be instructed in the correct way of thinking and behaving towards others.

Stigma as a concept has developed greatly since Goffman’s classic study, and no doubt will change again in interaction with theoretical and societal developments. That is why we need to be careful that in our efforts for political change we do not so much as challenge stigma as replace one stigmatised group with another.

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[i] This section is from an article I wrote at the time, see 'Who's afraid of a Halloween costume', Spiked, 26/9/13 https://www.spiked-online.com/2013/09/26/whos-afraid-of-a-halloween-costume/