“Stigma is a Weird Amoeba of a Word”:

Exploring mental health stigma as a multi-level concept through the experiences and conceptualisations of young people and staff members from stakeholder organisations in Scotland

Amy Morrison Tucker

School of Social Work and Social Policy

University of Strathclyde

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# Author’s Declaration

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# Abstract

A 2019 report from the Youth Commission on Mental Health Services highlights that stigma of mental ill health still has an impact on young people, despite various the attempts of the Scottish Government and other third sector partners, to address this through anti-stigma campaigns. Existing research demonstrates that there is substantial prevalence of public stigma towards young people with mental ill health. However, there is limited understanding about how young people in Scotland conceptualise stigma and the ways in which they experience stigma of mental ill health at multiple social levels.

This qualitative study collected data over the course of eight months in 2019. This involved four focus groups (five participants per focus group) and ten interviews with young people who had lived experiences of mental ill health. Fifteen staff members who worked in ten Scottish mental health organisations were also interviewed to gain perspectives from individuals who work within institutions and contribute to policy and practice. Thematic analysis identified four overarching themes about stigma: understandings, experiences, sources and effects. Discourse analysis principles were then applied to identify different ways young people and mental health were constructed, which found that young people were framed as “attention seekers” and mental health is prioritised less than physical health.

This study found that participants described experiences of structural stigma within mental health services, by mental health service providers and through the lack of access to services. Stigma was understood by participants as embedded within dominant discourses which constructed young people and their mental health in stigmatising ways, which, they suggested, restricted access and limited the prioritisation and resourcing of CAMHS. However, participants also struggled to provide consistent definitions of “stigma”. Therefore, the key contribution of this research is developing understandings that suggest stigma is embedded within powerful and elite discourses that are not always accessible to many young people.

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# Chapter 1: Introduction

## 1.1 Chapter Overview

This chapter provides an introduction to the thesis and the problem which will be addressed by the research. Firstly, this chapter discusses the context of young people and their mental health in Scotland and the UK and the ways in which this is constructed by dominant discourses. Secondly this is followed by the context of mental health stigma with a particular focus on the See Me Scotland anti-stigma campaign. Thirdly, this chapter provides an overview of how this thesis understands the key concepts used in this research: mental health, mental health stigma, and young people. The fourth section of this chapter gives a rationale for the research, alongside a discussion of the research questions. An outline of the rest of the thesis will be provided followed finally by a chapter summary.

## 1.2 Young People’s Mental Health in Context

The focus of this thesis is ultimately on young people’s mental health and their access to mental health services. This topic is of key importance globally, with the right for children and young people to receive good quality health care established by Article 24 of the United Nations Convention on the Rights of the Child (United Nations Convention on the Rights of the Child, 1989). Despite this, young people’s mental health is of increasing concern, particularly recently due to the COVID-19 pandemic. However, even before this global catastrophe, child and adolescent mental ill health was becoming increasingly constructed as a “crisis”. It has been demonstrated that 50% of mental illnesses begin by the age of 14 and it therefore important to understand the mental health of adolescents (Kessler et al, 2005; Bruha et al., 2018). There appears to be a general trend of increasing diagnosis of anxiety and mood disorders in children and young people (Colinshaw, 2015; Wilkinson & Pickett, 2019 (Wilkinson & Pickett, 2019). However, it is important to note that the actual prevalence of mental illnesses in young people at a global level is a difficult picture to provide due to varying levels and quality of available data (Ford & Cross, 2021). The available data only demonstrates the mental health of children and young people who have a diagnosable mental health condition, and there is currently no national data about the mental health needs of children and young people who do not meet a clinical threshold (Crenna-Jennings & Hutchinson, 2020). This data does suggest that over time young people’s mental health appears to be deteriorating.

Across the UK young people’s mental ill health has been of increasing concern. However, due to the devolution of health to Scotland, Northern Ireland and Wales, recent prevalence statistics on mental ill health is measured separately by each of the individual nations within the UK. In 2017, NHS England reported that one in eight (12.8%) 5- to 19-year-olds had at least one mental disorder (Sadler et al., 2018). Further, 10.8% of 5- to 16-year-olds in England had at least one diagnosable mental health issue in 2017, which is an increase from 10.1% in 2004 (Sadler et al., 2018). This demonstrates a general trend of increasing mental ill health for children and young people in England. This further increased in 2020 to 16%, the reason for which was suggested to be the anxiety brought about by the COVID-19 pandemic and lockdown restrictions (Vizard et al., 2020).

Despite the perception of worsening mental health of children and young people, only a third of children with a diagnosable mental illness in England are able to access help (Crenna-Jennings & Hutchinson, 2020). It was noted by the Education Policy Institute that 26% of referrals to Child and Adolescent Mental Health Services (CAMHS) in England were rejected in 2018-2019 (Crenna-Jennings & Hutchinson, 2020). Reasons provided for these rejections were that children’s conditions were “not suitable for treatment”, or that their “conditions did not meet eligibility criteria” (Crenna-Jennings & Hutchinson, 2020, pp. 16). This report also highlighted that 87% of providers reported that they signpost the children and young people with rejected referrals to other services, however 24% of local authorities have decommissioned “lower-level” mental health services for youth since 2010 (Crenna-Jennings & Hutchinson, 2020; Young Minds, 2019). Further, for those whose referrals were accepted, the average time between this and beginning their treatment was two months, which led to three quarters of young people feeling more unwell during this waiting time (Crenna-Jennings & Hutchinson, 2020; Young Minds, 2019). This could suggest that the long waiting times in England and lack of access to appropriate mental health services could add to the deterioration of youth mental health.

### 1.2.1 Young People’s Mental Health in Scotland

There are a number of reports which substantiate the perception that young people are increasingly experiencing mental ill health in Scotland. A key figure used by organisations in Scotland who support children and young people is that 10% of young people, aged 5 to 16, have a clinically diagnosable mental health problem (Audit Scotland, 2018; Mental Health Foundation, 2016). This statistic is based on a 2004 study of 5-16-year-olds in the UK (Green et al., 2005). It should be noted that while this statistic has been widely used, at the time of writing, this report is 17 years old. More recent investigations in Scotland found that 37% of adolescents were classified as having low mood (Inchley et al., 2020), and that by the time Scottish pupils are 16-years-old there will be “three in every classroom” who have experienced mental ill health (Gordon & Platt, 2017, p.6). In addition, mental ill health including low mood and risk for depression, has been found to increase with age (Inchley et al., 2020). According to a 2018 study which surveyed Scottish school age children, 51% of 11- year-olds reported that they felt “very happy”, while only 23% of 15-year-olds reported this (Inchley et al., 2020). Additionally, this study found that 15-year-old girls were the least likely to report excellent wellbeing (Inchley, 2020; Scottish Government, 2018). Pertinent to the age group examined in the current study (15 to 25-year-olds), a recent Mental Health Foundation survey revealed that that three quarters of university students in Scotland reported moderate to severe symptoms of depression and low wellbeing (Maguire & Cameron, 2021). Overall, there appears to be a negative trend in the wellbeing of young people; the average wellbeing score for Scottish pupils in 2014 was 48.4, but in 2018 it decreased to 26.9 (Scottish Government, 2018). These figures demonstrate both that young people’s wellbeing is worsening over time.

The Scottish Government highlighted some key reasons for the low wellbeing of young people in Scotland. One report from the Scottish Government found that key reasons for low wellbeing scores for 15-year-old girls were issues such as sleep disruption, social media use, concerns over body image, and pressures at school (Scottish Government, 2018). However, another important determinant of mental ill health for young people in Scotland is socio-economic deprivation and poverty (Friedli 2009; NHS Health Scotland, 2018). Mental health problems disproportionately affect children and young people in lower income households and areas of deprivation (Gordon & Platt, 2017) and 24% of children in Scotland are living in relative poverty (before housing costs) (Scottish Government, 2019). Poverty appears to impact children’s physical health as well as their social, behavioural and cognitive development (NHS Health Scotland, 2018). It is clear that with the high proportion of children and young people experiencing poverty and attempting to access support services for their mental health that addressing socio-structural influences on mental health and wellbeing should be a priority for the Scottish Government.

It has been demonstrated that maintaining the mental health and wellbeing of young people is an important task for government and health services in Scotland, as half of mental health problems begin before the age of 14 (Gordon & Platt, 2017). It is suggested throughout policy documents that “children and young people’s mental health and wellbeing is a priority for the Scottish Government” (Audit Scotland, 2018, pg. 3; NHS Health Scotland, 2013; Scottish Youth Parliament, 2016). Just as with England, it could be understood that children and young people’s mental health is worsening in Scotland. Between 2014 and 2018 there was a 22% increase in the number of referrals made to Child and Adolescent Mental Health Services (CAMHS) (Audit Scotland, 2018). However, similar to England, there was a 24% increase of rejected CAMHS referrals during this time (Audit Scotland, 2018). An audit of CAMHS referrals was carried out in 2018 and it showed that 1 in 5 CAMHS referrals were rejected (Scottish Government, 2018). This audit found that most decisions were based on paper referrals rather than face to face assessment (Scottish Government, 2018). Audit Scotland reported that these referrals were rejected because they did not meet the clinical criteria for intervention (Audit Scotland, 2018). This meant that the child was at an early stage of mental illness, their mental illness was classified as mild, or there was no mental health issue (Audit Scotland, 2018). However, I would argue that despite a child not meeting a clinical threshold, they may still benefit from other forms of support which are not always made available. A referral could also be rejected if the child or young person was outwith the NHS board catchment area (Audit Scotland, 2018). The young people who faced a rejected CAMHS referral reported feeling that they would not be seen unless they were suicidal or at risk, and that the signposting provided in the rejected referral letter felt unhelpful, generic and were based on resources they had already tried (Audit Scotland, 2018).

It therefore appears that young people’s mental health is worsening over time and that those who seek help do not always receive it. This is despite the Scottish Mental Health Strategy stating that appropriate provision of mental health services for children and young people is a priority (Scottish Government, 2017). It could be argued that this is partly due to the austerity policy agenda which has seen both the restriction of funding for clinical youth mental health services, and other social and community services which can act as an early intervention and prevention of mental ill health in young people (Cummins, 2018; Nuefeld et al., 2017).

Young people’s mental health has also become constructed as a crisis within the news media; however, these constructions tend not to take structural impacts on young people’s mental health into account and instead individualises the problem. The following section discusses the ways in which young people and their mental health are constructed through dominant discourses in news media reports.

### 1.2.2 Constructions of Young People’s Mental Health in Media Discourses

This section examines some of the media discourses which construct young people and their mental health in the UK. As noted above, there has been an increase in young people’s mental ill health in the UK and this has been picked up by news media. Media representations are a powerful way of defining social problems and shaping public discourses (van Dijk, 2008). My examination of current news media reporting on young people’s mental health in the UK identified two competing discourses. The first constructs young people’s mental health as in crisis. The second constructs young people as “snowflakes” who lack resilience and are overly sensitive. While there are no existing examinations of these discourses in empirical research, they both follow previously identified constructions of young people as both denigrated and in need of protection (Aldridge & Cross, 2008).

At the beginning of my investigation into this topic in 2017,  prominent discourses in news media constructed youth mental health as in “crisis” across the UK: “150 children a day being denied mental health treatment” (Sky News, 2017).

This headline from a Sky News article is based on a freedom of information request to NHS Trusts in England from the NSPCC. This article showed that 17% of CAMHS referrals were rejected between 2015 and 2017. In the article, the denial of mental health treatment for children is framed as the result of a lack of CAMHS services, despite the assurance of the incumbent Prime Minister Theresa May,  that mental health was a priority. Another example is the following headline in the Guardian in 2018:

“One in three young people have mental health troubles, survey finds” (The Guardian, 2018).

This article reports on an Action for Children survey which suggests that the respondents experienced mental health troubles such as depression, anxiety and lack of sleep. This finding is framed as demonstrating more young people than initially thought were struggling with their mental health. Similar to Sky News, The Guardian suggests that Theresa May had planned to improve the prevention and early detection of mental ill health in youth, but the NHS had been struggling to cope with the rise in demand for children’s mental health services. The reason for young people experiencing mental health troubles is also framed as the result of the pressures of school, social media and navigating 21st Century complexity and precarity, which, the article suggests, can prove “too much” for young people (The Guardian, 2018).

These are just two examples of the nature of the framing of youth mental ill health in this time period, however these discourses continue to be prevalent as I complete this thesis in 2021. There is now a particular focus on the role of the COVID-19 pandemic in the increase of youth mental ill health:

“Mental health disorders rising in young people according to new NHS survey” (BBC Newsround, 2020),

“Children’s Mental Health Services Reach Breaking Point as COVID Sees Demand Soar” (The Independent, 2021).

The BBC article highlighted that in a survey of English youth, more than half of respondents reported that the Coronavirus lockdown/s had made their lives worse. If the NHS had been struggling with a rise in demand before the pandemic as reported in the above examples, it now appears even more difficult to provide support for the increasing demand that has resulted from the pandemic’s negative impacts on youth mental health. These news articles based on reports from charities and organisations clearly construct youth mental health as a problem in the UK. The UK news media typically utilise existing hegemonic discourses which construct youth mental health as a medical issue that requires clinical intervention. This can be seen in the above examples which focus on “disorders” and classifications of mental illnesses as well as the lack of Children and Adolescent Mental Health Services (CAMHS) which are typically based on provision of clinical intervention.

However, young people are not only constructed by discourses which suggest their mental health is in crisis. There have also been counter discourses, usually promoted by tabloids that take a different view about the reasons for this crisis. These discourses construct young people as lacking the required levels of resilience:

“Millennials and Gen Z really ARE snowflakes: Scientists find people aged 18 to 25 are the most upset when they're labelled narcissistic, entitled and oversensitive” (The Daily Mail, 2019)

“Jeremy Clarkson slams ‘snowflake' students over recent backlash: ‘I was flabbergasted'” (The Express, 2020)

These discourses can be found in newspapers which adhere to different journalistic standards than those which frame young people’s mental health as a crisis. The Express for example constructed the above “news” article around the opinion of a television personality, which demonstrates their level of dedication to rigorous reporting. The labelling of young people as “snowflakes” was particularly prevalent in 2016, when it was entered into the dictionary and was defined as:

“a person who believes they have special qualities and should receive special treatment; a person who is too sensitive to criticism and easily upset” (Oxford English Dictionary Online, 2016).

This term is used to insult young people through popular discourse. Fight Club author Chuck Palahniuk has been given the tenuous honour of coining this insult:

"You are not a beautiful and unique snowflake. You are the same decaying organic matter as everyone, and we are all part of the same compost pile” (Palahniuk, 1996, p 133)

Taken together, the prevailing discourses about young people suggest their mental health is in crisis, but popular tabloids construct reasons for youth mental ill health as a result of their oversensitive personalities, lack of resilience and an unjustified sense of entitlement. It is also important to note that in much of these news articles fail to include the voices and perspectives of young people, therefore removing the potential for exercising their agency in constructing their own lives and experiences. These discourses could be understood as framing youth and their mental health in a way that is “stigmatising”. If young people are understood to be subject to more mental disorders than previous generations and if this construction is tied up with discourses which suggest that young people are at fault for their mental ill health, this suggests that young people experience specific stigmatising contexts that adults do not. It was the identification of these intertwining discourses that lead to my interest in understanding the ways in which young people’s mental health can be subject to stigmatising structural discourses.  The next section discusses the context of mental health stigma in the UK, and Scotland specifically.

## 1.3 The Context of Mental Health Stigma

Mental health stigma is framed as a problem by research, policy and practice. Previous research has indicated that stigma directed towards mental ill health results in lack of treatment uptake, poor individual, social and medical outcomes and a lack of policy and funding for treatment (Martin et al., 2007). In 2001 the World Health Organisation defined stigma as:

“a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society” (World Health Organisation, 2001, p. 16).

A key claim by the WHO is that stigma is the “single most important barrier to overcome in the community” (WHO, 2001, p. 98) and highlighted that stigma can cause feelings of shame when trying to access mental health support which in turn can lead to reluctance to seek help. This report suggested that public education and awareness campaigns would be a key way in order to tackle stigma and discrimination. More information about the nature, prevalence and impact of mental illnesses is required for tackling stigma, as suggested by the WHO report and this has been done to an extent in many anti-stigma campaigns across the globe since the WHO report was published (WHO, 2001).

For example, a recent study examined knowledge and behaviour change focussed anti-stigma campaigns such as Time to Change in England and Beyond Blue in Australia (Walsh & Foster, 2021). This study highlighted that anti-stigma approaches often take an exclusively biomedical approach to mental health and illness education and that this is based on an assumption that the public have a lack of accurate knowledge about mental health (Walsh & Foster, 2021). For example, Beyond Blue and Time to Change both focussed on improving mental health literacy by providing information about mental illnesses such as schizophrenia, depression and psychosis (Corrigan, 2018). These mental illnesses are framed as a disease like any other physical illness (Corrigan, 2018). However, this approach is not without its complexity. Although it is hoped that education about mental illness through a biological framework removes shame, it has also been demonstrated this can lead to label avoidance which can impact the desire to seek help (Angermeyer et al., 2011; Corrigan, 2018; Walsh and Foster, 2021). The study by Walsh and Foster highlighted that very few anti-stigma campaigns have long term improvements on public attitudes and suggest that the focus on medicalised knowledge of mental health continues to contribute to the public perception of differentness between those with and without experiences of mental ill health (Walsh & Foster, 2021). The following section will now examine the Anti-Stigma campaign in Scotland, See Me.

### 1.3.1 See Me Scotland

This current research study takes place in Scotland and it is therefore pertinent to examine See Me, Scotland’s anti-stigma campaign. This campaign initially focussed on education and awareness raising, however more recently it has developed a programme which focusses on influencing behavioural change through highlighting people with lived experiences of mental ill health (Cameron et al., 2019). It has been demonstrated by previous research that anti-stigma campaigns which focus on contact-based interventions involving connecting the public with people with lived experience of mental ill health have small to medium improvements in stigma outcomes, particularly in comparison to educational approaches alone (Corrigan, 2018; Gronholm et al., 2017; Mehta, et al., 2015; Walsh and Foster, 2021).

Tackling the stigma of mental ill health has been a policy priority in Scotland for many years. The current mental health strategy states that a key priority is to challenge all mental health stigma and discrimination (Scottish Government, 2017). The Scottish Government’s prioritisation of improving public mental health by tackling stigma and discrimination began explicitly in 2002 with the establishment of See Me the Scottish anti-stigma campaign (Pilgrim et al., 2013). See Me was set up after the Millan committee, which was set up to review the Mental Health Scotland Act 1984, suggested there should be a public education campaign to improve attitudes towards people with mental ill health (Myers et al., 2009). This suggestion was embedded in the National Programme for health improvement and See Me was established to “eliminate stigma” (Scottish Government, 2003).

See Me was one of the earliest national campaigns, and it has been suggested that it is an “international pioneer” of raising awareness of public mental health stigma (Myers et al., 2009; Pilgrim et al., 2013). Initially See Me was a national publicity campaign directed at the general population, alongside targeted campaigns to young people and in work places (Pilgrim et al., 2013). This campaign had 5 key objectives which involved: improving public knowledge of mental health and raising awareness of how stigma and discrimination affect people with mental ill health, challenging individual incidents of stigma and discrimination, involving people in anti-stigma activities across Scotland, ensuring the voices and experiences of people with mental health problems are heard, and to promote a culture of learning and evaluation (Myers et al., 2009). This campaign benefitted from long term consistent policy commitments and government funding (Pilgrim et al., 2013). The policy and funding priority of tackling mental health stigma and discrimination both highlighted the stigmatisation of mental health as a problem, and a governmental commitment to tackling this problem. This prioritisation and commitment to mental health stigma prevention has continued for the Scottish government, as unlike it’s English counter-part Time to Change, See Me has continued to be funded to the present day.

At the time of writing, the most recent report, by See Me evaluators the Mental Health Foundation, highlighted that while there appears to be an increased prioritisation and a positive profile of mental health in Scotland, this does not necessarily mean that there has been a reduction in mental health stigma (Cameron et al., 2019). This report demonstrated that See Me has moved away from raising awareness of mental illness, and is now focussing on behaviour change. The Mental Health Foundation report noted that, while the campaign is still having a positive effect on stigma and discrimination, it is still a prevalent issue in Scotland (Cameron et al., 2019). It could be argued that See Me have a difficult task in terms of their evaluation. As the organisation has been funded for over 15 years, they are faced with a Catch-22 of evidencing that they have been successful enough in tackling mental health stigma in order to justify what they have been doing since 2002. However, they also have an interest in keeping the organisation funded by evidencing the need for their existence and therefore demonstrating that stigma is still a problem without inviting questions of whether they are indeed making much of a difference.

However, See Me are not the only organisation who have highlighted that mental health stigma is a problem in Scotland. The perseverance of stigma is also highlighted by the Scottish Youth Parliament in a report in 2016. This report highlighted the importance of addressing mental health stigma for young people in Scotland because they experience stigma in a different way to adults (Scottish Youth Parliament, 2016). Participants in this report highlighted that young people were often concerned that others would accuse them of attention seeking if they asked for help for their mental health (Scottish Youth Parliament, 2016). This report also highlighted that young people themselves held stigmatising beliefs about mental health, sometimes equating mental illnesses with dangerousness and dismissing their peers as attention seeking (Scottish Youth Parliament, 2016). Further, the Scottish Youth Commission highlighted stigma as a barrier to help seeking a result of a lack of public understanding about mental health (Young Scot Observatory, 2019).

It has so far been established that young people’s mental health and the stigma of young people’s mental health is a concern in the UK and Scotland specifically. This section has discussed the context of mental health stigma and the attempt of the See Me campaign to tackle this in Scotland. The following section will now discuss the ways in which these key concepts of mental health, stigma and young people are understood theoretically in this thesis.

## 1.4 Understanding Key Concepts in This Thesis

### 1.4.1 Mental Health

This section will discuss the dominant framework through which mental health and illness is understood, namely the medical or psychiatric model. The dominance of discourses which construct mental ill health in terms of medically diagnosable diseases will be discussed. The counter-hegemonic discourses which critique the dominance of psychiatry will also be discussed to demonstrate the possibility of alternative ways of understanding mental health which place more importance on the lived experience of individuals and their own understandings of what they need to be supported. The benefits of considering the social determinants of mental health will also be discussed as this allows us to understand contextual factors that impact the lived experience of mental health generally.

My personal understanding of mental health is based on a continuum of various states of wellbeing. I chose to refer to “mental ill health” throughout this thesis, rather than “mental disorder” or “mental illness” as these terms hold specific clinical diagnostic meanings, and it could be argued these terms are linked to stigmatising discourses and assumptions. I understand mental ill health as a level of distress that requires intervention, or something that the individual cannot cope with alone. However, this understanding is based on personal experience of mental ill health rather than taking a particular epistemological view. It should be noted at the outset however that I will not define mental health or mental illness for the participants in this study. Those invited to participate in this research study were given space to define mental health and mental ill health in ways that were applicable to their own experiences. Each and any of the ways the participants understood mental health and mental ill health was regarded as valid within this study. It is however important to know about the various discourses which construct dominant understandings of mental health as they are consistently drawn upon to construct and constitute what mental health “is” in research policy and services. This section will now discuss the different ways in which mental health is constructed.

#### 1.4.1.1 Medical Understandings of Mental Health

The ancient Greek philosopher Hippocrates is credited for introducing a rational and systematic approach to health. Hippocrates is said to have suggested that treating people with mental ill health should be approached in the same way as physical health (Cockerham, 2000). These ideas remain in contemporary discourses which frame mental ill health and treatment through a medical lens.

The medical model views mental ill health as a disease that can be treated like any other through medical intervention (Cockerham, 2000). In this view mental ill health is caused by psychological, biological, chemical and genetic factors (Cockerham, 2000). Psychiatry is a speciality within medicine, and psychiatrists are trained under a medical framework (Rogers & Pilgrim, 1996). Therapeutic approaches involve physical intervention, most commonly through psychopharmacology, although brain surgery and electroconvulsive therapy have also been used for serious, life-threatening mental illnesses (Busfield, 2011; Pilgrim & Rogers, 2010). Spitzer and Wilson suggest that most mental illnesses do not have observable causes that would constitute them as a disease such as being caused by a germ or virus, showing physical changes, nor do they proceed unaffected by environmental factors (Spitzer & Wilson, 1975). Despite these critiques Spitzer and Wilson advocate treating mental illnesses under a medical model, as they suggest many do respond positively to medical treatment (Spitzer & Wilson, 1975).

Despite the medical model being the dominant understanding found in mental health services (Rogers & Pilgrim, 1996), there are several issues with this way of understanding mental health. I will now go on to discuss the anti-psychiatry and more sociological understandings of mental ill health. Burstow critiques psychiatry as a dominant “regime of ruling” which dictates what counts as “true” or “knowledge” in terms of mental health (Burstow, 2018, p. 31). Burstow argues that psychiatry enacts discourses about what mental health is in a way that is conveyed as “truth”. This assertion of unequivocal fact provides psychiatrists with the ability to hold power in society and this knowledge and subsequent power is understood as benevolence towards their patients (Rogers & Pilgrim, 1996). In Burstow’s view however this power is not always enacted benevolently and draws on the role of psychiatry in compulsory treatment and detainment (Burstow, 2018).

Burstow also contends that psychiatry fails to provide objective truth and evidence for their understandings of mental illnesses (2018). One example of this can be seen in a reading of the DSM. The Diagnostic and Statistical Manual. Bentall explains that this manual has evolved over time, changing its use and inclusion of different mental disorders without clear evidence for their inclusion (Bentall, 2004). Psychiatry is framed as a positivist science which is based on empirical evidence, however there remains debate about mental disorders and their definitions. The DSM IV suggested that:

“A mental disorder is a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with significantly increased risk of suffering, death, pain, disability or an in important loss of freedom” (DSM-IV, 1968).

This definition does not provide any indication of the cause of the mental illness and focuses more on the presentation of symptoms either through ways of thinking or behaving. The definition also focusses on the effects of the mental illness for the person experiencing it and the requirement that the mental illness has some negative effect on their ability to function in life. The DSM V on the other hand provides a longer and arguably less coherent account of what mental illness is:

“A mental disorder is a syndrome characterised by clinically significant disturbance in an individual’s cognition, emotion regulation or behaviour that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities” (DSM-V, 2013).

This definition is similar to the previous edition as it focuses on the symptoms and the distress caused. However, one key difference is this definition’s focus on the source of the mental illness. This definition suggests that the cause of the mental illness is found within the person experiencing it. It goes on to state this point:

“An expectable or culturally approved response to a common stressor or loss such as the death of a loved one is not a mental disorder” (DSM-V, 2013).

This could be said to be contradictory to the first point. The DSM-V states that as long as a person reacts in a way that is socially acceptable then they do not have a mental illness. This then implies that if the reaction is different to what society would say is acceptable then that person has a mental illness. It calls into question the source of the mental illness. Despite stating that the person’s dysfunctional reaction is the result of a problem with their biological based functioning, it is only seen as a dysfunction if others agree that it is so. This suggests that the cause of mental illness is not necessarily a stable observable fact that can be found within the individual, but that it is also subjective and can change depending on the cultural environment. The introduction of subjectivity into the definition is contradictory to the psychiatric empirical epistemology. I would argue that this undermines its claims to objective truth which is a key source of psychiatric authority.

The dominant model of understanding mental health is problematic in terms of this thesis as it does not consider the lived experience or understandings of mental health from the view of the person experiencing it. It is important to this study that the understandings of young people and their experiences are prioritised over the discourses of “experts”, particularly because hegemonic discourses are being reconsidered and challenged. Understanding the views of participants and providing space for counter-narratives to be foregrounded is a key foundation of this work.

#### 1.4.1.2 “Post-Psychiatry” & Mental Health

Post-structural views of mental health have also criticised the dominance of psychiatric model. Foucault is key to the understanding of mental health which is adopted in this thesis. Foucault understands that “madness”, or “mental illness” is evidence of a “broken dialogue” between reason and madness, in which the dominance of psychiatry has come about as a result of the silence, or rather silencing and control of the mad person (Foucault, 1967). Foucault offers an archaeology of madness which demonstrates that discourses surrounding mental illness have not always been fixed within a bio /psychiatric model. He argues that it is only in the 18th century, with the development of the dominance of reason and enlightenment that madness came to be understood as unreason, and therefore became subject to medical expertise (Foucault, 1967). Power is therefore enacted through psychiatric discourse, which has constituted understandings of valid knowledge.

Another postmodernist thinker, Dwight Fee criticises how the dominance of biomedical understandings of mental health dictates that only these understandings of mental health and illness are valid or represent “real” illnesses (Fee, 2000). Instead, Fee presents a useful understanding of mental health and mental ill health which is useful for this thesis. Fee suggests that mental illness should be understood as a social object which is shaped by and within institutions, language and interaction (Fee, 2000). Mental ill health is therefore not something which should be assumed to be self-evident, and instead the categorisation of what is ‘normal’ and what is ‘pathological’ is often in flux and consistently renegotiated (Fee, 2000). I would also add the importance of lived experience to this understanding of mental ill health. Within the shifting conceptualisations of mental health and illness, the testimonies of those experiencing it in all its various forms must count as valid. This is how the accounts and discourses of participants are understood in the data collection process in this study. However, the main way of investigating this lived experience used in this study is by examining the discourses and constructions used through language and text. Key to understandings of mental health in this thesis is the focus on the lived experience of participants, how they themselves understand these experiences and how they understand the role of social structures and discourses in shaping these experiences. The ways in which mental health stigma has come to be understood, and is conceptualised in this thesis will now be discussed

### 1.4.2 Mental Health Stigma

This thesis critically investigates the concept of mental health stigma, however providing a definition of stigma is not a straightforward endeavour. Research, policy and stakeholder organisations have identified stigma as a key issue facing the lives of people who experience mental ill health; however, it is a complex and multifaceted concept. There have been various definitions and theoretical constructions put forward over time. Within existing youth mental health stigma literature there appears to be two prevailing definitions of the concept. Firstly, the concept of stigma is often understood through a Goffmanian lens as an:

“attribute that is deeply discrediting… which reduces the bearer from a whole and usual person to a tainted discounted one” (Goffman, 1963, pg. 3). However, since Goffman’s seminal text on the issue, there has been numerous empirical and theoretical contributions to the concept. A second prominent definition of stigma in the existing youth research contributes a psychological definition of stigma. Much of the youth mental health stigma literature understands stigma as a psychological process which is interpersonally manifested through a process of labelling, stereotyping and discrimination (Corrigan & Bink, 2005). Individuals with undesirable characteristics are categorised, or labelled, by others as outwith normative expectations of society (Link & Phelan, 2001; Corrigan & Bink, 2005). It has been well demonstrated over time that experiencing stigma has a detrimental effect on the lives and wellbeing of the stigmatised, such as having negative influences on self-concept, life satisfaction and acts as a barrier to seeking treatment (Corrigan & Kleinlein, 2005; Corrigan et al., 2014; Markowitz, 1998).

It has also been demonstrated that this is the case for young people and adolescents who experience stigmatising attitudes towards them and their mental health (Ferrie et al., 2020). Stigma is a barrier to young people seeking help for mental ill health and can have a deleterious effect on their self-esteem and relationships with others (Ferrie et al., 2020; McMahon et al., 2020; Moses, 2010a). A key limitation of existing youth stigma research is that the concept of stigma is applied without critical questioning of how the youth within the studies conceptualise stigma. The conceptualisation of stigma is not problematized and there is an assumption that the participants and the researchers share the same understanding of the concept of stigma. A deeper understanding of this could potentially provide us with a wider understanding of the ways in which youth construct and experience mental health stigma, in a way which may lead to alternative ways of combatting this issue.

The existing literature which examines mental illness stigma experienced by young people, frames the problem of stigma through psychological and interpersonal lenses. However, there is a rising interest in the concept of structural stigma, which is understood as “societal level conditions, cultural norms and institutional practices that constrain the opportunities, resources, and wellbeing for stigmatized populations” (Hatzenbeuhler & Link, 2014, p. 2). This research, whilst relatively sparse demonstrates that structural stigma is experienced by youth with anxiety (Woodgate et al., 2020), LGBT youth (Charlton et al., 2019; Hatzenbeuhler, 2017) and family members attempting to access mental health care for young people (Liegghio, 2017). What is not clearly understood is the ways in which structural stigma can be identified in young people’s conceptualisations of stigma, and the ways in which structural factors influence young people’s experiences of mental ill health stigma.

The following table provides key examples of definitions of stigma which I identified during the literature search for this thesis. It provides examples of the different ways stigma in understood in the existing literature, and the names and dates of key authors who provided these definitions.

#### Table 1. Theories of Stigma

|  |  |
| --- | --- |
| Type of stigma | Definition |
| Stigma | “An attribute that is deeply discrediting… which reduces the bearer from a whole and usual person to a tainted discounted one” (Goffman, 1963, pg. 3) |
| Stigma | Across Corrigan’s work he categorises stigma as the interaction of stereotypes, prejudice and discrimination for example:  “Three factors describe public and self-stigma: Stereotypes, prejudice and discrimination” (Corrigan & Lam, 2007, p. 53) |
| Modified Labelling Theory | Stigma is a process which involves labelling, stereotyping, separation, status loss, and discrimination  (Link & Phelan, 2001) |
| Public stigma | “Public stigma is the phenomenon  of large social groups endorsing stereotypes about and acting  against a stigmatized group” Corrigan, (Kerr & Knudsen, 2005, p.179) |
| Personal stigma | “An individual’s personal attitudes or beliefs about a condition” (Calear et al., 2017, p.208-209) |
| Perceived stigma | “a person’s recognition that the public holds prejudice and will discriminate against them because of their mental illness label”  (Corrigan & Rao, 2012, p. 465) |
| Anticipated discrimination | The potential and expectation that one could be discriminated against (Thornicroft, 2006)  “Anticipated discrimination occurs when a person  limits involvement in important aspects of everyday life because of the fear of being discriminated against”  (Lasalvia et al., 2015 p. 1035) |
| Experienced Discrimination | “An individual’s perception that he or she has been  treated unfairly by others because of a mental health condition”  Lasalvia et al., 2015, p. 1035 |
| Internalised / self-stigma | “The loss of self-esteem and self-efficacy  that occurs when people internalize the public stigma” Corrigan, Kerr & Knudsen, 2005 |
| Associated / Courtesy Stigma | Stigma directed at individuals who have some degree of association with the ‘marked’ individual – Goffman, 1963 |
| Structural / Institutional Stigma | “Societal level conditions, cultural norms and institutional practices that constrain the opportunities, resources, and wellbeing for stigmatized populations” (Hatzenbeuhler & Link, 2014, p. 2 |

This section has discussed the complexity of providing a definition of stigma due to its nature as a multi-faceted concept which is not consistently applied in the literature. It is because of this complexity that I therefore do not provide my own definition here. Instead, this research critically examines the concept of stigma in order to determine how young people and staff members working in mental health and youth organisations conceptualise stigma, and how they describe their experiences of unfair treatment that results from experiences of mental ill health. I argue that all of the conceptualisations of stigma held by the participants in this study are valid. Due to its complex and multifaceted nature and all of the possible conceptualisations of stigma from participants are accepted as valuable and true throughout the course of this research (Burr, 2015).

### 1.4.3 Young People

This section gives a brief overview of how youth and young people are understood through the lens of the discipline of the new sociology of childhood (James & Prout, 2015). Similar to mental health, this thesis understands young people’s experiences and the way they construct these experiences as being of key importance to the research. However, it is important to note the different discourses that have shaped societal understandings of children and young people over time.

The work of James, Jenks and Prout (1998) highlights key ways in which children and young people are understood. The first of the constructions of young people introduced by James, Jenks and Prout, suggests that children must be controlled by adults in order to prevent deviant behaviour, and they conceptualise this as “the evil child” (1998). In this view children are seen as holding the potential for evil within them, and this can only be curtailed by discipline and punishment (James, Jenks & Prout, 1998). This idea of children holding a potential for evil can be seen in literature and media, including Lord of the Flies and the Exorcist as well as discourses that construct the criminal acts of children.

Conversely, the second understanding of childhood outlined by James, Jenks and Prout (1998) is that of childhood innocence. This conceptualisation of childhood suggests that children are innocent and must be protected from harm. This perception frames childhood as an experience that should be universally protected from adult life (James, Jenks & Prout, 1998). Wyness conceptualises a similar understanding of children as existing within a realm of “play” and the antithesis of adult life at work (2019). However, this not a universal experience for all children. James Jenks and Prout highlight that globally, children are expected to work both within and outwith the home including domestic chores, taking care of family members, and are often involved in the labour market (1998). Current figures show that 160 million children are involved in the labour market globally (International Labour Office & UNICEF, 2020). It could be argued then that exclusively understanding childhood through a lens of innocence fails to take into account the multiple, various experiences of being a child which changes over time and place. By dictating what a child is like or should experience removes the nuanced understanding of their lived experience.

Wyness contradicts the lived experience of the “innocent child” by drawing on experiences of child soldiers in several wars across the globe (Wyness, 2019). Child soldiers are constructed in different ways. One explanation is that children are easier to exploit than adults as they are more obedient (Wyness, 2019). Another is that children are more “brutal” than adults, having less concern with morality, which connects to the construction of children as having more potential for “evil” (James, Jenks & Prout, 1998; Wyness, 2019). Both of these understandings of child soldiers do not take into account the lack of power they have been positioned with within society. Both understandings of young people as evil or innocent suggests that they are easily manipulated, incomplete in comparison to adults and removes any opportunity for children to exercise their own agency.

A further construction of youth which is particularly pertinent to this thesis is the “naturally developing child” (James, Jenks & Prout, 1998). This construction focuses on the natural, universal child’s biological and psychological development. Psychologist Jean Piaget set out parameters of normal development and milestones for a child’s motor, sensory and intelligence (Piaget, 1972). James et al., suggests that these milestones are privileged by the child becoming more adult and reaching a “complete state” which undermines the child as a valid ontological being in and of themselves (James, Jenks & Prout, 1998). This connects to Uprichard’s (2008) work which demonstrates that this conceptualisation of youth within developmental stages constructs young people as “becomings” and “beings” in their own right (Qvortrup, 2009; Uprichard, 2008, p. 303). Uprichard (2008) suggests that it is important to take into account both of these constructions as it highlights the temporality of youth as well as the agency they have (or I would argue are restricted from having) in the social world.

Despite Uprichard’s suggestion that it is important to consider youth as both beings and becomings, I would argue that the construction of youth, particularly in terms of their mental health, is dominated by discourses which prioritise their “normal” psychological development. Young people who experience mental ill health and distress are constructed through a psychiatric lens and compared to a “normal” standard, in which psychological distress is not a part (Coppock, 2020; Liegghio, 2016). “Normal” mental health is not always clear cut and could be ambiguous for youth who experienced mental ill health (Liegghio, 2016). Understanding young people through a developmental psychology framework can remove their potential for agency as social beings, privileges “normal” development and pathologizes mental distress which can lead to stigma and discrimination (Coppock, 2020; Liegghio, 2016). I argue that understanding children and young people in singular, specific ways, either as innocent or evil; developing “normally” or pathologically, impedes our ability to access young people’s own accounts of their experiences.

This section has discussed the various ways in which mental health, stigma and young people are constructed through theoretical understandings of these key concepts. However, I argue that while acknowledging these different constructions is important, I endeavour to hold the participants own constructions as important and valuable throughout this research in order to more fully understand their perceptions and experiences of being a young person with experience of mental ill health and stigma in Scotland.

## 1.5 Research Rationale

This research was initially motivated by the overall suggestion from policy and existing research, that while attempts have been made to prioritise the reduction of mental health stigma, it remains an important issue for young people, who may experience stigma in a unique context that is not well understood. The Scottish Government has prioritised tackling mental health stigma and discrimination, however, despite attempts to do so, mental health stigma appears to be prevailing in Scotland and a key issue for young people. This was highlighted by the Youth Commission for Mental Health. Participants in this study stated that:

“Currently the stigma surrounding mental health, and problems with some of the mental health services, make receiving support extremely difficult.” Millie Carter, 19, Scottish Borders (Young Scot Observatory, 2019, p. 7)

“Young People are often made to feel like their feelings are invalid just because they are young” Zoe Mason, 20, Fife (Young Scot Observatory, 2019, p. 7).

These quotes highlight that young people in Scotland are aware that stigma is attached to talking about mental health and that this can affect how they access support. Further, the second quote demonstrates that young people often experience being treated unfairly due to the context of their chronological age. This report highlighted to me the importance of understanding young people’s lived experience of mental ill health stigma. Another key rationale for this study came from one of the recommendations from the 2019 review of See Me’s Education and Young People’s Programme. This report highlighted that improving the mental health literacy for young people with a particular focus on understanding “what stigma and discrimination is, how it presents, and how it is embedded in every-day life and systems” (Cameron et al., 2019, p. 30). This recommendation suggested to me that little is understood about how young people conceptualise mental health stigma, and whether these understandings situate stigma as an interpersonal process part of everyday life, or if stigma can be understood within structural systems in the experiences of young people in Scotland.

While youth mental health is stated to be a key policy priority in Scotland, and the UK more widely, I argue throughout this thesis, that youth who have experiences of mental ill health are subject to uniquely stigmatising discourses. Young people who have experienced mental ill health are consistently disadvantaged by hegemonic adultism and sanism which results in layers of disadvantage and epistemic injustice (Fricker, 2007; Liegghio, 2020). Epistemic injustice here refers to Miranda Fricker’s concept of testimonial injustice in which a lower status of credibility is inferred onto a speaker (Fricker, 2007). This thesis therefore seeks to hear and amplify the voices of young people who have experienced mental ill health. However, in order to gather a rich understanding of the Scottish mental health context, those with power to contribute to knowledge or regimes of truth were also consulted (Foucault, 1977).

This qualitative research study was carried out in 2019 using interviews and focus groups. The 35 participants were made up of young people who have experiences of mental ill health (n= 20) and members of staff (n=15) from stakeholder organisations. This research explored the ways in which mental health stigma in Scotland was conceptualised and experienced by two sample groups. The first group was young people aged 15-25. The focus on young people aged 15-25 came from my own experiences of mental ill health through this time period, and my interest in exploring the conceptualisations of this age group who have arguably less access and opportunity to shape societal discourses and knowledge. However, much of the existing literature examines youth attitudes towards mental health and frames these attitudes as stigmatising, there are very few research studies identified here which examined how young people understand the concept of stigma, and no studies of this nature have taken place in Scotland, despite the work of See Me.

The second sample group was members of staff who work in mental health and youth organisations. Some of the organisations approached for this aspect of the study have contributed to policy recommendations and research in the context of young people’s mental health in Scotland. Other organisations work directly with young people who require support for their mental health. All of these organisations held charitable status. There are no research studies which have investigated the ways in which staff who work in youth mental health organisations in Scotland conceptualise stigma and I felt it was important to examine the conceptualisations of individuals who work in organisations which have a level of influence and power in shaping public discourse and who engage regularly with young people experiencing mental ill health and stigma. I wanted to investigate the experiences and conceptualisation of groups which had different levels of access to power in order to shape discourses, hence the inclusion of both young people and staff members from organisations with power to influence policy priorities and discourses in relation to youth mental health in Scotland.

Further, much of the existing empirical work on stigma investigates stigma at an interpersonal or psychological level with very little consideration for the concept of stigma power and structural factors which lead to the manifestation of stigma. Therefore, this thesis focusses on investigating the ways in which mental health stigma could be better understood by considering the ways in which power, societal structures and discourses contribute to youth experiences of mental health stigma in Scotland.

### 1.5.1 Personal Rationale

I also have my own personal rationale for exploring young people’s experiences of mental health stigma in Scotland. I found my own experiences of attempting to access support for my mental health to be a challenging and complex process. When attempting to access mental health support for panic attacks and Post Traumatic Stress Disorder I regularly felt that my doctor did not believe in the seriousness of my distress and I was often classified as “sensitive” and “a bit of a worrier”. However, when I did receive a diagnosis of PTSD I was taken more seriously and received treatment. But my distress was still constructed in an individualised way in which my reaction to trauma was a pathological response, rather than an understandable reaction to assaults which were endorsed by patriarchal social structures. Discourses used to construct my distress by professionals individualised my mental ill health as a personality trait and my chronological age was used to dismiss and undermine my testimony of lived experience. For example, my experiences of mental distress were dismissed as stress related to school and the socially accepted “turbulence of adolescence”. Further, these discourses were used to individualise and problematize my reaction to gender-based violence rather than frame these experiences as a structural problem. The discourses that were used to construct my distress were complex and also contradictory at times. This could be understood as stigmatising as these discourses placed upon me a “mark of disgrace” and led to feelings of shame for not being more robust and able to cope with the things that had led to my distress. It was these stigmatising and frustrating attempts to access support for my mental health as a young person in Scotland that led to my interest in and development of this research study.

### 1.5.2 Research Questions

Due to the ways in which youth mental ill health is constructed through dominant discourses, and the lack of understanding we have around young people’s conceptualisations and experiences of mental health stigma at a social-structural level, this research therefore addresses the following questions:

#### Research Question 1

In what ways is mental health stigma in Scotland conceptualised by a) young people who have experienced mental ill health and b) members of staff who work for youth and mental health focussed organisations?

#### Research Question 2

In what ways are experiences of mental health stigma in Scotland described by a) young people who have experienced mental ill health and b) members of staff who work for youth and mental health focussed organisations?

#### Research Question 3

In what ways can the conceptualisations and experiences of mental health stigma from a) young people who have experienced mental ill health and b) members of staff who work for youth and mental health focussed organisations be understood through a framework of societal level factors and discourses?

This section has discussed the rationale for and research questions which are answered by this thesis. The following section provides an outline of the rest of this thesis.

## 1.6 Thesis Outline

[Chapter 1](#_Chapter_1:_Introduction) introduced the background and context of young people’s mental health and stigma. It gave an overview of the ways in which the key concepts of mental health, stigma and young people can be understood in this thesis. This chapter also provided the rationale for this research and the research questions that are addressed.

[Chapter 2](#_Chapter_2:_Theoretical) discusses the theoretical framework that is used in this study which is based on Stacey Hannem’s recommendations of combining Goffman and Foucault is used in order to investigate stigma at various sociological “levels”. Goffman allows understandings of stigma at a micro-interactionist level, and Foucault allows the investigation of powerful discourses that construct young people and their mental health as “stigmatise-able”. This chapter then goes on to provide a genealogical overview of the stigmatisation of mental health and the theoretical development of the concept of stigma.

[Chapter 3](#_Chapter_3:_Literature) evaluates the existing literature about young people and mental health stigma. The existing literature examines stigma from an individual perspective in terms of attitudes and beliefs held by and towards young people and their mental health. This chapter demonstrates that stigma is experienced by young people from family, friends and is a key barrier to help seeking and finally addresses the ways youth cope with stigma. It will be demonstrated that the concept of power, knowledge and discourse have not previously been used to investigate the manifestation of stigma experiences for young people and the views of third sector staff members have been overlooked.

[Chapter 4](#_Chapter_4:_Methodology) describes this study’s methodological approach. The ontological and epistemological underpinnings of the study is based in social-constructionism which underpins the discourse-thematic approach to data analysis. This chapter also discusses the data collection process and ethical considerations of carrying out the research.

[Chapter 5](#_Chapter_5._Results) addresses research question 1 and the data which describes how participants constructed and explained their understandings of mental health stigma. Members of staff suggested that stigma is not well defined or understood, which was echoed by some young people who suggested they did not know what stigma meant.

[Chapter 6](#_Chapter_6._Results) addresses research question 2 which concerns participant’s experiences of stigma. Many participants discussed experiencing stigma in individual interactions with adults in particular. However, young people suggested that access to and their treatment within mental health services is more important than the stigmatising attitudes held by those around them. Many participants questioned the prioritisation of their mental health and access to mental health care. This chapter highlights structural levels of stigma may be just as important to young people as stigmatising interpersonal interactions.

[Chapter 7](#_Chapter_7._Results) addresses research question 3. This chapter discusses the discourses highlighted by participants as used to construct young people and their mental health in a way that is stigmatising. The participants’ understandings of structural stigma as something that is present but covert is also discussed.

[Chapter 8](#_Chapter_8:_Discussion) discusses how the participants understand stigma as something that is ill defined and often couched in an expert discourse that is inaccessible to them. This chapter highlights how the data demonstrates that experiences of stigma come from different societal levels. This chapter suggests that understanding stigma at a structural level may have more value for young people for describing and understanding their experiences. Suggestions for policy and practice are provided. This chapter also provides a conclusion to the thesis.

## 1.7 Chapter Summary

This chapter has introduced the topic of the thesis and the research questions that will be addressed. The context of ways in which youth mental health is framed in the UK has been established and the background of mental health stigma campaigns in Scotland was discussed. This chapter has also established the ways in which stigma, young people and mental health can be understood throughout this thesis. Finally, the chapter provided an overview for the rest of the thesis. The following chapter provides a genealogical approach to the conceptualisations of stigma through theoretical and empirical studies, with a particular focus on youth mental health stigma literature.

# Chapter 2: Theorising Stigma

## 2.1 Chapter Overview

This chapter explores the ways in which discourses have constructed mental health as a stigmatised way of being over time. Firstly, this chapter takes a genealogical approach to examining the stigmatisation of mental illness over time. Secondly, this is followed by a discussion of the ways in which the concept of stigma has been theorised over time. Lastly, this chapter discusses the novel approach of using Foucauldian concepts such as discourse and power-knowledge to understand the stigmatisation of mental ill health. This Foucauldian approach is used to move forward the existing understandings of mental health stigma, which historically has examined stigma as an individual psychological process (Corrigan & Watson, 2007; Hatzenbeuhler, 2014). Instead, this research explores stigma at the micro, meso and macro sociological levels (Giddens, 2001).

## 2.2 The Stigma of Mental Health and Illness: A Genealogical Examination

This section will discuss the application of Foucault’s Genealogical principles of historical interrogation to the stigma of mental health and illness. First the rationale for applying a genealogical approach to the investigation of the concept of stigma will be explicated. An historical investigation of the concept of stigma and a demonstration of the understanding of this concept and its subsequent application to mental ill health will be discussed. Thirdly the theoretical and empirical development of the concept of stigma will be examined in order to demonstrate the lack of consensus and coherence of the concept. This is undertaken in order to disrupt the taken-for-granted-ness of the concept of stigma in current research.

### 2.2.1 Why A Genealogical approach to Stigma?

Genealogy is an approach developed by Michel Foucault, to critically interrogate the past in order to reframe the present. Foucault’s genealogy works on key principles, rather than providing a concrete methodological recipe (Hook, 2005). Foucault used Genealogy in Discipline and Punish in order to ask which practices, discourses and conditions have led to our current situation, in the context of modern prisons and surveillance, allowing us to disrupt taken-for-granted assumptions (Gutting, 2005). Applying the principles of genealogy allows for the illumination of power struggles that have led to current “knowledge” and use of existing discourses (Baert & Carriera da Silva, 2010). The present is critiqued through the demonstration that current understandings have not come about as a result of logical or natural progression, and that there is a lack of coherence due to the existence of multiple layers of meaning for the same discourses and concepts (Baert & Carriera da Silva, 2010).

In her book, *Stigma: The Machinery of Inequality*, Tyler (2020) applies a similar genealogical approach to her understanding of stigma. Tyler argues that stigma manifests as a form of power which has been used over time in order to subjugate populations. Tyler takes an historical approach to understanding stigma as she traces different meaning and applications of the concept. Tyler traces the physical application of a mark through branding or tattooing bodies of enslaved and imprisoned people in order to mark their lack of power and social status. She demonstrates how the application of stigma to devalue a person, and to exploit and dehumanise them, remains a method of exploitation today (Tyler, 2020). By quoting Judith Butler, Tyler argues that “power etches itself into us” demonstrating the embodiment of devaluation, and highlighting that power and stigma (as it is understood as a “mark of disgrace) are intrinsically linked (Tyler, 2020; Goffman, 1965). Power is the force through which stigma is applied in order to reproduce inequality and maintain power structures (Tyler, 2020).

In a similar fashion to Tyler, in this chapter I apply Foucault’s principles of genealogy to the concept of stigma by tracing an historical line which connects past understandings of stigma to its current link to mental health and illness. I will demonstrate that the stigma of mental health and illness has come about as a result of power struggles and subjugation. In this section I demonstrate how the meaning of the word “stigma” has changed and developed over time from a mark of holiness to a mark of shame and disgrace, while academic understandings of the concept currently overlap, compete against one another and are often murky. I cannot provide a full historical examination of the stigma of mental illness, as this is not the key purpose of this thesis. However, I intend to demonstrate the messiness of the concept of stigma and its attachment to mental illness over time. By doing so I attempt to destabilise current discourses which take the stigma of mental health as the “natural order of things” (Hook, 2005). It will be shown that these discourses became dominant through power struggles of knowledge and the institutional adoption and application of these discourses (Gutting, 2005). This endeavour seeks to critique the taken-for-granted-ness of the connection between mental ill health and stigma. By questioning these present assumptions by tracing how they came to be, I intend to provide space for subjugated knowledge to challenge the dominance and power of hegemonic knowledge (Hook, 2005).

### 2.2.2 Historical Origins of the Stigma Concept

In his book Stigma: Notes on A Spoiled Identity, Goffman suggests the term stigma comes from the Greek word Stigmata. He suggests this refers to marks or signifiers on the body which demonstrate the lowered moral status of the person to which they are attached (Goffman, 1963, pp. 11). He suggests the sign was burned or cut onto the body to identify the bearer as enslaved or criminalised by society so that others may avoid them, or note their lower social status. We can see this conceptualisation of stigma as a mark throughout Imogen Tyler’s work on stigma as she also draws attention to the Greek origins of stigma as a forced tattoo which signifies the permanent decreasing of social power for the tattooed. She identifies one of the first uses of the word ‘stigmatias’ can be traced to the sixth century BC in a poem by Asius of Samos, to describe an enslaved person (Tyler, 2020). Tyler highlights that the act of marking a person in the age of ancient Greece and Rome was used to note the lack of citizenship held by enslaved people and religious minorities which demonstrates the intricate connection between stigmatisation and racism, discussed in Tyler’s work (Tyler, 2020, p. 35). Within this work we can see the development of Goffman’s conceptualisation of stigma, in which he converts the physical demarcation of a devalued individual to a metaphorical label to signify a person’s social disgrace (Goffman, 1963; Tyler, 2020).

While the idea that stigma has always been about marking a socially disgraced individual is useful, there is also evidence that the word stigma, or stigmata, has been understood as a mark of positive identity of the bearer. For example, Roman soldiers would receive tattoos demonstrating their loyalty to the emperor (Muessig, 2020). There is also the instance of the word in connection to a mystical or religious mark which in some contexts does not devalue a person, but instead raises a person’s value, particularly in the eyes of The Roman Catholic Church. This form of sacred stigma is said to come about as a result of unrelenting faith. St Francis of Assisi is generally held to be the first receiver of divine stigmata which manifested as 5 wounds visible on his hands, feet and the side of his torso (Muessig, 2020). These wounds were said to cause pain and nails could be seen protruding from them (Muessig, 2020). These stigmatic wounds appear to represent those suffered by Jesus during his crucifixion, with other instances of sacred stigmata involving bleeding marks on the forehead denoting the crown of thorns (Whitlock & Hynes, 1978). Francis of Assisi is said to have developed these wounds after 40 days of fasting and meditation which involved falling into a trance-like state of religious rapture and having a vision of a Seraph (Muessig, 2020; Whitlock & Hynes, 1978). St Francis was canonised as a result of the miracles he performed and manifested, including his stigmatisation (Muessig, 2020). This suggests that in the context of the Catholic church the manifestation of stigmata is a blessing, demonstrating devout commitment to the religion. However, through the descriptions of St Francis’ religious zeal we can begin to see connections with descriptions of psychiatric illness.

Religion and “madness” appear connected throughout history. Madness was often described as being caused by being possessed or tormented by evil spirits or displeasing one’s God/s (Scull, 2015, Cockerham, 2000). Scull suggests that many prophets, who are seen to have a unique connection to a God are described as lacking reason, exhibiting erratic behaviour, having religious hallucinations and delusions that they could perform miracles (Scull, 2015). Therefore “madness” or mental ill health, was explained by religion as divine interference with the mind. Here we can see madness understood through a religious framework which links stigmata to a sacred fervour, however stigmata and the “religious fervour” are viewed positively in this context.

However, we can begin to see a power struggle between these discourses if taking a genealogical view. As psychiatric discourses become more powerful, phenomena that would have a religious explanation in the past, began to have psychiatric explanations. Stigmata has been connected to experiencing “hysteria” by Maclellan who highlights that in 1897, French psychiatrist Jean Marchelle Charcot suggested that St Francis was hysterical as a way of explaining his injuries (Maclellan, 2020). Charcot linked the appearance of similar stigmatic wounds on a patient with her presentation of “hysteria” (Maclellan, 2020). Charcot attempts to explain the manifestation of the marks of stigmata through a frame of psychiatric illness (Maclellan, 2020). The struggle between discourses of religious and psychiatric, mystical and observable “science”, irrational behaviour and enlightenment, can all be seen in this example. Here we can see the linking of madness with the term stigma, as well as framing stigma, the mark, as denoting a negative, or pathological trait. We can now begin to understand how discourses of stigma and mental illness begin to connect and intertwine over time.

This section has discussed the historical origins of the concept of stigma and has demonstrated how discourses of stigma and mental ill health have become intertwined over time. The following section discusses the theoretical development of the concept of stigma within academia.

## 2.3 Theoretical Developments of the Concept of Stigma

It was important for this thesis to consider all the various ways in which stigma has been conceptualised over time in order to develop these understandings further and to evaluate the benefits and weaknesses of these theories. This section provides an overview of the development of stigma theories. This begins with Goffman who was an influential figure in the initial conceptualisation of stigma. Secondly this section discusses the development of the concept of stigma through labelling theories, followed by conceptualising stigma as a process of stereotypes, prejudice and discrimination.

### 2.3.1 Goffman

Erving Goffman was the seminal figure in the sociological and theoretical development of stigma’s connection to mental health and illness. Goffman was an influential sociologist whose work focussed on micro-sociology and individual interactions. Both Goffman and symbolic interactionism eschew encompassing system-based explanations, instead focussing on the interaction between individuals and the agency they have to influence their situations (Baert & Carreira da Silva, 2010). Goffman was interested in the ways individuals presented themselves through negotiations between social actors (Cuff, Sharrock & Francis, 2006). This focus is clear within his work on Stigma which attempts to understand how individuals are treated differently than others within social interactions.

One of Goffman’s first pieces of work, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (1968), focused on what he called “total institutions” and the interactions between individuals within these institutions. Total institutions were conceptualised as institutions which were encompassing of activities of daily life for those within them, and were cut-off, barriers to social interaction out with the walls (Pescosolido & Martin, 2015). Goffman outlines the possibilities of interaction for those who enter such institutions, and the ways in which the processes of mental hospitals have an impact on the self (Goffman, 1968; Pescosolido & Martin, 2015). Similarly, Goffman’s interest in micro-interactions continued into to his work on stigma. Goffman’s seminal work on stigma still holds dominant in our understanding of the concept. Half a century after Stigma: Notes on a Spoiled Identity was published; his key definition of the concept is still used by researchers investigating the phenomenon, which will be discussed later in this chapter. Goffman’s definition of stigma is that a person in possession of an undesirable attribute is viewed negatively by others. The person is viewed as “bad, dangerous or weak” and therefore “reduced in our minds from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p.12). Stigma is therefore a characteristic of the person that influences how other people perceive them, so much so that they are seen as less of a person.

Goffman highlights three different kinds of stigma that can elicit this negative reaction. The first he terms “abominations of the body” which are physical disabilities or illnesses that affect a person’s physical appearance (Goffman, 1963, p.12). The second is termed as “blemishes of individual character” which Goffman suggests are a result of mental illness, imprisonment, addiction or homosexuality (Goffman, 1963, p.12). Thirdly, “tribal stigma” is described as the result of a person being from a group who are a particular race, nation or religion that others find different and view negatively (Goffman, 1963, p.12). Here Goffman explicitly connects stigma to mental ill health as a characteristic that can be understood as discrediting.

A key aspect of Goffman’s understanding of the stigmatisation of mental ill health is that it is a relationship between characteristic and stereotypes. There is then an expectation that the person with the characteristic will behave differently to someone without the characteristic. Goffman’s definition of stigma suggests that “normals” learn what is acceptable in society through socialisation and then make a judgement about whether the person before them fits with this understanding. A stigma is attached to a person when they appear different from what others expect of them and this difference is viewed as undesirable and unacceptable (Goffman, 1963). Goffman highlights that it is this relationship between “normals” and stigmatised that leads to stigma being attached to a person with undesirable characteristics. Goffman also suggests that the role of mental hospitals was to “re-socialise” individuals who behaved in ways that were outwith the expectations of society (Goffman, 1961). Goffman’s ideas of stigma are therefore focussed on how the interactions between individuals lead to a person to experience stigma.

Within Goffman’s theory of stigma, he also describes mechanisms for coping with stigma that individuals employ. The first method of coping is called “defensive cowering” which is not given an expansive explanation from the author but is illustrated by two examples. The first example is a person avoiding meetings with other people. This is evidenced in empirical research which demonstrates that some young people experiencing stigma can isolate themselves from others in order to avoid further stigmatising interactions (Kranke, 2010). The second example, is of a woman believing that her fear of being ridiculed has made her more open to further taunting. Thus, suggesting that behaviours associated with avoiding stigma can in themselves lead to further experiences of stigmatisation, noting a cyclical nature of stigma.

Goffman also suggests that individuals cope with stigma by approaching interactions with others with “hostile bravado” which is given little further explanation but could be related to addressing others in an aggressive way, which has been demonstrated to be used as a coping method by youth with lower self-esteem (Moses, 2015a). A third coping method described by Goffman, was finding a place with “sympathetic others” who also experienced the same stigma as the individual in order to mitigate the sense of isolation. This has been demonstrated as a key coping mechanism for youth experiencing mental health stigma (Kranke, 2010; Moses, 2015a).

However, Goffman suggested that being with others experiencing similar stigma may not always be beneficial to the individual. Goffman used quotes from individuals in a mental asylum whose language demonstrates the individual’s wish to distance themselves from others within the group: “I’m not crazy but even if I was, I don’t belong in here with these low-grades” (Goffman, 1963, p. 33). The language is used here in order to distance the individual from the stigmatised group by contributing to the stigmatisation of the individuals within that group. This can be seen as a coping mechanism to defend oneself against stigma. This demonstrates that while people with mental ill health can experience stigma, they can also enact stigma onto others. Instances of this can also be found in existing empirical literature. Previous studies have highlighted that young people receiving mental health care and treatment position themselves outside of the expected stereotypes of people receiving mental health care, and often use derogatory language to indicate different categories of mental health patient (Mitten, 2016; Prior, 2012).

Despite the importance of Goffman’s ideas, there have been some critiques of his investigation of stigma solely at the level of personal interaction. Tyler (2020) critiques Goffman’s work as being apolitical and highlights that he ignores the politics of segregation and the impact of stigma on the lives of black people under the Jim Crow laws at the time of his writings (Tyler, 2018). She notes that the dominance of Goffman’s micro-interactionist understandings of stigma has led to overlooking key questions such as where stigma comes from, for what purpose and for whom it is beneficial (Tyler & Slater, 2018). This research, building on Tyler’s, therefore seeks to move beyond only considering stigma at a micro-interactionist level and towards a greater focus on the role of social structures, discourses, knowledge and power in order to address this theoretical gap in dominant conceptualisations of stigma in the extant literature on young people’s mental health.

Goffman was a seminal stigma theorist and is useful for understanding that stigma is a way by which individuals are identified as different. However, this section has highlighted that his conceptualisation of stigma fails to explore the role of power and structure in its manifestation. The concept of stigma has developed over time and the following section will demonstrate a conceptual move to consider stigma as a process through which the individual is labelled and ostracised because of this difference.

### 2.3.2 Labelling Theories

Moving on from Goffman, the theoretical development of stigma can be traced through to labelling theory which was first introduced by Howard Becker. Labelling theory is tied to ideas of deviance, which understands as “anti-social behaviour that threatens the norms and values of society” (Becker, 2003). Becker’s theory of deviance involves the process of applying social labels to individuals. These labels influence how people are treated, which reinforces and amplifies their deviancy (Becker, 2003). Thomas Scheff then applied labelling theory to the context of mental illness. He suggested that people who experience mental ill health break “residual rules of society” which results in labelling (Scheff, 1974). Scheff views these residual rules as unwritten but important aspects of social interaction between individuals, which were based on Goffman’s understandings of the presentation of the self (Scheff, 1974). Scheff suggests that those labelled are rewarded for maintaining their role as a person with mental illness, become trapped in their role, or can be punished for attempting to reject this role (Scheff, 1974). Goffman offers a similar suggestion in his work Asylums where he suggests that there are mechanisms within psychiatric institutions which reward patients for conforming to their “sick role”. This conceptualisation of labelling was criticised for its assertion that labelling was a direct cause of mental illness and as a result has been developed by Link & Phelan to take into account this criticism (Scheff, 1974; Gove, 1975; Link & Phelan, 2013).

A key contribution to theoretical understandings of stigma is Modified Labelling Theory. In their article “Conceptualizing Stigma” Link and Phelan describe stigma as: “the co-occurrence of its components: labelling, stereotyping, separation, status loss and discrimination” (Link & Phelan, 2001, pg. 363). Throughout this article they highlight that the concept of stigma has been met with criticism due to a lack of clarity in its definition; its conflicting utilisation, and inconsistent application to various circumstances (Link & Phelan, 2001). Link and Phelan also highlight that because of the dominance of social psychologists in the investigation of stigma, the concept of stigma focusses on interpersonal interactions that create stigma to the exclusion of other factors, specifically the exercise of power (Link & Phelan, 2001). The authors highlight the inconsistencies of the concept of stigma and move forward to their own theoretical development of stigma, which they refer to as a modified labelling theory which outlines key components of a process of stigma (Link & Phelan, 2001).

Modified Labelling Theory begins similarly to Goffman, with an observation that people develop understandings of what mental illness means through socialisation. Link & Phelan then posit that people will use these understandings about mental illness to develop expectations about how society will react towards people with mental illnesses and how they might be responded to if they experience mental illness. If a person believes that others will reject those with a mental illness then this rejection will also apply to them (Link & Phelan, 2009). Link & Phelan also highlight that those who have been labelled as mentally ill and expect rejection, experience negative consequences as a result. They demonstrated that these negative results occur in those who have labelled as mentally ill but not in those who are unlabelled. This demonstrates that labelling does have an effect on how people with mental illnesses are treated (Link et al., 1989). Like Goffman, Link & Phelan (2009) suggest ways that individuals cope with labelling and stigma. Secrecy is adopted which involves concealing that a person has been treated for mental illness. Withdrawal involves avoiding situations in which a person may be subject to threatening stigmatising behaviour or attitudes from others. Finally, it is suggested that individuals attempt to educate others in order to disconfirm the negative stereotypes applied to them (Link & Phelan, 2009).

### 2.3.3 Stigma as a Process of Stereotyping, Prejudice and Discrimination

Psychological understandings of stigma also began to be developed, which aid in our conceptualisations of stigma as a multifaceted process. This psychological understanding of the concept of stigma suggests that it is a process of stereotyping, prejudice and discrimination. Patrick Corrigan is one such proponent of this description of stigma. His work focuses on the use of stereotypes and prejudice to enable the discrimination and exclusion of people with mental ill health and is used as a key definition in many other empirical works on stigma (Corrigan & Watson, 2002; Hanlon & Swords, 2019; Kasow & Weisskirch, 2010). Corrigan defines stereotypes as “seemingly fact-based knowledge structures” which involve negative assumptions (Corrigan & Bink, 2016, pp. 230). Stereotypes are used to demonstrate differences between “insiders” and “outsiders” (Maier et al., 2014, O’Driscoll, 2015), and this becomes a prejudice when there is agreement with the stereotypes and people feel a negative emotional response towards the object of the stereotype (Corrigan & Bink, 2016; Corrigan & Shapiro, 2010, McKeague et al., 2015, Woodgate et al., 2020). McKeague highlights that in the context of youth mental health the stereotypes applied to young people with mental ill health are connected to dangerousness which leads to fear, avoidance and rejection of them (Mckeage et al., 2015). Other assumptions about people with mental illness that become stereotypes are also highlighted in the literature, such as perceptions that people with mental ill health are responsible for this (Corrigan & Bink, 2016; Mitten et al., 2016). It is also noted that people with mental ill health are considered to be weak, flawed, socially incompetent and lacking capacity (Clark et al., 2020, Chandra & Minkovitz, 2006). Discrimination is described as the behavioural enactment and response to stereotypes and prejudice and can manifest in exclusion from housing, jobs and other aspects of social life (Corrigan & Bink, 2016; Kasow & Weisskirch, 2010; Woodgate et al., 2020)

This section has examined the theoretical conceptualisations of stigma which focus on interpersonal interactions and psychological processes which manifest stigma. These conceptualisations are embedded within current discourses about stigma and mental ill health and are regularly used in empirical investigations (Corrigan, Markowitz & Watson, 2004). This section has highlighted that Link & Phelan amended some of the issues with Labelling Theory and their Modified Labelling Theory is often cited, as well as Goffman’s conceptualisation, in empirical literature. Stigma has been a highly researched and theorised, however it has also been suggested that stigma can be a useful concept for individuals who experience mental ill health, due to its emancipatory potential (Pescosolido, 2015). Goffman’s work on stigma has been cited as helping to transform the understandings of those with lived experience of mental ill health, and contributed to the rise of the psychiatric survivor movement as it provided a framework through which to view their experiences in psychiatric hospitals (Pescosolido, 2015). Some critical psychiatrists such as Thomas Szasz (1960) and RD Laing (1960) attempted to consider the impact that stigma and labelling had on those being diagnosed and treated within the psychiatric system. However, Pescosolido (2015) contends that the key focus of psychiatry remains categorising different diagnoses which could suggest that psychiatry can add to experiences of mental health stigma. I would add that considerations of the role of power and social structures remain under investigated, particularly in empirical youth stigma research. Theories which attempt to incorporate power into the concept of stigma will now be discussed.

### 2.3.4 Stigma Power

As noted above much of the existing theorising on the concept of stigma has involved individual interactions and psychological processes, however these previously discussed theories fail to take power into account, which leads them to be less useful in this current research. However, Link and Phelan extended their understanding of stigma to include the concept of power (2014). Link and Phelan demonstrate that in order for stigma to exist there must be a group that possesses social, economic and political power that provides the identification of differentness, the construction of stereotypes and the resulting rejection and discrimination. They demonstrate that stigma power is often covert and difficult to identify. This stigma-power concept suggests that those who stigmatise have three key motivations to do so. The first is to keep people down, as wealth, power and higher social status can be achieved when one group holds dominance over another (Link & Phelan, 2014). The second is to keep people in: stigma maintains normative expectations of behaviour by punishing those that violate said norms thus reminding people to adhere to them. Thirdly stigma power is used to keep people away in an attempt at disease avoidance. There may have been an evolutionary advantage in avoiding people who looked or behaved in a way that was incongruent with that of a “healthy” person in order to maintain distance from a potential contagion (Link & Phelan, 2014).

Through the model of stigma-power Link & Phelan demonstrate mechanisms through which this is enacted. Direct person-to-person discrimination is difficult to maintain, it is argued, because it is easy to highlight these instances. Stigma works better if it is “misrecognised” as just the natural order of things, such as the acceptance that people with mental illnesses are to be considered weak, to be feared and to be avoided. The idea of the taken for granted nature of stigma is similar to the idea of unintentional structural discrimination and can be connected to understanding of structural reinforcement of stereotypes and prejudicial beliefs in a way that is covert but not benign (Corrigan & Lam, 2007). Empirical work which examines structural stigma will be discussed in more detail in Chapter 3: Literature Review.

This section has discussed the theoretical developments of the concept of stigma. It has demonstrated that the majority of the conceptualising of stigma has focussed on individual interactions and psychological processes. Link and Phelan’s (2014) concept of stigma power is useful for this current research study, however I felt that operationalising this concept alone was not enough to develop a full understanding of stigma at various different sociological levels. This chapter will now go on to discuss the use of Foucauldian concepts I this study and their usefulness for investigating stigma in a new way through discourses which construct mental ill health as a stigmatise-able way of being.

## 2.4 The Use of Foucault’s Concepts in This Thesis

I felt that using a theoretical framework which focusses on objectivity and rationality may not be necessarily appropriate for this research study. Judgements based on whether a social actor is “rational” in that they can accurately represent reality through language can, and historically has, excluded testimony on the basis of race, gender, age and perceptions of whether that social actor is “sane” or not (May & Powell, 2008). Young people who have experiences of mental ill health can often be subject to epistemic injustice due to hegemonic discourses of adultism and sanism which position those out-with these constructed identities (young people as not-adult and mental illness as insane) as deficient (Fricker, 2007; Liegghio, 2016). I therefore chose a paradigm which acknowledges that the research participants co-create reality through engaging with the researcher and drawing on discourses that are available to them in the specific time and place of the research encounter. The researcher themselves is situated in society, and I take this approach in order to attempt to critically question what has come to be hegemonically “known”.

Throughout his career, although shifting through different “phases” of work and focus, Foucault was concerned with the historical development of knowledge and the creation of outsiders in society (Cuff, Sharrock & Francis, 2006). His work is therefore particularly useful for this study. This study was theoretically led by critical questioning of the concept of stigma, how society came to know that experiencing mental ill health is a “stigmatise-able” state of being. Similarly, I also wanted to investigate the ways and extent in which young people who have experienced mental ill health are discursively constituted and categorised as outsiders in society. Foucault has already investigated the classification of madness through his archaeological approach in Madness and Civilisation (1967), however he did not provide a critique of the concept or process of stigma in this endeavour. This study therefore uses Foucauldian conceptualisations of discourse, knowledge and power in order to critically investigate youth mental health stigma. This section will discuss the key concepts of knowledge, power and discourse and the ways in which they will be utilised in this study. It will then be discussed how I intend to use these concepts alongside existing understandings of stigma, such as Goffman (1963) and Link & Phelan’s stigma power (2014) in order to investigate stigma at multiple sociological levels.

One key concept that is used throughout this study is discourse. Foucault defines discourse in many different ways throughout his work (Mills, 2003). In Archaeology of Knowledge, he refers to discourse as a group of statements, or regulated practice that represents these statements (Foucault, 1972). These statements can be anything that have meaning and effect, and often Foucault suggests that discourse is a form of structure and rules which allow particular statements to be produced (Mills, 2003). This, to me, suggests that discourse can be understood not only in terms of linguistic utterances but also as structurally embedded practices which have a role in constructing and defining what it is possible to think, do and say in specific contexts of time and space. Foucault also uses the concept of episteme in theorising discourse. The episteme is considered by Foucault as the structure, context and socio-historical conditions in which knowledge is created and produced (Cuff Sharrock & Francis, 2006).

Discourse is tied into another of Foucault’s key concepts which is power/knowledge. Foucault was particularly interested in how things came to be considered as facts, how some things become “true” and others not (Foucault, 1980). Foucault’s conceptualisation of power is useful for this thesis as he uses it to demonstrate how the knowledge developed by science and medicine has led to discourses that reinforce the power of doctors, and psychiatrists (Foucault, 1965; Foucault, 1973 in Lagrange, 2003). Psychiatrists have access to specific knowledge about illness disease and the body. Therefore, they have power to define people as having a mental illness, and also the power to define what these mental illnesses are (Bentall, 2003; Foucault, 1974 in Lagrange 2003). Psychiatry has used the legitimacy that comes with the discourses of science and medicine, based in the epistemology of positivism, and the claim that these disciplines have unique access to “truth” (Bentall, 2003; Burr, 1995; Nettleton, 1995). Foucault argues that this power is then enacted through institutions of the hospital and the asylum and the application of treatments to psychiatric patients (Foucault, 1965; Foucault 1973 in Lagrange, 2003). Foucault’s concept of power that is produced from knowledge and discourse is helpful in order to understand power as a process.

Foucault’s conceptualisations of power change over the course of his writings. The particular approach to power that is useful for this research is the concept of power/knowledge which is useful for understanding the ways power is connected to knowledge and hegemonic discourses which construct what is counted as knowledge and by which groups (Foucault, 1978). Foucault’s work was also concerned with the ways in which individuals are able to uphold or resist the effects of institutions, and placed importance on the way power operates within everyday relationships between individuals and institutions (Mills, 2003; Foucault, 1977; 1978). For Foucault power is not only repressive but it is creative in that it manifests the possibility of behaviour, discourse and knowledge. This is an important way of considering power as it gives rise to considering individuals as active agents of power in their everyday lives; rather than as exclusively consider power as coming from the “top down” as an oppressive force. This approach is useful for advancing our understanding of stigma as something that only operates between individuals and allows to understand the ways in which individuals relate to institutions and the interactions which manifest and constrain stigma across multiple societal levels.

Foucault sees knowledge construction through power relations and suggests that knowledge is not an objective reflection of reality but the product of power struggle (Foucault, 1980; Mills, 2003). He suggests that “disciplinary technologies” such as surveillance, bureaucracy and biopower (institutional regulation of the body) are used to produce normative expectations which are reinforced throughout society (May & Powell, 2008). Arguably individuals become both the object and the subject of societal power. Foucault suggests all that is required is a gaze that each individual will internalise so that they become their own overseer. I argue that through this conceptualisation of power we can also see the role of stigma, to the extent that stigma, or even the threat of it, is used in an attempt to regulate the behaviour of the individual and the concept of self-stigma demonstrates the internalisation of this power in order for one to govern themselves.

Arguably the disciplinary technology of bio power is exercised on youth with mental ill health in many ways. Young people in educational institutions are subject to bio power in terms of control over absences, lateness, where you can go and when, when you can use the bathroom, when you may stand up or sit down, specific behaviours and attitudes are prohibited. This extends further in terms of youth with mental ill health – their behaviour and emotions are pathologized if they do not fit within expectations of developmental or societal norms and are subject to increased observation and reduced autonomy. While the body / self becomes the target of power, it can also become the centre of resistance to power and through which struggles of power are exercised. It is therefore important in this study that I am aware of the power that I as a researcher has in shaping “knowledge”, but by centring the accounts of the participants the power imbalance might be redressed and knowledge can be understood as co-created.

There have however been criticisms of Foucault to take into account here. Foucault’s conceptualisation of power has been critiqued for examining the repressive force of power, despite his insistence that it is productive (Mills, 2003). Foucault’s suggestion that power is the force through which resistance can be achieved undermines the agency of individuals to counter repressive discourses, particularly through his suggestion that powerful discourses shape the individual. Further, feminist critiques of Foucault’s concept of knowledge/power highlight that taking all knowledge claims to be “innocent” and that one cannot be prioritised over the other has been challenged in terms of social justice aims (Fawcett, 2000; Fraser, 1993). Fraser highlights that power cannot be identified without attaching value to the knowledge claims that to which power is attached, despite Foucault’s attempts to do so (Fraser, 1993). This could be challenging for research such as the current project, which attempts to challenge dominant regimes of knowledge and power in order to redress oppression and injustice which result from them. However, the key aspect of Foucault’s conceptualisation of power as productive rather than repressive helps to add hope to our understandings of power as it can be manifest everywhere and holds the potential for the production of counter-knowledge. Further, Foucault’s concept of power does not suggest equal access to knowledge, discourse or power. Unacknowledged power can lead to its maintenance and that taken-for-granted knowledge as truth can lead to its dominance (Fawcett, 2000; Foucault, 1978). In order to challenge this, it is important to highlight the way stigma is manifested through power, discourses and knowledge. This challenge to hegemony allows space to suggest positive and emancipatory alternatives.

While the concepts of discourse and power / knowledge are useful in order to interrogate stigma from a novel perspective, exclusively considering the entire research study in terms of the structural discourses that constitute the participants experiences would risk undermining their lived experience. In order to overcome this, I have taken the suggestion provided by Stacey Hannem (2012) in her work, of combining Foucault and Goffman in order to investigate stigma at multiple sociological levels.

This thesis developed iteratively over time and the decision to utilise Foucauldian concepts resulted from examining the existing theoretical and empirical literature. Stigma has previously been conceptualised and investigated at a predominantly psychological and interpersonal level. Goffman (1965) initially introduced the concept of stigma from a micro-sociology tradition which took a particular view of stigma as something that was produced through interactions between people. While this is a useful approach to an extent, Goffman is critiqued for not considering the structural aspects of society which lead to and allows the manifestation of stigma (Tyler, 2020). A key question for me during this research process has been about how mental ill health came to be a stigmatised way of being in the first place. I argue that a key issue missing from Goffman, and other theoretical and empirical examinations of the concept of stigma, is an issue of power. While Link & Phelan (2001) have developed the concept of stigma power, I argue this understanding of stigma has been under-utilised. As a result, theoretical tools provided by Foucault’s work are applied to this research in order to advance understandings of the stigmatisation of mental ill health through a lens of power - knowledge and discourse. This section discusses the use of Foucault as a way of moving Goffman’s understanding of stigma forward (Hannem, 2012).

## 2.6 Combining Foucault & Goffman

Stacey Hannem suggests that stigma should be considered as something that is symbolically enacted through interactions and structurally embedded within cultural institutions (Hannem, 2012). Hannem (2012) highlights that Goffman’s work alone, while useful, is not conducive to understanding stigma at a structural level or investigating how social structures and institutions contribute to the stigmatisation of particular groups (Hannem, 2012). She therefore suggests that Michel Foucault’s work on truth, power and knowledge provides useful conceptualisations of structural conditions for stigma (Hannem, 2012).

However, she also highlights that Foucault’s work alone would neglect the agency and subjective experience of her participants. This was also a concern for me. I had intended to explore the concept of structural stigma in relation to the lives of youth with mental ill health in Scotland and I was unclear on how to access structural understandings of something that had predominantly been investigated through interactions with others at a micro-level.

Using both Goffman and Foucault together can balance each of their limitations. Foucault can add to Goffman’s lack of attention to social structures and the concept of power. Goffman has been accused of being “apolitical” (Tyler, 2020) and Foucault’s attention to power provides space for considering ways of identifying and challenging power structures which reinforce stigma towards people with mental ill health. Goffman can attend to Foucault’s lack of focus on the subjective experience and agency in interactions allowing for the consideration of resisting stigma within interpersonal situations.

Hannem’s (2012) combination of Foucault and Goffman is based on the suggestions of Ian Hacking (2004). Hacking argues that Goffman and Foucault, despite appearing to have different priorities in their theoretical understanding, are both interested in how individuals can and cannot be constituted (Hacking, 2004). Hannem uses this suggestion of combining Foucault and Goffman in order to understand how the lived experience of her research participants are shaped by social structures and attempts to expand Goffman’s insights on stigma by adding Foucauldian concepts. Foucault can add to Goffman’s understanding of stigma by allowing us to investigate the historical and structural origins of the definition of attributes that are deemed discrediting (Hannem, 2012). Goffman and Foucault can be complimentary within one framework due to their shared relativist ideas. For Foucault, reality is manifested through societal power structures (Gutting, 2005). For Goffman reality is constituted through interactions with others. For both Foucault and Goffman reality is relative depending on different social contexts.

In order to understand young people’s experiences of mental health stigma in Scotland, I believe it is important to examine their lived experiences and place importance on how they describe their experiences. This means that Goffman’s understanding of symbolic interaction and stigma as a process that happens between individuals at a micro-sociological level remains important for this study. However, there is a dearth of understanding of structural stigma, particularly in terms of the operationalisation of this concept in the context of young people and mental health stigma in Scotland. In order to access a macro-level understanding of stigma a post-structuralist lens will be used to enhance our understandings, using key concepts in Foucault’s work of discourse and power/knowledge. I intend to use Foucauldian concepts in order to develop an understanding of stigma as a discourse which operates at a structural level which constructs mental health and mental illness. Our understandings of mental health and mental illness are perpetuated through discourses of stigma as attached to mental health and illness in a way that is uncritically accepted as fact. This thesis uses Foucault as a way of understanding the dynamic aspect of stigma that can change and develop over time.

When I set out to find instances of structural stigma, such as discrimination in policy and institutions I realised this was not fully achievable due to, as Link and Phelan highlight, the covert nature of stigma power (Link & Phelan, 2001). Stigma is not always explicit, and it is difficult to pin down stigmatising instances, even in empirical research that attempts to investigate stigma. It is difficult to investigate structural instances of stigma when it is not explicit or easily identifiable. If we accept Foucault’s understanding of discourses and view them as ratified by the powerful, and are therefore structurally perpetuated, this allows us to understand the ways in which hegemonic discourses are used by social actors to create meanings. The concepts provided by Foucault will therefore allow this thesis to understand the ways in which mental health and illness have been constructed through the use of dominant discourses, as something that can be stigmatised. This ties in with a social constructionist epistemology which is useful for this thesis as it accepts that knowledge is a relative concept and can change over time and place, however this is discussed in more detail in Chapter 4: Methodology.

## 2.7 Chapter Summary

This chapter has demonstrated how the concept of stigma has developed over time, highlighting multiple different understandings and inter-related stigma concepts and the ways in which this thesis builds on previous theorising of stigma by using Foucauldian concepts of discourses and power-knowledge. The following chapter examines how the concept of stigma has been empirically investigated in the context of youth mental health.

# Chapter 3: Literature Review

## 3.1 Chapter Overview

This chapter is a synthesis of findings from existing empirical literature based on a review of 167 empirical studies examining aspects of young people and the stigma of mental ill health. This review was primarily exploratory in nature in order for me to gain an understanding about what was already known about young people’s experiences of the stigma of mental ill health and to be able to identify what was yet to be investigated (Fink, 1998; Hart, 2006). Based on Aveyard, Payne & Preston’s (2016) suggestion, this literature set out to answer the following question:

“What is currently understood about young people’s experiences of mental health stigma?”

The literature search therefore aimed to find literature that converged on three key concepts: Mental ill health, young people and stigma. Key words were used to represent variations of these key concepts that may exist in the literature:

### Table 2: Review Search Terms

|  |  |  |
| --- | --- | --- |
| Young People | Mental Ill Health | Stigma |
| Youth | Mental illness | Discrimination |
| Adolesc\* | Mental disorder | Attitud\* |
| Teen\* | Mental health | Belief\* |
| Young Adults | Psychiatric Illness | Stereotype |
| Child\* | Mental health problem\* / issue\* | Prejudice |

ProQuest, PsychInfo, Strathclyde University library database Suprimo and Google Scholar were used to search for articles. The literature review question allowed the literature search to be specific and to aid in the definition of inclusion and exclusion criteria (Aveyard, Payne & Preston, 2016). Inclusion and exclusion criteria were applied to this search which resulted in 167 articles being included in this review. The inclusion and exclusion criteria were:

### Table 3: Inclusion & Exclusion Criteria

|  |  |
| --- | --- |
| Inclusion Criteria | Exclusion Criteria |
| About young people AND mental health stigma | Exclusive focus on adults |
| Adult attitudes, beliefs and behaviours towards young people who have experienced mental ill health | No explicit discussion of stigma |
| Young People’s attitudes, beliefs and behaviours towards people who have experienced mental ill health | About other kinds of stigma such as HIV, learning difficulties, racism, migration, LGBTQIAA+ etc |
| Young people’s stigma experiences | Focus on infants |
| Peer review journals | Not accessible through the University of Strathclyde |
| In English | Not in English |
| Empirical Research | Textbooks / Non-peer reviewed book chapters |
| Literature Reviews | Book Reviews |
| Qualitative Research | Opinion Articles |
| Quantitative Research | News articles |
| Mixed Methods Research | Policy documents |
| Within date range: 2000-2020 | Grey literature |
| Result of University of Strathclyde Suprimo search | Theoretical articles |
| Result of ProQuest search | Control trials that focus on testing interventions |
| Result of Psych Info search | Testing psychometric measures of stigma |
| Result of Google Scholar search | Abstracts only |

This review includes mixed methods, qualitative, quantitative and other literature review studies. Once I had read the articles I added key details to an Excel spreadsheet, an example of which can be found in Appendix 1. This allowed me to thematically organise the findings of these disparate articles and identify four key themes in the existing literature which were pertinent to this study: i) adult attitudes about young people’s mental ill health ii) young people’s attitudes about mental ill health iii) Young People’s Experiences of Stigma iv) Structural Stigma.

The first section of this chapter discusses the literature examining adults’ stigmatising attitudes towards young people who have experienced mental ill health (Martin et al., 2007; Mukolo & Heflinger, 2011; Perry et al., 2007; Pescosolido et al., 2007a). This section also discusses general adult attitudes towards young people disclosing mental ill health (Buchholtz et al., 2015; Corrigan et al., 2016; Mulfinger et al., 2019), and finally the specific attitudes of adults who are around young people such as parents (Koike et al., 2017; Mueller, Callanan & Greenwood, 2014), teachers (Cooke, King & Greenwood, 2016; Danby & Hamilton, 2016) and medical staff (Sandhu et al., 2019; Timson, Priest & Clark-Carter, 2012).

The second section of this literature review discusses literature which focusses on young people’s attitudes towards mental ill health (Bradbury et al., 2020; Kerr et al., 2012; Pang et al., 2017; Pinfold et al., 2003; Wahl et al., 2012). The second section also goes on to discuss literature which focusses on young people’s attitudes towards specific diagnoses such as schizophrenia (Wright, Jorm & Mackinnon, 2011), depression (Georgakakou-Koutsonikou & Williams, 2016), and anxiety (Hanlon & Swords, 2019). This section lastly examines young people’s behaviours which manifest from these stigmatising attitudes such as willingness to help a person experiencing mental ill health (Law, Rostill-Brookes, Goodman, 2009) and the avoidance (social distance) of people with mental ill health (Faulkner et al., 2010; Kasow & Weisskirch, 2010; O’Driscoll et al., 2014).

The third section discusses literature which specifically engages with young people’s experiences of mental ill health stigma. This includes direct experiences of self-stigma (Moses, 2009a; Moses, 2010a; Kranke et al., 2011) and stigma from others (Elkington et al., 2012; Elkington et al., 2013; Moses 2010b). This section also deals with literature which examines experiences of stigma when young people attempt to seek help for their mental ill health (Bluhm et al., 2014; Kranke et al., 2010; Mitten et al., 2016; Plaistow et al., 2013) as well as parents’ experiences of stigma when attempting to seek help for their child’s mental health (Moskos et al., 2007; Hickman et al., 2010). Finally, this section discusses studies which investigate ways in which young people attempt to cope with mental ill health stigma (Issakainen, 2014; Kranke et al., 2015; Prior, 2012; Rickwood et al., 2007).

Finally, this literature review examines studies which investigate structural stigma. There is a little research exploring structural stigma in the context of young people and mental ill health, and as such this section widens its scope to investigate what is understood about the concept of structural stigma in empirical literature (Hatzenbeuhler & Link, 2014; Corrigan & Lam, 2007; Pugh et al., 2015), before the section goes on to investigate what is known about young people and structural mental ill health stigma (Woodgate et al., 2020).

## 3.2 Adult Stigmatising Attitudes towards Young People with Mental Ill Health

This section discusses literature which examines general public attitudes towards young people’s mental health. The research discussed in this section is based on nationally representative samples of adults in the USA, but there is currently no literature on adult attitudes towards young people’s mental health in the UK. These research articles are based on quantitative surveys with similar methodologies in which respondents were asked about vignettes which depicted scenarios including adults and children with depression and adolescents with ADHD, depression, asthma and “daily troubles” (Martin et al., 2007; Pescosolido et al., 2007a; Mukolo & Heflinger, 2011). Vignettes are a useful tool for eliciting responses to situations in a way which can overcome social desirability bias due to the ability of the respondent to be detached from the situation being described (Erfanian et al., 2019; Mukolo & Heflinger, 2011). However, using vignettes has also been critiqued due to their hypothetical nature, responses may only reflect what the respondent thinks they would do, rather than what they would do in such situations (Barter & Renold, 2000; Erfanian et al., 2019; Mukolo & Heflinger, 2011).

A key finding of these studies which investigate American adults’ attitudes towards youth mental ill health is the concern of dangerousness. Using data from the National Stigma Survey- Children (NSS-C), Pescosolido and colleagues investigated the perceptions of children’s potential to harm themselves and others in relation to four different conditions: ADHD, depression, asthma and daily troubles (Pescosolido et al., 2007a). This study found that 33% of respondents did endorse the view that children with ADHD would be somewhat or very likely to be dangerous (Pescosolido et al., 2007a). 81% of the sample endorsed this view about children with major depression (Pescosolido et al, 2007a). This was compared to children with asthma, where 15% agreed that they could be dangerous, and those with “daily troubles”, where 13% agreed they could be dangerous (Pescosolido et al., 2007a). It is interesting to note that children with asthma were still perceived by some to have a potential for dangerousness, however the study does not provide an explanation for this view.

This small group of research studies which investigate adult stigma towards youth mental ill health demonstrates that respondents who labelled the child in the vignette as “mentally ill” were more likely to report the child’s potential for violence and to support forced treatment for the child (Pescosolido et al., 2007a; Martin et al., 2007). The results here suggest more people endorse the stigmatising view that children with ADHD or major depression are dangerous than those with “normal troubles” (Martin et al., 2007; Pescosolido et al., 2007a). This could suggest that the labelling of the child as having a mental illness leads to the perception of dangerousness, rather than what the behaviour or experiences of the child (Pescosolido et al., 2007a). A similar survey compared responses to vignettes of adults with depression to vignettes of children with depression. Respondents were more likely to see children with depression as violent, than they were adults with depression (Perry et al., 2008). This suggests that adults hold more stigmatising attitudes towards children with mental ill health than adults (Perry et al., 2007). It has been suggested that the perception of dangerousness of young people with mental ill health is related to heightened media attention surrounding school shootings and other forms of youth violence in the USA (Perry et al., 2007). However, actual instances of youth violence are complex phenomena with multiple contributing factors, and mental illness alone has a weak correlation with violence (Elbogen & Johnson, 2009).

Behaviours that result from stereotyping children and young people with mental ill health as dangerous have also been examined in the literature. The impact of labelling a child as having a mental illness is examined by Martin et al., 2007, a study which also used the NSS-C, attempted to rank the degree to which respondents held a desire for social distance from children with ADHD and major depression, compared to asthma and “normal troubles”. Social distance is a variable that is regularly used in stigma studies to examine the degree to which individuals would avoid others with mental illnesses (Martin et al., 2007). It is measured by asking questions such as how willing the respondent would be to move next door, have their child spend time with and be in a classroom with a child-like one depicted in the vignette (Martin et al., 2007). This study found that there is a gradient of rejection in terms of the illnesses examined in this study (Martin et al., 2007). Children with ADHD were the most likely to experience rejection, followed by major depression, “normal troubles” and finally physical illnesses such as asthma (Martin et al., 2007). Levels of rejection are two to three times higher for children with ADHD and major depression (Martin et al., 2007). These studies demonstrate that children who experience mental ill health must also contend with social rejection due to the perception that they could be dangerous.

Mukolo and Heflinger, 2011 examined the public’s attribution of causal factors to children’s mental health difficulties in comparison to adults’ mental ill health. By using vignettes, it was found that almost all respondents attributed biology/ genetics and parental blame to mental illnesses, which demonstrates that accepting that biological factors contribute to mental ill health does not shield parents from blame (Mukolo & Heflinger, 2011). Disorders with externalising behaviour such as ADHD were attributed to parental inadequacy more than internalising disorders such as depression (Mukolo & Heflinger, 2011). This could be due to a lack of understanding of ADHD in which the child’s behaviour is categorised as “naughty” and due to poor parenting, rather than neurodiversity. Parental blame is understood as a proxy stigmatising attitude in the youth mental health stigma literature (e.g. Mukolo & Heflinger, 2011), and suggests that key adults around the child can be influenced by courtesy stigma, which is when stigma is applied to those who associate with a person with mental ill health (Mukolo & Heflinger, 2011; Mulfinger et al., 2019; van der Sanden et al., 2016). When blame was directed towards the child the respondents were more likely to endorse a desire for social distance (Mukolo & Heflinger, 2011). The relationships between these factors and stigmatising attitudes requires further assessment, as this study found that biological and genetic understandings of mental ill health did not necessarily reduce stigmatising attitudes. There were fewer stigmatising attitudes towards asthma however, which was attributed to biological and environmental factors. This demonstrates a complex and unclear picture about the relationship between attributions of the causes of mental ill health and stigmatising attitudes.

This section has demonstrated that a key attitude held by adults towards youth mental ill health is an assumption of dangerousness and potential for violence. This can influence a greater desire for social distance from young people with mental ill health and can lead to greater rejection and isolation (Martin et al., 2007; Perry et al., 2007; Pescosolido et al., 2007a). These results also indicate that labelling a child with mental illness can lead to more stigmatising attitudes than considering their experiences as “daily / normal troubles” (Perry et al., 2007). It also appears that young people with depression may experience more rejection than adults with depression. These studies are however more than ten years old and attitudes in the USA may have changed since the data was collected. There are no existing similar studies at the time of writing which investigate adult attitudes towards youth mental health in Scotland or the UK more generally, which means it is difficult to ascertain the status of mental health stigma directed towards youth in this context at this time. In addition, as noted above, surveys using vignettes may only demonstrate hypothetical attitudes, and do not provide indications of enacted stigma for young people. This present study attempts to address these gaps by exploring youth experiences of mental health stigma in Scotland.

### 3.2.1 Adult Attitudes about Young People Disclosing Mental Ill Health

The following studies examine adults’ perceptions of young people disclosing their mental ill health to others in their lives. In one study, adults suggested that there would be more benefits than risks when disclosing mental ill health (Buchholtz et al., 2015). Adults suggested that if a young person was to disclose this would reduce isolation, promote mental health discussion and let others know that they are not alone (Buchholtz et al., 2015; Corrigan et al., 2016). Corrigan et al (2016) carried out a quantitative follow-up component of this study which adds more insight. The quantitative findings suggested that adults who had children with experience of mental ill health were more likely to report risks as a result of disclosing mental ill health (Corrigan et al., 2016). The suggestion that disclosing mental ill health can help others, and promote the discussion of mental health raises the question of who is responsible for tackling stigma. Arguably, this suggestion places the responsibility of tackling mental health stigma on those who are experiencing mental ill health. Even if disclosure would eventually aid in encouraging others to report their mental ill health, the risk remains that after disclosing the young person would still experience stigma. This is demonstrated by the young people in Buchholtz’s study, who contrasted with the adults by suggesting that disclosure of mental ill health was often met with mixed results because it was rarely discussed at home or school. They also reported that their peers often used derogatory terminology when referring to people with mental ill health, referring to them as “crazy” or “attention-whores” (Buchholtz et al., 2015, p. 162). While the students also reported potential benefits, they also reported worrying about experiencing stigma and rejection after disclosure (Buchholtz et al., 2015).

Mulfinger et al (2019) carried out a study in Germany with a similar focus on disclosure. This study used focus groups with adults and young people without mental illness to explore attitudes towards disclosure and secrecy of mental ill health in adolescents. Teachers in the focus group suggested that they had experienced colleagues believing that mental illness was used by their students in order to avoid doing homework and that teachers generally lacked awareness of mental illnesses (Mulfinger et al., 2019). This study demonstrated that mental illness was viewed as stigmatising across most participants. This study contrasts with Buchholtz’s findings, as the adults in this study believed that there were more risks to disclosure, a key one being the risk of being labelled as having a mental illness and the resulting experiences of stigma. The findings of these studies could suggest that if those with lived experience of mental ill health (either direct experience or caring for their child) are more likely to be wary of the risks of stigmatisation that could result from disclosing mental ill health. This highlights the importance of involving young people with lived experience of mental ill health in research, as if we had taken the view of adults who had not experienced mental ill health alone, we would have a very different picture of the perceived risks of stigmatisation. This present study aims to ensure the lived experience of young people with mental ill health is considered fully in order to explore stigma in Scotland in more depth.

### 3.2.2 The Attitudes of Adults around the Young Person

This section discusses the attitudes of adults around young people such as parents, teachers, and mental health professionals, and the impact this has on young people. Research demonstrates that parental attitudes have an influence on their children. One key study examined the ways in which parents communicated with their primary school aged children in the UK. This qualitative study aimed to understand how stigma develops by parents passing on messages about mental health and mental illness to their children (Mueller, Callanan & Greenwood, 2014). The semi-structured interviews suggested that parents’ communications were based on a dichotomy of “Them” (mental ill health) or “Us” (mental health) (Ibid, 2014). In terms of discussing “us” parents felt able to communicate openly about learning and physical disabilities, emotional wellbeing and used words such as “stress” and “worry” and applied these to contexts of people known to their children (Ibid, 2014). However, in the context of “them” parents demonstrated avoidance and contradictory information about mental illness. The authors of this study highlight that parent’s communication about mental illness was stigmatised in an unconscious way in which parents enacted their discomfort by fidgeting (Ibid, 2014). However, parents also stated explicitly that mental ill health is stigmatised and stigmatising language is regularly used.

Another study in Japan compared parent attitudes about serious mental ill health to their children’s attitudes using self-complete questionnaires. Parents in this quantitative study appeared to hold more negative views towards schizophrenia than their children (Koike et al., 2017). However, the parents held the same or lower levels of stigma towards other mental illnesses. A key finding in this study demonstrated that the stigmatising views of parents and their children towards mental illness were correlated (Koike et al., 2017). Parental attitudes can therefore impact the stigmatising attitudes held by their children, and that stigmatising attitudes and discomfort discussing mental ill health could be communicated unconsciously.

Feelings of discomfort when discussing mental health can be identified in teachers’ communications with their pupils about mental health. In two key studies investigating the ways in which teachers discuss mental health with their pupils in the UK, result indicated that teachers were reluctant to do so (Cooke, King & Greenwood, 2016; Danby & Hamilton, 2016). In both studies teachers reported that they felt anxious about talking about mental health and using specific terms related to mental health and mental illness with primary school pupils. There existed a perception that mental health was not an appropriate topic for young children due to the stigma attached to mental health, however it also appeared that teachers themselves endorsed aspects of this stigma. Teachers were fearful of people with mental ill health and felt the need to shelter their pupils from these issues, and were similarly worried that parents would feel the same way (Cooke, King & Greenwood, 2016; Danby & Hamilton, 2016). There was also a perception that mental health is a difficult topic to teach and to also understand (Cooke, King & Greenwood, 2016). Teachers reported fear of stigma that discouraged them from using the term “mental health” with school children, instead preferring to use “softer” language referring to emotions and that “mental health” held negative connotations (Danby & Hamilton, 2016). Teachers were also conscious of trying to protect children from mental health, fearing that it may upset them, this suggests that teachers believe mental health is frightening and undermines the children’s ability to cope with the topic (Cooke, King & Greenwood, 2016; Danby & Hamilton, 2016).

There was a further indication that teachers lacked the training and specialist knowledge themselves to teach their pupils about mental health (Cooke, King & Greenwood; 2016; Danby & Hamilton, 2016). Teachers appeared to hold two contrasting understandings of mental health and mental illness, suggesting that children’s mental health and wellbeing were important and could be influenced by several environmental and social factors (Danby & Hamilton, 2016). But when a child was struggling with their mental health teachers tended to classify this behaviour and emotion within a deficit model, as something that was a medical issue requiring specialist treatment (Danby & Hamilton, 2016). Teachers also suggested that mental health did not come up in class, mental illnesses were only experienced by certain adults and therefore it was not relevant to discuss with the pupils in their class (Cooke, King & Greenwood, 2016). There appeared to be a similar dichotomisation of understandings of emotions and physical illness as topics which were acceptable to discuss versus mental illnesses or mental health problems which were not, to parents’ categorisations of mental health discussions noted above. It did not seem to be considered a key aspect of the teachers’ role to communicate mental health information to the children in their classes as it was not in the curriculum and they did not feel they had enough training (Cooke, King & Greenwood, 2016; Danby & Hamilton, 2016). However, it should be noted that the lack of discussion in class does not mean that children have no communication about mental health, and the lack of discussion and comfort in discussing mental health and mental ill health could in itself communicate that this a stigmatised topic that is not acceptable to discuss. Teachers’ discomfort and stigmatising attitudes could be communicated to children, even inadvertently.

Another study identified in this review compared the attitudes of Child and Adolescent Mental Health Services (CAMHS) staff, Accident and Emergency staff (A&E), and teachers in regards to adolescent self-harm behaviours (Timson, Priest, Clark-Carter, 2012). Timson et al., (2012) suggest that there was a lack of research into professional and teachers’ attitudes towards children and young people’s mental health and this has continued to be sparse. This quantitative study found that CAMHS staff held more positive attitudes, more accurate knowledge and felt more effective providing treatment for self-harm than both teachers and A&E staff (Timson, Priest, Clark-Carter, 2012). For the whole sample a significant correlation showing that increased knowledge led to decreased negative attitudes, and those that felt more effective in treating self-harm, held fewer negative attitudes. A&E staff and teachers both suggested that they would benefit from more training. The role of staff knowledge in influencing attitudes was also found to be important in a study comparing the explicit and implicit stigma attitudes of students and psychiatrists. Sandhu et al (2019) compared the attitudes of undergraduate students, medical school students and psychiatrists in Canada. This study found that knowledge developed through contact with people, or having been diagnosed, with mental illness was significantly correlated with lower explicit stigmatising attitudes (Sandhu et al., 2019). It was also found that psychiatrists, due to their knowledge and experience had significantly lower implicit and explicit stigmatising attitudes towards mental illness (Sandhu et al., 2019). However, this study did note that these groups would benefit from anti-stigma interventions in order to reduce negative attitudes.

This section has discussed attitudes held by adults regarding adolescent mental health. Key attitudes highlighted by the studies in this review concerned stereotypes of dangerousness and that mental illness is generally understood to be stigmatised and that there are pros and cons to disclosing mental ill health. However, it has been shown that attitudes are also tied to perceptions of specific diagnoses and there is a gradient of rejection with more externalising disorders such as ADHD viewed in more stigmatising ways than physical illnesses and internalising mental health issues such as depression. There are a few studies which focus on specific attitudes of adults around the young person such as parents, teachers and other professionals which demonstrate a level of discomfort with discussing mental ill health from some of these groups and that the level of knowledge held by these adults has an impact on the negative attitudes they hold. However, I would also argue that the nature of the knowledge held by these adults has an impact on the attitudes held as some studies highlighted those who understood mental health in terms of medical disorders and mental illnesses considered this as an outsider status, this could lead to more negative views.

The existing literature examines adult attitudes towards young people and mental ill health rather than exploring how stigma is understood as a concept. Further, the majority of these studies are quantitative in nature and do not explore the nature, source, experiences or impact of these attitudes in depth. Crucially, I did not identify any studies which examined the views of staff members within charitable mental health or youth organisations. These perspectives may have been overlooked as it is not always obvious how these attitudes have an impact on the lives of young people. However, members of staff in third sector often engage with young people with mental ill health either in service provision or in their capacity in influencing policy and practice. This current study aims to address the lack of understanding of the ways in which adults understand the concept of stigma. Further, the lack of exploration of the perspectives of staff members working in mental health and youth organisations will be addressed by including them in the study and enquiring into their perceptions of youth mental health stigma.

## 3.3 Young People’s Attitudes towards Mental Health & Illness

This section will now discuss literature which examines young people’s attitudes towards mental illness. The above section demonstrated that the literature concerning adult public stigma towards youth mental ill health has been concentrated around adults in the USA, and has a focus on perceptions of dangerousness. There is therefore a need for further research to explore adult perceptions of youth mental health in other contexts and using a range of research methods. Conversely the literature examining young people’s attitudes towards youth mental ill health, covers more geographical areas. However, the youth stigma literature provides a complex picture, the results of which are often contradictory and fragmented. The studies discussed below measure stigma in different ways which I have used as the organising principle for the discussion of the articles. The first section examines attitudes and knowledge concerning mental illness generally, followed by studies that examine specific mental illness diagnoses, and finally studies that examine the behaviours that result from stigmatising attitudes.

Similar to literature on adults’ attitudes towards young people’s mental ill health, there appears to be a perception that young people with mental ill health can be dangerous, violent and out of control. Secondly, a key theme in this literature is the role attribution of cause of the mental illness and the attitudes and behaviours that result from these attributions. Thirdly, the role of familiarity and contact in shaping youth attitudes and behaviours towards mental ill health have been explored.

Generally, studies indicate that youth are aware that people with mental ill health are subject to stigmatising attitudes and depicted in stereotypical ways (Dogra et al., 2011; Wahl et al., 2012). These studies demonstrate that young people hold mixed understandings of the causes of mental health stigma, giving different suggestions of aetiology, and confusion over whether mental illness was caused by biological factors (Dogra et al., 2011; Wahl et al., 2012). The literature also represents attitudes that recovering from mental ill health requires effort, with some participants suggesting that those who experience depression for example need to “snap out of it” or try harder. Some studies indicate uncertainty over whether or not it is possible to recover (Kerr et al., 2011; Wahl et al., 2012; Watson et al., 2005). Overall, however studies indicated that girls had more positive attitudes than boys towards mental illness (Bradbury et al., 2020; Watson et al., 2005).

One key finding in the literature on young people’s attitudes towards mental health is the perception of dangerousness. However, unlike adult literature, there is less consistency in attitudes among young people. In a study of young people in the United States, Watson, et al., (2005) attempted to investigate dimensions of stigma by assessing youth attitudes towards “serious mental illness”. They found evidence of stigmatising attitudes where young people associated people with mental illness as violent and out of control. The authors note that this kind of stereotypical and categorical thinking must be addressed in anti-stigma strategies for high school youth in the USA (Watson et al., 2005).

Perceptions of dangerousness were also identified in adolescents in Nigeria, in which 80% of the sample agreed that people with mental illnesses can become violent (Dogra et al., 2011). Additionally, 66% suggested they would feel embarrassed if others knew that their family member had a mental health problem (Dogra et al., 2011). The authors suggested that mental health services and information are scarce in Nigeria which could indicate a reason for these negative attitudes. However, this study also highlighted that the youth were more likely than school students from western countries to agree that recovery from mental health issues can be achieved. 91% of youth in this study agreed with the statement compared with 68% agreed in a British study (Dogra et al., 2011; Pinfold et al., 2003).

A later study suggested a change in attitudes in regards to violence and dangerousness in the USA. In a study examining adolescent attitudes and knowledge about mental ill health, only 10% of adolescents in the study agreed that people with mental illness could be violent and should be avoided (Wahl et al., 2012). The authors of this study suggest that this contrasts with studies carried out with adults, as discussed above (Martin et al., 2007; Perry et al., 2007; Pescosolido et al., 2007a) and this could indicate that young people hold fewer stigmatising attitudes towards people with mental ill health than adults. However, this contention that young people are less stigmatising than adults is not supported by Bradbury (2020), whose study compared the attitudes of young people and adults over 40. Contrary to Wahl et al., the 40+ age group consistently reported lower levels of stigmatising attitudes towards people with generalised anxiety disorder and schizophrenia (Bradbury, 2020). Bradbury suggests that as an individual ages they become more knowledgeable and have increasingly accepting attitudes towards people with mental ill health, and this age group may be more likely to have been in contact with people with mental ill health, which is demonstrated by previous research (Bradbury et al., 2020; Watson et al., 2005).

However, contradictory findings are reported by Corrigan et al (2005) in terms of familiarity. Familiarity with mental illness was more likely to result in stigmatising attitudes towards mental illness. In a study of 303 adolescents, the vignette of an adolescent with mental illness with alcohol misuse, was considered more dangerous than the vignette of an adolescent with mental illness caused by a brain tumour and the adolescent with Leukaemia (Corrigan et al., 2005). The authors suggested that adolescents who indicated greater familiarity with mental illness, and more contact with individuals with mental ill health were more likely to endorse stigma of mental illness. This study suggested that data related to the nature of contact with people with mental illnesses was not collected for this study, and that meeting people who challenge stereotypes of mental illness can lessen stigma, but contact with those who reinforce stereotypes could strengthen stigmatising attitudes.

The influence of contact with people with mental ill health appears a complex relationship in the literature. Pang et al., (2017) surveyed 940 Singaporean young people (aged 14-18) about their perceptions of serious mental illness. This study found that 44.5 % of the respondents associated derogatory terminology with mental illness, words such as “crazy”, “rare” and “weird” were amongst the most common (Pang et al., 2017). However, 83% said that they would visit a classmate in hospital for mental health problems and 89% said that they would tell a teacher if a classmate was being bullied because of their mental illness (Pang et al., 2017). This demonstrates that while derogatory terminology is used, this does not have an impact on their behaviour towards a contact with mental ill health. However, this study describes intentions rather than what the children would actually do in the situation, so they may be responding based on social desirability bias. Teng et al. (2017) found that when conceptualising mental ill health in relation to real life examples, such as their peers, young people trivialised and questioned the legitimacy of their peer’s experiences of mental ill health. Mental ill health was conceptualised as something that was difficult to evidence as it did not manifest physically and the adolescents in this study suggested that their peers may be “attention seeking” rather than experiencing genuine mental ill health (Teng et al., 2017). The participants conceptualised mental ill health in a non-stigmatising way when considering it in the abstract or applying it to hypothetical others and exhibited concern over doing something wrong when interacting with people with mental ill health, or upsetting them (Teng et al., 2017). This could suggest that when considering the role of mental ill health in their own lives they are more likely to reject it the closer to them it becomes. Teng et al also suggest that negative attitudes towards mental ill health are indicative of western neo-liberal ideology that places worth on individualism and reduces empathy and desire to support others (Teng et al., 2017).

The stigmatisation of those close to young people can also be found in Liegghio et al.’s (2017) study which examined the attitudes of youth (aged 13 to 21) whose siblings experienced mental ill health. This study found that many of the young people in this study conceptualised their sibling and their family as “flawed” and that having a mental illness was “bad” and caused the family stress (Liegghio et al., 2017). The young people’s interaction with their siblings who were experiencing mental ill health in this instance did not mitigate stigmatising attitudes, particularly due to the way mental ill health was conceptualised as something within the sibling, either in terms of their morals, personality or motivations (Liegghio et al., 2017). It has been demonstrated in previous studies that those who believe that that young people have personal responsibility for their mental ill health also believe that the person is more dangerous and behave towards them in more discriminatory ways (Corrigan et al 2005).

This section has demonstrated that youth generally accept that people with mental ill health are stigmatised and many of the young people in these studies hold stigmatising attitudes in relation to attention seeking, dangerousness and attributions of blame towards people with mental ill health (Dogra et al., 2011; Pang et al., 2017; Teng et al., 2017; Wahl et al., 2021). However, these cannot be taken as applicable across the board, taken together these studies indicate a complex picture and it appears to depend on where the studies take place, when they took place and the ways in which stigma has been measured. Current understandings of adolescents’ attitudes towards mental ill health are not holistic due to the disparate nature of the extant literature. What is clear however, is that similar to adult literature stigma is measured through a combination of attitudes, knowledge and desire for social distance towards people with mental ill health, and literature examining youth understandings of the concept of stigma is sparse.

### 3.3.1 Young People’s Attitudes towards Different Diagnoses

The complex picture of youth attitudes towards mental ill health continues throughout literature which examines stigmatising attitudes towards different mental health diagnoses. It appears generally that there appears to be a gradient of rejection based on the perceived seriousness of the mental illness. Jorm & Wright (2008) investigated dimensions of stigma by measuring attitudes towards psychosis, depression, depression with alcoholism and social phobia. This study was carried out over the telephone with 3746 young people (age 12-25) in Australia. Four dimensions of stigma were identified in this study: social distance, dangerousness and unpredictability, weak not sick and stigma perceived by others (Jorm & Wright, 2008). This study found that different diagnoses were stigmatised more in one stigma dimension than other. For example, psychosis and depression with alcoholism were seen as more dangerous than social phobia and depression alone (Jorm & Wright, 2008). However, a person with social phobia was perceived as weak not sick and perceived to be more stigmatised by others in society (Jorm & Wight, 2008).

Wright, Jorm and Mackinnon, 2011 found in a survey of 2802 Australian young people (age 12-25 years), that those who accurately labelled a young person featured in a vignette as having schizophrenia or psychosis were most likely to attribute dangerousness or unpredictable attributes to the person, however this was not the case with the correct labelling of other diagnoses (Wright, Jorm & Mackinnon, 2011). This demonstrates that psychosis and schizophrenia are associated with stereotypes of dangerousness in this instance.

Other studies examined young people’s knowledge and attitudes towards depression. For example, one study carried out a literature review and demonstrated that there is a negative understanding of depression (Georgakakou-Koutsonikou & Williams, 2016). This systematic literature review found 36 qualitative and quantitative studies, which included 9930 young people. Studies included were international including USA (n=13), Canada (n=6) and the UK (n=3) and were published between 1985 -2016. Participants ranged from 6-years-old to 19 and there were an equal proportion of boys to girls (Georgakakou-Koutsonikou & Williams, 2016). Depression was correctly identified by 40% of the participants, however the authors note that this indicates the majority did not know the symptoms of depression and this could be a due to a lack of education and awareness (Georgakakou-Koutsonikou & Williams, 2016).

Conversely, a South African study by Aggarwal and colleagues (2016) noted that 90% of the 2050 participants aged 13-22 believed that depression was an illness which suggests an understanding of depression based on psychological education. One study attempted to examine the role of the school environment in the differences in depression literacy (Townsend et al., 2017). Positive school climate, which involved examining the engagement of teachers, parents and peers with the school, was associated with greater depression literacy and endorsement of fewer stigmatizing beliefs among students (Townsend et al., 2017). Poor quality educational environment and a lack of engagement in the school led to more stigmatised beliefs about people with depression (Townsend et al, 2017).

Overall, the studies which examine depression knowledge and attitudes are predominantly quantitative and use vignettes. These studies demonstrate that while young people have some neutral attitudes to depression such as suggesting that it is caused by environmental or relational problems, they also hold negative views of depression with suggestions that depression was connected to attention seeking, a sign of weakness and low effort to improve life (Aggarwal et al., 2016; Georgakakou-Koutsonikou & Williams, 2016).

Studies also compared Depression to ADHD. These studies also utilise survey and vignette methods. Walker et al (2008) investigated a national sample of youth aged 8 to 18 in order to investigate stigmatising attitudes towards peers with depression and ADHD in comparison to asthma. This study found that survey respondents were more likely to attribute anti-social behaviour and violence to peers with ADHD and depression than they were to asthma (Walker et al., 2008). Similarly, Bellanca and Pote (2001) highlighted that the 273 7-11 year olds in their study held more negative attitudes towards the vignettes depicting mental health disorders than those depicting learning difficulties.

There does appear to be mixed findings across studies. While Walker et al., (2008) suggested that young people in their study were more likely to avoid those with depression than ADHD; this is in contrast to other studies which suggest that children experiencing ADHD have more negative attitudes directed towards them than those with depression (Bellanca & Pote, 2013; Martin et al., 2007; O’Driscoll et al., 2012). It was suggested that this may be due to the age group of children sampled, as ADHD symptoms at this age may be more disruptive leading to more negative views and experiences of peers with the same symptoms described in the vignettes (Bellanca & Pote, 2013), however the age groups covered by these studies appear to be fairly similar in range. It should be noted that while O’Driscoll and colleagues (2012) reported that young people in their study held more stigmatising attitudes towards AHDH overall, they were specifically more likely to be fearful of and perceive depression as more dangerous than ADHD. Overall though, these studies suggest that young people do not have positive attitudes towards those with depression or ADHD (Bellanca & Pote, 2013; Walker et al., 2008).

Anxiety disorders have also been subject of stigma research studies. Hanlon & Swords (2019) found in their study that anxiety disorders are not as associated with stereotypes of dangerousness, however perceptions of personal responsibility, weakness and social abnormality were associated with anxiety disorders. Calear et al (2017) also examined young people’s attitudes towards Generalised Anxiety Disorder (GAD). This study used the Y-Worri questionnaire which asked young people about their perceptions of stigma towards GAD in the community (perceived stigma) as well as their own perceptions (personal stigma) (Calear et al., 2017). Overall participants reported greater perceived stigma than personal stigma towards GAD (Calear et al., 2017). It was suggested that the discrepancy in the young people’s perceived and personal stigma could be down to social desirability bias. This would mean that the young people responded to the questionnaire in ways that they believed were required of them by society and did not reflect on their true beliefs, this has been highlighted in other studies using self-report measures (Calear et al., 2017; Mason et al, 2015). It could also be due to young people believing they hold different attitudes to wider society and as a result incorrectly perceived a greater level of stigma in the community than is found in reality (Calear et al., 2017). This study found those who exhibited personal stigma were male, from non-English-speaking backgrounds, had lower anxiety literacy and were not living with one or more parents, explanations of this final factor are not provided here and requires further investigation (Calear et al., 2017). It was suggested that males have less exposure to anxiety disorders than females and that lack of anxiety literacy also explains the stigma found in diverse ethnic backgrounds (Calear et al., 2017). However, the effects of masculine normativity on young men’s perceptions of anxiety discussed in previous studies (See Randell et al., 2019 for example), was not mentioned here but could also explain the differences in attitudes between male and female participants. Overall, more research is required to more fully understand the role of demographic characteristics on perceptions of anxiety and stigma more generally.

There appears to be a difference in perceptions about different mental health conditions highlighted by these studies. However, there are also different perceptions about the same condition if it presents differently, as demonstrated by Garcia-Sorianos & Roncero (2017) who investigated Spanish adolescents’ attitudes towards OCD. 102 adolescents aged 16-19 were surveyed for stigmatising attitudes towards order and aggression-related OCD. Results showed that adolescents recognized the impact of order- and aggression-related OCD and understood that a peer with order- or aggression-related OCD would require treatment and that they would recommend their peer sought a formal source of help (Garcia-Sorianos & Roncero, 2017). This study also highlighted adolescents showed more stigma towards aggression-OCD than order-OCD, however this study generally demonstrated low levels of stigma associated with the order-OCD (Garcia-Sorianos & Roncero, 2017).

The existing literature on youth attitudes shows a mixed picture of the level and nature of attitudes directed towards mental health. The level of stigma identified in these studies is dependent on the age group, gender and mental health diagnosis that is investigated in the study. The majority of these studies are based on quantitative surveys of attitudes towards hypothetical situations. The existing literature does not provide a depth of understanding about the ways in which these attitudes are experienced for those with mental ill health. There is also very little explanatory examination of the sources and causes of these attitudes. However, other studies have focussed on the behavioural manifestation of these stigmatising attitudes which will now be discussed.

### 3.3.2 Behaviours Influenced by Stigmatising Attitudes

This section discusses literature which is similar to those discussed above but investigate the potential behavioural outcomes for young people who hold stigmatising attitudes towards mental ill health. They are similar in methodological approach to those in the previous section, in that the following studies are predominantly quantitative surveys which gauge attitudes and potential behaviour using hypothetical vignettes (Kasow & Weisskirch, 2010; Law, Rostill-Brookes, Goodman, 2009; Mason et al., 2015; Yap et al., 2011), excluding the work by O’Driscoll et al who, although still using vignettes, these studies employed qualitative thematic analysis of interviews (O’Driscoll et al., 2015a; O’Driscoll et al., 2015b). The following studies primarily focus on the potential for helping behaviour and how this is impacted by various stigmatising attitudes such as the belief that people with mental ill health are weak, not sick, or that they are potentially dangerous. Studies also discussed in this section examine desire for social distance, and rejection of peers who experience of mental ill health (Faulkner et al., 2010; Mukolo & Heflinger, 2011; O’Driscoll et al., 2015a; O’Driscoll et al., 2015). Overall, these studies demonstrate that stigmatising attitudes held by young people have a negative influence on the quality of help provision and the desire for social distance from those with mental ill health (Kasow & Weisskirch, 2010; Law, Rostill-Brookes, Goodman, 2009; Mason et al., 2015) but that greater knowledge and awareness of mental illnesses such as schizophrenia reduces the desire to avoid people experiencing mental ill health (Faulkner et al., 2010).

#### 3.3.2.1 Willingness to help

Generally, studies demonstrate that stigmatising attitudes can lead to less willingness to help. Law, Rostill-Brookes and Goodman (2009) investigated the stigmatising attitudes held by health and non-health care students towards people who self-harm and the effect this had on their willingness to help. This study surveyed 184 students in health care subjects such as nursing and medicine, as well as physics. Those who believed that a young person was responsible for self-harm behaviours felt angrier towards them which in turn was associated with less willingness to help (Law, Rostill-Brookes, Goodman, 2009). The authors of this study suggest that this perception of responsibility is connected to the belief that self-harm behaviours are a form of manipulation (Law, Rostill-Brookes, Goodman, 2009). Importantly, medical students held more negative attitudes towards self-harm. The authors of the study suggest that this may be due to less familiarity with self-harm than nursing or clinical psychology students (Law, Rostill-Brookes, Goodman, 2009), which could indicate a lack of education on this subject within the medical discipline. This is a concern as medical students are more likely to interact with young people who engage in self harm and suggests that they may behave discriminatorily towards patients they encounter who do self-harm. Similarly, Mason et al. (2015) found in a survey of 518 secondary students in Australia that those who perceived the person in the example vignette as weak rather than sick reduced help provision. This demonstrates a similar perception that those who have a level of responsibility, either through deliberate action or through personal weakness, reduces the likelihood of provision of help. First aid provision, as well as encouraging individuals with suicidal thoughts to seek help were impacted by negative attitudes (Mason et al., 2015).

Conversely, other studies examined young people’s first aid intentions and discovered that the perception of dangerousness increased the likelihood that the participants would encourage the person to seek help (Yap et al., 2011; Mason et al., 2015). Yap et al (2011) suggested that the young people who held the belief that people with mental ill health are weak not sick would be less likely to provide first aid help for those close to them experiencing mental ill health. These studies examined the quality and likelihood of adolescent mental health first aid provision. It is highlighted that social desirability bias may affect their responses and not adequately reflect what they would really do in a similar circumstance in real life (Mason et al., 2015). While this may suggest that stigmatising attitudes influences young people providing help for their peers, it could also be argued that if young people are not given advice on the best course of action to take in these circumstances it may also be due to lack of knowledge or fear of doing something wrong.

#### 3.2.2.2 Social distance

The impact of stigmatising attitudes on social distance (the desire to avoid people of a specific group) was also examined in the literature. In keeping with research in relation to attitudes it appears there is a gradient of desire for social distance based on the perception of mental illness severity. This is demonstrated in a study by Mukolo & Heflinger who investigated adult desire to social distance from children with mental ill health. This study suggested that greater social distance was indicated for ADHD than with asthma (Mukolo & Heflinger, 2011). These authors highlighted the association between blame towards the child or parent and the desire for social distance, whereas this was not the case for those who perceived biological or environmental causes of the child’s mental ill health (Mukolo & Heflinger, 2011). This is also found in young people, as a study surveying undergraduates suggested that there was greater desire for social distance towards people with schizophrenia than for less severe and enduring mental illnesses and physical illness, and they suggest that this may be connected to a lack of awareness and unfamiliarity with more serious mental illnesses (Kasow & Weisskirch, 2010). However, Faulkner et al (2010) investigated adolescent (Canadian 7th-12th grade students) knowledge and desire for social distance towards people with schizophrenia and conversely found that the majority knew about schizophrenia and had low desire to social distance (avoid contact) from people with schizophrenia (Falkner et al., 2010). This still suggests though that greater awareness of schizophrenia may be connected to less desire for social distancing (Faulkner et al., 2010; Kasow & Weisskirch, 2010).

Finally, O’Driscoll et al carried out two qualitative studies which investigated the accounts given by adolescents for the exclusion and the fairness of rejecting peers with mental ill health (O’Driscoll et al., 2014; 2015). One reason given for the exclusion of peers from friend groups was the perceived social and personal risk that could come with being associated with a peer with mental ill health (O’Driscoll et al., 2014). These risks involved the risk to their social reputation as well as “emotional contagion” or the concern that the depression of the peer would be transferred to other members of the group (O’Driscoll et al., 2014, p. 719; O’Driscoll et al., 2015). The peers with mental ill health were also considered socially incompetent, boring, self-centred, however the authors suggest there was not a perception that the peer was violent or dangerous (O’Driscoll et al., 2014; 2015). In general, the young people believed that the exclusion of peers was unfair, apart from the vignette depicting a peer with ADHD (O’Driscoll et al., 2015). When asked in more detail about the fairness of excluding a peer the responses were complex. The respondents highlighted that their perceptions of fairness were influenced by the causes of their peers’ behaviour (O’Driscoll et al., 2015). When participants suggested that the peers’ behaviour may have been caused by a mental health diagnosis the peers’ behaviour was viewed as not their fault (O’Driscoll et al., 2015).

Overall, the studies which examine both attitudes and behaviours which result from these attitudes demonstrate that both young people and adults hold stigmatising attitudes towards young people with mental ill health and that these attitudes can manifest in behaviours which reduce willingness to help and increases the desire for social distancing. Most of these studies are quantitative and based on surveys in which the participants are asked about hypothetical vignettes. There is little in-depth qualitative investigation about the source of stigmatising attitudes or why mental health is conceptualised in a stigmatising way. Further, the concept of stigma is primarily investigated through proxy measures such as knowledge about, attitudes towards and desire to avoid different mental illnesses rather than examining the concept of stigma itself and what this means for those experiencing mental ill health. Finally, these studies which examine attitudes do not provide an in depth understanding of what it is like to experience mental health stigma. The existing literature which does attempt to provide such insight will now be discussed.

## 3.4 Young People’s Experiences of Stigma

Another group of studies identified in this review are those which examine young people’s experiences of mental health stigma. This section will discuss studies which examine direct experiences of stigma, self-stigma, and experiences of stigma when attempting to seek help and finally ways identified for coping with stigma. These studies are more varied in terms of methodological approach, with a variety of mixed methods (Moses, 2009a; Moses 2009b; Moses, 2010a), quantitative (Moses, 2014; Moses, 2015a; Moses, 2015b) and qualitative methods (Elkington et al., 2012; Elkington et al., 2013; Moses, 2010b) being applied to investigate young people’s experiences of mental health stigma.

### 3.4.1 Self Stigma

The work of Moses presents a complex picture of self-stigma in adolescents. Moses examined self-stigma in two studies which used quantitative stigma measures with 60 adolescents (aged 12-18) who accessed treatment for at least one mental health diagnosis (Moses, 2009a; Moses 2010a). In the first study (Moses, 2009a) it was reported that the most reported aspect of self-stigma was feeling fearful that others would not like them if their mental ill health was known about, with 32% of the participants endorsing this aspect of the self-stigma scale. However, only 25% of respondents reported feeling embarrassed about their mental ill health (Moses, 2009a). It should be noted however that self-stigma was only expressed as a concern in 20% of the participants in this sample (Moses, 2010a). Higher perceived public stigma and reported self-stigma were associated with higher rates of depression and lower self-esteem (Moses, 2009a). Further, Moses (2010a) reported that adolescents who perceived themselves to have lower social skills and that their parents were being secretive about the young person’s mental health were more likely to experience self-stigma. A final mixed methods study by Moses (2010b) examined the impact of self-labelling on 54 adolescents attending mental health services. This study found that a minority (20%) of adolescents labelled themselves with a mental health diagnosis, and that others either did not know how to conceptualise their mental ill health (42.6%) or used non-clinical descriptions of their mental ill health such as “teenage problems” or behavioural problems like getting into fights (37%) (Moses, 2010b, p. 573). However, those who did self-label using psychiatric diagnoses reported higher ratings of self-stigma and depression, however there was no association with self-esteem (Moses, 2010b). This demonstrates that while self-stigma may not be a concern for the majority of participants in these studies, experiencing self-stigma can have a negative impact on experiences of depression for young people (Moses, 2009a; Moses, 2010a). It also suggests that experiencing stigma from others and that understanding mental ill health through a clinical lens can increase the likelihood of experiencing self-stigma in young people (Moses, 2009a; Moses, 2010a; Moses, 2010b).

Finally, a study by Kranke et al., (2011) investigated the self-stigma experiences of young people taking psychiatric medication. This qualitative study interviewed twenty-seven adolescents aged 12-17 and identified three components of self-stigma. First adolescents endorsed stereotypes which they had heard from family and peers, using words such as “psycho” and “crazy” to describe people taking psychiatric medication (Kranke et al., 2011). Secondly, participants highlighted that taking psychiatric medication led them to feel different from their peers (Kranke et al., 2011). Lastly, adolescents in this study attempted to protect themselves from feeling different by concealing their medication use (Kranke et al., 2011). This suggests that it is not only self-labelling that influences experiences of self-stigma, but that taking psychiatric medication can also lead to self-stigma. The following section will now examine the impact of stigma generally on young people attempting to seek treatment for their mental ill health.

### 3.4.2 Direct Experiences of Stigma from Others

It is clear from the research discussed in the above sections that both adults and young people hold stigmatising attitudes towards young people with mental ill health, however it is also important to understand this from the point of view of those directly experiencing stigma. In 2016 the YMCA and NHS released a report examining young people’s experiences of mental health stigma. Youth agency YOUTHSIGHT carried out interviews in England and Wales with 2072 young people age 11 to 24. This study encouraged the young people participating to identify themselves whether they had experience of mental ill health (YMCA, 2016). This was in order to prevent imposing diagnostic criteria that the participants did not believe applied to them and to reduce feeling stigmatised by the research process (YMCA, 2016). 52% of the participants said they had experienced mental ill health. This report found that 75% of participants believed that people with experiences of mental ill health are treated negatively because of stigma. This study also found that one third of participants had felt they had experienced stigma and 37% of these participants experienced stigma around once a week. It was found that stigma mostly came from those closest to them, particularly at school and from their friends. 70% of the participants in this study suggested that they had been subject to prejudice, 54% had been left out of activities and 36% said they had been verbally abused (YMCA, 2016). Stigma had a negative effect on confidence and 74% said they were unwilling to go out. 56% said that stigma made them less likely to seek help. This study very clearly demonstrates that young people experience stigma due to their mental ill health.

Other studies use qualitative methods in order to investigate young people’s experiences of mental health stigma from those closest to them. Elkington et al., (2012) provides insight into young people’s direct experiences of stigma from family and friends. This study carried out interviews with 24 young people who were psychiatric outpatients, and 13 respondents mentioned being overtly rejected by others because of their mental ill health (Elkington et al., 2012). Participants believed that others rejected them because others were afraid of them, or because their mental health symptoms made them difficult to be around (Elkington et al., 2012). Others reported that family members rejected of their diagnosis and dissuaded them from seeking professional help for their symptoms (Elkington et al., 2012). Ten out of the 24 respondents noted that while they were not rejected; they had perceived negative changes in their relationships with others (Elkington et al., 2012). This included other people struggling to trust the respondents and that their behaviour was solely attributed to their mental health diagnosis (Elkington et al., 2012). While many of the respondents of this study did report experiencing stigma from others, some did mention that the changes in relationships were for the better and that other people understood them more as a result of telling them about their mental health diagnosis (Elkington et al., 2012).

Elkington et al., (2013) also carried out a study examining young people’s experiences of mental health stigma in romantic and sexual relationships. This study interviewed 20 young people from psychiatric outpatient wards in New York City (Elkington et al., 2013). Interviews were carried out by asking young people to assess a vignette depicting a young person with mental ill health in order to prompt discussion of the sensitive issues that the young person could be facing (Elkington et al., 2013). 25% of respondents spoke about direct experience of stigma from their partners (Elkington et al., 2013). These participants highlighted the perceptions that people without mental ill health viewed those with mental ill health to be undesirable romantic partners. Almost all of those who described direct stigma from a partner had a psychotic disorder and were over the age of 17 (Elkington et al., 2013). These experiences, coupled with the perception of general societal level stigma towards them, led the young people to internalise the stereotypes of people with mental ill health being an undesirable partner. This led to risky sexual behaviour such as feeling unable to be assertive in relationships, and insist on contraceptive use (Elkington et al., 2013). This study highlights that stigma can have a negative effect on young people’s romantic relationships which in turn can compromise their physical health.

The work of Moses is also useful for understanding young people’s experiences of mental health stigma from those around them. In one study Moses qualitatively analysed the narratives produced through mixed methods interviews with 56 adolescents who had experienced mental ill health (Moses, 2010b). Participants (46%) in this study noted that they experienced stigma from family members which tended to manifest itself through mistrust, avoidance and assumptions of wrongdoing (Moses, 2010b). Participants also noted that close family members such as parents contributed to stigmatisation from extended family members through communicating “unflattering” information about them and “gossiping” (Moses, 2010b, p. 991). Stigma from school staff such as teachers was also reported to manifest in similar ways to family members (Moses, 2010b). Moses reported that 22% of participants experienced stigma from school staff, and this came in the form of avoidance, dislike, mistrust and assumptions of wrongdoing (Moses, 2010b).

Moses (2010b) found that the majority (62%) of the participants in this study reported stigma from peers. Stigma from peers manifested itself in the loss of friendships, and ten of the young people in this study reported feeling like they did not have any friends at all as a result of their experiences of mental ill health (Moses, 2010b). Some (n=21) of the participants suggested that they did not experience stigma from friends because they did not disclose their mental ill health to friends or that they only socialised with others who had similar experiences and described this as being “in the same boat” (Moses, 2010b, p. 989). However, this finding is complicated slightly by another of Moses’ studies. In a quantitative study, which followed up with 80 adolescents 6 months post discharge from psychiatric hospitalisation, Moses found that those who affiliated with friends who also experienced mental ill health, was a greater predictor of experiencing enacted stigma (Moses, 2014). However, this can be explained as the stigma experienced by those in the 2014 study reported stigma from other peers who were not their friends. In essence then, associating with friends who also experience mental ill health protects the young person from stigma and rejection from those friends, but not necessarily the rest of the young persons’ peer group (Moses, 2010b; Moses, 2014). As Moses highlights, the dual deviant identities of associating with those experiencing mental ill health, as well as experiencing it directly leads to rejection from the “popular” peer groups (Moses, 2014, p. 31). It should be noted however that these studies take place in the USA which has a specific culture of adolescence in which peer groups are stratified by status (Moses, 2014) and this could be different in other contexts. These studies demonstrate that stigma is experienced by young people from those around them such as intimate partners family, friends, and teachers and that these experiences of stigma can manifest in different attitudes and behaviours from these sources. However, we also know that adults can experience self-stigma, which is the internalisation of public stigmatising attitudes, and this can negatively impact their lives (Corrigan, Watson, Barr, 2006; Evans-Lacko, Mojtabai, Thornicroft, 2011). It is therefore important to examine what is understood about young people’s experiences of self-stigma, which will be discussed in the following section.

### 3.4.3 Stigma in Help Seeking

This section examines the experiences of stigma when attempting to seek help for mental ill health. Within the literature, stigma is consistently cited as a barrier to young people seeking help for mental ill health, for both young people themselves (Bluhm et al., 2014) and their parents who are seeking help on their child’s behalf (Boyd et al., 2007; Bradby et al., 2007). The following sections will discuss both young people’s and parents’ experiences of stigma when seeking help from child and adolescent mental health services.

#### 3.4.3.1 Young People’s Experiences of Stigma when Seeking Help

Key barriers to young people accessing mental health services have been identified throughout the existing literature. Bluhm et al (2014) highlighted that the participants in their study were unsure about whether the experiences of depression or anxiety were the result of a mental disorder, or just ‘‘normal’’ experiences, and were therefore unsure about whether to seek medical treatment for their mental ill health. Participants in this study also felt that it was important to them to be active participants in their own care, and that if this did not happen, they were reluctant to continue (Bluhm et al., 2014). Other studies noted that mental health resources were scarce, particularly in schools which could be a reason for a lack of help seeking (Bowers et al., 2013). Barriers to help seeking in young people could also be explained by a lack of information about the available supports, and a lack of continuity of care (Plaistow et al., 2014). Young people also suggested that feeling listened to, cared for, and supported were key facilitators in accessing mental health services (Bluhm et al., 2014; Plaistow et al., 2014).

Stigma appears to be a major barrier to help seeking within the literature, and it appears that more young people report stigma as the largest barrier to accessing mental health services in comparison to staff members in those services (Bowers et al., 2013; Davidson, Zamperoni & Stain, 2017). In a literature review by Plaistow et al (2014) 31 studies were identified, which captured the views of 13 605 young people including 625 young people who had experience of services in the UK. This review found that stigma was a major barrier to help seeking in 14 studies (Plaistow et al., 2014). It was also found that stigma was a key concern for young people transitioning from child and adolescent to adult mental health services (Paul et al., 2015).

A study by Kranke et al (2010) demonstrated experiences of mental health treatment and the stigma associated with this. Forty adolescents were interviewed in order to understand more about their experiences of being on psychiatric medication. Participants were aged between 12 and 17 and they all met DSM-IV criteria for a mental disorder (Kranke et al., 2010). 90% of the participants endorsed at least one of the measures of stigma used in this study which were: secrecy, shame and limiting social interaction (Kranke et al., 2010; Link et al., 1989). The participants also provide examples of their experiences of enacted stigma from others. Participants mentioned experiencing stigma from family members:

“My mom would be like, “You're psycho. You're crazy.” My brother would be like, “You're freakin' psychotic. You're a nut case,” (Kranke et al., 2010 p. 500).

Responses such as these from family members reinforce negative stereotypes and feelings of shame and this can have negative consequences on self-esteem and willingness to seek treatment (Kranke et al., 2010). Furthermore, the young people in this study also reported stigma at school including from peers and teachers:

“He (teacher) was like… we're going' push you down and shove that medication down your throat, (if) you keep on acting crazy” Kranke et al., 2010 p.501).

From the examples provided by young people’s experiences of mental health stigma we can understand why they often keep their problems a secret from others and limit their interactions (Kranke et al., 2010). Young people suggested that they keep their diagnosis and medication use a secret from other people due to fear of how others will react (Kranke et al., 2010). One participant highlighted that they could not mention their diagnosis to anyone at school as they would be made fun of (Kranke et al., 2010). Keeping secrets from others, and the perception that others will make fun of them leads to young people feeling shamed of their diagnosis and medication use. This is highlighted by one participant who stated: “I was kind of like ashamed 'cause I don't want to be bipolar. Who does?” (Kranke et al., 2010, p. 499).

Finally, the experiences of stigma for adolescents who had been admitted to psychiatric inpatient treatment have been investigated by Mitten et al., (2016). This study found that throughout their time in hospital young people felt that their problems were invalidated and that there was a lack of understanding that they had little control over their mental ill health and why they were struggling to overcome this (Mitten et al., 2016). The young people in this study suggested that people felt afraid of them because of their mental illness, were labelled by their peers. They highlighted that receiving a mental health diagnosis was important in order for them to access mental health treatment in the first place but that it demonstrated to others that they were different (Mitten et al., 2016). The clinicians in the mental health service were perceived to be stigmatising as they made assumptions about their patents, minimised their problems and were gatekeepers for the service (Mitten et al., 2016). The young people in this study also suggested that there were instances of stigma between patients in the mental health service, there were perceptions of fear and that they should be avoided and were often gossiped about (Mitten et al., 2016). Finally, participants noted that they too stigmatised others when they felt afraid and judged the other patients (Mitten et al., 2016). It should also be highlighted that this is one of the only studies that investigated adolescents’ own definitions of stigma. Half of the participants in this study were able to define stigma and identified it as a negative prejudice and making generalisations about people (Mitten et al., 2016).

#### 3.4.3.2 Parent’s Experiences of Stigma when Seeking Help for Their Child

Parent’s also experience stigma when they are seeking help for their child’s mental ill health. For example, Bradby et al (2007) asked British Asian families about barriers to mental health care. Key to parent’s reluctance to seek help for their child was the stigma of mental illness and fear of gossip in their community, however discrimination was also experienced in health and social care, (Bradby et al., 2007). In addition, a study by Moskos et al., (2007) interviewed 270 parents of adolescents who completed suicide. Participants of this study discussed the barriers that prevented their child from seeking help were the belief that nothing could help them, reluctance to admit they had a mental health problem, embarrassment about seeking help and viewing help seeking as a sign of weakness, which can also be found throughout the literature (eg. Mason et al., 2015; Stone & Merlo, 2011; Wright, Jorm & Mackinnon, 2011). These beliefs act as barriers to seeking help and can have fatal consequences as demonstrated by this study.

Hickman et al (2016) investigated the accounts of parents caring for their children who had symptoms of early psychosis and the impact of hospitalisation. This study found five themes which described different feeling experienced by the parents: accepting and blaming, feeling out of control, feeling let down by services, hospitalisation as temporary containment, and stigma (Hickman et al., 2016). There were some positive aspects of hospitalisations such as describing it as supportive and crucial, however the process of hospitalisation of their child was generally negative (Hickman et al., 2016). Parents’ perceptions of hospitalisation as a difficult, and sometimes distressing, experience, and this was exacerbated by the complexity of being the carer of the young person. Negotiating services and boundaries within the context of this relationship contributed to parents feeling excluded and disregarded by professionals and services. Participants perceived services and hospitalisation as stigmatising, but also suggested that society at large had negative attitudes towards mental health. The nature and practices of services were experienced as stigmatising and embarrassing. This demonstrated how parents experienced the hospitalisation of their child but did not investigate how the child felt.

Throughout the literature, parents reported concerns about stigma which led to their reluctance to seek help or to continue with treatment for their child (Goncalves & Moler, 2012; Salloum et al., 2016). Parents were concerned about the impact stigma and being labelled as having a mental health disorder would have on their child and that this could impact any future opportunities (Sayal et al., 2010; Chavira et al. 2017). Other parents suggested that stigma towards their child’s symptoms led to their reluctance to seek help, this was connected to concerns about how other people would view them and their child (Chavira et al., 2017). However, other key barriers within the mental health services were consistently highlighted by parents. Parents did not always know where or from whom to seek mental health services for their child (Salloum et al., 2016). Parents in one study identified appointment systems as a key barrier, as many parents felt that short appointments did not enough time for their child’s difficulties to be addressed (Sayal et al., 2010). Other parents suggested that they did not want their child to take psychiatric medication because of concerns over side- effects, or stigmatising reactions from the wider community which equated the need for psychiatric medication with bad parenting (Chavira et al., 2017). Mental health services working with parents and children who are from migrant backgrounds were found to feel discriminatory and should create a space that is culturally sensitive (Bradby et al., 2007; Goncalves & Moler, 2012)

This section has demonstrated that experiencing stigma can act as a barrier to seeking help in various ways for both young people and parents who are seeking treatment on their child’s behalf. The following section discusses ways in which the literature suggests young people cope with experiences of stigma.

### 3.4.4 Coping with Stigma

A number of studies addressed adolescents’ methods of coping with stigma. It appears that young people attempt to keep their mental ill health and treatment a secret and limiting their interactions with others in the attempt to prevent others from knowing about it and stigmatising them (Kranke et al., 2010; Bluhm et al., 2012; Elkington et al., 2012). Young people with lower self-esteem and more severe symptoms are more likely to deal with the stigma encounter in an aggressive way, which could be unhelpful (Moses, 2015).

Other studies highlight ways in which young people buffer against stigma. One study examined the cases of three young people taking psychiatric medication for a DSM-IV diagnosis (Kranke et al., 2015). This study found three factors that helped young people cope with stigma. The first was “diminish” which was the reduction of the negative impact of the diagnosis to their sense of self, which they were able to reinforce through their support system also not applying negative connotations of the diagnoses to the young people (Kranke et al., 2015). This was also found in a qualitative study by Issakainen (2014) who found that the participants reframed their depression as a “normal but serious affliction” and as a result they felt less stigmatised (Issakainen, 2014). The second factor identified in Kranke et al.’s (2015) study was “normalise” which was encouraged by the young person’s support system reacting nonchalantly to their mental health diagnosis and helping to normalise their experience (Kranke et al., 2015). Finally, young people “attribute” the positive changes they experience to helpful psychiatric treatment which further helped to buffer against psychiatric medication stigma (Kranke et al., 2015). However, a negative method of distancing the negative connotations of mental ill health was noted by Elkington et al., (2012) who noted that some of the young people in this study attempted to distance themselves from the stigmatised group, by using stigmatising language about people with mental ill health and suggesting that they had witnessed others who were “crazier” in an attempt to normalise their own experiences (Elkington et al., 2012 p. 302). However, this study also found that some of the young people rejected stigma and talked about their mental ill health openly with their peers (Elkington et al., 2012a).

While young people can view help seeking as a weakness (Rickwood et al., 2007), a study by Prior (2012) found that receiving help for their mental health was used as a way of mitigating experiences of stigma. This study of young people in Scotland who had accessed counselling for mental ill health found that they initially held negative views towards seeking counselling and associated counselling with “somebody who was, like, mental” (Prior, 2012, p. 703). However, after receiving counselling the young people changed the way they viewed themselves and positioned help seeking as a way of solving their own problems (Prior, 2012). This was in keeping with their developmental imperative to enact agency and self-determination over their own lives (Prior, 2012). This is summed up by a participant, who, when criticised by her boyfriend for going to counselling told the him that “it’s no’ up to you whether I go to a counsellor or no’, it’s up to me” (Prior, 2012, p. 708). Overall, these studies suggest that the ways in which young people cope with their experiences of mental health stigma involves changing the ways in which they see themselves in the context of their mental ill health.

This section has discussed the ways in which young people experience mental health stigma from those around them such as family, friends and teachers, as well as themselves. It also discusses the ways in which stigma is perceived to be a barrier to help seeking for young people and parents and these studies tend to highlight the concern for what others will think of them if they look for mental health treatment. Further, this section has discussed the intrapersonal processes used by young people to cope with stigmatising encounters with others. These studies primarily focus on a micro level of analysis in which stigma is conceptualised and manifested through inter and intra-personal processes. There are very few studies which examine experiences of mental health stigma at multiple sociological levels, however there are some key studies which examine structural stigma which will now be addressed.

## 3.5 Structural Stigma

Hatzenbuehler (2016) has critiqued dominant conceptualisations of stigma in research which focused almost exclusively on internal psychological manifestations of stigmatising attitudes and recommends extending investigations of stigma to a structural level (Hatzenbuehler, 2016). Hatzenbuehler and Link (2014) provide a definition of structural stigma as the “societal level conditions, cultural norms and institutional policies that constrain the opportunities, resources and wellbeing of the stigmatised” (Hatzenbuehler & Link, 2014, p. 2). This general definition provides a focus away from individual psychological process and instead focuses questions about stigma on the socio-structural sources which could result in the stigmatisation of people who experience mental ill health.

Another key article defines structural discrimination as “a stigma that results from social forces that develop over many years which diminish a group’s resources and support” (Corrigan & Lam, 2007, p53). This paper gives more specific indication of the social factors which over time reinforce prejudice and discrimination (Ibid, 2007). Specifically, Corrigan & Lam suggest that it is the political, economic and historical conditions of a society which influences the stereotypes and prejudicial attitudes in a society. This article suggests that there are two forms of structural discrimination intentional and unintentional discrimination. Intentional discrimination can be found in the policies of institutions which deliberately restrict the rights and opportunities of people with mental ill health. However, unintentional discrimination is the result of decisions that did not intend to cause discrimination and does not seem to be based on prejudice, but the outcomes of these decisions still restrict the rights and opportunities of people with mental ill health. Corrigan and Lam’s conceptualisation of structural discrimination is also important because of the inclusion of a temporal aspect of structural stigma, which is missing from Hatzenbuehler & Link’s definition.

Pugh and colleagues (2015) reviewed existing literature which focussed on structural stigma and mental ill health. Most of the work identified in the review was carried out in a North American context which will have implications for whether or not we can expect to see similar factors in Scotland. At the time of their review there was a lack of research which actively deploys the concept of structural stigma, but they found some work which examined the structural barriers faced by people with mental ill health (Pugh et al., 2015). Firstly, they found research which suggested that structural stigma could be identified in private and public institutions. This was identified in policies within these institutions which specifically targeted people with mental ill health. These studies found that the rights of people with mental ill health were restricted in many policies and policy proposals in the United States (Pugh et al., 2015). The restriction of liberty through coercive treatment was one such way, as well as restriction to purchasing weapons, voting and serving on a jury (Hemmens et al., 2002; Corrigan et al., 2005). Pugh et al. (2015) highlight that these restrictions are applied to a person with mental illness regardless of their diagnosis, and it is therefore this arbitrariness which leads to the classification of discrimination (Pugh et al., 2015).

Another aspect of the structural stigma identified by Pugh et al (2015) in their review was an investigation of how effectively people with mental ill health are protected from discrimination. The persistence of stigma and discrimination despite legislation to prevent this demonstrates how entrenched stigma is within social interactions and societies. It could also be that the legislation is poorly enacted which further demonstrates the lack of importance placed on protecting people with mental ill health. This ties to Corrigan and Lam’s discussion of unintentional structural discrimination as mentioned above. The legislation intends to protect people with mental ill health but fails to do so or is in enacted ineffectually (Corrigan & Lam, 2007). It is therefore difficult to investigate stigma when it is hidden and covert in this way. Stigma is not always explicit in policy, phrases which actively stigmatise people cannot always be identified; however, this does not mean that structural stigma does not exist. Often it is the lack of protective policies or flawed implementation of good policy which can lead to stigmatising experiences (Corrigan & Lam, 2007).

This can also be seen in health care. When there is a lack of prioritisation of mental health care, lack of funding, disparity of health care between mental and physical health care and lack of funding and resources it can be difficult to investigate what is not there. This lack of prioritisation and funding was found in Pugh et al.’s review (Pugh et al., 2015; Heflinger & Hinshaw, 2010). Corrigan and Lam (2007) highlight key ideas about stereotypes, which are used in order to justify a lack of funding and services. They suggest that ideas of cost-effectiveness are reinforced over time alongside stereotypes about the characteristics of people with mental ill health, as being weak, incapable, unpredictable and dangerous (Corrigan & Lam, 2007). These beliefs can lead to structural and interpersonal discrimination of people with mental ill health.

A final important contribution to structural stigma research is the examination of the role of the media in perpetuating negative attitudes towards mental illness. It has been demonstrated that news media in particular often focus on dangerousness and violence when covering news articles about people with mental ill health, particularly around schizophrenia (Corrigan et al., 2005; Knifton & Quinn, 2008). This has been demonstrated to influence the negative attitudes held by the general public towards people with mental ill health (Dietrich et al., 2006). Negative portrayals of youth with mental ill health were also found to be more prevalent than negative portrayals of adults with mental ill health (Henson et al., 2010). However, it has also been demonstrated that positive reporting of mental health, such as the disclosure of a prominent celebrity can lead to improvement in attitudes that people with mental ill health are sick, not weak (Morgan & Jorm, 2009). The structural reporting and contribution to discourses from the media is an important aspect of structural stigma, however due to the recent developments in media discourse and the influence of social media on perceptions of mental ill health, more up to date research would be beneficial.

### 3.5.1 Young People’s Experiences of Structural Stigma

There is a small pool of literature which examines structural stigma for young people. Woodgate et al., (2020) is the only study at the time of writing which examined stigma experiences at multiple sociological levels. This qualitative study interviewed 58 Canadian youth aged 10-22 who had a diagnosis of an anxiety disorder and found that stigma was experienced by these participants on three different levels: intrapersonal, interpersonal and structural (Woodgate et al., 2020). Experiences of intrapersonal stigma were described by participants as adopting social stereotypes and applying these to themselves. This reduced their self-esteem and led to them feeling shame and isolation. Young people also suggested that they experienced interpersonal stigma from peers and staff at school (Woodgate et al., 2020). These interactions were framed by the participants in this study as bullying and involved people in their life not understanding their mental ill health, minimising their experiences or exaggerating the seriousness of their mental ill health (Woodgate et al., 2020). Finally, the participants in Woodgate et al.’s study described structural stigma including school, employment and health care. These instances discuss interactions with others within social institutions as well as systemic problems such as a lack of available mental health treatment (Woodgate et al., 2020). This suggests that young people are aware of the different sources of stigma in their lives. Stigma held by others, internalized by youth and embedded in social institutions led to compromised relationships with family and peers, low self-esteem and self-efficacy, reduced help-seeking, and discrimination in school, workplace and health care settings (Woodgate, 2020).

It has been demonstrated that young people experience stigma in education and work environments as well as within health care services (Liegghio, 2017; Woodgate et al., 2020). Structural stigma has been demonstrated to manifest in different ways such as professional attitudes and behaviours towards their patients. This can include referring to the child by their diagnosis, focussing on the deficits of the child and their family and not taking the whole child into consideration, as well as excluding the child and their family from treatment decisions (Heflinger & Hinshaw, 2010). Caregivers of children attempting to access mental health care for their child have suggested that these micro-aggressions which occur within institutions cumulatively create a stigmatising environment (Liegghio, 2017). However, it can also manifest in more covert ways through the fragmentation of services, waiting times and complex routes of access which are not explicit interactions with individual professionals but still communicate a lack of respect and prioritisation (Liegghio, 2017; Woodgate et al., 2020).

These studies demonstrate that structural stigma is experienced by both young people and their caregivers, however to date there has been no investigation of these issues in Scotland. Further, considerations of the source and manifestation of structural stigma still appears assumed to be the attitudes of individual agents within these structures and there has been little investigation of the sources of more systemic aspects of stigma. A wider investigation of young people’s experiences of the multiple levels of stigma is required in order to gather a more in depth understanding of where these attitudes come from and the different ways in which structural stigma could be understood outwith the individual attitudes of those embedded within them.

## 3.6 Chapter Summary

In summary, much of the existing literature focusses on individual attitudes towards mental illnesses and the impact of these attitudes on the individuals to which they are directed. The majority of studies in this literature review were quantitative studies and used vignettes and questionnaires. While this is useful, the dominance of quantitative approaches has resulted in a lack of subjective experience in the existing body of research. This is why, in the current study, I have chosen to employ a qualitative methodology in order to develop deeper understandings of participants’ interpretations of the concept and experience of mental ill health stigma. There is also very little research into the specific context of Scotland, despite the prevalence of the See Me anti-stigma programme which has identified mental ill health stigma as a specific problem to be addressed in Scottish society.

The literature considers attitudes from the general public towards young people and their mental health; specific adults such as parents and school teachers and their attitudes towards young people and their mental health; and young people’s attitudes towards mental health. The literature highlights attitudes that perceive young people with mental ill health as having potential for violence and dangerousness, as well as assignation of blame towards the youth for their mental ill health. However, the concept of stigma appears to be taken-for-granted throughout this literature. There is an assumption that the ways in which the researchers conceptualise stigma is the same as the ways in which participants conceptualise and experience stigma. There is a lack of critical investigation into the ways in which participants themselves understand the concept of stigma. Stigma instead is measured by examining individual’s perceptions of people with different mental illnesses and highlights key stereotypical assumptions which is useful to an extent. In addition, the concept of stigma appears to have come from academics, researchers and theorists. However, there is no investigation into the ways in which staff members who work in mental health organisations conceptualise stigma. Staff members working with young people and within mental health organisations have power to operationalise, problematize and define stigma for the young people they work with as well as within the policy agenda. I argue that academic understandings of the concept of stigma could be enhanced by centring the conceptualisations and experiences of those with experience of it, either directly or through their work within a mental health landscape. As a result of the taken-for-granted nature of the concept of stigma within extant literature, and the distinct lack of lived experience in its conceptualisation, I posed research question 1 in order to address this gap:

Research Question 1: In what ways is mental health stigma in Scotland conceptualised by a) young people who have experienced mental ill health and b) members of staff who work for youth and mental health focussed organisations?

This chapter also demonstrated that there were some studies which investigated the ways in which young people experience mental ill health stigma. The existing literature tended to focus on the interpersonal manifestations of the stigmatising attitudes held by people around the child. Existing literature also examined intrapersonal processes which manifest in self-stigma. Generally, aside from the work of Woodgate et al., (2020), there was a lack of investigation into experiences of stigma at multiple social levels. While Woodgate et al (2020) highlighted that young people experience stigma at intra, inter and structural levels, there was a lack of description of the meanings, explanations and discourses used by participants to construct their experiences. Therefore, I posed research question 2 in order to gather more in-depth understandings about the ways in which young people and members of staff construct their experiences of mental ill health stigma:

Research Question 2: In what ways are experiences of mental health stigma in Scotland constructed by a) young people who have experienced mental ill health and b) members of staff who work for youth and mental health focussed organisations?

Finally, much of the mental health stigma research discussed in this chapter has a strong foundation within the psychological sciences. Much of the existing literature focusses on micro-level processes which occurs psychologically or interpersonally which leads to the manifestation of stigmatising attitudes. However, the extant literature is distinctly missing considerations of power. There is a lack of investigation into the societal-level factors and conditions which leads to experiences of mental ill health stigma for young people. Further, stigma is currently predominantly conceptualised within a positivist framework as something which exists in a way which can be measured empirically, rather than something which is constructed through powerful discourses which shape knowledge and experience. I therefore posed question 3 in order to address some of these more theoretical gaps in existing conceptualisations of stigma:

Research Question 3: In what ways can the conceptualisations and experiences of mental health stigma from a) young people who have experienced mental ill health and b) members of staff who work for youth and mental health focussed organisations be understood through a framework of societal level factors and discourses?

The following chapter will now go on to discuss the methodological approach used to answer these questions, including the philosophical underpinning and the qualitative methods of data collection used to carry out this research. This research therefore seeks to address these three questions by examining the conceptualisations and experiences of mental health stigma. The methodological approach taken to addressing these questions will now be discussed.

# Chapter 4: Methodology

## 4.1 Chapter Overview

This chapter discusses the methodological approach to the research study. Firstly, this chapter discusses the use of social constructionism as the philosophical underpinning for the research. Secondly, this chapter discusses the use of qualitative methodology for undertaking the research. This is followed by discussions of the recruitment process, data collection and data analysis. The ethical considerations of the research are then discussed, and finally the importance of a reflexive approach to qualitative research is highlighted.

## 4.2 Philosophical Underpinning

This section discusses the use of social constructionism in this thesis as the theoretical underpinning for the research. I use social constructionism as the foundational epistemological paradigm. While epistemologically social constructionism is useful for considering multiple ways of knowing as a way of critiquing dominant knowledge of mental ill health and stigma, there are some difficulties with employing social constructionism as an ontological standpoint, both of which will be addressed in the following section.

### 4.2.1 Epistemology & Social Constructionism

Epistemology is the theory of knowledge. Epistemological standpoints determine the kinds of knowledge that is possible and legitimate (Blaikie, 2010). The epistemological assumptions held by a researcher should be addressed in order to understand the foundation upon which the research questions are asked, and the methods used to answer them. As discussed in chapter 2, this study uses a Foucauldian framework which is in keeping with a social constructionist epistemology. This section addresses the epistemological assumptions of the thesis and how they have influenced this research study.

The specific epistemological position of this research is social constructionism. Social Constructionism suggests that knowledge is a product of human experience and is mediated historically and culturally and through the use of language (Willig, 2008). Knowledge is therefore never a direct reflection of reality, instead knowledge is regarded as context specific and that there can be conflicting “knowledges” that simultaneously co-exist (Willig, 2008). This epistemological standpoint allows us to understand diversity of knowledge and experience in the social world (Burr, 1995). It also allows for critique of taken-for-granted, dominant knowledge systems. Research that is carried out using a social constructionist perspective is concerned with identifying these differing knowledge systems that construct social reality (Willig, 2008). It also attempts to understand how these constructions of reality are used, by whom and for what purpose. Finally, social constructionist research allows us to understand the effects of social constructions on the lives of social actors.

Vivien Burr (1995) provides a comprehensive examination of the features of social constructionism, and suggests that there are four key assumptions held by this epistemological standpoint. The first is that social constructionism allows researchers to make critical examinations of taken-for-granted ways of understanding the world (Burr, 1995). It allows for challenging dominant understandings of the world by questioning the notion of objective fact that is observed un-problematically and objectively (Burr, 1995). Secondly, Burr suggests that social constructionism encourages us to view dominant understandings of the world as culturally and historically specific, and not only should this knowledge be understood as specific to the context, but that they are also produced by cultural and historical conditions. Therefore, knowledge changes over time and place.

The third feature of social constructionism suggests that our common knowledge of reality comes about as a result of daily interaction between social actors (Burr, 1995). We can see the usefulness of this way of understanding the construction of reality for considering Goffman’s conceptualisation of stigma. Goffman suggests that stigma is the disgrace applied to an individual by another through interactions or “social intercourse” (Goffman, 1963 pg. 12). The stigmatised person is identified through interpersonal interaction that they possess attributes which differ to those expected and that these attributes are less desirable. Therefore, according to Goffman, the enactment of stigmatisation of an individual by another, results from social interactions that are dependent on knowledge about what is or is not different and desirable. Therefore, there appears to be nothing “objective” about the stigmatisation of an individual, stigma is a constructed category that results from subjective knowledge and experience.

A particular concern for social constructionism is the development and construction of knowledge through language. Foucault suggested that language is a structure through which knowledge is conveyed, however there are many different “bodies” of knowledge that exist within different contexts (Foucault, 1972; Burr, 1995). The meaning of words or “signifiers” depends upon the context in which it is being used (Foucault, 1972; Burr, 1995). Ian Parker provides a useful working definition of discourse as a “system of statements which constructs an object” (Parker, 1992, p.5). Burr develops this definition by suggesting that discourse is more than just words but also meanings, images, and representations that when used together present a specific version of a thing or event. Social constructionism suggests that as there are multiple possible ways of knowing, that there are many different discourses used to describe the same thing (Burr, 1995). Burr also makes it clear that certain discourses have an impact on the expected actions of social actors and are connected to the structure and function of society (Burr, 1995). Discourse is a useful concept for this study as it allows many different ways of understanding mental ill health, as well as understanding how these various discourses and resulting constructed knowledge affects young people’s experiences.

The fourth aspect of social constructionism is the suggestion that knowledge and social action go together (Burr, 1995). The way different things are understood have effects on the responses or actions in relation to it. Foucault suggests that knowledge is a result of power imbalances and negotiations. Social actions, carried out in attempts to maintain or resist power, produces what can be known, in the form of epistemes (Foucault, 1972; Foucault, 1980; Mills 2003). Therefore, for Foucault, power is interwoven with knowledge (Foucault, 1980). Foucault attempted to uncover the material conditions and institutional practices which can lead to the dominance of certain epistemes at the cost of others using his genealogical method (Foucault, 1970; 1972; 1980). Power relations are therefore key to understanding what can be constituted as knowledge:

“It is not possible for power to be exercised without knowledge; it is impossible for knowledge not to engender power.” (Foucault, 1980, p. 52).

The concept of power is vital to this study. As demonstrated above, the construction of knowledge through discourse is rooted in power relations (Burr, 1995). Power imbalances exist when one person has access to resources (or knowledge) that others do not, and these inequalities are upheld by discourses that reinforce the status-quo (Burr, 1995; Lukes, 2004). Again, Foucault’s work is useful for demonstrating how power and discourses are connected within the social constructionist framework. For Foucault, knowledge refers to the prevailing construction of reality which is legitimised as “truth”. This “knowledge” that is accepted provides opportunities and places constraints on social practices (Foucault, 1975). Therefore, the power to act in certain ways depends upon the prevailing “knowledge” or discourses within society (Burr, 1995). Foucault does not see power as a resource to be wielded, or as something that can be possessed, instead it is an effect of discourse. The power to define the world in a way that allows the bearer of the knowledge to act the way they want to, is to exercise power. Knowledge is the power to define others, however resistance to this knowledge also exists and power can be obtained when resistance has been overcome (Burr. 1995; Foucault, 1970).

The social constructionist metatheory came about as a result of sociologists’ exasperation with the dominance of positivist science. Positivism claims to be able to determine one existing truth dispassionately through observation of reality (Gergen, 2001). While the empirical approach is useful in natural and physical sciences it becomes problematic when applied to the social world, as the dominance of certain bodies of knowledge or “discourses” (Foucault, 1967) can result in the suppression of marginal voices and experiences (Gergen, 2001). Foucault’s work suggests that the power held by those arguably using a positivist standpoint, which makes claims about what reality and truth are, is enacted through discourses of medicine and institutions such as hospitals and asylums producing knowledge which constructs the nature of mental health and illness (Parker, 1992; Foucault, 1973).

### 4.2.2 Social Constructionism: An Ontological Quagmire

Social constructionism is often paired with the ontological standpoint of relativism. Ontology is concerned with reality and makes claims about what can and does exist (Blaikie, 2010). Ontology is the study of being and existing (Blaikie, 2010). It is important to state ontological assumptions as they dictate what can be said to be “true” or “real” as a result of research. A relativist ontology suggests that reality is made up of constructions of the human minds and suggests that reality is not a fixed entity which can be objectively measured (Blaikie, 2010). However, social constructionism’s pairing with relativism has often left it open to many criticisms even by its own proponents (Burr, 1995; Willig, 2013).

Both Vivien Burr (1995) and Carla Willig (2013) hold issue with social constructionism and the difficulty of making suggestions for emancipatory change (Burr, 1995; Willig, 2013). A social constructionist epistemology draws attention to the fact that knowledge, particularly about the social world, does not result from straightforward, objective observation as asserted by positivism (Burr, 1995). Instead, social constructionism demands that researchers are consistently aware of our own bias as well as those of the research participants. Using this epistemology will mean that what is demonstrated as knowledge by this research will be historically, culturally and linguistically mediated. This is also tied to understandings therefore of what constitutes “reality”. What is real is therefore understood as something that is constructed by social actors and there is the possibility that several co-existing realities exist (Gergen & Gergen, 2003). This understanding of the constructed, relative nature of reality and knowledge allows us to question dominant understandings of mental health and stigma. However, it also makes it difficult to prioritise one form of knowledge over another (Burr, 1995). It has been argued that because social constructionism calls all knowledge constructed but equally valid as a representation of reality, it is difficult to prioritise certain kinds of knowledge over others. This has also been suggested to created difficulties in giving recommendations about the way things should be and make recommendations for change (Burr, 1995).

A further criticism of social constructionism is that it undermines lived experience and the reality of distress (Busfield; 2000). It is argued that due to social constructionism’s assertion that knowledge is constructed and not a direct reflection of social reality that therefore reality is unknowable and therefore nothing can be said to be “real”. This could therefore undermine the real experiences of pain and distress of people with mental health difficulties and suggests that they are “mere” constructions (Gergen, 2001; Busfield 2011), however, this criticism results from taking social constructionism to its logical extreme which I do not advocate here. What we know to be mental illness and mental health, changes over time and place but this knowledge does not necessarily preclude knowledge of the material reality of distress or experiences of mental ill health (Rosenberg et al, 1992). I would argue that social constructionism provides the potential for developing multiple knowledges of various experiences of mental ill health and mental distress. Assuming that there is only one way of experiencing a mental illness has the potential to discount experiences which do not fit within the dominant (often biomedical) discourse. A social construction approach allows for the destabilisation of dominant understandings and this work privileges the realities of those who are often excluded from dominant discourses.

Despite these issues, using social constructionism as a philosophical framework allows for the investigation of multiple discourses and experiences, as well as the power relations and institutional contexts which manifest them. Taking a social constructionist view leads to a proposition that our current understandings of mental illness have been socially constructed as a stigmatising condition. In turn, this allows this research to examine the role of constructing discourses on young people’s lives.

### 4.2.3 Social Constructionism & This Study

This study uses social construction as the epistemological foundation in order to investigate the experiences and understandings of mental health stigma in Scotland. However, it must first be reflexively considered that my assumption of social construction pre-dated the setting of the research questions. The key assumption that has led to the development of the research aims is that mental health and illness have been socially constructed as a stigmatised condition. I assume that there is nothing inherently or naturally occurring about mental health or illness that would in itself lead to stigma. I argue that without the contextual, linguistic and historical construction by social actors and power structures mental illness would not necessarily be stigmatised.

These assumptions have led to the manifestation of the research aims which attempt to develop new understandings of the nature of stigma through young people’s conceptualisations and experiences. By investigating young peoples’ understandings and experiences of stigma, we may gain more insight into the nature of this constructed concept and be able to develop mental health and illness into an emancipatory, rather than stigmatising social category. While mental health stigma may be a reality for many people there is no “natural” or “objective” reason for its persistence, and I therefore argue that stigma is socially constructed through power relations and discourses. This research therefore attempts to determine whether stigma can be located in power structures in society in order to understand how mental illness has come to be socially constructed as stigmatising. This necessitates a shift in understanding about stigma away from being solely focussed on micro-interactions between individuals that label each other linguistically and symbolically which leads to discriminatory behaviours at an individual level, and towards our understandings of how power structures contribute to the stigmatisation of mental illness. By identifying the ways that power structures influence the social construction of mental illness as stigmatising, we may be able to tackle the stigma-power (Link & Phelan, 2001) of institutions and social structures more directly.

#### 4.1.3.1 Social Construction & Research Participants

This research holds an emancipatory aim of changing understandings of mental illness as a stigmatising condition through the suggestions of young people who have experienced it. This aim has come about as a result of a second assumption, which is around the value of involving young people in research. I hold the assumption that young people’s understandings and experiences are valuable to understand in and of themselves. Their experiences, understandings and suggestions are also useful for helping to develop alternative discourses and they should be consulted about their own lives. Children and young people are often constructed as immature and incompetent who passively absorb social mores through the process of socialisation (James, 2001; James & Prout, 1997; Kirk, 2007) which arguably has resulted in experiences of epistemic injustice. Epistemic injustice is a situation in which an individual or group find that their value as a “knower” is discredited (Fricker, 2007). This can be the result of prejudice held by others about that group, which Fricker terms Testimonial Injustice, or when a gap in collective interpretation puts an individual at a disadvantage, known as Hermeneutical Injustice (Fricker, 2007). This concept of epistemic injustice is particularly important for this study as young people may also be subject to discourses that question their capability and competence, and therefore the legitimacy of their claims may be undermined (Carel & GyÖrffy, 2014; James, Jenks & Prout, 1992).

The participants in this study could arguably experience epistemic injustice due to both of their status as a young person and the socially constructed connotations of their mental ill health. In a similar way to young people, Lakeman (2010) demonstrated that people who use mental health services often experience epistemic injustice. Particularly, people using mental health services can experience testimonial injustice due to the dominant preconception that their understandings and their choices lack coherence and credibility due to their perceived incapacity to make decisions for themselves (Lakeman, 2010). This discourse of incapacity leads to the undermining and de-legitimization of the knowledge and experience of people who have experienced mental ill health (Fricker, 2007; Lakeman, 2010). The young people in this research study are arguably doubly disadvantaged and could therefore be affected by epistemic injustice due to both their chronological age and their experiences of mental ill health.

Social constructionism allows this research to accept the validity of different and potentially conflicting understandings and experiences. It also allows this research to challenge the persistence of epistemic injustice experienced by young people with mental health difficulties. The assumptions of this epistemology suggest that each different assumption is as an equally valid form of knowledge as the next. This allows this research to accept many different understandings and experiences as valid and has the potential to challenge dominant understandings of mental health stigma. Social constructionism allows this research to understand the dominant discourses surrounding the key concepts of this study: young people, mental health and stigma. It will also give this research the potential to develop these understandings by allowing for the possibility that these concepts are not fixed categories that have resulted from unbiased observation, but that they have been socially produced over time and that they are context dependent.

## 4.3 Qualitative Methodology

This section discusses the use of qualitative methodology for investigating understandings and experiences of mental health stigma in Scotland. This research study adopted a qualitative research methodology as this was the most appropriate way of gathering detailed understandings and accessing discursive constructions of young people and staff member’s conceptualisations and experiences. Qualitative research allowed for more flexible methods of developing understanding stigma experiences at different sociological levels and interrogating power dynamics. Qualitative research tends to use empirical data in the form of words and descriptions of social life which are not reducible to numbers (Flick, 2007; Denzin & Lincoln, 2008; Silverman, 2008). This allows qualitative researchers to gather “thick descriptions” of the context and complex experiences of participants (Geertz, 1973; Denzin & Lincoln, 2008; Braun & Clarke, 2013). Qualitative research tends to adopt a relativist ontological position, and assumes that there are multiple possible versions of reality that cannot be considered outside of the social contexts in which they occur (Braun & Clarke, 2013). Social constructionism is particularly compatible with qualitative methodologies as it focusses on the way knowledge and meaning is produced by social actors. Using qualitative data collection methods provides a way in for researchers to access the meanings produced by participants, usually through language (Braun & Clarke, 2013). Another important aspect of qualitative research is the relationship between the researcher and what (or whom) is being studied (Denzin & Lincoln, 2008) and the importance of the researcher to be reflexive about the process is a key aspect of this methodology (Alvesson & Sköldberg, 2000). Qualitative research is appropriate for this study as it allows investigation into how participants experience and understand the social world as well as specific phenomena, in this case mental health stigma (Denzin & Lincoln, 2008; O’Reilly et al., 2013).

Qualitative methods were used in this study in order to gather deeper understandings of the stigma experiences of young people and members of staff from key mental health organisations. Much of the existing literature that investigates stigma and young people, uses quantitative measures such as attitudes, literacy and social distance scales (Martin et al., 2007; Mukolo & Heflinger, 2011; Aggarwal et al, 2016; Townsend et al., 2017; Pang et al., 2017; Stone & Merlo, 2011). The concept of structural stigma appears to have mostly been investigated by aggregating public attitude survey data and carrying out policy analysis (Hatzenbuehler, 2016). However, after searching through existing Scottish mental health policy documents, I found that it was difficult to identify stigma in this way. Stigma was consistently problematised in Scottish mental health policies and suggestions for solutions were often made. Mental health policy in Scotland does not appear to actively contribute to the restriction of rights and opportunities for people experiencing mental ill health in an explicit way (Corrigan, Markowitz & Watson, 2004). Link & Phelan also demonstrate that power to use stigmatising discourses is often covert and “hidden” (Link & Phelan, 2001). A quantitative study would arguably struggle with researching something that is not directly observable to the human eye due to its dependence on positivist and empiricist philosophy. However, qualitative research has been previously used to investigate structural stigma (Woodgate, 2020; Liegghio, 2017) and would allow for this current study to access experiences of stigma from various sociological levels. Qualitative methods allowed access to lived experience and understandings that have been socially constructed and facilitated descriptions of the impacts and experiences of stigma at a structural level without having to quantitatively measure something that is often imperceptible and clandestine.

It has also been highlighted by previous researchers, that qualitative methods are more accessible for young people. Being able to talk about experiences and explain their worlds in their own ways allows them to feel engaged with the process of research, rather than feel “tested” which could happen with a limited response survey (Thomson, 1999). This study attempted to consider suggestions from previous research which demonstrated that some methods are better at engaging young people by being more interesting and “fun” than others (Punch, 2008; Thomson, 1999). Visual methods such as taking photographs, writing, and drawing or painting has been demonstrated to engage young people more than more formal methods such as interviews or surveys (Thomson, 1999). The following section will discuss the data collection tools that have been used in this study.

## 4.4 Data Collection

This research study used interviews and focus groups as data collection methods. I employed face-to-face interviews with 15 members of staff from mental health and young people focussed organisations, and 10 young people aged 15-25. The interview guides for staff members and young people can be found in the Appendices. This method allows for the researcher to interact with individuals who have specific lived experience and knowledge which can be accessed through verbal communication (Liamputtong, 2020). I also carried out four focus groups with young people who were engaged with mental health support groups in two different charities. These focus groups allowed me to gather data by using small group discussions based on a specific topic (Liamputtong, 2020). The focus group allowed for interaction between participants, instead of individually answering my questions the participants often spoke to each other providing greater depth of understanding and negotiation of the topics. The topic guides for these focus groups can be found in the Appendices section. I also used creative methods in the focus groups, encouraging participants to draw, write and map out their experiences. This following section discusses the use of interviews, focus groups and the effectiveness of these methods for this research study. This is followed by a reflexive discussion of participatory methods in this study.

### 4.4.1 Interviews

Qualitative interviews were used as a data collection tool as they allow an exploration of the participants’ experiences and perspectives in their own words, using their own concepts (Braun & Clark, 2013). This was the most appropriate data collection tool as I felt it allowed participants space and privacy to explore complex and possibly sensitive experiences and concepts and would allow for depth of experience. Interviews are useful, particularly when interviewing young people as they are flexible, allowing a choice of which questions are asked and when (O’Reilly & Dogra, 2017). I believed interviews would be useful for this research are they provide the opportunity for in depth understanding of phenomena as well as the flexibility to learn about participant experiences (Bryman, 2012). In total I carried out 25 interviews, with 15 staff members and 10 young people. The interviews ranged from 30 minutes to 65 minutes in length. The amount of time the interviews took varied based on the participant. Those which lasted longer resulted from high engagement from the participants who engaged in the interview and had a lot to say. Those which were shorted tended to be due to my consideration of the participants time and energy levels. There were instances in which some of the young people suggested near the end of the interview that they were feeling tired, so I checked in to make sure they wanted to continue and wrapped up questioning soon after this.

The interview schedules for staff and young people were semi-structured and can be seen in Appendices 8 and 5 respectively. I opted for a semi-structured approach as it allowed me to ask questions which were pertinent to the research, however, I also wanted the topics to be based on what was important for young people particularly (O’Reilly & Dogra, 2017). I felt that semi-structured topic guides would allow space in the interview to follow other issues of interest which may come from the participants themselves and I felt a more structured interview, in which everyone is asked the same questions in the same way, would hinder this process (May, 2008). Further, taking a semi-structured interview approach allowed a greater rapport to be built with participants as I was free to probe and respond to what they were saying (May, 2008).

### 4.4.2 Focus Groups

Focus groups are a form of data collection which uses the interaction between participants to generate data (Kitzinger, 1995). Focus Groups are a useful data collection tool when attempting to explore dynamics around a topic (May, 2008). They allow for the negotiation around a topic to take place with more than just one participant and a researcher (Braun & Clarke, 2013). I believed that a focus group would be beneficial for this research because it allowed me to collect multiple perspectives from young people who had a shared experience (Bryman, 2012). I had hoped a focus group approach would lead to a co-construction of the concept of stigma, however, as will be discussed in Chapter 5, this was not always the case as many of the participants did not have a clear understanding of this concept to begin with. The focus groups with young people in this study was useful in some ways as it allowed the participants to discuss concepts with each other. The instances in which participants disagreed with each other often led to interesting discussions. There were also instances in which they encouraged and supported each other to tell a story. However, there were some instances in which it did not work so well, for example one group discussed at length a recent crime that had occurred in their local area and it was difficult to get them back on track. It was difficult to balance the guided-discussion approach of questioning in the focus groups, in which I wanted the young people to be able to discuss topics which were important to them, but I was also keen to acquire useful data which was pertinent to my research questions. The topic guides for all four focus groups can be seen in Appendix 7.

The initial form of data collection was a pilot focus group with 3 young people who had worked with an anti-stigma organisation. Typically focus groups are made up of 3-8 participants and I had initially hoped for around 5 participants for the focus group in order to gather more viewpoints and to encourage more of a discussion (Braun & Clarke, 2013). However, only 3 young people from the organisation agreed to participate and having a smaller group did mean that the discussion was detailed and as I was the only person facilitating the focus groups it was easy to manage and engage in the discussion. I chose to carry out this pilot focus group mainly to investigate how to talk about stigma with young people. I was eager to avoid discussing stigma in a way that would in itself be stigmatising for young people. The young people in this focus group had received training about mental health stigma, and I therefore drew on this knowledge in order to receive feedback on the semi-structured interview schedule. Secondly, I hoped that this group would use the creative materials provided in order to produce artwork which could be used as prompts in interviews with young people who had not received mental health stigma training. I had intended these artworks to be used as both methodological tools in eliciting responses in interviews as well as data that could be analysed.

I had approached a different mental health organisation in an attempt to recruit participants and after meeting with them they agreed to allow me to carry out focus groups with the young people they worked with, instead of conducting interviews which I had initially requested. This negotiation was based on pragmatic considerations of the time and resources available to the organisation as well as their own priorities. Present in the focus groups was one consistent staff member who had existing relationships with the participants, who also contributed to the discussion. The participants in this focus group knew each other and the staff member which was useful in terms of creating a safe space for young people to share their experiences with people they had an existing relationship. However, the presence of the staff member also proved a slight challenge because they often answered the question before any of the young people, setting up an expectation of what the “correct answer” was.

There were three focus group sessions which was based on the wishes of the gatekeeping organisation. The participants could opt in to one or all three of them but because of the semi-structured nature of the discussion the sessions were never the same. One participant attended all three sessions, two attended the final two focus groups and five participants attended only one session. The possibility for a participant to attend more than one focus group is an unconventional practice, which could be seen as a limitation of this study. However, I feel that this was a helpful arrangement for the particular participants who opted to attend more than one session. It allowed these participants to get used to the process of being asked questions, allowed me to get to know them better and they helped to facilitate the discussion as they grew in confidence over the course of the three sessions. The data that resulted from these focus groups provided key insights into the lives of young people with mental ill health in Scotland and helped to contextualise parts of the study.

### 4.4.3 Participatory Methods

It has been highlighted by previous researchers that qualitative methods are more accessible for young people. Being able to talk about experiences and explain their worlds in their own ways allows them to feel engaged with the process of research, rather than feel “tested” which could happen with a limited response survey (Thomson, 1999). The current study attempted to consider suggestions from previous research which demonstrated that some methods are better at engaging young people by being more interesting than others (Punch, 2008; Thomson, 1999). Visual methods such as taking photographs, writing, and drawing or painting has been demonstrated to engage young people more than more formal methods such as interviews or surveys (Thomson, 1999). Creative methods such as drawing and writing and use of prompts are often used often with young people (Clark et al., 2015; Punch, 2002; Wyness 2019). Previous research has used art-based methodology to engage participants in expressing themselves in ways that do not depend on verbal communication (O’Donoghue, 2018; Punch, 2001). The use of creative and “child-friendly” research methods appears to be based on the assumption that young people are different from adults and communicate in different ways (Punch, 2002). It is assumed that using creative methods in research encounters is more effective with young people as they are more used to communicating in this way through school work (Punch, 2002). It also assumes that young people expect not to be taken seriously by adults and communicating in other ways and can break down power imbalances (Punch, 2002). However, it is important to critically evaluate the use of these methods as their application can have mixed success. The use of creative methods such as drawings may not necessarily be a comfortable format due to the young person’s perceived artistic abilities (Fargas-Mallet et al, 2010; Punch, 2002).

Based on reading I had done around creative and participatory methods I had assumed that this would be a suitable approach with the participants in this study, particularly due to the assumption that drawing and using prompts would help to stimulate conversation and may reduce power imbalance (Fargas-Mallet et al., 2010). I used creative methods in each of the focus group where the participants were asked to draw or creative depictions of where they had experienced stigma, as well as using cut-out people to demonstrate how they felt when experiencing stigma. The participants were asked to create resources in order to convey their ideas of how they understood the concept of stigma, mental health and mental health services. They were then asked to present their artwork to the group and to explain it. These discussions and explanations were recorded and analysed alongside the analysis of their creations. The use of these methods did help to facilitate some discussions when describing their creations. However, I felt that some of the participants were initially uncomfortable using arts-based methods. Some suggested that they were “rubbish” at art and felt self-conscious about showing their work to the rest of the group. Therefore, most used mind or word maps and utilised word association to demonstrate the meaning of mental health for them. It may be the case that creative or arts-based methods are a useful approach for younger children than the age groups involved in this study. The participants in this study were generally more comfortable with verbal communication.

Participants in the focus groups were also asked to consent to the use of their art work in interviews with other young people and all consented. I attempted to use their creations as prompts in interviews such as asking the participant if the example felt the same as their own understanding of stigma. However, these prompts were not particularly effective in facilitating discussion. Most participants suggested that the representations were a pretty comprehensive representation of how they also understood stigma and did not have anything to add to them or found something that shouldn’t have been. I attempted to use prompts as a way of making something abstract (stigma) more concrete for the discussions of it, however I am not sure this technique added anything to the discussion. Most of the participants in the interviews responded with shrugs, most agreeing with what was depicted and not suggesting or adding anything new.

The following images are examples of what was created in the focus groups:

Text, letter

Description automatically generated A picture containing text

Description automatically generated

A picture containing text, whiteboard

Description automatically generated A picture containing text

Description automatically generated

## 4.3 Recruitment Process

The recruitment process for this study involved three separate recruitment processes which happened simultaneously. One stage of recruitment involved recruiting staff members for interviews. The other stages involved recruiting young people for interviews and focus groups. The following sections discuss the recruitment processes for these three aspects of the research.

It appears that sample size of qualitative research studies can be flexible based on the requirements of the study (Patton, 2002; Braun & Clarke, 2013). This study used purposive sampling in order to hear from specific kinds of participant who have experiences and perceptions about the topic being studied (Braun & Clarke, 2013; Bryman, 2015). A key concept used when deciding when to cease recruitment of participants was saturation (Saunders et al., 2018; Braun & Clarke, 2013). I adopted the concept of theoretical saturation. I understood this to be a method in which, through the iterative process of data collection, fewer and fewer new themes were found until eventually no new thematic categories could be identified even when participants were recruited from different organisations and areas of Scotland (Glaser & Strauss, 1967; Bryman, 2015).

### Table 4. Total Participants

|  |  |
| --- | --- |
| Staff Members | 15 |
| Young People Interviews | 10 |
| Young People  Focus Groups | 10 |

### 4.3.1 Recruiting Staff Members

The motivation behind interviewing staff members was that I wanted to gain insight into those who worked in key organisations which had a role in shaping discourses about mental health, mental health stigma and young people. I wanted to get a sense of the structural-institutional contexts in Scotland from those who work day-to-day within them. In order to be interviewed the staff member had to have worked for the organisation for a year or more and the organisation had to have a connection to mental health and/or supporting Scottish young people.

I compiled a list of relevant organisations through which I would recruit staff members. I did so through a comprehensive search for third sector organisations in Scotland, which included charitable and voluntary organisations, non-governmental and non-profit organisations, as well as associations and community groups. Staff members were recruited by contacting them directly via email and inviting them to an interview. The staff member was given information about the study, why they were being asked to participate and what the interview would ask of them. If they responded positively a consent form was sent to them to be completed. This resulted in the recruitment of 15 staff members from ten different organisations across three Scottish cities. Of these ten organisations, six organisations were mental health and wellbeing focussed, and four focussed on supporting children and young people. The following tables provide the inclusion and exclusion criteria I used in order to determine which staff members should be approached for interview, and an alphabetical list of the pseudonyms of the staff who participated. In order to maintain confidentiality and anonymity I do not provide information here about the organisations from which the staff members were recruited.

#### Table 5 Staff Members Inclusion & Exclusion Criteria

|  |  |
| --- | --- |
| Inclusion Criteria | Exclusion Criteria |
| Staff member works for third sector organisation | Staff member works for private sector organisation |
| Staff member works for third sector organisation which focusses on supporting mental health and wellbeing AND / OR supporting young people | Staff member works for a third sector organisation that does not work to support mental health or young people |
| Staff member has worked for organisation for 6 months or longer | Staff member has worked to support mental health or young people for less than 6 months |

#### Table 6 Pseudonyms of Staff Members

|  |
| --- |
| Staff Pseudonyms |
| Anna |
| Barbara |
| Catherine |
| Danielle |
| Elaine |
| Fiona |
| Gabrielle |
| Hannah |
| Isabelle |
| James |
| Kyra |
| Lilly |
| Mandy |
| Nick |
| Yvonne |

### 4.3.2 Recruiting Young People for Interviews

The definition of “young people” used in this study is those aged 15-25. The issue of the categorisation of children and young people, and the point at which they become adults is contested both practically and theoretically. In terms of the Scottish anti-stigma campaign’s See Me young people’s programme, young people are eligible to be a “young champion” between the ages 16 to 25 (See Me, 2019). The Scottish Government define a child as anyone under the age of 18 (Scottish Government, 2014). The categorisation of “young people” is therefore flexible and context dependent. This research intended to focus mostly on the stage of life primarily classified as “adolescence” or “teenage years”, however this age range was expanded to include those who had reached early adulthood in order to widen the opportunities for participation. The age range was expanded to 25 as I wanted to be able to include young people who had previous experiences of mental ill health during their adolescents but had time to reflect on these experiences. This research was interested in listening to the voices of young people, and accepting their accounts and understandings as valid expertise in their own lives. This motivation is grounded in the United Nation Convention on the Rights of the Child (UNCRC) 1989 which states that young people have the right to be consulted and listened to about factors that affect their lives. It is important to understand young people’s understandings of mental health stigma as “by the time they are 16, roughly 3 children in every school class will have experienced a mental health problem” (Green et al., 2005). This is a large section of the population who are not only experiencing mental ill health, but could arguably be experiencing stigma and discrimination further negatively impacting their lives. Further, has been demonstrated that half of all mental illnesses begin before the age of 14 (Gordon & Platt, 2017; Kessler et al., 2005).

Another categorical stipulation for youth participants was that the young person involved were to identify for themselves that they had experienced mental ill health. I felt that including only those who had a formal diagnosis of mental illness would restrict the opportunity for participation for those who may have not had access to mental health services or had been informed of a diagnosis. It also opened up the possibility for participation for those who had experienced mental distress of some kind, but did not involve me applying my own definitions of what mental health or mental illness was onto a young person who may not agree with that categorisation. The following table provides inclusion and exclusion criteria used alongside support workers to identify young people who would be approached for participation.

#### Table 7: Inclusion & Exclusion Criteria for Young People’s Participation

|  |  |
| --- | --- |
| Inclusion Criteria | Exclusion criteria |
| Young person identifies as having experienced mental ill health | Young person does not identify as having experienced mental ill health |
| Aged 15-25 | Younger than 15 or older than 25 years |
| Currently in Scotland | Not currently in Scotland |

The recruitment of young people for interviews was more difficult than had originally been anticipated. I had planned to recruit young people through gatekeeping organisations within the third sector, as I was not looking for a sample of young people within clinical settings, I did not approach any medical or NHS services. I wanted a wider sample of young people who did not necessarily need to have a clinical diagnosis, but they did need to identify themselves with experiencing mental ill health. It was therefore important that I was able to carry out the interviews with young people in spaces where they would be able to seek help from a trusted person if they needed to during or after the interview. In addition, due to lone working and ethical policies at Strathclyde University, I was not permitted to meet young people in their homes. I therefore initially planned to recruit young people through third sector organisations that worked to support young people, as this would allow me to ensure the young person was receiving support for their mental health and they could access support, if necessary, in order to reduce the potential for emotional distress or risk of harm. As a result of contacting potentially every relevant third sector organisation in Scotland, five young people were recruited for interviews through this strategy. I then extended the recruitment avenues to include counselling services in higher education colleges and universities, from which another five participants were recruited for interviews. The following table provides the pseudonyms of the young people who participated in the interviews, organised alphabetically. Some of these pseudonyms have been chosen by the young people themselves and this will be discussed in more detail in the Ethics section of this chapter.

#### Table 8: Pseudonyms of Young People Interviewed

|  |
| --- |
| Pseudonym: |
| 1. Hotwheels |
| 2. Liam |
| 3. Orpheus |
| 4. Penny |
| 5. Ross |
| 6. Sansa |
| 7. Steven |
| 8. Tess |
| 9. Violet |
| 10. Zoe |

Recruitment procedures were carried out with the agreement of the gatekeeping organisation. Information sheets were sent to organisations via email. Gaining access to young people through gatekeeping organisations was difficult although I can only speculate about the reasons why this was as many organisations did not respond to enquiries. Those organisations and counselling services that did respond positively were incredibly helpful and all agreed for me to use their premises in order to carry out the interviews. This allowed me to ensure that there would a member of staff available that the young person knew and trusted. I also ensured that I received a PVG check from the government in order to certify myself as appropriate to work with potentially vulnerable groups. Staff members who worked for these organisations were asked to contact the young people they work with on my behalf in order to recruit participants for interviews. This allowed the staff members to consider whether it was appropriate to ask the specific young people that they worked with to participate or not. For me this approach was a double-edged sword. It allowed the young person to consider their participation without potential pressure or feeling coerced and made sure that participants were only approached if the staff member knew participation would be possible and appropriate for the young person. However, it also gave the power to the staff member to make a decision on the behalf of the young person. By not telling them about the research this could have prevented the young person exercising their agency in deciding whether or not they wished to participate (Holland et al., 2012). Overall, this recruitment strategy was implemented in an attempt to protect young people who may be particularly vulnerable.

### 4.3.3 Recruiting Young People for Focus Groups

Contacts and pragmatic negotiations with gatekeeping organisations also led to four focus groups with young people. One of the focus groups acted as a pilot in order to test the interview schedule and crucially interrogate ways of discussing stigma with young people in non-stigmatising ways. A support worker at the gatekeeping organisation identified young people who had taken part in training about mental health stigma who they believed may wish to take part in the focus group and extended the invitation to them. This focus group involved three young people and they provided feedback and instruction about the way in which the subsequent interviews and focus groups should be carried out. They also provided suggestions of topics that they thought would be important to be address with both young people and staff members in the study.

The other three focus groups took place within a mental health organisation with members of an existing young people’s mental health support group. I liaised with the manager and a support worker in this charity in order to schedule and run these focus groups. The recruitment for these focus groups was in the hands of the support worker who identified young people in the mental health support group who she believed would be interested and able to participate in the focus group. The support worker invited the identified young people to attend the focus groups at a specific time and place. Consent forms were signed by those who arrived. The support worker attended these three workshops in order to support any of the participants should this be necessary. The first focus group consisted of four young people, the second had three young people and the final focus group had four young people. However, there was some overlap in participants as one attended all three focus groups and another attended two. The following table provides the pseudonyms of the young people who attended the focus groups:

#### Table 9: Pseudonyms of Focus Group Participants

|  |
| --- |
| Pseudonym |
| Amir |
| Heather |
| Xander |
| Emilia |
| Oscar |
| ManBat |
| Tom |
| Caitlin |
| Alice |
| William |

This section has examined the recruitment process of staff members, young people who were interviewed and young people who took part in the focus groups. The following section will go on to reflexively discuss the data collection process of interviews, focus groups and the use of participatory methods.

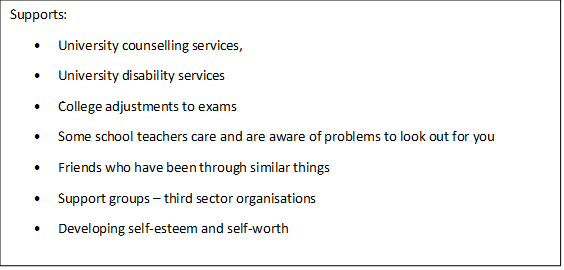
## 4.5 Data Analysis

This section discusses the analysis of data collected in this study. I treated all sources of data as a complete data set and used the same method of data analysis for the data gathered in interviews with staff and interviews and focus groups with young people. The data was analysed using what Braun and Clarke (2013) call constructionist thematic analysis and is informed by Foucauldian concepts. I had initially intended to use the step-by-step guide provided by Willig (2008) for Foucauldian Discourse Analysis, however after applying each step to a data transcript, I found that aspects of the FDA approach were too prescriptive and theory driven (Braun & Clarke, 2013; Willig, 2008). I felt that Foucauldian Discourse Analysis attempted to place theoretical concepts on to the data in a deductive way, as though I was attempting to test Foucauldian concepts against the data I had collected (Blaikie, 2010). However, I instead felt that it was more important for the analysis to be inductive in nature as I was attempting to explore conceptualisations and experiences which were important to the participants. Taking a constructionist thematic analysis which was informed by Foucauldian concepts allowed the voices of the participants to take prominence through the analysis.

Constructionist thematic analysis aims to identify themes and patterns the data, with a particular focus on the ways in which topics are constructed (Braun & Clarke, 2013; Potter & Wetherell, 1987). A key strength of thematic analysis generally is its flexibility and allows themes to be derived from the data in a “bottom up” way based on what the participants have said, which I felt was key for this study as I wanted to centre their experiences and testimonies (Braun & Clarke, 2013). I initially analysed the data using a thematic analysis approach. I transcribed the interviews and focus groups throughout the process of data collection and while doing so I made notes about key points and themes that I felt were beginning to repeat themselves. This practice of note taking allowed me to get a sense of when I felt theoretical saturation was being reached and no new themes were being raised by participants in the data collection process (Braun & Clarke, 2013; Willig, 2008). Transcribing the interviews and focus groups myself allowed “immersion” in the data and allowed me to become familiar with the concepts, themes and priorities of participants (Braun & Clarke, 2013, pg. 204). However, this led to a more iterative approach in which I began to pick up things which were being raised in interviews that I had not considered or expected and then asked about these things with other participants. This could be understood as a less rigorous and standardised approach to data collection (Bryman, 2010) however, this was not necessarily the aim of this research and it allowed for the exploration of priorities of the participants and interrogation of concepts which I had not initially considered.

Once all of the interviews and focus groups were transcribed, I began a stage of complete coding where I went through each transcription assigning relevant codes to the data (Braun & Clarke, 2013). I did this in a manual way in which I read each transcript and then used colour coding to identify different aspects of what the participant was saying. The colours were then given a label to describe what the coded data was about. However, there were several times in which many different codes were applied to the same piece of data. I then organised these codes into themes, and summarised different aspects of the data which could be included in the theme. For example, one theme was supports in participants mentioned various ways of accessing support for mental ill health:

### Table 10. Theme Examples



The second stage of analysis involved more theoretical interrogation of the data. The first stage involved identifying key themes and priorities in the data in a way which avoided placing any value, judgement or interpretation on these codes and themes. The second stage however involved developing an understanding of the discourses used by or referred to by participants in order to construct their experiences. In the second stage I began to question each extract in terms of power, knowledge and discourse. In order to organise the coding of data in a more manageable way I created tables for each transcript which had columns for the code, the theme and subthemes which could be relevant and the extract of data which applied to the code. I also had a final column for notes in which I recorded theoretical aspects of the data or other relevant thoughts about the extract. The below table is an example of one analysis of discourses used by one participant:

### Table 11. Example Analysis: Discourses

|  |  |  |  |
| --- | --- | --- | --- |
| Code: Discourse | Theme: Discourse Strand | Example quote | Notes |
| Stigma as a word / concept | A word that is used because it is in fashion not because it is well understood – jargon | “I think stigma is a buzz word” | Stigma as a word that is used a lot but not necessarily well understood. “Bullying” is used as a comparative word which the interviewee suggests is used a lot but most understand what that is. |
| Stigma as a word / concept | Different definitions | “lots of different groups of people define it in different ways compared to other big words you hear with young people” | This suggestion that there is not one agreed upon definition can call into question its usefulness.  “Big” words – other dominant discourses around children and young people? |
| Stigma as a concept / word | Usefulness | “it seems to be helpful if you can put a word to validate it” | Stigma can be useful as a word to validate the experience of being treated unfairly because of mental health. Validation of experience  Stigma concept has power for validating experience? |
| Stigma as a concept / word | Usefulness | “Knowledge that stigma exists is power” | This interviewee suggests knowing that people might stigmatise you is helpful because then you can work out what to do about it and tackle it  Foucault knowledge power |
| Experiences of stigma | Stigma is not always about mental health | “I know when I’ve felt stigmatised has been in regard to sexism” | How is stigma different to prejudice? Is it? |
| How young people experience stigma | Young people put on a risk register feel stigmatised – signalled as different to other people | “that could largely be down to stigma if young people are part of a risk register or a matrix, they often feel different because of the times they are flagged up or called in to be spoken about” | “Spoken about” suggests young people are not involved in the conversations about them  Power – being kept out |
| How young people experience stigma | Feeling different | “Stigma seems to come from feeling different… If there is anything that represents a difference that will start causing the feeling of difference” | Mental health signals difference to young people which leads to feelings of stigma? |
| How young people experience stigma | Otherness | “Something’s not the same as other people and that creates a feeling of otherness which creates attitudes or actions or behaviours that further the differences” | Feeling different or othered leads the “stigmatised” person to distance themselves further, reinforcing the feeling of otherness. Cyclical nature of stigma? Who has power to define different / other? |

I approached this theoretical examination of the data by considering two of Willig’s (2008) suggestions for Foucauldian Discourse Analysis. Willig (2008) suggests that the first step of applying FDA to data is concerned with the ways in which discursive objects are constructed (Willig, 2008). In this case this would involve the identification of stigma, and the ways in which it is discussed or alluded to in the participants’ responses. It was also important to look for omissions or the ways in which stigma was not discussed or mentioned as a priority (Willig, 2008). Another aspect of Willig’s FDA approach looks for differences between the ways in which the discursive object has been constructed in a wider context of other discourses and how these are linked (Willig, 2008). For example, in this study this would refer to the ways in which stigma was constructed in relation to other discourses that constructed young people and their mental health. Key to this research was examining the conflicts between discourses which construct the concept of stigma in differing ways, and the interactions between discourses of stigma, mental ill health and young people.

It must also be noted that analysis continued throughout the process of presenting and writing up the findings of this data, particularly in terms of relating the data to other existing pieces of research. The results are presented in the following three chapters. I attempted to use an extract which most fully represented the explanatory point being made, however this does mean that some participants are less quoted than others as some were more concise in their explanations. This does not mean that the participants who were less quoted were less valuable to the research but achieving a balance of participants’ voices was challenging whilst attempting to be succinct and explicatory. The findings are presented in the following three chapters in a way which takes a micro, meso and macro lens respectively. The first findings chapter looks at micro-level analysis of staff members’ and young people’s conceptualisations of stigma. The second findings chapter looks at participants’ accounts of micro-interactions with individuals and experiences of stigma at a meso level of institutions. The third chapter discusses the structural sources of stigma identified by participants and finally macro-level discourses which are conceptualised as holding power for the construction of mental ill health and young people.

## 4.6 Ethics

This section discusses the ethical implications and considerations for this research. This study received ethical approval from the University of Strathclyde Ethics Committee. Firstly I will address the issues relating to ensuring voluntary participation and informed consent. Secondly, I discuss the process by which I ensured participant anonymity, followed by issues of privacy and confidentiality. Lastly, I discuss the measures taken to reduce the risk of harm to participants.

### 4.6.1 Voluntary Participation & Informed Consent

Obtaining voluntary and informed consent is an important ethical issue that must be addressed. This is particularly the case when gatekeepers are used for accessing young people, as it is difficult for the researcher to know the level of coercion applied when the information about the study is given to the potential participant (Wyness, 2019). The ethical principles of this research were based on following the guidelines from United Nation Convention on the Rights of Child (UNCRC). This involved respecting young people’s consent or refusal to participate which upholds their right to have their views listened to and the right to thought and conscience (Alderson & Morrow, 2011; UNCRC, 1989, Article 12 & Article 14). Participants were therefore provided with information about what would be asked of them in the study to allow them to decide for themselves if they wished to participate. In addition to information about the research, the participants were given information about the data that would be collected about them and the ways it would be stored, Consent was also sought from participants in the focus groups to use their creations (creative artefacts) in the interviews with other young people. The participant information sheets and consent forms can be seen in the appendices.

As per the recruitment procedures the gatekeeping organisations were informed about the exclusion and inclusion criteria of participants and were then able to make a decision about the appropriateness of asking young people connected with their organisation if they would like to participate. The gatekeeping organisation’s policies on gaining consent from young people were followed. It was assumed that these organisations knew what would be best for each individual young person and would be able to assess the ways in which the wellbeing of the young person may be affected by their participation. I did not believe that it was in the young people’s best interests for me to assess whether they are able to participate and give informed consent as I did not know the young person and did not possess the relevant clinical skills for this. None of the gatekeeping organisations required parental consent for young people to participate in the study. Therefore, consent from the individual young person was deemed sufficient regardless of their age (Coyne, 2010). However, gatekeeping organisations had the power to affect participation in the study either by persuading or dissuading young people to participate as they saw fit, and the young people themselves may not be given the chance to exercise their full agency (Alderson & Morrow, 2011), although there is no evidence that this was the case in this research.

Similarly, a pressing issue for me was to ensure that when a person agreed to participate, they did so willingly and that they did not feel obliged or pressured into doing so by either myself or the gatekeeping organisation. It was therefore made clear in the participant information sheet that they did not have to participate, and the support they were receiving from the organisation would not be affected by whether or not they participated. This was extended to included members of staff who may have felt that they had to participate if they were asked to participate by a manager in the organisation for example and they were informed that their participation was confidential from their employer. Obtaining consent is an iterative and ongoing process (Alderson & Morrow, 2011). Particular sensitivity was paid to ways in which participants “say no” or “show no” (Skånfors, 2009). This happened a few times in research interviews with young people. For example, one participant started to fidget, loose eye contact and yawn after about half an hour of the interview. The participant also started to say things like “my brain isn’t working” and stopped answering questions as coherently as they had been previously. As a result, I checked in with the participant to see if they wanted to finish. Initially, they refused however this behaviour continued and I was concerned that they just didn’t feel that they could say they wanted to stop. I checked in again, asked if there was anything else they wanted to add and when they said there was not, I concluded the interview.

Due to the limited funding for this research and my own ethical ambivalence, I did not provide participation incentives. It is sometimes ethical and appropriate to offer payment or gifts as a thank you for participating, or to compensate a participant for their time and contribution (Alderson & Morrow, 2011). I feel that advertising a prize or payment for participating in the recruitment processes would have resulted in far more young people agreeing to participate, however I felt that this could be taken to be an incentive and result in some young people feeling coerced, or that they had to finish the interview in order to receive the incentive (Alderson & Morrow, 2011). This, for me, felt as though this method of recruitment had a higher risk of influencing or coercing participants who perhaps would not have wanted to participate otherwise.

### 4.6.2 Anonymity

Using pseudonyms in order to protect participants’ anonymity is a standard practice in qualitative research (Allen & Wiles, 2015; Braun & Clark 2013; Bryman, 2015). However, Alderson and Morrow highlight an incidence in which young people in a study wished to be identified in order to take ownership of their own data (Alderson & Morrow, 2011). During the process of signing the consent form, participants were asked to choose their own pseudonym. Only a minority of participants took up this offer and most who did choose actual names. There are a few whose names may seem “unusual”, but these names tended to have a special meaning for a participant, such as showing a participant’s personality or it more suited an identity that they felt their own name did not, but not all of the meanings were shared with me. Participants who opted to choose their own pseudonym therefore have a way for identifying themselves in the research that only they know about and I felt offering that opportunity was important for participants’ sense of ownership and agency over their own data. For those who did not wish to choose to their own pseudonym, I assigned each participant a letter of the alphabet and assigned a name, from an online random name generator, based on this letter. (For example, one participant was assigned the letter E I used the random generator until I found a name beginning with E).

I did not collect demographic information about the participants. Due to the qualitative nature of this study, I did not feel that demographic variables would be necessary to collect for the study as I was not carrying out a comparison. A key principle of the General Data Protection Regulation (GDPR) is to only collect data that is required (Information Commissioner’s Office, 2018). I felt that the participants in this study were giving a lot of personal information already in terms of telling me about their experiences of mental ill health and stigma, and that information such as socio-economic status, religion, sexual identity was not necessary for their participation. I felt it was important to ensure participants privacy and more identifying information would put confidentiality and anonymity at risk. However, this means there are little contextual information about the accounts of the young people that they do not provide themselves.

### 4.6.3 Privacy & Confidentiality

Children have the right to privacy (UNCRC, 1989, Article 16). This study attempted to uphold the right to privacy in two ways. Firstly, participants were only asked about aspects of their lives that were required to answer the research questions. Secondly the information provided by the participants and/ or the gatekeeping organisation about the participants have been kept confidential, securely stored and will be destroyed appropriately after use. During the focus groups the importance of confidentiality was highlighted. It was stressed that participants should not repeat what had been said or by whom to anyone out-with the focus group session in order to protect everyone’s confidentiality and privacy. However, it was also highlighted to participants that there are limits to confidentiality. The participants were informed that if they disclosed that someone was at risk of harm, that I would need to tell someone in the gatekeeping organisation. This included if a staff member disclosed risk of harm that was not already known and being dealt with. In this instance the breach of confidentiality and any action taken would be discussed with the participant unless this would potentially cause further harm. However, no disclosures of the potential harm were made.

### 4.6.4 Reducing Risk of Harm

Safeguarding policies and guidelines from the gatekeeping organisations were adhered to during data collection in order to reduce the potential risk of harm to participants. The interviews with young people took place in a familiar and comfortable setting. Participants were asked prior to the start of the interview whether they would like someone else that they trusted to sit with them in the interview, however none of the participants opted for this. However, there were members of staff of the gatekeeping organisation available in case of an instance where a participant felt upset in the course of the interviews or focus groups, again though this was not necessary. In order to further minimise the risk of emotional distress for participants, they were informed about what they would be asked about before they provided their consent to participate, thus allowing them to consider for themselves if it was appropriate to participate or not.

Potential harm may also have been caused if the interview process reinforced stigma. It was important that whilst talking about stigma with participants that the research did not suggest that the young person was stigmatised if they did not feel this way, or hadn’t realised that they felt this way before the research. Shaw et al., (2011) recommend using props, visual prompts or asking questions in the third person may help when asking sensitive questions of young people. As a result of these suggestions prompts created by the initial pilot focus groups were used to introduce the idea of stigma. I also adapted questions about experiences of stigma to ask “do you think you or anyone you know might have experienced mental health stigma before?” This allowed the young person to talk about experiences that may have happened to other people or frame their own experiences as something that had happened to someone else, allowing them to slightly depersonalise the sensitive nature of the question (Shaw et al., 2011)

## 4.7 Reflexivity

Reflexivity is understood as an essential aspect of qualitative research and can be used as an evaluation of the quality of qualitative research (Braun & Clarke, 2013). Reflexivity is the critical reflection on the knowledge produced by researchers and the process of doing so (Braun & Clarke, 2013). Qualitative research takes an antithetical view to that of quantitative in which the researcher is objective and external to the research process. Instead, qualitative research accepts that knowledge, particularly knowledge of the social world, is subjective, value-based and socially and personally constructed (Etherington, 2004). Functional (or epistemological) reflexivity involves critical attention to the way the data collection, analysis and the research process overall could influence the data gathered (Braun and Clarke, 2013; Willig, 2013). As the researcher, I must therefore consider how the ways in which the research questions are defined and the methods used has delineated what can and cannot be investigated and identified in this research. For example, this research uses both interviews and focus groups and it is important to understand that the data which was produced in the context of a focus group would have been different had it been produced in the context of an interview. Personal reflexivity involves making the researcher visible in the research process and considering how their assumptions and standpoint influences the knowledge that is produced (Braun & Clarke, 2013; Etherington, 2004). I therefore endeavour to consider personal and functional reflexivity throughout this thesis in order to more critically understand the power I have in co-constructing the knowledge alongside participants.

### 4.7.1 Positionality

I had to consider carefully how to position myself in terms of the interviews and focus group interactions, particularly with young people as I have my own experiences of mental ill health and stigma. It is important to consider my own positionality in the research process, particularly in terms of the interaction with research participants. In some ways I share insider status with the participants, in that I have experience of being a young person with mental ill health and attempting to access mental health services. I must therefore consider my position as a “service user” as well as other the other intersecting identities that has influenced the way in which I approach this research, such as gender, age and social class and the ways in which these identities interact with my identity as a social science researcher and PhD student.

Wilkinson and Kitzinger (2013) suggest that there are four ways of managing the insider experience. The first way is to minimise it, effectively ignoring the similarities in experiences the researcher has with the participants. This is in keeping with a positivist approach which insists that the researcher should be objective and detached (Wilkinson & Kitzinger, 2013; Braun & Clarke, 2013). Secondly a researcher may utilise their insider status in order to gain access and use their connections to certain groups who otherwise may be difficult to reach (Wilkinson & Kitzinger, 2013). Thirdly, a researcher may maximise their insider status through the study of their own experiences exclusively (Wilkinson & Kitzinger, 2013) which can take the form of an auto-ethnography. Lastly a researcher may incorporate themselves in the research, treating herself as through she has the same status as the participants (Wilkinson & Kitzinger, 2013). Throughout the research process, I would say that I considered using all of these approaches to manage my insider status as someone with experience of being a young person with mental ill health. I minimized, utilised and incorporated my insider identity in the research process at different stages of the research.

“Maximising” my experiences however, was something with which I had difficulty. I wanted the research “voice” to be mostly that of the participants, I did not want to make it about me as I was aware of the privilege I held as a researcher in comparison to participants in the study. In the end I had power to interpret and disseminate their experiences through this thesis and as it was ultimately not a “co-produced” piece of work. The participants had little control over this once the interview was over. The young people in this study could arguably be understood to experience levels of testimonial injustice in which their experiences are undermined and devalued by society (Fricker, 2007). I therefore did not wish to “take up space” with my own experiences as it was more important to me that the participants’ experiences and perceptions were valued in ways which may not be the case elsewhere. I was concerned that if I drew too much attention to my own experience, this would detract from the experience of participants which was felt like it went against the aims of the research (Wilkinson & Kitzinger, 2013).

I was initially tempted to take the first approach of “minimisation” (Wilkinson & Kitzinger, 2013) however, this was as problematic as it was unrealistic to maintain. I was cautious about the potential harm that could be caused by introducing the idea of stigma to young people who may not have experienced it before. I wished to avoid inadvertently suggesting that their experiences or their mental ill health would be something that was stigmatising, which may have led to them feeling stigmatised by me or by the research process. I wanted to avoid suggesting what stigma was or how it could be experienced to reduce the potential of suggesting that I was validating or approving of it, or potentially steering participants based on my own views. Further, I was interested in gathering data which would tell us about young people’s understandings of mental health stigma in a way that was meaningful to them. Therefore, I withheld my own understandings of stigma and feigned naivety about the concept or experience of it, to elicit explanatory responses from participants. This can be found most explicitly through the utilisation of the “alien” question. Through this question I framed myself as an intergalactic non-human entity without knowledge of mental ill health and stigma, and asked the participant to explain why mental ill health was stigmatised. I used this question to encourage participants to break down assumptions.

However, on reflection this approach of attempting to be an objective onlooker, in which I did not reveal what stigma meant to me, had its own problems. For one thing it was disingenuous and I believed the participants could see through this - I am not a blank slate, and so I did come to the research site with my own positionality, experiences and understandings (England, 1994; Freeman, 2019). I realised, after a few interview and focus group interactions in which participants revealed that they did not know what the word “stigma” meant at all, that I was not positioning myself as a “tabula rasa”, but as holding more knowledge, and power, in that situation, as a “gatekeeper” to understanding stigma. These interactions with young people led me to understand the problem of unacknowledged power and positionality – instead of facilitating explication it ran the risk of shutting down the potential for co-creating knowledge and understanding (Fawcett, 2000). Within these interactions I then felt I had to give the participants an explanation of how I understood stigma, how it felt for me and what it was about this concept that I was struggling with understanding. Highlighting to participants both that I had my own lived experiences and also that I was unsure about the concept led to some of the most interesting and illuminating interactions in the data collection process, because this broke down a barrier of “researcher” vs “participant” and moved the relationship more towards a dialectical exploration of the issues being discussed. This led me to further question the possibility and usefulness of minimising my lived experiences.

However, despite becoming aware that I could not minimise or omit my experiences, I was unsure about *how* to manage and represent my insider status and lived experiences. It felt exploitative to “use” my status as someone who had accessed mental health services to gain trust with the gatekeeping organisations in order to secure access to participants as suggested by Wilkinson & Kitzinger (2013), however I cannot say that this did not ultimately act in my favour when meeting with gatekeeping organisations to negotiate working with them. For example, when asked about why I was doing this project by participants and gatekeepers I would acknowledge that I had my own experiences of mental ill health as a young person which had led to my interest in the topic, thus making it impossible to completely minimise or omit my positionality from the research.

Further, my experiences of mental ill health and distress were the result of traumatic life experiences and I was cautious about revealing details about this in the research process, particularly as the thesis may become public and could potentially implicate other people. I was keen to protect my own privacy and adhere to my own personal boundaries around disclosure. “Managing” my identity as someone who has been diagnosed with Post Traumatic Stress Disorder remains a difficult negotiation and I often say I experience anxiety, or depression instead as I do not wish to upset anyone or have them attempt to guess or extrapolate what the “trauma” was. In my experience, revealing the diagnosis of PTSD can alter the way others perceive me, or interact with me in a way which I cannot always predict, so informing participants about my specific diagnosis did not seem appropriate, nor was it something I was comfortable doing on a personal level.

However, I would argue that completely concealing my position as someone with lived experience was not possible and was reconsidered. Instead, I took the approach of using “anxiety” as a description of my experiences of mental distress, and reflecting on the similarities of experiences in accessing services between my own and the participants where I felt this to be appropriate in the data collection process. I incorporated my insider status and became a contributing participant in the focus groups, where I also carried out the art tasks and used my own experiences as a facilitator for the discussion. I felt that this helped to lessen the feeling that I was questioning or examining the participants work and that by contributing I was demonstrating that I had similar experiences to them and were not asking them to do something that I would not, in an attempt to address the power imbalance. I was careful not to present or explain my creation before the rest of the participants in the group as I was concerned that this would influence the participants and suggest that I wanted their experiences to be similar to my own, even if they were not (Dwyer & Buckle, 2009).

Another instance of incorporating my own experiences was in an interview with a young person, she revealed that she had not had particularly useful guidance from healthcare professionals about what to do when she experienced a panic attack. I could empathise with both the panic attacks and the lack of suggestions for dealing with them from mental health practitioners. I asked: “would it be useful to talk about what I do when I have a panic attack?”. The participant affirmed that this would indeed be helpful and we had a short discussion about the things that helped, or didn’t, when we were experiencing an onset of panic. I was worried that this may have crossed the threshold from being a sympathetic researcher towards an empathic or therapeutic interaction, I am not a qualified mental health practitioner and I felt that our discussion could have erred on the side of “advice”. However, I would also argue that sharing and empathising with this participant put her more at ease, reassured her that I was on her side and not acting on behalf of the services that she was critiquing. It could be argued then that in this instance my insider status and shared lived experience added value to the data collection process as revealing the similarities in our experienced helped me to empathise and developed rapport with this participant (Braun & Clarke, 2013).

My initial inclination of minimising or avoiding my insider positionality and lived experience can be understood in further depth by examining other intersectional aspects of my identity. I often feel an “imposter” within academic spaces. This is due in part to being female, young (when I started this PhD I was in the “young people” category of this research at 25 years old) and of a Scottish working-class background (Breeze, Addison & Taylor, 2022). Throughout the process of this PhD, I have been concerned that I will be found out as not clever enough or deserving of my place here. I worry people ask “who let in that wee lassie”? It felt foolish to even consider revealing yet another aspect of my identity, my experiences of mental ill health, which could further call into question my place as a PhD student.

I also felt that I therefore had to be as scientific as possible in order to justify my position as a social science researcher. I am aware of the value of feminist and survivor research as knowledge which highlights different and useful standpoints to emancipatory ends (Rose, 2009; England, 1994). Further, it was to challenge the hegemony of what could be understood as truth and reality that I undertook this research. However, I missed the point when it came to considering myself, I remained swayed by hegemonic discourses which constructed my experience and my knowledge as biased and unhelpful.

This research sets out to challenge positivist frameworks that dominate current knowledge of youth mental health which is understood through a predominantly medical lens. Mental health research is dominated by quantitative and positivist approaches to research (Rose & Beresford, 2009) which is demonstrated in Chapter 3 of this thesis. The dominant approach of positivist research takes the view that objective knowledge is inherently better, and closer to “truth” and “reality” than subjective knowledge as the researcher remains detached from the knowledge produced, they are less likely to “contaminate” it (Rose & Beresford, 2009; England, 1994).

The thoughts and beliefs I hold about myself as inadequate, not clever enough or undeserving are tied to hegemonic understandings of what is considered valuable knowledge (Fricker, 2009). I embody/ied various identities which have typically been considered irrational and whose knowledge has been supressed and devalued: women, mad people, young people, working class (Fricker, 2009; Hewertson & Tissa, 2022). Typically identities which hold positions of powerlessness. Yet, I now find myself in a position (as a researcher and in higher education) in which I have greater access to capital, resources and knowledge, and therefore power to shape and challenge hegemonic discourses (Foucault, 1980). By ignoring and minimising my experiences there is potential to contribute to this marginalisation. By applying a framework in which the researcher must be silent only further values the empiricist notion that only certain kinds of knowledge and experience are valid. It is therefore only by acknowledging and incorporating my own knowledge alongside the knowledge of the participants in this study can I truly begin to challenge these hegemonic constructions of “truth” and “reality”.

## 4.8 Chapter Summary

This chapter has demonstrated the benefits of using social constructionism as an epistemological foundation for this study as it allows for the possibility of valuing multiple ways of knowing and validating multiple experiences. It also discusses the challenges of using social constructionism as an ontological framework as although it allows for plurality of experience, if taken to a logical extreme it can inadvertently undermine experiences of distress. However, I argue that using social constructionism allows hegemonic understandings of young people and mental ill health to be challenged by the participants and allows for contextual and social understandings of plural experience. This chapter has also discussed the usefulness of qualitative data collection methods of interviews and focus groups due to their flexibility and the provision of space for co-constructing conceptualisations and experiences between the researcher and participants themselves. The chapter has also provided a reflexive discussion of the use of participatory methods in which I acknowledge that this research study, while attempting to be consultative and take participants lead on what was important, was not a fully co-produced piece of work due to the pragmatic difficulties and lack of power sharing involved in decision making. This chapter discussed the ethical issues and the ways in which they were addressed and finally a reflexive account of my own positionality is provided. I will now go on to discuss the findings that resulted from the data collection discussed here.

# Chapter 5. Results 1: Conceptualisations of Mental Ill Health Stigma

This chapter addresses the findings from this research study which address the first research question. This first results chapter focuses on the ways in which staff members and young people conceptualise stigma, or perhaps more importantly struggle to do so. It will be demonstrated that staff members found it difficult to provide a consistent definition of stigma, even when this was part of their job. However, when taken together members of staff provide a conceptualisation of stigma that is fairly similar to Link and Phelan’s (2001) Modified Labelling Theory, however there is a greater focus on the impact of a lack of help seeking in reinforcing a cycle of stigma. As staff members hold an understanding of the concept of stigma which is consistent with previous theorising, their accounts are presented first, followed by youth conceptualisations. Young people also struggled to provide a definition of stigma and suggested they did not typically use the word to describe their experiences. Those who did describe a definition of stigma suggested that stigma was about the behaviour of others rather than an issue with the individual experiencing mental ill health.

## 5.1 Staff Members Conceptualisations of “Stigma”

This section will demonstrate how the 15 members of staff interviewed in this study constructed stigma. Staff members found it difficult to articulate a definition of stigma and suggested they would use alternative words when describing stigmatising situations. Across participant accounts there lacked a consistent definition of stigma, even from members of staff working in anti-stigma campaigns. Staff suggested that stigma has value as an emancipatory tool however I argue that this may be undermined by the complex and abstract nature of the concept.

### 5.1.1 Difficulty Defining “Stigma”

I included the question “what does mental health stigma mean to you” in the semi-structured interview schedule for members of staff, in order to determine a consistent definition of the word “stigma”. It was important that I established how each participant understood the concept, however I was also hoping to identify consistencies, and/or discrepancies across participants’ definitions of stigma. However, staff members sometimes found it difficult to provide any definition of stigma, for example:

“Em… pff… I was gonna say we do this all the time -you ask me questions I’m no prepared for them!” Danielle (SM)

This participant initially found it difficult to articulate an answer to the question about what mental health stigma meant. It is important to note that Danielle works for an organisation that aims to tackle mental health stigma in society. As she highlights in the above quote, part of her job is to regularly discuss stigma. However, she initially found providing a definition or explanation of stigma difficult. A key reason for this could be that there are various definitions or ways of understanding stigma. This was highlighted by other participants:

“Stigma is kind of used as a catch all and people just say stigma in general and it’s quite an easy word to bandy around but it’s difficult to articulate” John (SM)

“It’s kind of a word people say without thinking what’s behind this” Yvonne (SM)

John and Yvonne suggested a generalist use of the word “stigma” that lacks specificity. They both suggest that stigma is a used to encapsulate various potential meanings, and suggest it’s use can lack intentionality. This is particularly noticeable in John’s use of the phrase “bandy around”, which has connotations of carelessness in the lack of specificity.

I highlighted the difficulty with obtaining a definition to another participant who works for an anti-stigma campaign. I was hoping that she would be able to provide me with the definition used by the campaign, however she highlighted that:

“there is no clear one definition, so I was looking across the programme and we use several definitions depending on the different environments” Mandy (SM)

This was also suggested by Anna:

“Lots of different groups of people define it in different ways compared to other big words you hear with young people” Anna (SM)

This suggestion that stigma does not have a specific or static definition is an issue highlighted by Link and Phelan. They argue that the definition of “stigma” changes depending on the person investigating it (Link & Phelan, 2001). They suggest that “stigma” is used in various situations and has evolved over time by use in different disciplines and to investigate different phenomena (Link & Phelan, 2001). The difficulty participants had with providing a definition, which suggests that even for those who are well versed in the topic of mental health stigma, the word can feel initially complex and difficult to articulate. This highlights the difficulty of discussing stigma, which could be an important challenge for anti-stigma campaigners to consider.

### 5.1.2 Using Alternative Words

Due to the difficulty of articulating a definition of stigma, alternative words were suggested. Staff members regularly suggested other words that they would use instead, for example:

“Sometimes I would use the word stigma but I suppose I would use other phrases like being treated differently or excluded or not heard or whatever so maybe I would use other words” Elaine (SM)

Other words were sometimes offered in comparison to stigma because of their clarity:

“like bullying there’s pretty clear, defined lines with that and even sometimes now with abuse there’s a lot of good resources on that, but stigma’s a funny one, isn’t it? It’s just…a bad word really” Anna (SM)

Both participants made suggestions about alternative words they would use instead of the word “stigma”. Anna suggested that she uses these alternative words because they have a clearer definition. It should be noted that the alternative words for describing stigma used by Anna and Elaine are different, and mean different things, which could suggest they have different understandings of stigma. Elaine’s “other words” suggest that a person is being rejected or singled out. Anna’s “other words” suggest cruelty or harm to a person. However, these words are suggested because they demonstrate more clearly what is happening to the person and are less abstract than “stigma”.

Yvonne in particular struggled with the word stigma and regularly suggested alternatives:

“But is that stigma or is that... well it's ignorance isn't it... I think it's a really ahhh it's a tricky concept.” Yvonne (SM)

“I also grapple sometimes with the word stigma because I think sometimes, we use the word stigma when we should be calling it racist or discrimination” Yvonne (SM)

“I’m thinking in my own work I don’t really use it…. I would talk about discrimination and I would talk about racism and I talk about the very real impact of poverty, I’d talk about shame… I’d rather talk about rights I think” Yvonne (SM)

These examples suggested to me that stigma could be used specifically because it is complex and difficult to understand. Yvonne suggests it is word we use when we mean discrimination, a breach of a person’s rights, or racism. Stigma, then, could be used euphemistically to describe situations that we are uncomfortable with calling out, because they exist within a framework dominated by powerful discourses. Obfuscating these situations by using a vague, complex concept like stigma could also make it more difficult to highlight and challenge these situations. Arguably then we must think about the privilege that comes with calling something stigma, and not racist or discriminatory. Discrimination, for people with mental health issues notes a behaviour that is legislated against, and so we must be mindful of who would benefit from the dominant discourse of stigma rather than discrimination.

A key finding was that many members of staff suggested they would not use the word stigma as exemplified by Danielle:

“Nobody uses the word stigma, stigma is a horrific word and it’s really difficult because in our day to day language we don’t use the word stigma” Danielle (SM)

Her suggestion that stigma is not used in common parlance could suggest that stigma is only a word that is accessible to an academic (or policy) audience and this could be particularly due to its complexity and lack of consistent definition. Even staff members like Danielle, who work in an organisation with a focus on tackling stigma, find the word difficult to use. The accounts from members of staff about the complexity of the word stigma suggests that its use should be questioned. If it can be used to obscure meaning, and in turn obscures discrimination, racism and infringement of people’s rights and is only a word that is valued because it is used in academic scholarship, it may not have a place in the daily lives of people who work in the mental health field and for those who experience mental ill health. If members of staff who use the word and whose aim is to “tackle stigma” find the word complex and difficult to define perhaps this makes it also difficult to identify the extent to which stigma is indeed being tackled. This led me to question the value of the concept of stigma in its current form as it does not take into account the perspectives of those with lived experience of mental ill health stigma.

### 5.1.3 The Value of the Concept of “Stigma”

Participants suggested that despite its complexity, “stigma” is still a valuable concept. Staff members noted that being able to name stigma, helped to challenge it and validate an experience of it:

“I think what our programme does is help them to articulate it to be able to name it and therefore challenge it” Mandy (SM)

“It seems to be helpful if you can put a word to validate it” Anna (SM)

Anna goes on to state that “knowledge that stigma exists is power” and this suggests that the word can have value as an emancipatory tool for those with experience of mental ill health. I would argue that a clear of understanding of the concept of stigma is necessary for this to be achieved. There were, however, other aspects of the word stigma that led me to question if it is people with experience of mental ill health who value the word:

“There’s something in policy that says it’s important because we’ve had a national campaign for many years now” Yvonne (SM)

“I think stigma is a buzz word” Anna (SM)

The above statements from Yvonne and Anna suggest that it is important because people who have power to influence discourse have placed importance upon it and have decided that this is the concept that will be utilised to describe the inequality faced by people experiencing mental ill health. “Buzz word” suggests that stigma is used because it is fashionable or holds worth within dominant discourse, not because of its usefulness or clarity. Yvonne demonstrates the importance placed on stigma within policy. This refers to the Scottish Government’s commitment, to “eliminate” the stigma and discrimination of mental ill health (Scottish Executive, 2003, p.2). To do this the Scottish Government set up anti-stigma campaign “See Me”. Reference to stigma in policy endures in the most recent mental health strategy (2017-2027) as discussed in Chapter One. This strategy refers to a goal of creating a Scotland in which “stigma and discrimination related to mental health is challenged” (Scottish Government, 2017, p. 2). Having gone from a goal of “eliminating” stigma to one where it is merely “challenged” may highlight the difficulty of achieving this goal. Both participants’ comments suggest that those who have power to shape discourse have found the concept to be useful for them. However, those with power to influence policy and hegemonic discourse, as well as distribute resources are not necessarily those with direct experience of mental health stigma.

Despite policy attempts to “address” stigma, and participants highlighting that using the word “stigma” can lead to identifying and challenging instances of unfair treatment and injustice, participants noted that stigma was still prevalent for people who experience mental ill health:

“We’ve had See Me for what 15 years? It must be something like that? And they’ve been doing brilliant work and are really well regarded and have got good knowledge about the topic and ((pause)) stigma still exists” Catherine (SM)

“I think things like See Me and anti-stigma campaigns have done a lot but there’s still a lot of ill-informed views” Yvonne (SM)

“It’s a bit more acceptable but we’ve got a long way to go really” Hannah (SM)

These participants suggest that while mental health is more acceptable there are still changes that need to be made to improve attitudes in order to challenge stigma. It could be argued that the complexity of the word stigma, makes it difficult to identify and directly tackle it (Link et al., 2004).

I have demonstrated in this section that finding a definition for stigma was difficult and participants often provided other words that they felt were clearer and more easily understood. Some suggested that they did not use the word at all. This led to my questioning of the usefulness of the concept of stigma, as it is something that has entered dominant discourses through academia, policy and government. This leads me to question the emancipatory potential of the word if it is complex and only valued by those who already have power in shaping policy and government priorities, rather than those with lived experience of mental health stigma. The next section will discuss how members of staff constructed different aspects of stigma.

## 5.2 Staff Members Construction of the Stigma Process

Obtaining a consistent definition of stigma from members of staff was difficult, as demonstrated above. However, if we are to understand stigma as an “overarching term” that incorporates several components, we can understand staff members’ suggestions about what stigma “is” as a process of several steps (Link & Phelan, 2001; Thornicroft, 2006). I thematically grouped statements from staff members about how they understood stigma, and found several steps within a process of stigmatisation. What resulted was incredibly similar to Link and Phelan’s stigma model.

Link and Phelan (2001) suggest 4 key components of their stigma model are: distinguishing and labelling differences, associating differences with negative attributes, separating “us” from “them”, status loss and discrimination. Link et al., later added the importance of emotional reactions to their conceptualisation of stigma (Link et al., 2004). They highlight the importance of emotional responses in the process of stigmatisation for both those that stigmatise and those being stigmatised (Link et al., 2004).

The following sections will demonstrate how the staff members interviewed in this study suggested different aspects of a stigma process that is similar to those suggested by Link and Phelan (2001), including identifying differences and making references to the importance of emotional reactions, with a specific focus on shame and fear. There are key differences however such as the specific focus on the role of stigma as a barrier to mental health support.

### 5.2.1 Stage 1: Identifying Differences

One of the ways in which members of staff conceptualised stigma was by using the word “difference”. This is also a key component of Link and Phelan’s stigma model. They suggest that the social salience of difference, is socially constructed and change over time and place (Link & Phelan, 2001). Throughout the interviews staff members described stigma as involving feelings of difference or being made to feel different from others. When asked to describe what mental health stigma meant this participant suggested that:

“So, it’s making suggestions that someone’s different, making assumptions that someone can’t do something… that this person has a different level of ability than this person for X reason” Anna (SM)

This description of stigma focuses on identifying and highlighting differences between an individual and the rest of society. In the above example Anna highlights a socially salient difference in terms of mental health stigma is an individual’s ability. Another salient difference found in other participants’ understandings of stigma appears to be an individual’s ability (or inability) to “cope” with life, or their experiences of emotional distress:

“Is it something that is just about us as humans and society in general that we’re always looking for difference, that is seen to be different or seen to be not coping is going to be looked down upon?” Catherine (SM)

Catherine places the understanding of identifying differences as something that is inherent within human beings, as though it is a “natural” response and as a result, stigma is something that cannot be easily addressed. Not coping is seen to be the identifier of difference for Catherine. Another participant highlighted that stigma comes from the inability to hide a “failure to cope” with life:

“I think it means not being able to or not wanting to be vulnerable and be open about what’s going on for someone because of shame, fear or being made to be different, to be seen as different…” Hannah (SM)

Catherine and Hannah suggest that “not coping” is the identifier of difference in the process of mental health stigma. This quote suggests that being “unable to cope” is seen as “difference” because of an expectation that people should be able to cope with things in life, an expectation that we do not demonstrate emotional distress or difficulties in our lives. One way of understanding the idea of “not coping” as an identification of difference, could be the importance placed on “resilience”. Resilience is a concept that is often described as a way of “bouncing back” from trauma or catastrophe (Kelley, 2005; Hu, 2014; Mackinnon & Derickson, 2012). Resilience is valued in Scottish and UK policy (Scottish Government, 2003; Scottish Government, 2019; Harrison, 2012). It could also be argued that resilience, or being able to cope has entered into dominant discourse and is a normative expectation. People who have mental ill health could be perceived as infringing on this expectation of being resilient or able to cope, therefore demonstrating an identifiable difference. This suggests that when someone is identified as different, they will be shamed, or there is a fear that they will be shamed for their difference, therefore leading to the concealment of this difference. The labelling of this difference will now be discussed.

### 5.2.2 Stage 2: Applying a Label

In Link and Phelan’s stigma model the identification and labelling of difference are grouped into the same component. Labelling theory is a key idea throughout the literature on stigma. Labelling theory is tied to ideas of deviance, which understood by Howard Becker as “anti-social behaviour that threatens the norms and values of society” (Becker, pg. 134, in Slattery, 2003). Becker’s theory of deviance involves the process of applying social labels to individuals. These labels influence how people are treated, which reinforces and amplifies their deviancy (Becker, 2003). Thomas Scheff then applied labelling theory to the context of mental illness, however this conceptualisation was criticised for its assertion that labelling was a direct cause of deviance and mental illness (Scheff, 1974; Gove, 1975; Link & Phelan, 2013). Link and Phelan moved away from Scheff’s conceptualisation of labelling theory in their development of a modified labelling theory. Instead, Link and Phelan provide a more nuanced account for the continuation of mental illness by highlighting the negative consequences and inequality of life chances that occur as a result of the application of labels to people with mental ill health. Similarly, members of staff in this study suggested the importance of labelling:

“People don’t want a label of “you’re mental” or “you’ve got depression” Fiona (SM)

Fiona uses both a psychiatric diagnostic label in this example as well as a word that is disparaging and connects a diagnosis with a negative attribute (Link & Phelan, 2001). The word “mental” is used disparagingly and connotes public attitudes about people with mental ill health as behaving erratically, dangerously or violently (Scottish Government, 2013).

“I think it’s stigma that they don’t want to be labelled… they don’t want to be known in their family that they have a mental health issue because they don’t understand it” Kyra (SM)

This participant specifically suggests that the words “mental health” lead to this labelling of difference. This participant also notes that people do not want their families to find out about their difficulties with mental health because their families do not have an understanding of what this means. This could again suggest that a mental health label would indicate a negative attribute for people whose families have a lack of understanding about the nature of mental ill health.

For some participants, labelling was a key aspect of stigma. An important part of the desire to avoid being labelled was the suggestion that that they would be treated differently, or unfairly because of the connotations and meanings attached to the label they have received:

“Stigma to me, labelling people and treating them accordingly” Yvonne (SM)

This quote highlights the connection made between being labelled and the way the person with the label is treated by others which is in keeping with modified labelling theory, (Link & Phelan, 2013). This leads us to the next stage of the stigma process highlighted by staff members in this study.

### 5.2.3 Stage 3: Treating People Differently

Link and Phelan highlight the status loss and discrimination of people subject to the stigma process. When individuals are labelled and linked to undesirable characteristics they are then devalued and excluded (Link & Phelan, 2001). People who experience status loss, or who are devalued in society, experience disadvantage in terms of life chances (Link & Phelan, 2001). They also draw on research that shows status loss has implications in terms of power and inequality within small group interactions (Link & Phelan, 2001; Mullen et al., 1989). Staff members in this study also highlighted the ways in which people are treated differently due to stigma. Some staff reflected the argument of Link and Phelan, and suggested that the act of labelling results in negative treatment of people:

“if you're attaching a negative label to someone then you're discriminating [against] them because you're no’ treating them equally and you're no’ viewing them the same as comparatively the same level as you, so if I labelled someone as with depression as weak and lazy then do I treat them the same as someone who I perceive not to be weak or lazy? So, stigma and discrimination function together” Danielle (SM)

This participant understands discrimination as actions against a person with a label. Here, Danielle’s construction of stigma follows closely to aspects of Link and Phelan’s as she discusses the conflation of a label to a negative characteristic and the resulting negative treatment. It is difficult to know if Danielle has experienced this (unlike Anna, below, for example). She works for an anti-stigma organisation and it therefore must be questioned whether she is describing stigma using academic discourse, and based on her reading of the literature, or from direct lived experience of working with people who have been stigmatised. Staff members understood “being treated differently” in different ways, some suggested that it was about how the person was made to feel about themselves:

“I think when you're made to feel uncomfortable about anything about yourself em anything that people say or do to you that make you feel not good” Barbara (SM)

Barbara indicates that stigma can be many different things, but focuses particularly on the way people are made to feel by the way others treat them.

Staff members also highlighted that the effects of status loss are not always directly observable, but can act cumulatively and covertly (Link & Phelan, 2001). This is demonstrated by a member of staff who suggests that:

“It comes from genuine observation of the times that I’ve felt stigmatised but there hasn’t been a specific incident that I can pin point and again that’s a problem cause… who are you going to go to… like if I put down on a piece of paper generally I don’t feel welcome by this person then what does that mean..?” Anna (SM)

This staff member draws on her own experiences of stigma to demonstrate her understanding of it as something that is difficult to highlight and pin down. She suggests that feeling stigmatised is often difficult to articulate which makes it difficult to address and prevent. In some cases, members of staff suggest that the way people are treated differently is about the way they are spoken about, rather than direct action towards them:

“There’s a lot of word of mouth that goes around rather than actual action” Kyra (SM)

It was also suggested that treatment towards those who had been labelled involved “silence” and exclusion of the individual from social life:

“Stigma can be about lots of different things not just name calling, it can sometimes be about silence” Barbara (SM)

Barbara and Kyra construct stigma as something that occurs covertly, or can function as an absence of interaction. This adds to the complexity of the concept and increasing the difficulty of identifying and challenging situations of stigma.

#### 5.2.3.1 Rejection and Isolation

The third component of Link and Phelan’s stigma model is the separation of “us” from “them”, or the identification of individuals to an “in-group” as fundamentally different from an “outgroup” (Link & Phelan, 2001). A way of identifying difference is those that have been labelled, vs those that have not (Link & Phelan, 2001). An important effect of stigma that was described by staff members was the rejection and isolation of an individual who was subject to the stigma process. One participant highlighted, that individuals in a group of people with mental ill health that she worked with reported being rejected by their friend group:

“Some of them were excluded on purpose because the circle of friends didn’t want to associate with them” Kyra (SM)

This suggests that a result of the stigma process is rejection by others because of the label that has been applied to them (Link & Phelan, 2001). This participant also states that stigma isolates an individual and prevents them from participating in social life as they would wish:

“It kinda isolates a person away from people, family, friends and it just builds up walls from everything you wanna do” Kyra (SM)

Stigma can lead an individual subject of the stigma process to avoid contact with others in their lives for fear of being rejected by them. This participant draws on her own experiences of feeling stigmatised in order to give an example of how stigma can be isolating for a person:

“I’ve kinda experienced stigma in my personal life and I feel like it’s excluded me from being myself and I had to portray a different role in the community just to hold off the actual issues that I was facing” Kyra (SM)

Kyra felt as though she had to portray a façade of coping to the community in order to prevent them from identifying her as different because of the struggles she was experiencing. Kyra’s experiences indicate that, even before being treated differently, an individual removes themselves from situations in which they may be actively rejected by others because of the perception of what could happen to them. This relates to “anticipated discrimination” put forward by Thornicroft, who draws on empirical research to demonstrate that individuals expect to be discriminated against, even when they do not have direct experience of discrimination (Thornicroft, 2006; Prince et al., 2002).

Another participant indicated that individuals who could be subject to the stigma process conceal aspects of their mental health:

“To me stigma is… a lot about covering it [mental health] up and hiding it, I think a lot of people do that because they are worried about what other people will say or how other people will view them” Gabrielle (SM)

This participant suggests that stigma involves concealment of an individual’s mental ill health due to the fear of the reaction of others. This means that individuals who may be having difficulties with their mental health will conceal these problems to avoid further rejection from social life, and could prevent them from getting help for their mental health difficulties (Thornicroft, 2006). This in turn could lead to greater emotional distress, which was what identified them as different in the first instance (Quinn et al., 2017). This could suggest that these conceptualisations of stigma result in a cyclical process from which it is difficult to escape.

### 5.2.4 Stage 4: The Role of Emotions

Link et al. (2004) acknowledge that their conceptualisation of stigma lacked important understandings of emotional reactions (Link et al., 2004). Similarly, many members of staff conceptualised stigma as connected to emotional reactions for those subjected to the stigma process and those contributing to it (Link et al., 2004). Many members of staff discussed the emotions associated with experiencing the stigma process as a way of describing the concept:

“It’s about feelings and actions, it’s about fear, embarrassment, judgement, burden, guilt, dismissal…” Danielle (SM)

Danielle places great importance on emotions in order to conceptualise stigma. She suggests that an important aspect of understanding stigma is the emotions that individuals feel when they are subject to it. The first two emotions she highlights in this quote, fear and embarrassment, were also key in many staff members’ descriptions of stigma, and what the word meant to them. While Danielle uses the word “embarrassment” many others highlight that shame and fear are also important emotions felt in the process of stigma:

“I think it means not being able to or not wanting to be vulnerable and be open about what’s going on for someone because of shame, fear of being made to be different to be seen as different” Hannah (SM)

It is important to note that within this quote we can see many aspects of the stigma process described above. Hannah suggests that individuals try to conceal their vulnerability because they will be identified as different and then treated as such. This participant attaches feelings of shame and fear to this process suggesting that it is also an internal one connected to feelings and emotions of the individuals participating and subject to the stigma process.

#### 5.2.4.1 Shame

One important emotion discussed by many members of staff in their interviews was shame. Thornicroft defines shame as “humiliation or distress caused by an awareness of wrong or foolish behaviour” (Thornicroft, 2006, pg. 159). Thornicroft argues that shame is a self-judgement and stems from a sense of guilt that has resulted from a perception that they have broken a socially prescribed moral rule (Thornicroft, 2006). Members of staff placed importance on the idea of shame:

“I just think they [mental health and stigma] are connected, not that they should be but they are there's stigma, there's shame, people are embarrassed to say they're struggling.” Fiona (SM)

Fiona notes that one reason that mental health and stigma seem to be linked is down to the perception that shame is attached to an individual not being able to “cope”. This could suggest that having mental ill health or experiencing distress is perceived as a moral failing, thus explaining the shame people feel as a result (Thornicroft, 2006). Similarly, another participant highlights that mental health, or a key aspect of a person, can be shamed by others:

“People can feel quite ashamed of who they are, and shamed” Yvonne (SM)

This comment was made in the context of discussing the process of self-stigma. Self-stigma, is the process of being aware of public attitudes and applying these attitudes to themselves (Corrigan, et al., 2010). This participant suggested that a better way of describing and talking about self-stigma would be to talk about the process of shaming an individual and how this affects those being shamed. Yvonne goes on to explain how she takes issue with the way that self-stigma is currently conceptualised and discussed:

“I would be more interested in thinking about shame and guilt like feeling shameful or feeling shamed and how that feels, ‘cause self-stigma feels like you're kind of accepting of it like I'm taking that and I'm going to stigmatise myself, you know what I mean? It feels like you’re actively participating in it” Yvonne (SM)

In this quote, Yvonne suggests that the phrase “self-stigma” suggests that the individual is an active agent in their own stigmatisation. However, she suggests that understanding this in terms of the individual feeling shamed by others is a different way of framing this experience of stigma as one that results from the actions of others. Thornicroft posits that shame, self-stigma and anticipated discrimination are linked together in a cycle. He suggests that people who feel shame about their mental ill health, and have therefore internalised social attitudes about mental health (self-stigma), will also anticipate discrimination to a greater extent (Thornicroft, 2006). He also notes that this anticipation of discrimination can lead to behaviour that can influence others to react in a stigmatising way (Thornicroft, 2006). Finally, these negative behaviours and beliefs can lead to the person with mental ill health isolating themselves from society (Thornicroft, 2006).

Another participant suggests that shame, or being shamed, is not always an active or overt process:

“But I feel as though there's something around, no one tries to tell you something's shameful, maybe you learn it, maybe it's pure brainwashed when you were four or something” Hannah(SM)

This suggests that understandings of what is shameful is learned, or communicated in a way which not explicitly discussed or stated (Thornicroft, 2006).

It should also be noted that another participant, also discussing her own experiences of feeling stigmatised highlighted that shame can be enacted in an overt way:

“I cut my wrists so seriously they had to reattach the tendons… she [Nurse] said no-one’s speaking to you, we have real patients to see” Barbara (SM)

This participant recounts her experience of attempting suicide and being taken to hospital. She describes in this interaction with a nurse in A&E as stigmatising and feeling shamed by the nurse’s comments that she was not a “real” patient. Barbara describes the nurse laughing at her and actively shaming her for her actions. This example suggests that stigma, and shaming of people experiencing mental ill health can be explicit and deliberate. These accounts from participants suggest that their understanding of stigma is tied to the idea of feeling shame, and being shamed because of an individual’s mental health.

#### 5.2.5.2 Fear of People with Mental Ill Health

Another important emotion discussed by staff members in this study is fear. Fear is connected to stigma by many members of staff.

“It’s a lot to do with fear of opening up and being vulnerable or being judged by people yeah it’s a lot to do with fear” Fiona (SM)

This participant highlights that people feel fear of being identified as different because of their mental health. Individuals are fearful that they will be judged by others but also fearful of being treated differently:

“A lot of it is based around fear, fear of judgement and fear of also how you’ll be treated” Barbara (SM)

In these examples, stigma appears to be connected to the fear of potential mistreatment of judgement from others. This is demonstrated clearly by one participant who provided an example of why someone might be afraid of being identified as different because of their mental health:

“I went to see a little boy today who refused to see me… his mum said I think he’s afraid he will be taken away… I think people have said to him ‘you’ll end up in the loony bin’” Barbara (SM)

Barbara suggests that for this child people around him have caused fear by suggesting that something bad will happen to him if he has mental health difficulties. This demonstrates that while stigma can be communicated covertly through “unwritten rules” (Thornicroft, 2006) about something that is shameful, it can also be quite overt.

In general, discussion of fear was connected to how an individual experiencing stigma would be fearful of how others would respond to their mental ill health, or perceived incapability of coping with negative emotions. Fear was connected to a lack of desire to talk about mental health or distress:

“maybe people are frightened of talking about mental health” Elaine (SM)

Previous literature suggests that violence and dangerousness is a key stigmatising belief about people with mental ill health (Martin et al., 2007; Pescosolido et al.1999; Rogers and Pilgrim 2001; Scottish Government, 2013).There were some suggestions that fear was tied to understandings about mental health:

“there is a misunderstanding about mental health and people are afraid, I think discrimination comes from a place of fear and misunderstanding” Gabrielle (SM)

“I think there are some times when somebody’s quite unwell, their behaviour can be challenging, it can be difficult… you can understand why people are fearful [of people with mental ill health] at times because it’s that lack of understanding” Mandy (SM)

The above examples suggest fear comes from not knowing about or understanding mental ill health. While Mandy highlights that a person’s behaviour can evoke fear, she suggests that this because there is a lack of understanding of how to interact with people experiencing mental ill health and exhibiting challenging behaviours.

However, Barbara also highlighted a level of fear from younger children she worked with:

“one wee girl told me that it [mental health] was about people removing their trousers and exposing themselves… two other children said they had heard mental health and it was people that killed people” Barbara (YP)

She suggests that this fear from the children she interacted with about mental health had learned these attitudes from their parents who were explaining upsetting news headlines. This suggests connotations of fear and dangerousness are still connected to mental health particularly in news media discourses (Reavley, Jorm & Morgan, 2016; Knifton & Quinn, 2008).

### 5.2.5 Stage 5: Help Seeking

A key component of stigma highlighted by many members of staff is that it prevents individuals accessing support and help for their mental health. One member of staff noted that it is the emotions individuals feel that lead to their reluctance to ask for help:

“then stigma, there’s fear, embarrassment, judgement, guilt and being a burden to the people that care for them and that they love all those key factors stop young people from accessing [support]” Danielle (SM)

This would suggest that the stigma process elicits emotions that cause individuals to feel as though they are a burden and that this prevents them from asking for help for their mental health (Yap et al., 2013; Chen et al., 2014; Mann & Heflinger, 2016). Another participant suggests that the presence of stigma means that people are fearful about drawing attention to their mental health by accessing support:

“It’s certainly something that people experience in terms of fear of coming forward and that prevents them seeking help when they should” John (SM)

One participant highlights that key to mental health and anti-stigma campaigns is the attempt to reduce the fear experienced by individuals speaking about their mental health:

“It’s a really big issue in terms of people getting support for their mental health… lots of publicity around mental health stigma is about trying to break down that fear to be vulnerable” Fiona (SM)

Fiona suggests, just as other staff members have, that vulnerability, or the perception of inability to cope with distress, is a way that society identifies an individual as “different”. This makes it difficult to reveal that a person is experiencing emotional difficulties or issues with their mental health, which in turn makes it difficult to ask for help. This then makes it more difficult to recover from these mental health and emotional difficulties.

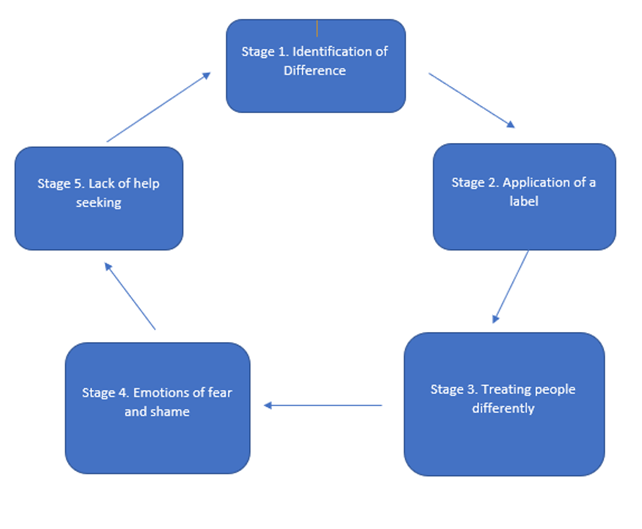
Mandy also demonstrates an understanding of stigma as a barrier to help which is due to the devaluing of the person with mental ill health in society:

“stigma affecting individuals in respect of self-stigma and their own belief that they’re not worthy, that they they’re labelled, that they’re marked…that they don’t deserve any intervention” Mandy (SM)

This understanding is in keeping with Thornicroft’s suggestion that self-stigma can act as an isolating factor and prevents help seeking (Thornicroft, 2006). Not seeking help for mental ill health due to shame and lack of self-esteem (Corrigan et al., 2010), will in turn affect a person’s ability to cope with distress, which is what identified them as different initially and provoked the stigma process to begin, thus stigma appears to be an ongoing cycle, from which it can be difficult to escape.

I have demonstrated in this section that staff members’ understandings of the process of stigma are similar to Link and Phelan’s conceptualisation of a stigma process. I have developed the below visual model which incorporates aspects presented by staff as key components for their own understandings of stigma.

#### Figure 1: Staff Members’ Understanding of Stigma as a Cyclical Process



The concept of stigma appears to have value in elite discourses of policy, however these discourses are constructed by those in power and is not necessarily based on lived experience. Staff members in this study suggested that the concept of stigma could be useful for highlighting and challenging instances of unfair treatment and inequality experienced by people with mental ill health. Staff also found stigma to be a complex concept to describe and identify, partly due to its lack of consistent definition and partly due to its covertness. This complexity calls into question the usefulness of stigma as a concept for those who do not have access to the elite discourses of those in power, therefore challenging its emancipatory value. Staff members also constructed stigma as a process that was in keeping with Link and Phelan’s conceptualisation of stigma and modified labelling theory. Staff members’ understandings focused mainly on the interpersonal aspects of a stigma process such as the identification of individual differences and individual emotional responses. While staff do suggest that this process has an impact on help seeking, which can reinforce the cyclical process of stigma, there is a lack of observation of power and structural factors within this conceptualisation. Link and Phelan have highlighted the need to consider the role of power within the process of stigma, however this is missing from much of these participants’ constructions (see Link & Phelan, 2014).

## 5.3 Staff Accounts of Young People and Stigma

This section will discuss how staff members working with young people in mental health organisations reported their understanding of young people’s use of the word stigma and young people’s understanding of the concept. Staff members in mental health organisations often have power to shape policy and social marketing campaigns that shape discourse about mental health stigma. How they understand young people’s relationship with mental health stigma could therefore impact policy and cultural sources of discourse and it is important to have a fuller understanding of this.

### 5.3.1 How Young People Use the Word Stigma

As demonstrated above, some members of staff suggested that they did not use the word stigma in their daily lives and work due to its complexity. I was interested to find out whether the young people they worked with used the word stigma and what discussions they had about it together. A few members of staff suggested that some of the young people they work with use the word stigma. One member of staff suggested that:

“one of the young people at the moment is a guy who speaks a lot about his experiences and he definitely uses stigma” Lilly (SM)

Other staff members suggested that young people they work with use the word but that this may only be because they have been involved with mental health services and have picked it up there:

“the youth commission for mental health were using phrases like stigma and stuff but I don’t know if that comes from them reading more adult policy” Anna (SM)

“our children and young people’s advisory group… they talked about the stigma around mental health and the lack of understanding” Catherine (SM)

Similarly, another participant was unsure whether the young people she worked with used the word only because she had mentioned it:

“There’s a few that have used that word, whether I’ve brought that word up (pause) a lot maybe wouldn’t use the word stigma and just speak about how it’s been difficult, how it had been challenging, how they didn’t want people to label them, I think labels could maybe more naturally used by them” Fiona (SM)

Fiona suggests here that young people are more likely to use their own words or phrases to describe stigmatising experiences than they are to use the word stigma. In this quote the word “label” is provided as a more commonly used word to describe stigma. This could indicate that young people who are involved in mental health organisations have heard this word used in the context of the organisations. It could be the case that young people who have contact with mental health organisations develop a greater level of mental health literacy through this contact and are therefore more aware of stigma and are more likely to use the word to describe situations they may face, however more research is needed in order to determine this. In this instance in could be argued that stigma is an empowering word for those young people who are aware of it and have access to the discourse around it.

### 5.3.2 Young People Use Their Own Words

Staff members also suggested that young people describe stigma in their own ways, but do not necessarily use the word:

“young children have never used that word with me, ever, they will come and say he’s been really mean to me” Barbara (SM)

“not the word stigma they describe it in their ways… things like oh they laugh at us they describe it but they won’t use the word” Kyra (SM)

“sometimes they say they’re being bullied by a teacher when they mean stigmatised” Anna (SM)

While Barbara works with primary school age children (5-11 years old) and suggests that they do not use the word stigma, Kyra and Anna work with older teens and those transitioning into further education (16-25). This suggests that in these instances regardless of age, young people did not always use the word stigma and find other words to describe their experiences. It should also be noted that the participants work with young people with contact with mental health organisations. Therefore, contact with mental health organisations does not always lead to young people using the word stigma as suggested above. More research to examine stigma literacy in young people is required in order to more fully understand this.

### 5.3.3 Young People Do Not Understand Stigma

A key reason provided by members of staff as to why they believed young people do not use the word stigma is that they do not know what it means:

“so, we talked about stigma and I said does anyone know what it means and none of them knew” Barbara (SM)

The word stigma is framed as something that is difficult to understand:

“even just the concept of what stigma and discrimination is quite a tricky one for them to get their head around… I think the way we talk about it for kids might need to be a little but more on their level, it’s a very big concept and I think to make any difference we need to bring it back to them, what does it look like in their lives?” Gabrielle (SM)

Gabrielle suggests that when talking about stigma to young people we should use words that are easier to understand. Just as staff members found it difficult to describe stigma, they also suggest that young people find the word stigma difficult to understand. Participants Anna and Mandy suggested in Section 1 of this chapter, that “stigma” could be valuable as an emancipatory word, to draw attention to and challenge experiences of unfair treatment. However, if young people do not use the word, this questions its emancipatory potential. If young people have other ways of describing stigma perhaps these ways should be incorporated into anti-stigma campaigns to encourage access to concepts that challenge stigma for young people.

### 5.3.4 Young People Experience Stigma

While staff members suggested that young people do not always use the word stigma and that they find the word complex, these participants also suggested that young people do experience stigma:

“I think it does exist particularly in the age group that you’re working in, they will have experienced it whether they know it or not” Anna (SM)

Here Anna suggests that young people will have experienced stigma, whether or not they know their experiences would be classified as stigma. This ties in with the assertion from other staff members above, that young people will use others words to describe stigmatising experiences, and that they may not have access to the concept of “stigma” as it is situated within elite discourses of policy and academia. Participants highlighted that young people do not necessarily use the word stigma, but that they do experience unfair treatment because of their mental health:

“So, the way they describe it is about people being treated differently so negative treatment, treating others differently, excluded, not accessing opportunities, again they talk about behaviours and the personal impact or attitudes, they don’t talk about stigma” Danielle (SM)

“they feel they have been treated unfairly or they have been fearful of having conversations about mental health, whether they would describe it as stigma is questionable, but actually they know what stigma is and when you explain it to them, they’ve absolutely experienced it or they’ve witnessed it” Mandy (SM)

These examples demonstrate that staff members construct situations reported by young people as instances of stigma. Even if young people do not use the word stigma to describe their experiences, staff construct their understandings of young people’s experiences of being treated differently as a stigmatising incident. The suggestion that young people do not seem to use the word could demonstrate that stigma is part of an “expert” discourse that only some young people have had contact with, thus restricting its potential value for young people who may not have had access or exposure to organisations.

Staff members describe young people’s experiences of stigma in a way that is in keeping with their own understandings of stigma, specifically the identification of difference:

“No, I don’t think I’ve ever heard young people saying that they’ve felt – or they’ve never mentioned stigma but they’ve mentioned being treated differently” Elaine (SM)

An important way in which young people are made to feel different was highlighted by one participant:

“Stigma seems to come from feeling different… If there is anything that represents a difference that will start causing the feeling of difference… if young people are part of a risk register or a matrix, they often feel different because of the times they are flagged up or called in to be spoken about” Anna (SM)

Anna describes the risk register as:

“people on a matrix or risk register who have defining characteristics that would flag them as potential at risk for drop out, or a potential for risk for not having a smooth transition so in one school I’m focussing on a targeted group for young people in that way” Anna (SM)

Anna works with young people who are identified as being at risk of having a difficult transition out of high school. The way young people are identified of being “at risk” is being placed on an “at risk register”. The act of doing this, according to Anna, signals to that young person that they are different from other people. She suggests they are also spoken about and to more than other people at school and highlights that they are different because they are treated as such. Anna highlights that placing young people on this risk register is an experience that young people can find stigmatising despite it being there seemingly to benefit and protect them. This is also highlighted by another staff member:

“they don’t talk about these things because they feel they’ll get judged and put into special groups whereas they want to be like everybody else” Kyra (SM)

Kyra suggests that young people do not want to talk about things that are troubling them or difficulties that they are having with their mental health because they will be singled out. Being “put into special groups” again could be seen as a way of helping and protecting young people, however these staff members suggest that young people feel they highlight that they are different to their peers and therefore frame the interventions as judgemental or stigmatising.

Overall, staff members indicate that while young people may not use the word stigma or particularly understand its meaning, they do experience being treated differently or unfairly because of their mental health.

### 5.3.5 The Impact of Stigma on Young People

The members of staff also discussed the effects of stigma on young people. The main effects discussed were young people’s resulting reluctance to discuss their mental health with others and to seek help for difficulties they experience. However, one participant suggested that young people also avoid situations in which they believed they would experience stigma:

“I guess what’s the word, disenfranchisement? Like I’m not going there anymore I’m not doing that or I’m not gonna show up…” Anna (SM)

Anna discusses young people feeling excluded from college life because of their stigmatising experiences. These experiences lead the young people to stop attending classes in order to avoid feeling stigmatised. Other participants note that young people avoid discussing difficulties with their mental health in order to prevent being identified as different:

“one of the wee boys started to say that he didn’t tell people when he didn’t feel happy because he was worried people would slag him” Barbara (SM)

Barbara’s story is an example of how young people conceal difficulties with their mental health. This was similarly discussed by Gabrielle:

“I think young people… they know what it feels like to be discriminated against and stigmatised and I’m sure they feel like they can’t talk about their mental health but whether they are consciously thinking about where it comes from, I don’t know” Gabrielle (SM)

Gabrielle suggests that young people may not necessarily know where the feeling of not being able to talk about their mental health comes from or realise that it is potentially the result stigma and discrimination. Not being able to speak about their mental health for fear of being judged or misunderstood could result in young people not accessing help:

“the young people, like in the project, thinking on their own experiences of the stigma they’ve received and how that’s impacted them it’s made it more difficult for them to get help” Lilly (SM)

This section has demonstrated that members of staff suggest that young people do not tend to use the word stigma or understand its meaning but they do describe stigmatising experiences and experience being treated differently and unfairly. It has shown that staff members gave accounts of young people and mental health stigma that were in keeping with their own understandings of stigma. As staff suggested that they found stigma complex and difficult to understand they too suggested that young people felt this way. Staff members indicated that young people they work with do not always use the word stigma. They also framed young people’s experiences as a result of the identification of difference. Staff members highlighted that a key effect of stigma on young people was isolation and a barrier to help seeking. Staff’s conceptualisations of young people’s understandings and experiences of stigma fit within an established understanding of stigma that is in keeping with Link and Phelan’s (2001) stigma process model. It could be argued that stigma is situated within an elite discourse, used only by those who have access to academic understandings of stigma, such as those with access to mental health organisations. This therefore raises questions about the utility and value of the concept of stigma for young people as a tool that identifies and challenges inequality and prejudice. It is therefore important to understand how young people conceptualise their experiences and how they understand mental health stigma, which will now be discussed.

## 5.5 How Young People Understand Stigma

This section will demonstrate how young people who participated in the interviews and focus groups for this study described and understood the concept of stigma. There are some parallel findings with members of staff from mental health organisations who struggled to provide consistent definitions. The young people involved in this study discuss how they do not use the word, just as members of staff suggested, and that they use other words to describe experiences of unfair treatment. This brings the utility of the word stigma for young people into further question. If stigma is given value in mental health discourse because of it’s potential to highlight and challenge unjust treatment, it’s complexity can undermine this potential. The prevalence of stigma will also be discussed, and the suggestion from young people that stigma does not have as much value for them as their concerns lie in their lack of access to mental health care and support.

### 5.5.1 A Complex Concept

Just as staff members of mental health organisations found it difficult to provide a definition of stigma, young people interviewed were also unsure about how to describe the word. Some young people explicitly stated that they found the word difficult to describe:

“I always stumble when I have to say what stigma means” Ross (YP, Interview)

Ross works with other young people in a mental health organisation which facilitates young people having a voice about things that affect their lives. He does go on to provide an explanation of stigma in the interview after the above qualifying statement:

“sometimes it's individual stigma so personal stigma coming from within, structural stigma so that's institutions and structures that em kinda maximise inequalities and then there's cultural stigma like the newspapers and the media only reporting very one sided em parts of the story I think” Ross (YP, Interview)

Ross’s understanding of stigma places importance on where stigma comes from. Other participants’ understandings of the sources of stigma will be addressed more fully in Chapter 7. Ross mentions that he has been given training from the mental health organisation he works for and suggests that he uses this training to convey what stigma means to the other young people he works with. However, even though he has been given training from a mental health organisation and suggests that he understands the concept, when having to describe what the word means he indicated that he always finds it initially challenging.

Another participant, who had heard the word began to describe what stigma meant, but seemed to lose confidence in her ability to describe it:

“stigma to me means kinda like a thought stuck to a certain subject like it might not always be correct… how do I describe it…?” Penny (YP, Interview)

Penny initially suggests that she knows what it means, she has heard it before. However, when asked to pin down what it means she can give a vague description. She also gives an example and suggests that the stigma around mental health is that “you’re always sad”. This helps to demonstrate that even though the word has been heard before it is difficult for young people to describe initially. Other participants also state that it is difficult to define:

“Yeah I’ve heard the word a few times I can’t define it though… oh just came to me stigma is the em thing around a certain topic like what it gets for being that topic is that right? Like vaguely is that what stigma means?” Liam (YP, Interview)

Liam gives a vague description of stigma which I took to mean that he thought stigma was the assumptions around a topic, similar to how Penny describes a thought stuck to a subject, which could be understood as a stereotype, as above. Liam seems to struggle with the concept of stigma throughout the interview and I should have clarified his understanding of what it meant at this stage. I did not adequately achieve this because at the time I was more interested in getting his own understanding of what stigma meant and I was reluctant to influence his response with my own ideas. Greater clarification of his understanding would have aided in communication between us throughout the rest of the interview. I make this mistake again in a focus group:

“To be honest I'm no’ really sure, like I don't unnerstaun' it like the whole stigma part, that's one of my problems I don't unnerstaun' it, I can't gie ye answers about it ‘cause I don't unnerstaun' stigma part” Tom (YP, Focus Group)

Other members of the focus group had been discussing what stigma meant and what it was during the focus group and Tom had been quiet during these discussions. It was near the end of the session that he admitted he didn’t really understand what the word meant. I felt this was a failing on my part to clarify nearer the beginning of the discussion what stigma meant to each of the participants and to provide a clearer definition for those who didn’t have an understanding. This highlights an issue of power, both in research spaces, but also connected to the word stigma. By withholding a definition about what was meant by stigma, I inadvertently excluded Tom from the discussion. I had been reluctant to provide a definition of stigma before finding out how the young people themselves understood it as I did not want to suggest that their understanding was incorrect or to change the way they understood without first finding out what they thought it meant. It also appears that I had assumed young people would know what it meant, or that they would have the confidence to say that they didn’t understand it but this may not have been the case for everyone. By not clarifying it’s meaning, with Liam or Tom, or with other participants, this led to the exclusion and inequality of participation in the discussion of those who did not have an understanding of what “stigma” meant. I had also inadvertently framed myself as holding more power than Tom in this situation, as the gatekeeper to understanding stigma. This suggests that stigma is not always an accessible or emancipatory word for young people and that it is couched in an “expert” discourse, and this was highlighted by Tom:

Tom: “I heard the word but I wouldny have knew the meanin’ behind the word so might have just been a word and might have been for some people, intimidating not knowing whit it wis”

Amy: “Are there other words you would use instead that you think are better?”

Tom: “em no really... well I would but I don't really know whit ones they were really”

Amy: “Yeah, just being treated unfairly maybe?”

Tom: “yeah that would be better for people, well for people under the stigma category they should probably say that to them instead ‘cause they wouldn't unnerstaun' what stigma is”

(Focus Group)

Tom’s suggestion that it could be intimidating having other people discuss a word and not know what it meant demonstrates that the focus group could be viewed a microcosm of society (Luke & Goodrich, 2019). If dominant discourse uses inaccessible concepts such as stigma, the value of these concepts as an emancipatory tool is undermined. The previous suggestions from staff that knowing how to articulate their experiences as stigma could be empowering for young people is called into question here. If stigma is indeed a word that is difficult to understand and describe, and if some young people do not have access to the word or it’s meanings, this places stigma within an expert discourse that policy makers, national campaigns and academics use, but that it is not particularly useful as an emancipatory tool for those who would most benefit from wielding it as such. This is highlighted by another participant in a different focus group who suggests that she has:

“Absolutely no clue though so I'm totally honest… Probably [heard the word stigma] in high school, some smart girl probably said it and I've felt stuck wae it but didn't ask” Caitlin (YP, Focus Group)

Caitlin’s response suggests that she didn’t feel she could ask anyone what “stigma” meant. This indicates that instead of being an empowering word, the use of the word stigma could lead to some young people feeling disempowered and excluded from discourse about things that affect them. This point is also reinforced by Ross who suggests:

“as a word em I think it’s often said and misunderstood… it’s often just thrown out there as another one of these buzz words and not really unpicked what it means” Ross (YP, Interview)

Ross’ suggestion of stigma as a buzz word, is also found in staff members’ perception of the word stigma as demonstrated in the previous section. “Buzzword” suggests that it is used because it is a popular word used within a specialist discourse, but he also suggests that there is a lack of clarity of the meaning by those who use it, which was also a point raised by Anna. The complexity of the word stigma is exemplified by another participant who suggested that:

“I don’t know how to explain it but I know it when I see it you know?... It’s like a weird amoeba of a word that’s encompassing different situations” Sansa (YP, Interview)

Sansa suggests that stigma is a complex word that is ill defined, but can be identified through experience. This participant indicates a gap between knowing how to explain stigma, and the experience of it. This duality of experiencing stigma and giving that experience an adequate name is found throughout the data and will be examined more fully in the Discussion Chapter. I felt that Sansa’s use of the simile relating the word stigma to an amoeba helpful and illustrative. This imagery suggests that, as amoeba can change shape, stigma has fluid boundaries of meaning. Amoeba also have the ability to move around freely and Sansa’s use of this imagery helps to demonstrate that she feels the word stigma can change it’s meaning in different situations, depending on people’s experiences of it.

This section has demonstrated that stigma is not a well understood word, and the meaning of stigma is difficult to describe. The complexity of stigma, and young people’s lack of awareness of the concept’s meaning, questions the value of using the word stigma to describe experiences of unfair treatment, as it is not always accessible for young people who may benefit from highlighting and challenging these experiences.

### 5.5.2 Using the Word “Stigma”

As demonstrated at length above, “stigma” is not easily understood or described by young people in this study. It is therefore important to investigate how young people understand and describe stigmatising experiences. Some young people suggest that they do not use the word stigma:

“Not really I don’t hear it dropped – like used a lot, not really the word stigma” Hotwheels (YP, Interview)

Hotwheels indicated that she knew what stigma meant because she had taken a mental health class at school, but that she nor her friends used the word. This participant does suggest however that she is not aware of many stigmatising experiences, so it could be the case she does not use the word “stigma” as it is not necessary in her daily life.

Other participants suggest that they would use the word stigma:

“not me personally but when I see it with other people, I have used it… like I’ve known some people who are suicidal and they’ve been pushed aside at work a lot” Zoe (YP, Interview)

Zoe gave this suggestion when asked if she would use the word stigma. This response could suggest that she does not feel she has had an experience that she would call stigmatising, but when she has noticed this in the lives of other people, she has pointed it out and used this word to describe their experiences. Another participant suggests that:

“Day to day probably-pft- I mean I'd say I have used it it's not in my every day vocabulary but I mean I probably would use it yeah” Penny (YP, Interview)

Another participant used the word before I brought it up when she was discussing accessing mental health support:

“that's scary especially if you're young then there's the stigma of like the police are for when you do things wrong rather than when you do things... that aren't wrong?” Tess (YP, Interview)

Tess is discussing how it is difficult to access help and suggests that the police could be one way of getting help but there is a stigma attached to having the police involved. This suggests that Tess uses the word stigma and highlights that she feels she knows what it means and that she understands it in the context of mental health. This will be discussed in more detail in the next chapter.

Participants also suggested that they would use other words instead of stigma:

Amy: “Would you use the word stigma?”

Everyone: “Nuh, no”

Amy: “Why not?”

Oscar: “Eh pff probably like ‘cause I think when people are actually stigmatising people I'd do it more like bullying, cause with stigma it's not like you're just not talking about it… I guess just putting it out your mind is still being stigmatised, but when I think about it I think about it as people actually talking about it telling you - more like bullying like I said just telling people to just get over it, overthinking all that kind of stuff”

(Focus Group)

Oscar suggests that instead of using the word stigma he uses the word bullying because it represents actively treating a person in a negative way, rather than just passively ignoring, or not discussing, the situation, or an absence of discussing it. He suggests that stigma could still be the absence of something, but that he prefers to use the term bullying. This is also seen in staff members understandings of stigma as acting both covertly and in overt action against a person. Oscar’s preference for the word bully could be explained by his perception that his peers are more likely to understand the word bullying. However, bullying also describes the behaviour in a more concrete way and makes communication of what is happening more explicit. Another participant suggests that:

“I’d be like that person annoyed me or discriminated; I think I’d say discriminated rather than stigmatised” Tess (YP)

A reason for Tess’s preference for the word discrimination could be that discrimination, if defined as being an action rather than an attitude (Corrigan & Watson, 2002) is easier to identify than stigma. Another participant suggested that she used words that were better understood by others:

Amy: “do you use the word stigma?”

Orpheus: “Um occasionally, I tend to be blunt and I use harsher words… so ignorance and then obviously stereotype was synonymous and often when I talk to people um they don't know bigger words which is sad \*laughs\* so words like stigma tend to go over their heads…”

Amy: “Mmm so would you use discrimination instead?”

Orpheus: “I mean yeah, because it is discrimination if you choose to be uneducated then you're choosing to discriminate”

(Interview)

Orpheus’ preference for “harsher words” links with members of staff preference for more overt descriptions. Orpheus’ statement here shows that words like “ignorance” and “stereotype” are perceived as “harsher” words than “stigma”. This could be because stigma is not well understood by other young people, and its use could be seen as a way of obfuscating or softening, what is happening in the situation being described. This example highlights the potential euphemistic nature of the word stigma, in that it is used because of its complexity and its function of obscuring what is happening in the situation.

### 5.5.3 Describing Stigma

The above sections highlight the complexity of stigma and the preference for other words among young people. However, this section will demonstrate how young people did provide examples and descriptions of stigma.

#### 5.5.3.1 Stigma as a Perception

As shown above, Ross focussed on the sources of stigma when providing a definition. However, he also understood stigma as based on a negative perception of a characteristic which is in keeping with Goffman’s (1963) conceptualisation of the concept:

“it’s like people being demonised by characteristics that they can’t help” Ross (YP & SM, Interview)

Ross’s use of the word “demonised” is interesting here. There is evidence that historical perceptions of the cause of mental illnesses was that the individual had been subject to demon possession or a curse from God (Scull, 2015). The word has connotations of evil and dangerousness which are characteristics associated with people with mental ill health (Link and Phelan in, Schied, 2018; Martin et al., 2007; Pescosolido et al.1999; Rogers and Pilgrim 2001; Scottish Government, 2013). In this instance Ross suggests that it is the individual with the characteristic that is affected by the negative perceptions of their characteristic, which is keeping with Goffman’s idea that a characteristic can devalue a person (Goffman, 1963).

Most of the young people suggest that stigma is about misunderstandings or erroneous judgements about mental health:

“I guess it’s sort of synonymous with stereotypes isn’t it yeah, stigmas kinda need to be destroyed, you should just take things as they are…not just use your preconceptions because preconceptions are also misconceptions” Orpheus (YP, Interview)

This idea of stigma as connected to stereotypes is in keeping with Link and Phelan’s 2001 conceptualisation of stigma which draws a relationship between the identification of a difference and negative stereotypes. Orpheus suggests that these stereotypes are assumed without necessarily experiencing them which is why they can be erroneous. Similarly, other participants suggest that the judgements or stereotypes that are attached to an individual are based on the subjective understandings that individuals have of the characteristic:

“it’s kind of a prejudice that someone attaches to somebody based off an arbitrary definition” Steven (YP, Interview)

“I think it’s very closed-minded perceptions on things and of opinions that become exaggerated” Tess (YP, Interview)

“I would probably say that it’s something like people think negatively or have a negative association… like with mental health” Violet (YP, Interview)

The above quotes show an understanding of stigma based on negative or erroneous understandings of a characteristic, in this instance mental health. In addition, some participants suggest that the way mental health is constructed by individuals is not based on clear evidence or objective fact.

Other participants focussed on the emotions connected with stigma:

“like if something’s stigmatised talking about it is just uncomfortable” Hotwheels (YP, Interview)

“I think it’s a lot of blissful ignorance at times it is like people are kinda scared of what they don’t know so they judge what they don’t know… the fear of I don’t want to be unwell, I’m not that person” Penny (YP, Interview)

Here Hotwheels and Penny highlight discomfort and fear of talking about mental health. Penny connects stigma to a lack of understanding about mental health which results in fear and judgement. Her statement suggests that people are fearful and hold judgemental attitudes about mental health. As a result, Penny suggests people are also fearful of experiencing this for themselves and also being identified experiencing it. “I’m not that person” suggests a desire to separate and distance from others who are “unwell”.

Lastly, stigma is described more as a perception rather than an actual event:

“what they think other people will think of them, or it might not necessarily be the case, but in their head they maybe feel like people are judging them, or thinking negatively about them so...” Alice (YP, Focus Group)

Alice’s understanding is in keeping with literature that suggests anticipated discrimination and self-stigma can occur if people internalise societal perceptions of a characteristic (Link et al., 1989; Thornicroft, 2006; Corrigan & Watson, 2002). However, her understanding also highlights that actual rejection or assumptions about them may not actually occur.

Zoe gave three different understandings of stigma and suggested that:

“I view it personally as how you’re interacting, OK it’s a bit of how you view your own issue… but I view it as largely how society is viewing your issue in general” Zoe (YP, Interview)

Zoe constructs stigma as a result of an interaction between an individual and others in society. Zoe’s understanding is in keeping with Modified Labelling Theory (Link et al., 1989) which suggests that when people expect to be rejected because of a devalued characteristic they will behave less confidently or more defensively which signals to potential stigmatisers that they are “different” (Link & Phelan, in Scheid, 2018). Zoe suggests that this is also about how an individual views their own issue (in this case their mental ill health), which takes into account factors such as self-stigma (Corrigan and Watson, 2002). This leads individuals to believe that these conceptualisations will apply personally (Link & Phelan, in Scheid, 2018; Thornicroft 2006). However, a key aspect of Zoe’s understanding is that she also places importance on how society understands individual difference as socially salient. Societal perceptions of mental health are given a great deal of importance by participants in their explanation of mental health stigma and this will be discussed further in the following chapters.

#### 5.5.3.2 Stigma as an Action

Other participants focus on active rejection in their conceptualisation of stigma:

“stigma like… out-casting someone because they have like in this case a mental illness or (pause)?” Zoe (YP)

Zoe suggests that stigma is the act of rejecting a person because of the perceptions about a particular characteristic they are thought to possess. This shows that there is some overlap in young people’s understandings of stigma, with their understanding of discrimination, which is also seen in their preference to use the more action- oriented word discrimination instead of stigma (e.g. Orpheus). This could be because discrimination is based on a concrete and identifiable action against someone which is more easily identifiable, whereas stigma is perceived as something that is vague. Sansa highlights this importance of action against a person:

“we feel this stigma like you are not necessarily oppressing but you are treating us differently or you are acting weirdly around us so it feels like we are slightly less of a person because we don’t have the proper brain chemicals runnin’ so we feel like slightly less human” Sansa (YP, Interview)

Sansa frames mental ill health as a biological issue, as an imbalance in brain chemistry and suggests that because of this people treat individuals will mental ill health differently. She suggests that this can result in an individual being devalued to such an extent that they become “less of a person”, and suggests that this is a dehumanising experience.

Oscar mentions being ostracised, however, his focus is more on the feeling of being dismissed because of his perception that mental ill health is not taken seriously:

“I guess it's like a feeling of being kinda like a feeling of being ostracised or just… people don't take it seriously a lot of people say you've just got to get over it like it's not difficult it's like medication and force yourself to have happier thoughts, force yourself to smile when you don't want to” Oscar (YP, Focus Group)

Oscar’s focus here is on how mental health is dismissed and the seriousness can be diminished which he feels is stigmatising.

This section has highlighted that young people view stigma as both something that is perceived and something that can happen as a result of a direct action from others. This theme of a gap between overt and covert, described and experienced, is found throughout the data and will be discussed in more detail in the discussion chapter.

### 5.5.4 Prevalence of Stigma

Much of the young people suggested that while they understand that people experience stigma towards mental ill health, they qualify this by suggesting it is less of a problem than it has been in the past. Ross suggests that he knows that stigma exists because he has felt it:

“all three kinds of stigma are really quite prevalent today I know I’ve felt a lot of personal stigma” Ross (YP, Interview)

Ross suggests that the three kinds of stigma he has identified, self-stigma and public and cultural stigma, are still common. This may be because he works with a mental health organisation and is generally more aware of the concept than other young people and so is more aware of its presence. While Ross feels he has experienced stigma and therefore thinks that stigma is a common phenomenon, most of the others suggest that it is less prevalent in Scotland than it is in other countries or than it has been in the past:

“mhm, I feel like em a lot of mental health and stuff I think… people in this country don't really realise em maybe how lucky you are as well we might be stigmatised but it's worse in other places cause there's some places where there's no talk about it, no talk about a lot of stuff” Oscar (YP, Focus Group)

Oscar suggests that in Scotland he feels mental health and mental ill health can be discussed, whereas he perceives other countries may have more stigma around mental health and illness and that people are less able to talk about it. Oscar highlights another way in which he perceives the prevalence of stigma:

“I think it's definitely an experience that people have I also think with most things and it's in the way media portrays things it's probably just overblown in some way even if it's a little over blown, everything seems to be overblown that's just how they make their money” Oscar (YP, Focus Group)

While Oscar accepts that people do experience stigma, he suggests that the media has exaggerated the level of stigma that is present. He does not go on to provide any reason as to why he thinks this.

Another participant also takes issue with powerful social discourses about mental health. William suggests that the level of discussion about mental health may have reduced stigma but it has created different issues:

William: “I think there's quite a lot of stigma although it's not as prominent as it used to be younger people are like I feel this way I feel that way whereas back when I was young it was like oh fuck it I feel shite let's get drunk in the park until we pass oot, but these days especially like the government and social media it is kinda brought to the foreground, they do talk about it although that might actually be a problem in itself”

Amy: Why?

William: “cause it kinda makes you question is that normal? Like if somebody dies and you're grieving is that depression? And I've noticed that quite a lot on social media but there is still that stigma of somebody's got mental health issues they're mental don't go near them”

(Focus Group)

In this interaction William makes several interesting observations. He initially suggests that there is still a lot of stigma about mental health. However, he qualifies this by suggesting that it used to be worse, and evidences this by recalling that when he was younger there was less discussion about mental health. William suggests that the result of talking about mental health less was that young people had few positive ways of dealing with mental distress. Instead, he suggests that part of the culture in the area that he grew up in provided a coping strategy for problems and distress in the form of alcohol misuse. He compares this to the current government’s priority of highlighting and talking about mental health, therefore reducing the perceived level of stigma. William seems to be thinking aloud here and suggests that with the government and social media talking about mental health so often this may have a negative impact on how young people identify what is a “normal” response to a life event or a clinical problem. William highlights that while social media is helpful to an extent for increasing awareness about mental health, he also suggests that stigmatising attitudes can also be found there. Social media is covered in more detail in Chapter 7 of this thesis.

Other young people in this study also highlighted a perception that stigma has been reduced:

“the stigma around talking about it like for everyone but especially for men I think it’s kinda you know being broken away… so people aren’t as shy or ashamed to talk about it” Zoe (YP, Interview)

Zoe’s comment demonstrates that she felt previously men would find it difficult to talk about mental health and face more stigma, but now society is more able to have discussions about mental health, men are also more able to talk about it. The relationship between stigma and men feeling able to seek help for mental health difficulties has been well examined in extant literature (Pattyn et al., 2015; Wahto & Swift, 2016), however this participant suggests that she has noticed that the men in her life seem less uncomfortable discussing mental health than they have in the past.

Similarly, Tess suggests that general attitudes and responses to mental health have been improved, therefore there is less stigma:

“yeah there’s a lot less obviously because if you have a mental health problem you don’t get locked up” Tess (YP, Interview)

Her suggestion that people get “locked up” because of their mental health relates to historical treatment of people with mental ill health during the “great confinement” when asylums were used to contain members of society who were deemed to be “insane” which influenced public perceptions of dangerousness and mental illness (Foucault, 1965; Scull, 2015).

Liam suggests that he sometimes encounters stigma but more often receives support when he has disclosed mental ill health:

“certain people have kinda went ah that’s fake and certain others have went ok cool we’re dealing with this now and more than most of the time it’d been the second one” Liam (YP, Interview)

In Liam’s experience he has mostly been met with accepting attitudes about mental health however, he does mention that occasionally people question whether or not his claims of mental distress are “real”. In general, the young people consulted for this study demonstrate that discourses around mental health is going through a transitional period in which public understandings are moving from stigmatising understandings of mental health and mental illness towards a more accepting understanding. However, one of the participants gives a very optimistic view of the situation as she suggests that:

“as much as I’ve seen people with mental health problems, I’ve never seen them having a problem talking about it…” Hotwheels (YP, Interview)

Throughout her interview, Hotwheels explains that she has not experienced mental health stigma and that it is not a big problem for her, which gives an optimistic view and demonstrates that people, at least in her social network, hold accepting views of mental health.

It is important to note that when asking young people about mental health stigma many of them were uncertain about it as a concept. In interviews and focus groups, when I, or they changed the subject to something that wasn’t about stigma, the participants became more engaged in the interview and spoke more. Hotwheels goes on to highlight that:

“Uh yeah I mean I... yeah it’s not the biggest problem you know to be fair I don’t think I’ve ever seen it as a problem until I’ve been told it was a problem um so um…” Hotwheels (YP, Interview)

I had a perception throughout the interview that she had difficulty describing stigma and talking about her experiences of it. She often struggled to answer questions about it and she was more confident when talking about other topics such as the need for young people to develop a sense of self-worth. I eventually realised that she may have found talking about stigma difficult because I had assumed it was an issue, but this assumption was not true for her and she had not initially felt comfortable correcting this assumption. She then suggested that it was not the biggest priority for her, that she had always felt comfortable talking about mental health and that boosting young people’s resilience and self-worth was more important to be thinking about. Similarly, another participant in a focus group suggested that I had indeed been focussing on stigma instead of what was important to her, which was access to and experience of mental health services:

Amy: “Is there anything like, ‘Amy you're looking at the wrong thing, this is what you should be looking at?’”

Caitlin: “I don't actually think like the mental health workers are the best thing to be honest if anything for myself I feel like yeah it's the worst thing I could do ‘cause I've been to like CAMHS whatever and I just think what's the point?”

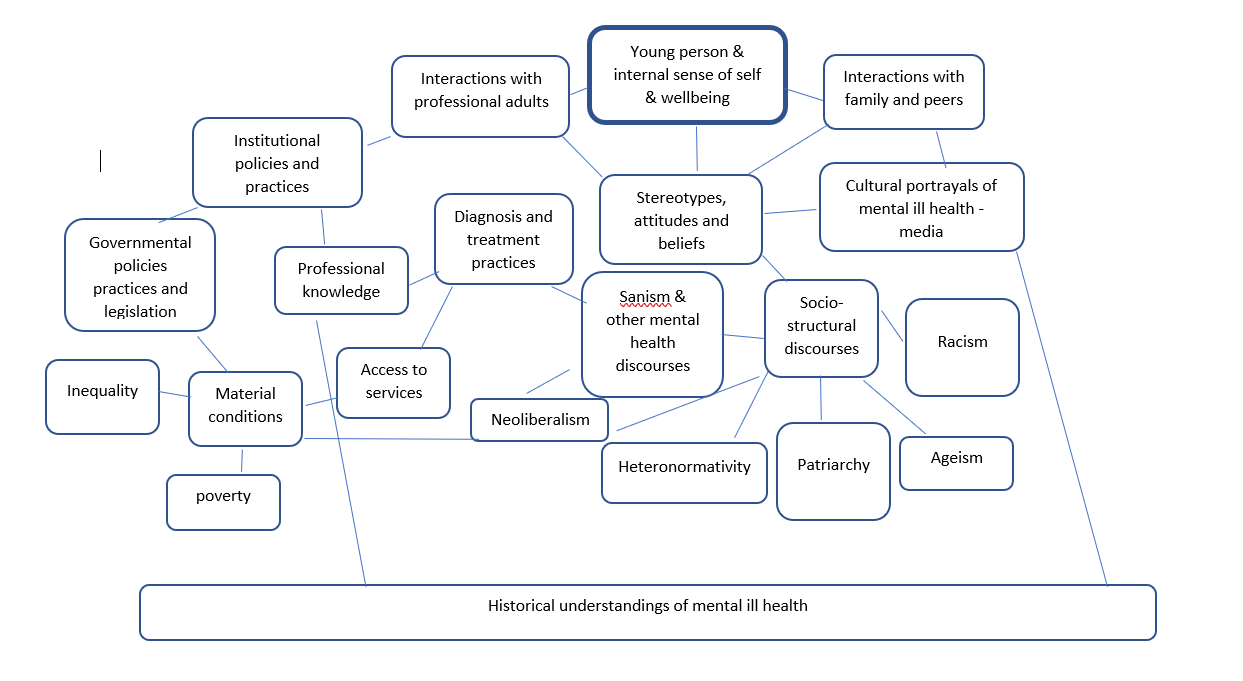
(Focus Group)

This exemplifies an overall finding from much of the interviews and focus groups with young people, that they engaged more in the discussion when I or they changed the subject to what was important to them, namely their experiences of and access to mental health support services which will be discussed in Chapter 7.

This section has demonstrated that young people found it difficult to describe what stigma meant, and did not always know about or understand the concept of stigma. Their view of stigma as a complex concept further questions its value for young people, particularly as they expressed preference for words that more concretely and overtly described their experiences. This could situate stigma within an elite discourse that young people do not always find accessible or useful for them. Young people also highlighted a dichotomy of stigma as perception and action. Some young people suggested that stigma was connected to subjective perceptions of mental ill health while others suggested that stigma was an action taken against individuals. It is important to note that many young people felt stigma was not the most pressing issue for them and suggested that a key concern for them was being able to receive treatment and support from mental health services.

### 5.5.5 Youth Conceptualisations of Stigma

#### Figure 2: Young People’s Conceptualisations of Stigma



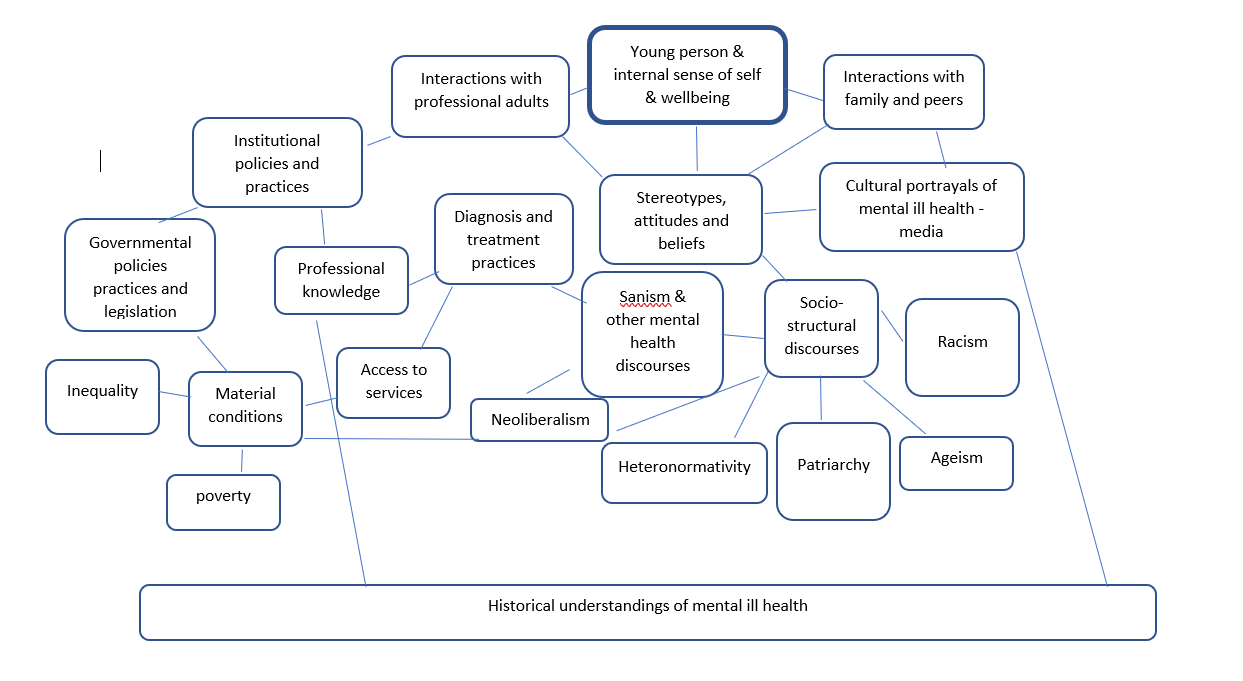
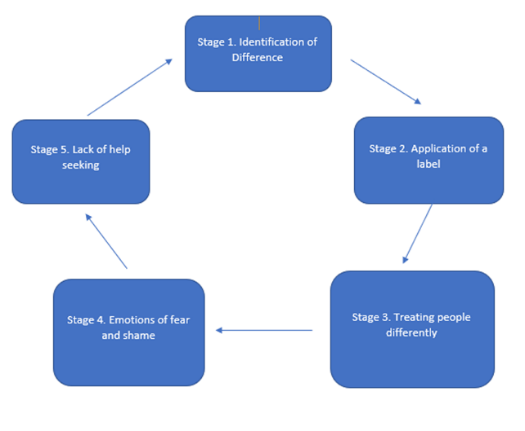
As demonstrated above, young people in this study often found the concept of stigma difficult to articulate. However, a key aspect of stigma that recurred throughout their definitions of the concept and descriptions of their experiences of it, was that stigma is manifested through a series of interconnected factors, as demonstrated by Orpheus who suggested

“*it’s kind of like a web, the more you interact the more harm that can be done or perhaps more positives but I don’t see any positives at the moment*” (Orpheus, Young Person, Interview)

This suggested that an individual’s daily interactions with multiple factors was interconnected much like a web. These factors appear to be individuals, professionals, institutional policies and practices, and dominant discourses which construct stigmatizing understandings of mental ill health. However, it is not only discourses about mental ill health that construct experiences of stigma, but also conceptualisations of other intersecting aspects of identity that compound these experiences, which are discussed in more detail in Chapter 7. This view of stigma acting as a web of interconnected factors links closely to Foucault’s conceptualization of power as a “net-like organization” (Foucault, 1980, p. 98) through which power flows in a dynamic, interactional way, rather than a static force held by one over another.

For Orpheus, this web of factors reinforces stigma and can lead to harm to the individual experiencing it. However, Orpheus also suggested that there is the potential for positive understandings, identities and experiences as a result of this web of factors. Whilst Orpheus suggests some pessimism over the existence of these positives at the time of the interview, there is space for this in this conceptualization. When we are able to identify the contributing discourses, we are then able to change and replace them with more positive ones. This invocation of an image of web, made me think about spider webs and how they are large complex structures in which prey become entangled, the more they attempt to escape the more stuck they become. I have therefore used this imagery to construct a diagram of key interconnected factors which were highlighted the young people in this study as leading to their experiences of stigma.

#### Figure 3: Staff Vs Youth Conceptualisations of Stigma



Staff conceptualizations of stigma demonstrate the effects of this process on the individual being caught in the cyclical process, and a focus on individual attitudes and emotions can be seen here. However young people’s conceptualisations appear to examine the external factors that contribute to their experiences which not only include the attitudes and beliefs of others but also highlights the external social factors which impact upon them. When compared next to the staff members conceptualization of stigma, this diagram of young people’s understanding appears to be far more complex and demonstrates vastly more contextual factors. It also places the focus of stigma less on the individual process of experiencing stigma, and more on the external social factors that ultimately contribute to their experiences.

The lines between these factors demonstrate the interconnectedness of the factors. However, taking a Foucauldian view of power they also demonstrate a dynamic flow of power relations between institutions, knowledge, discourse and individuals’ interactions. Foucault’s focus on power was particularly concerned with the power relations between institutions, groups and individuals and the ways in which people can affirm or resist the effects of these power relations (Foucault, 1980; Mills, 2003). Whilst I would argue a key flaw in Foucault’s work is that there is no clear manifesto for this resistance, unlike a Marxist view of power which suggests revolution as a solution, Foucault’s view of power attempts to move away from considering power as solely an oppressive force and instead highlights the productive action of power relations. Foucault suggests that power relations create action as well as censor it (Foucault, 1980). This helps us to extend previous understandings of stigma as something which is manifested through micro-level interactions between individuals, by viewing them in the discursive contexts, regimes of practice and the epistemes which facilitate them (Foucault, 1980; Fawcett, 2000). Power in this view can be found through all relations in society which is useful for understanding the complexities of stigma that are illustrated in the diagram below. This diagram might be understood in a way that shows that dominant / historical understandings of mental ill health permeate society resulting in stereotypes, cultural portrayals, attitudes and beliefs and professional epistemes which then impact the young person’s interactions with others in their lives. These discourses can be seen in more detail in the diagram depicting structural stigma on page 181. Importantly though, this model also contains the possibility that young people have the agency to reverse these power relations through interactions and understandings of mental ill health which in turn will have influence on policies and practices and to therefore alter the conditions which lead to stigma. Thus, we can use Foucault’s understanding of power as something that “circulates” around a system, rather than something which is possessed by one over another (Foucault, 1980, p. 98).

I would therefore argue that Link and Phelan’s conceptualization of stigma power can be taken further by incorporating Foucault’s conceptualization of power. Stigma power as understood by Link and Phelan appears to be understood as a resource which is utilized to oppress – to keep people in, down and away (Link & Phelan, 2014, p.24). While their use of Bourdieu’s understanding of symbolic power, which demonstrates how power is best used when it is hidden and misrecognized is useful, this understanding of misrecognition can be added to Foucault’s understanding of power as an interaction which is hidden through dominant discourses. Instead of considering stigma as a phenomenon which can only manifest through the application of power to another person, I would suggest that stigma is power. When we talk about stigma, we are in fact talking about power, knowledge and the interaction of dominant discourses which produce conditions of inequality. Crucially these conditions can be renegotiated by agentic actors through changing and altering the discourses which construct these stigmatizing conceptualisations in the first place.

## 5.6 Young People Can Be Stigmatising

The above section shows that many of the young people in this study do not feel stigma is as prevalent as it once was. However, it would be erroneous to accept this perception as a reflection of “reality”. As well as their own lived experience of stigma from others, some of the young people interviewed in this study discussed their own stigmatising views which in itself demonstrates that stigma is still prevalent. Some of the young people suggested that in retrospect they understood their actions and attitudes were stigmatising to other people with mental ill health in their lives:

“to be honest I’ve actually thought that [people experiencing mental ill health were attention seeking] about other people but I’m really not proud that I’ve thought that, it comes as an instinctive thought…it really feels like they’re just looking for attention… but then you have to remind yourself you don’t know what reality they’re experiencing” Zoe (YP, Interview)

Zoe talked about how she thought other people in her life were seeking attention when they spoke about their own mental ill health. She frames stigma as something that is entrenched within her understanding of people experiencing mental ill health through use of the work “instinctive”. Zoe suggests that it was a reaction that she then had to correct. Similarly, Steven suggests that it was through experiencing stigma that he recognised it in himself:

“I certainly think I’ve experienced it… and it’s through experiencing it I thought oh crap perhaps I was contributing to it in the first place” Steven (YP, Interview)

He goes on to explain that:

“my best friend at school… he had a lot of difficulties in his life…he got depression and dropped out and spent the next two years of his life not doing a lot… I couldn’t understand that I tried to be a good friend but to me it just seemed like he was giving up and being lazy…” Steven (YP, Interview)

Steven notes that through his own experience of stigma connected to his own mental health difficulties that he was then able to understand his reaction to his friend was based in stigmatising attitudes. Steven had been influenced by stigmatising discourses that misrepresented mental ill health as being lazy. Both Zoe and Steven reflect on their attitudes towards others with mental ill health and are aware that they were based on stigmatising attitudes, however some participants were less aware of the stigmatising potential of how they understood mental health:

“yeah I get that I think there are people who kind of use it as a crutch but I think you can see through that sort of fakeness quite easily, they tend to be people who don't actually come to things like this or have any medication or have anything like that they just say they're going through something but…” Oscar (YP, Focus Group)

Oscar suggests that in his experience some people who disclose that they have mental health difficulties are not genuine. This is similar to Zoe’s suggestion above that sometimes people who claim to have mental health difficulties are doing so just to “get attention”. In this instance, Oscar frames other young people as not having a legitimate claim to mental health support and treatment spaces. Here Oscar frames himself as the gatekeeper of this claim for legitimacy as he suggests he can “see through the fakeness” suggesting that if others experiences are not the same as his, they cannot claim access to mental health support spaces. It could be that due to a lack of available mental health services and resources, Oscar feels responsible for ensuring adequate rationing of these services, and only those whose experiences are similar to his are deemed worthy. This idea is exemplified most strongly in the interview with Liam. Liam suggests throughout his interview that people use mental ill health as a way of getting attention or “getting away with” things and that they feel they can do this because mental health is a popular topic:

“It’s like oh I can get away with saying I’m depressed in school when it’s just ‘cause it’s a common topic and you know you can get away with it, it does give it a bad name it’s why I feel like schools don’t take the issue so seriously” Liam (YP, Interview)

Liam goes on to suggest that stigma is discussed a lot but that sometimes people take advantage of the awareness of mental health stigma. He suggests that people use awareness of stigma and the prevalence of mental health as a topic of societal discourse to avoid taking responsibility for aspects of their lives that are not going well:

“but no as far as stigma it’s got a huge thing but people ((pause)) hide behind it instead of taking responsibility for so much” Liam (YP, Interview)

Throughout the interview with Liam, I was often unsure what he meant, and again this pertains to my failure to clarify his understanding of stigma. I have spent a long time wondering what he meant by this quote in particular:

“I do agree with stigma to a point it has its place but people do use it a bit too much like oh I’m so depressed please send me a message” Liam (YP, Interview)

Does Liam mean that awareness of stigma has its place, but people use the awareness that stigma is a bad thing to have their calls for help answered immediately? Liam could be suggesting that people who express a need for help because there are struggling with mental health expect these calls to be answered immediately because not doing so would be called stigmatising. I also wondered if he was suggesting that the stigmatisation of mental health was useful to an extent, but part of me really hopes he did not mean that, so it is difficult to entertain that idea. Liam also appears angry about people who go to support services like GP’s or psychological appointment, as he has a perception that many of them do not need the support:

“a lot of the time people are going to it [support services] … but a lot of people were never actually in any problems to begin with there was no danger they just wasted the time pretty much” Liam (YP, Interview)

Liam suggests here that there are people who attend GP / health care appointments, or who do not attend and therefore “waste” the appointment, are not in need of the appointments. This echoes Oscars claim of concern for those abusing mental health services. It may be the case that the sparsity of mental health support services creates a level of competition for these services which manifests itself as “stigma”.

The interview with Liam was enlightening, however a little disheartening for me. I understood his stigmatising views of mental health to be a result of existing within a habitus that had such entrenched stigmatising attitudes about mental health that it was difficult to identify them, to the extent that the participants applied them to others in similar situations to themselves. This suggested to me that stigma towards mental health could be part of the hegemonic discourses, despite many governmental and organisational attempts to highlight its existence. In this instance stigma appears to be a covert, but powerful discourse, from which it could be difficult to escape.

This section has demonstrated that stigma as a concept is not always particularly clear or helpful for young people, that they do not use the word, and when asked about its prevalence many of them suggest that it has improved or is not the main problem for them. However, some of the young people demonstrated their own stigmatising attitudes, suggesting that stigma may be so entrenched that it is often difficult to recognise it. The next chapter will go on to describe young people’s experiences that could be understood as stigmatising. This suggests that while stigma as a word is complex and not particularly useful, this does not mean that young people do not experience unfair treatment and negative attitudes connected to their mental health.

## 5.7 Participant Perceptions of Structural Stigma

This chapter has demonstrated that for participants, stigma occurs at an interpersonal level, but that it is also important to consider stigma at institutional and structural levels through their discussion of stigma manifesting covertly as an absence of application of policy and provision of resources. Some participants gave examples of how they understood structural stigma:

“I guess stigma that is built into the fabric of our society without us even knowing it’s there… I think it’s less conscious in somehow in a structural way but it’s a bit more conscious when you’re walking down the street and you… articulate these thoughts and emotions about somebody who you perceive to be struggling with their mental health” Gabrielle (SM)

Gabrielle suggests that structural stigma is covert and embedded within habitus which makes it unconscious. Young people also describe how they understand structural stigma:

“structural stigma so that’s institutions and structures that kinda maximise inequalities… I see structural stigma everywhere in access to healthcare…. For young people with mental health concerns there’s a lot of gatekeepers and structural barriers that come up in the way… I think cultural stigma and structural stigma couldn’t impact us the way that it does if we didn’t have personal stigma and vice versa” Ross (YP, Interview)

Ross suggests that structural stigma and interpersonal stigma interact and feed into each other. Tess and Zoe also highlight the importance of the interaction of interpersonal and structural stigma:

“like every individual has their own responsibility to like be kind to everyone… but if you don’t have policies and government understandings… there’s only so much that you as an individual can do… stigma comes from a community or a society or a government” Tess (YP, Interview)

Tess highlights the importance of the interaction of interpersonal and structural stigma. She suggests that stigma occurs at both the individual and structural levels and these interact with each other and reinforce one another. Tess also suggests that a lack of policies and legislation to protect individuals can be understood as structural stigma. This is also suggested by Danielle:

“Structural stigma does exist, we do not make reasonable adjustments for individuals we don’t have policy and procedures… whether it’s mental health or whatever issue it is based around stigma if you don’t perceive that you have a level of protection how do you see yourself in the world around you, you see that the structural stigma is there, you see the public stigma is there cause look at how folk are treating you and I do start to believe that’s because there’s nobody stopping that” Danielle (SM)

“you’ve got government policy and legislation… I actually think the government could be more explicit around mental health and how we talk about mental health… how do we actually support them structurally in relation to legislation or policy so that people are actually protected?” Danielle (SM)

Danielle suggests that legislation needs to be more overt in its protection against inequality and discrimination for people with mental ill health. This suggests that the absence of this is one way in which stigma can be covertly enacted. Isabelle also suggests that structural stigma is covert:

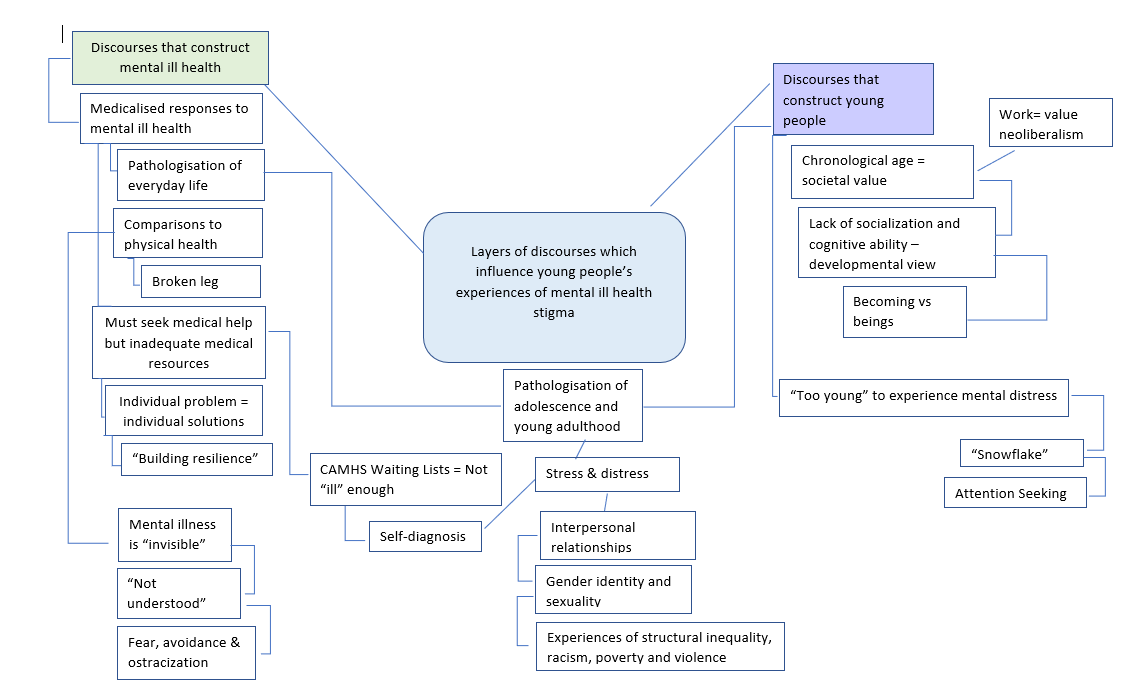
“100% I think that it’s now something that is harder to be explicit about… structural stigma for me would be around the kinda policies and attitudes that get in our way in a much more problematic sense” Isabelle (SM)

Conversely Fiona suggests that policies may be in place but if they are not enforced it does not protect against individual stigma:

“I think in terms of what’s communicated by politicians is like yeah it’s great you can talk about it, great, everyone’s equal amazing, and I think policies like HR policies are all written out to be inclusive and supportive but I don’t know if that always translates to the individual person” Fiona (SM)

This demonstrates that some of the participants in this study were able to provide conceptualisations of structural stigma, however all participants had to be asked about their understandings of this concept, none used it spontaneously and many had not heard or the concept and were unable to provide a description of it. This demonstrates that stigma is not as commonly conceptualised through a structural lens, than it is through an interpersonal lens.

#### Figure 4: Stigmatising Discourses



This diagram demonstrates the multiple layers of discourses within dominant frameworks of understandings that construct young people’s experiences of stigma. This diagram highlights the multifaceted and connected nature of these discourses which construct understandings of mental ill health as well as young people and their experiences. This diagram can be understood as a detailed exploration of the socio-structural discourses highlighted in [Figure 2](#_Figure_2:_Young).

## 5.8 Chapter Summary

This chapter has outlined how staff members and young people constructed their understandings of mental health in the interviews and focus groups for this study. While staff members suggested that stigma is a dominant discourse within a policy context, as well as aiding the identification of and challenge to stigmatising experiences, both staff and young people found stigma a complex concept, and difficult to describe or explain. Both staff and young people indicated a preference for other words that more accurately described their experiences and were less abstract. This suggests that while stigma has value for elite discourses in a policy and government context, its complexity has less value for young people, which is particularly emphasised by young people’s suggestion that stigma is less of a priority for them than addressing access to adequate mental health support.

Staff’s constructions of stigma were similar to Link and Phelan’s (2001) conceptualisation of stigma and modified labelling theory. While they highlight the role of stigma as a barrier to help seeking, particularly for young people, their understanding was focussed mainly on individual interactions and emotions. Staff differed from Link & Phelan (2001) in that they did not identify the role of power in the stigma process, although they did highlight the role of emotions in the stigma process and the importance of the lack of help seeking to a greater extent than the work of Link & Phelan (2001).

Young people understood stigma as both a direct action towards someone as well as a perception. It will be demonstrated in the forthcoming findings chapters that young people placed a priority on how mental health is understood at a societal level for conceptualising how stigma manifests. This indicates a move away from solely interpersonal understandings and more of a focus on socio-structural sources of stigma. The construction of stigma as containing a dichotomy of perception vs action demonstrates that stigma often covert and difficult to highlight which can also be seen in Link and Phelan’s understanding of stigma power (Link & Phelan, 2014). It is therefore important to understand how participants describe their experiences of stigma as this may be different from how they describe their understandings of it. The next chapter will now discuss how participants construct their experiences mental health stigma.

# Chapter 6. Results 2: Experiences of Mental Ill Health Stigma

## 6.1 Chapter Overview

This chapter will discuss the findings which address the ways in which experiences of mental ill health stigma is described by participants (Research Question 2). This includes data from staff members who describe their own experiences as well as the experiences of the young people they work with, and the young people who participated in the interviews and focus groups for this study. It was demonstrated in the previous chapter that participants found it difficult to provide a clear definition of stigma. Similarly, it was difficult for me to define situations described in the data as “stigma” as many of the participants did not use this term themselves. Further, when asked about stigma many described instances of sub-optimal mental health care, and I found it difficult to determine if this was directly related to stigma. It will therefore be demonstrated that stigma manifests itself both as an interpersonal interaction between individuals, as well as through institutional policies, practices and resources; or the lack thereof, and that stigma can be covert. This chapter attempts to advance understandings of structural mental health stigma for young people in Scotland.

This chapter first discusses instances of anticipated discrimination described by participants. This is followed by descriptions of experiences of interpersonal stigma from friends and parents.

## 6.2 Anticipated Stigma & Discrimination

Just as it was difficult to give a consistent definition of mental health stigma in the previous chapter, participants found it difficult to give concrete examples of mental health stigma. Many however, suggested that the anticipation of stigma was a key issue. Anticipated discrimination is the perception that someone could be stigmatised or discriminated against (Thornicroft, 2009; Link et al., 1989). For participants the anticipation of potential discrimination or stigma meant that they did not speak to other people about the mental health issues they were experiencing:

“I didn’t really like to talk about it because I was worried about what other people would think” Violet (YP, Interview)

Violet describes feelings of isolation throughout her interview. She suggests that she concealed her mental ill health from her friends and other potential sources of support because she was concerned that their perception of her would change.

Zoe indicated a concern about seeking help from university support services:

“I wasn’t entirely comfortable using university services because I was worried that if I went to the service like then maybe it would be like black listed on my degree or something or somehow my supervisor… finds out” Zoe (YP, Interview)

Zoe was concerned that seeking help from the university would highlight her mental health issues to her supervisor and that this would have a negative effect on her degree. She highlights that she discovered that this was not the case and felt “silly”, but she was initially concerned about potential discrimination. Both Zoe and Violet suggest that they initially felt the need to conceal mental health issues from potential sources of support in order to avoid being stigmatised. It has been demonstrated in other studies that young people’s help seeking is affected by their perception that other people hold stigmatising beliefs about mental health issues (Nearchou et al., 2018).

Steven also discussed his fear about being discriminated against in employment:

“when you have to disclose you have like a mental health problem or whatever, I’ve never done that and I’m never gonna do that because I’m pretty sure it’s going to go against you, I know there’s legislation that exists so that you can’t be discriminated against on those ground but they find other ways for people with disabilities, race, gender so I don’t see how mental health would be different” Steven (YP, Interview)

Discrimination is still a worry for Steven, despite being aware of protective legislation. This suggests that Steven is not convinced that antidiscrimination legislation is put into practice in order to provide the protection it aims to. Steven therefore is wary about disclosing mental health issues, despite the fact that doing so may allow employers to put adjustments in place to support him. This concern suggests that protective measures to prevent discrimination in employment could go further and needs to be more explicitly enacted.

These participants’ perceptions of other people’s beliefs lead to concealment, and non-disclosure of their mental health difficulties. This non-disclosure occurs despite the potential that telling other people about their difficulties would benefit and support them. There are many studies that demonstrate that stigma can act as a barrier to help-seeking (eg: Nearchou et al., 2018; Chen et al., 2014; Yap, Reavley & Jorm, 2013; Rusch et al., 2013). The findings of this current study also suggest that the fear that one could be stigmatised is enough to prevent help seeking for mental ill health. The discourses that create understandings of mental health as a stigmatised condition operate covertly here and influence the young people’s actions without direct experience of stigmatising encounters. This is highlighted further by one participant who suggested that the fear of being stigmatised was more prevalent than actual experiences of stigma:

“I think it’s more of like a fear rather than a result” Hotwheels (YP, Interview)

It should therefore be considered that hegemonic discourses that create stigmatising understandings of mental health, as well as discourses that suggest stigma is prevalent, could be a potential contributor to the anticipation of stigma. This occurs despite protective legislation within institutions, and without actual instances in which a young person is stigmatised.

## 6.3 Interpersonal Stigma

Previous research has focussed on stigma as an interpersonal process through which individuals are labelled as different and then treated accordingly (Goffman, 1968; Link & Phelan, 2001). This section will discuss the interpersonal stigma experienced by participants, specifically from parents and friends. It is important to note that participants did not always use the word stigma to describe their experiences. This contributed to the difficulty of identifying concrete experiences of stigma within the data. An example of this is Violet, who framed her experiences as:

“this is what I’ve been through, and all these people have done wrong by me” Violet (YP, Interview)

While not necessarily using the word stigma to describe her experiences, Violet highlights the difficulties she has faced both in accessing and receiving mental health support and treatment. As demonstrated in Chapter 5, young people do not always use the word stigma to describe experiences of unfair treatment due to their mental health and this is exemplified here. This section will discuss young people’s experiences of stigma with different individuals from their support network, namely their friends and family. Ross suggests that friends and family were key contributors to his experience of stigma:

“I think when I opened up to my friends and family about it [depression and anxiety] a few of them started to treat me differently, started to think oh he’s one of those mentally ill people so em he’s obviously just going to dunno blow his lid every now and then and be really aggressive and angry” Ross (YP, Interview)

Ross’ statement highlights that some of his friends and family held understandings about mental health that were connected to violence, aggression and dangerousness which is an assumption regularly referred to in other literature (e.g. Angermeyer et al., 2003; Phelan et al., 2000). His suggestion about how friends and family treated him differently is slightly vague and Ross does not give concrete examples of how this manifested itself. Ross also claims to know what his friends and family were thinking about him, and does not say if they actually said these things to him, or whether he has extrapolated this from their behaviour towards him. I took this vagueness to be a discomfort in talking about what could be potentially upsetting at the time, however due to other instances of vagueness in describing experiences of stigma from other participants, I wonder if this could be explained by stigma manifesting covertly, as a “feeling” or as an anticipation of stigma, as above. The difficulty of identifying concrete instances of stigma could also be explained by the complexity of stigma as a concept.

### 6.3.1 Experiencing Stigma from Friends

Extant literature suggests that young people can experience mental health stigma from their peers (Dolphin & Hennessey, 2007; O’Driscoll et al., 2015; Jorm & Wright, 2008, Moses, 2010). Participants in this study also discussed instances in which they felt that their friends did not understand what was going on for them:

“as soon as I tell friends like I’m not feeling good they’ll text you for a couple of days… then they don’t wanna know about it” Penny (YP, Interview)

Penny felt that when she told her friends about how she was feeling they eventually stopped contacting her. Penny explained that her friends stopped contacting her because she did not want to do the same things that they were doing like going out or drinking alcohol. She also suggests that her friends may have found it awkward and did not know what to do to help. This is similar to Violet’s experience where she describes feeling rejected by her friends when she disclosed her mental health difficulties:

“I had no contact with my friends at all they didn’t really have intention to contact me or talk to me about it” Violet (YP, Interview)

These accounts suggest that disclosing their mental ill health to other young people resulted for them in feeling rejected by their peers. These instances of rejecting behaviour are important to note as much of the current research has suggested that when young people are asked about how they would treat someone with mental health difficulties they indicate that rejecting a person with mental ill health is unfair (O’Driscoll et al., 2015). However, these participants indicate that in their experience their peers exercised social distance after a disclosure of mental ill health. This highlights that previous research may be subject to social desirability bias when participants are asked about what they may do rather than investigating what actually happens. The participants in the current study suggest a passive rejection from their friends, that their friends ceased communication rather than actively bullied or rejected them from a group. The young people who brought up stigma from their friends suggested that more education about mental health, mental illnesses and how to help would have helped their friends understand more about what they were going through:

“you know bring it in to secondary schools and stuff being real about it and not em like just saying this is this people have this and how to like if someone else is going through something like that then like what do you do about it?” Violet (YP, Interview)

However, it should be noted that not all young people felt that their friends were unsupportive:

“the young people I was in school with were really supportive of mental health which is surprising cause you hear all these stories about people bullying you and like bullying was quite bad where I grew up but not in terms of mental health because I think everyone either went through it or they had friends who were going through something and everyone was quite supportive” Heather (YP, Focus Group)

Heather is clear in her explanation that the reasons she feels her friends understood is because they had knowledge and experience of mental ill health themselves or with others in their lives. This is in keeping with previous research that shows that social contact with people or lived experience of mental ill health reduces stigma (Corrigan et al., 2001; Pinfold, 2003) and adolescents who socialised with peers with similar experiences felt less stigma (Moses, 2010).

Despite Penny suggesting above that her friends stop talking to her when she told them that she is not feeling mentally well, she also suggests that not all of her friends reacted in this way:

“people do listen to you and that's when I start coming to terms with alright, “maybe I do have like mental health issues” and my friends were like “oh me too”, like my friend was like oh I've been on sertraline for two years I was like I didn't know that why didn't you tell me, she was like I dunno…” Penny (YP, Interview)

This further suggests that young people who have lived experience of mental ill health are more accepting and have a better understanding of how to interact and support others with mental ill health. This is reflective of previous studies that demonstrate social contact models of stigma interventions are the most successful (Yamaguchi, Mino & Uddin, 2011).

This data suggests that a key issue for young people may be the difficulty of knowing how to have conversations about mental health with their friends. There were few instances of young people reporting direct discrimination or bullying because of their mental health, however Penny and Violet highlight that it was the passive rejection, lack of contact with their friends and feelings of exclusion that they found difficult.

### 6.3.2 Experiencing Stigma from Parents

Existing literature demonstrates that parents can influence the stigma beliefs of their children and can have an impact on whether their children seek help for mental health difficulties (Buchholtz, 2015; Jorm, 2008; Koike, 2017; Mueller, 2014). Kranke et al., highlight that family members can both help and contribute to young people’s experiences of stigma when taking psychiatric medication (2010). Participants in the current study demonstrated explicit instances of stigma from their parents:

“I come from a pretty traditional background my parents don’t believe in it… it’s kinda funny because they buy into the stigma in that no one can know, you’ll never get a job you’ll never get a house or whatever if people think you’re crazy… when I had problems… I’m not trying to blame my parents but they kinda kicked me out… cause it was just like em they didn’t believe they had raised me to be like that” Steven (YP, Interview)

Steven recounted a time when he was experiencing mental ill health. He highlights that his parents did not understand mental ill health and held stigmatising attitudes about it, and so he could not return home from university to see them. Steven suggests that his parents have learned more about it now, but at the time it was very difficult for him. Similarly, Heather highlighted that:

“I remember being younger and in school and they called me selfish for it and that will always stick with me that conversation and it was awful but that's just how they were at first because they had no idea what was happening” Heather (YP, Focus Group)

Heather qualifies this by saying that they did learn about mental health as a result of what she was going through and that they are now very supportive of her. Participants frame their experiences of stigma from their parents as their parents not understanding mental health. This is also found in Zoe’s account:

“yeah I worry about telling my parents that I’ve gone to counselling because I don’t want to worry them… they might panic because they don’t understand” Zoe (YP, Interview)

Zoe had decided not to inform her parents about the difficulties she was having with her mental health whilst at university because they did not have enough knowledge and understanding of mental health. Zoe suggests that her parents’ lack of understanding would lead them to worry so she withheld information about what was going on for her. While no one really suggests this in the interviews, the accounts from these participants could suggest that more mental health information for parents would be beneficial for them and their children. It has been highlighted in previous research that concern for parental disapproval is a hindrance for young people seeking help (Chandra et al., 2006) and so greater mental health information for parents may be one way of addressing this issue.

Staff also highlight their experiences of stigma from families. For example, Lilly draws on her own experiences of mental health stigma from her family:

“I think for me it has been more the personal how I’ve been treated in terms of family and in terms of like the stuff I’ve seen” Lilly (SM)

Gabrielle suggests that parents do not always seek treatment for their children’s mental health because of stigma they or their child may experience:

“I know somebody who I think has a child who would have benefitted from speaking to somebody like a counsellor or somebody, but I know that… doesn’t conform to the parent’s idea of what they want their life to be, what they want their child to be, and I think that’s because mental illness – mental illness!- mental health any question mark over somebody’s mental health is a problem” Gabrielle (SM)

Reardon et al., (2017) highlight that there are many reasons for parents not seeking help for their child’s mental health, including attitudes and beliefs about consequences of this treatment for their child. Gabrielle suggests that cultural attitudes about mental health influenced this parent’s decision on whether to seek mental health treatment for their child.

Barbara also gives examples of explicit stigmatising attitudes and language from parents she works with:

“I’ve had children say to me… my mum and dad say to me if I don’t stop it, they’re going to send me to the nut house…” Barbara (SM)

“There was a parent that said “I’m totally convinced he’s going to end up in Carstairs” and this wee one said “what’s Carstairs?” and she said, “It’s for the criminally insane and that where you will end up because you’re a nutter” Barbara (SM)

Barbara highlights that the children and parents she works with use stigmatising language that connotes fear and perceptions of dangerousness when discussing their child’s mental health difficulties. She demonstrates that these attitudes and beliefs are conveyed to the child. Parents in these examples make reference to forensic and psychiatric hospitals in relation to their child’s behaviour, in front of their children. It could be argued these parents use the fear of these institutions as a way to regulate aspects of their children’s behaviour that they find troublesome or challenging. Instead of understanding their child’s behaviour as a manifestation of trauma or mental distress, the parents in these examples appear to frame their child as misbehaving. Just as some parents may threaten to inform Father Christmas of their child’s behavioural transgressions, these parents use psychiatric detention as a form of “bogey man” to frighten their child into compliance in an attempt to control or regulate the child’s behaviour (Corsaro, 2018). Parents were reported to lack understanding of mental health and explicitly use stigmatising language about and towards their children.

## 6.4 Stigma Experienced in Institutions

This section will discuss instances of stigma enacted within and through social institutions. This demonstrates a shift in focus and further development in understanding of stigma from an interpersonal to a structural construct. Stigma within institutions can affect the lives of young people because of the contact that they have with various socio-cultural institutions. This is highlighted by Anna:

“maybe the institutions that they’re in or the establishments already there that are mainstream aren’t for them” Anna (SM)

Here, Anna is referring to the perceptions of the young people she works with, that mainstream schools are not designed with them in mind and do not take what they need into account. This can alienate young people from accessing societal structures and institutions such as education, employment or healthcare.

### 6.4.1 Experiencing Stigma in Education

This first section describes experiences of stigma within educational institutions, firstly through interpersonal interactions with teachers and secondly through the ways in which education and schools are structured.

#### 6.4.1.1 Experiencing Stigma from Teachers

Participants discussed instances in which they felt stigmatised by teachers and at school. This section demonstrates the enactment of stigma both through individual teachers interacting with young people, as well as institutional policies, or lack thereof that result in young people’s mental health being misunderstood and under prioritized.

It should be highlighted however that stigma is not always found in schools as exemplified by Hotwheels:

“I mean school they talk about it a lot I think it's becoming more and more of a priority with the whole mental health class and you've got all like the support systems you can get really if you need them” Hotwheels (YP, Interview)

Hotwheels was able to do a qualification in Mental Health and suggested that the teachers in her school were generally available to help when needed. Hotwheels discussed her experience at school in positive ways and that mental ill health was addressed in school in a way which was non-stigmatising.

Staff members in this study on the other hand highlighted explicit instances that they had observed of teachers being stigmatising about young people with mental ill health. One participant highlighted teachers stigmatising comments about self-harm in particular:

“so, I hear teachers saying “it wasn’t even a scratch” and “that’s just attention seeking” Barbara (SM)

This example demonstrates dismissive attitudes from teachers towards young people intentionally injuring themselves. The idea of attention seeking was also highlighted in the previous chapter by young people holding this view of their peers. It is also a particularly pervasive stigmatising attitude that is found in previous literature (Teng et al., 2017; Mitten et al., 2016; Timson et al., 2012). These comments attempt to diminish the injury the young person had caused themselves as well as the intention behind it. The attitude based on “attention seeking” frames the person as narcissistic and vain, personality traits that are seen as innate and based on individual vice, or as a personality disorder that is difficult to treat . This delegitimises the young person’s distress and right to access support, thus relieving the responsibility of providing that support.

Another member of staff highlighted a culture of stigmatisation within schools:

“I was in a school the other day and I walked by and I was talking to a teacher and another teacher walked by and was like “oh she's a pure nutter”, talking to the teacher being like haha bants…” Danielle (SM)

Danielle used this example to demonstrate that teachers within this school used stigmatising words to talk about mental health, even though the teacher was aware that Danielle worked for an anti-stigma organisation. The culture of treating mental health like a “joke” appears so ingrained in this particular school the teacher was not fully cognizant that what she did was stigmatising. If teachers actively use stigmatising words like “nutter” at this school with other teachers, this could perpetuate stigmatising attitudes throughout the school for both teachers and pupils and this could be a particularly stigmatising environment for those working and learning within this institution.

Anna was a participant who worked closely with young people in schools and had many insights into stigma amongst teachers and within educational institutions:

“Teachers have been really unkind about these young people” Anna (SM)

Anna highlighted the ways in which teachers spoke about young people who have been identified as having difficulties in stigmatising ways. She recalled teachers' conversations in meetings about these young people:

“and teachers say “she’s never going to manage though”, I’ve heard teachers say “her mammy’s no well she’ll not be fine”, or “she thinks her mums gonna get a job in KFC” and the other teachers laugh and write down the words KFC in a circle in their notepad and that’s the extent that this conversation has gone” Anna (SM)

During these meetings teachers spoke about the young people to each other in ways that were unhelpful and judgemental. The examples provided suggest that teachers undermined the young people’s ability to cope with their difficulties while failing to put supports in place to ensure that they were able to cope. The example about the girl whose mum wants to get a job in a fast-food restaurant also had connotations of class-based prejudice. Anna described how these meetings were arranged between teachers in order to put support in place for the young person who had been identified as having difficulties, but these meetings often fell short of this goal. Anna noted the young people were rarely involved in these meetings, which acted as a barrier to their ability to exercise agency and participation in their own lives. Decisions are therefore made for them not by them. While the students are excluded from these meetings and therefore not privy to the way they are spoken about, they are often aware of the attitudes their teachers hold because of how they behave towards them:

“so, the young people are conspiring that maybe the teachers think differently of them that affects their attitudes and make them act differently towards their peers but also the teachers are actually thinking about them differently and talking about them behind closed doors and they are not wrong so it’s really hard to empower that individual to ignore that when like their support network are actually being stigmatising” Anna (SM)

In the experience of this participant, the students believed teachers behaved differently towards them than they would to their peers because the teachers held more negative attitudes about them. Anna placed herself as having knowledge that validates the young people’s beliefs. She was aware that this belief was justified as teachers did hold negative attitudes about them and suggested that she cannot ease their concerns about this. Her use of the word “empower” could suggest that she felt providing them with the knowledge that teachers do not think differently about them would allow them to “ignore” the feeling that they were being stigmatised, however she felt unable to do this. I asked Anna why she thought teachers behaved in this way:

“a lot of people are under pressure in work and don’t have time or resources or funding… person power to maybe get to know the story of each person… a lot of the time it feels like the teachers and tutors that have the stigmatising attitudes just don’t know what to do with this person, like what box to put them in or how to like allow them to be successful in their own right if their mental health is causing barriers to attainment or attendance or performance then it’s just like sort of treated as hassle and that’s where the bad words seem to come from” Anna (SM)

Anna suggested that due to the inflexibility of the practices and policies in place at the schools, teachers find it difficult to look at their students in a holistic way. Anna posited that teachers are mainly focussed on complex issues and difficulties faced by the young person, rather than other things they are good at that may not fit with the desired criteria. She also noted that teachers lacked resources that would allow them to work with the young person in ways that are best for them. Anna suggested that the inflexibility of the way education is structured and the focus on the perceived deficit of the young person leads to teachers using stigmatising categories and labels for their pupils.

Young people also highlighted stigma from teachers. Liam mentioned that when he was at school his teachers did not really understand what it was like to experience mental ill health:

“like certain teachers don’t appreciate that like mental health isn’t just oh I showed up but I didn’t listen, mental health is the fact that you showed up like straight up, I know for a fact that certain days I felt really shit I was just like no not doing that today” Liam (YP, Interview)

Teachers, in Liam’s experience, did not take into account how difficult it was for him to attend class and suggests that teachers should be more sympathetic to what their students are going through. Liam noted that the teachers at his school did not have a good understanding of mental health that would create an environment in which it was easier for him to engage with learning.

Violet also highlighted stigmatising experiences with teachers:

“I felt dismissed when I talked about stuff at school from teachers and I just felt they didn’t really believe what I was saying” Violet (YP, Interview)

Violet’s account suggests that her teachers were not taking her difficulties with mental health seriously. She discussed feeling as though her teachers did not really believe that she was struggling as much as she was.

#### 6.4.1.2 Stigma in the School Structure

Violet also described how it was not only interactions with individual teachers, but that the school as an institution was unsupportive and stigmatising:

“school wasn't being supportive I was still enrolled in that school, there was no communication at all they didn't send work home, they didn't, they refused, they treated me like a truant” Violet (YP, Interview)

Violet talked about how the school she was at treated her non-attendance as truancy without considering why she was not attending school. The story about how the school treated her suggests that they were not helpful or sympathetic to her mental health difficulties which became a barrier to her education. Similarly, Penny spoke about how she was often late for school because walking amongst crowds caused anxiety for her:

“’Cause I used to be late every day for school on purpose so people didn't need to see me like that wasn't- I was getting in trouble for being late every day like why are you doing this? You're just - it's a laziness thing you're just not getting out your bed like and it was no I need to put a full face of make up on and I need to stay back so everyone in the corridor can't see me” Penny (YP, Interview)

Penny’s school framed her lateness as her being “lazy” rather than seeking to understand why she was late for school and the self-esteem and mental health issues she was facing went undetected. This suggests a lack of mental health awareness in Penny’s school. This was also highlighted by Caitlin:

“A few teachers kind of look out for you, but other than that you're on yourself” Caitlin (YP, Focus Group)

Caitlin’s comment highlighted that there were some teachers who would be aware of the difficulties that their pupils were facing, however the use of the phrase “look out for you” suggests an informal attitude to mental health from her teachers, and could suggest that the teachers who took a particular interest were helpful, but there was not an over-arching policy that ensured all teachers prioritised the mental welfare of their pupils. This is similar to an account from Heather:

“teachers weren't, like they tried to be but they just couldn't, they just didn't know how to handle it and they all went about it in the completely wrong way, I remember in school there was one teacher who trained himself a bit on mental health in the entire school and he was the only one who kind of knew how to handle it” Heather (YP, Focus Group)

Teachers at Heather’s school were not provided with training, nor did they feel comfortable talking about mental health with their pupils. Those who did try to engage with mental health did so in a way that was unhelpful. Heather identified one teacher who appeared to take it upon himself to become more knowledgeable about mental health and that he could be approached if someone was struggling. However, mental health support in this school depended on individual teachers taking a personal interest, which suggests there was no policy or framework in the school that trained teachers about how to support their pupils and their mental health.

Participants highlighted that stigma was enacted through teachers as well as the way in which schools are structured. Teachers appear to lack understandings of mental health and schools do not facilitate teachers easily supporting young people’s mental health due to lack of time and resources. It could also be suggested that a lack of policy in individual schools that focus on ensuring the mental health of their students could lead to some of the experiences described here. The suggestion that there are a few teachers who take it upon themselves to educate themselves about mental health suggests that there is not a culture or institutional practice that ensures this.

### 6.4.2 Experiencing Stigma in Employment

Some of the young people I interviewed for this study were entering, and already in employment. Young people are often employed on precarious contracts due to lack of power and control over the contracts they take up, and this can have a negative impact on their mental health (MacDonald & Giazitzogu, 2019). Further barriers to employment such as mental health reduces young people’s access to social and financial capital, and their participation in social life. Young people with mental ill health have layers of inequality and disadvantage in terms of employment.

Some participants highlighted feeling stigmatised because of their mental health in employment settings. It was highlighted that young people don’t feel comfortable talking to their manager about the reason they were off work due to the perception they would think they were malingering:

“like when they were in work a couple of times they were talking around if you were to maybe speak to your manager and say around like mental health days quite a lot of the time if you didn’t have a good manager they would just see that as aw’ like dipping [avoiding] work” Nick (SM)

This shows that mental health issues have been constructed as laziness for some people. Fiona suggests that people do not come forward to employers about mental health because there is not a culture of this in workplaces:

“the fact that so many people aren’t admitting the reason they’re off is because of poor mental health you think there’s got to be something there to do with how work places are set up” Fiona (SM)

Anna suggests that workplaces are not built for people with mental ill health:

“the rigid terms of employment like a Monday to Friday 9-5 can be stigmatising…” Anna (SM)

This is reinforced by Nick who highlights that there is a lack of flexibility around work and the focus is on working a lot rather than working well:

“they just think well if we have them in five days you know working every hour making sure it’s so strict, we’ll be working the best…” Nick (YP & SM)

Nick suggests that employers hold the perception that working five days a week with long hours is ideal in terms of productiveness of the workforce, however he goes on to suggest that this is not always the case as this is not always conducive to positive mental health. This suggests that the way workplaces are structured make it difficult for people with mental ill health. This could also suggest a source for the laziness perception highlighted above. The suggestion that people who have mental ill health are lazy could be connected to their lack of participation in the labour economy (Tyler, 2020). The suggestions above, that stigma makes it difficult to ask for adjustments in employment, mean that it is difficult for people experiencing mental ill health to access employment. In addition, austerity, coupled with welfare stigma creates additional layers of inequality and hardship for people with mental ill health under neoliberal governments (Tyler, 2019; Beresford, 2016). Scambler (2018) highlights that stigma can only be understood within a macro-level understanding of financial capitalism. He argues that stigma is used to reinforce class inequalities and exploitation. Stigma is “weaponised” by highlighting and punishing deviance (Scambler, 2018, p.766). Those considered deviant under a neoliberal ideology are those who cannot contribute to financial capitalism, such as people who are disabled or have mental ill health (Scambler, 2018). This is highlighted further by Tyler who suggests the UK government’s policy of austerity, which is described as the systematic dismantling of a welfare state, uses stigma to ration welfare provision (Alston, 2018; Tyler, 2020). The stigmatisation of those attempting to access welfare support allows neoliberal governments to withdraw support. It could be argued that Neoliberalism and a policy of austerity “weaponizes” stigma to keep people “in, down and away” (Scambler, 2018, p. 766; Link & Phelan, 2014, p.2). The word weaponize is accurate here, as since 2013 more than 17,000 people have died waiting for disability benefits in the UK (Bulman, 2019).

It could be argued that the level of stigma within the current milieu, whilst covert, is so insidious that participants in this study argue for their own discrimination in employment. Liam also appears to apply his own stigmatising attitudes towards himself:

“if employers did give them the same chances it would make a massive difference and it would cheer a lot of them up… but at the same time if there was someone else at that interview at the same time I went who was completely functional… I honestly hope they would hire him better than me…” Liam (YP, Interview)

In this instance Liam initially suggests that the alleviation of discrimination in employment would benefit people with mental ill health. However, he goes on to advocate for the hiring of a hypothetical other person for a job over himself because of his mental health difficulties. This demonstrates the internalisation of structural discourses that stigmatise individuals with mental ill health.

### 6.4.3 Stigma in Mental Health Care & Services

Participants also highlighted stigmatising experiences from mental health professionals and support systems. Stigma can prevent young people from seeking help for their mental ill health (Schnyder, Panczak, Groth & Schultze-Lutter, 2017). Participants suggested that there was stigma attached to accessing mental health treatment for young people:

“a lot of young people don’t want to be seen as part of CAMHS because there’s still that kind of oh if they’re going to CAMHS then there’s something seriously wrong with them” Lilly (SM)

Participants also highlighted interpersonal stigma from mental health professionals. Violet is one such participant who recounts the first time she attended an appointment with her GP when she was a young child:

“that initial doctor’s appointment when I was self-harming, em that's another stigma thing, I was told off for doing it so it was like an attention thing, she was like you shouldn't do that why are you doing that and I couldn't - like that was my GP” Violet (YP, Interview)

Violet talks about how the GP sent her mother out of the room and “gave her a row” about harming herself. She describes feeling as though she could not come forward about anything and ask for help from other professionals because she was worried about being told off again. She also suggests that she felt she could not explain what was going on for her. Her GP held power in this situation and had a duty of care for a young child which is undermined through this response. The doctor’s abuse of their power in this situation is exacerbated by not allowing Violet’s mother in the room during this interaction. Violet’s description of her interaction with her GP is not only stigmatising, it goes against several child protection policies such as Getting It Right for Every Child (Scottish Government, 2015).

Tess also discussed a stigmatising incident with a psychologist from a Child and Adolescent Mental Health Service:

“I was sat with her and it was the first session and she was like have you ever been diagnosed and I was like yeah I’ve been diagnosed with depression and anxiety and she was like no you haven’t… you’re sat upright you’ve got your make up on you came here today, if you were depressed you would be slumping in your chair, you wouldn’t be able to make eye contact you would look awful…” Tess (YP, Interview)

Tess felt that the psychologist was suggesting that Tess did not have depression because she looked presentable. Tess framed this interaction as demonstrating the psychologist's understanding of mental health as prescriptive and inflexible, and because Tess did not fit this image, she was dismissed. Unlike the stigmatising instances with friends or parents, professionals in services that are supposed to be there to help people with their mental health, a lack of education cannot be said to be the cause of stigma.

Orpheus highlights the stigmatising experience experienced by their mother:

“I actually haven’t met someone I know with mental health who has been treated fairly… my mother she has mental health issues and the way she has been treated by the system or I guess multiple systems really is kind of appalling” Orpheus (YP, Interview)

Orpheus highlights the structural nature of stigma by referring to the way their mother was treated unfairly by “systems” and frames their mother’s experiences of stigma as something that is not always perpetuated by individuals.

Orpheus goes on to discuss the perception that the social workers abused their power:

“they abused their power a lot…she took me out and she would try and talk to me about how my brother would hit my mother, just try and get the nitty gritty details” Orpheus (YP, Interview)

This highlights a key issue with the instances of stigma described by the participants in this study. Mental health and other associated support professionals hold power. They have the power to diagnose, or not, to refer the young person for support, or not, and to make radical changes to the young person’s life. These findings are in keeping with previous research which highlights that young people have experienced stigma from mental health professionals (Heflinger & Hinshaw, 2010).

Caitlin describes an interaction with a mental health professional in CAMHS as unhelpful:

Caitlin: They were so helpful in fact I get blamed for everything. I was told they need to find somebody else cause I was too... what was the word... rude

Amy: Rude? Is that ‘cause you were just telling them the way it was?

Caitlin: So, say you're explaining a story and they go that's not how the story goes and I'd say how do you know? Are you me? Are you living in my house? And they're like no but I know the difference, I'm a doctor you're a young person it's sort of that I'm older; you're younger, sort of thing. Like, don't treat me like I'm a baby and don't know my own self.

Amy: Yeah totally

Caitlin: I still get that and I'm like my doctor goes sure you don't want your mum and I just think I don't need her, it's like that look they give you like you sure you do not want an adult? I'm almost 20 and the funny thing is they don't know how to talk to you they sit there and they go eh how you been and I'm like well that's why I'm here it's kind of... they need to get over the awkwardness of speaking to us

Focus Group

Caitlin highlights that the mental health professionals she interacted with framed her as being “rude” when she challenged their attempt to dominate the narrative of what was happening to her. It appears from this account that the professionals undermined her ability to know and understand what was happening for her, because of her age and positioned themselves as “older and wiser”, and therefore more powerful in the situation, which ultimately lead to a delay in her treatment as she had to find another practitioner. By asking if she wanted an “adult”, the mental health professional in this instance suggests that they were unable or unwilling to believe what she was telling them and required verification by someone else. This could arguably be a case of epistemic injustice in which Caitlin’s testimony is undermined by those in power because of how they understand young people’s abilities (Fricker, 2017). The examples provided here demonstrate that participants framed interactions with individual healthcare providers as stigmatising, dismissing and reflects power disparities in patient and professional interactions. The following section discusses participants highlighting the stigmatising nature of diagnostic practices within young people’s mental health services.

#### 6.4.3.1 Experiencing Stigma in Diagnostic Practices

When asked about experiences of mental health stigma, some participants discussed their experiences of mental health services and the process of diagnosis. There were some conflicting accounts with some suggesting getting a diagnosis was difficult for them, whilst others suggested that they didn’t get a diagnosis but that it would have been useful if they had. Diagnosis of mental illnesses has been demonstrated to increase the stigma faced, particularly if diagnoses of schizophrenia or personality disorders are given (Koehene, 2012).

Participants overall had a complex relationship with diagnostic criteria and terminology. Yvonne suggests that one of the key focusses of mental health services is to provide a diagnosis for people with mental health issues:

“traditionally services have been caught up around diagnosis, thinking there’s a perfect way of formulating someone’s condition which is out of context of their life” Yvonne (SM)

The predominance of the medical model of mental illness is prevalent here, and Yvonne suggests that this does not take social or structural causes of distress into account. She highlights the value that having a mental illness diagnosis can have for people:

“In our culture diagnosis means something and sometimes not having a diagnosis means you can’t actually access help and support…” Yvonne (SM)

Violet suggests that had she been told what her diagnosis was, this would have been helpful:

Violet: I didn't really have a label but I also when em I was diagnosed -I wasn't really told that I had anxiety

Amy: You weren't told your diagnosis?

Violet: No em there's, I think there's a whole thing with CAMHS and labels they just don't like giving labels to young people

Amy: Would it have helped to have that?

Violet: I think it would have, maybe an explanation

(Interview)

This was also highlighted by Yvonne:

“it’s very important for some people to have a diagnosis and to know that they have a condition and there’s a reason why they’re feeling this way and equally there’s things that can help them” Yvonne (SM)

In Yvonne’s interview she gives a similar picture of CAMHS practitioners’ complex relationship with diagnosing young people:

“I remember having many discussions with CAMHS practitioners about them not wanting to use a diagnostic manual or call it a diagnosis but they were comfortable saying this is a presenting problem…I think people can be written off at quite a young age by psychiatric diagnosis” Yvonne (SM)

However, she goes on to suggest a key problem with CAMHS practitioners’ reluctance to inform young people about their diagnosis:

“I think there’s a power differential that comes across for me that’s kind of withholding, and it might be withholding for what the person perceives to be the right reason… but equally I think… if it was a diagnosis of schizophrenia or borderline personality disorder by giving people that diagnosis there’s a huge set of beliefs that go along side it as well from a system point of view…” Yvonne (SM)

Xander also suggests that for him, receiving a diagnosis was positive:

“I think when it comes to the professional an’ their opinion on you I think it makes you feel a bit better when they say you have or you're showing signs of anxiety or depression or something like you feel awrite it's not just me that's going through that other people are going through it too” Xander (YP, Focus Group)

Throughout the interviews and focus groups, participants highlight an ambivalence about the use of diagnostic criteria. It seems that if clinical diagnoses are used, to withhold them is on the whole detrimental. However, some suggest that not using them at all may be more helpful particularly in relation to stigma:

“so like having a certain like this is what anorexia looks like and this is the stereotypical view of anorexia and then kind of seeing it in a very negative way I suppose um and even, not just eating disorders in particular, but that whole kind of perception that people with mental health and being seen as weaker and just not given the same opportunities” Lilly (SM)

“making their own assumptions what mental health or bad mental health is or what a certain diagnosis means and then being set on that” Lilly (SM)

Lilly suggests that the rigid criteria of eating disorder diagnostics, specifically weight categories, can exclude many young people who do have disordered eating. This precludes them from accessing support.

One focus group particularly highlighted their complex experiences of receiving a mental health diagnosis:

Amy: “Do you find diagnoses helpful?”

Tom and Caitlin: “no”

Tom: “Nah it's just a title just gets doon tae labelling that your just like everybody else in that category”

Here, Tom highlights that there is a lack of consideration of individual differences between those with the same diagnosis. Caitlin goes on to say:

Caitlin: “Changes people around you, I'm only sayin’ that cause I hadn't told the group, but I might as well now, people don't notice about autistic people ‘cause I'm actually one of them, well I'm not actually on the spectrum to be honest but I feel like they misdiagnosed me at first, I went take your test back cause there's some other girl you've mixed me up with”

Amy: “You felt like the diagnosis they initially gave you just didn't fit?”

Caitlin: “Yeah and then once people knew they totally just discarded me, like threw me out so that made it even worse it's like huh”

Amy: “Why do you think they did that?”

Caitlin: “I mean I don't know”

Tom: “’Cause you've got your answer, to them, that's you”

Caitlin: “yeah my dad is so in denial, he was like you're going back and we're paying for a different test, he's so in denial”

Amy: “’Cause he wants a different answer?”

Caitlin: “He's so in denial, he wants a different answer I'm like you might not get that”

Amy: “And what do you want?”

Caitlin: “To be honest I would wanty never have went that day and to never have knew about it… I don't think it would have caused problems if I didn't”

(Focus Group)

While autism is not considered a mental illness diagnosis, what is clear from this interaction is Caitlin’s struggle with the diagnosis of autism she has been given. Initially she appears to identify with the label, suggesting she’s “one of them” but then emphasises that she does not feel it is applicable. Key to Caitlin’s experience is other people’s rejection of her once they know about her autism diagnosis which leads her to her desire to not have been given the diagnosis at all. This highlights the difficulty and complexity of the diagnostic process for young people. I attempted to get an understanding of the value of a diagnosis for these participants:

Amy: “And do you feel like once you get a diagnosis the professionals then know what to do with you?”

Tom and Caitlin: No

Tom: “no really but it's a bit of direction ‘cause you know whit tae look oot for so you can dae your ain like research on it just tae understaun it unnerstaun' aboot whit this is then you're just startin a’er again and find oot how tae deal wi it but at least it cuts oot the majority of whit it could have been and then you know what it is your dealin wi”

Amy: “is there a sense you've got to help yourself?”

Caitlin: “yeah it's just yourself”

(Focus Group)

This extract demonstrates the difficulty of receiving a diagnosis and the stigmatising effects this can have on the young person receiving it. It also suggests that even with a diagnosis, the young people in this interaction did not feel this aided them in their access to further support and felt they were left to move forward with their diagnosis with no further support. This demonstrates that receiving a diagnosis is not always helpful for young people and that perhaps a change in the way this is carried out in CAMHS could be improved.

Yvonne highlights the complex relationship between mental health diagnosis and stigma:

“It’s weird we’ve focussed on stigma when actually might be better to focus on labelling because it’s a diagnosis that comes with the stigma, diagnosis creates the stigma” Yvonne (SM)

This highlights that often diagnoses contribute to stigmatising assumptions about people with mental health issues, however Yvonne suggests that one way of overcoming stigma is through talking more openly about diagnoses and developing counter-narratives about their impact on the individual:

“we’ll never be able to challenge stereotypes around people with a diagnosis if we don’t say well actually, I have that diagnosis and look what I’ve been able to achieve…” Yvonne (SM)

Alice suggests an alternative to clinical diagnosis:

“I think they need to look at the person as a whole, rather than categorising them so they can find the one thing that's wrong with them so they can diagnose that, and it's difficult I know for GPs especially cause they've only got a certain amount of time that they're able to see everybody and I think especially nowadays that's maybe where the GP side of things needs to change cause like 10 minutes isn't enough, and it's maybe taken somebody months to build up the courage to actually go to the doctors and then they might not necessarily get everything out that they want to” Alice (YP)

Here Alice suggests that mental health professionals should take a holistic approach to mental health treatment, and a move away from a preoccupation with classifying and diagnosing mental health difficulties and emotional distress.

This section has demonstrated that participants identified stigma within employment, educational and health care institutions. It has also been highlighted that receiving a diagnosis has been a complex process for participants, with some not being informed of their diagnosis when this would have been beneficial, and others receiving a diagnosis but ineffective support. It is difficult to determine the extent to which participants frame their experiences, particularly diagnostic experiences as stigmatising, this may be due to the covertness of stigma which will now be discussed.

## 6.5 Covert Stigma

This section will discuss instances of stigma that could be described as covert stigma. Participants highlighted that stigma can manifest itself in covert ways:

“100% I think that it’s now something that is harder to be explicit about…” Isabelle (SM)

Participants throughout this study indicated that stigma manifested itself as an absence of prioritisation, policy and resources:

“stigma in terms of policy can be quite difficult to articulate I think because often it seems to me to be the absence of a policy” James (SM)

This section will discuss participants’ perceptions of covert stigma, manifesting itself as an absence of prioritisation of mental health in policy and practice settings and the effects that this has on access to services for young people.

### 6.5.1 Lack of Prioritisation of Mental Health Services

A key priority for participants was the lack of prioritisation of mental health services in Scotland. Throughout the interviews, participants highlighted that they did not feel that mental health was a priority in Scotland:

“no I don't think it's enough of a priority it should be more…” Gabrielle (SM)

Despite mental health policy suggesting that: “improving mental health is a national priority in Scotland” (NHS Health Scotland, 2013) participants suggest that this is not reflected in their lived experience of accessing mental health services:

“they say it’s a priority they say it all the time but the reality is if they came and worked in a school or even go out in the community there's all these projects set up but the funding, you'll maybe get a project for a year but then it disappears” Barbara (SM)

Barbara highlights that while policymakers and politicians emphasise the importance of mental health, this priority is not enacted through the provision of funding. This is also highlighted by Catherine:

“there’s opportunities to fund whatever we want to why isn’t it a big enough priority?” Catherine (SM)

Barbara goes on to reflect on the lack of funding for youth mental health services in particular:

“I hear from teachers, primary and secondary and parents how disillusioned they are and it’s not because CAMHS are bad people at all it’s because CAMHS are overwhelmed and sadly they’ve cut funding for so many projects and what happens to these families?” Barbara (SM)

Similarly, Hannah suggests that in her experience of working with young people she feels CAMHS is not funded adequately:

“what I see is a service that's in crisis, I think it's always been in crisis actually. In my experience it's always been a really tiny part that's been part of a bigger organisation which is the NHS, and mental health is small and children and adolescent's mental health is even smaller so in terms of funding there's definitely not enough funding” Hannah (SM)

It is also suggested that the way funding is spent is not effective:

“we are not spending public funds in a sensible or proportional way in Scotland we’re replicating piecemeal pieces of work” Danielle (SM)

The Scottish mental health strategy 2017-2027 also “aims to give the same priority to mental health as physical health” (Audit Scotland, 2018), however despite this assertion, participants highlighted that this was not their experience. Mandy suggests that mental health is the most prioritised in Scotland than it ever has been:

“I think there's more funding now and more priority than ever before so I think we've been pretty bold in Scotland in prioritising mental health” Mandy (SM)

Mandy’s statement differs to other members of staff working with young people, and young people themselves who suggest there is still not enough of a priority. Mandy’s comment is based on her experience of working in a policy environment. However, she goes on acknowledge the lack of parity with physical health:

“In respect of parity with physical health it doesn't come close so you know physical health attracts much, much more funding doesn't it across different government priorities so in terms of equity no it's not equitable at all” Mandy (SM)

Mandy suggests that the reason for the lack of priority is due to the dominance of the medical model and focus on physical health:

Mandy: “the medical model runs large and the physical health concerns still dominate so I think that is just reality so we're still noticing if you take the biggest killers for Scotland for example it's physical health stuff so cancer stroke heart condition so the investment goes towards”

Amy: “But across the board… the thing that costs us the most is depression and anxiety....”

Mandy: “Well I guess it's that morbidity mortality cost isn't it so people don't die of a mental health condition…”

Mandy suggests that the focus on physical health issues means there are less resources for mental health. She initially suggests that this is valid way of framing resource distribution, as it is based in reality and that physical health conditions contribute to mortality more than mental health issues. However, I feel I perhaps should have questioned her assertion that people don’t die of a mental health condition as suicide is a possible outcome of mental ill health, there were 784 suicides in Scotland in 2018 (Scottish Public Health Observatory, 2020). The key point here is that mental health is constructed as something that is less important or pressing to devote funds to than physical health.

Nick suggested that the young people he works with have highlighted that they see the difference in prioritisation of physical health to mental health:

“they're talking about physical illnesses to like mental illnesses it should be given the same priority and they did mention that it should be given the same priority in terms of how it's like cared for within like hospitals, doctors, schools, everywhere really, workplaces. It's you know, just as bad if not worse because the person who's maybe broke their leg they'll maybe feel a little bit better in a couple weeks whereas it might be worse if you're mental health is really bad” Nick (SM)

Young people interviewed in this study also suggest that physical health is prioritised over mental health:

“I don't see why mental health is less of a priority than physical health… Just because you can't see it doesn't mean it's not real” Orpheus (YP, Interview)

Orpheus ties this lack of prioritisation to the lack of visibility of mental health issues. Orpheus suggested that because mental illnesses are less visible than physical health issues and are not directly observable, they are less of priority as the problem is less obvious. Tess also connected this discourse, of mental and physical health existing at odds with each other, to stigma:

“I think ever since mental health has ever been acknowledged it’s been less important than your physical health which creates a stigma because it’s always been there and is just kind of associated with it” Tess (YP, Interview)

Tess suggests mental health is prioritised less than physical health because of stigma. She also suggests that stigma has always been there which demonstrates that she understands mental health stigma to be based in historical understandings of mental ill health.

Participants highlight the lack of prioritisation, however there is some ambivalence over whether this is stigma:

“stigma has a role into it because it’s seen as not as important as other services…” Lilly (SM)

“I don't think it's fully because of stigma I think it's because of lack of funding and resources and…I feel like mental health is a priority, well in terms of what's being said, but in terms of like the waiting lists and their criteria for getting support…[it is not a priority]” Fiona (SM)

Fiona initially suggests that this lack of priority is not because of stigma, however she does go on suggest that what is said by those with power over funding and what they do are different. This could suggest that while those in power talk about the prioritisation of mental health, stigma could manifest covertly in the lack of prioritisation of funding mental health services.

### 6.5.2 Waiting Lists

The length of time young people have to wait for an appointment to see a mental health professional was also highlighted as a manifestation of the lack of prioritisation of mental health services. This is demonstrated in an interview with a young person:

Amy: Mm... do you think that young people's mental health is enough of a priority in Scotland?

Tess: Eh no

Amy: Ok why is that?

Tess: Because the length of waiting lists for example is absolutely shocking

Another young person noted:

“like my friend she was like in an abusive relationship and she was really depressed and had like anxiety and she’s been in a waiting list for help for ages and people keep telling her to get help and she can’t… treatment isn’t as readily available as it should be” Hotwheels (YP, Interview)

This could indicate a cycle of being told to get help but being denied access to this help. Tom consistently highlighted his frustration with waiting lists throughout the focus group he participated in:

“the waiting lists and all that you're tryin’ to go through it all and it's 7-8 months for an appointment you need to go an wait another three months, it's always months it's no weeks and it's bad enough wi weeks but months is just like 7 month. Everything could have changed by that point… I feel frustrated because I'm stuck in this situation and there’s naewhere tae go or for them to send you, you just go back on the waiting list and then get sent to them” Tom (YP, Focus Group)

Staff members also highlighted the waiting times for support for the young people they support:

“I just don't think like mental health services are able to cope with the amount of people who are accessing or trying to access their services and there’s huge waiting lists, especially for young people…” Elaine (SM)

“that's another big thing I've noticed is people who are brave enough to say that they are struggling then they could be on the waiting list for 18 months to actually see someone so if it was more of a priority actually at that ground level” Lilly (SM)

Barbara highlights that this is a detriment to young people they are trying to help, as there are not enough resources:

“the children I see now in schools… they display the kind of behaviours and trauma that the children in units used to” Barbara (SM)

Barbara suggests that children who would previously have been treated in CAMHS or children’s units are no longer having access to services because the waiting lists are so long.

Fiona suggests that the lack of prioritisation of mental health is due to the disparity of resources between mental and physical health:

“there’s an idea that you can be left for a bit longer on a waiting list for mental health…” Fiona (SM)

Stigma could act covertly in reducing the priority of funding mental health services as it is seen as having less value than funding physical health services. This results in a scarcity of resources which means young people have to wait a long time to access support for their mental health. This could in turn, mean their mental health deteriorates while waiting. As demonstrated by staff accounts of the cycle of stigma in chapter 5, stigma could be understood as cyclical here, in that deteriorating mental health may get worse due to lack of help seeking. This makes it more likely that a person is identified as different for having mental health difficulties thus beginning a cycle of interpersonal stigma for an individual, but this is also exacerbated by structural sources of stigma, such as a lack of resources. Understanding stigma both in its interpersonal and structural sources is important here.

### 6.5.3 Service Provision & Treatment

Literature consistently highlights that seeking mental health treatment is affected by stigmatising attitudes, and that the fear of being stigmatised prevents disclosure of mental ill health (Corrigan, 2004; Bracke, Delsrulle & Verhaeghe, 2019). The participants in this study understand stigma as a barrier to treatment in that stigma is something that prohibits access to and provision of treatment rather than something that prevents young people asking for help. They highlight that there are instances of stigma when they do ask for help, and that there is a lack of effective support after accessing the services. Participants in this study frame stigma as contributing to the de-prioritisation of mental health services, particularly in comparison to physical health services. This leads to greater waiting lists but also a tighter gatekeeping to accessing treatment at all. One of the key issues highlighted by participants is the tier system used by CAMHS:

“you’ve got the CAMHS tier system… because of the level of demand unless there’s a level of suicidal ideation or self-harming behaviour they’re unlikely to have an accepted referral…” Danielle (SM)

“CAMHS in particular would be the place that young people are referred and if they don’t meet certain criteria then they’re not accepted into the service, then where do they go?” Elaine (SM)

The tier system involves identifying levels of intervention in which the child or young person must meet specific clinical thresholds in order to receive treatment. Isabelle suggests that because mental health has been medicalised it is difficult to see all the young people with a diagnosis, which means a child must be in crisis in order to receive support:

“I call it CAMHS bashing so if you go to like any mental health meeting around children and young people is about CAMHS bashing really, and so we should, we should be critical and questioning the resources that are there, you know the fact that it takes 24 weeks, the fact that that's our target's no' good enough… so people understanding when somebody doesn't meet a criteria for CAMHS it means that they don't meet a clinical criteria but distress isny always clinical but you still need some level of intervention and support” Isabelle (SM)

This is also highlighted by Hannah:

“And they often close the door, a child has to be a certain high level to get into CAMHS and they have to wait a long time for that but if we could work better at prevention but it's so difficult to measure preventative work” Hannah (SM)

Lilly highlights the effects that this can have for young people’s access to support:

Lilly (SM): “you do need to meet that criteria for having an eating disorder and be very ill to get into that service and it is seen as a different service than just general CAMHS for other stuff but yeah I don't know how easy it is to actually get referred yeah or how many people get missed because...”

Amy: “they're not ill enough?”

Lilly (SM): “yeah but again like a lot of that is because they want - not because they want but because they can't see everyone so there has to be a way of keeping numbers down to certain degree but if they had more people or more money put into it then they wouldn't have to make people become ill in order to get help”

In this example the lack of resources for eating disorders means practitioners must exclude people based on stricter diagnostic criteria. The way CAMHS assigns diagnoses can block access for those who need it. This is also highlighted by Ross:

“a few young people came to me and said they were at crisis point said they were wanting to kill themselves then when I spoke to them like 6 months afterwards they said they made it up just to get the support they needed because the gatekeepers that were there were in place and could only listen to them if they were in crisis point and I think that's really dangerous” Ross (YP, Interview)

It is also highlighted that when they do manage to access treatment, it is not always particularly beneficial. Isabelle suggests that the structure of services is detrimental to those who need it most:

“ultimately services are still designed around the sensibilities of someone who’s well” Isabelle (SM)

Isabelle’s suggestion is exemplified by Violet’s discussion of her experiences of accessing support for mental health issues:

“I hated going to CAMHS appointments and stuff cause first of all they would make me really stressed and there was a while where someone could only do appointments or 3 or 3:30 and that was when the schools came out and it terrified me and I couldn't because there was school people everywhere” Violet (YP, Interview)

“I had a negative association with school and I couldn't do the appointments with the educational psychologist at school em and I had to meet a psychiatrist ‘cause I was still taking that medication, at CAMHS which was round the corner em from the school and I just didn't go in” Violet (YP, Interview)

“it's starting from the beginning and I have to explain everything again and I have to get used to someone again em so that wasn't great at all it was kind of like going back to the start with someone new and this was every few months” Violet (YP, Interview)

Violet sought help for anxiety from CAMHS. She discussed how school had been an exacerbation of this anxiety, but when she attempted to get help from CAMHS they set her appointments in which she was required to face aspects of her anxiety in order to receive help such as going near the school, or being around students at the time they were finishing school. While this is a specific example for Violet, she highlights that because CAMHS had limited time and resources she regularly faced treatment options that were not appropriate for her. She also suggested later that due to the lack of resources, the psychologists she would meet with changed regularly, she felt like having to start all over again and continue to go over old ground, re-telling her story and feeling like she was not making progress. This example highlights the role of structural issues around funding, resourcing and provision of CAMHS treatment acting as a barrier for young people attempting to access support for their mental ill health.

Violet’s difficulty with having to repeat her story was also highlighted by Nick who also suggests that the young people he works with mentioned the difficulty of speaking to a counsellor:

“the counsellor you’re going in and you need to feed them everything and bring everything up… and before you know it you kinda feel worse because you need to talk about everything that’s made you feel bad… they were saying there’s that kinda stigma of when you walk in and you need to bring up everything again …” Nick (SM)

Tom also described the difficulty he faced when accessing support and treatment:

“you'll deal wi' the same sort of stuff if you were going to the doctors or college or going for specific help or if you're waiting for it, a lot waiting for it to happen as well em they can be helpful once you get it but it's usually like too late. You get put under pressure for being there like why are you there? Em they gie you suggestions and then they just leave you there you've tried them then you need to wait on a waiting list again get referred again and if it doesn't work you're back to square one em half the time there's nae answers at all they compare you to other people's like coping methods and all that but it might not work for you” Tom (YP, Focus Group)

This further suggests a cyclical process of referral, waiting and treatment. He suggests when the treatment suggestions do not help, he is back on a waiting list before other treatment is provided. Tom also describes feeling a sense of judgement when he is granted access to treatment services, when asked why he is there which connotes to him that he shouldn’t be there or he is not ill enough to warrant attention.

Another key aspect of young people’s concerns when accessing mental health treatment, was the provision of medication. Young people in this study discussed their difficulties when given medication for their mental health:

William: “a lot of GPs these days, I have a GP that's really guilty of this they'll go oh lets treat it with science, it's just a case of lets throw medication at it and you'll be fine but that then like kind of I can't remember the word I was gonna say but it solidifies that thing oh, there's something wrong if I have to take medication every day to treat this issue when if you probably changed the first step like we'll get you to a counsellor or a therapist or somebody who can be that outside source to sit and listen to what you have to say and be like, well as somebody as an outsider or someone who's been through similar things and came through the other side I can say this whereas that doesny happen these days”

Amy: “do you think that "let's tackle this with science" is a helpful attitude?

William: No… the whole science thing never actually solves the problem I think it instates the problem, because you're being told this is a chemical imbalance when a lot of the time it's natural like depression especially, like oh you won't be happy unless you take these wee happy pills”

Caitlin: “I think they give you medication because they can't be bothered, that's it, sign something off, that's you, they're covered aren't they”

(Focus Group)

William suggests here that medication reinforces for him that there is something wrong. This could suggest that medication and the medical model in general, for William pathologizes his experience of mental health difficulties. William highlights that he would prefer to speak to someone like a counsellor, or someone who has been through something similar who could empathise.

Violet also describes her own difficulties with taking medication:

“I think they were just like OK you're gonna take this tablet every day and it's gonna happen and I took it- or I was supposed to be taking it for a year but I think at first I was really resistant to it and I just took it but I ended up getting not so great side effects like I would have headaches and not be able to think properly and stuff like that and then I was just like you know what I'm not taking it so I wouldn't take it and it was really bad as in I pretended to take the tablets near people then I would like stash them somewhere because I didn't want to take them” Violet (YP, Interview)

Steven reflects his perception of a wider public attitude when he suggested that there is a stigma attached to taking medication:

“If you have to manage it with sertraline or whatever it’s just a bit soft maybe like um you know bullshit condition, bullshit solution, a little bit namby-pamby” Steven (YP)

This is also highlighted in literature (Kranke et al., 2011). Steven’s suggestion here is slightly contradictory to the previous suggestion that medication reinforces a problem. Instead, Steven suggests that if mental health difficulties can be treated by taking medication then it suggests the person was not experiencing “real” issues and were just weak. This suggests there are conflicting discourses about mental health that construct it in different stigmatising ways. This could reflect the complexity of stigma and tackling the different ways in which stigma manifests covertly through discourse.

“some doctors are amazing because they've researched it themselves and know a lot about it from their own experiences whereas some just have no idea how to handle it like they would deal with it better but they just have no idea because they haven't gone through anything like that” Alice (YP, Focus Group)

Alice suggests that doctors are most effective at providing treatment if they have taken a personal interest or have personal experience. Similar to the suggestions about teachers, this suggests that there is a lack of training and structural frameworks that help doctors to treat their patients with mental ill health. In this instance it could be argued that stigma is enacted covertly in a lack of the implementation of the stated prioritisation of mental health within policy and practice.

I found it difficult to determine whether what was being described was stigma, as the participants rarely used the word stigma to describe these experiences. However, these experiences were clearly important for participants as many became more engaged when discussing their difficulties with accessing and receiving mental health treatment. Because stigma can manifest covertly, and at a structural level that is not always directly accessible to young people, it is more difficult to identify and call out. It could be argued however that the way mental health is constructed within systems via stigmatising discourses contributes to the way young people experience services, where there is a lack of resources and prioritisation of their mental health and wellbeing that do not adequately meet their needs.

## 6.6 Chapter Summary

This chapter has discussed how participants described their experiences of mental health stigma. Despite their difficulty describing the concept demonstrated in Chapter 5, they do experience stigma in their lives. Stigma is experienced both through interpersonal interactions with family members and through passive avoidance by peers. Participants also highlight that stigma manifests through social-structures and institutions including employment and capitalist structures, through attitudes of teachers and lack of support in educational institutions. In addition, participants described stigma within mental health care and services and in the process of diagnosing young people. Participants also placed importance on their difficulties of accessing and receiving appropriate mental health support, which could be understood as a manifestation of covert stigma. The next chapter will discuss how participants understood the structural sources of mental health stigma and the hegemonic discourses that construct mental health in a stigmatising way.

# Chapter 7. Results 3: Structural & Discursive Sources of Stigma

## 7.1 Chapter Overview

This chapter presents the sources of stigma described by participants. This research aimed to explore the ways in which the conceptualisations and experiences of mental ill health stigma could be understood through societal level factors and discourses (Research Question 3). This chapter firstly introduces the structural level factors identified by participants which impact their experiences of stigma. These factors include the media, society as a whole, socialisation and history. Secondly, this chapter highlights key discourses identified and used by participants which construct their experiences of mental ill health and being a young person. These discourses contextualise and contribute to their experiences of mental ill health stigma at multiple social levels and enhance experiences of injustice.

## 7.2 Sources of Stigma

This section describes participants’ understandings of the structural sources that contribute to dominant discourses that construct understandings of mental health in a way that is stigmatising. Cultural factors such news and social media as well as socio-cultural practices will be discussed. This will then be followed by the temporal factors of historical and generational discourses that remain embedded in social structures.

### 7.2.1 Media

There are many instances of existing literature that highlight the pervasiveness of stigma about mental ill health from media such as news, television and films which tend to link mental ill health with crime and violence (Goodwin, 2014; Harper, 2005; Morgan & Jorm, 2009; Knifton & Quinn, 2008). Participants in this study also highlighted that stigmatising language and misunderstandings about mental ill health are perpetuated by the media:

“one of my pet peeves is language we use around mental health so that's in the media and just using- and I try and clock myself sometimes when I do it, because I still do it like saying oh that's mad, that's mental, that's crazy, are you insane? Or psycho is the worst one, and I think there's a real like trying to make people a wee bit more aware of that because that's really stigmatising language and even just little things like even now how people with mental health problems are presented in movies, like people who struggle with you know it's like they're the joke or the scary person” Gabrielle (SM)

Participants highlighted the connection between crime reporting and mentioning mental health issues, therefore reinforcing perceptions of dangerousness:

“If I’ve ever read anything about mental health and someone with a mental health issue, they’ve committed a crime or they’ve done x, y and z but a lot of the time they don’t report the other side of things” Elaine (SM)

It was also highlighted that media perpetuates messaging which suggests it’s not ok to speak about mental health, and this is filtered down through the media to parents and young people:

“that kind of “I can’t say that” (about mental health) because of the kind of messages that have been filtered down through media and sadly through parents who’ve also had that filtered down” Barbara (SM)

Barbara suggested that the stigmatisation of discussing mental health has been accepted by individuals in society but the source of these stigmatising attitudes is from media outlets such as the news.

Young people in this study also highlighted the negative aspects of media perpetuation of stigma. Steven commented on the discussion of mental health in the media and suggested it is insincere and contributes to perceptions that mental health is “trendy” but not serious:

“it's certainly in the media now more and it's being approached but I have a few friends who have suggested it's quite superficial like “hashtag mental health” type stuff and it doesn't really em you know it's great to talk a bit more about it but it's a little meaningless maybe” Steven (YP, Interview)

For me Steven’s conceptualisation of the media discourses was that there appears to be more conversation about mental ill health in the media, particularly in terms of social media, that but there does not appear to be a shift in how people with mental ill health are treated.

In a focus group, Alice and Caitlin discuss the power that the media has in representing people with mental ill health:

Alice: “I think there is that dangerous side to it cause the media get to control what side of mental health is put out”

Caitlin: “who says what and when”

(Focus Group)

Caitlin’s comment here speaks to a Foucauldian conceptualisation of power and discourse, that those with power, in this instance the media, have control over which discourses or cannot be used to construct reality (Foucault, 1991; Mills, 2004). The media then can be seen as holding power over the ways in which mental health is constructed.

Another participant in a different focus group, suggested that the media contributes to the medicalisation of distress:

“it's like anything else, internet stuff in general, but I think that's where some of it comes from just like what people have seen on TV if someone sees a programme about depression they might think they have it but they don't really I think some people don't realise what they're going through until they see as well so it's good thing because it lets someone know what they're going through know but at the same time it gives a - it brings in people who aren't genuine as well that's a side effect of it” Man Bat (YP, Focus Group)

This is a complex statement from Man Bat. Man Bat suggested here that the media holds both a positive and a negative role in terms of mental health awareness. He suggested that representations of mental health diagnoses such as depression can raise awareness for people who may be experiencing something similar, however he also suggested that this can to the inappropriate medicalisation of experiences for others. The concern for medicalisation of experiences is addressed later in this chapter, but this statement demonstrates a dual role of the media.

Oscar responded to the discussion in this focus group about the ways in which the media constructs mental ill health. He suggested a way of tackling misunderstandings of mental health perpetuated by the media:

“even some professionals haven't actually gone through it themselves which makes it more difficult, they might be professionals they might know the signs and all that but I think the main people that should be really talking about it in the media, writing articles or whatever should be people that are actually going in the midst of it so they know the ups and downs of it they know what's yeah” Oscar (YP, Focus Group)

This suggestion about hearing the voices of people with experiences of mental ill health is pertinent here as it could address Man Bat’s suggestion about the sometimes inappropriately medicalised understandings of mental ill health, as well as stigmatising representations of mental ill health.

This section has demonstrated that for participants, a key way in which stigmatising discourses about mental health are perpetuated is through news and television media. While there is a suggestion that the media can raise awareness of symptoms of mental ill health, overall though, there appears to be a concern about the power the media has over discourses which construct perceptions of people with mental ill health and a medicalised understanding of mental ill health which for one participant was not always a helpful or appropriate construction of mental health.

#### 7.2.1.1 Social Media

While social media was not initially intended as a focus of this study, it came up a lot in the discussions with participants, and it became clear that it was of interest to the young people in particular. Social media is represented as a “double edged sword” or “morally grey” with some lamenting its dangerousness, and others suggesting that it is a source of support for them and their mental health. While an investigation into the effects of social media on young people’s mental health could be a project in itself it is represented here as it was a key factor brought up by participants to explain certain aspects of the perception that young people’s mental health is in “crisis” and contributed to stigmatising discourses about mental health. Some participants, mostly staff, had a strongly negative view of social media:

“I think social media is the devil I really do it's such a sad state of social interaction it really gets me down” Gabrielle (SM)

Similar to the young people in the above section on media, participants were concerned about the role of social media in the medicalisation of experiences. Barbara suggested that social media can lead to parents inappropriately diagnosing their children with mental health conditions:

“they’ll [parents] say you know I’ve read about bipolar and like I know one minute he’s fine and the next he’s not and I’m thinking that’s a teenager!” Barbara (SM)

This suggests that there is an uncertainty about young people’s behaviour that is “normal” or needs clinical intervention, and that access to information on the internet is contributing to this.

It was also noted that social media can have a negative impact on young people’s mental health itself. Danielle indicated that what young people see online can have negative consequences:

“they [young people] find all this shit and the hidden hashtags and all that kind of stuff about self-harm” Danielle (SM)

Danielle suggests that aspects of social media actively encourage young people to hurt themselves, which is something that would benefit from future empirical investigation. However, it was not only staff members that highlighted negative aspects on young people’s mental health. Some young people highlighted that social media is difficult to detach from:

“I struggle to switch off I just get bothered wound up care about things I shouldn't care about I think it's good for other people, other people use it for social support” Steven (YP, Interview)

Participants also drew attention the damage that comparing one’s actual life, to the curated life of someone posting on the internet could have on the mental health of young people:

“social media does terrible things for our self-confidence because we’re always comparing ourselves to the beautifully crafted images on Instagram” Catherine (SM)

Lilly highlighted that this can influence young people and be a pathway for eating disorders and body confidence issues to manifest:

“like I was talking about Instagram and perfection that people have to look a certain way or have a certain lifestyle or doing a certain thing and that's still there and that constant comparison is the one thing that comes up all of the time in schools” Lilly (SM)

This negative view of the effects of social media on the mental health of young people was contested by some of the young people participating in this study. One participant highlighted that sometimes it can be useful to see that successful people can also struggle with their mental health:

“there's all this advertisement about it and there's people talking about it and there's all this stuff online about people talking about their experiences and it's quite helpful having both being able to educate yourself quite well using social media and everything and also like the whole fact that it’s all publicised now and you can see that other people are going through stuff it's not just you even celebrities posting and stuff and you know that even this massive person who has loads of fans, loads of friends and loads of money and everything can still go through all these problems” Emilia (YP, Focus Group)

Other participants suggest that social media can lead to greater access to support and have positive effects on mental health:

“digital online peer to peer contact has saved people’s lives” Catherine (SM)

Despite her initial scepticism, Catherine highlights that online, 24-hour access to support systems have been used by people considering ending their lives. Orpheus suggests that she was able to find other people with similar experiences to her and gain information about what she was going through which was helpful for her:

“[I found] representation, knowledge not just misconceptions or myths and legends but just like legit facts and then I could start to form my own opinions and realise I wasn't fucked up or not in the way they made me out to be! \*laughs\*” Orpheus (YP, Interview)

It was suggested that social media can be used as an effective way of increasing discussion about mental health and would be useful to tackle the stigma of talking about mental ill health:

“it raises awareness on a general level that mental health topics exist and that’s great and it seems to remind on some level it reminds people that mental health affects everyone” Anna (SM)

Other participants suggest that social media can be good or bad depending on its use:

“and it wasny that social media time was bad it was what you were looking at that was causing the issue so if you were spending your time thriving and like learning and understanding, finding all these good things socialising with all your friends through Facebook… but at the same time there could be somebody else you know like sitting next door in a really dark way, looking at bad things causing themselves more issues” Nick (SM)

There was also a suggestion that social media is not going away and so it would be beneficial to educate people on using social media and the dangers and benefits of it:

“I think if it's used properly and taught properly like about the dangers of social media like I think it could be a really good place to connect with other people” Ross (YP, Interview)

“I think there needs to be more education about how it affects you and how to put up healthy boundaries on your time and on how you perceive what you're seeing because I think that can have a really negative effect on people if they're not really understanding what they're seeing and they're not really limiting how much they're being influence by it” Zoe (YP, Interview)

The perceptions of social media are mixed in this data, some suggest that it is a very negative factor and contributes to mental health difficulties. Others suggested that it is useful for raising awareness and that it had helped people to access support from informal networks. Most suggest that both of these aspects of it were prevalent, however Ross and Zoe’s suggestions about highlighting the dangers of social media so that the benefits can be utilised is a useful suggestion. Whether social media is a useful or damaging factor for young people’s mental health is beyond the scope of this study, however it does contribute to discourses about mental health and has potential as a tool to influence understandings of mental health and tackle stigma by providing a platform for counter narratives and lived experience.

### 7.2.2 Society & Culture

Participants suggested that stigma was pervasive and could be felt:

“everywhere to a greater or lesser extent” Catherine (SM)

This suggests that stigma is pervasive throughout society and participants understood stigma as insidious and embedded within society and culture to the extent that it is sometimes difficult to highlight specific instances and sources of it:

“there are lots of cultural echoes about mental health which have been appearing for a very long time… and they make people feel more reassured in their biases” Zoe (YP, Interview)

“just kinda comes from ground level people’s home life, family, just people’s ground roots, school, it just seems like it’s already there in society… for me it just seems like it’s common place” Lilly (SM)

This suggests that stigma is so embedded into culture and as a result it is reinforced as “reality” and taken for granted. Zoe highlights that this is partly due to the presence of these “cultural echoes”, or dominant discourses, throughout time. The stigma of mental ill health could therefore be understood as manifested through powerful discourses which constitute reality. Participants highlight that a consequence of these cultural narratives is the devaluation of people with mental health issues:

“well people are discriminated against because of their mental health conditions that’s kind of fact people feel less valuable to society because of their mental health” Yvonne (SM)

Similarly, Orpheus suggests a possible reason for the perseverance of stigma within society is due to power structures that are embedded within society:

“cause it’s not helpful to mainstream society, it’s a hindrance to them so they’ll take any flaws in it and they’ll exaggerate and weaponize it against you instead of helping” Orpheus (YP, Interview)

Orpheus and Yvonne both suggest that people who experience mental ill health are devalued and viewed negatively. This suggests that for those in power, actually eradicating mental health stigma and valuing people with mental ill health may not be beneficial. This suggests that the maintenance of discourses which construct mental ill health in a stigmatising way be embedded within power structures, such as the media as demonstrated above, as well as those with political and financial power and reinforced and embedded within social institutions, as Lilly highlighted above.

Danielle also highlights cultural attitudes towards emotion that are specific to Scotland that adds to the ways in which mental health is constructed:

“I started to cry, my mum was like stop that you’re in public, no’ bothered that I was coming out but she did not want me to be displaying emotion in public… the whole [place redacted] are super like that, push it down, suck it up, don’t display emotion” Danielle (SM)

Steven suggests that in order for real change to happen, a culture shift needs to occur:

“it's not the sort of thing we can just throw money at there's gonna have to be a big cultural shift and I couldn't tell you how to begin with that but em yeah I suppose that's the main thing we have to change our culture as well not just spending, of course that's going to help because I know there is nowhere near enough resources to deal with it but culture's going to have to change” Steven (YP, Interview)

This section has demonstrated that participants understand the stigmatisation of mental ill health to be embedded within society in a way which is accepted as reality and reinforced by conceptualisations of mental ill health and emotion more generally.

### 7.2.3 Socialisation & Generational Reinforcement

The above section demonstrated that the participants in this study understood the stigma of mental ill health to be embedded within society. Similarly, it was suggested that this is reinforced over time through generation and a process of socialisation. The dominant understandings of mental health as something to be stigmatised is highlighted as persisting through replication by generations. Participants suggested that a key way young people acquire knowledge of mental health and stigma is through socialisation from older generations. Danielle and Anna suggest the attitudes of adults influence young people:

“Between peers I think they’re learning it from the adults that don’t know why they’re doing it…” Anna (SM)

Anna’s suggestion here suggests that stigma is so embedded within adult’s understanding of mental ill health that it is “hidden” or that there is a lack of critical inquiry into why this should be the case (Link & Phelan, 2014, p. 24). This is similar to Link and Phelan’s conceptualisation of stigma power in which power is understood as “misrecognised” or covert (Link & Phelan, 2014, p. 24; Bourdieu, 1990). This can also be seen in Foucault’s conceptualisation of power which is enacted through discourses embedded and reinforced within society.

Young people in this study highlighted the differences in generational attitudes to mental health:

“so like older people, or maybe older professors, teachers, they’re not understanding why some of their students aren’t coming to class…” Sansa (YP, Interview)

“my generation and the past generations, when we felt low for extended periods of time we were just told to ‘buck up’” Ross (YP, Interview)

Ross suggested that his generation have been affected by the attitudes of previous generations and Sansa highlighted a lack of understanding about mental ill health from those older than her. Zoe also highlighted key stigmatising attitudes were passed down by previous generations:

“I think certain people particularly older generations, they tend to see it as something sinful or abnormal or dangerous” Zoe (YP, Interview)

“I think it’s learned through socialisation from external sources and then you kind of self-reinforce it and it’s just a cycle” Zoe (YP, Interview)

Here Zoe draws on pervasive understandings of mental health as well as historical constructions of mental health and mental ill health being connected to a moral failing (Scull, 2015). Participants also suggested that because mental health was less spoken about in previous generations that parents, and grandparents felt ill equipped to help the young people in their lives:

“I feel like the older generation as well as like my grandpa… he didn’t know what to do about it” Violet (YP, Interview)

As a result, young people often felt dismissed:

“it’s like definitely from the older generation the amount of people who’ve said like “oh you’re too young to feel stress...” Tess (YP, Interview)

Tess demonstrates that older generations have particular difficulties in understanding young people’s experiences of mental health issues as they perceive young people to not have legitimate reasons for feeling stress or distress. She also highlights this could contribute to the reinforcement of these attitudes by those in power:

“I’ve actually experienced more stigma from middle aged people and that’s the age of all our politicians” Tess (YP)

This further highlights the role of the powerful in proliferating stigmatising discourses about mental health.

However other participants highlight that there is a generational change with young people becoming more aware:

“I guess it’s still in that transition of like, is it awrite to talk about it? I don’t quite know, like, I’ve lived through this period of time where it [mental ill health] was once different and noo we’re like ‘ok we can talk about it’” Nick (SM)

“I think now maybe in the past year I’ve seen older people come to terms with things… but it’s kinda just because our generation are more open to talking about our feelings” Penny (YP, Interview)

Some young people in this study believed that they have the power to change discourses and tackle stigma themselves due to the knowledge and skills that they have developed in talking about difficulties they face. This section has demonstrated that current stigmatising discourses about mental health are perpetuated by older generations. This is said to be due to a historical “hangover” of erroneous understandings of mental health which will now be discussed.

### 7.2.4 History

Participants highlighted that current stigmatising attitudes are remnants of historical understandings of mental health:

“I guess it’s cause it’s always been stigmatised and looked down upon… I mean it could be because there wasn’t a lot of awareness before… it’s always been, like, a taboo topic” Hotwheels (YP, Interview)

“dunno just think that’s the way it’s always been… I think in the past if someone was known to have a mental health issue they would be seen as incapable or you know less than other people… I think a lot of people thought it was for people that were crazy or psychopaths or whatever” Elaine (SM)

Hannah highlighted that even as someone working in the mental health system, she initially held attitudes based on past representations of mental health services:

“I think I look back historically… when I first worked for CAMHS I was expecting to go into a mental health asylum where it was going to look like ‘One Flew Over the Cuckoo’s Nest’” Hannah (SM)

Ross noted that the medicalised understanding of mental health comes from past discourses about it:

“it comes probably from a very historic view of mental health as being very medicalised and you have depression, anxiety, PTSD, bipolar disorder” Ross (YP, Interview)

While Ross suggested that a medicalised understanding of mental ill health is a “historic” view, I would argue this understanding remains dominant today within health services. The participants in this study suggested that historical understandings of mental health remain over time. This could be understood through the power of the discourses which construct mental health in specific ways. Stigma therefore could be understood as reinforced by powerful discourses embedded within societal structures of the media, culture and reinforced over time through generations. The discourses which construct mental health which were drawn on and referred to by participants will now be discussed in the following section.

## 7.3 Discourses that Construct Mental Ill Health

This section will discuss the discourses drawn on and referred to by participants which construct mental ill health. It should be noted that not all of these discourses could be understood as stigmatising, and some are used to demonstrate counter-discourses which could be used to undermine stigmatising ones.

Some participants suggested that mental ill health is stigmatised due to a lack of understanding about mental ill health:

“I think it’s not their fault, it’s less awareness, it’s probably not enough education” Kyra (SM)

Kyra points to a lack of understanding about mental health. There is a theme throughout the data about the need for more awareness and education about mental health in order to reduce stigma. They suggest that the way mental health is understood, or the lack of accurate understandings of mental health, leads to its stigmatisation. James suggests that this lack of understanding is due to the fact that mental health and illness cannot be directly observed by someone who has not experienced it:

“often stigma relates from lack of awareness, or prejudice or ignorance and it’s probably easier to be ignorant of someone’s mental health ‘cause it can be more easily hidden” James (SM)

James suggests there is not enough understanding about mental health because it is not obvious or visible. The invisibility of mental health is one such discourse that constructs understandings of mental health that will be discussed in this section. There have been many campaigns focussed on awareness raising and is a key aspect of Scottish anti-stigma campaigns (See Me, 2020). However, this lack of “accurate” understanding of mental health highlighted by participants could be understood through the pervasiveness of discourses which construct mental health in stigmatising ways, and the power these discourses have could be one reason that awareness raising campaigns have not yet countered the stigmatising constructions of mental ill health.

### 7.3.1 A Universal Experience?

The experience of mental health difficulties was constructed in several ways by participants. Some participants gave descriptions of what mental health meant to them in a way that was neutral and not situated within a medicalising discourse. One young person suggested that mental health is:

“Just emotions em feelings em mental state stuff like that” Tom (YP, Focus Group)

Tom frames mental health in neutral terms and does not give positive or negative adjectives to describe the presence of emotions or feelings. Similarly, another young person suggests that:

“mental health just your general wellbeing, your ability to function not just a case of being happy or unhappy cause you know they're appropriate depending on the scenario um but your ability to cope with life's stresses” Steven (YP, Interview)

Steven also highlights here that mental health is about an appropriate response to life events, which could include being happy or unhappy and his understanding of mental health is encompassing of all emotional states. Yvonne also gives a more general understanding of mental health:

“I want people to be thinking about just the way they are in the world, ‘cause that is mental health” Yvonne (SM)

For Yvonne, mental health is not a specific diagnosable or medical category. Yvonne frames mental health as a “way of being”. This ties in with other suggestions that mental health is something that everyone has:

“it’s about being mentally healthy and that everybody has mental health it’s not just about mental illness” Gabrielle (SM)

Anna also suggests that:

“if we all agree that everyone has mental health then I want to see sessions… in an old age pensioners group” Anna (SM)

Anna suggests here that this is a dominant discourse when she suggest that “everyone agrees” that mental health is a universal attribute that can be present at any stage of life, which is an idea found throughout mental health policy (See Me, 2019; Youth Mental Health Commission, 2019). She also suggests that if this is the case, she would like to see mental health being addressed in all areas of life.

The above examples demonstrate neutral conceptualisations of mental health as a universal experience framed as emotional reactions to life events. However, Yvonne highlights that there are competing discourses than those demonstrated here:

“I think things like See Me and anti-stigma campaigns have done a lot but there’s still a lot of ill-informed views and I think [there is] just this whole thing that mental health belongs to other people” Yvonne (SM)

While Yvonne notes that awareness raising and education has been a priority for anti-stigma campaigns, there is still a long way to go to incorporating the understanding of mental health as something that is a universal resource. She highlights that the understanding of mental health as an “othering” experience, or something that happens to “other people” still needs to be challenged. This is also suggested by Sansa who highlights:

“people who couldn’t get help or couldn’t afford medicine or afford therapy or find someone to connect and it was a big group of people and normal people, “normal” looked at them and be like you aren’t acting like a regular person… you aren’t in our box of normal therefore you must be abnormal” Sansa (YP, Interview)

Sansa highlights how she perceives mental health as defined as something that exists for other people and is perceived as something that is different or abnormal. This moves away from the conceptualisation of mental health as a universal experience and suggests that mental health issues are still considered by some as “other”, therefore leading to its stigmatisation (Goffman, 1963).

### 7.3.2 Physical Health Comparison

The above section introduced the construction of mental health as a universal experience, something that everyone has. However, mental health is consistently contrasted to physical health throughout the data:

“So, the best example I can give you is when we go into schools and we say... you know mental health, what comes to mind? So like word association, so whether you’re in P7 or 4th year they say depression, anxiety, suicide, some people even say like sociopath, they'll just say like really- and see if you ask the same question two minutes later, tell me word association health you know thinking your physical health, they say apples, hospital, water they don't say, there's no clinical- maybe twice in my life have I ever had the situation where their words have been a diagnosable condition like asthma or diabetes they don't they tend to focus more on the solution, prevention, early intervention what keeps us well” Isabelle (SM)

Isabelle uses the responses of the children and young people she works with to highlight their conflicting understandings of mental health and physical health. Physical health appears here to be something that everyone has, and that they know what they need to keep themselves physically healthy. However, the young people in Isabelle’s example use medical and diagnostic labels to describe mental health, which suggests that they do not associate mental health as something universal, but only think about the ways in which it can go wrong, or when it is different.

Participants use the example of physical health to demonstrate the differences in how mental health and physical health are treated and understood. Barbara suggests that the way mental health is spoken about is different to physical health:

“you’ll hear people saying oh I had to go to casualty last night I fell and I did whatever… you will never hear somebody come to the staff room and say last night I had a really difficult time, I felt really mentally unwell I had to go and speak to the emergency duty team” Barbara (SM)

Barbara suggests that mental health is not discussed in public in the same way as physical health is. Further, Mandy highlights that talking about mental health can lead to rejection from others when this is not the same for physical health:

“you're not stigmatised for physical health conditions if anything you get incredible empathy and sympathy whereas if you share a mental health condition in some work places it would seem you're isolated, immediately ostracised you know you're seen as different the stigma kicks in” Mandy (SM)

Other participants discuss the different experiences of physical illness in comparison to mental health issues:

“my father has like a chronic illness and it's different because you get frustrated but you get frustrated at the illness not at the person whereas sometimes when it's a mental health issue you get frustrated at the person as opposed to their illness so it's where you're directing your frustrations” Zoe (YP, Interview)

Zoe suggests here that physical illnesses can be separated from the person themselves, whereas mental illnesses, are understood as being linked to personality and subjectivity. Similarly, Tess suggests that others accept physical health issues more than they do for mental health issues:

“if you had to leave because you're having a panic attack like a lot of people would be like get over it it's just a lecture hall so stop attention seeking like you're fine but if it's diabetes it's a physical illness you could die but you can also die from mental health if it gets - if you lose control” Tess (YP, Interview)

According to Tess, mental health is not taken as seriously because it is not linked to an immediate risk of mortality, whereas physical health issues could be fatal. However, Tess notes that this is an erroneous assumption and that mental health issues can be very serious and should be treated as such.

Participants highlighted here that mental health issues are not treated in the same way as physical health issues. They demonstrate that they are not spoken about in the same ways and that physical health appears to be more easily spoken about, and taken more seriously than mental health issues. This dichotomy of mental health and physical health demonstrates a lack of prioritising of mental health and contributes to stigmatising and delegitimising discourses around mental health.

#### 7.3.2.1 The Broken Bone Analogy

Similar to the comparison of physical health to mental health as above, a regular comparison of a broken leg was regularly utilised. The broken bone analogy is used by larger organisations, who have some power over the construction and use of discourses to shape understanding which could explain why so many participants had heard and used the analogy. For example, the Scottish anti-stigma campaign suggests that: “A broken leg takes time and medical support to heal. A broken mind is no different.” (See Me Scotland, 2019). The anti-stigma campaign suggests that just like a broken leg, mental health issues require support and there is no judgement for seeking medical support in either of these situations.

Kyra explains her use of the broken leg analogy to help draw similarities between seeking help for physical and mental health:

“I always give that example as well, a broken leg, it's the best example. You would know it if it was broken you'd know I can't walk on my leg but if I'm not feeling ok today would you know that? No, it's hard to pick up but if you know it then you should treat it as well then” Kyra (SM)

Kyra notes that a broken leg can stop you from doing things and so can mental health issues, and so just as help would be sought for a broken leg, so too should this happen for mental health. She does highlight though that mental health issues can be hard to identify, suggesting that this lack of clarity is a key difference between mental and physical health.

Danielle uses the broken leg analogy to highlight a similar point:

“We know its ok to contact emergency services, you know you’re not going to get into trouble if you call somebody if I’ve broke my leg, we don’t have the same connotations in relation to mental health” Danielle (SM)

Through this analogy Danielle highlights that asking for help for a broken leg is viewed as acceptable, but that this is not always the case for a mental health issue and suggests that this is not how it should be. Tom also uses the broken leg analogy by highlighting that it is just as important to seek help for mental health issues as it is for a broken leg:

“like if I break my leg and don't get it fixed it causes mare problems and it'll take longer tae heal and stuff like that and obviously mental health is similar to that like if you don't find help it can get worse and can lead tae it getting worse” Tom (YP)

While the above participants suggest that getting help for mental health issues should be considered the same as getting help for a broken leg, this is not what actually happens. Ross uses the broken leg analogy to highlight the differences in access to treatment between physical and mental health concerns:

“so just like somebody doesn't choose to go out and break their leg, someone doesn't choose to go out and get depressed or anxious I know that when... so my mum broke her leg last summer so it's a really like topic anecdote she broke her leg last summer and because of the trauma that she went through with that she got a counselling appointment two weeks after she was out of hospital she waited no time at all, she's struggled with depression and anxiety for quite a few years and when she first accessed counselling for that she was on a waiting list for nine months so there's definitely a discrepancy in that case” Ross (YP)

Participants use the broken leg to highlight the differences between mental health treatment and the treatment of physical health issues:

“when it comes to physical health there's a definite, like if you've hurt your leg there's a definite answer you've hurt your leg, you've hurt bones but I think with mental health it's like a scale people can have slightly poor mental health or people can be at the other end of the spectrum and are unbelievably - but everyone has different thresholds and kinda like I don't wanna say breaking points but that sort of thing so because it's an evaluation it's your opinion about how you feel about yourself that it can be quite hard to get your point across and that sort of thing, it's more of a spectrum than a definite answer” Xander (YP, Focus Group)

Xander explained that experiencing mental ill health is a subjective experience and can be different for different people, however this is not the same as breaking a leg. It should also be highlighted that a person seeking help for a broken leg would not be refused treatment, and there are not the same eligibility criteria as there is for mental health support. Emilia highlighted that the treatment for a broken leg will work the same for everyone, however this is not the case for mental ill health:

“I think because there is a procedure to help with a broken leg that's specific and everyone kind of fits that way of healing it but with mental health it's very very different so I think like I don't know if this is a very extreme example but like you know with like treatments for cancer for example everyone responds differently to treatment and you need to use different methods I guess for different types and things I don't know like if that would be a more, I don't know how to word this sorry, I think just kinda that idea that not one size fits all with mental health whereas one size kinda does fit all for a broken leg” Emilia (YP, Focus Group)

Penny discussed the time limit of breaking a leg, that the bone will eventually heal, however this is not always the case with mental health:

“you could break your arm and then have it heal and then break your arm five times again and have it heal but then break it again, but you don't know you're going to break your arm 5 times again, I know this is going to come back I know I'm going to feel bad again at some point because I know the way I get…” Penny (YP, Interview)

Penny understand mental health as something that cannot be fixed or cured as a broken bone can.

James highlighted a problem with the equation of a broken leg to a broken mind:

“I shy away from it slightly. Is the broken leg as opposed to a sort of broken mind? It's a horrible phrase, it maybe implies a little bit too much that it's a very serious thing that needs clinically attended to, so I think that’s also something we want to be careful of is the sort of over medicalisation and often when we talk of stigma prevents help seeking, often that's sort of saying it prevents help-seeking because we don't go to a psychiatrist or a psychologist or a GP but I think maybe that's taking it a little bit too far, to sort of over medicalising what might be a problem of loneliness or a social problem” James (SM)

James highlights that equating the treatment of a broken leg with the treatment of mental health issues is problematic and connects mental health issues with an overly clinical or medical understanding. He suggests that a clinical intervention, while usually required for a broken leg, is not always an appropriate response to mental ill health, particularly as he points to social causes for mental distress. The medical model is a prevalent discourse and the next section will go on to discuss this understanding of mental health. This concept of equating mental ill health to a broken bone was found consistently throughout the data and participants had a lot to say about it. There appears to be some participants who suggest it is beneficial as it “normalises” seeking help for mental ill health just as one would seek help for a broken bone. However, for many others this discourse which connects mental ill health to a physical ailment is problematic due to the lack of equitability between these problems as well as the responses to each of these issues from health care settings.

#### 7.3.2.2 An Invisible Illness

It was demonstrated above that in order to understand mental health, physical health was regularly used as a comparison. Mental health and physical health were regularly compared throughout the interviews to demonstrate the differences in how mental health is understood. The discourse of mental illness as invisible was connected to the use of the broken leg analogy discussed above. This was used to demonstrate a physical health issue that can be seen and measured objectively,

“a lot of people say if I had a broken leg people would understand and I understand that this is just as important or serious as a broken leg, and I don’t visually represent that to people so people don’t know whether to be kind for me” Anna (SM)

We see the importance of being able to directly observe an illness in Anna’s use of the broken leg analogy here. She suggests that people can see and understand the impact a broken leg can have on a person, and that a mental health issue is just as important to be taken care of as a broken leg. However, she also highlights that there is a difference as mental health cannot always be directly observed in the same way a broken bone can, and so people do not respond with sympathy.

Mental health is understood as something that is harder to prove and requires more evidence of its impact on people before help is offered. While not all physical health issues are visible, there is the perception that they can be observed directly by medical experts, whereas mental health issues were constructed as subjective and difficult to measure:

“I also think because maybe it's not visible you can't see it, like physical health, it's not taken as seriously or people don't really understand it that way people think it's in your head you can't really see what someone's going through so I think it's something that people don't take as seriously as physical health” Xander (YP, Focus Group)

Xander demonstrates here that he conceptualises physical health as something that can be seen, but mental health is not, which affects the way it is understood. Participants felt that one of the reasons that mental health is stigmatised, and treated differently to physical health is because of its invisibility:

“I think with our mental health there’s more of a stigma around that because it feels like an abstract concept because we can’t see it… it feels less tangible so it’s more open to interpretation” Isabelle (SM)

Isabelle suggested that because it cannot be objectively observed or measured necessarily, that mental health issues are not as well understood. She also goes on to say that:

“our mental health is much more related to our identity and who we are in the world isn't it so like our personality and our mood and our social interactions and everything about being alive that's not your physical body so I think there's something about any kind of like diversity around what is normal it's harder to interact with it” Isabelle (SM)

Isabelle highlights that mental health is related to our subjective experiences of life which makes it more difficult to understand and relate with if it is not the same as what is classified as “normal”. This could suggest that because of a medicalised understanding of mental health there is a disconnect between positivist understandings of illness, which focuses on what can be directly observed, and how mental health can be understood, which in itself is a subjective experience that cannot be measured. This could suggest that there is a dissonance between the medical model’s construction of mental health issues as an illness and how mental health issues manifest.

Other participants highlight that because mental health issues are not always directly observable it leads to the subject of mental health being more easily ignored:

“there's a whole thing about it being invisible illness a lot of the time so and I think people haven't really talked about it much until more recently it's just kind of been another thing that's just pushed away” Violet (YP, Interview)

Violet suggests that because mental health issues cannot be directly observed, that it is easier to hide and not discuss them which has contributed to the subject being taboo or something that does not require attention.

Fiona extends this understanding further by suggesting that because mental health issues can be easily hidden and are not always directly observable, that this benefits those who have power over deciding which services to fund:

“is it easier to make people wait for so long and cut services because it’s kind of a hidden illness… it’s not prioritised as it should be” Fiona (SM)

Participants in this study highlight that one of the reasons mental health is not understood is because it is easily hidden and not always directly observable. This could have ties to Link and Phelan’s (2014) understanding of stigma power. In this instance stigma is covert, and could be being used as a way of keeping people “down, in or away” (Link and Phelan, 2014, p. 25). The dominance of a positivist and medicalised view of mental health gives legitimacy to illnesses that can be directly observed or measured through scientific means, however the discourse of mental health issues as something that is “invisible” suggests that it cannot be directly observed, and is experienced subjectively, delegitimises people who experience mental health issues as well as their value in society and the power they have to legitimately access resources and support.

#### 7.3.2.3 Fear of Mental Ill Health

The theme of fear is prevalent throughout the data and participants connect with the invisibility and misunderstandings of mental health. Zoe suggests that fear and misunderstandings are linked:

“people are always scared of things that they don’t understand” Zoe (YP, Interview)

Gabrielle highlights a similar connection:

“there is a misunderstanding about mental health and people are afraid, I think discrimination comes from a place of fear and misunderstanding” Gabrielle (SM)

Here we can see that Gabrielle suggests that fear and misunderstandings about mental health contribute to the stigmatisation of people with mental health issues. Our understandings about mental health include discourses that construct people with mental health issues as holding the potential for dangerousness and violence (Corrigan & Watson, 2002; Angermeyer et al., 2003; Feldman & Crandall, 2007). This is also demonstrated by Steven:

“that might be because they think that they’re um dangerous or it’s upsetting, maybe it’s just very awkward it’s just very awkward to talk about personal problems” Steven (YP, Interview)

Steven shows that negative reactions to individuals with mental health issues can range from discomfort, upset or even the assumption that they will be a danger towards others. Mental health is constructed as something to be feared. Catherine connects feeling fearful with understanding mental health only in terms of it as an illness:

“so people… traditionally don’t really understand mental health, they know of it as a concept but they tend to think of it when it goes wrong rather than in terms of it being an asset… and those are scary bad things to some people especially if you don’t understand them” Catherine (SM)

Participants also suggest that discomfort and being unsure about what is going to happen is also a prevailing factor in feeling fearful of interacting with people with mental health issues:

“I wonder if stigma’s related to that there’s a feeling of being out of your depth and distress is very uncomfortable and we assume or catastrophise” Isabelle (SM)

Isabelle suggests that when people feel uncomfortable, they will assume something bad is about to happen which can lead to the feeling of fear and desire to avoid people with mental health issues. These participants show that the way mental health issues are constructed are erroneous and this leads to being fearful of people with mental ill health.

Participants also highlight the connection of fear with the construction of mental health issues as invisible, as discussed above:

“I think there is a fear, because it’s invisible your GP won’t understand it or just give you medication” Fiona (SM)

Fiona suggests here, that people are afraid to seek support for mental health issues (as discussed above) because they feel that doctors operate under a medical model that assumes an ability to directly observe mental health issues, but this is not always the case. Fiona also demonstrates a stigma of receiving medication here and the perception that “just” receiving medication is an inadequate response. As demonstrated above, mental health issues are seen as a subjective experience and the lack of understanding this leads to, can also lead to fear as demonstrated by Lilly:

“it's the fear you can kind of logically understand how someone breaks their leg but you can't understand why someone develops depression or anxiety it's that kind of there's not really an answer as to how or not really a straightforward answer as to how depends on what circumstances that person has going on for them” Lilly (SM)

In Madness and Civilisation, Foucault suggests that society became afraid of mad people through the same mechanism that they became fearful of people with leprosy, that they feared transmission of disease (Foucault, 1965). He suggests that institutions which set to contain people with mental health issues was part of a protective move to contain and prevent the spread of disease (Foucault, 1965). This is similar to an argument made by Corrigan, Kerr and Knudsen (2005) who suggest that stigma functions to legitimise the existence of institutions and the containment of people with mental health issues within them. They also suggest that stigma serves an evolutionary role of maintaining the safety of “in group” members by ostracising “outgroup” members who do appear to be behaving differently (Corrigan, Kerr and Knudsen, 2005). Mandy suggests in the quote below, that behaviour can act as a way of indicating mental ill health and leads to fear:

“I think there are some times when somebody’s quite unwell, their behaviour can be challenging, it can be difficult… you can understand why people are fearful at times because it’s that lack of understanding” Mandy (SM)

Nick highlighted the connectedness of misunderstanding mental health, mental health issues as an invisible illness and fear. He suggests that engaging in conversations about mental health issues are often difficult and create a sense of fear because, unlike a visible issue like a broken leg, because there is a lack of understanding about how mental health issues are caused:

“People are I guess also quite scared in terms of you know if you had two people sitting one with a mental health problem one with like a leg break or whatever you might turn around and say how did that happen but you might not turn around and say how did that happen you know you kinda fear the answer whereas you know the answer you might get from somebody's that's broke their leg is like oh I was away playing football, skate boarding, dancing, fell whereas the answer you might get from someone with mental health might fear or scare other people to say what is wrong ” Nick (SM)

The participants in this study often drew on comparisons of physical and mental ill health to demonstrate the differences between them. Mental health is understood as something which is in contrast with physical health in terms of accessing treatment, its lack of visibility and the subjective experience of mental health that cannot always be objectively observed. It is therefore suggested that because mental ill health is not understood in the same way as physical illnesses, leads to reactions of fear towards those experiencing mental ill health. . The use of physical health as a contrast in participants conceptualisations of mental health, suggests that it is not understood through a medical framework as physical health is. However, this was not the case as participants also suggest that mental ill health is often overly conceptualised through a medicalised framework and that this is often inappropriate. The following section will now discuss this potentially contradictory discourse.

### 7.3.3 Medicalising Distress

This section discusses the ways in which participants suggested that emotional distress has become medicalised. Participants highlighted the equation of mental health with mental illness throughout this study. It has been argued that mental health and mental illness are two distinct, separate ways of understanding mental health (Westerof & Keyes, 2010). However, the participants in this study highlight that this is not an understanding of mental health that prevails within dominant discourses. This is contradictory to the above suggestion that mental health is something that everyone has, and instead constructs mental health as something that is understood as “other”. Members of staff suggested that when they speak to young people about mental health, they tend to focus on illness or different clinical diagnoses:

“when you mention mental health they [young people] talk about mental illness” Gabrielle (SM)

Another staff member suggested that that negative emotions are understood within a frame of pathology and clinical intervention:

“yeah I definitely see stigma within families I definitely do, of something that maybe someone was able to cope with maybe someone seeks help and that's a difference, what's the difference between someone with depression and someone just being moody and doesn’t want to engage” Hannah (SM)

Hannah noted that parents are often concerned with their children’s behaviour and seek clinical help for this, when sometimes she feels their child is exhibiting “normal” teenage behaviour, such as moodiness. She posed the question of how not wanting to engage and being moody can be differentiated from a clinical diagnosis of depression. Hannah suggested that what may could been understood as a young person exhibiting normal behaviours for their developmental age, is becoming more understood as a clinical or pathological problem that needs intervention.

Isabelle highlights that she is keen to change the assumption of a clinical level of distress:

“one of the things I'm trying to do is to change the dialogue around that so it becomes more about not all emotional distress is clinical, life has serious ups and downs and how do you find your edge and know what's clinical or what's not and normalising ups and downs I think and taking a self- management approach” Isabelle (SM)

Isabelle suggested a more open dialogue about what a “normal” reaction to a life event would be with greater discussion of how to manage emotions in a non-clinical way. Isabelle suggests a more holistic understanding of the social issues impacting young people is required, and suggests that a dependence on medical help is not always appropriate:

“we have an over focus on clinical interventions rather than societal relationship based and attitudes so I think that we're there in terms of you know that we think about it a lot but I think that what often people try and do is try to depoliticise the work around young people's mental health and I just don't believe that it's possible, you canny separate it from housing and education and - it's seen as such a health issue and it's not for me it is a political issue, it's a long term political issue it's not 100 more counsellors, that's my worry” Isabelle (SM)

Lilly highlighted a key issue for the young people she works with who have experiences of disordered eating:

“like because they’re not the stereotypical person who looks like they have an eating disorder then therefore they find it even harder to get help and even services don’t see them as needing help…one of them talks about their experience of not fitting the image of what an eating disorder would look like and that barrier of not getting help because they don't look like what people think they would look like” Lilly (SM)

The clinical diagnostic criterion works against some of the young people Lilly has worked with because they do not fit the perception of what a person with an eating disorder should look like. In this instance the rigid terms of the diagnostic criteria can prevent access to the required medical help.

Mandy highlighted that for her the best way of overcoming this issue is to listen to the individual and find out what is “normal” for them:

“so there is a bit about over medicalisation for some not for all, but the key thing for me is actually allowing people to talk about what is affecting them and not being overly quick to make a judgement about that but actually listen, understand and provide a compassionate response” Mandy (SM)

Mandy suggested practitioners should prioritise the individual and their needs, rather than finding a diagnosis.

Participants highlight that the medicalisation of distress is due to the dominance of the medical model of understanding mental health:

“I would say we’re still working to a very medical model of mental illness and we don’t really think about the social model of mental health…” Yvonne (SM)

Steven suggested that the medical model is not currently helpful for people in ensure adequate access to help and support:

“whatever we're doing right now isn't working very well and so it doesn't look great for the medical model I think we kind of have to um stop treating it that way and perhaps there's things that can help but maybe it is part of life for some people” Steven (YP, Interview)

Similar to Steven’s suggestion that mental health issues could be “part of life”, Emilia highlights her uncertainty about the way mental health is discussed in terms of diagnostic understandings of emotion that can be explained by life events:

“I think if it's not explained properly like… with depression because depression is characterised by low mood and obviously if someone has gone through a hard period in their life and they have been sad for a couple of days they might instantly think like oh that's me I have depression, like you say it's a side effect they might assume because they have that one symptom, and I'm not saying that talking about mental health is bad, I'm very very for it but I think sometimes you need to be careful like what you're um how you characterise it in the media and things” Emilia (YP, Focus Group)

Several of the extracts above suggest that identifying the differences between clinical and “normal”, and non-clinical responses to life events needs to be understood more clearly, however William highlighted that what is “normal” or not is not always agreed upon:

“I think these days with social media and stuff we’re starting to learn that what society's ideas of what’s normal aren't certain, like subcultures or other cultures idea of normal, so it kinda like blurs the lines and usually we'd be like well nobody in this culture acts like that so that's no’ normal but it is normal it's just how somebody else reacts, so me personally when I go through grief I do this whole like snappy one minute laughing at the next … other people go through anger and especially with anger that's no really seen as normal and if they punch something it's seen as impulsive rather than they're upset they've got a reason to it” William (YP, Focus Group)

Participants also highlighted that this medicalised understanding of mental ill health leads to stigma. Oscar highlighted that in general mental health is understood mainly in terms of when it “goes wrong”:

“But I also think when people think of mental health, they're thinking of the bad stuff they're not really thinking of the good like when they say mental health I think of straight away like depression and dying don't think of good things, that's the way it's portrayed in media as well all just the bad stuff” Oscar (YP, Focus Group)

Oscar highlights that mental health is often equated with mental illnesses, which in turn has negative connotations. Participants suggested that this understanding of mental health in terms of mental illness and medical terminology, leads to stigma:

“there’s a stigma around kinda like more pronounced presentations of mental health problems – it’s ok for us to be like vulnerable as long as it’s poetic on Instagram” Isabelle (SM)

Isabelle highlighted an intrinsic and taken for granted link between stigma and mental ill health because of the negative connotations around an illness that is serious and in need of clinical intervention.

### 7.3.4 Constructions of Young People and Their Mental Health

This section aims to contextualise young people’s lives in Scotland. Media reports currently suggest that young people’s mental health is in crisis (O’Hara, 2018; Shraer, 2019; Coughlan, 2020). Participants often drew on this discourse, as well as evidencing their own experience of young people’s mental health crises:

“maybe the earlier intervention approach is better for that school and that is in a region with the highest teen suicides in the past year, so there were 11 teen suicides in this region with that school so I’m linked between that school and that college for that reason” Anna (SM)

Anna demonstrates a high level of suicide rates at this particular school and this demonstrates that young people can be understood as experiencing a high level of emotional distress. Participants gave explanations of why young people may be experiencing higher levels of emotional distress and mental ill health than previous generations. This section will demonstrate that young people who experience mental ill health face many layers of inequality and are subject of various discourses and to material conditions that devalue and disadvantage them. This will be demonstrated by discussing how participants constructed the lives of young people. This section will discuss how young people were constructed as developing by some staff members and the critiques of this construction will be examined. It will be then demonstrated that discourses that situate young people in crisis and in greater need of resilience were used by participants. Participants’ perceptions of young people’s relationship with and ability to talk about mental health will then be discussed. Finally, young people’s reports of inequality and poverty will be discussed.

## 7.4.1 Listening to Young People

Miranda Fricker’s describes epistemic injustice as “a wrong done to someone specifically in their capacity as a knower” (Fricker, 2007, pg.1). Arguably, young people with mental ill health experience layers of epistemic injustice, as a result of how both young people and mental health are constructed by powerful discourses (Coppock, 2020; Crichton, Carel & Kidd, 2016; LeFrançois & Coppock, 2014). Overcoming this epistemic injustice involves listening to those whose testimony and knowledge are undervalued. Many participants highlighted that listening young people was of key importance:

“Yeah I think I'm learning more and more about getting young voices is so important… I want to hear young Scottish voices ‘cause we don't hear them” Hannah (SM)

Hannah highlights that in the resources she uses with the young people she supports the voices are English or American, but that young people from Scotland are rarely featured and under-represented. It is for this reason I aimed to transcribe the interviews verbatim, to include colloquialisms and accent particularities in order to fully represent the participants of this study. Anna highlights that decisions are often made about young people without including them in the conversation:

“young people who might not advocate for themselves or be in the room when teachers are using stigmatising language” Anna (YP)

Anna highlights that young people may not be given the opportunity to say what they want or need and that teachers can use stigmatising language about them because they are not consulted. Young people are often kept out of conversations about their lives which reduces the power they have to participate in decisions that are made about them. Fiona highlighted that while some young people are consulted, they do not always know what will happen to their information and do not see changes to their lives which can result in a feeling of tokenistic inclusion in consultations:

“there was a couple of young people who spoke about (pause) asking me where does this information go? Just feeling like sometimes people come and talk to us and get all this really personal information and then we never see what happens… we never see anything changing” Fiona (SM)

This suggests that while it is important to consult young people about things that affect them, if not conducted ethically it can be perceived as tokenistic. If young people do not see direct benefit to their lives, or are consulted but not then fully informed about what their contribution and information will be used for, this undervalues young people and their contribution in research.

Participants highlighted that asking young people about their experiences of mental ill health was valuable:

“it seems that young people are articulate and more able to describe their experiences and the experiences and feelings of others” Anna (SM)

Anna suggests that the young people she works with have a better ability to talk about their feelings than they did when she was at school and college. Young people who participated in this study also suggested that young people can articulate their feelings better than previous generations:

“I think we have a lot of social pressure and things now wi’ things like social media and then eh we just are open to a lot more than maybe our parents were, but also they maybe didn't really talk about it, maybe people were feeling down or stressed or had some anxieties but never really talked about it just kept it to thereself because maybe they would be seen as weak or that sort of thing” Xander (YP, Focus Group)

Xander suggests that his generation, while having more pressures placed on them, are more willing and able to discuss how they feel and their mental health than their parents were. Ross suggests that young people’s interest and ability to talk about mental health is influencing older generations and policy:

“I think the young people are learning to articulate things they might not have fully understood before so it's feeding its way from the bottom up…mental health has always been an issue there but it's becoming more prevalent as like the number one thing talked about amongst young people” Ross (YP, Interview)

Ross suggests that awareness of mental health and young people being able to talk about it has increased the priority of it for others. It is difficult to determine whether young people are talking about it because it is affecting them more than it has in the past however Ross’ suggestion that young people are changing the discourse about mental health is a positive understanding of the situation.

### 7.4.2 Pathologizing Young People

It was highlighted by several participants that the suggestion that young people’s mental health is in crisis has created an uncertainty about what is “normal” behaviour and emotions for young people and what requires clinical intervention:

“there's something around young people hearing a lot about mental health and are losing sight a little bit of what's normal and a normal response to something before they're diagnosed or diagnose themselves and access mental health treatment” Hannah (SM)

Steven highlights that life is tricky for young people, but that it is not always clinical:

“as you're growing up and past the age of 18 life is difficult and it is emotional and we will get depressed and anxious over it and that is part of growing up maybe umm of course it could be clinical as well it could be extremely serious but some people would argue that it is a stage in life too” Steven (YP, Interview)

This suggests that mental health literacy would benefit from informing young people about when their behaviour or emotions require clinical interventions and when other forms of support should be sought. Isabelle also highlights issues with current mental health literacy programmes:

“teachers say this all the time, they're saying their depressed and anxious and they're self-diagnosing because we've taught them all these words” Isabelle (SM)

This comment was based on her experience of going into schools and speaking to young people in schools about mental health and stigma.

Isabelle suggested that young people use clinical diagnoses to describe and articulate how they are feeling because these are the words they have been equipped with. Isabelle also goes on to suggest that this can lead to young people’s experience being pathologized, again suggesting a dominant medical discourse. Similarly, Danielle demonstrates that:

“what we have at the moment is a situation in Scotland where young people are saying that they are experiencing depression, anxiety the referrals are getting put into clinical services, young people are waiting a long time for clinical services and it’s about that self-fulfilling prophecy” Danielle (SM)

Danielle suggests that young people are using clinical terminology to describe what they are going through, which has led to an increase in CAMHS referrals. However, she also highlights that while support may be necessary for young people, it is not always necessary to refer them to CAMHS:

“just because you invest in clinical services, you’re actually not supporting prevention or early intervention, you’re medicalising and making it a clinical issue rather than everybody’s issue” Danielle (SM)

This is also highlighted by an account given by Yvonne:

“a colleague of mine works with young people she was doing a pilot in a GP practice, a young guy came with his mum and they had a pilot where they could see a GP or see a psychologist so she was seeing this young man, and he was avoiding school and he was really anxious so she spoke to him and he said I'm really scared because I feel I'm attracted to other men and I feel that's a bit freaking and odd and she was able to say look you're exploring your sexuality, that's perfectly normal and I'm not worried about you and so she normalised something for him, and when she spoke to the GP, because part of the pilot was what would the GP do, what would the psychologists do, and the GP said I would have referred him to CAMHS so actually by doing that what you just said to that young man, yeah it is a problem, you're going to have to see a specialist CAMHS would have looked at the referral and gone well it's not a priority we put him on the waiting list, meanwhile the poor guy's like there's something wrong with me and six months later I'm still waiting, I was avoiding school, now I'm definitely not going cause there is something wrong with me so you can see, I think that first conversation with the young person and then how you formulate together what's going on here is so important” Yvonne (SM)

Yvonne ’s example and other participants in this study demonstrates that the clinical focus on mental health has led to greater need for clinical intervention for young people leading to longer waiting lists and the perception that young people’s mental health is in crisis. However, young people’s emotions and behaviour are not always pathological and clinical intervention is not always an appropriate or necessary approach.

This section has demonstrated how young people and their mental health are understood by the participants in this study, as well as examining the factors that participants believed to be important for affecting their mental health in the context of Scotland. This chapter will now go on to discuss how the young people consulted for this study understand and experience mental health stigma.

### 7.4.3 Young People: Beings and Becomings

Key to sociological theorising about young people is the notion of children as “beings” or “becomings” (Uprichard, 2008; Mayall, 1994; Wyness, 2019). The construction of children as “being” suggests that they are social actors with the capacity to exercise agency (Uprichard, 2008; Wyness, 2019). The construction of children as “becomings” however is highlighted as being an intrinsic part of dominant discourses that construct children as important because of who they will become (an adult), rather than who they are now (Uprichard, 2008; Wyness, 2019). Discourses about children as developmentally lacking in comparison to adults, and the importance of socialisation in young people’s development contribute to this construction of children and young people (Prout & James, 1997; Wyness, 2019). Critics of this dominant discourse suggest constructing young people as “becomings” undermines their current competencies and leads to the under investigation of issues that affect children (Prout & James, 1997; Wyness, 2019). Adolescence is conceptualised as an extension of childhood, reinforcing the dominant construction of young people as ‘not-quite adults’ which leads to their devaluation and undermines their potential to exercise agency (Mayall, 2000; Erikson, 1965).

Some staff members in this study conceptualised young people within the dominant discourse of children as becomings:

“how do we reduce the prevalence of mental health problems in our children and young people, tomorrows adults” Isabelle (SM)

Here Isabelle constructs children and young people explicitly as “tomorrows adults”. This construction could suggest that improving the mental health of young people is a valuable endeavour because of the adults with mental ill health that they will become if their mental health is not improved, not because of the distress they experience now. Danielle also frames young people as “becomings”, rather than “beings”:

“for young people I genuinely believe there’s real risk because of the developing body and mind…” Danielle (SM)

Here Danielle frames young people as the adults they have yet to become due to their continued development. The perception that young people have not become fully adult is used to explain higher levels of risk of mental ill health. Isabelle and Danielle frame young people as “becomings” which could undermine their value as people with agency and capabilities. This construction is often based in the presumption of protection, which is particularly highlighted by Danielle’s reference to risk, however this can act as a barrier to young people’s opportunity to exercise agency (James, Jenks & Prout, 1992). It has been suggested in previous research that the discourse of adults acting in the “best interest” for young people removes active participation in decision making for these young people (LeFrançois & Coppock, 2014).

A criticism of the dominance of focus on children’s development is that it suggests a lack of competence, which can only be overcome by reaching adulthood (James, Jenks & Prout, 1998). This can be seen in Danielle’s assertion that young people are incapable of understanding the complexities of mental health:

“children and young people are lacking an ability to articulate how they feel… and they lack an understanding of mental health, they often associate mental health with mental illness” Danielle (SM)

Danielle suggests that young people cannot understand mental health, however this is contradicted by other participants as demonstrated above.

This understanding of young people as incapable can also extend to their ability to experience mental ill health. This is highlighted by Tess who suggested that her mother’s boyfriend does not believe that young people can feel stressed:

“my mum's boyfriend, I was like oh you know I'm feeling stressed today can I just have some space so I don't lose it and he was like oh you're too young to feel stress and I feel like that's stigma, his own stigma against mental health, it's like young people don't feel mental health” Tess (YP, Interview)

This highlights her mother’s partner’s understanding of mental health as something that you only experience when you are older, perhaps as a result of the pressure of adult life, and Tess describes feeling dismissed. These attitudes highlight that young people experience dismissal based on how adults understand what it means to be young person.

Other young people highlight their own experiences of this perception of young people as incapable:

“I think they talk about young people like we're stupid sometimes like most of the time” Oscar (YP, Focus Group)

Tess ties her dismissive interactions with adults as down to their understandings of young people as “developing”:

“That they should be taken more seriously, that just because they're a young person doesn't mean that they know nothing and they're stupid and they're just over sensitive because they're going through hormone changes or that their struggles are invalid just because they're young like I feel that is one of the main things” Tess (YP, Interview)

Orpheus suggests that she is not treated with respect when interacting with adults:

“I tend to be mocked more and made the victim when I'm talking to adults and yeah it's kinda just shitty” Orpheus (YP, Interview)

Orpheus suggests that she is not treated with respect and is made fun of, or she is treated as though she is a “victim”. The word victim suggests that adults perceive Orpheus as helpless and passive in the things that happen to her. Both not taking her experiences seriously through “mocking” and treating her as a victim undermine her agency.

Danielle also mentions this and suggests that young people being dismissed and not being treated the same as adults with mental ill health is stigmatising:

“That’s stigma and discrimination because you’re treating a child differently to how you would treat an adult if they presented just because they’re a child but you’re applying a level of stigma to them just because they’re young they’ve nothing to be concerned about” Danielle (SM)

Danielle’s understanding of young people here appears to suggest that while young people can experience mental ill health, they do not have the capability to understand or describe these experiences.

### 7.4.4 Experiences of Stress & Distress

Further to constructions of young people experiencing high levels of mental ill health it has been demonstrated by The Mental Health Foundation that 60% of young people experienced stress due to pressure to perform well at school. This study also found 45% of young people felt stress about body image (Mental Health Foundation, 2018). Participants in the current study also conceptualised young people as particularly at risk of stress and mental distress:

“young people are always hard done by parents by schools and they're always complaining that it's hard, but it is, it can really be quite hard and tough as a young person. You go through quite a lot not just mentally but your whole body's completely changing and sometimes it's just that aspect of who you grow up wi’, what support you've got, to then how even harder it can be for somebody growing up” Nick (SM)

Nick draws on ideas of youth and adolescence being a universal experience, by suggesting no matter when a person grows up the experience is “always” hard (James, Jenks & Prout, 1992). Similar to Danielle’s suggestion above, Nick places importance on the “developing body and mind” in creating this hardship. Nick’s conceptualisation of young people is that they will always face a level of crisis because of the interrelationship between the difficulty of “development” and being unsupported by a lack of social supports. It must be noted that Nick was under 25 when interviewed, and referred to his own experiences as a young person throughout, as well as his experience of working to support young people in a national organisation. This is important because he is not removed from what it is like to be a young person and is reflecting on his own experiences in which development was framed as a key concern. Despite the above criticisms of understanding young people solely as “becomings”, Nick’s statement would suggest that utilisation of theory that does not take effects of the developmental, physical and mental changes that occur could be a disservice to young people, therefore both of these aspects of young people are required for our understandings (Uprichard, 2008).

Nick does note the importance of social support on how well an individual is able to cope with these developmental changes and transitions. Other participants also highlighted the role of social factors on young people’s stress:

“Yeah I think life's more stressful for young people going through school and so much pressure being put on attainment and exams and league tables and things I think there's a lot of pressure being put on young people” Ross (YP, Interview)

“part of what has got us to the point that children and young people’s mental health isn’t as it should be is the pressure they put on themselves to do well in their exams to get a job in a really difficult financial climate, to worry about the world going up in a ball of flames because of climate change…” Catherine (SM)

Ross and Catherine highlight that young people experience stress due to pressures of school and educational performance, which is similar to the findings from the study carried out by the Mental Health Foundation (2018). Catherine goes on to suggest that pressure at school is a result of the precarity of employment in an unstable economic environment. She also highlights a key concern for young people about the climate emergency. The impact of concerns about climate change on young people’s mental health were also highlighted by Tess:

“I do feel like there's a lot of unpredictable things especially climate change, I feel like this whole climate change cause that's the focus on young people, is affecting a lot of young people's mental health because there's so many young people I've spoken to who are like oh my gosh I'm terrified like I can't sleep at night because of it and they're saying that it's making them more anxious or depressed because they are so worried about our future” Tess (YP, Interview)

Tess highlights that understanding young people’s concerns about their future is important. Catherine and Tess place importance on precarious and uncertain socio-political, economic and environmental factors in increasing the stress of young people. They do not construct young people’s distress in a frame of developmental incapacity to deal with this uncertainty, but focus more on what is affecting young people now. However, they still acknowledge the temporality of youth and concern for young people’s future, in terms of future jobs and the future survival of the planet. From this data it would suggest that following Uprichard’s (date) suggestion of conceptualising young people as both “beings” and “becomings” allows young people both the acknowledgement of their agency and capabilities without suggesting their own concerns about developmental changes and future potential as unimportant (Uprichard, 2008).

Another instance of stress was highlighted by Tom, who suggested that where he lived had an impact on his mental health and made it more difficult to do things to look after his mental health:

“you grow up in the east end eh Glesga’, aw scheme territorial, and my doctors said have you tried goin’ ootside have you tried goin’ a walk? I'm like mate I walked tae the corner shop and there was a fuckin’ young team hanging aboot it man I end up nearly stabbed fae it… that put me off goin’ ootside for a long time. [The GP would ask] “How come you don't get a bus or public transport?” [I responded] “‘Cause the last time I went on a bus the windaes git panned in. Livin’ here my fuckin stress levels have went pure high” \*chuckles\* so there's stuff like that. I have tae gie them answers. Have you tried stuff like this? I'm like aye you're livin’ in La La Land here” Tom (YP, Focus Group)

Tom shows here that there are clear differences between his life and the life of his GP which could be reflective of class differences and the impact of living in an area of social disadvantage. This suggests that these differences impair the ability for support services to provide adequate advice if they do not have a good understanding of the lived experience of those who they are attempting to treat/ support. The doctor here lacks an understanding of the social stress and threat of violence that impact Tom’s mental health. This suggests that general practitioners who interact with young people would benefit from taking a more holistic view of what is going on in the young persons’ life. It also suggests that socio-environmental factors can create a great deal of stress for young people.

Other participants in the study took issue with discourses that construct young people as holding unrealistic expectations of what society owes them:

“I think people are coming down really heavy on us and I think sometimes they forget that times are different you know economically and academically and the pressures are a bit different and I think it's really unhealthy to have this image that young people are all entitled and they’re all leeches and they're all lazy” Zoe (YP, Interview)

It could be argued that these constructions highlighted by Zoe have a direct effect on how young people view themselves:

“when I've seen so many people with all these problems that like and it just comes from a place like they just don't like believe in themselves almost and I'm like I'm not trying to blame them for all these problems but like I can see that if they grew up in a way where they did have worth within themselves then they would be able to get through some of these things” Hotwheels (YP, Interview)

Hotwheels suggests that young people lack a sense of self-worth. It could be argued that if dominant discourses construct them as “leeches” they may internalise these discourses, just as individuals internalise stigmatising discourses about mental health.

Both constructions of young people as under pressure to excel and as idle freeloaders with a sense of entitlement appear to be contradictory, however they both manifest as a preoccupation with young people’s place within a capitalist economy. The age group being examined here are mainly those who could be categorised as existing within a transitional phase of leaving childhood and entering into adulthood, a move from “play to work” (Wyness, 2019). The description Zoe gives of dominant understandings of young people suggests young people are constructed as reluctant to enter the workforce and are therefore using resources of society without giving back, however she highlights that this construction fails to understand the complexity of pressures being put on young people in a time of economic uncertainty. This is also highlighted by Isabelle:

“I'm worried about the dilemmas of adolescence [they] are much more public now and they used to be a bit more private and they used to be a bit more supported in a more community context and I'm worried about young people, including myself I'm not that young 30's whatever, our sense of stability in a world when everything is much more fast paced, house prices are extortionate, whatever, I think we have it a bit more complex or a bit less stable or something like that...” Isabelle (SM)

As well as demonstrating economic uncertainty here, Isabelle highlights that young people are constructed within the public sphere, and their development is more publicly scrutinised than previous generations. LeFrançois and Coppock highlight this in their work by suggesting that there is greater surveillance and psychiatrisation of children and young people (2014; Coppock, 2020).

### 7.4.5 Resilience

Resilience is a concept that is prevalent throughout policy and mental health literature. For example, a key goal of the Child and Adolescent Mental Health Taskforce is to build “a resilient generation” (Child and Adolescent Mental Health Task Force, 2019). It is sometimes conceptualised in psychological literature as an innate personal trait that allows the individual to “bounce-back” from trauma (Kelley, 2005; Hu, 2014; Mackinnon & Derickson, 2012). Resilience was also an important concept for some participants:

“…resilience is really important so I think rather than saying there's a mental health crisis, let’s have a conversation around how can we make our young people more resilient? How do we build up the things we know are important to young people and value the contribution that they're making?” Yvonne (SM)

Danielle and Yvonne highlight that young people need to be taught about how to build their resilience and develop coping strategies. Yvonne suggests that instead of talking about young people’s mental ill health, we should be focusing on how to support their mental health through building resilience and helping them to learn ways of coping with bad things that might be happening to them. Similarly, Kyra suggests that resilience is necessary in order for young people to access opportunities and to move forward with their lives:

“building resilience is highly important that's a foundation once they've kinda built up and built their pieces up again then they can go ahead looking into further opportunities or taking more steps to their future plans or road to recovery” Kyra (SM)

However, Kyra does go on to suggest that some services may need to be a bit more direct in helping young people to develop their resilience, as it can be overwhelming and difficult to ask for help in the first instance:

“a place where they will have to self-refer and do all the work themselves then that would be a struggle if you're not confident enough to speak to someone they will have to have enough confidence and be more resilient to walk through the door to get to the service depends on the service” Kyra (SM)

Kyra suggests that if young people do not have enough confidence or resilience, they may find it difficult to attend support appointments which reinforces Danielle and Yvonne’s suggestion that resilience needs to be a resource that is taught and built up in young people, rather than seen as something that is an innate character trait (MacKinnon & Derickson, 2013).

Young people also highlight the importance of resilience for them:

“I mean I do I think it's important to be a resilient person cause if you have no one else in the world you are always gonna have yourself so I think it's important to be your number one person” Hotwheels (YP, Interview)

Hotwheels suggests throughout the interview that instilling a stronger sense of self-worth and resilience is important for young people. Her quote suggests however that the reason young people need to be resilient is because they may be going without mental health support. She suggests that young people have to be resilient as it may be the case that they are alone and isolated from other support networks.

Ross highlights the importance of teaching young people about what resilience means, but suggests that similar to stigma, it can be seen as a “buzz-word” without substantial understanding of its meaning:

“I think it's really important for myself to build up my own resilience and it's really important with the young people that I work with to help them build up resilience help them understand what resilience and agency and capacity really mean because I think there is a tendency to just throw buzz words at young people” Ross (YP, Interview)

Ross also goes on to highlight, similar to Kyra and Hotwheels that resilience is necessary for young people because of a lack of sufficient support services:

“there's the services that these young people interact with are so inadequate so they have to either build resilience just individually or group resilience in peer support and a lot of informal care. In an ideal world that wouldn't happen, in an ideal world they would be adequately supported by services by institutions and structures but I just think the political landscape that we're in right now that's sadly a little while off I think” Ross (YP, Interview)

Ross suggests a sense of cynicism about the capacity for structures and institutions to make improvements to mental health services. Similarly, Steven is critical of resilience and suggests that the concept implies for him that people who need to be more resilient are at fault:

“it is important but it kind of implies that anybody who experiences problems aren't resilient or they're not doing enough or whatever and sure if you were more resilient maybe you would cope a bit better but that's not necessarily a person's fault… but maybe we've got to come up with a different way of marketing it because I feel like it's putting blame on the individual a bit” Steven (YP, Interview)

Steven’ s account is also found in literature such as that of Kristina Diprose (2014) who argues that resilience is arguably a discourse utilised by governments to reinforce neoliberal ideologies of self-reliance and “enduring” through poverty and precarity (Diprose, 2014; MacKinnon & Derickson, 2012).

The idea of blaming the individual highlighted by Steven is also connected to the work of Graham Scambler who suggests that neoliberal governments use the concept of stigma as a way of classifying individuals, particularly those in the working and precariat classes, and assigning blame to the individual for their situation, which has been created by austerity and financial capitalism (Scambler, 2018). It could be argued that the connection between resilience and stigma is that of enhancing neoliberal ideologies of the powerful in order to maintain dominance. If young people are placed within a discourse of “resilience” or the need to develop “resilience” to adverse childhood experiences, mental ill health, poverty and indeed stigma, and are “blamed” if they cannot be resilient, they will internalise this blame, not hold governments accountable or call for change. It could be argued that resilience, amongst other discourses, function similarly to stigma. We can see here the emergence of understandings of stigma as a structural force, and how it could be argued that stigma and resilience are used as a “machine” to perpetuate inequality (Tyler, 2020).

### 7.4.6 Intersectional Stigmatised Identities

A key finding of this study was that it was not only the experience of mental ill health that led to young people’s experiences of stigma, but also other intersectional aspects of their identities such as age, sexuality and socioeconomic status (SES). Whilst I did not explicitly gather demographic data such as ethnicity, religion or SES, these issues were still apparent and important aspects of the participants’ experiences of stigma. Intersectionality is an important concept when challenging taken-for-granted knowledge as this research seeks to do (Grzanka, 2019). Intersectionality is a way of understanding the complex ways in which experiences of inequality are linked to multiple layers of an individual’s identity (Crenshaw, 1991; Collins & Bilge, 2016). Considering intersectionality allows for the demonstration that individuals inhabit multiple positions in everyday life and that each of these positions must be taken into account in order to fully understand power relations that create and result from them (Phoenix & Pattynana 2006).

Participants in this study highlighted key discourses which constructed intersectional aspects of their identities which led to their experiences of stigma. It has been demonstrated above that young people are dismissed because of their age. Discourses which construct young people as too young to feel mental distress, or that they are attention seeking when discussing their mental ill health contribute to this experience of stigma. However, there are discourses which construct other intersectional aspects of the participants’ identities which further impact their experiences of stigma. Sexuality and gender identity, ethnicity and socioeconomic status are all highlighted by participants to demonstrate the intersecting identities that manifest in experiencing stigma.

Ross highlights that being a member of the LGBT+ community can add to the level of stigma experienced:

“I’m a gay man and there’s a huge stigma attached to that, so having that dual identity of being a mentally ill gay man, you’re kind of put in a box sometimes by people” Ross (YP, Interview)

Ross highlights that both homophobic discourses and discourses which construct mental illness can lead to experiences of multiple layers of stigma. Ross goes on to give an example of attending a counselling service for his mental health where the counsellor erroneously assumed that he was feeling distressed because he was gay. Ross used this example to demonstrate the different layers of stigma he faced when seeking help for his mental ill health. The counsellor’s assumption suggested to Ross that being gay was something to be distressed about whilst simultaneously undermining the bereavement and exam stresses which were in fact more important factors in hindering his wellbeing.

Orpheus similarly highlights various intersectional identities which led to experiences of stigma:

“I'm both LGBT, autistic and eh I have mental health issues and I can say that they've all been different in their own sense but the struggle has been consistent and the way people treat me has been more or less the same to be honest if someone accepts me for being autistic then it's LGBT thing they have a problem with or if they're fine with LGBT they still call me a retard you know” Orpheus (YP, Interview)

Orpheus highlights several intersecting aspects of discrimination attached to their identity including being referred to using offensive slurs, which multiply experiences of stigma. A question which arose for me around this was the connection between mental distress such as depression and anxiety and neurodiversity such as autism. The interconnectedness between attitudes towards and experiences of stigma which result from this would benefit from greater investigation in future research.

Amir highlights both his ethnicity and his experience with dyslexia as contributing to his experience of stigma:

“For me I'd say that even in my high school, there's like two or three parts of it, one of them was that in high school I was in quite a small minority group and on top of that I was very dyslexic and so em like I don't think school administrators always knew how to handle those two aspects um I used to live in [Place redacted] and those were worse in [place redacted] in quite a big school” Amir (YP, Focus Group)

Amir talks about how he found primary school difficult because he was a member of an ethnic minority community, and that the school did not know how to support him with his dyslexia. These two intersecting aspects of his identity resulted in feeling stigmatised, isolated and unsupported by the school. It appears that lack of understanding about how to work with a person from an Asian background meant there was little attempt to do so. The intersectionality of racism and mental health stigma is a vast area of study and particularly worthy of future research and investigation of how this operates in a majority white population such as Scotland, which could build on existing work which demonstrates that mental health stigma, in conjunction with greater mental ill health and deprivation affects groups in Scotland such as people with Pakistani, Chinese and Indian heritage (Knifton et al., 2010; Knifton, 2012).

Violet suggests that gender norms effect people’s stigmatising attitudes about mental health:

“also my mum’s partner who is from a very traditional catholic family and is very em (pause) I’m trying to think of the word (pause) toxic masculinity type person… I’ve only really recently been able to talk to him about my anxiety without him shutting it down…” Violet (YP, Interview)

Violet gives several aspects of her mother’s partner’s identity that she feels affects his understanding of mental health. Not only does she suggest that he subscribes to norms about masculinity which she describes as toxic, which could suggest that discourses which construct masculinity as something which does not involve talking about mental health could influence his response to Violet’s distress.

Tess also suggests that gender affects how people who are experiencing mental ill health are treated:

“I think there’s still a stigma of oh well boys are boys they’re men they’re not allowed to cry… but then if a boy is crying and a girl is crying a lot of people will sympathise more with the boy because girls cry all the time…” Tess (YP, Interview)

This is a fairly complex understanding of gender norms which goes past the existing dominant understanding that men cannot talk about mental health. Tess also suggests that girls are taken less seriously if they are experiencing mental ill health because they are expected to be emotional. This demonstrates that different gender identities could have their own specific experiences of stigma based on the discourses that construct normative assumptions and expectations. Existing studies suggest that boys have higher rates of stigmatising attitudes than girls (Chandra & Minkowitz, 2006) however Tessa’s account here suggests that the relationship between gender and mental health stigma may be more nuanced and therefore a more detailed investigation may be warranted.

Clearly intersectional aspects of the participants’ identities have different effects on how they experience stigma, and that there are multiple stigmatising discourses which can influence young people’s lived experience of mental ill health.

#### 7.4.7 Poverty, Inequality & Mental Health

Another aspect of identity that had an impact on participant’s experiences of stigma was social class and socioeconomic status. This was particularly prevalent for participants interviewed in Glasgow possibly due to high levels of poverty and inequality in the city (Scottish Government, 2022; NHS Health Scotland, 2018). A class analysis was not carried out as part of this study, as I felt a focus on the structural aspects of economic deprivation and poverty were more key to understanding the structural factors that lead to experiences of mental health stigma. However, future research could benefit from examining the effects of class identity and the experience of mental ill health on young people. This would be particularly pertinent for Scotland due to the particular context of what Tom referred to “scheme territorial” (Kintrea et al., 2008). However, this current study has focussed on structural aspects of poverty and socio-economic depravation rather than class identity, due to the aims of investigating structural stigma more fully.

Participants highlighted poverty and inequality in contextualising their experiences of mental health stigma. Staff members drew on poverty and inequality as an explanation for high instances of youth mental ill health:

“In some parts of Scotland there's still 40% of children living in poverty which is really hard to stomach as a country that should have enough money to be able to deal with that. And I know the reasons for it are complicated and I know some of it is about decision making at Westminster and austerity measures and benefits and what have you but we should have it within our abilities to do something about that” Catherine (SM)

One in four children in Scotland are believed to be living in poverty, which is measured as a household income being 60% less than the average (CPAG, 2019; Poverty & Inequality Commission, 2020). However, in cities such as Dundee and Glasgow the child poverty rate is higher, 31% and 37% respectively (CPAG, 2019; Scottish Government, 2022). Catherine highlights that Scotland should have enough wealth for this to be less of a problem than it is. Danielle also draws attention to inequality faced by young people in Scotland and suggests a reason for this:

“we do not have a socially just society, we have a society that looks at those who experience challenges and aligns a level of blame towards them” Danielle (SM)

Catherine and Danielle suggest social structures perpetuate, instead of alleviate, inequalities experienced by children and young people in Scotland. Structural discourses that blame individuals, as well as the programme of austerity exacerbates experiences of poverty (Tyler, 2020; Scambler, 2019). Catherine suggests that the Westminster Government’s programme of austerity is one such reason for this. Danielle suggests that society blames individuals for their own difficulties. This is in line with Graham Scambler’s work which argues that the neoliberal ideologies of David Cameron’s coalition government perpetuated the discourse of deviance about people in poverty, in order to blame them for their own problems, through the application of stigmatising labels (Scambler, 2018).

Poverty, inequality and adverse childhood experiences can negatively affect young people’s mental health (Friedli, 2009). This is also highlighted by participants in this study:

“you've got kids who don't eat dinner and they live in houses or kids that live in abusive households, domestic violence and you know these traumatic experiences, adverse childhood experiences impact so then you get a 12 -year- old who presents with mental health problems” Gabrielle (SM)

This highlights that one explanation for young people’s experiences of distress is their experiences of material inequality, social class and emotional trauma, out with their control. Young people in this study also highlighted the effects of poverty on mental health. One focus group discussed rates of suicide in areas of socioeconomic deprivation where they live:

William: “I actually found out as well I live in an area that they call suicide corridor cause there's so many suicides and they've put up Samaritan's signs”

Amy: “do you know why there's such a high suicide rate in your area?”

William: “there is some areas that are quite deprived, it’s weird ‘cause there's like G--- which we don't need to explain that one, then there's like wee posh bits like C--- then you've got P--- which is quite a dive as well and I think most people see the railways there and there's nothing blocking it really it's at the bottom of their garden so they think that's better than taking pills and lying there for hours, it's instant”

Focus Group

William discusses the peculiar geography of Glasgow with areas of privilege and wealth near other areas of high deprivation (SIMD, 2020). He suggests that living in a deprived area could be one reason for the high instances of suicide in his area, and that the available options to relieve the distress people face in these areas are not seen as particularly beneficial.

It has been demonstrated here that, poverty and inequalities can have an impact on young people’s mental health. While young people are said to have high levels of mental ill health, it cannot only be understood as an individual problem based on developmental concerns or a lack of personal resilience. It could be argued that these individualising discourses work alongside and compound mental health stigma, as they do not place enough importance on the structural inequalities faced by young people. The focus on individual stigmatising attitudes and interpersonal responses to mental ill health distract from asking why mental health is still stigmatised despite attempts to change this. If mental ill health, and similarly mental health stigma, is understood as exclusively an individual problem, the structural factors that perpetuate stigma and mental ill health cannot be fully understood and addressed.

## 7.5 Conclusion

This chapter has demonstrated that structural level discourses affect the way that young people and their mental health are understood, and that these constructions can lead to the stigma of mental health. Mental health is understood in opposition to physical health, as it is perceived to be subjective and difficult to observe. Participants believe mental health is stigmatised due to the way it is constructed by discourses and how these discourses have been embedded in temporal and cultural social structures. It also demonstrates how participants believed change could be enacted.

# Chapter 8: Discussion & Conclusions

## 8.1 Chapter Overview

This section discusses the original contributions to knowledge provided by this research study. Firstly, the empirical findings which address each of the research questions will be discussed. This is followed by the methodological and theoretical contributions of the study. The limitations of the study will then be addressed. Lastly the recommendations for policy, practice and future research will be discussed.

## 8.2 Addressing Research Questions

The original contribution to knowledge of this study is the reconceptualization of mental ill health stigma through the lived experiences, perspectives and conceptualisations of young people in Scotland, and staff members who work in third sector mental health and youth focussed stakeholder organisations. This study has used a qualitative methodology to explore a concept which is most commonly measured using quantitative attitude scales and has used a novel theoretical approach to critique a concept which is often taken for granted. As a result of this study stigma has been demonstrated to be a complex concept, the meaning of which is not always accessible or useful for young people experiencing injustice and unfair treatment due to their mental ill health, or for the members of staff working in third sector organisations who aim to tackle mental health stigma and support young people’s mental health. Stigma can also be conceptualised as multi-faceted and experienced at multiple social levels, intra- and interpersonally, through societal institutions of schools, employment, health care and media. However, the analysis of this data has also demonstrated that societal factors and discourses construct young people and their mental health in specific ways which leads to uniquely stigmatising experiences. This section addresses each of the research questions in turn, demonstrating and discussing the key findings of this study.

### 8.2.1 Research Question 1

*In what ways is mental health stigma in Scotland conceptualised by a) young people who have experienced mental ill health and b) members of staff who work for youth and mental health focussed organisations?*

This first research question was proposed in order to address a key gap in the literature concerning young people and mental health stigma, namely a lack of attention to the way young people understood the concept of stigma. Existing studies used various understandings of stigma which included: social distancing (eg.Bellanca & Pote, 2013; Kasow & Weisskirsch, 2010; Mukolo & Heflinger, 2011), and measuring various attitudes towards mental illnesses such as perceptions of individuals who experience mental ill health and beliefs relating to causal attributions (e.g. Buchholtz et al., 2015; Calear et al., 2017; DuPont-Reyes et al., 2020; Martin et al., 2007; Pescosolido et al., 2007a). While this literature is useful for telling us about the levels of stigmatising attitudes in relation to mental ill health held by and directed towards young people, it does not tell us about how young people themselves understand the concept of stigma. I was unable to identify any existing research which investigated the ways in which young people understood the concept of stigma, and if this concept was useful for young people to describe their experiences. Similarly, I was unable to identify research which examined the ways in which members of staff from third sector stakeholder organisations understood the concept of stigma. There has been some research which investigates health care professional stigma towards young people with experiences of mental ill health (Heflinger & Hinshaw, 2010; Lieghhio, 2018; Timson, 2012), however there is a lack of research which investigates non-academic conceptualisations of “stigma”. I therefore found it prescient to explore how staff members within key organisations who work to tackle mental health stigma and support young people understood the concept of stigma.

Through the process qualitative interviews and focus groups, this research identified several findings which address this research question. Firstly, for some young people consulted in this study, stigma was a complex concept which they did not understand and/or found it difficult to define. This was also the case for many staff members, even those who worked in a context in which “tackling” stigma was a key goal, found providing a definition of the concept initially challenging.

It was suggested by young people that stigma was something which could be identified through actions of others but not something which in itself was easy to define: “I only know it when I see it”. Some young people suggested that while they may have heard the word before, they hadn’t known what it meant. Similarly, most of the young people suggested that they would not use the word in their everyday language. The young people who were open with their lack of understanding of the concept suggested how they felt “intimidated” by this lack of knowledge. This is a useful finding as it could suggest that the way stigma is understood as a complex or difficult word to define excludes young people from using it in their daily lives. This is especially important when we consider the usefulness of stigma as a concept. One participant suggested that “knowledge that stigma exists is power”, and the concept has previously been used by adults to highlight injustices faced within the mental health care system (Pescosolido, 2013). Without access to knowledge of the concept of stigma, the power to highlight stigmatising instances and ultimately challenge stigma is diminished for young people. This finding therefore suggests that stigma should be elucidated more clearly when used and that its meaning should not be taken for granted. Further, the dominance of the concept of stigma over concepts that appear to be more meaningful and better understood by young people can be exclusionary.

Such concepts that young people preferred to use instead of stigma, were often highlighted by those young people in the study who did make attempts to describe what stigma meant for them. Key descriptions of stigma by the young people suggested that they understood stigma as an attitude held by someone else. Stigma was constructed using concepts such as stereotype, prejudice, judgement, and a negative or restricted understanding of mental health. For the young people in this study, stigma was constructed within someone else, the attitude of the stigmatiser, rather than the problem of the stigmatised. It was also described as the actions of others such as bullying, discrimination or ostracising. This could be understood as attempting to move the blame away from the person who is subject to stigma, towards the attitudes and behaviours of the stigmatiser. It could be argued then that the young people in this study considered stigma, no longer a “mark of disgrace” attached to the stigmatised, but as a “mark” upon the stigmatiser. This is useful as it advances our understanding of stigma in terms of moving the locus of investigation onto the source of stigmatising attitudes and behaviours rather than the person subject to them. While previous research has highlighted that a lack of mental health literacy may be one such source of stigmatising attitudes (Armstrong & Young, 2015; Townsend et al., 2017; Wahl et al., 2012; McMahon et al., 2020; Rickwood et al., 2017), it may be appropriate to carry out future research into other factors that lead to negative attitudes and behaviours towards people experiencing mental ill health.

Members of staff working in organisations have more power and access to specific knowledge about mental health and stigma, and I wanted to understand stigma from those working in structural-level institutions. By asking this group about the concept of stigma I was hoping to achieve a “working definition” of the term which would help me talk about stigma with young people. However, many staff members also found providing a definition of the concept of stigma difficult. Even those who worked within organisations with a focus on anti-stigma work suggested that the concept was complex and not used in everyday language. It was also highlighted that stigma had multiple definitions in different settings in the same organisation. This inconsistency in definition across and within organisations goes some way to explain why young people were unsure about what stigma meant. Staff members suggested that the young people they worked with did not tend to use the word “stigma” but experienced it and felt its effects. It was highlighted that those young people they worked with who did use the word stigma had been given training and access to knowledge about stigma through contacts with organisations.

Staff members held different understandings of stigma, however, taken together they depict a cyclical process of stigma in which an individual can find themselves. Staff members highlighted different aspects of a cyclical stigma process involving: The identification of “difference”, applying a label to the difference (of a mental health diagnosis), being treated differently because of the label and their “different” behaviour”, feeling shamed or fearful of being treated differently, avoiding seeking help and not addressing the “difference”. A key difference between the staff members’ understandings of stigma and the understandings of young people in this study is that staff members tended to construct aspects of this stigmatising cyclical process as something that happens to the stigmatised individual. In comparison, young people positioned stigma as something held by the “stigmatiser”.

The process described by the staff members’ constructions is similar to the work of Link and Phelan. Link and Phelan (2001; 2014) suggest that stigma involves the distinguishing and labelling of differences, associating these differences with negative attributes, separating “us from them”, status loss and discrimination and the dependence of stigma on power. Some key similarities between the existing work (Link & Phelan, 2001; 2014) and staff members’ constructions of stigma is the notion of being identified and treated differently from others in society who do not have that perceived difference. However, the members of staff in this study placed more emphasis on the experience of emotions in the stigma process such as feeling of shame and fear which can lead to people not asking for help. Which highlights the importance of stigma as a barrier to help seeking. A further difference is the lack of recognition of power in the stigma process put forward by staff in this study. The staff members collective understanding of stigma fails to acknowledge the role of power in the manifestation of stigma and place the focus on the individual experiencing the process at a solely micro-level analysis.

This study has therefore addressed the first research question by investigating young people’s understandings of stigma which suggests that it is a complex concept, not always well understood and difficult to articulate. However, the findings could also suggest that Goffman’s understanding of stigma as a “mark of disgrace” placed on the stigmatised person may not be encompassing or fully useful for understanding young people’s relationship to the concept. However, in terms of staff member’s understandings of mental health stigma, Link and Phelan’s (2001) conceptualisation of stigma has some key similarities, however the findings from this study expand on this model through the inclusion of emotional reactions and the role of help seeking in contributing to the cyclical nature of stigma.

### 8.2.2 Research Question 2

*In what ways are experiences of mental health stigma in Scotland described by a) young people who have experienced mental ill health and b) members of staff who work for youth and mental health focussed organisations?*

This question was posed in order to determine how stigma was experienced and described by participants. I initially wanted to explore whether stigmatising experiences could be understood at a structural level, or whether stigma was mainly experienced through interpersonal interactions. However, the situation appears more complex than an either / or answer. This research question benefitted from a social constructionist paradigm as it allowed for multiple theoretical orientations in order to develop an understanding of stigma experiences that encompassed multiple societal and interpersonal contexts. This research aim led to an understanding of stigma that is experienced within and contextualised through multiple layers of societal milieu which influenced and contextualised the participants’ experiences of mental health stigma.

Despite young people highlighting the complexity of the concept and not using the word stigma in their everyday language, they did not necessarily suggest that the concept was irrelevant to them and their experiences. Many drew on their experiences of mental ill health in Scotland and described how these experiences felt for them, even if they did not classify these experiences as “stigma”. Some participants highlighted a feeling of injustice towards them as a result of their experiences. Others suggested that they felt different from other people or that their opportunities were restricted. Similarly, participants suggested a “general feeling” of stigma, which could be understood as anticipated or perceived stigma (Thornicroft, 2006; Elkington et al., 2012). Participants described this feeling of stigma as something that they knew could happen to them but found it difficult to pin point exact instances of. It should also be highlighted that some participants also held stigmatising beliefs about others with mental ill health, some admitting that they had been stigmatising towards others, some being so unconsciously when describing others as attention seeking, or not “really” feeling depressed. These unconscious acts of stigma and the feelings the experiences evoke, such as anger, suggest that aspects of stigma are not always obvious and easy to highlight. This could suggest that stigmatising attitudes/discourses about young people and mental health are embedded within society that it is something that is experienced unconsciously and covertly.

Stigma can be understood as a complex and multi-layered concept based on the findings of this study. The first of these multilayers is at an interpersonal level which was described as occurring through interactions with others. Explicitly stigmatising interactions were usually with parents, teachers or mental health professionals. This is in keeping with existing micro-analyses of stigma such as Goffman, in which stigma is manifested through the attitudes and behaviours of individuals due to the outsider status of the individual to which stigma is directed (Goffman, 1969). However, this current research also highlights the importance of stigma power (Link & Phelan, 2014) in these interactions. Power negotiations occur through interpersonal interactions which lead to the manifestation of stigma for the participants in this study. This is mostly demonstrated by the participants who highlighted stigmatising interactions with individuals who held more power than they did in the situation, such as those who were treated unkindly by medical professionals.

Stigma can therefore also be understood in the context of social institutions. The policies and practices of these social institutions which are reinforced by hegemonic discourses could be understood as social contexts in which stigma is manifest and perpetuated. This can be seen for example in the way young people understood their experience of stigma at school to result from the ways in which the institution treated them and their mental health as bad behaviour and truanting. The majority of existing literature focusses on separate types of stigma, for example: public (Corrigan, Kerr & Knudsen, 2005), self (Corrigan, Kerr & Knudsen, 2005), courtesy (Goffman, 1963), structural stigma (Hatzenbeuhler & Link, 2014). It also investigates stigma from different sources: family (Elkington et al., 2012; Kranke et al., 2010; Moses, 2010b), peers (Kranke et al., 2010; Mitten et al., 2016), professionals (Bluhm et al., 2014; Bowers et al., 2013; Plaistow et al., 2014). The existing body of literature is useful for understanding different ways in which stigma manifests but does not take a unified understanding of stigma. In contrast the findings of this current study suggest that stigma could more usefully be understood as a holistic and multi-layered entity that can manifest itself at different levels of social context and is dependent on power. Participant experiences of stigma demonstrated that stigma can manifest itself at several levels of social context simultaneously. This supports the work of Woodgate et al., (2020) which also highlighted that stigma was experienced by young people in terms of intrapersonal, interpersonal and structural stigma. However, the current study adds to the work of Woodgate et al (2020) by highlighting the importance of hegemonic discourses and power negotiation in manifesting stigma at each of these levels, which will now be discussed in relation to research question 3.

### 8.2.3 Research Question 3

*In what ways can the conceptualisations and experiences of mental health stigma from a) young people who have experienced mental ill health and b) members of staff who work for youth and mental health focussed organisations be understood through a framework of societal level factors and discourses?*

This question was posed in order to investigate sources of stigma at multiple societal levels and the ways in which stigma was manifested through discourses. This study has demonstrated that mental health has been constructed through discourses which can lead to experiences of mental health stigma. A key finding of this study was that the ways in which mental health is constructed by hegemonic discourses and how they influenced experiences of stigma. One key discourse used by participants was the dichotomy of mental health to physical health. Mental health was consistently constructed as at odds with physical health. It has been demonstrated in previous research that mental health is often more stigmatised than physical health conditions (Martin et al., 2007). Participants in this study also highlighted this and suggested that physical health conditions received more of a priority, funding and resources than mental health. A key comparison was that of a broken leg which it was suggested that mental health should be treated the same as. One reason for this was suggested that mental health is invisible and cannot be seen like a broken leg. This was both in terms of the aetiology and the manifestation of mental ill health. The invisibility of mental illness was suggested to reduce sympathy and to increase fear. Fear and invisibility were also connected to a lack of understanding about mental ill health. Many participants suggested that a lack of understanding, or having incorrect understandings of mental ill health lead to stigmatising attitudes. This has been consistently evidenced by existing literature which suggests that a lack of mental health literacy contributes to stigmatising attitudes (Armstrong & Young, 2015; Perry et al., 2007). Participants suggested that because mental ill health was “invisible” and difficult to identify meant that it was easily hidden and because it was feared led to a lack of information about it. The fear, invisibility and lack of understanding of mental health appear interrelated and multidirectional within the data from this study.

However, there was also a conflicting discourse which existed simultaneously. Some participants suggested that the conflation of mental ill health with a broken leg and the physical health comparison was unhelpful and led to inappropriate pathologisation of everyday distress and medicalisation of young people’s emotions and experiences, thus leading to greater and not always necessary, request for clinical support. There therefore appears to be two conflicting discourses in use within the mental health space. One which advocates moving conceptualisations of mental health towards a similar understanding to that of physical health; and one which advocates the opposite and to move mental health away from physical health comparisons. According to staff members in this study, anti-stigma campaigns and mental health literacy programmes use a medicalised approach due to the perception that physical ill health is less stigmatised (Del Casale et al., 2013; Wahl et al., 2012; Yamaguchi et al., 2011). However, I wonder if physical disability activists would also agree that experiences of physical ill health is stigma free (Corrigan, 2014; Thomas, 1999; Williams, 2001).

One way of understanding the presence of these contradicting discourses is the way in which mental health is currently conceptualised within a dominant medicalised framework. In this study mental health and mental ill health was constructed by some participants through medical terminology and highlighted their experiences of diagnosis and treatment in a medical setting. This influenced the level to which young people’s experiences were framed as a medical problem, which made it difficult for young people to ascertain what was going on for them. For some young people it was difficult for them to determine whether their distress required clinical intervention, or whether they were experiencing difficulties and their reaction was proportionate and therefore not pathological. It could be argued therefore that their own testimony and understanding of their experiences is generally not of importance for accessing support services, where there may be more prioritisation of fitting experiences and distress within clinical diagnostic criteria rather than listening to the needs and experiences from the perspectives of young people. Medical terms to describe mental ill health are often used within literacy programmes in order to improve mental health literacy (Armstrong & Young, 2015; Lanfredi et al., 2019) and to investigate the attitudes they hold about mental illnesses (Bellanca & Pote, 2013; Wahl et al., 2012). Participants highlighted professionals consistent use of the medical model, diagnostic criteria and suggestions of fixing their problems with “science”. However, for some young people this was not the most effective approach. Many of the young people had highlighted social causes of their mental ill health such as relationships, stress of school and experiences of violence and poverty. This suggests that perhaps a more structural and holistic understanding of ways to help them would be more useful. However, the medical model was used by those in power in the lives of the young people in this study and they suggested this led to key experiences of unfair treatment, such as being diagnosed inappropriately, or having their diagnosis withheld from them and not being consulted about their treatment. The medicalisation of mental ill health led to participants feeling stigmatised as the expectations of the medical model did not always meet their experiences and led to their individual needs being over looked.

Discourses that construct young people were also found in the data in this study. The discourses that construct young people were complex and sometimes conflicting. However, what is clear from many of the discourses identified, is their role in situating young people in lower positions of power, both in society generally, but also in individual interactions with parents, teachers and health care providers. Mayall’s work demonstrates that young people are positioned as “not adults” and therefore have a lower social status position to those who are adults (Mayall, 1998). She highlights that, children and young people are constructed as being at a deficit to adults due to their developmental stage, which is used to justify their lower social positioning (Mayall, 1998). The discourses used to construct young people in this study also demonstrate the power relations which position young people in a lower social status.

Young people were often framed as “becomings” by members of staff in this study who focussed on their development which suggests they were yet to become “full” adults. This idea of “becomings” vs beings comes from the work of Uprichard, 2008 who demonstrates that the agency of children and young people are considered as temporally contingent upon them meeting development milestones and reaching full “beings” (Uprichard, 2008; Mayal, 1998). This understanding of young people can be found in the undermining of their testimonies when asking for help for their mental health. Some were told they were “too young” to experience mental ill health which suggests that they do not have complete inner lives and experiences which could cause stress, distress or mental ill health. This idea of young people as “becoming”s can also be seen in discourses which constructed young people as bad or naughty for their behaviour which was connected to their mental health. Some participants highlighted being told off or contradicted when asking for help. It could be argued that because young people are often constructed as needing to be contained and “socialised” before they become full humans, their mental ill health and behaviour associated with this was understood as a manifestation of deviance (James, Jenks & Prout, 1992).

The dismissal of young people’s mental health concerns can also be seen in the construction of young people as attention seeking or malingering. This was often reflected by other young people who often reported doubting the veracity of their peers’ claims of mental distress as “not real”. This suggests that young people sometimes felt the need to gate-keep access to the identity of “having mental ill health” which could suggest they were attempting to maintain power of a situation in which they usually face a lack of power. It could also suggest that the discourses which construct young people and their mental ill health are so embedded and covert that they manifest themselves in stigmatising ways that are not always identifiable by those enacting them. This is also connected to the discourse that constructed young people as “naughty” which was used by healthcare practitioners and schools to construct young people’s behavioural manifestations of their mental ill health. This can be understood similarly to Foucault’s conceptualisation of docile bodies. Children are constructed with the possibility of behaving badly due to their lack of socialisation and development of morality (James, Jenks & Prout, 1998). This construction leads to a perceived requirement to maintain control and punish children’s behaviour that is not in keeping with expected social mores (Foucault; 1977). Mental ill health, and the enactment of this mental ill health could be understood as deviant in this context, which leads to punishment rather than treatment.

Another discourse identified in the data was that young people were facing a mental health crisis more than previous generations due to a variety of social factors. This could be understood as contradictory to the former discourse which suggested that young people could not experience mental ill health due to their youth. Some of these reasons given for young people experiencing greater levels of mental ill health were climate change concerns, an increase in stress at school and in educational settings, poverty, violence and an insecure economic context. It was consistently highlighted that because of this young people needed to be resilient. These two discourses of an increase in mental ill health in young people and that young people needed to be resilient were intertwined to suggest that young people had to build their own resilience to in order to make their mental health more robust. It was also suggested however that young people needed to be resilient because of the lack of support from mental health services.

The data in this study also suggests that layers of discourse are applied to young people experiencing mental ill health in ways that compound their experiences of stigma. Young people in this study experienced stigma due to both experiencing mental ill health and how they had been constructed as a young person. Further hegemonic discourses which influenced the participants experiences of stigma included racism, homophobia, capitalism and neoliberalism. These discourses have been present and reinforced over various time periods. Tyler (2020) highlights how these discourses work together in order to reinforce stigma as a form of power and amplify inequality. Tyler discusses how stigma is enacted through the branding of enslaved people, the application of badges on those deemed unworthy of life by the Nazi’s during the holocaust, to the stigmatisation of impoverished people seeking benefits through the discourse of austerity (Tyler, 2020). We can therefore locate stigma throughout history, which is reinforced by hegemonic discourses which construct young people and their mental health within a context of stigma. This stigma context is layered and multifaceted and often covert because it is made up of discourses maintained over time by the powerful. This study therefore argues that the ways in which young people and their mental health are constructed through powerful discourses impacts their experiences of stigma in Scotland. This section has discussed the key findings within each research question, demonstrating the empirical contributions of this research study.

## 8.3 Methodological Contribution

The majority of empirical research which investigates stigma does so using quantitative questionnaires to gather responses to information presented in vignettes which are often hypothetical scenarios (e.g. Bellanca & Pote, 2013; Dolphin & Hennessy, 2017; Kasow & Weisskirch, 2010). There have been quantitative attempts to develop a measure of stigmatising attitudes in children and young people (Kaushik et al., 2017; Mckeague et al., 2015), some have involved attempts to validate adult measures of stigma in adolescent populations (Pinto et al., 2012), and have demonstrated that attitudes towards mental illnesses are made up of perceptions of dangerousness and weakness (Yap et al., 2014). However, there is no existing literature which attempts to explore conceptualisations of stigma. These studies however did not investigate what the concept of stigma meant to young people, nor did they attempt to measure or capture their experiences of stigma.

I did not attempt to fill this gap in quantitative data, as I did not feel that developing a stigma scale would be beneficial without first exploring the ways in which the concept of stigma was used and understood by young people. I instead wanted to explore the priorities, perspectives and experiences of young people participating in this study, and therefore opted to use qualitative methodology to critically interrogate a concept which has primarily been quantitively investigated.

It should also be noted that this particular body of literature focusses on stigma as a psychological process, manifesting between individuals based on attitudes and behaviours. This led me to consider literature which examined macro-levels of stigma. However, there is also very little existing literature which investigates structural stigma in terms of young people’s mental health. The majority of existing literature regarding structural stigma primarily focussed on quantitative measures which examined the outcomes for different populations such as LGBTQ+ groups (Hatzenbuehler et al., 2014) and people with HIV/AIDS (Miller, Grover, Bunn, & Solomon, 2011). However, there are a few studies which have taken a qualitative approach to young people, mental ill health and structural stigma (Liegghio, 2018; Woodgate et al., 2020), which demonstrated to me that it would indeed possible to investigate structural stigma using qualitative methodology. This study has therefore contributed to a growing body of literature which investigates stigma using qualitative methodology.

Taking this methodological approach allowed me to explore the complexity of stigma as a concept and allowed me to access experiences of stigma and constructions of mental ill health and young people at various social levels including interpersonal, institutional, and the role of power and discourse, which in turn facilitated the theoretical contribution which will be discussed in the following section. However, there are a few methodological limitations of the study which will now be discussed.

### 8.3.1 Methodological Limitations

Firstly, the sample of young people could be understood as a limitation of this study. The sample of young people was made up of young people who self-identified as having experienced mental ill health as I did not wish to impose restrictions on who could participate or impose diagnostic criteria upon participants. Had I recruited through the NHS (National Health Service) and recruited young people who had exclusively been given a mental illness diagnosis or had accessed clinical services the results and experiences may have been different. The sampling approach I took therefore did not lead to the representation of all possible experiences and understandings of mental ill health and stigma, and experiences of severe and enduring mental illness and hospitalisation are therefore underrepresented. This sampling method could explain the existence of conflicting discourses, as some of the participants had clinical diagnoses and experiences of mental health treatment and other did not. However, I feel ultimately highlighting these contradictory discourses is a useful contribution.

Linked to this sampling issue is the collection of participant demographic information. The lack of data about the participants mental health diagnoses, race and ethnicity and socioeconomic status, may lead to questions about where their testimonies and accounts are situated in the wider social context. However, I chose not to collect this data as I felt I was already asking them for a lot of personal information and I was concerned that this level of data may lead to breaches of confidentiality and privacy issues. I also did not think that this data was necessary, nor do I believe that their accounts or testimonies should be taken more or less seriously because of any aspect of their identity.

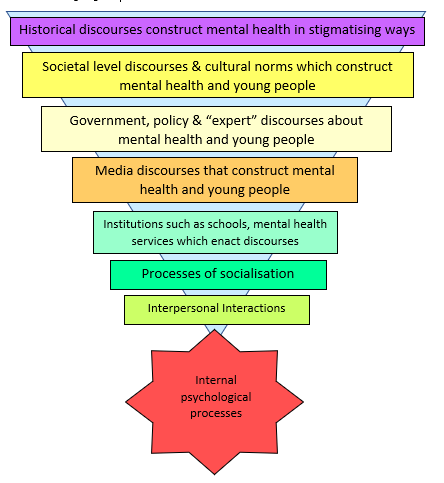
Similarly, while every attempt was made to have a balance of participants voices in the result chapter, and a conscious effort was made to give young people an equal voice to staff members, this may not always have been the case, as some participants had more to say than others, or said things more concisely. I acknowledge that in some instances it may be perceived that some participants have more quotes featured than others, particularly those participants in focus groups who may not have had the opportunity to speak up due to the vocalness of others (Braun & Clarke, 2013).

Finally, I had intended for this research study to be greatly more participatory and informed by coproduction principles that it has been. While in the data collection interactions the participants were given scope to state what was important to them and I would take their lead on what was important to them, this was not the case for the rest of the research design such as analysis or dissemination (Hart, 1997). This is mainly due to questions about ownership of the project, as this study was for a PhD, I had to be the sole researcher. In order to achieve research which would have been fully co-produced, it would have been necessary to share power and ownership with young people to direct the scope and nature of data collection, as well as the analysis, write up and dissemination (Ergler, 2017). It would also involve greater safeguarding and supervision of any co-researchers which I did not have the funding or resources to provide, neither could they be paid as co-researchers (or even as participants). Despite these limitations I feel this research has contributed to the body of work which attempts to understand stigma at multiple-levels through qualitative exploration.

## 8.4 Theoretical Contribution

This research has contributed a theoretical reconceptualization of stigma as a complex and multi-faceted concept, and raises critical questions about the usefulness of the concept of stigma for young people experiencing mental ill health. Much of the existing literature focuses on young people’s experiences of interpersonal stigma (Elkington et al., 2012; Elkington et al., 2013; Kranke & Floersch, 2009; Kranke et al., 2010; Liegghio, 2017: Maier et a., 2014; McKeague at al., 2015; Mitten et al., 2016; Moses, 2010b; Moses 2014) and does not examine these experiences at meso or macro levels. Similarly, previous research has often approached the investigation of different types of stigma in silos and suggests that structural discrimination is a distinct phenomenon to individual stigmatising attitudes (Angermeyer et al., 2014; Hatzenbeuhler & Link, 2014). Conversely, this current study suggests that stigma could be understood as something which is interconnected and manifests throughout various levels of society. By taking a theoretical approach suggested by Hannem (2012) of employing Foucauldian concepts of power/knowledge and discourse to explorations of stigma, this multi-level theorisation of stigma was developed. This study suggests that the stigmatisation of mental ill health is influenced over time through the development, alteration and reinforcement of these hegemonic discourses. I therefore present the following model of stigma as a multi-layered concept which is manifested and reinforced over time.

### Figure 5. Multi-Level Stigma Model



This model is based on the data from this study and demonstrates the sources of stigmatising experiences and the ways in which powerful discourses are manifested, learned and reinforced over time leading to individual experiences of stigma. The recommendations for future application of this research will now be discussed.

## 8.5 Recommendations: A Little Less Conversation a Little More Action Please

This section discusses the recommendations for policy and practice as well as future research endeavours. The majority of these recommendations are based on suggestions for change from participants and examples from the data will used to exemplify these recommendations. These recommendations are also based on my own analysis of the data. Overall, a key theme throughout recommendations for change addresses the positioning of mental health within discourse and the disconnect between the dominant medical discourse and lived experience. It is consistently suggested that a move away from discourses which construct mental ill health as an individual problem is needed, and suggestions that an understanding of mental health as something which is impacted by social and economic factors and inequality leads to more potential for to improve mental health and wellbeing for young people and to tackle the stigma of mental ill health.

### 8.5.1 Recommendation 1: Prioritisation of Mental Health across Policy Landscape

Firstly, participants suggested that demonstrating real priority for improving mental ill health, services and reducing stigma is necessary. From participant accounts there appeared to be a disconnect between discourse and action; that what is stated by policy makers and those in government, is not what is experienced by those delivering and accessing mental health services. Many highlighted that while those in power say that mental health is a priority, in terms of policy and funding it does not always feel as though this is the case. In order to demonstrate real priority, it was suggested by participants that including mental health across the policy landscape would demonstrate the prioritisation of mental health in real terms, rather than as an act of rhetoric and nothing more. Including considerations for mental health across policy, including education, housing and employment, rather than viewing it as a standalone issue would more clearly demonstrate the prioritisation of mental health for the participants of this study and allow provision for mental health improvement across society. This in turn would demonstrate a move away from considering mental ill health as an exclusively medical issue to be addressed only by healthcare professionals and individuals; and towards considering the wellbeing of the population as a socio-economic experience (Wilkinson & Pickett, 2020).

### 8.5.2 Recommendation 2: Mental Health Education

Participants also suggested that more education about mental health would be beneficial for tackling mental ill health stigma. For example:

*“the kids I speak to say we get one mental health class a year in PSE that's just not enough it needs to be something that infiltrates throughout” Gabrielle (SM)*

A key theme throughout staff members’ suggestions for educational improvement was more consistent education embedded throughout the curriculum, rather than the ad hoc approach they had witnessed in their work. Some staff members suggested that improving mental health education for young people would help them to identify when they needed mental health support and would also address historical misunderstandings of stigma which they believe led to stigma.

Similarly, some young people in the study believed teachers would benefit from more training about how to support their students who experience mental ill health, in order to reduce stigmatising responses:

*“the teachers need proper training and I feel like the selection of teacher, like when you become a teacher you need to undergo like proper training and kind of like tests to make sure you have the compassion and ability… cause there are a lot of teachers who will be like “shut up you're fine”” Tess (YP, Interview)*

While it appears that throughout the data participants believed that education was a useful way of reducing stigmatising responses to mental ill health, the frequency of mental health education classes is only one aspect of this recommendation. However, there were other findings in this study which suggested that mental health education which exclusively focusses medicalised understandings of mental ill health can lead to young people, as well as the adults around them inappropriately diagnosing clinical mental illnesses and can also lead to greater stigmatising understandings of mental ill health. As a result of this I would suggest taking a more holistic view of mental health and wellbeing in mental health education, possibly describing mental health as a continuum (Schomerus et al., 2020). I would argue that understanding mental ill health in less medicalised ways may lead to a greater understanding for the need for more early intervention and prevention supports and less expectation of clinical support which in turn could also reduce waiting times for CAMHS.

### 8.5.3 Recommendation 3: Improvement of Mental Health Services

There is a consistent suggestion that mental health services for children and young people should have more funding. A key action that would indicate prioritisation of mental health for participants in this study, was the provision of greater funding for mental health services. There was a perception amongst young people in the study that funding for mental health services was not being utilised efficiently:

*“I think there should be more investment in mental health services but I think that how the money is invested should be careful and really well planned so money doesn't get lost into a vacuum” Zoe (YP, Interview)*

While efficient funding of mental health services is an important recommendation in order for more young people to access the services they need, it has also been suggested in the data that medicalised understandings of mental health can lead to more young people believing that they require clinical intervention for their mental health when this may not necessarily be the case. It is therefore suggested in the data that more services which are directed at prevention and early intervention could reduce the waiting times for child and adolescent mental health services to support those most in need and allow young people who need support for mental ill health which is not necessarily a clinical issue to receive support.

### 8.5.4 Recommendation 4: Activism

As mentioned above, some of the young people in this study did not believe that their experiences of injustice and unfair treatment could be improved through policy and practice and expressed a lack of hope that stigma could ever be eradicated. This is exemplified by the following interaction in a focus group:

*William: “I think if there is gonna be change it's gonna come from a radical movement of protesting, but then I don't think that will happen because of the amount of stigma that's still around mental health and people with depression are like I don't want people to know they'll think I'm suicidal and treat me like I'm fragile…”*

*Emilia: “the irony in it is that it's gonna take people who've actually lived through certain experiences are gonna be the ones that are kinda left to help other people through that cause it seems to be that if you've not went through it, you don't know how to help people”*

*(Focus Group)*

The discussion here about the need for activism, protest and hearing the voices of those with lived experience demonstrated to me the need to incorporate more radical theorising and researching stigma. For example, there is very little critical consideration of the concept of stigma in mad studies work, despite the critical counter-hegemonic positioning of this field. If research which is underpinned by activism and focusses on emancipatory change, interrogates the taken for granted nature of stigma, this could lead to a greater potential for hope for change which was missing from the young people’s testimonies in this study. Further, community spaces for young people to come together to share their experiences, enact their own agency and find solutions that work for them is key to ensuring hope for change is possible.

### 8.5.5 Recommendations for Future Research

There are certain aspects of this research which I believe would benefit from being taken forward for further theoretical and empirical consideration. Firstly, I aim to take forward research into mental ill health stigma by applying social justice approaches to the concept which involve concept. Russell suggests that social justice research with young people and adolescents need to take into account power and privilege, considers inequalities in their lives and deals with issues that impact their wellbeing (Russell, 2016). This thesis makes an attempt to address these things and I intend for my future research to build on these social justice aims in that it moves forward research to action in order to transform the world (Freire, 1993).

A key critique of Foucault (e.g., Fraser, 1993; Alcoff, 1988) is that while his theories help us to examine phenomena as they are they do not necessarily help us to suggest improvements of potential for change. I therefore feel that taking a social justice approach to examining stigma will be a useful approach to this concept that has been underutilised. This will involve developing my own reflexivity as a person with lived experience and a commitment to conduct more participatory action research focussed work in the future, not only to understand the world but to change it (Fine, 2015; McIntyre, 2008; Freire, 1993). Secondly, in keeping with the above suggestion, I believe that more space and time is necessary, than was available in this thesis, in order to fully interrogate the ways in which intersectionality plays a role in young people’s experiences of mental health stigma. The various identities highlighted by participants in this study such as race and ethnicity, gender, LGBT and social class would benefit from more detailed investigation in a future study.

## 8.6 Final Thoughts

This study has critically interrogated the concept of stigma in the context of young people who have experience of mental ill health in Scotland. This qualitative study explored the conceptualisations and experiences of both young people and staff members in stakeholder organisations in order to develop a theoretical conceptualisation of stigma as a complex concept which is experienced at multiple societal levels and is manifested through, and embedded within powerful discourses which construct young people, mental ill health, and stigma as a concept. In order to address stigma then, the discourses which construct mental ill health in stigmatising ways need to be addressed, as well as greater investigation into the ways in which power /knowledge contributes to these stigmatising discourses. Based on the findings of this study that suggest that stigma is a complex concept which is not always useful due to inaccessibility to expert discourses which construct and operationalise the concept, I would argue that future research into the concept requires engaging more with people with lived experience of mental ill health and developing more useful terminology which can be used for emancipatory practice. While some participants suggested that “knowledge that stigma exists is power” to address it, this is not the case if it remains couched within an inaccessible expert discourse. Instead, work should be carried out with those who experience mental health stigma to develop a more accessible concept which can be used to highlight instances of it and challenge it. It may also be beneficial for fields of study which are based on anti-psychiatry and activism to undertake critical investigations of the usefulness of the concept of stigma for emancipatory activism and future research.

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# Appendices

Appendix 1. Example of Literature Review Framework

Graphical user interface, application, table

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Appendix 2. Gatekeeping Organisation Information and Consent Forms

Logo

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**Participant Information Sheet for Organisations**

**Name of department: Social Work and Social Policy  
Title of the study: Understanding structural stigma through young people’s experiences of mental health difficulties**

**Introduction**

This research is being carried out by Amy Tucker, a current doctoral student in the School of Social Work and Social Policy at the University of Strathclyde. You can contact her by email: [amy.tucker@strath.ac.uk](mailto:amy.tucker@strath.ac.uk) for more information.

**What is the purpose of this research?**

This research is about understanding stigma and its presence in cultural and social institutions in Scotland. Stigma is negative attitudes held by individuals and society as a whole about certain groups in society. Stigma within social and cultural institutions is known as structural stigma. This study would like to know if you have experienced structural stigma and in what ways it has affected your life. The study also wants to know how you understand stigma, what it means to you and how you might like to change it.

The aims and objectives of this study are:

1. To investigate how young people who have experienced difficulties with their mental health understand the concept of stigma

2. To investigate how young people who have experienced difficulties with their mental health experience structural stigma

4) To investigate how young people who have experienced difficulties with their mental health are impacted by structural stigma

5) To investigate whether structural stigma can be identified by examining social policies that affect Scottish young people who have experienced difficulties with their mental health

6) To investigate how members of staff who work in organisations that support young people understand structural stigma and its effects on those they work with

7) To investigate if and how we can understand structural stigma using qualitative research methods.

**Do you have to take part?**

You do **not** have to take part.

**What will you do in the project?**This project will involve recruiting staff from your organisation and young people that you work with based on your guidance about the appropriateness of participation. There will be focus groups of young people as well as interviews with young people and staff members. These interviews will take place at your organisations premises with your agreement.

**Why have you been invited to take part?**You have been invited to participate because this organisation works with Scottish young people who have experienced mental health difficulties.

**What are the potential risks to you in taking part?**There may be the risk that participants feel upset during the interview if they are being asked about their lives and stigma they have experienced. The researcher is keen to work with your organisation to have an appropriate member of staff on hand in order

**What information is being collected in the project?**We will collect information through your participation in the project that might be personal to your staff and the young people you work with including experiences of mental health difficulties and treatment, race or ethnicity, and age. Participants will be given a false name in the report of the project and data will be kept in line with GDPR requirements.

**Who will have access to the information?**

Only the research team will have access to the information provided by participants, it will be kept anonymous and confidential.

**Where will the information be stored and how long will it be kept for?**

Information will be stored securely by encryption and will be password protected. It will be destroyed when it is no longer needed for the study.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

Please also read our Privacy Notice for Research Participants <https://www.strath.ac.uk/media/ps/rkes/ethics/Privacy_Notice_Research_Participants_Oct18.pdf.pagespeed.ce.7zptN2u_gT.pdf>

**What happens next?**

If you would like more information or would like to participate in this project please let NAMED PERSON at GATEKEEPING ORGANSIATION know. You will then be able to meet with the researcher to ask any questions. You will also be asked to sign a consent form.

If you does not want to be involved in the project, thank you for your attention.

The results of this research will be sent to you for you to read if you would like to.

**Researcher contact details:**

Amy Tucker

PhD Candidate

School of Social Work and Social Policy

University of Strathclyde

Lord Hope Building

141 St James Road

Glasgow

G4 0LT

amy.tucker@strath.ac.uk

**Chief Investigator details:**

Dr Gillian MacIntyre

Senior Lecturer

School of Social Work and Social Policy

University of Strathclyde

Lord Hope Building

141 St James Road

Glasgow

G4 0LT

Gillian.macintyre@strath.ac.uk

This research was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee  
Research & Knowledge Exchange Services  
University of Strathclyde  
Graham Hills Building  
50 George Street  
Glasgow  
G1 1QE

Telephone: 0141 548 3707  
Email: [ethics@strath.ac.uk](mailto:ethics@strath.ac.uk)

Appendix 3. Participant Information and Consent Form: Young People Interviews**Logo

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**Participant Information Sheet for Young People: Interviews**

**Name of department: Social Work and Social Policy  
Title of the study: Understanding structural stigma through young people’s experiences of mental health difficulties**

**Introduction**

This research is being carried out by Amy Tucker, a current doctoral student in the School of Social Work and Social Policy at the University of Strathclyde. You can contact her by email: [amy.tucker@strath.ac.uk](mailto:amy.tucker@strath.ac.uk) for more information.

**What is the purpose of this research?**

This research is about understanding stigma and its presence in cultural and social institutions in Scotland. Stigma is negative attitudes held by individuals and society as a whole about certain groups in society. Stigma within social and cultural institutions is known as structural stigma. This study would like to know if you have experienced structural stigma and in what ways it has affected your life. The study also wants to know how you understand stigma, what it means to you and how you might like to change it.

The aims and objectives of this study are:

1. To investigate how young people who have experienced difficulties with their mental health understand the concept of stigma

2. To investigate how young people who have experienced difficulties with their mental health experience structural stigma

4) To investigate how young people who have experienced difficulties with their mental health are impacted by structural stigma

5) To investigate whether structural stigma can be identified by examining social policies that affect Scottish young people who have experienced difficulties with their mental health

6) To investigate how members of staff who work in organisations that support young people understand structural stigma and its effects on those they work with

7) To investigate if and how we can understand structural stigma using qualitative research methods.

**Do you have to take part?**

You do **not** have to take part. Refusing to participate or changing your mind about participating will not affect the support you receive.It will also not have any negative consequences for you or anyone.

**What will you do in the project?**This project will involve chatting with you for about an hour. This will take place at the GATEKEEPER ORGANISATION offices. The researcher will ask you if you feel you have had experienced difficulties with your mental health and what that was like. She will also ask you about seeking support for your mental health difficulties and what this was like. The researcher will show you some artwork made by other young people who have also experienced their own difficulties with mental health. You will be asked to have a look at this artwork and will be asked questions about it. You will be asked about stigma and if you feel you have experienced it, from whom and what this word means to you. If you decide you want to participate after reading this information, you can meet with the researcher to ask any questions you may have. If you would still like to participate you will be asked to sign a consent form. You can have someone come in with you if you would like and you can let the researcher know if there is anything you would like to make participating easier for you.

**Why have you been invited to take part?**You have been invited to participate because you are aged 14-18 and have sought support from GATEKEEPING ORGANISATION to help with mental health difficulties.

**What are the potential risks to you in taking part?**There may be the risk that you are asked questions that make you feel uncomfortable or bring up some upsetting memories. You can stop the interview at any time. A member of GATEKEEPING ORGANISATION will be on hand in case you feel upset.

**What information is being collected in the project?**We will collect information through your participation in the project that might be personal to you including your experiences of mental health difficulties and treatment, your race or ethnicity, and your age. You will be given a false name in the report of the project and no one will know it was you who participated. ORGANISATION will not know what you said. No one will know you access ORGANISATION for support.

**Who will have access to the information?**

Only the research team will have access to your information. You will be kept anonymous. The information you give in the project will be confidential and will not be traced to you. However, there are limits to confidentiality, such as revealing that someone might be at risk of being harmed. The researcher will speak to you about this, and may have to tell someone from ORGANISATION.

**Where will the information be stored and how long will it be kept for?**

Your information will be stored securely by encryption and will be password protected. It will be destroyed when it is no longer needed for the study.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

Please also read our Privacy Notice for Research Participants <https://www.strath.ac.uk/media/ps/rkes/ethics/Privacy_Notice_Research_Participants_Oct18.pdf.pagespeed.ce.7zptN2u_gT.pdf>

**What happens next?**

If you would like more information or would like to participate in this project please let NAMED PERSON at GATEKEEPING ORGANSIATION know. You will then be able to meet with the researcher to ask any questions. You will also be asked to sign a consent form.

If you do not want to be involved in the project, thank you for your attention.

The results of this research will be sent to GATEKEEPING ORGANISATION for you to read if you would like to.

**Researcher contact details:**

Amy Tucker

PhD Candidate

School of Social Work and Social Policy

University of Strathclyde

Lord Hope Building

141 St James Road

Glasgow

G4 0LT

amy.tucker@strath.ac.uk

**Chief Investigator details:**

Dr Gillian MacIntyre

Senior Lecturer

School of Social Work and Social Policy

University of Strathclyde

Lord Hope Building

141 St James Road

Glasgow

G4 0LT

Gillian.macintyre@strath.ac.uk

This research was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee  
Research & Knowledge Exchange Services  
University of Strathclyde  
Graham Hills Building  
50 George Street  
Glasgow  
G1 1QE

Telephone: 0141 548 3707  
Email: [ethics@strath.ac.uk](mailto:ethics@strath.ac.uk)

**Consent Form for Young People**

**Name of department: Social Work and Social Policy  
Title of the study: Understanding structural stigma through young people’s experiences of mental health difficulties**

* I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
* I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
* I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
* I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data:
  + audio recordings of interviews that identify me;
  + my personal information from transcripts.
* I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
* I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
* I consent to being a participant in the project.

I consent to being audio and/or video recorded as part of the project

|  |  |
| --- | --- |
| (PRINT NAME) |  |
| Signature of Participant: | Date: |

Pseudonym:

Appendix 4. Participant Information and Consent Form: Young People Focus Groups

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Description automatically generated**Participant Information Sheet for Young People: Focus Groups**

**Name of department: Social Work and Social Policy  
Title of the study: Understanding structural stigma through young people’s experiences of mental health difficulties**

**Introduction**

This research is being carried out by Amy Tucker, a current doctoral student in the School of Social Work and Social Policy at the University of Strathclyde. You can contact her by email: [amy.tucker@strath.ac.uk](mailto:amy.tucker@strath.ac.uk) for more information. .

**What is the purpose of this research?**

This research is about understanding stigma and its presence in cultural and social institutions in Scotland. Stigma is negative attitudes held by individuals and society as a whole about certain groups in society. Stigma within that exists in policies, institutions and cultural attitudes is known as structural stigma. This study would like to know if you have experienced structural stigma and in what ways it has affected your life. The study also wants to know how you understand stigma, what it means to you and how you might like to change it.

The aims and objectives of this study are:

1. To investigate how young people who have experienced difficulties with their mental health understand the concept of stigma

2. To investigate how young people who have experienced difficulties with their mental health experience structural stigma

4) To investigate how young people who have experienced difficulties with their mental health are affected by structural stigma

5) To investigate whether structural stigma can be identified by examining social policies that affect Scottish young people who have experienced difficulties with their mental health

6) To investigate how members of staff who work in organisations that support young people understand structural stigma and its effects on those they work with

7) To investigate if and how we can understand structural stigma using qualitative research methods.

**Do you have to take part?**

You do **not** have to take part. Refusing to participate or changing your mind about participating will not affect the support you receive.It will also not have any negative consequences for you or anyone.

**What will you do in the project?**This project will involve being part of a focus group consisting of other See Me Young Champions. This will take place at the SEE ME offices. You will be part of a group of around 3 or 4 other people, who you may know or you may have not met before. You will be asked about the concept of stigma and what it means to you, where you think stigma comes from, as well as your own experiences of this. You will be asked to look for articles, images or other resources about mental health and stigma with you. You will also be provided with other similar resources on the day. You will be asked to create a piece of artwork, collage, zine or do some writing, which describes your understanding and experiences of stigma. This artwork will be used to help other young people who have experienced difficulties with their mental health to talk about stigma and their own experiences.

**Why have you been invited to take part?**You have been invited to participate because you are aged 14-18 and have taken part in training by See Me, or are a See Me Young Champion.

**What are the potential risks to you in taking part?**There may be the risk that you are asked questions that make you feel uncomfortable or bring up some upsetting memories. You can stop the interview at any time. A member of GATEKEEPING ORGANISATION will be on hand in case you feel upset.

**What information is being collected in the project?**We will collect information through your participation in the project that might be personal to you including your experiences of mental health difficulties and treatment, your race or ethnicity, and your age. You will be given a false name in the report of the project and no one will know it was you who participated. ORGANISATION will not know what you said. No one will know you access ORGANISATION for support.

**Who will have access to the information?**

Only the research team will have access to your information. You will be kept anonymous. The information you give in the project will be confidential and will not be traced to you. However, there are limits to confidentiality, such as revealing that someone might be at risk of being harmed. The researcher will speak to you about this, and may have to tell someone from ORGANISATION.

**Where will the information be stored and how long will it be kept for?**

Your information will be stored securely by encryption and will be password protected. It will be destroyed when it is no longer needed for the study.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

Please also read our Privacy Notice for Research Participants <https://www.strath.ac.uk/media/ps/rkes/ethics/Privacy_Notice_Research_Participants_Oct18.pdf.pagespeed.ce.7zptN2u_gT.pdf>

**What happens next?**

If you would like more information or would like to participate in this project please let NAMED PERSON at GATEKEEPING ORGANSIATION know. You will then be able to meet with the researcher to ask any questions. You will also be asked to sign a consent form.

If you do not want to be involved in the project, thank you for your attention.

The results of this research will be sent to GATEKEEPING ORGANISATION for you to read if you would like to.

**Researcher contact details:**

Amy Tucker

PhD Candidate

School of Social Work and Social Policy

University of Strathclyde

Lord Hope Building

141 St James Road

Glasgow

G4 0LT

amy.tucker@strath.ac.uk

**Chief Investigator details:**

Dr Gillian MacIntyre

Senior Lecturer

School of Social Work and Social Policy

University of Strathclyde

Lord Hope Building

141 St James Road

Glasgow

G4 0LT

Gillian.macintyre@strath.ac.uk

This research was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee  
Research & Knowledge Exchange Services  
University of Strathclyde  
Graham Hills Building  
50 George Street  
Glasgow  
G1 1QE

Telephone: 0141 548 3707  
Email: [ethics@strath.ac.uk](mailto:ethics@strath.ac.uk)

**Consent Form for Young People**

**Name of department: Social Work and Social Policy  
Title of the study: Understanding Structural stigma through young people’s experiences of mental health difficulties**

* I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
* I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
* I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
* I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data:
  + audio recordings of interviews that identify me;
  + my personal information from transcripts.
* I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
* I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
* I consent to being a participant in the project.
* I consent to my artwork being used and shown to other participants in this project.
* I consent to being audio and/or video recorded as part of the project

|  |  |
| --- | --- |
| (PRINT NAME) |  |
| Signature of Participant: | Date: |

Pseudonym:

Appendix 5. Participant Information and Consent Form: Staff Members Interviews

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**Participant Information Sheet for Staff Interviews**

**Name of department: Social Work and Social Policy  
Title of the study: Understanding structural stigma through young people’s experiences of mental health difficulties**

**Introduction**

This research is being carried out by Amy Tucker, a current doctoral student in the School of Social Work and Social Policy at the University of Strathclyde. You can contact her by email: [amy.tucker@strath.ac.uk](mailto:amy.tucker@strath.ac.uk) for more information. .

**What is the purpose of this research?**

This research is about understanding stigma and its presence in cultural and social institutions in Scotland. Stigma is negative attitudes held by individuals and society as a whole about certain groups in society. Stigma within social and cultural institutions is known as structural stigma. This study aims to find out about structural stigma and how it affects those you work with. The study also wants to know how you understand stigma, what it means to you and how you might like to change it.

The aims and objectives of this study are:

1. To investigate how young people who have experienced difficulties with their mental health understand the concept of stigma

2. To investigate how young people who have experienced difficulties with their mental health experience structural stigma

4) To investigate how young people who have experienced difficulties with their mental health are impacted by structural stigma

5) To investigate whether structural stigma can be identified by examining social policies that affect Scottish young people who have experienced difficulties with their mental health

6) To investigate how members of staff who work in organisations that support young people understand structural stigma and its effects on those they work with

7) To investigate if and how we can understand structural stigma using qualitative research methods.

**Do you have to take part?**

You do **not** have to take part. Refusing to participate or changing your mind about participating will not have any negative consequences for you or anyone else.

**What will you do in the project?**This project will involve participating in an interview. It will take place at ORGANISATION offices and will last for about 60 minutes. You will be asked about structural stigma, and how it effects the work you do and the lives of the young people you work with. But please do not reveal confidential information about anyone you work with.

**Why have you been invited to take part?**You have been invited to participate because you have worked with ORGANISATION for over a year.

**What are the potential risks to you in taking part?**There may be the risk that you are asked questions that make you feel uncomfortable or bring up some upsetting memories. You can stop the interview at any time.

**What information is being collected in the project?**We will collect information through your participation in the project that might be personal to you including your job, your race or ethnicity, and your age. You will be given a false name in the report of the project and no one will know it was you who participated. ORGANISATION will not know what you said. No one will know you work with ORGANISATION.

**Who will have access to the information?**

Only the research team will have access to your information. You will be kept anonymous. The information you give in the project will be confidential and will not be traced to you. However, there are limits to confidentiality, such as revealing that someone might be at risk of being harmed the researcher will speak to you about this, and may have to tell someone from ORGANISATION.

**Where will the information be stored and how long will it be kept for?**

Your information will be stored securely by encryption and will be password protected. It will be destroyed when it is no longer needed for the study.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

Please also read our Privacy Notice for Research Participants: <https://www.strath.ac.uk/media/ps/rkes/ethics/Privacy_Notice_Research_Participants_Oct18.pdf.pagespeed.ce.7zptN2u_gT.pdf>

**What happens next?**

If you would like more information or would like to participate in this project please let NAMED PERSON at GATEKEEPING ORGANSIATION know. You will then be able to meet with the researcher to ask any questions. You will also be asked to sign a consent form.

If you do not want to be involved in the project, thank you for your attention.

The results of this research will be sent to GATEKEEPING ORGANISATION for you to read if you would like to.

**Researcher contact details:**

Amy Tucker

PhD Candidate

School of Social Work and Social Policy

University of Strathclyde

Lord Hope Building

141 St James Road

Glasgow

G4 0LT

amy.tucker@strath.ac.uk

**Chief Investigator details:**

Dr Gillian MacIntyre

Senior Lecturer

School of Social Work and Social Policy

University of Strathclyde

Lord Hope Building

141 St James Road

Glasgow

G4 0LT

[Gillian.macintyre@strath.ac.uk](mailto:Gillian.macintyre@strath.ac.uk)

This research was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee  
Research & Knowledge Exchange Services  
University of Strathclyde  
Graham Hills Building  
50 George Street  
Glasgow  
G1 1QE

Telephone: 0141 548 3707  
Email: [ethics@strath.ac.uk](mailto:ethics@strath.ac.uk)

**Consent Form for Staff**

**Name of department: Social Work and Social Policy  
Title of the study: Understanding structural stigma through young people’s experiences of mental health difficulties**

* I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
* I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
* I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
* I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data:
  + audio recordings of interviews that identify me;
  + my personal information from transcripts.
* I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
* I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
* I consent to being a participant in the project.
* I consent to being audio and/or video recorded as part of the project

|  |  |
| --- | --- |
| (PRINT NAME) |  |
| Signature of Participant: | Date: |

Pseudonym:

Appendix 6. Interview Schedule: Young People

Interview Schedule – Young People

Check recording equipment

Check they would still like to participate–The consent form will have been signed and discussed before the start of the interview

1. Thank participant for coming and offer refreshments, try to create a relaxed atmosphere
2. Check they are ok to be audio recorded
3. Go over confidentiality

Part 1 – understanding their experiences

Tell me a little bit about yourself – what age are you, do you work or go to school?

Can you tell me a bit about why you came to ORGANISATION?

Have you experienced difficulties with mental health?

What was it like trying to get support for this?

Part 2 – Understanding stigma – Use creations from Focus Group Here

Have you heard the word stigma before?

What does it mean to you?

Where do you think stigma comes from?

Do you think the people that made these creations have had similar experiences to you?

What do you think about the creations? How do they make you feel?

What do you think the creations tell us? What do you take from them?

Do you think the media contributes to stigma?

Do you think there are certain policies that contribute to stigma?

Are there institutions that contribute to stigma?

Is social media a help or a hindrance when it comes to stigma?

Why do you think stigma exists?

What do you think structural stigma is?

Do you think it exists in Scotland?

Part 3 – Impact

How has stigma impacted you?

What has your experience at school/work/college/university been like?

Have you been supported by friends and family?

Have you had trouble at work?

Part 4 – Change

Is there anything you would like to tell policy makers, or people in charge, in order to help make changes?

How would you tackle stigma?

What would help?

Is there anything else you would like to say that I haven’t asked?

Thank you for participating.

Appendix 7. Focus Group Schedule

Focus Group Schedule

Check recording equipment

Consent forms to be signed before the focus group starts – check audio recording is ok at this point

Introductions (15 Mins)

1. Offer refreshments to group to create a relaxed atmosphere
2. Check whether they all know each other or not, ask them to introduce themselves
3. Go over confidentiality agreements
4. Double check there are no objections to audio recording then switch it on
5. Thank everyone for giving their time and reiterate the point of the research

Discussion 1 – Understanding “stigma” (30 mins)

Q1 – What does the term “stigma” mean to you?

Q2 – Where do you think stigma comes from?

Q3 – What do you think structural stigma is? – Using resources brought in by participants and the researcher to act as prompts for this discussion

Creations (40 Mins)

How would you describe stigma to someone else?

Time to create a zine, collage, drawing or do some writing

[BREAK – 10 mins]

Discussion 2 – Experiences

Q1 Have you experienced stigma?

Q2 Who from?

Q3 How did it impact your life?

Q4 Do you think you have experienced structural stigma?

Q5 What would you like to tell policy makers or people in power in order to change / tackle stigma?

Sum up

How did this go?

Is there anything you want to tell me that I haven’t asked?

Are you all happy to still be included in the project?

Can I use your creations to help others talk about stigma?

Appendix 8. Interview Schedule: Staff Members

Interview Schedule – Staff

Check recording equipment

Check they have signed consent form

Check they would still like to participate

1. Thank participant for coming and offer refreshments, try to create a relaxed atmosphere

2. Check they are ok to be audio recorded

3. Go over confidentiality

Part 1 – Their experiences

What do you do in ORGANISATION?

How long have you worked here?

Do you enjoy your work?

Part 2 – Understanding Stigma

What do you think stigma means?

How would you explain stigma to a young person?

Where do you think it comes from?

What does structural stigma mean to you? – Use creations from focus groups here

What do you think of these creations?

How do they make you feel?

What do they tell us?

Do you think structural stigma exists?

Do you think the media helps or perpetuates stigma?

Do you think social media is a way of combatting stigma, or does it make it worse?

Do you think there are stigmatising policies?

Are there stigmatising institutions?

Part 3 – Young people’s experiences

Do young people you work with experience stigma?

Do they talk about it?

How do you think it impacts their lives?

How does stigma affect your role in supporting them?

Part 4 – Change

What would you want to tell a policy maker, or someone in charge, in order to make changes and tackle stigma?

How would you tackle stigma?

Is there anything else you would like to tell me that I haven’t asked?

Thank you for your participation