Commentary

Reconceptualizing Stigma: Toward a Critical Anti-Oppression Paradigm

Lynn C. Holley, PhD, ACSW[1,*], Layne K. Stromwall, PhD, ACSW[2], Kathy H. Bashor, MC[3]

[1]School of Social Work, Arizona State University, Phoenix, AZ, USA
[2]School of Social Work, Arizona State University, Phoenix, AZ, USA
[3]Arizona Department of Health Services, Phoenix, AZ, USA

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This paper first arose from conversations between the first author, who conducts research and teaches about diversity, oppression, and social change, and the second author, whose area is mental health stigma. As we researched perceived discrimination against people with mental illnesses, we often experienced difficulties in communicating our ideas to each other. We realized that our respective theoretical paradigms – or ways of viewing the problem – caused these communication difficulties. We found that mental health stigma is conceptualized differently than prejudice and discrimination based on race, ethnicity, gender, and other forms of difference. In conversations with the third author, we found much work of community activists to be consistent with the latter paradigm, but their perspective has not been fully incorporated into the mental health stigma literature. To address this issue, we use a critical perspective for understanding and changing systemic mental health oppression and privilege. Informed by critical theorists and the work of community advocates, our critical anti-oppression paradigm focuses on power dynamics, so people with mental illnesses and their allies can change oppressive structures and processes.

Theorists concerned with racism, sexism, heterosexism, and other forms of inequality emphasize power dynamics as they analyze, evaluate, and transform the systemic nature of oppression. Critical theories use a complex matrix to describe how the structures and processes of institutions and social systems – as well as individual attitudes and behaviors – oppress members of subordinated groups while simultaneously privileging members of dominant groups (e.g., whites, men, heterosexuals).

Many contemporary theorists concerned with mental health prejudice and discrimination have conceptualized these problems as *stigma* using an attributional model (Stuart, 2008). This model is typically understood as a labeling process that triggers stereotyping, followed by acts of discrimination that result in loss of status and reduced life options for people who are perceived to have mental illnesses (Scheff, 1974; Link & Phelan, 2001). Although these researchers recognize that the ability to label a group as inferior requires access to social power, most research applying this model has focused on understanding the experiences of individuals who are stigmatized or on individual-level cognitive processes rather than on power dynamics (see Link & Phelan, 2001; Parker & Aggleton, 2003). Some theorists have advanced the consideration of stigma by adding meso- and macro-level variables or social justice considerations (e.g., Corrigan, Markowitz, & Watson, 2004; Corrigan, Watson, Byrne, & Davis, 2005; Pescosolido, Martin, Lang, & Olafsdottir, 2008). This paper adds to this effort by presenting an oppression/privilege-informed paradigm that can be used to understand and transform oppression based on perceived mental health status. We conclude with implications of this critical anti-oppression paradigm for practice and research.

Literature Review

We first present an overview of theoretical models used to examine mental health stigma, followed by

*Corresponding author: Lynn C. Holley, PhD, School of Social Work, Arizona State University, USA.
E-mail: lholley@asu.edu

key concepts from oppression frameworks and critical theories.

Theoretical Models of Mental Health Stigma

Perhaps the strongest influence on the literature related to mental illness stigma is Goffman's (1963) work that described stigma as a response to a negatively-viewed attribute, leading to a *spoiled identity*. Although access to power is arguably needed to label others, Goffman did not emphasize the power dynamics inherent in this social construction of *deviance* (Parker & Aggleton, 2003). Research building on Goffman's work has focused largely on understanding the experiences of stigmatized individuals or on individual-level cognitive labeling processes, rather than on structures or systems that create or reinforce negative social constructions (see Link & Phelan, 2001; Parker & Aggleton, 2003).

Foucault (1965) and Szasz (1961) also used social constructionist approaches to understand the experiences of people with mental illnesses, but their models emphasized power dynamics. Examining the construction of *madness* across eras, Foucault focused on modern medicalization by experts as a means of social control. Although we believe that this concept is critical in understanding systems-level perceptions and treatment of people with mental illnesses, Foucault did not apply these ideas to mental illness stigma (Parker & Aggleton, 2003). Further, Foucault *perceives deviance as a social fact, a function of the normal, and focuses on how it is dealt with, and by whom, during various historical periods* rather than seeking to understand inequality with the goal of social change (Kurzweil, 1977, p. 395). Szasz (1961) similarly focused on the power of the medical community to construct *mental illness* as a means of social control.

One of the first to examine stigma-related contextual issues, Link (1982) advanced Scheff's (1974) Labeling Theory, focusing on the consequences of a mental illness label on the labeled person within her or his environment. This work led to fruitful research on the interrelationships of a stigmatizing label, environmental consequences of that label, and the effect of these on the individual (self-stigma).

Over the past 20 years, Corrigan and various colleagues (e.g., Corrigan, 2000) have advanced stigma theory using a cognitive–behavioral model with cognitive, affective, and behavioral components termed stereotypes (a cognitive belief), prejudice (an emotion or attitude based on the cognition), and discrimination (acting on that attitude in a negative way) (Ottati, Bodenhausen, & Newman, 2005). While acknowledging the need to reduce discrimination, these models focus on the cognitive and/or affective components of stigma.

Link and Phelan (2001) furthered the conceptualization of stigma by explaining that it *exists when elements of labeling, stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold* (p. 382). They also note that resistance to stigma takes place within a *context of a power struggle* (p. 378). While recognizing that power differences are fundamental in understanding the context of mental illness prejudice and discrimination, some critical elements of an oppression framework are not included. First, these authors assert that a more powerful group *allows these processes to unfold* (p. 382), thus implying lack of intention on the part of, and ignoring the benefits accrued by, the powerful group. Ignoring benefits leads to consideration of only the negative effects on people with mental illnesses in discussing *the outcomes of stigma* (pp. 378–379). Further, while Link and Phelan describe the importance of power in creating stigma and refer to structural discrimination, their consideration of access to power focuses on ***people*** *who might stigmatize* (p. 376, emphasis added).

Recently, Pescosolido et al. (2008) created a conceptual map of stigma that combines micro-, meso-, and macro-level factors, adding meso-level factors of organizations and treatment systems and the macro-level factors of national and cultural contexts. Still, the map's description focuses on cognitions, attitudes, and behaviors of individuals within these systems.

Mental health stigma theory has been informed by parallels to the concept of institutional racism (Link & Phelan, 2001; Corrigan et al., 2005) and homophobia (Corrigan et al., 2009). Corrigan et al. (2004) analyze several systems that intentionally and unintentionally discriminate against people living with mental illnesses. Corrigan et al. (2005) propose an integrated framework by adding a social justice component to the traditional public health/medical model of stigma, which they assert would shift our focus from individual attitudes and behaviors to *target[ing] institutions. . . that marginalize, exploit, or . . . victimize people with mental illness. . .* (Corrigan et al., 2005, p. 367). In the latter two papers, Corrigan and colleagues make significant contributions by analyzing processes of structural and institutional discrimination. However, these analyses do not reference some elements of oppression frameworks, particularly those regarding privilege.

Perlin and colleagues (e.g., Perlin & Dorfman, 1993) stand alone in the specific examination of oppression and privilege within one institution, the

legal system. Perlin uses the term *sanism* to describe the complex set of factors that influence the legal system to be both oppressive to people with mental illnesses and privileging to individuals who are not so labeled.

Oppression Frameworks and Critical Theories

In this section, we describe selected key concepts of the many theories, paradigms, and frameworks developed to understand and transform social injustice related to difference, described as critical theories (e.g., see Hulko, 2009; Davila & de Bradley, 2010; Huber, 2010; Ortiz & Jani, 2010).

Oppression and Social Groups

Oppression refers to systemic processes and structures that inhibit the ability of members of less-powerful social groups *to develop and exercise their capacities and express their needs, thoughts, and feelings* (Young, 1990, p. 40), preventing them from being *more fully human* (Freire, 2003, p. 57). Members of a social group do not necessarily consider themselves to be group members and can be *thrown into* a group by others (Young, 1990). Thus, even if they do not claim a particular social identity, they are subject to the disadvantages of being a member of the social group.

Levels of Oppression

Oppression is viewed as a *complex web* of structures and processes that are pervasive in everyday life (Bell, 1997, p. 4) and is manifested at individual, institutional, and social/cultural levels (Young, 1990; Bell, 1997; Hardiman & Jackson, 1997; Rauscher & McClintock, 1997; Andersen & Collins, 2004).

At the **individual level**, people are socialized to accept stereotypes and internalize messages of inferiority and superiority about their own and others' social groups (Ortiz & Jani, 2010). As in mental health stigma models, this internalization leads to prejudice and individual-level discrimination. Unlike stigma models, though, this framework recognizes that individuals who are members of dominant groups (e.g., whites, people perceived as not having mental illnesses) receive unearned privileges, such as being assumed to be capable, receiving priority in hiring, and being elected to leadership positions that are less available to members of subordinated groups.

At the **institutional level** the practices and policies of media, legal, health care, religion, and other institutions negatively affect members of oppressed groups while simultaneously privileging members of more powerful groups. As noted by Andersen and Collins (2004) in their discussion of racism, this concept reveals that *[r]acism is structured into the society, not just in people's minds* (p. 81).

At the **social/cultural level**, *beliefs, symbols, and underlying cultural rules of behavior* produce and reproduce oppression (see Derman-Sparks & Phillips, 1997). For example, societal beliefs about the dangerousness of certain groups and accepted practices regarding ways of interacting with – or avoiding – them may be manifestations of social/cultural oppression.

Common Characteristics of Oppressions

Though racism, sexism, and other forms of oppression have different manifestations, they all share some characteristics (Pharr, 1988). In each form groups are judged in relation to a defined norm, which is supported with institutional power (e.g., media, economic system). Groups who do not fit this norm are defined as 'Others'. The behaviors of the Others may be either invisible or distorted. This may occur through presentation of false information or emphasizing group members' failures (e.g., media sensationalizing violent acts of members of certain groups without corresponding stories about their achievements). These practices reinforce stereotyping, through which *people are denied their individual characteristics and behavior and are dehumanized* (Pharr, 1998, p. 59). When people accept stereotypes, they tend to blame the victim for her/his situation. Further, members of oppressed groups may be isolated from larger society.

Oppression frameworks recognize that oppression at all three levels may be conscious and overt (e.g., use of derogatory names, laws restricting voting or other civil rights) or unconscious and covert (e.g., failing to include people affected when decisions are made). In addition, oppression frameworks assume that for every oppressed group there is a least one group that is privileged in relation to that group; just as members of an oppressed group might internalize messages that they are not as good as members of the powerful group, members of dominant groups internalize messages that they are better than the Others. Further, as noted by McIntosh (2004) in *White Privilege: Unpacking the Invisible Knapsack*, members of a dominant group might recognize some disadvantages experienced by subordinated groups but are not taught to recognize their own privileges. For example, dominant group members may not recognize they are privileged when they appear to be resilient in the face of adversity; this resilience actually may be due to additional institutional supports that are available to them.

Faces of Oppression

Young (1990) presents fives *faces* to assess if a group is oppressed; if a social group experiences any of these faces, then it is oppressed. People with mental illnesses experience at least three faces: marginalization, powerlessness, and cultural imperialism. *Marginalized* groups are excluded from the labor market; they then are dehumanized when the social service system subjects them to *patronizing, punitive, demeaning, and arbitrary treatment by the policies and people associated with welfare bureaucracies* (Young, p. 54). Powerless groups are denied the opportunity to make decisions and often are required to take, but not give, orders. Groups that experience cultural imperialism are judged by the norms of the dominant group and are socially constructed as outside the norm – as Other. These groups find that they are simultaneously stereotyped by and invisible to the dominant group. Because the stereotypes often are related to their physical bodies, it is more difficult to deny them.

Commonalities Among Critical Theories

Numerous critical theories (e.g., critical race theory, critical Latina/o theory, Black feminist thought and other critical feminisms) have been developed to understand and transform oppression. We present some common elements of these theories to inform a critical anti-oppression paradigm for the mental health field.

Critical theories assume that all theories and research endeavors are political; the clearly-stated purpose of critical theories and research is to transform society, not only to understand it (Hulko, 2009; Davila & de Bradley, 2010; Huber, 2010; Ortiz & Jani, 2010). As with the theories of Foucault (1965), Goffman (1963), and Szasz (1961), critical theories assume that social groups and characteristics associated with them are socially constructed, rather than essential (Anderson & McCormack, 2010; Ortiz & Jani, 2010). Rather than focusing solely on ways in which subordinated groups internalize oppression, however, critical theorists also focus on understanding privilege (Hulko, 2009; Dermer, Smith & Barto, 2010), in recognition that it is dominant groups and institutions that need to be the primary targets of change efforts (Aguinaldo, 2008; Ortiz & Jani, 2010). When focusing on oppressed groups, researchers focus on resilience and resistance to oppression, rather than only on the negative effects of oppression (Davila & de Bradley, 2010; Huber, 2010; Pyke, 2010): What strategies are members of subordinated groups using to empower themselves and to change dominant groups and institutions? Being a member of a subordinated group is viewed as a risk factor for oppression, rather than only as an indicator of possible culture-related beliefs or experiences (Ford & Airhihenbuwa, 2010). These theories assume that institutional-, cultural-, and individual-level oppression should be the focus of analysis and change (Ford & Airhihenbuwa, 2010; Ortiz & Jani, 2010). Intersections of difference or social location are emphasized, with recognition that group memberships (e.g., those based on class, race, ethnicity, sexual orientation, gender, disability status) intersect at the individual level; people's experiences with oppression and privilege vary related to their multiple group memberships (Andersen & Collins, 2004; Hulko, 2009; Huber, 2010; Ortiz & Jani, 2010). Finally, critical theorists emphasize the historical, social, and political contexts in which oppression occurs (Davila & de Bradley, 2010; Hawkesworth, 2010), including recognizing variations across social settings and time (Hulko, 2009; Wilson, Okwu & Mills, 2011).

Critical Anti-Oppression Paradigm for the Mental Health Field

Presenting a critical paradigm for understanding and transforming oppression based on perceived mental health status without a term for this form of oppression is problematic. We find the term *stigma* to be inadequate. As noted by Castro and Farmer (2005) in their discussion of AIDS-related stigma, *stigma is often just the tip of the iceberg. . . and has frequently served as a means of giving short shrift to powerful social inequalities. . . that are much harder to identify and conceptualize* (p. 53). Occasionally the term *ableism* has included oppression based on perceived mental health status; however, this term is most widely used in relation to physical disabilities. While the community has not widely accepted the term *sanism*, its parallel to terms used to denote oppression and privilege for other marginalized groups (e.g., heterosexism, nativism) offers certain advantages.

As with other forms of oppression, sanism is pervasive and includes *institutional and systemic discrimination, personal bias, bigotry, and social prejudice in a complex web of relationships and structures that saturate most aspects of our society* (Bell, 1997, p. 4). As with physical ableism, this perspective assumes that people experience isolation and other negative experiences as a result of prejudice and discrimination, rather than solely due to their disabilities (see Rauscher & McClintock, 1997).

A critical anti-oppression paradigm seeks to analyze and transform social/cultural-, institutional-, and individual-level structures and processes that oppress people who are perceived to have mental illnesses. Column 2 of Table 1 presents examples of ways in which oppression against people with mental illnesses may be manifest at these three levels. This paradigm assumes that institutional- and cultural-level, in addition to individual-level, oppression should be foci of analysis and change.

Table 1: Examples of Cultural, Institutional, and Individual Oppression of People with Mental Illnesses and Recommendations for Research

Level of Oppression	Examples of Oppression	Possible Areas for Transformative Research[a]
Cultural		
Language	Conscious/Intentional/Overt/Blatant: 1. Use of derogatory terms directed toward people with mental illnesses Unconscious/Unintentional/Covert/Subtle: 1. Use of derogatory terms directed toward people without mental illnesses (e.g., *Are you crazy?* when addressing a person with whom one disagrees) 2. Using illness-focused terms (*a schizophrenic* rather than *a person [living] with schizophrenia*)	1. Examine how people with mental illnesses actively resist stereotypes manifest in oppressive language. 2. Examine individual and institutional contexts in which oppressive language is/is not used and the impact of use/non-use. 3. Identify major influencers on use and non-use of oppressive language (e.g., parents, peers, various institutions). 4. Examine effectiveness of interventions to decrease use of oppressive language.
Traditions/ Practices	Conscious/Intentional/Overt/Blatant: 1. Seeking to exclude people with mental illnesses from neighborhoods: Not in my backyard (NIMBY) 2. Lower level of welcome or failing to invite cultural members with mental illnesses from attending celebrations, public meetings, etc. Unconscious/Unintentional/Covert/Subtle: 1. Excluding people with mental illnesses in everyday interactions	1. Examine strategies used by people with mental illnesses and their allies to overcome these traditions/practices. 2. Examine contexts and actors involved in NIMBY actions and effectiveness of interventions designed to decrease NIMBY. 3. Examine ways in which society sends the message that it is acceptable to exclude people with mental illnesses and the effectiveness of interventions designed to interrupt these messages/practices.
Institutional		
Schools (K-12)	Conscious/Intentional/Overt/Blatant: 1. Policies on punishing/expelling children/youth for behavioral issues related to mental illnesses 2. Ignoring oppressive language of teachers, staff, or children/youth directed toward people with mental illnesses Unconscious/Unintentional/Covert/Subtle: 1. Segregating children and youth with mental illnesses for *their own benefit* 2. Use of oppressive language of teachers or children/youth directed toward people without mental illnesses 3. Faculty and staff acting on internalized stereotypes regarding people with mental illnesses 4. Lack of "out" people with mental illnesses in leadership positions	1. Examine how faculty, staff, and students with mental illnesses and their families resist these policies and practices. 2. Examine the effects of oppressive policies and practices on those with and without mental illnesses. 3. Examine organizational culture and practices that limit and support employees' abilities to be 'out' as persons with mental illnesses.
Schools (Higher Education)	Conscious/Intentional/Overt/Blatant: 1. Decreased availability of campus mental health services despite recent well-known on-campus incidents related to students with mental illnesses 2. Referring students to off-campus services only if they have insurance or can privately pay Unconscious/Unintentional/Covert/Subtle: 1. Attendance or assignment policies that do not consider individual needs/situations of students with mental illnesses 2. Lack of attention to oppression in mental health curricula	1. Examine strategies that have successfully challenged these practices. 2. Examine the effects of oppressive and anti-oppressive policies and practices of vocational schools, colleges, and universities on those with and without mental illnesses. 3. Examine organizational culture and practices that limit and support employees' abilities to be 'out'.

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Table 1: *(Continued)*

Level of Oppression	Examples of Oppression	Possible Areas for Transformative Research[a]
	3. Tenure expectations that limit opportunities for professors with mental illnesses to obtain tenure (i.e., requirement for intense publications over a short time period that might not be possible if certain symptoms occur) 4. Lack of "out" people with mental illnesses in leadership positions 5. Lack of attention to the brain and mental health conditions in human biology courses/texts	
Legal System	Conscious/Intentional/Overt/Blatant: 1. Laws limiting civil rights of people with mental illnesses (rather than people who currently have debilitating symptoms) Unconscious/Unintentional/Covert/Subtle: 1. Inadequate training for law enforcement for handling situations involving people with mental illnesses	1. Examine who supports and opposes oppressive laws to identify strategies for education and change. 2. Examine the contexts in which oppressive and anti-oppressive legislation, policies, and practices take place and their effects on people with and without mental illnesses.
Mental Health System	Conscious/Intentional/Overt/Blatant: 1. Insurance companies provide less extensive coverage for mental health than for physical health conditions 2. Lack of adequate state funding for mental health systems Unconscious/Unintentional/Covert/Subtle: 1. Discrimination perpetuated by staff (e.g., not valuing contributions of peer employees, having low expectations for clients) 2. Lack of peer employees and others with mental illnesses in decision-making and other leadership positions 3. Focus solely on individual treatment rather than on individual and institutional-level anti-oppression interventions	1. Document and evaluate interventions that focus on consciousness-raising and strategies for institutional-level change. 2. Document and evaluate strategies aimed at developing positive group identities among people with mental illnesses. 3. Develop and evaluate strategies for increasing mental health funding. 4. Examine the effects of oppressive and anti-oppressive policies and practices on providers and clients. 5. Examine organizational culture and practices that limit and support persons with mental illnesses in serving in leadership positions.
Physical Health System	Conscious/Intentional/Overt/Blatant: 1. Government policies that funnel people with mental illnesses to certain systems or providers Unconscious/Unintentional/Covert/Subtle: 1. Patronizing or not listening to patients with mental illnesses 2. Assuming that physical symptoms are due to mental health conditions 3. Lack of training on treatment options (beyond prescribing medications) for people with mental illnesses	1. Examine the effects of oppressive and anti-oppressive policies and practices on providers and patients. 2. Document and evaluate strategies of resistance to oppressive practices. 3. Develop/document and evaluate curricula for physicians, nurses, and other physical health care providers.
Businesses/ Workplaces	Conscious/Intentional/Overt/Blatant: 1. Advertising that reinforces stereotypes (e.g., *March Madness*, *crazy sale*) 2. Applying leave policies differently for people with physical vs. mental health conditions Unconscious/Unintentional/Covert/Subtle: 1. Employees acting on internalized stereotypes regarding people with mental illnesses (e.g., assuming their ideas/ contributions are not valuable, assuming that they cannot handle certain responsibilities) 2. Lack of "out" people with mental illnesses in leadership positions	1. Document and evaluate strategies used by people with mental illnesses to resist oppressive workplace policies and practices. 2. Examine the effects of oppressive policies and practices on those with and without mental illnesses. 3. Examine organizational culture and practices that limit and support employees' abilities to be 'out'.

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Table 1: *(Continued)*

Level of Oppression	Examples of Oppression	Possible Areas for Transformative Research[a]
Religious Institutions	Conscious/Intentional/Overt/Blatant: 1. Blaming the victim by asserting that mental illnesses can be cured through religious practices (e.g., prayer) Unconscious/Unintentional/Covert/Subtle: 1. Teachings that may lead practitioners to associate mental illnesses with demonic possession	1. Examine the beliefs and practices of religious groups that may perpetuate oppression and those that challenge oppression. 2. Identify strategies for influencing religious groups to challenge oppression.
Housing	Conscious/Intentional/Overt/Blatant: 1. Refusing to rent to people who are perceived to have mental illnesses 2. Lack of publicly-funded housing for people with mental illnesses Unconscious/Unintentional/Covert/Subtle: 1. Publicly-funded housing located in lower-income neighborhoods	1. Examine the effects of oppressive and anti-oppressive policies and practices on the availability of housing for people with mental illnesses. 2. Document and evaluate strategies to resist discrimination in housing.
Media (e.g., movies, newspapers, television, internet, music, books, magazines)	Conscious/Intentional/Overt/Blatant: 1. Reinforcing stereotypes through characters in movies and television (e.g., advertising the lead character on *Monk* as *the defective detective*) 2. Reinforcing stereotypes in news (e.g., intentional sensationalizing of violent actions of people who are perceived to have mental illnesses) Unconscious/Unintentional/Covert/Subtle: 1. Lack of positive lead characters or 'out' actors in movies, television, and books who are living with mental illnesses 2. Accepting stereotypes (e.g., reporters assuming that persons who commit violent acts have mental illnesses; lack of positive news stories about people living with mental illnesses; not interviewing people with mental illnesses as 'experts' on living with mental illnesses) 3. Lack of 'out' people with mental illnesses in leadership positions	1. Examine the effects of oppressive content on people with and without mental illnesses. 2. Evaluate interventions that aim to decrease oppression in the media for their effectiveness within various contexts and on various groups of people.
Research Institutions	Unconscious/Unintentional/Covert/Subtle: 1. Researchers' emphasis on individual-level causes and effects of prejudice and discrimination on people with mental illnesses 2. Lack of 'out' people with mental illnesses in leadership positions on research projects and in research institutions 3. Lack of collaboration with people with mental illnesses in designing and carrying out research projects	1. Collaborate with people with mental illnesses in designing and carrying out research projects, focusing on asking research questions that are important to people with mental illnesses. 2. Critically examine the reasons for and effects of the mental health field's primary focus on understanding individual-level prejudice and discrimination and lack of collaboration with people with mental illnesses on research teams. 3. Develop, implement, and evaluate strategies for increasing funding for mental health research that considers system-level oppression as a legitimate focus of mental health research.
Political Arena	Conscious/Intentional/Overt/Blatant: 1. Targeting programs for people with mental illnesses in making budget cuts Unconscious/Unintentional/Covert/Subtle: 1. Not including people with mental illnesses in making budgetary and programmatic decisions	1. Examine instances of conscious and unconscious oppression practiced by politicians to uncover the contexts and effects of such practices. 2. Document/develop and evaluate anti-oppression interventions aimed at politicians

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Table 1: *(Continued)*

Level of Oppression	Examples of Oppression	Possible Areas for Transformative Research[a]
Individual (General Public)	Conscious/Intentional/Overt/Blatant: 1. Using oppressive language about people who are perceived to have mental illnesses 2. Teaching children stereotypes and myths, such as that people with mental illnesses are dangerous or incompetent 3. Telling children to not tell others if they or a relative has a mental illness 4. Telling or laughing at oppressive jokes or stories Unconscious/Unintentional/Covert/Subtle: 1. Using oppressive language toward people who are not perceived to have a mental illness 2. Not seeking accurate information about people with mental illnesses 3. Not correcting others when they behave in oppressive ways 4. Not talking openly in a supportive way about people who are perceived to have mental illnesses 5. Not seeking treatment for a family member who exhibits symptoms of having a mental illness 6. Viewing or listening to oppressive media without considering the overt or covert oppression that it depicts 7. Exhibiting patronizing behaviors when interacting with people with mental illnesses or their families	1. Examine contexts and actors involved in teaching individuals about oppressive language, practices, and roles. 2. Examine processes that lead to, and the effects of, internalized privilege and internalized oppression. 3. Develop tools to measure awareness of prejudice and discrimination against people who are perceived to have mental illnesses. 4. Examine effects of intersections of oppression/privilege related to multiple social group memberships on physical health, mental health, and other domains. 5. Document/develop and evaluate anti-oppressive interventions to address individual-level oppression.

Note: This table presents each level of oppression and each institution separately for purposes of clarity. In reality, each level interacts with each other area. It thus is important to consider, for example, ways in which two or more levels and/or institutions work together to create or challenge oppression. In addition, it is assumed that this form of oppression interacts with other forms of oppression (e.g., racism, classism, sexism) but these relationships are not presented here.

[a]The aim of any of these areas of research would be to identify strategies for change/transformation.

Researchers and practitioners using this critical paradigm would seek to identify effective strategies that individuals and groups have used to promote resilience and resist oppression related to perceived mental health status. For example, what strategies have community activists developed to empower individuals and families to resist internalized oppression, to work within mental health organizations to ensure that they are active participants in decision-making and other processes, to lobby for needed programs and services, and to effect other community-level transformations?

Rather than focusing on understanding universal experiences of oppression, privilege, and resistance related to perceived mental health status, a critical paradigm recognizes that individual and group perspectives and experiences vary as a function of historical, social, and political contexts. Social locations are critical areas of emphasis, with recognition that multiple group memberships, including those related to class, race, ethnicity, sexual orientation, gender, national origin, physical (dis)ability, and religion lead to different experiences with privilege, oppression, and opportunities for resistance related to one's perceived mental health status. For example, a woman who is white and upper class will have different mental illness-related experiences than will a Mexican-American man who is living in poverty. In addition to facing oppression related to their mental illnesses, the former will experience privileges related to her race and social class and oppression related to her gender; the latter will experience privilege related to his gender and oppression related to his ethnicity and social class. When analyzing the effects of these differences, attention to oppression, privilege, and resistance related to racism, sexism, classism, and other forms of oppression are considered, rather than considering these group memberships as reflecting only cultural differences.

Because dominant groups and institutions must be targeted as the primary focus for change, this paradigm includes a focus on understanding ways in which privilege related to one's mental health status is internalized by individuals and woven into the fabric of institutions. Such analyses can inform change strategies for community activists and their allies.

As in the work of Foucault (1965) and Szasz (1961), this paradigm assumes that the group that society has labeled as people with mental illnesses is socially constructed. This assumption does not deny that there may be some differences between people with and without mental illnesses, nor that treatment for mental health conditions is not helpful. It does assert, however, that it is a social construction that has led society to consider this difference as significant enough to assign people to this social group, assign negative stereotypes to the group, consider its members to be inferior to those without mental illnesses, and use stereotypes and perceived inferiority to justify discriminating against members of the subordinated group and awarding privileges to dominant group members. Evidence that this group is a social construction can be found in the fact that people with a history of such a wide variety of symptoms or illnesses, ranging from those that cause no to extensive disability, are placed in the same social group whether or not they currently have any symptoms. It also is important to consider that just as gender and racial groups have been socially constructed based on differences attached to the physical body, recent anti-stigma efforts that have emphasized the biological underpinnings of mental illness may have unintentionally reified the social construction of this group as inherently inferior and permanently disabled; they may have inadvertently solidified the embodiment of this social construction.

Just as critical race theorists do not seek to eliminate 'African American, Latina/o', or other labels and feminists do not seek to eliminate the labels 'girl' and 'woman', a critical paradigm for understanding oppression based on mental health status does not seek to eliminate the label 'people with mental illnesses'. Rather than denial of group differences or attempting to *eliminate or transcend* differences, a critical paradigm advocates that *a **positive self-definition** of group difference is in fact more liberatory* and strives for a society in which different social groups respect and affirm each other with full awareness of their differences (Young, 1990, p. 157, emphasis added). Such an approach would be evident when community activists focus on individual and community empowerment, for example. Of course, people with mental illnesses must decide on the group's preferred labels and whether "people with mental illnesses" is an acceptable term, rather than automatically accepting the labels created by outsiders. With full awareness of the devastating pain experienced by people who are labeled as having mental illnesses – due in large part to the internalization of stereotypes – we recognize that there is a risk in not seeking to eliminate the label/social group. But as Young (1990) asserts, getting rid of the label does not get rid of the group itself. Even without the label, people with mental illnesses will continue to be different in some ways than people without mental illnesses and will continue to be oppressed. If the existence of this group is denied, then the possibility of anti-oppression organizing by members of the group and their allies is hindered. People with mental illnesses would continue to be *invisible* when institutions develop policies and programs.

Implications for Social Change and Research

This critical anti-oppression paradigm adds several elements not present in traditional stigma models. Its focus on transformation; interactions of social/cultural-, institutional-, and individual-level oppression; resilience and resistance; understanding privilege as well as oppression; social locations; and contexts has many implications for social change and research. We offer a few of these implications below.

Implications for Social Change

Peer and clinician practitioners need to recognize that unlike people who move from identifying with certain other privileged groups (e.g., those who shift from a heterosexual to a lesbian or gay identity), the social identity shift for newly-diagnosed individuals may be swift and occurs when a diagnosis is assigned by a professional rather than explored and accepted over time. Practitioners and community advocates thus need to implement strategies (e.g., consciousness-raising) for developing positive social identities and avoiding internalization of oppression.

A critical anti-oppression paradigm asserts that transformative social change efforts cannot be divided into micro and macro levels. Individual-level interventions are necessary, but must be combined with strategies that aim to change oppressive institutions and cultural practices. Strategies to raise critical consciousness (e.g., see hooks, 2000; Crethar, Torres Rivera & Nash, 2008; Abrams & Moio, 2009) of people with and without mental illnesses are required. This consciousness-raising might be particularly important for people working in mental health organizations so they can become aware of their own internalized privilege or oppression. With critical consciousness, people with mental illnesses and their allies can work together to identify effective strategies [e.g., tactics that lead to full inclusion of consumers in decision making, protests or boycotts (Corrigan et al., 2005), affirmative action (Corrigan et al., 2004), education] to change mental

health, physical health, legal, workplace, educational, and other institutions. Existing mental health organizations can plan programs and services with the full participation of clients (Crethar et al., 2008) or collaborate with people with mental illnesses as they create consumer-run organizations (see Corrigan et al., 2005). Powerful managed care organizations particularly require advocacy so that consciousness-raising and other actions can become a part of interventions.

Implications for Research

A critical anti-oppression paradigm calls for changes in the mental health research agenda and process. Principles of critical theories need to guide research, including a focus on documenting effective strategies of resistance, understanding how a previous identity as a member of the privileged group may contribute to internalized oppression after diagnosis, analyzing and transforming institutions and social/cultural practices, and seeking to understand the structures and processes that lead to internalized privilege. As noted by Aguinaldo (2008) in discussing heterosexism, *When we can identify and understand how people create and sustain such an oppressive world, we have gained important tools we can use to change it* (p. 94).

Column 3 of Table 1 presents examples of areas to be examined using a critical anti-oppression research paradigm. In all research, collaborations should occur between individuals with research expertise (those with and without mental illnesses), community members with mental illnesses, and their allies. In these collaborations, research questions, methods, analyses, and reports derived from the life experiences of people with mental illnesses can lead to a transformative research agenda (see Huber, 2010; Ortiz & Jani, 2010).

Perhaps the most important first step in developing such a research approach is to analyze existing stigma research, as the research endeavor itself is an institution that must be critically evaluated for its unconscious participation in oppression (Pyke, 2010). To do so, we first must raise our own consciousness and consider several crucial questions: Why has this field focused primarily on understanding individual-level cognitive processes related to prejudice and discrimination? Why have we often failed to take a clear political stance, to analyze power issues, to focus on internalized dominance and privileges accorded to people without mental illnesses, to collaborate with people with mental illnesses and their families in our research, and to ignore the acts of resistance of community advocates? Is it possible that researchers, who may be members of the dominant group in relation to people with mental illnesses, need to *unpack the invisible knapsack* of mental health status-related privileges, as McIntosh (2004) did with white privilege?

Conclusion

This paper has offered theoretical arguments for replacing the current stigma model with a critical anti-oppression paradigm. This proposed paradigm expands our lens from a focus on individual-level cognitive processes and the negative effects of oppression on people with mental illnesses. It emphasizes power dynamics inherent in current system-level structures that privilege those who are perceived as not having mental illnesses while disadvantaging others who are perceived to have mental illnesses. We hope that community members and researchers who identify as having mental illnesses and their allies (including researchers without mental illnesses) can work together to contribute to our understanding of the specific characteristics, processes, and effects of this form of oppression and identify or develop and evaluate effective transformative strategies.

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