HSN
University College
of Southeast Norway

Key Figures

17.000
STUDENTS
1.500
EMPLOYEES
BA
88
BACHELOR PROGRAMMES
MA
44
MASTER PROGRAMMES
PhD
7
PHD PROGRAMMES
8
CAMPUS
BØ – DRAMMEN – KONGSBERG
NOTODDEN – PORSGRUNN
RAULAND– RINGERIKE – VESTFOLD

CAMPUS BØ

CAMPUS DRAMMEN

CAMPUS KONGSBERG

CAMPUS NOTODDEN

CAMPUS PORSGRUNN

CAMPUS RAULAND

CAMPUS RINGERIKE

CAMPUS VESTFOLD

Research areas

// Economy, management and politics
// Health and welfare
// Humanities
// Kindergarden, schools and higher education
// Nature, health and environment
// Maritime enterprise
// Outdoor life, sports and physical education
// Technology
// Traditionale arts and practical-aesthetic subjects
// Vision Science

PhD Programmes

// Applied Micro-and Nano-systems
// Cultural studies
// Ecology
// Marketing Management
// Person-centred Health Care
// Process, Energy and Automation Engineering
// Research training in pedagogical resources and learning processes

ANTI STIGMA

- SPOC and aims
- A qualitative study of social identity
- Anti stimga campaigns and actions

SPOC – anti stigma

- Primary goal: Combating stigma and discrimination, directed towards mentally ill people

Specific objective (objectives), if applicable:

- Raising social awareness in regard to the mental health issues;
- Diminishing negative beliefs and stereotypes;
- Establishing support environment for mentally ill people, equal treatment and social inclusion;
- Encouraging the protection of mentally disordered people’s human rights- in both social and economic perspective
- Inspiring the social awareness and commitment in the topic of the mental health and welfare.
- Stimulating the anticipatory prevention of mental problems;
- Strengthening of the cooperation in the process of introducing best European practices;
- Increasing the partnership collaboration practice within the institutional and social framework;

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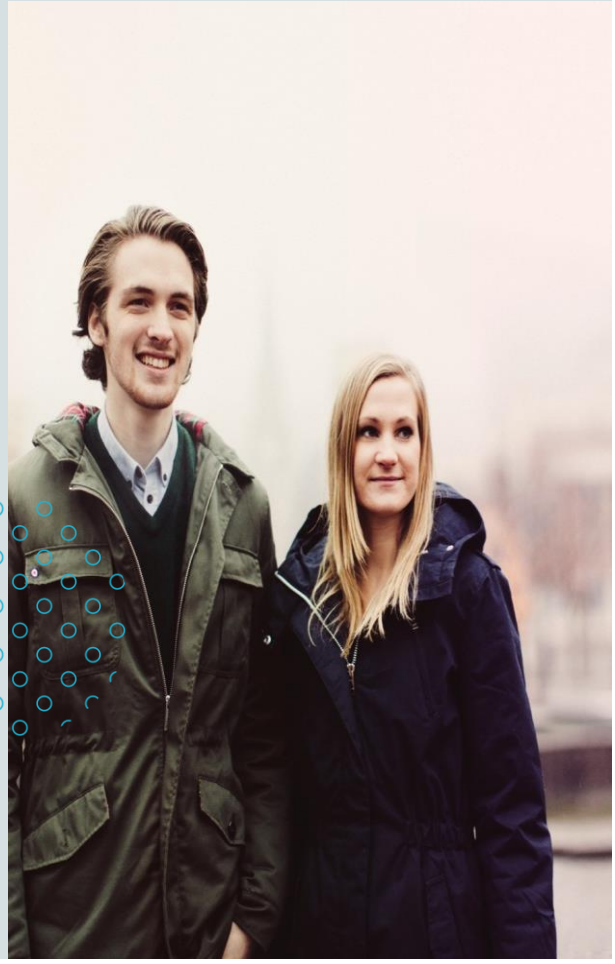
Service users' experiences of the impact of mental health crisis on social identity and social relations



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Програма БГ07
"Инициативи за обществено здраве"
Проект „Ние Ви разбираме и подкрепяме“, договор № BG 07 РД-13-136/14.09.2015

The aim of my study was

to explore reflections on the experiences of mental health crises, social relationships and social identity from the service user's perspective, using the following questions as the lead-in questions in the interviews:

- Can you say something about how mental health crisis experiences impact your relations to others? (partner, children, parents, sibling, friends and colleagues)
- Can you say something about your meetings with the mental health services?

The identity of normalcy («normality»)

Normality is defined and constituted in societies through formal and residual rules and norms (Becker, 1973; Scheff, 2007; Thoits, 1985).

The process of stigmatization, both public and self-stigma, involves three parts:

- stereotyping (negative belief),
- prejudice (agreement with belief), and
- Discrimination (response to prejudice) (Corrigan & Watson, 2002).

This process in relation to mental health labelling, often based in misconceptions, is revealed in the attitudes and behavior both by the service-users, people in general and mental health providers, as well as in the media.

Main Theme “ Experiences of being looked down on”

- four sub-themes:
  - “once mentally ill, always mentally ill”,
  - “labelled by oneself”,
  - “labelled by social networks” and
  - “labelled in mental health services”

Experiences

It is difficult, very difficult being mentally ill (…) because you get looked down on… I will never… I believe, I hope I can do it, but I think I will never say that today a somatic or mental illness is the same. It's just nonsense, really nonsense, that people look down their noses at people with such problems.

This statement reveals the experience of one participant in this study regarding his social identity as a person who has experienced a mental health crisis.

Once mentally ill, always mentally ill.

It is difficult to get away from the role of a mentally ill person. Sarah experienced that the problem was that people around her thought that «once mentally ill, always mentally ill»:

> *(…) even if things have improved, I think, in recent years in relation to mental illness, that there is more openness about it, which there is, probably, but still a lot of taboos and stigmas associated with it. That is, one time mentally ill, always mentally ill. (…) Like if you have a depression when you're 25 and have another when you're 45, then it's sort of like «yeah, well, I remember that she was ill, and she has probably been ill all the time», but if you catch the flu when you're 25 and again when you're 45 nobody will say that you have a chronic flu. Right?*

Labelled by one-self.

Low self-esteem and the feeling of not being «normal» were described by the participants. Philip experienced in general that it is difficult to suffer a mental illness and hard to be pictured as a person with those kind of problems. He felt that being mentally ill was something totally different from having a somatic disease. He stated that he was ashamed when he had a beer in a public place, and mentioned this situation from last summer.

> *We were going to a concert, my wife and I, then my wife says: «Fancy a pint?». (…) So I sit there with my pint, and I start thinking: «Good Lord, if anyone should see me now», me with my disability pension, problems with the upstairs compartment and then he sits there drinking.*

Labelled by social network.

This theme is based on the informants' interpretations of how people acted and felt toward them in relation to mental health problems. Philip felt that people he had been in good relationships with previously now looked down on him because of the mental health crisis, mentioning one concrete situation in which he and his wife met a friend while they were out walking.

> *(…) I'll tell you one thing, I had a colleague, we met him in town; my wife, me and him are standing there, and he's talking to my wife for at least 10 minutes, without speaking a word to me.*

Labelled by social network.

Sarah thinks that people do not in general understand what it means to have a bipolar disorder and how it affects people's lives both personal and social. She pointed out that she might experience prejudiced because she has a bipolar disorder.

> *(…) I think that not very many people know what it is, and that it sounds a little scary. (…) It's sort of how you have to face up to … some strange looks and people scrape their feet and start speaking of something else when you … or like when you've been on sick leave people ask: «So why are you on sick leave, then?» (hawks) «Ehh, well, I have a mental illness…», then just «Yeah», and then they change the topic. That it … it is, I've seen it many times, and there are many others I've talked to whom also, then, people sort of go silent. (…) And then people don't know.*

Labelled in mental health services

Another finding is about the experience of

being labelled by mental health service providers in the context of being a «mental health patient». One should expect understanding and caring from mental health professionals and the mental health services, however, this is by no means always

the case. For instance, Nora felt she was not being taken seriously or competently at all in the mental health hospital unit. During one admission, she fell and broke her leg; nobody believed her and it took several hours before she was taken to the

emergency unit. When she was finally transferred to a somatic hospital, she had the same feeling of not being trusted, and that she was seen as an incompetent person.

> *And I was laying there in bed and I knew it was broken. (…)(a nurse asked) «Are you sure it's broken?» (Imitates the voice) «What do you think?» I said, but I came from the mental health hospital, y' know, so they all thought I was a nutter, right.*

Nora also experienced that the staff overlooked her in conversations about

Labelled in mental health services

Cathrine described that she felt labelled when she was admitted to the mental health hospital, feeling humiliated by the fact that she was not handling things well and by the feeling that the staff degraded her because of her mental health crisis.

> *(…) I don’t like going to a therapy in a hospital, I never liked it. (…) It was, like, then you feel even sicker and labelled when you go there. (…) And to me that’s just like labelling people on the forehead, saying that «oh well, you can’t function in daily life, so now we’ll cook for you and arrange things for you». (…) To me it becomes a sign that you’ve quit, because you give up your own independence, then you’ve just lain down to die.*

Step forward…

There is a need to emphasize the **emotional, relational, and contextual** aspects of mental health care, and the care and services for persons experiencing mental health crises need to include socio-cultural and psycho-dynamic perspectives (Scheff, 2007; Thoits, 1985).

Developments in community-based mental health services need to be focused on integrating a more **humanistic and social orientation** and relying on the knowledgebase drawing on such as social models, social network and anti-stigma theories, which are critical, especially in the current culture of pharmacotherapy and narrow treatment models (Tew, 2005; Wahl, 2012; Walker & Read, 2002; World Health Organization (WHO), 2010, 2013).

One conclusion… (among others…)

We can hope for the day when people with mental health illness are allowed to focus on their convalescence and recovery without the added burden of stigma and of needing to become someone other than who they already are.

There is a need to change both the organizational structures and philosophy for mental health services, shifting its emphasis on control and narrow treatment guidelines to context-oriented recovery care and flexible support (Davidson 2005).

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