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Distinguishing Post-traumatic Stress Disorder (PTSD) from Complex PTSD (CPTSD): A Review of Intervention and Treatment Pathways

The Experiences of Living in an Emergency Reception and Orientation Centre in Ireland: A Qualitative Study

The Power Threat Meaning Framework and Covid-19

Mental Health Stigma: An Exploration of Certain Irish Service Users' Experiences and Coping Processes

Society's Anxiety

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FOREWORD

Hi all,

First of all, our hopes are very much that you and loved ones are keeping well in these challenging times. As authors of some of the following pieces have said, these times put a lot of our concerns into perspective, and make us grateful for many things previously taken for granted. In such uncertain times it was always comforting to have others in our company helping us to make sense of the world. In this regard, we're particularly pleased to have such a diverse and thoughtful range of papers in this edition.

Inevitably, the Covid-19 crisis looms large in our minds and in this regard the application of the Power Threat Meaning Framework (PTMF) to understanding its impact makes for thought-provoking reading. Similarly, the use of the PTMF model to explore societal pressures, and their impact on youth mental health, challenges our individualistic take on young people's difficulties.

Given the traumatic impact of the current pandemic on many, an exploration of PTSD and its differentiation from 'complex PTSD' is timely and provides a really helpful insight into the literature in this area. It is the most vulnerable who will be on many of our minds at present. Consequently hearing the 'lived experience' of individuals suffering from stigma as a consequence of their mental health difficulties and from those refugees struggling to survive and thrive while living in an Emergency Reception and Orientation Centre (EROC) makes for compelling reading.

In the journal's working group itself we have been thinking about issues of diversity and difference as apply to this journal; so see our diversity statement at the end of this edition as an indication our initial thoughts in this regard.

Finally, immense thanks as always need to go to the authors, the reviewers, the CPT steering group and especially to Siobhán O' Neill, without whose creative contribution this journal would not be possible.

With thanks,

Edition Co-Editors: Pádraig Collins, Lynn White

DISTINGUISHING POST-TRAUMATIC STRESS DISORDER (PTSD) FROM COMPLEX PTSD (CPTSD): A REVIEW OF INTERVENTIONS AND TREATMENT PATHWAYS

MARY EGAN



INTRODUCTION

Post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (CPTSD) are similar but distinct diagnoses. While PTSD has an evidence-base, CPTSD is an emerging area. Certain authors have expressed the hope that the introduction of CPTSD to the 11th version of the International Classification of Diseases (ICD-11) will encourage research into efficacious interventions¹. However, bearing in mind the debate within Clinical Psychology, of whether individualised

formulations or diagnostic categories based on biomedical models are most appropriate, the addition of a new diagnostic label may be a controversial decision for some clinicians and service users²⁻⁵.

Both PTSD and CPTSD consist of four core difficulties: re-experiencing, active avoidance behaviours, passive avoidance behaviours and heightened physiological arousal⁶⁻⁸. CPTSD contains three additional core clusters: affect dysregulation, interpersonal difficulties and pervasive low self-esteem^{1, 6-8}. CPTSD and PTSD are also reported to differ in terms of aetiology. PTSD can be diagnosed after experiencing a single traumatic event, while CPTSD is associated with multiple⁹ and frequent traumatization⁶, which is inescapable⁹. CPTSD is associated with certain traumas, particularly of an

interpersonal nature^{1, 6-8, 10-12}. This article will discuss the current evidence-base of interventions for PTSD and CPTSD focusing on meta-analyses, systematic reviews and current guidelines for each diagnosis. A discussion of the rationale for different treatment pathways for each diagnosis will follow.

THE EVIDENCE-BASE FOR PTSD INTERVENTIONS

Evidence-based interventions for PTSD include exposure therapy, eye movement desensitization and reprocessing (EMDR), trauma-focused cognitive behavior therapy (TFCBT) and anxiety management, with EMDR and TFCBT reported as the most efficacious¹³⁻¹⁵. However, this does not take into account the impact of the therapeutic relationship and individual therapist characteristics which have been reported to contribute to greater variance in outcomes (including how an intervention is adapted to a client's particular formulation and needs) than the particular intervention selected¹⁶⁻¹⁷. Therefore, clinicians should remain mindful of the impact of these factors on client outcomes when implementing any of the above interventions. While the use

of anxiety management is beneficial for short-term alleviation of the physiological symptoms of PTSD, trauma memories are not targeted directly, which is unlikely to achieve long-term gain¹⁸. However, providing immediate improvements is necessary to increase motivation and reduce high attrition rates, which is a problem in all presentations of trauma¹⁹. Anxiety management provides lower dropout rates than TFCBT or EMDR¹³. Therefore, anxiety management is an important component of TFCBT and EMDR that should not be overlooked.

Meta-analyses and systematic reviews have found TFCBT and EMDR to be equally efficacious^{14,20}. This is reflected in the NICE guidelines, which recommend TFCBT for PTSD occurring within 1-3 months of the event, and either TFCBT or EMDR if symptoms persist longer than 3 months in duration²¹. The CBT model of PTSD posits that following a traumatic incident, similar situations are interpreted as dangerous due to danger magnification. The interpretation of these previously neutral situations as dangerous, triggers the fight or flight response and results in a physiological response of anxiety. To reduce anxiety, situations are then

avoided or individuals may compensate by introducing safety behaviours which they believe will reduce the danger in the situation¹⁹. All trauma-related stimuli, including the trauma memory, are then avoided to prevent re-experiencing of the physiological arousal and trauma-related cognitions. TFCBT utilizes relaxation techniques to target physiological arousal, cognitive restructuring to reduce the perception of threat and challenge trauma-related schemas, and exposure therapy to eradicate the feelings of fear¹⁹. EMDR uses bilateral stimulation concurrently with imaginal exposure of the traumatic memory to habituate anxiety, change negative cognitions regarding the trauma and enable processing and integration of the trauma memory²². However, there is evidence to suggest that TFCBT is more effective than EMDR¹⁹ and provides stronger maintenance of improvements²³⁻²⁴. Exposure therapy is the key component of EMDR reliably demonstrated as responsible for improvements in PTSD²⁵. However, as exposure therapy is a shared component of TFCBT and EMDR, the additional elements of EMDR (i.e. bilateral stimulation) could arguably prove to be

unnecessary components. However, these reviews did not include an exploration of differences with regards to the therapeutic relationships and therapist characteristics, which could also account for differences in outcomes. This is a significant limitation in the evidence base, as these are crucial elements of change.

A systematic review of 8 studies on PTSD, which also included a meta-analysis of 7 of the 8 studies, has reported that while both interventions are equally efficacious, future research should investigate if certain clients may be more responsive to one intervention over the other¹⁵. A survey of 330 individuals who had engaged in interventions for PTSD, endorsed cognitive therapy (CT), exposure therapy and psycho-education as 'highly preferred treatments', while EMDR and psychodynamic psychotherapy received the lowest preference rating and endorsements²⁶. A review of the current research into PTSD reported that prolonged exposure therapy was the essential ingredient in CBT and EMDR, with other components of CBT providing less improvement and the eye movement element of EMDR providing no change²⁷. This would explain why both interventions

provide similar outcomes. Further research is required to determine which client would benefit from which intervention. One factor to consider is acceptability of treatment. While TFCBT and EMDR have provided similar outcomes and are superior to waitlist controls, dropout rates remain high. Therefore, finding treatment acceptable to clients that reduce high attrition rates is important. Finding a more acceptable method of conducting exposure therapy may improve attrition rates and provide positive outcomes¹⁵. Rodenburg, Benjamin, de Roos, Meijer and Staams reported that EMDR demonstrated a medium effect size that was significant ($d = .56$) at follow-up, in a meta-analysis of 7 randomized control trials (RCTs) for children diagnosed with PTSD³⁰. Further, when compared to CBT, EMDR was reported to add small but significant incremental efficacy. If exposure therapy is the shared efficacious component in both interventions, this meta-analysis suggests that the method in which exposure therapy is conducted in EMDR is more effective than in CBT.

However, there is also contradictory research to suggest that interventions

excluding exposure therapy achieve similar outcomes to those including exposure therapy²⁸⁻²⁹. For example, one RCT comparing interpersonal psychotherapy (IPT), relaxation therapy and prolonged exposure found that IPT achieved similar outcomes to prolonged exposure therapy ($d = 1.69$; $d = 1.88$, respectively), with the main differences being that prolonged exposure therapy achieved somewhat more rapid results and IPT yielded lower attrition rates (15% vs 29%)²⁸. Another meta-analysis reported no differences between present-centred therapy (PCT) and exposure-based therapies, including lower attrition rates for PCT²⁹.

Overall, the evidence for EMDR and TFCBT suggests that both interventions are effective. Some research suggests that this is due to the shared component of exposure therapy, with individual differences determining who responds to either treatment and differences in the acceptability of each treatment. However, the common factors (i.e. warmth, empathy and unconditional positive regard) may also account for the similar outcomes reported for both interventions³¹. Service users have

reported the most essential elements in EMDR as the creation of a safe environment in therapy and a trusting therapeutic relationship³².

CURRENT RESEARCH INTERVENTIONS FOR CPTSD

While there is currently a scarcity of RCTs of interventions for CPTSD, currently evaluated interventions include: phase-based interventions, compassion-focused therapy (CFT), dialectical behavior therapy (DBT), exposure therapy, TFCBT and EMDR. The literature on CPTSD emphasizes the selection of interventions based on specific presenting difficulties rather than a 'one size fits all' (e.g. dissociation or interpersonal difficulties)^{11,33}. A main focus in CPTSD research thus far is on the sequencing of treatment into phases, beginning with a stabilisation phase and trauma-focused intervention occurring thereafter. This is in keeping with existing guidelines on CPTSD^{6,33}.

PHASE-BASED APPROACH

The International Society for Traumatic Stress Studies (ISTSS) completed an expert opinion survey with 25 CPTSD experts and

25 PTSD experts. 82% of professionals recommended a phase-based approach, beginning with stabilisation as a first-line intervention for CPTSD³³. Emotional regulation skills training and psycho-education on trauma were also rated as efficacious, acceptable and safe for clients. The remaining interventions were rated either as effective for some, but not all, components of CPTSD, or rated as effective but not safe (defined as an intervention with a risk of increasing distress) or acceptable to clients. Of note, psycho-education on trauma was described as an effective intervention for all symptoms of CPTSD³³.

However, it has been argued that a stabilisation phase is an unnecessary delay to effective treatment and concerns have been raised regarding the high dropout rates, lack of control groups, RCTs or comparison of a stabilisation phase with trauma-based interventions³⁴. This is reflective of the area of CPTSD as it stands, as there is a scarcity of research into effective interventions. Further, dropout rates are a common concern throughout both PTSD and CPTSD populations.

While the evidence-base is still building for this approach, it has face validity based on clinical observations. As clients describe re-experiencing traumatic memories as highly distressing, reduction of distress is paramount to ensure clients will succeed in and continue with trauma-focused interventions³⁵. Further, as the experience of interpersonal trauma may create a schema of others as untrustworthy, time to build a therapeutic relationship may be an important step to ensure effective treatment³³.

Current research into phase-based approaches has demonstrated positive outcomes. Connor and Higgins implemented a phase-based approach with 10 participants diagnosed with CPTSD³⁶. Treatment initiated with a stabilisation phase and was followed by concurrent individualised individual therapy and group therapy based on client need. Eight of ten participants demonstrated marked improvements in PTSD and CPTSD symptoms and qualitatively reported positive changes. Results must be interpreted with caution due to the small sample size, lack of effect sizes reported, self-selected recruitment

methods and the lack of a comparison group.

Similarly, Courtois has advocated that following a stabilisation phase, interventions may be transtheoretical, suggesting a sequence of: phase 1: Building a therapeutic alliance and psycho-education; phase 2: Habituation and re-integration of trauma using narrative therapy or gradual exposure therapy; phase 3: Interpersonal interventions focusing on specific developmental difficulties (e.g. parenting skills or current relational difficulties)³⁷. There is some evidence that this approach leads to improvements in both CPTSD and PTSD, with improvements being maintained over time. An open pilot trial of stabilisation group treatment for women with child-abuse (CA) related CPTSD and PTSD demonstrated a reduction in the number of individuals meeting criteria for both PTSD and CPTSD. At the end of treatment 22% of participants no longer met the criteria for PTSD, while 64% of participants no longer met criteria for CPTSD. At follow-up, 35% of participants no longer met criteria for PTSD, while 64% of participants no longer met criteria for CPTSD³⁸. However, these

interventions were not compared to active treatments or waitlist controls.

On the basis of the recommendation that interventions should be individualised based on presenting problems, interventions based on the same presenting problem in other diagnoses may be applicable. CFT has been recommended as an effective intervention for pervasive low self-esteem in CPTSD³⁹, while DBT is recommended for affect dysregulation and interpersonal difficulties⁴⁰. It may be beneficial to further explore their efficacy within CPTSD.

COMPASSION FOCUSED THERAPY (CFT)

Herman hypothesized that in early childhood experiences where the caregiver is also the abuser, children learn to internalise anger and shame rather than express these emotions, which are unsafe¹¹. This leads to self-critical schemas and negative self-concept. A negative correlation has been found between self-compassion subscales and the clusters of CPTSD features (relational problems - $r = -.21$ to $-.26$; negative self-

concept - $r = -.20$ to $-.45$; hyperarousal - $r = -.27$ to $-.43$)⁴¹. Therefore, improvements in self-compassion may also improve self-esteem, affect regulation and interpersonal relations. However, the bidirectional nature of correlation must also be considered.

Shame is a predictor of dropout from treatment^{8, 42}. This is significant as shame, guilt and fear are characteristics of both PTSD and CPTSD^{1, 8-9, 42}. CFT has been proven effective in reducing shame and increasing self-compassion³⁹. While exposure therapy is targeted to reduce fear, this may be less appropriate for individuals where shame or guilt is the predominant affect. CFT may be a helpful approach in these cases⁴¹.

DBT

A RCT of a DBT program for PTSD demonstrated a large effect size (Cohen's $d = 1.5$.) compared to treatment as usual (TAU)⁴³. Further studies are to follow. However, this is promising as DBT contains specific modules on emotion regulation and interpersonal difficulties, two of the core clusters of CPTSD. Of note, this program also included skills-assisted

exposure in relation to feared memories, whereby a script detailing the feared memory is created collaboratively by both the client and therapist and then read aloud in the session. The therapist then continually encourages the client to describe differences between then and now, to keep the client engaged, prevent dissociation and challenge the belief of negative consequences occurring from recalling the feared memory. Furthermore, a review of emerging treatments for PTSD has found evidence to support the efficacy of DBT for women who experienced childhood abuse⁴⁴.

Overall, the most promising intervention for CPTSD may be a phase-based approach. Phase-based approaches could start with a stabilisation phase in order to build a therapeutic relationship, provide psycho-education on trauma and focus on building skills in emotion regulation to enable clients to tolerate trauma-focused interventions in latter phases.

GENERALIZING EVIDENCE-BASED INTERVENTIONS FOR PTSD TO CPTSD

The predominant models of PTSD are the diathesis-stress model and the threshold model. The diathesis-stress model proposes that an interaction of genetics, personality factors and the traumatic event lead to PTSD, while the threshold model proposes that the nature of certain traumas provoke the PTSD response and would occur for any individual, regardless of their personal history or genetics⁴⁵. Recovery from PTSD is hypothesised to occur when a new narrative regarding the traumatic event is created, allowing it to be integrated into the individual's life⁴⁶.

In contrast, CPTSD is described as the experience of multiple or severe trauma that is likely to be interpersonal in nature, leading to difficulties with affect regulation, interpersonal relationships and poor self-concept^{1, 8, 10, 47}.

Due to the interpersonal nature of trauma, trauma-related schemas are likely to be triggered within the therapeutic relationship⁴⁸. Frequent exposure to trauma in early life impacts on the development of neurobiological processes necessary for emotional regulation, interpersonal skills and secure attachment processes⁴⁹.

It has been proposed that by using the first phase of treatment to form a therapeutic relationship and create a place of safety, clients will feel empowered and confident to explore traumatic memories in subsequent phases as per attachment theory⁵⁰⁻⁵¹. Van der Kolk supported the application of phase-based treatment, starting with a stabilisation phase to allow the formation of a secure base and trusting relationship⁴⁸.

Simple PTSD is associated with activation of the sympathetic nervous system, resulting in the fight or flight response⁵². Therefore, exposure therapy works to habituate anxiety so that this response is eradicated. Conversely, CPTSD is associated with both the sympathetic and parasympathetic nervous systems, engaging all six responses of freeze, fight, flight, fright, flag and faint⁵². For example, the flag response is likely to be activated when reminded of trauma, leading to dissociation. The flag response occurs as the parasympathetic nervous system is activated, where a threat continues to persist. In this stage, the parasympathetic nervous systems elicits a shut-down, leading to dissociation, numbed emotions

and a drop in heart rate and blood pressure⁵². During exposure therapy, the same threat response that was activated during the initial trauma is re-activated⁵². Therefore, relaxation techniques are contraindicated for individuals who experienced fright, flag and faint responses, as these will elicit the parasympathetic nervous system⁵². As these three responses are reported commonly in individuals with a diagnosis of CPTSD, active interventions are recommended to prevent this response from being triggered and focus on keeping the individual grounded and engaged in the exposure work⁵². Recommended interventions include sensory stimulation, muscle tension and a careful balancing of narratives between past and present within the therapy session⁵².

As CPTSD and PTSD present with distinct physiology, cognitions, behavior and affect, using the same interventions is contraindicated¹⁰. The literature has reported high dropout rates and fewer improvements when evidence-based interventions for PTSD have been applied to CPTSD³³.

ADAPTING INTERVENTIONS FOR CPTSD

It has been suggested that the evidence-base for PTSD can be applied to CPTSD if adapted⁵³. Both the ISTSS guidelines for children and adolescents with CPTSD and the ISTSS guidelines for adults with CPTSD argue that the evidence base for PTSD (e.g. TFCBT) results in some but lesser improvements in CPTSD⁵⁴⁻⁵⁵. Therefore, the guidelines recommend research into more efficacious treatments that will yield higher levels of improvement⁵⁴⁻⁵⁵.

One systematic review and meta-analysis of 51 studies on PTSD reported that not only did CBT, EMDR and exposure therapy alone (EA) demonstrate superior effects than TAU for PTSD; CBT and EA improved negative self-concept ($g = -0.82$ and $g = -0.73$ respectively) and CBT, EA and EMDR demonstrated moderate and moderate-large effects on interpersonal problems ($g = -0.66$; $g = -0.59$; $g = -0.76$ respectively)⁶. Large effects were also reported for CBT and EMDR on affect dysregulation ($g = -1.42$; $g = -1.64$, respectively). The authors reported no studies had investigated the use of EA compared to TAU on affect dysregulation. However, these

participants did not report experiences of multiple traumas and were based on clients with reported difficulties of interpersonal and negative self-concept, rather than having the diagnosis of CPTSD. Further, these results cannot be generalized to affect dysregulation as this was not investigated. Of note, less promising outcomes were reported for individuals with childhood trauma. While the authors were in favor of using evidence-based interventions for CPTSD they also suggested that further research is required into how interventions should be adapted for this population, including the optimal duration of interventions and how to phase the order of treatment (for example, if a stabilisation phase is required prior to starting an intervention). The authors also suggested an exploration of treatment acceptability and which interventions are most effective for each key feature (i.e. effective interventions for interpersonal difficulties, negative self-concept and affect dysregulation) rather than effective interventions for CPTSD as a whole. This lends further credence to the concept of phase-based interventions. Karatzias et al. also advocated for the use of different interventions for different

symptoms, rather than the use of one intervention to reduce all symptoms⁶. One such recommended avenue to explore was attachment-based interventions, alongside analysis of the acceptability and appropriate duration of interventions for CPTSD⁶.

Other reviews have advocated for the use of phase-based interventions, beginning with a stabilisation phase and individualising subsequent phases based on particular presenting difficulties (e.g. affect dysregulation, dissociation, self-harm etc)⁵⁶. Cloitre et al. previously highlighted the need to consider an increased number of sessions if applying interventions for PTSD to CPTSD³³. This has also been recommended in the NICE guidelines for PTSD, which states complex trauma is likely to require more than 12 sessions²¹. The increased duration may reflect the need for stabilisation phases to enable trauma-focused intervention in subsequent phases to run more smoothly.

However, studies have found that interventions without a stabilisation phase are effective in reducing PTSD and comorbid diagnoses³⁴. In place of a stabilisation phase, they recommend

increasing the number of sessions in trauma-focused interventions for PTSD in CPTSD. One systematic review of 6 RCTs on the efficacy of EMDR in childhood trauma demonstrated reductions in PTSD symptoms and comorbid depression and anxiety⁵⁷. However, this was a small sample. EMDR has not been recommended for other forms of trauma, such as sexual trauma³⁰.

EMDR has been reported to conduct exposure therapy more indirectly and can occur more gradually than exposure therapy within CBT, suggesting it may be more appropriate for individuals struggling with this phase of intervention⁴⁸. A phased approach to EMDR has been recommended in one study exploring emotion regulation in CPTSD. In a literature review of EMDR in CPTSD, Korn raised concerns regarding the generalization of RCTs on PTSD to CPTSD and highlighted the need to conduct exposure therapy gradually to avoid re-traumatizing clients and prevent dropout from treatment⁵⁸. This review reported lower dropout rates for EMDR suggesting that this is due to the way in which exposure therapy is conducted, as clients are given control in selecting tasks and

exposure therapy is conducted over shorter periods of time.

Another recommendation for adapting exposure therapy in CPTSD is the phasing of exposure, starting with trauma experienced in adulthood before moving towards historical, childhood trauma⁵⁸. The author also suggested 20-25 sessions as a more appropriate number of sessions to consider than the usual 12 in PTSD. This evidence further supports the need for adaptations in well-established interventions for PTSD if they are to be considered for use in CPTSD. For example, including a stabilisation phase, extending the number of sessions and adapting exposure therapy to make it more acceptable and safe for clients.

Dorrepaal et al. conducted a meta-analysis of 6 studies reviewing interventions for child-abuse (CA) related CPTSD, PTSD and CPTSD associated with other trauma⁵⁹. Large effect sizes were reported for exposure therapy in CPTSD, but less so in CA-CPTSD. Instead affect management yielded greater improvements and lower attrition rates than that of exposure in the CA-CPTSD. Overall recovery rates were higher in

PTSD (65%) than CPTSD (35%), suggesting that CBT is unlikely to yield the same size of improvements in CPTSD⁵⁹.

CONCLUSION

While efficacious treatments have been established for PTSD, CPTSD remains an emerging area that requires further research into effective, safe and acceptable interventions. RCTs will shed further light into this. At present, while TFEBT and EMDR are 1st line interventions for PTSD, it has not been reliably demonstrated that this is the case for CPTSD. Current research suggests that adaptations of these approaches may yield successful results for CPTSD. Clinicians should assess which nervous system response is being activated to avoid triggering a dissociative response. This will inform treatment plan selection.

Phase-based interventions are currently the 1st line of intervention for CPTSD, starting with a stabilisation phase and subsequent phases remaining dependent on client need (e.g. CFT for pervasive low self-esteem). This will be prioritized based on which symptom is causing most distress for the client (e.g. DBT for self-

harm in affect dysregulation). Phase-based approaches require refinement. Clinicians require guidelines on when to move to the next phase of treatment without delaying or prematurely advancing intervention. However, this will require a level of flexibility based on the individual, their formulation, progress and a collaborative decision with the service user. Current research is limited in terms of small sample sizes, lack of RCTs and the use of proxy measures for CPTSD.

FUTURE DIRECTIONS

Ford et al. support the focus of research into phase-based interventions for CPTSD, while highlighting the need for guidelines into when clinicians should move intervention into the next phase of treatment³⁵. At present it is down to clinical judgment when the second phase of treatment can be initiated. This could lead to unnecessary delays to treatment, dropout if the second phase is initiated too early and difficulties replicating studies reliably. Strides should be made to involve the service users' experience of treatment and perspectives on useful treatment components, including pacing

of treatment. Therefore, future research should investigate service users' experiences of different interventions, including the effective components of intervention, phasing of components and duration of intervention. Future research would also benefit from larger sample sizes, RCTs and the inclusion of a measure of the common factors (i.e. empathy, warmth and unconditional positive regard). Clinicians must remain mindful of the need to select interventions based on which part of the nervous system is being activated (i.e. sympathetic or parasympathetic).

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THE EXPERIENCES OF LIVING IN AN EMERGENCY RECEPTION AND ORIENTATION CENTRE IN IRELAND: A QUALITATIVE STUDY

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ABSTRACT

Objectives: In 2015, the Irish Government agreed to accept 4,000 refugees into Ireland via The Irish Refugee Protection Programme (IRPP). Refugees who enter Ireland via this pathway are offered temporary accommodation for 12 weeks in Emergency Reception and Orientation Centres (EROC) upon arrival to Ireland before being offered permanent resettlement within the community. The

aim of this research was to explore programme refugees' experiences of living in an EROC.

Design: This research adopted an exploratory approach using a qualitative framework.

Method: Semi-structured individual interviews were conducted with eight individuals (4 males, 4 females) with an average age of 33 years and an average of 7 months spent living in an EROC.

Results: Thematic analysis underpinned by a critical realist epistemology was used to identify three main themes; 'Powerlessness', 'Sense of Community' and 'A New Life', each with a number of subthemes.

Conclusion: Programme refugees living in an EROC experience significant psychosocial stress as a consequence of their lack of autonomy, feelings of uncertainty, and experiences of multiple losses. However, feelings of hope and

optimism as well as a strong sense of community among residents can foster resiliency. Limitations and suggestions for future research are highlighted.

Keywords: Refugees, mental health, resettlement, thematic analysis

INTRODUCTION

The United Nations High Commissioner for Refugees (UNHCR) defines a refugee as someone who has been forced to flee his or her country due to fears of persecution, war or violence¹. Due to an on-going humanitarian crisis, there has been a significant increase in asylum seekers seeking refuge within the EU. Between 2015 and 2016, over one million people entered the EU from Turkey via small, overcrowded and unseaworthy boats². The United Nations has described the situation as the worst humanitarian crisis that has ever occurred³, resulting in a growing number of refugee camps within the EU. In response to this crisis, the Irish Government established the Irish Refugee Protection Programme (IRPP) through which 4,000 programme refugees were to be offered resettlement in Ireland. Although Ireland has had formal

resettlement programmes since 2000, the IRPP has resulted in an influx of programme refugees entering Ireland. By the end 2019, 3,151 programme refugees from refugee camps in Lebanon, Jordan and Greece had entered Ireland via this programme⁴.

The literature highlights how refugees are continually forced to adapt to multiple environments despite enduring extremely difficult circumstances^{5,6,7,8}. Programme refugees come from camps which are often criticised for being overcrowded, with the limited resources available being largely overstretched⁸. Research suggests that those who have experienced living in a refugee camp outside of their home country have an increased risk of experiencing violence, psychological distress and mental health difficulties^{9,10,11}. Ben Farhat et al.⁵ surveyed 1,293 refugees living in refugee camps in Greece and found that a high majority of refugees experienced acts of violence when leaving their country of origin and while living in a refugee camp. The most common acts of violence included 'being bombed', 'being beaten' and 'receiving threats'. They also found that at least 75% of refugees screened positive for anxiety as measured using the Refugee Health Screener-15⁵. The

prevalence of PTSD in refugee camps has been found to be between 43%¹² and 52%¹³. Those refugees who meet the criteria for PTSD were significantly more likely to have witnessed murders, kidnappings and other extremely violent events^{12,13}. However, these studies used Western developed self-reported questionnaires to assess for Western developed constructs of mental health. The validity of doing so has been widely debated^{14,15}. Other research has employed self-reported questionnaires and a psychiatric interview to assess for PTSD and found a lower prevalence of 34%¹⁶.

Emergency Reception and Orientation Centres (EROC) were generated to temporarily house newly arriving programme refugees via the IRPP for approximately 12 weeks until permanent resettlement became available in communities around the country^{17,18}. However, the wider housing crisis in Ireland resulted in some refugees spending longer than a year living in an EROC^{19,20}. Research carried out by UNHCR Ireland concluded that long periods of time spent in temporary accommodation can increase dependency and disempowerment among asylum seekers²¹. These findings are supported by the literature which describes how stressful the migration journey can be,

placing refugees are at an increased risk of developing poor psychological well-being and mental health difficulties following resettlement^{22,23,24,25,26,27}. Bogic, Njoku & Priebe²⁸ reviewed 29 studies evaluating the long-term mental health outcomes among resettled refugees from war-torn countries and found varied prevalence rates; 4.4% - 86% for PTSD, 2.3% - 80% for depression and 20.3% - 88% for anxiety. Likewise, Tinghög et al.²⁹ found that 30% - 40% of resettled Syrian programme refugees living in Sweden had poor mental health outcomes. Although these findings use different criteria, diagnostic manuals and methodological procedures, they all conclude that refugees are at risk of developing or exacerbating pre-existing mental health difficulties following resettlement. One Irish research study exploring the prevalence of trauma among 178 psychiatric outpatients found that refugees were significantly more likely to have experienced multiple traumas than those native to Ireland³⁰. Traumas included lack of shelter, food, water, experiences of sexual and physical abuse, torture, imprisonment, forced separation from family and witnessing murders. The lifetime rate of PTSD symptoms among refugees was 32.8% compared to the Irish natives which was 6.1%³⁰. In 2016,

SPIRASI (Spiritan Asylum Services Initiative), the national centre for the rehabilitation of victims of torture in Ireland, reported a significant increased demand for their services³¹. This raises concerns regarding the current mental health services and questions if they are adequate to meet a refugee's multifaceted needs³².

Research among programme refugees is an area that has been overlooked. The limited research in this area has been highlighted in Irish research exploring the experiences of accompanied and unaccompanied children and adolescent refugees in Ireland²⁰, resettled Somalian refugees in Wicklow³³ and resettled Rohingya refugees in Carlow³⁴. Programme refugees differ from convention refugees and asylum seekers in terms of their pathway into Ireland which in turn impacts on their experiences towards resettlement. Research among programme refugees in Ireland may have been overlooked because they spend less time living in state-funded temporary accommodation compared to asylum seekers and are thus sometimes excluded from research³⁵. However, programme refugees are significantly vulnerable to poor mental health outcomes because their pool of resources are often depleted prior to arrival in Ireland increasing their risk of

further resource loss within Ireland^{36, 37}. Hobfoll's Conservation of Resources (COR) theory^{36, 37} argues that resource loss is the central component underlining the stress process. This model implies that the loss of resources among refugees significantly contributes to the development of psychological stress. For example, refugees new to host countries have lost familiar surroundings, employment, social support and social status^{38, 39, 40, 41}. The ability to demonstrate resilience is highly dependent on one's ability to access available resources, thus an increase in resources can result in an increase in resilience. As resource loss is inevitable during the migration journey, research is needed to explore how individuals prevent further resource loss, acquire new resources or substitute resources in order to cope with adversity.

Watters¹⁵ argues that researchers should give individuals an opportunity to have their views heard in an attempt to avoid further institutional responses that may have historically been influenced by the homogenising and pathologizing of refugees. Thus, there is a pressing need to explore the experiences of programme refugees living in temporary accommodation as there is currently a significant influx of individuals entering

Ireland via this pathway. An in-depth exploration of programme refugees' multifaceted needs while living in temporary accommodation will greatly contribute to greater service provision and resettlement policy development. This knowledge is required for staff working with programme refugees in temporary accommodation as well as those working in resettlement services.

METHOD

Design

A qualitative research design was considered the most appropriate approach in order to elicit a rich insight into participants' experiences of living in the EROC. All interviews were semi-structured, guided by an interview schedule which was developed by the main researcher based on the literature. The interview schedule

was reviewed by an experienced clinical psychologist working in the area.

Participants

Eight individuals who were living in an EROC in Ireland with an average age of 33 years participated in this research. The average length of time spent in the EROC was 7 months. Seven of the eight participants entered Ireland via the IRPP from Lebanon and had spent an average of 6 years in a refugee camp before arriving in Ireland. One participant entered Ireland from a refugee camp in Greece via The Red Cross. Seven of the eight participants were married and travelled to Ireland with their spouses and children, one participant travelled on his/her own. Further details on participant characteristics are illustrated in Table 1.

Table 1: Participant Characteristics

Participant No.	Gender	Age	Length of time living in the EROC	Pathway to Ireland	Marital Status	Length of time living in refugee camp
1	Male	40	7 months	IRPP	Married	7 Years
2	Male	48	1 month	IRPP	Married	6 years
3	Male	25	24 months	Red Cross	Single	6 years
4	Male	34	4 months	IRPP	Married	6 years
5	Female	21	4 months	IRPP	Married	6 years
6	Female	43	4 months	IRPP	Married	6 years
7	Female	33	4 months	IRPP	Married	5 years
8	Female	21	8 months	IRPP	Married	7 years

Procedure

Data collection occurred in March 2019. During this time there were 175 residents in the EROC (87 adults, 88 children). The lead researcher (CW) attended weekly mental health seminars delivered to residents by a clinical psychologist (WM). Following these seminars, the lead researcher (CW) informed the residents about this research project and offered them the opportunity to seek further information should they wish to participate. An information sheet in both Arabic and English was given to those requesting further information. The lead researcher (CW) was also available throughout the day for informal conversations in relation to the research to those residents that did not attend the seminars. HSE liaison keyworkers working in the EROC assisted in informing residents about the research and how they can partake. The lead researcher (CW) explained the purpose of the research again before obtaining written informed consent on the day of the interview. Interviews were conducted by the lead researcher (CW) in a clinic room in the health centre in the EROC. Interviews lasted approximately 70 – 90 minutes. All

interviews were audio recorded using a digital WS-852 voice recorder in order to be transcribed. Participants were given the option of working with either a male or a female professional interpreter who were known to the residents. The interpreters used in this research were employed from an independent service who were trained to work with sensitive information and had previous experience working with this population group. In line with EU guidelines, the interpreter used was of a migrant background. Interpreters imitated the tone and pitch of the participants when translating their narratives which aided rapport building. Guidance on working with interpreters was sought from the British Psychological Society⁴² and the HSE Social Inclusion Unit⁴³. Participants were informed about the on-site psychology service in the EROC and were offered an A4 handout (both in Arabic and English) on how they can access this service. A reflective journal was maintained throughout data collection and analysis.

Analysis

The aim of the analysis was to inductively identify, interpret and report patterns of

shared meaning across participant’s narratives using Thematic Analysis underpinned by a critical realist epistemology⁴⁴. This analysis initially involved the researcher becoming more familiar with the data in order to generate initial codes based on the shared meaning within the data. Themes were then developed from clustering the codes in order to accurately reflect the complexity of the data. Following reflection and advice from clinicians and researchers in the field, themes were revised and further defined.

Ethical Approval

The School of Psychology Research Ethics Committee National University of Ireland Galway and the Galway Clinical Research Ethics Committee granted ethical approval

for this research. This study also adhered to the EU guidance note regarding safeguarding and best practice with regards to conducting research with a vulnerable population⁴⁵.

RESULTS

Three themes were developed from the analysis; Powerlessness, Sense of Community and A New Life, each with a number of subthemes (see Fig. 1). The themes are discussed in detail with quotes from interviews provided. The number in brackets after each quote indicates the interviewee, ellipses (...) indicates words omitted from the quote and words within brackets demonstrates explanations made by the author to aid accessibility.

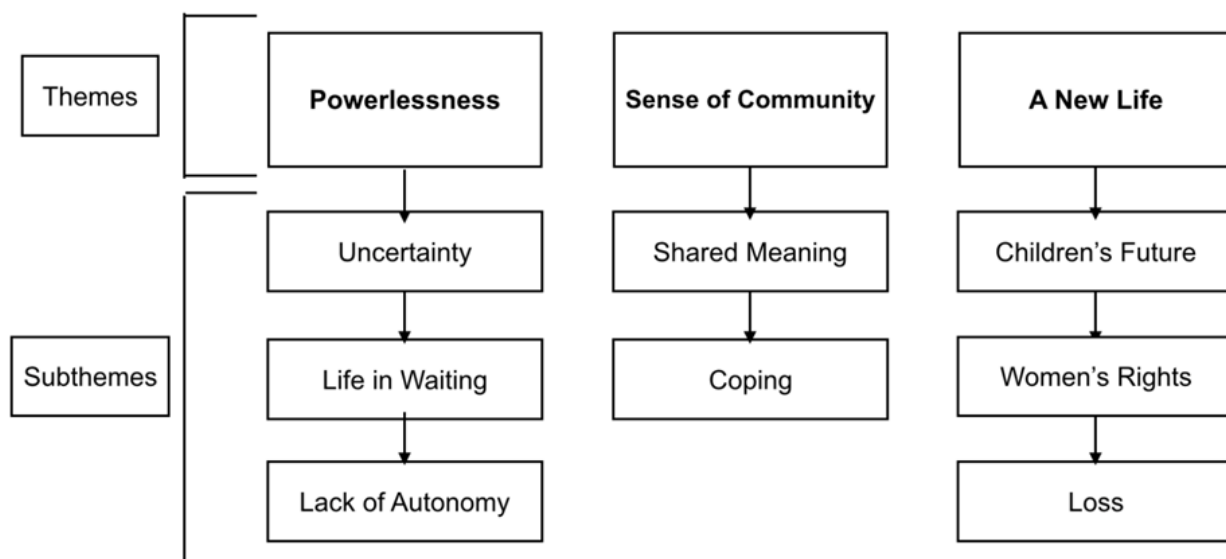


Figure 1: Illustration of themes and sub-themes

Theme 1: Powerlessness

Sub-theme: Uncertainty. Feelings of uncertainty were predominantly expressed throughout the narratives. Uncertainty and confusion with regards to status, expectations of Ireland, housing and the reasons why participants are living in the EROC longer than the proposed three months was a source of significant stress.

“The first 3 months we were all excited and happy, going to classes and then when we are passed three months, we got anxious – ‘when are we going to move?’ You get anxious, you are not in a house, you are not in a private house yourself...it is difficult to live more than 3 months here...The food, the children, the stress 24 hours” (8)

Broken promises and unmet expectations fostered a sense of mistrust in services, ultimately establishing a disconnection from Irish society. Participants expressed uncertainty whether resettlement in Ireland was a good decision for their family.

“They promised me only stay 12 weeks in the hotel, that’s it and then we will have a house. Then after they denied. They denied us...I am here 6 months so what is the problem?” (1)

“I just heard ‘oh Europe is this, Europe is that’. But then I came here and all I have seen is nothing what I expected...I haven’t gotten used to the life here yet, so I don’t know if this is right or if that is right because I haven’t really mixed in yet” (4)

Living with overwhelming feelings of uncertainty and despair is anxiety provoking. However, participants disclosed that they perceived it as futile to engage with psychology while they remained in the same situation that underlies the source of their distress.

“I don’t need a doctor, I need a house...I remember I say to you if you give me a nice house and a college and school and I will be fairly good and I won’t need a doctor” (5)

Sub-theme: Life in Waiting. After years of living in refugee camps, life in an EROC

presented different challenges. Participants expressed a lack of opportunities to engage with meaningful activities and spent their time waiting to begin a new life in Ireland. A comparison between a previous 'busy life' and their current reality of living with little stimulation was evident. Participants disclosed spending their mornings in English classes and their afternoons eating and sleeping. The EROC was described as an "open jail" (7), with the surrounding gates resembling "a prison" (1).

"It's just a complete change for people that come. For example, we were in our country, we were working, we had this constant routine and then we come here and then we have nothing...It's just complete boredom" (3)

Although life in the EROC was considered a better quality of life than living in a refugee camp, a lack of engagement in activities left some participants ruminating on their difficult migration trajectory to date.

"It (memories) affects me, it affects us as a family. It's like something contagious. I eat, I sleep, I drink, I sleep, I eat, and then I drink" (2)

"You just sit there, and you think about this stuff that happened, for any human being of course they just sit there and get all of these memories" (3)

Sub-theme: Lack of Autonomy.

Participants frequently expressed their awareness over their lack of control and autonomy over where they lived, who they lived with or even daily decisions such as what they ate.

"I get a sore stomach so I can't eat rice or I can't eat bulgur but I go into the canteen sometimes and that is exactly what they have cooked. If I can't eat, I just stay without food" (3)

"They force you to live this way. They force you to live with these people, I'm not choosing...after all I'm here and what I've been through I'm now here and living with

those people...I want to live how I want to live" (1)

A lack of independence caused distress to one mother who felt unable to soothe her children. The lack of facilities to cook appeared to threaten her perceived role as a mother.

"My son as a child, he might like some food and we can't find it in the canteen...It is upsetting because I can't do anything, I can't cook for my son so that is upsetting for me as a mother. He's always asking me to cook, he wants my cooking because I am his mother" (5)

Theme 2: Sense of Community

Sub-theme: Shared Meaning. The act of forced migration inherently disrupts lives in which individuals lose their social supports and communities. However, there was a strong sense of shared meaning within the narratives that may

have intensified bonding among residents defending against isolation. Participants reported spending their evenings visiting each other's rooms and offering support, with longer term residents offering new residents' guidance and advice.

"We are social, we like to be social. So for example, we are here, refugees. We sit together, we talk together so we don't make judgements like he is rich or he is poor. If someone has a problem, we like to solve it, we like to help each other. If someone's family member has died, we sit around that person and try to help them the best we can" (1)

"We all think of each other as just one big family now...we came here we knew nobody and now we think of each other as very close friends and we will stay friends forever" (4)

"what we do is we go visiting the rooms so let say for example 10 ladies will go to 1 room so we do visit each other's rooms. Sometimes until 12 midnight talking... Sometime I feel they're like my daughters" (6)

Sub-theme: Coping. Individuals offered narratives that were consumed with hardships of life in refugee camps and beginning a new life without family members and social networks. Participants acknowledged their difficult experiences and questioned their own ability to cope.

“What I’m talking about is really hard, and I’m wondering ‘how am I still standing?’ Because bad things have happened to me before, I ask myself ‘how am I still standing?’” (1)

A collectivist culture appears to have been established within the EROC, in which relationships with others plays a central role in coping with difficult experiences.

“Well in Syrian culture, if someone doesn’t leave their house or their room, then their neighbour checks on them after 4 days. I want to check on my neighbour, I want to make sure” (6)

Some residents indicated the importance of becoming a role model for the group, challenging the stigma and group norms towards mental health and demonstrating support seeking behaviours.

“No I want to come to see (Psychologist) because I want to prove opposite to them (other residents). When I go to see (Psychologist), the other men will see me going in for the chat. So I want to prove something, that I can go in and chat to (Psychologist)...I want to talk with (Psychologist), not for myself but on behalf of others” (1).

Theme 3: A New Life

Sub-theme: Children’s Future. Hopes for a new and better life were evident throughout the narratives. Participants sought safety and refuge by coming to Ireland for themselves and their families. Participants noted the hope and optimism they experienced when they first arrived to the EROC, some describing the experience *“like a dream” (7) (8)*. However, the longer participants spent in the EROC, their optimism diminished *“for the worse, it’s changing for the worse” (4)*. All participants pinpointed their children’s future as the main reason for coming to Ireland. The majority of children did not attend schools in refugee camps and instead were required to work in order to survive.

“Believe me, I am only here for my other children and their future. I give up my 3 children in Syria for my children here. I felt that if I stayed in Lebanon, then I am destroying their future. Especially my youngest one. So I am here for their future” (6).

Sub-theme: Women’s Rights. Participants described how their human rights were violated on a daily basis while living in refugee camps. It was difficult for them to practice their religion, shop in local markets, seek employment and education.

“I can practice it (religion) more here than in Lebanon. Here I am free to do whatever I want, I can fast, I can go to the mosque, nobody says anything to me. In Lebanon, they just wait for the slightest thing to tell you that you are wrong and they just take you in and beat you up” (4)

“In your country, no discrimination, no racism, freedom...You can live a good and safe life here” (8)

However, women in particular voiced their optimism for a new life in Ireland with

enforced rights for women. The women in this research narrated their decisions to marry early in life, obtaining a primary level education only. All women expressed a desire to acquire further education and determination to learn the English language that will aid future employment. The process of forced migration may have fostered an inner strength and empowered them to improve future outcomes for themselves, their children and their family’s ‘new’ life.

“I want my daughters to get for example, university studies degrees. There are more rights for the woman here than the Middle East” (8)

“I’m going to work hard for myself even if I need to repeat the leaving cert and I want to work here in Ireland...I want to study, I want education, I want to change my life” (5).

Sub-theme: Loss. In the development of a new life there is the insurmountable feeling of loss over a life left behind. Participants expressed grief over the loss of family members, their previous lifestyle

as well as the childhood their children could have had.

“My son in Lebanon, they took his name out from the list (EU relocation list)” (6)

“I have lost everything. My mum, my dad, my brothers, my family, everything. The country, the passport, everything” (4)

The theme of loss also presented itself in terms of friendships lost as a result of families leaving the EROC into permanent housing.

“We come altogether from Lebanon and we make friends and then just suddenly the friends moving, and they get the houses and we really, it is very upsetting for us, we feel so sad” (5).

Living in the EROC with growing feelings of uncertainty and ambivalence, participants conveyed a sense of missing out on life, losing or wasting time while living in the hotel. Participants were anxious to start their new lives outside of temporary accommodation, resettled permanently in Ireland.

“I have been living here 7 months and the children, I feel have lost 7 months... When I leave the hotel, that will be the first day I am in Ireland” (8)

“I just have to be patient and wait until I move out to a house to start my life” (4).

DISCUSSION

This research explored the lived experiences of individuals living in an EROC in Ireland using a qualitative framework. Eight residents were interviewed and their narratives were analysed using Thematic Analysis⁴⁴ underpinned by a critical realist epistemology. Codes were inducted from the data to develop three themes; Powerlessness, Sense of Community and A New Life. Programme refugees are a population that have been overlooked within research^{33, 20, 34, 41}. The increase of programme refugees from refugee camps in Lebanon, Jordan and Greece into Ireland means that it is imperative their experiences of living in temporary accommodation is explored. These experiences may impact on their ability to

integrate and adapt to Irish society while in the next stage of their migration journey; resettlement into permanent accommodation.

The key findings from this research highlight how programme refugees are a significantly vulnerable population with limited control over their environment which has a significant impact on their psychological well-being. Participants narrated how they have experienced a lot of loss contributing to significant psychological stress, offering support to Hobfoll's COR theory^{36, 37}. Participants describe how they have limited engagement in meaningful activities within the EROC resulting in feelings of boredom and with ongoing uncertainty about when they might leave temporary accommodation. There was a strong sense of powerlessness in participant narratives and many expressed feeling like they were living 'a life in limbo', a feeling widely documented in the literature⁶. Although their physiological needs are being met within temporary accommodation, their higher up psychological needs are being overlooked⁴⁶. Living in an EROC is a stressful experience in which many residents living together may not share

similar perspectives about the ongoing war in Syria. This further highlights participant's feelings of powerlessness and lack of control over their circumstances.

Participants described the importance of a sense of community within the EROC which was evidenced by how they highlighted their shared meaning within the EROC. A sense of community was used as a means to cope with difficult experiences endured during the migration journey as well as within temporary accommodation in Ireland. Community resilience and social support have been shown to play an integral role within the literature, mediating the relationship between forced migration experiences and psychological distress⁴⁷.

Conducting research with multiple interpreters can interfere with the integrity of qualitative research. In addition, there may be a double interpretation occurring when using a translator in research; between participant and translator, and between translator and researcher. In order to reduce the risk of bias, all interpreters used were trained in research, highly experienced working with this population group and were known to

participants. This fostered a safe environment in which participants could speak about their experiences freely. The use of a reflexive journal during data collection and analysis was used to reflect on the research process in order to further reduce the researcher's bias. The main strength of this research is that it adds to the limited literature available on the lived experiences of programme refugees living in temporary accommodation within an Irish context.

The influx of refugees in Ireland poses new challenges to the delivery of mental health and primary care services. There is a need for greater flexibility among health services in order to alleviate refugee suffering. It is paramount clinicians strive to understand an individual's unique migration trajectory and how they make sense of it. This involves systematically exploring the common themes found from this research and how they can affect one's ability to successfully adapt and resettle into a new host country. Wider community involvement could encourage integration into Irish society as well as offering meaningful activities to further foster the resident's inherent resilience. The development of peer support groups

within the EROC could further build upon the strong sense of community as well as alleviating a sense of uncertainty and mistrust among residents. Adopting a holistic approach and naturally building the collectivist perspective found in the narratives towards offering support may be an effective means to offering support to programme refugees living in temporary accommodation.

It would be worthwhile for future research to consider the next stage of the migration trajectory and explore the lived experiences of programme refugees who have resettled into permanent accommodation following life in the EROC. Although Ní Raghallaigh et al.²⁰ offers a detailed account of the experiences of child programme refugees entering Ireland via the IRPP, more research is needed in this area. This final phase of migration may pose different challenges to programme refugees as well as to services offering support. The majority of participants in this research travelled with family members, only one male travelled alone who had spent a significantly longer amount of time living in the EROC as a result. The experiences of single and unmarried programme refugees may differ to that of

those travelling with families. Future research should consider focusing on this smaller cohort of individuals.

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THE POWER THREAT MEANING FRAMEWORK AND COVID-19

DECLAN AHERNE AND CIAN AHERNE



INTRODUCTION

Covid-19 has forced many of us into introspection in attempts to figure out what is important to us individually and as a society. Here we have used the Power Threat Meaning Framework¹ as a framework of reflection in an attempt to illuminate some understanding of Ireland's responses to the illness and some thoughts on how to approach things going forward. In this, we acknowledge the authors' influence and input on the piece from a social constructionist perspective whereby our opinions, backgrounds and bias have all clearly played significant roles in its development. Nonetheless, unique

perhaps to this potential trauma, is the universal similarity with what objectively has happened and how it is a uniform virus that we all have had to contend with (albeit in our own unique manner). What follows are intended as prompts for each of us to consider in terms of how we have engaged with Covid-19. Our invitation is that we all might seek to use this template to explore our own experience of the pandemic and how we are dealing with it. Notably the PTMF is as relevant for identifying a community response as it is for individual responses, and so by pooling together our individual responses we may also be able to identify community-wide responses.

THE POWER THREAT MEANING FRAMEWORK (PTMF)

The PTMF was published by the Clinical Psychology Division of the British

Psychological Society in 2018. Its core tenets are four questions:

- What happened to you? (i.e. how is power operating in your life?)
- How did it affect you? (i.e. what kind of threats does it pose?)
- What sense did you make of it? (i.e. what is the meaning of these situations and experiences to you?)
- What did you have to do to survive? (i.e. what kinds of threat response are you using?)

With two additional questions:

- What are your strengths? (i.e. what access to power resources do you have?)
- What is your story? (i.e. how does all this fit together?)

We feel this can be a helpful framework through which to view current responses to Covid-19 in Ireland. It offers a non-medical perspective on our mental health which we believe can be a nourishing approach to our reflection.

Please see Special Issue of Clinical Psychology Forum for relevant

individual and systemic examples of its use².

WHAT HAS HAPPENED TO YOU: HOW IS POWER OPERATING IN MY LIFE?

The world has been infected with a deadly virus putting all of our lives in danger. This poses a definite risk to all of our health. The power invested in this virus is palpable. It is invisible and yet it has the potential to kill. Healthy bodies have the power to fight against the virus and those with good health can be grateful for it. The power posed by this virus is its potential to cause so much damage worldwide and frontline workers are particularly at risk of becoming ill. It has the power to at least make some sick and confined to bed and isolated for a short while. We may be feeling somewhat powerless against this virus and yet we can also be aware that we have power over certain aspects of our own self-care which we can endeavour to exercise as best we can.

Because of the power that this virus possesses, there is the knock-on effect of how the power of the State can be used for the greater good, forcing us to behave in a way that is alien to us. The Law is being used to ensure that we all behave in a certain way so as to limit the spread of the virus. We are no longer free to come and go as we please and to do what we want right now. It is strange to be in such a position whereby the State can control all of our activities, up to and including preventing us from leaving our own homes. We are helpless in this situation but realise that it is for our own good. Because the country was in almost complete shutdown and business had come to a halt, there is the knock-on effect of limited income and realising all of a sudden that the availability of finance that was there, is no longer present. The security that finance provides is absent and we are not all in the same boat when it comes to financial security and, as research has shown, social inequality is one of the major determinants of mental distress³. There is a lack of money available now and a resulting inability to plan to

purchase things we may have hoped to purchase or invest in. Under the circumstances, there is little that can be purchased in this climate anyway which somewhat mitigates the impact of having a lack of money.

Throughout this emergency, the importance and power of relationships, has become particularly salient. Relationships can provide us with the love and understanding and support needed at such a difficult time. Relationships are also being truly tested through this. This may hold especially true for relationships with conflict. In addition, this emergency has challenged us all to revisit our priorities and realise what values are worth upholding at this time. We might find that these have changed. The ideologies that promote economic agendas for example have become less a priority right now. Of more priority for governments as well as our own local communities has been to protect and look after one another, by co-operation and loving kindness, rather than using war and conflict or buying power to resolve matters. Such a

governmental response may actually prove to be what our collective mental health has needed all along⁴.

Other paradigms of mental health may not acknowledge the extent to which the current pandemic has “happened to us” and may look instead at how “mental health disorders” are going to be widespread following the virus⁵. Reflecting on the PTMF, however, helps us to see that it is natural that such a universal trauma has happened and is going to impact on our mental health in various ways. Framing our reactions to Covid-19 as “Adjustment Disorders” for example obfuscates much of the context that each individual is uniquely experiencing.

HOW DOES IT AFFECT YOU: WHAT KIND OF THREATS DOES IT POSE?

Health and livelihoods have been threatened. Freedom to do the things we want to do has been curtailed majorly. Emotions are under threat because we don't know how to react or

how to feel. The future is very uncertain now, so planning a future is difficult. What the future will look like is uncertain. Relationships have had to be let go or neglected. The threat to the long-term viability of relationships is evident. Will we be in isolation forever? The future is under threat for all of society. All behaviour has been affected. Social distance is now in the vernacular. Hand-cleansing is the norm. It is affecting our daily routines. We are unable to carry out our work as we had been able to do. We cannot plan for holidays and we have to cancel plans already made. Our abilities to financially support our families throughout this is under threat. Our values are under threat with the tension between survival of the fittest/looking after ourselves versus the greater good and looking after those most vulnerable. Can we do both? How well will we cope with this emergency if it goes on for more than two or three months? What are the possible outcomes? How might we not cope? Our identities are at stake here, in so far as we don't know what the outcome will be and if we will be in the same

position socially as we were before this. How important is that to us?

The virus was not a deliberate act by anyone. However, how individuals respond to the virus leaves open the possibility of people deliberately infecting others or not being compliant with general guidelines on keeping safe and thus putting us all at risk. It's an ongoing threat, not just a once-off and it has many off-shoots. This is a shared threat and so it can be shared by everyone across the world - we are all in this together. The threat it poses for all of us therefore is the challenge to our whole belief system, our identity, our very survival on this planet, our economic survival, our ability to think of others and our overall ability to cope with the uncertain nature of our existence.

WHAT SENSE DID YOU MAKE OF IT: WHAT IS THE MEANING OF THESE SITUATIONS AND EXPERIENCES FOR YOU?

Humans' default strategy is to try to make sense of things and we use this to

good effect in many aspects of our lives - through much struggle and pain at times. In the current crisis we are made acknowledge that the world is not under our control and we are very much at the mercy of Mother Nature. Ultimately, we are powerless when faced with the Universe in action. The human race is vulnerable and is capable of being made extinct. This has always been a possibility but one that we have tended to keep at a distance⁶. This existential angst is hidden deep within us and rarely aired. Now it is unavoidable. That being the case, the current crisis allows us time to reflect, therefore, on our priorities given that the world is not ours to control. Being forced to accept this fact encourages us to review our priorities in life, what life is about and what gives us meaning and purpose to go on. We end up asking ourselves what is life about and if this is how it can all end?

Again, each individual's experience is unique but it is worth reflecting that for many of us, this crisis may have made a

bad situation worse. This becomes yet another trauma on top of a whole life of trauma we may have had to be dealing with. The increased stress this emergency presents, may be the tipping point for many, leaving them feeling totally abandoned and helpless in the face of overpowering forces. This could lead to a total collapse of one's ability to cope and manage from day to day. Interestingly, however, it may be that in the face of this great adversity, we discover inner strengths, wisdom and insights that can help us in carrying on. These may be strengths that we never realised we had, until faced with the stark reality of Covid-19.

For sure, many of us will have discovered that many of those things which we had previously considered essential to our happiness and well-being are not in fact as vital and as necessary as we had assumed. Could this be a good thing? Paradoxically, in the midst of such devastation and tragedy, there may be a brightness shining through that will enable us to

carry on into our futures in a less stressful world.

We may inevitably end up reflecting upon our spiritual roots in search of answers to these questions. Having a spiritual base can be an anchor point since the spiritual journey carries on regardless⁷. Almost everything about the world has changed radically this past month but one thing that does not change is the spiritual path. This is the path that can lead us towards contentment, regardless of what is happening in our environment; the rules and values do not change. The current predicament has got us all to stop and recognise what is really important in life, the importance of loving, kindness, relationships, connection, co-operation and being able to let go of our incessant drive to achieve more and more success. This is the Universe teaching us a lesson in how to survive and what is most important to Mother Nature for this survival. We are being forced into having to consider others, not just ourselves. In doing this, we are learning

to appreciate acts of kindness and realising that it is not as difficult as we may have thought. In a weird way, many of us can be grateful to this virus for getting us to stop in our tracks. Yet sadly, that is obviously not the case for all.

WHAT DID YOU HAVE TO DO TO SURVIVE: WHAT KINDS OF THREAT RESPONSES ARE YOU USING?

We are discovering sadly that many people are not surviving this pandemic. But even among those who are surviving, there will be casualties. For many, despite their best intentions, the responses will be unhealthy. Fear will take over and lead to adjustments that will make life very difficult for themselves and those around them. For these people, the response to a very real felt threat, will be to collapse into further addiction or obsession or despair. The Covid-19 pandemic will confirm their worst fears, of not being in control, that life is unbearable and that they are not 'good enough' or worthy enough to survive. The feelings of fear and anxiety are too much for

them and they will seek out ways and means of numbing this emotion or suppressing it, believing that it is stronger than they are.

A significant (and possibly helpful) threat response is finding meaning that makes sense and with which we can live. Once we can make sense of things, we feel safer and more secure - or at least we feel in control of not being in control. Whilst we may not be able to make sense of the virus as an entity in itself, we can recognise that it is part of the bigger picture of how the universe functions. Our practical responses to this threat have to do with taking all necessary measures to keep ourselves as safe as possible and then resigning ourselves to the fact that we still may get sick. At some point we will realise that chance and luck may play a role. We may need to face into the existential realisation that our time may come. We may need to prepare ourselves to be ready for this and we may need to find solace in the experiences that we have had to date and be grateful for these. Trying our

best to be good people can be part of that. Everyone has had pain and suffering in their lives, no one is immune; these are the commonalities of human existence in living and in death. Maybe some of us can find comfort in this considering the background of what is going on in our lives right now. Coming to terms with our lives on a personal level is needed to try and bring some level of peace.

The other more practical response to the threat is to be patient and still. Over-eating, over-drinking or drugs to numb feelings can be tempting at this time. On the other hand, examining our feelings more deeply as we reflect on this experience can help us to discover more about ourselves. Taking good care of ourselves, having a regular daily schedule and looking for opportunities where we can be of help to others can help us to cope with the invisible threat that is presented. These can lessen the fear and the stress. It's important not to lose faith in mankind. In fact, the world's response when 'the chips are down' may restore our faith. Thus far,

we are surviving as a human race and we are not letting this virus get the better of us – though much tragedy continues to happen. Many are taking on a "Fight Response" ("Bring it on!"), mobilising our energy to defend ourselves and our families against this virus.

Other mental health frameworks of understanding may look at our responses as symptoms. For example, obsessional thoughts, anxiety, low mood/energy and substance misuse are all often commonly cited as symptoms in medical frameworks. Reflecting on the PTMF, however, can help us to see the meaning in these responses for some people. Anxiety and obsessional thoughts, for example, are keeping people safe right now. These emotional responses are helping us to self-isolate and look after ourselves and others. If these responses come to a point that they feel overwhelming for an individual then help may be sought but the PTMF gives us insight into why they might be there in the first place and what need they are meeting.

WHAT ARE MY STRENGTHS: WHAT ACCESS TO POWER RESOURCES DO I HAVE?

Strengths may include loving and secure relationships, a supportive family and a good sense of belonging. Having people in our lives who love us and to whom we can turn and depend upon should we need their help is important. We need people with whom we can be vulnerable and be ourselves. Many of us can access self-care programmes and we can find out what is good for us in terms of food, rest and relaxation, exercise and companionship.

For those less fortunate, who do not have access to these resources, the challenge is going to be even greater. It may be that people will discover strengths that they did not know they had. As a community, for example, we are witnessing a collective response to behaviour changes and providing supports to the more vulnerable, in a manner that we probably never imagined possible prior to this. If we can learn to maintain social isolation, go without pubs and golf courses, queue in an orderly fashion at our supermarkets

and not travel more than 2km from our homes unless necessary, then perhaps there is a lot more resilience and capabilities in each one of us that we had not realised until now.

From dealing with trauma and post-traumatic stress, we have learned the importance of facing our fears and experiencing as fully as possible what is happening at the time it is happening, so as to empower ourselves to do the best we can with what we are facing. Very often in the midst of trauma we need to switch off and dissociate in order not to have to feel the overwhelming and overpowering nature of what is occurring to us⁸. In the case of Covid-19, where the trauma is a community wide experience, there is every reason to be open to as much of this experience, as it's happening, as possible, and not to ignore what is going on. By doing so we are more likely to take direct action in the present moment that is empowering and constructive.

Many of us can be thankful that we have come into this crisis in a good state of health and this can help us to

cope with whatever comes our way. This may be time to reflect upon what we are grateful for such as the opportunities afforded to us in our lives to date. Many have had the benefit of a good education and don't lack for material things. Many are healthy and intelligent. We are lucky that we live at a time of technological advancement and information and connection is immediately available throughout the country.

In conjunction with all of these strengths and resources, again we can always turn to our spiritual lives and what strength our spirituality provides for us in times of difficulty. Belief systems and Faith can enable us to have the courage to face life's challenges and be open to whatever happens⁹. Spirituality and spiritual practice, communities of Faith and having people close to us share in these beliefs and struggles can be helpful. At this point in time, there is great strength in knowing that the world will eventually be ok. We can gain strength also from being able to offer help to others in this time of need. This can give us a very real practical sense of purpose.

WHAT IS YOUR STORY? (I.E. HOW DOES ALL THIS FIT TOGETHER?)

The answer to this question is still in our hands to decide. We are in the middle of the story and watching it unfold in real time. For now, our government and our people are putting life and our most vulnerable in society as our priorities. Social isolation, cocooning and practical health guidelines are mostly being implemented. Social welfare is available to those negatively affected and many business owners are offering reasonable delays in payments. People are reaching out over the airwaves, meaningful voluntary movements are being created on a daily basis, front line workers continue to tackle the problem and many are voluntarily being redeployed in the health system to help. The world is slowing down. The response to the virus has been swift and the power of human action when confronted with a crisis is in full flow. It remains to be seen how long these efforts can last, what the ultimate trajectory of illness and death will be, how the world will have changed (or not) when this is hopefully all over. We are learning so much about

ourselves and what is most important to us. For now, Ireland is fighting. We are fighting for survival, no one is yet giving up and we are trying our very best to influence our story in the direction of life, recovery and love for ourselves and our fellow humans. All the chapters have yet to be written to this story. It is important to realise how much we can contribute to how these chapters will be recorded, so that when we read our story 20 years from now, we can look back with some satisfaction that we did all that was asked of us, and that we were capable of, at the time.

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MENTAL HEALTH STIGMA: AN EXPLORATION OF CERTAIN IRISH SERVICE USERS' EXPERIENCES AND COPING PROCESSES

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ABSTRACT

Background: Previous research indicates that those with mental health difficulties can experience stigma as a result of their diagnosis. The extent to which this affects the individual may depend partly on their coping processes. The current study aimed

to contribute to the limited existing research within Ireland by exploring stigma experiences and coping processes among mental health service users.

Method: Participants were selected from a cohort of service users attending a secondary mental health care service. Two focus groups were conducted (N= 10), exploring mental health stigma and coping processes. The data were transcribed and subjected to thematic analysis.¹

Results: Three core themes were identified. These included: stigma experiences; negative implications of experiences; and coping. Subthemes included: externalised stigma; institutional stigma; internalised stigma; loss; safety behaviours; wellness and recovery; and the need for mental health education.

Conclusion: Participants reported experiencing stigma at an interpersonal, community, and institutional level which

contributed to internalised stigma and a sense of loss. Participants developed safety behaviours as a means of coping. They highlighted self-acceptance as an important coping factor. They also suggested the need for more comprehensive mental health education in Ireland.

INTRODUCTION

Stigma is a complex phenomenon, fuelled by negative attributions about some perceived potential threat of another person/group, due to a 'social identity that disqualifies them from full social acceptance'.^{2,3} Research has consistently found that people with mental health difficulties are regularly the subject of stigma, i.e., being treated and thought of less favourably because of their difficulties, be that in the workplace, in healthcare settings, or in the community more broadly.^{4,5}

Corrigan and Watson postulate a twofold model on the impact of mental health stigma: public stigma and self-stigma.⁶ Public stigma refers to a generally biased attitude or response toward those with

mental health difficulties within a community/population. This can lead to people with mental health concerns being stereotyped, discriminated and prejudiced against.^{6,7} The experience of being stigmatised in this way has the potential to compound mental illness and reduce the likelihood of recovery.^{8,9,10}

Meanwhile, self-stigma occurs when individuals internalise the perception of public stigma.^{6,11} People often respond to this with diminished self-esteem, anger, or indifference.⁶ It also has the potential to be damaging as it is associated with less positive attitudes towards treatment.^{12,13} Although self-stigma is commonly cited as a barrier for intentions to seek treatment, there is little published exploration into how mental health stigma occurs (if at all) once the person is receiving professional support.

Some individuals do not internalise public stigma into self-stigma due to their process of coping, i.e., the conscious and/or unconscious strategies employed to protect themselves against potentially negative outcomes.^{14,15,16,17} For example, Heath and colleagues found that self-compassion may be a protective factor

against the internalisation of stigma for those with psychological difficulties.¹⁸ This suggests that personal coping processes may determine the impact of mental health stigma on an individual.

Research suggests that 'identity', the construction of a positive, authentic sense of self, is a particularly important concept for coping with stigma. This necessitates a rejection of public and/or self-stigmatising beliefs.¹⁹ This might explain why efforts to cope via identity concealment efforts, through secrecy about psychological difficulties, are typically ineffective.^{20,21,22} Research exploring the way in which Irish people cope with mental health stigma remains limited.

A number of recent reports have identified the ongoing prevalence of mental health stigma in Ireland.^{23,24,25} In the 2016 Listening Meetings, Irish service users name this stigma as a significant problem in Ireland, causing difficulty in employment and accessing services.²⁵ Similarly, the 2018 Attitudes to Mental Health Survey found significant levels of stigmatising attitudes among the 500 Irish respondents. For example, 61% felt that mental health

difficulties would be viewed as a sign of failure in Ireland.²⁶

The current study explores Irish mental health care services users' experiences of stigma (i.e., how participants experience mental health stigmatisation) and their coping processes (i.e., what approaches participants use to buffer against the negative implications of stigma). The current study also explores whether the use of mental health supports contributes to the experience of stigma in any way. The aims of this is to contribute to the limited literature on mental health stigma in Ireland and to provide an insight into what mental health services users are doing in their lived experience to cope.

METHODS

Participants

Participants were service users at an Adult Mental Health Service (AMH) in Limerick, Ireland. The study explored the experience of stigma across diagnostic categories and as such all service users were invited to take part. However, those experiencing florid psychosis or mania were excluded.

Ten participants took part, of which six were male and four were female. Two participants were between the ages of 18-30, four were between the ages of 31-43, and four between the ages of 44-56. Five participants were diagnosed with mood disorders, one with an anxiety disorder, one with obsessive compulsion disorder (OCD), and two with schizophrenia.

Procedure

The study protocol was approved by the local Health Service Executive ethics committee. 30 service users responded to an advertisement placed in the waiting room of the service. Two were screened out; one because of florid psychosis and one because of mania.

The remainder were contacted via telephone by the researchers. 15 people continued to express willingness to attend. Given that the room being employed for the focus group accommodated no more than 12 people, it was decided that the 15 people would be split into two groups.

Each potential participant was sent a letter confirming the date of their focus group. Four people attended the first focus group and six attended the second focus group.

Each focus group lasted approximately two hours.

The same two researchers, a Clinical Psychologist and an Assistant Psychologist, facilitated both groups. Guided by the research questions which were drawn from both the findings and the gaps in the literature, a semi-structured interview schedule was developed. This comprised of the following questions:

- *“What does stigma mean to this group?”*
- *“What is the impact of these experiences?”*
- *“What is the impact of stigma within the community?”*
- *“What is your experience of support services?”*
- *“What has helped you deal with these experiences?”*

Participants' data was anonymised following transcription to protect their confidentiality. Each participant was assigned a letter in order to identify their individual comments.

Analysis

Data from the focus groups were audio recorded, transcribed, and subjected to thematic analysis. Thematic analysis is a

method for analysing qualitative data by reporting characteristic themes across the data.¹ This results in a rich, yet accessible, account of the data to capture groups of insights among participants.²⁹ A realist method was used, i.e., each participant's experience was interpreted as a unidirectional relationship between language and meaning. The thematic analysis was carried out in sequential stages.³⁰

Once familiarity with the data was established, the researchers manually developed a coding framework based on the interview data. From this, a bottom-up approach was used to generate themes. This inductive approach allowed themes to be constructed directly from the interview data (as opposed to theoretically driven), whilst simultaneously constraining the researchers' epistemological perspectives. This coding was then cross-validated for consistency as emerging themes were reviewed against the interview transcripts. This was carried out until no new themes were discovered, suggesting saturation had been achieved. Thematic tables were created, listing participants' insights and linking them to the identified themes.

Three other researchers, independent of the study, cross-validated the data. They were provided with the thematic tables and asked to agree/disagree with the presence of the themes. Agreement between raters was 95%, exceeding the required level (>85%) to accept the reliability of the theme.³¹

RESULTS

Three major themes were identified: stigma experiences (subtheme: public, institutional); negative implications (subtheme: self-stigma, loss); and coping (subtheme: safety behaviours, coping processes, the need for mental health education). Each subtheme is reported in turn.

Stigma Experiences: Public Stigma

Public stigma was a collective experience across this cohort, even within close relationships. Participants described feeling blamed for their conditions.

My depression one time was described to me one time by the person who was meant to be closest to me as, 'you and your selfish depression'. (M)

Others felt they had been implicitly and/or explicitly encouraged not to speak about their difficulties. This perpetuated the idea for participants that mental health difficulties were something to be ashamed of and thus, should be hidden.

Then there was, I was told (by mother) not to tell members of the family and that kind of (mental health) stuff, don't let anybody know because, it'll bring shame to the family. (Y)

Experiences of stigma was also reported in direct interactions within the community as perceived prejudice from others.

I've OCD, so if somebody notices my odd behaviour they maybe start laughing at me and you know people can pick up on it. (B)

Participants also perceived stigma in less direct ways within the community. The following quote, part read from a leaflet about a local mental health community initiative, was considered to promote a sense of 'otherness' about people with mental health problems.

"Raising awareness in the different services available...in relation to mental health"... This all sounds fairly positive...it says "on the day, music will be played as well

as"....and this is the beauty of it... "normal activities in the milk market, including cooking of food, market stalls". So the inference of this is... we are all mental but we are going to have normal activities as well....(M)

Stigma Experiences: Institutional Stigma

Participants reported perceived stigma from within services when seeking mental health care. General practitioners (GPs) were seen as the gatekeepers to mental health services, but participants reported experiences of stigma in these consultations.

I'm bi-polar...I said it to the doctor And he leaned across the table and shook my hand and told me how sorry he was... And I went to myself, oh my god, it's like what you'd say to somebody who is actually terminally ill. (C)

Participants revealed their perception that society views mental health treatment less seriously than treatment of physical health. They outlined their view that this can lead to mental health resource shortages.

I think if it was actually as acceptable as it is in the wider community, there wouldn't be a huge waiting list here (at the AMH

service), or there wouldn't be a bed shortage everywhere, there would be equal treatment for mental health as physical health. (C)

Participants also reported stigma at an organisational level. Some felt encouraged to omit their difficulties to ensure fair treatment

If I was applying for a job in the morning... there is no way I would mention any mental health....(B)

Some felt prejudiced against when they were open about their mental health. One participant reported that the latter occurred in the justice system.

But the solicitor I had at the time said "my client is suffering greatly from not seeing his daughter... and is suffering from depression at the moment".... The judge said, the words were ... "I suppose you have hit the bottle too". (M)

Upon being refused disability payments, one participant felt this was because mental health wasn't seen as a legitimate reason to make an application.

When you can get a letter from a doctor.... that's not good enough. They don't accept it, you're a fraud, you're a fake, you're a

liar. And you are put through the ringer. I have to sit with a civil servant and bare my soul to make my case. (M)

This was validated by one participant who actually worked in one of these organisations.

The first thing the other workers say is..." for god's sake...another depressed person, wouldn't they get up and get on with it". (N)

Negative Implications: Self-Stigma

There was a strong sense of shame and self-blame amongst participants. Participants described the internalisation of others' attitudes towards them.

You would take it all on board (and think) that it is my fault, that you'd start blaming yourself, therefore then I'm ashamed of this (M)

As a result of this self-blame, stigma experiences could be viewed as confirmatory evidence that the participants themselves were at fault for their difficulties.

I am ashamed of my illness, I'm ashamed. It's more than that, I'm ashamed of myself and for some reason I blame myself for my

illness, and so when stuff like that (stigma) happens, it feeds those voices that I already have in my head. (Y)

Negative Implications: Loss

Two significant areas of loss were identified by the participants as a result of mental health stigma. The first was loss of professional potential, the second was loss of relationships.

My job coach says whatever you do don't tell about your (mental) illness, any employers kind of don't want to know like...(E)

And that's what I think for me, relationships won't work...There's always been a negative connotation associated with my depression. (J)

Participants also reported a perceived negative impact on their human rights as a result of stigma. Again, this was noted in the justice system.

(The solicitor)... said to me, "everything that you are telling me is indicative of sexual harassment...but... if we take the legal action here, the first thing they will do is bring up your history of mental illness. They will bring this up, the guy will just get

a slap on the wrist, and you will lose your job and on top of that, you probably won't ever get a job again". (V)

There was also a perceived loss of control around personal identity due to mental health diagnosis. Participants reported feeling powerless to re-claim this control.

My biggest fear is that I then become known as a label and not as a person, because I am defined by my illness. Now, if I have a broken leg, I would never be defined by the man (with the broken leg)...but I'm defined as a mental case. (M)

Coping: Safety Behaviours

Some participants were concerned about being the target of stigma and engaged in concealment, secrecy or self-isolation efforts in a bid to prevent this happening.

I definitely think the stigma is probably the reason I'm staying at home now, more than the OCD. Because I have, I have kind of overcome some of the OCD problems (B)

All participants reported that at times they avoided an association to the part of their identity that included mental health difficulties. One participant described

presenting themselves differently in public to how they feel internally.

If you met me outside of here, you'd find it very hard to believe that I suffer from depression. It's been said to me actually several times. I would be a very happy person in the, as I appear to people. (A)

Coping: Coping Processes

In order to cope with self-stigma, some participants spoke about self-acceptance. Participants spoke about dropping safety behaviours and understanding they were ineffective as a means of self-protection.

I'm lucky that two are coming together for me: getting an understanding of my illness and self and understanding coming together...I realised what was wrong with me, I spent most of my life trying to avoid showing it (D)

Those who received talk therapy viewed this as an important factor in fostering self-acceptance.

Well, I would have...attended (the Psychologist) here and I have to say it's been life changing...I would use the description, I would have very often just held up a mirror, you know, and reflect

back... it was all about changing the way I was thinking about myself, viewing myself, and personal development, and it was life changing. (M)

For another, self-acceptance included the allowance of having a bad day and having a distinct strategy for coming through it.

You know... I allow myself one pyjama day. I don't call it a depressed day... I can play computer games, I can listen to...the radio anyway, I can bring all my food up to bed.... But that's it then (V)

Coping: Need for Mental Health Education

There was a consensus among the cohort that stigma was rooted in a lack of public understanding about mental health. Participants considered that greater public and professional mental health education would reduce stigma and minimise personal distress.

It's like, you know from a young age not to touch the stove or whatever coz you'll get burned, so if they learned from a young age not to make fun.... education is key...so the prevention of people being made fun of. (B)

It was considered that GPs could improve their understanding about how to work

with mental health, to prevent feelings of stigma in those who use their services to access support.

And the doctor as well...he was talking about football... and then I said depression and he was physically...it was like, I had something that, em, shocked him or was contagious that he didn't want to have.... It made me uncomfortable. (D)

DISCUSSION

This study provides some insight into how mental health stigma is experienced by a cohort of service users, how they cope with it, and what they feel needs to be carried out to reduce its prevalence.

Participants experienced mental health stigma in various domains. This occurred within the community and interpersonal relationships, both through others' direct behaviours (e.g. explicit invalidation of mental health) and in subtler acts (e.g. the language used to talk about mental health).

Furthermore, participants reported perceived stigma when engaging in professional support. This occurred in GP

consultations and also within the mental health services. Participants reported feeling stigmatised in their perception of society's view that mental health problems are not as serious as physical health problems. They felt this was evident in resource shortages and long-wait lists in mental health services. These accounts provide a novel insight into how one might perceive mental health stigma when actually receiving professional support.

The experience (and consequent expectancy) of stigma had two main impacts: the internalisation of stigma, and loss. Participants internalised public stigma as postulated in Corrigan and Watson's model⁶. Participants were shameful and self-blaming, aligning in part with Corrigan and Watson's model (as there were implications for self-esteem, but anger and indifference were not evidenced).

There were losses associated with mental health stigma. Professionally, participants felt they were treated unfavourably by prospective employers. Participants also felt an impact on their human rights both in the legal and the welfare systems. Furthermore, there was a perceived loss of control among participants. They felt

unable to shape others' opinions of them against the weight of the expected stereotypes associated with their mental health diagnosis.

In the face of stigma, participants developed coping responses: safety behaviours and, at times, self-acceptance. Participants talked about maintaining a clandestine attitude regarding their mental health status, keeping this part of their identity secret to avoid being stigmatised. They reported these measures were ineffective, aligning with previous research on the futility of concealment efforts as a means of self-protection.^{20,21,22}

Participants talked about self-acceptance and personal coping strategies. Talk therapy was considered by some participants as useful in helping them expand their identity beyond that of a 'patient' with a 'diagnosis'. This finding aligns with previous research on the role of identity in buffering against self-stigma.²⁵ It also points to the effective role that talk therapy can have for those struggling with this sense of identity following experiences of mental health stigma.

A number of recommendations for the future are highlighted in the narratives of

participants. Stigma was felt to be rooted in public misunderstanding of mental health. To target this, all participants wanted education: for themselves, for GPs, for the public, and for institutional entities such as the social welfare service.

The strengths of this study include the rigorous thematic analysis and the use of focus groups, a well-validated technique for capturing qualitative data.^{30,31} The use of focus groups over one-to-one interviews reduced the likelihood that service users would respond to the facilitators as clinicians rather than researchers.³² Focus groups were therefore seen as the most appropriate method of data collection for casting participants in the role of 'experts'.

The limitations of this study include the small sample size and the use of heterogeneous participants in terms of diagnosis, age, and social status. As this is a small-scale study, it is not possible to generalise the findings as representative of all Irish mental health service users. Whilst the study was interested in capturing trans-diagnostic stigma, this approach may simultaneously have also lost the nuanced stigma that occurs between diagnoses

(with schizophrenia being the most commonly stigmatised condition).³³

Acknowledging these limitations, this study provides an insight into an under-researched area in Ireland. It provides direction for further research in a number of ways. Firstly, larger scale research employing service users from AMH services nationwide would permit generalisability of findings. Secondly, similar research specifically exploring different diagnoses, age, and social status may elucidate a clearer representation of whether and how stigma is experienced by different cohorts. Finally, an empirical exploration of the experience of stigma and coping processes would be an appropriate and complimentary next step.

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SOCIETY'S ANXIETY

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ABSTRACT

Background: There has been a trend of increased levels of anxiety amongst young people in Ireland over the last decade. Reasons given for this trend are often over-simplistic in nature. This article aims to reflect deeper on the context of youth mental health in Ireland and to contribute to the theoretical understanding of this context.

Method: This is an in-depth opinion article that explores the perspectives of two of the authors as professionals working in youth mental health on a daily basis. Two members of Youth Advisory panels in

Jigsaw have also offered perspectives throughout the piece. The Power Threat Meaning Framework (PTMF)¹ is used as a theoretical framework for exploring the case example of youth mental health in Ireland. Two youth advisory panels of young people then offered a collaborative summarised response to the final question of the PTMF: “*what is your story?*” as a conclusion.

Results: A case example is provided, from a youth mental health-based perspective, of the context and understanding of the rising levels of anxiety for young people in Ireland.

Conclusion: Some of the themes alluded to by the authors and the contributors include the disconnect between generations, the impact of social comparison and thwarted connections. The youth advisory panels also offered suggestions for ways forward from current levels of anxiety.

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INTRODUCTION

“It is no measure of health to be well adjusted to a profoundly sick society.”

Krishnamurti

Anxiety is the highest presenting issue for young people to mental health services in Ireland². Young people are now more likely to be in the mild, moderate, severe or very severe ranges for anxiety than they were in 2012 and the proportion of adolescents reporting very severe anxiety has doubled in this time. This in-depth opinion article aims to explore perspectives on the high prevalence of anxiety for young people in Ireland, from the points of view of Clinical

Psychologists working in a youth mental health service (Jigsaw – The National Centre for Youth Mental Health) alongside the perspectives of some young people engaged with this service as volunteers (from the Youth Advisory Panels; YAPS in Jigsaw Limerick and Jigsaw Kerry). Youth Advisory Panels in Jigsaw comprise of up to 20 young people aged 16-25 who have an interest in youth mental health. They meet on a regular basis (at least once per month). Part of their work is to help inform the service that they are aligned with about what is relevant for young people at present. This helps to shape the service so that it is relevant for young people. Two of the authors of the current article are young people who are in the Jigsaw Kerry (Karen) and Jigsaw Limerick (Lloyd) YAPs. The Jigsaw Kerry and Jigsaw Limerick YAPs also met in groups to inform the concluding section of this article. The young people’s words have been left unchanged and are envisaged to serve as examples of the social commentaries that young people engage in regarding anxiety and mental health. When a young person’s point of view is being expressed, these are identified by their name at the beginning of a paragraph which is in parentheses. As

clinicians working in youth mental health, many of the examples provided also come from the Clinical Psychologist authors' commonality of experiences on a daily basis in clinical spaces with young people. We acknowledge all of our values and experiences in relation to gender, class, culture, age, ability, etc., have influenced and limited this paper.

This paper begins with a historical perspective on anxiety. This is followed by an exploration of current perceived societal norms and of how these relate to anxiety for young people. We conclude with a case example of a structured alternative to individualised and symptomatic understandings of anxiety through the lens of the Power Threat Meaning Framework¹. The piece is looked at through the lenses of individual professional mental health support with young people and engagement with young people and others in the community.

HISTORICAL AND SOCIAL CONTEXT

It is postulated that individualism (where the interests of the individual are valued

over the interests of the group) in western society increased during the 1950s post war capitalism and has continued to grow through to today³. Further recognition of this is apparent in more recent neo-liberal societal developments where we have moved away from the physical personal and into the online space where communication has become potentially more depersonalised. No war or large-scale life threatening struggles on a societal level had occurred in the Western world since this time (until more recently with Covid-19) so community or collective responses to difficulties have not been as necessary⁴. On an individual level, however, people continue to struggle with perceived life threatening situations. This relates in particular to identity and sense of self; both of which are constructs of an individualised society. Threat responses therefore often hone in on the individual and perceived threats as opposed to actual physical threats. For example, a young person's threat response may be to make every effort to perform well in exams and achieve perfect scores (even to the detriment of their mental health) for fear that their identity or self-image as 'a high achiever' is under threat.

Clinical Psychology, alongside other 'psy-complex' professions⁵ has been critiqued for its direct contribution to the societal control through the perpetuation of individualised psychological measurement and responses to problems with living, and to confounding the economic argument that the more well-adjusted people are to society the more economically productive they will be⁶. People's struggles lead to individual help-seeking, assessments, leading to diagnoses of clinical difficulties lying outside the 'normal' range which often ignore context, history and socioeconomic situations. Then on to individualised therapeutic interventions through structuralist and modernist therapeutic modalities such as Cognitive Behavioural Therapy. This then colludes with governmental population responses to distal distress factors such as poverty with mass therapy, for example Increasing Access to Psychological Therapies in the UK, as a cheaper response to changing governmental policies or societal systems.

Significant crises do still occur such as climate change and biodiversity, the onset of Covid-19 and physical threats (i.e. living in a dangerous neighbourhood and/or

experiencing physical assault or theft) and these too bring mental health challenges with them. Furthermore, social inequality appears to play a major role in levels of mental health difficulty⁷. Even with such collective crises, however, the focus for coping in western society can still be on the individual – for example, people's understanding of wearing face masks to protect themselves rather than others⁸.

Despite some governmental efforts to regulate and co-opt, power seems to have increasingly been removed from local communities and the idea of approaching daily living collectively. A stark example of this is the increase in community fear (i.e. fear to knock on a neighbour's door, to have a chat to neighbourhood children and to show disapproval at unacceptable behaviour). It is our hypothesis that this relates to high levels of anxiety of retribution such as litigation, the disintegration of communities and our collective inability to cope with this in non-individuated ways^{9,10}.

Karen: "I feel that community isn't something which is enjoyed but rather feared. People are afraid to open up and take part within the community. Even to

avail of any services I feel there is a sense of judgement especially within a smaller community e.g. being seen walking into a church as a young person, going to the shop and buying lots of crisps. Everyone is judging each other. As a young person, it creates a certain amount of worry and fear. Communities (including young people themselves) could be oppressing the youth of today and not creating an environment where one can express themselves.”

Each generation shapes the next thus this culture of individualism has been transferred from previous generations to the current one in different ways¹¹. New generations often subsequently rebel. These rebellions are mostly entirely understandable though may not seem so at the time (Examples include rock music, TV, the internet and social media). The issues are often responses to societal moments or cultures that younger people take on in their responses (a striking recent example is that of modern environmentalism, Fridays for Future and the rise in prominence of Greta Thunberg). Younger generations, we see, continue to have a profound and arguably progressive impact on society and

community. This may also need to be the case for the culture of individualism that has been thrust upon the current generation of young people.

Karen: “Topics often criticised in today’s modern world include the age of technology, music and the lost art of conversation. I don’t think these criticisms are limited to our generation but are actually the product of a repeating pattern. It is probably a way for the older generations to cope with the changing world and look back on their past with rose-tinted glasses. This is damaging for young people. It is interesting how I can identify with the song My Generation by the Who which was recorded in 1965. It explores the voicing of the youth as the other generations try to cope with the new generations. I agree that there needs to be a more helpful approach and that the youth are not always praised for the good things about the generation such as an accepting nature and willingness to create change.”

The difficulty with social commentary is often that it leaves people wondering and leaning towards simple solutions or

narratives (e.g. “The Snowflake Generation”)¹². Attributing high levels of anxiety and other mental health difficulties to flaws in the current generation of young people is not helpful and does not offer us any pathways toward a more mentally healthy and better connected society. Furthermore, such emphasis ignores the many structural, social and cultural forces that affect the mental health of young people though being entirely outside of their control. Examples include prolonged adolescence¹³ and greater dependence on family for longer periods of time¹⁴. It is important to seek out more nuanced understandings for the difficulties experienced by the current generation of young people, particularly through discussing these with young people themselves, and to then look towards helpful routes of support and change. It is time to (re)consider placing the agency of young people at the centre of the responses to the systems in which they are located, and by extension placing communities and service users collectively at the heart of the questions and solutions to the concerns in their lives¹⁵.

PERSPECTIVES ON CURRENT LEVELS OF ANXIETY

This section explores some of the prevalent individual and perceived threats which we consider impact on societal anxiety in Ireland – we recognise that these are likely to be culturally and socially bound.

We live in a world where narrow ideas of academic, sports or social achievement and success are treated as social capital¹⁶. The messages that young people get on a daily basis (often from parents, teachers, coaches and peers) include that we need to be resilient, successful academically, financially, socially and in our outward-facing persona if we are to be of worth. These norms are set from an early age as young people are compared via grades and performance throughout their scholastic and recreational lives¹⁷. As a result, there is constant pressure on young people to project or live up to an image of themselves as happy, well-adjusted and exceptional individuals. Being average is out of fashion. Not projecting this image is linked to stigma and being seen as different/defunct¹⁸. The pressure to

portray oneself as well-adjusted adds to increasing rates of anxiety and mental health challenges¹⁹. Examples include young people seeing the number of friends/followers they have online as a reflection of their worth, the Leaving Certificate as the pivotal standpoint for their life trajectory and sexual attractiveness as the key to being liked. In addition, young people openly experiencing this environment as challenging are often seen as the individual loci of their problem rather than there being consideration given to the societal, political and cultural pressures that they have been put under²⁰. The current generation has been faced with a proliferation of therapeutic approaches and self-help guidelines to promote positive thinking²¹. It appears that the language of cognitive behavioural therapy has crossed from professional dialogue into everyday vernacular and is being held up as a panacea for all challenges. One need only Google “celebrity positive thinking” to see hundreds of quotes attributed to famous figures as to how their positive thinking is what led to their success and well-being. This appears to further reinforce an individualistic

understanding of distress. The high dependence on cognitive explanations over an embodied and more collective human experience reinforces the split of mind/body/brain/soul/spirit from environment and context. Though the reasons for high anxiety are complex and multi-faceted, we suggest that the focus on achievement plays a major role in the high levels of anxiety experienced by young people of the current generation²².

Adolescence in particular brings with it an increased risk of poor mental health. In fact, 75% of future diagnosed mental health ‘disorders’ are identified as having started before age 24, 50% by age 14²³. As a result, anxiety, depression, deliberate self-harm and suicidality appear to have become part of the dialect for Irish young people²⁴.

Lloyd: “It feels like this generation of young people is living in an ‘age of anxiety’ and that this problem is an ever-growing epidemic amongst Irish youth. As a young person myself, I see an increase in mental health issues such as anxiety amongst my peers and on an even wider spectrum throughout social media. It has become quite common to see other young people

discussing mental health issues, with anxiety being most common. In my opinion, however, it is unclear whether the current growing popularity of mental health discussion in Ireland is due to our society becoming more accepting of these issues and that stigma is being broken down (with these levels of anxiety having been there all along) or whether, due to a multitude of contributing factors, anxiety is on the increase leading to the necessity for discussion. It could also be simply a mixture of both.”

Karen: “I feel that anxiety is a word commonly used among young people these days. It is difficult for someone to distinguish between an anxiety disorder and the feeling of being anxious if any difference at all. I believe that many of these people do suffer from anxiety, however, it’s about understanding the concept which I feel is not clearly explained to the youth. I think that many young people put how they are feeling down to the ups and downs of growing up and in life in general. We are expected to deal with what life throws at us and if we don’t, we are not seen to be coping like everyone else. I feel that if we are going to

get anywhere with improving how we deal with youth mental health, we have to change as a culture how we view mental health. Mental health issues aren’t a result of losing control of life, but they are a part of life as everyone has mental health. It’s unrealistic to think otherwise. Also, the fact that we often don’t have control of our surroundings (which can heavily influence our mental health) shows how this is a societal problem rather than an individual problem.”

The young people attending Jigsaw services often describe this anxiety as being entirely their fault and seek support in eradicating difficult thoughts that they may be having. They see these thoughts as personal flaws and want to take responsibility and action for them. One of the most common derivatives of this anxiety is young people seeing themselves as ‘different’ to their peers. They feel strange or defective in some way because they surmise that they are not coping as well as their peers or are “not doing life right”. It is ironic that their peers are often also attending services with similar challenges seemingly unaware that they are connected in their commonality of

distress. Another possibility, therefore, is that anxiety has become a more common identification for communicating the need for support or connection. It appears that the messages for life success that young people are given from a young age set deep in the psyche with very little consideration or acceptance of other powers and forces at play²⁵.

WAYS FORWARD

It's important to point out that not all anxiety is to be feared. Yes, there is a rise in anxiety but (as we've mentioned) this is for good reason. Perhaps the rise in anxiety is telling us something extremely important as a society and should lead to action rather than further fear. It's unclear whether or not our tolerance for coping with anxiety has lowered or if unmanageable anxiety has increased. We may not acquire the answer to that question but the development of education curricula for mental health has been regularly touted as one of the solutions for how we respond to the rise in anxiety.

Lloyd: "In an ideal society, I would love to see more support for young people's mental health available, whether this is rolled out more within the education system or the community. It would be fantastic to see this being done at a prevention level as opposed to an intervention level to avoid young people arriving to avail of help at a crisis point. I personally think a key factor to addressing anxiety in Ireland is education. What I am referring to is education that involves teaching young people from primary school years onwards how to express themselves emotionally and giving them the permission to do so freely. This alongside teaching coping skills, self-awareness and some cognitive-behavioural skills could potentially reduce the issues we are currently facing."

Karen: "I think that services should be built into school life to help students throughout their education journey. I believe that it is important to mention school as this is where young people spend a massive portion of their lives. The stress and pressures of school impact mental health. I believe that the fear of being judged by peers is a significant fear for

young people. I feel that there is pressure in school to perform well academically. Once a standard is set you are expected to keep up that standard. There is not much of an opportunity for the school to know what is going on in a young person's life. I think that school/education is a big element in a young person's life and maybe should be mentioned more because of this."

The wellbeing component of the Junior Certificate cycle is encouraging and it's important that strong emphasis is put on the worth of this education and on the need for holistic education (rather than strictly academic). Furthermore, we are excited by the One Good School initiative through Jigsaw whereby schools are signing up for staff and pupil training on mental health as well as peer mentoring education. This is a whole school approach to helping teachers and pupils supporting themselves and each other through mental health challenges. While there have been some changes in how distress is approached, it remains from an individual perspective. The State education system in Ireland as elsewhere is based on a curriculum that allows little flexibility for

individual differences in children's abilities and interests²⁶. Arguably, by trying to meet an average need this may therefore not meet any child's particular needs²⁷. Alternative schools, such as Steiner schools have arisen out of teachings on critical pedagogy where the model of learning is set by the subject²⁸, as a means of liberation and transformation, not driven by an analysis of future economic needs.

Karen: "I think that the education system in Ireland needs to be completely changed if we are to change our attitudes and structures to deal with youth mental health in this country. It has already been noted that the pressure of achieving at high levels and consistently can be incredibly damaging for young people. We need to redefine what it means to be "achieving at a high level" in order to cater for more talents, values and attitudes. For someone who is struggling with anxiety they may find it difficult to even go to school. Therefore, going to school consistently or trying their best in class is going to be an achievement for them. However, this won't be recognized at the end of their secondary education when

they are handed their Leaving Certificate. Only their performance in exams will be shown, nothing else. If the systems that we put the youth of today through are changed to take pressure off young people to be performing well i.e. coping well with life, only then can we create a shift in societal attitudes towards the youth and we can understand their needs better.”

Other systemic approaches to the rise in anxiety may include people connecting with each other in person in community initiatives such as Transition Towns, GAA, Tidy Towns, or anything which gives people access to each other and to helping other people. Additionally, family support and parent education could be more widespread. Parents are being faced with having to support young people with high levels of anxiety without being given any further information about what this means and about what helps. A major aspect of such education that might be helpful is that they are led or co-led by parents and families who have experienced such difficulties themselves, in order to role model emotional literacy, self-care and help seeking behaviour so that young

people can have a template for how to cope. Intergenerational projects that draw on the wisdom of community elders could also be beneficial to all engaged.

Clinical Psychology has generated some alternative collective (post-structuralist, often social constructionist or social materialist) responses whose origins derive in cultures outside the western industrialised nations, such as the Tree of Life²⁹ and campaigning on austerity, such as Psychologists for Social Change³⁰. Furthermore, Clinical Psychology has contributed to alternative ways of formulating the challenges we experience such as such as Power-Mapping^{31, 32} or Societal Case Formulation³³. The PTMF is a further non-medical framework for formulating difficulties that takes a social justice perspective. We are familiar with the PTMF in Jigsaw³⁴ and thus have utilised it for the current article.

THE POWER THREAT MEANING FRAMEWORK

In this section we look at what an alternative and non-medical framework for understanding mental health difficulties in understanding societal anxiety. The PTMF was published by the Clinical Psychology Division of the British Psychological Society in 2018. Its core tenets are four questions:

- What happened to you? (i.e. how is power operating in your life?)
- How did it affect you? (i.e. what kind of threats does it pose?)
- What sense did you make of it? (i.e. what is the meaning of these situations and experiences to you?)
- What did you have to do to survive? (i.e. what kinds of threat response are you using?)

With two additional questions:

- What are your strengths? (i.e. what access to power resources do you have?)
- What is your story? (i.e. how does all this fit together?)

We feel this can be a helpful framework through which to view current high levels

of anxiety in the young people of Ireland. It may illuminate different perspectives that are not often cited in popular social commentary and that cannot be explained by previously existing medical frameworks for mental health (such as DSM-V or ICD-10). The following are answers to the questions of the PTMF informed by the perspectives of young people and professionals working in the area of youth mental health.

What has happened to you?

Young people are telling us that there are high levels of pressure being put upon them on a daily basis to 'be well'. Mixed messages are being relayed to young people at every juncture about what anxiety is, why they might be experiencing it and what they should do when they notice it. We posit that this is largely related to the aforementioned neo-liberal ideals being played out in young people's early development whereby they are given the message that they have total control and responsibility for the challenges that come their way in life, and yet they are not eligible to vote. TV and media play a huge role in this when one thinks of the many celebrities and TV shows that give the

message “you will feel good if you work hard enough at it.” This puts the onus entirely on young people as individuals to sort out their own difficulties and can be divisive, rather than seek out a collective or common understanding that could lead to solidarity. The powerful message, that achievement is the means to living a successful life, also puts pressure on young people to perform at the highest level in all that they do. This can be exhausting and place people in a physiological threat response mode.

How did it affect you?

We hypothesise that this constant pressure has significantly contributed to a high prevalence of anxiety for young people. Whether individually, interpersonally or systemically, it is clear that many young people are having regular experiences of anxiety in Ireland. There are also high levels of confusion as to what this means and what can be done about it as well as high levels of other mental health difficulties (such as low mood and stress) as a result. Individual identities are constantly under threat, with the need to fit in being constantly to the fore. Furthermore, relationships and

family/community systems are breaking down when the constant emphasis on success is individualistic in nature, as they are subject to the same messages and forces, resulting in the degradation/removal of potential sources of solace and help.

What sense did you make of it?

Young people are finding it difficult to make any sense of it. Common causes cited are the rise in social media usage, lack of services and lower levels of resilience. Valid research pertaining to these reasons are hard to come by, however, and it feels mostly like people are clutching at over-simplified and familiar narratives for meaning. A prevalent question in community fora is “are young people more anxious or are we just talking about it more?”. Sense-making still eludes us and, as a result, young people are often seeing themselves as the ones responsible (i.e. “if I can’t understand it and the adults in my life cannot explain it to me then it must be me”). The lens of the young person often cites individual/personal explanations whereas if we look to make sense of this from a systemic/societal level, there is strong

evidence that increased economic and social inequalities in our society and the associated achievement-focused pressure are clearly negatively affecting all of our mental health⁷.

What did you have to do to survive?

There is a myriad of responses that young people are having as a result of high levels of anxiety and distress. The most concerning of these being self-harm where young people commonly cite harming themselves as a means of release from the emotional pain. Other common responses include poor sleep, refusing to go to school, isolation from friends, misuse of substances, anger and aggression and difficulties with eating. These responses are often explained as 'symptoms' of an underlying mental health difficulty/diagnosis (i.e. Generalised Anxiety Disorder or Depression). From the perspective of the PTMF, however, these make more sense as functional responses to real threats to identity and meaning in young people's lives, which may become dysfunctional. Examples include self-harming to regulate unbearable pressure, eating difficulties to maintain a sense of control in confusing and chaotic

circumstances and aggression in order to hold on to any perceived level of status available.

What are your strengths?

Young people experiencing high levels of distress often do not see the strengths or accesses to resources that they might have. Ironically, though individualistic messages tend to inform the problem, young people's unique and innate worth as human beings is not emphasized nor encouraged. Many of the young people attending Jigsaw have incredible creative talents, hugely caring spirits and vast amounts of energy that they are looking to put into meaningful ways of living. The power of connection is also a huge strength of the youth of today. Again, interestingly, lots of this connection now occurs in the online space where rallies of young people can form rapidly when in pursuit of the same goal (e.g. Fridays for Future).

What is your story?

The Jigsaw Limerick and Jigsaw Kerry YAPs convened separately to review the article to this point. Their discussions were facilitated by a Youth & Community

Worker in each instance. The Youth & Community Workers transcribed the main points made by the young people present and relayed them back to the groups to see that they agreed with what was noted. The answer to the question “what is your story?” therefore is an amalgamation of both groups’ summaries and is written entirely in their words.

It feels like there is a wide culture gap between generations of adults and young people. Adults see anxiety as only a problem for this generation of young people. They seem to forget what it was like to be young and that they possibly had similar feelings in their youth. They don't see it as their problem so they don't relate. There is a lack of understanding and, as a result, young people's experiences of anxiety have often been dismissed, young people have been blamed for their problems and young people have then been made feel guilty for having these feelings. Even coping strategies such as recreation have been looked down upon (though young people need these for self-care) – it's not all about the pub!

The generation gap and culture of pressure are linked by changes in technology. Young

people are now exposed to so much more information, dangers, experiences and everything is instantly accessible. There is now global news “on tap”. Adults blame young people's “overuse” of technology for their levels of anxiety but social media now means that young people are exposed to anxiety-provoking news (with everything else) all the time, all day long. Adults don't understand what this experience is like. Young people are changing with technology and do not always find it to have a negative impact. Adults, however, are not changing with the relationship between young people and technology – they are instead blaming it.

Adults are often too busy to prioritise helping young people when their problems are small. They have transferred their high paced, capitalistic culture into a world where young people are under constant pressure to grow up and “be an adult quicker”. We don't have to buy a house and get married young! The bar of expectations is higher and often unattainable. Young people are in constant competition with each other from an early age and this stretches through to State Exams and higher education. All of these

are made feel absolutely necessary if young people are to have any chance of getting a job to earn money to buy things.

The constant competition even extends to young people's problems. You have to be aggressive and competitive, on the verge of a nervous breakdown, completely stressed or lacking time, or else you're not "doing it right". Anxiety and stress are turning into social capital and young people become competitive about who is experiencing more problems. Being stressed or anxious almost proves that you are working toward something and that you are trying and putting an effort in - it's a symbol of productivity. Stress therefore is seen as desirable but finding it difficult to cope with stress is then frowned upon.

Existential crises confront us at every turn and there is a longing for connection. People don't want to have to fend completely for themselves. It is not in our nature. We want to solve problems together/communally, but capitalism encourages us to do otherwise. It may be linked to the disintegration of community. There doesn't seem to be as many community initiatives and people tend to

be more self-serving. Anxiety is rooted in young people's desire to connect with others. To be the 'most anxious' is often actually a cry for connection. Young people are again, comparing themselves to others – "Why can't I cope? Why can't I do what they do?". We used to be compared to just our neighbours but now we are constantly compared to neighbours, previous years at school and the rest of the whole world! Anxiety is something we all experience. It is a vicious cycle – there is much to cause anxiety for young people now, but because it is seen as normal to experience anxiety on a regular basis, young people also expect themselves to just pull their socks up and deal it, especially because it seems others are doing this.

Young people are blaming themselves for their anxiety. They assume others are experiencing the same thing, but seemingly dealing with it very well and they wonder why they can't cope. Young people then have to put up a defence which means they don't talk about or acknowledge their anxiety in meaningful ways. This means there is no space to talk properly talk about anxiety and what is

underlying it. It needs to be quite severe before support is provided. We need to respect and listen to each other's voices more. As a way forward, change is a group process that starts with the individual – we need to stop comparing ourselves to others, or be competitive, but rather try to empathise and be supportive. Some paths forward may include:

- Peer-to-peer support – as young people are experiencing the same thing, they can relate and empathise.
- Challenging the norm and what is deemed as acceptable - this is important because the issue is not individual, it's societal and cultural and there is a need to stand against it.
- Spending time alone – often not promoted. We're encouraged not to think about what we want. Instead we look at what others think/are doing.
- Sharing experiences – i.e. posting on social media and starting authentic and genuine conversations about things that matter to young people.
- Acceptance of recreation and breaks because the rest of our life is "always on".
- There is a need to educate with the need to support young people at the point when their problems are small, rather than waiting until crisis point. There are very few programmes for parents to understand what's going on for their children (often not focused on building understanding but more on how to discipline).

We get a lot of blame. This has made us angry and as a result we are standing up for ourselves with strong opinions and loud voices.

CONCLUSION

We outlined in the beginning of this article how the transition to more of an individualistic society has likely had a negative impact on young people's levels of anxiety. We cited a deterioration in community/collectiveness/togetherness as playing a significant role. We also noted how this culture has been transferred from

generation to generation. Stress has been passed on and promoted as social capital yet older generations tend to blame younger generations for their threat responses and condemn their coping strategies.

In using the PTMF as a means for reflection, the young people who were consulted with for this article seemed to recognise much of what was outlined in the introduction. They reflected that the culture gap between generations feels wider than ever and that, rather than try to understand young people, adults continue to tell them that they're not coping properly. On the flipside, the young people noted that much of the anxiety that they are dealing with has been passed on from older generations where the emphasis has been on striving, pressure and productivity.

The young people acknowledged that they feel that relationships and connectedness can be means for working through and potentially overcoming the high levels of anxiety. They see the anxiety as rooted in

thwarted connections on different levels and that empathy and support are means for coping with the difficult emotions. The practical steps suggested by young people include themes of acceptance, support and sharing; values that may well be sustaining for generations to come.

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Clinical Psychology Today: Noticeboard



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