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Experiences of otherness among students diagnosed with depression and/or anxiety disorder

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Abstract

Introduction. People with mental disorders sometimes experience that they are perceived as abnormal or different.
Aim. The study aimed at investigating the experiences of otherness among students diagnosed with depression and/or anxiety disorder who participated in a psychosocial rehabilitation program.
Method. The data were gathered with focus groups by interviewing eight groups of students (n=47) aged 16−25 years diagnosed with depression and/or anxiety disorder who participated in a rehabilitation program during 2011−2013.
Results. Seven themes were discovered related to the sense of otherness: 1) Carnival of depression, 2) Stereotypes, 3) Shame, 4) Ethos of self management, 5) Overabundance of help, 6) Minimisation and lack of understanding, and 7) Power of peer support.
Conclusion. Sense of otherness is related to stigma experiences which may carry both negative and positive meanings. Health care professionals should be aware of the power of peer support and humour among young adults with mental disorders.

KEYWORDS: depression, young people, otherness, stigma, peer support

Introduction:

Depression in adolescence or in young adulthood may severely impair psychological, social and occupational development indicating a broad, lasting tendency toward psychosocial problems in later life (Kessler et al. 1995).The prevalence of depression increases significantly during the transition from childhood to adolescence (Lewinsohn et al. 1994, Hankin 2009), with the highest incidence at ages 15 to18 (Hankin et al. 1998). The continuity to adulthood is very common (Hankin et al. 1998; Kessler et al. 2012). Lifetime prevalence of major depressive disorder of children in early adulthood varies between follow-up studies of community samples from 23 to 43 per cent (Merikangas et al. 2009). In the WHO Mental Health Survey, the average 12-month prevalence of major depressive episode in developed countries was 7 % among young adults (18–34 years) and of these, only 48 % reported receiving some kind of treatment (Kessler et al. 2010).

Individuals suffering from mental disorders are sometimes affected by the experience of being perceived as abnormal or different (Leavey 2005; Moses 2009). The term "otherness" is well established and central to sociological analyses of how majority and minority identities are constructed. The dictionary defines "otherness" as "being or feeling different in appearance or character from what is familiar, expected, or generally accepted (Cambridge Advanced Learner’s Dictionary & Thesaurus © Cambridge University Press). According to Bauman (1990), the notion of otherness is central to the way in which societies establish identity categories. These social categories shape our ideas about who we think we are and the groups to which we belong. They represent an established social order - hierarchy where certain groups are established as being superior to other groups. Ideas of similarity or difference are central to the way in which we achieve a sense of identity and social belonging. In the view of Bauman, identities are set up as dichotomies, for example, illness represents the opposite of the norm or the ideal of health. (Bauman 1990.)

In health sciences, the term otherness has been applied rarely. The focus of research interest has rather been on stigma and stigma experiences, which can be seen as a marker of otherness. Stigma is a social construction that defines individuals in terms of a distinguishing characteristic of mark and, as a consequence, devalues them

(Crocker et al. 1998). Goffman (1963) describes stigma as a process by which the reaction of others spoils normal identity. The concept of stigma is a power-dependent phenomenon which consists of labeling, stereotyping, cognitive separation, emotional reactions, loss of status and discrimination (Link & Phelan 2001). Due to this process, stigma can be seen as a meaningful indicator of otherness.

Stigma and its effects are commonly distinguished into two forms: public and self-stigma (Corrigan & Watson 2002). Public stigma refers to stigmatizing perceptions among the general population whereas self-stigma occurs when people with mental illness self-label themselves as someone who is socially unacceptable. According to Corrigan et al. (2009), self-stigma comprises three steps: awareness of the stereotype, agreement with it, and applying it to themselves. As a result of this process, people suffer reduced self-esteem and self-efficacy. Label avoidance has been seen as a third level of stigma (Ben-Zeev et al. 2010). This is the case when people with mental health problems avoid seeking help from mental health services because they do not want to be categorized as a "mentally ill person" or they do not want to face the prejudice and discrimination that the label entails.

Stigma is one of the main reasons why individuals with mental illnesses hesitate in seeking mental health services (Chen-Fang et al. 2005, Schomerus & Angermeyer 2008, Bowers et al. 2013). Studies have shown that only about half of young people with mental health problems had used mental health services (Aalto-Setälä et al. 2002; Sourander et al. 2004; Biddle et al. 2006; Kessler et al. 2010). Self-stigmatization, particularly, has been seen as an important mechanism decreasing the willingness to seek psychiatric help (Corrigan 2004; Cheng-Fang et al. 2005; Schomerus et al. 2009). Moreover, fear of negative attitudes among peers towards people with mental disorder in general may hinder young people with mental problems to seek help (Rose et al. 2007). Stigma has also been seen as a barrier to recovery from mental illness (Link et al. 2001) as it may harm self-esteem among individuals with mental health challenges.

Secrecy, shame and limited social interaction are often related with having mental health problems among adults (Link et al. 1989). However, less is known about experiences of otherness among young adults diagnosed with a psychiatric diagnosis. Knowledge on this area is crucial as these aspects have an impact on the quality of life, help seeking behavior and recovery (Link et al. 2001; Ceng-Fang et al. 2005; Schomerus et al. 2009; Ben-Zeev et al. 2010; Bowers et al. 2013). In this study, we set out to investigate the experiences of otherness among young adults with depression and/or anxiety disorder. Study participants were students with these diagnoses who participated in a psychosocial rehabilitation program.

Materials and methods

Study design

This study was a part of a larger evaluation study in which feasibility, perceived impact and benefits of the OPI rehabilitation program for students with depression and/or anxiety disorder were investigated (Appelqvist-Schmidlechner et al. 2015). The project was implemented and funded by the Social Insurance Institution of Finland (Kela) and the study was conducted by the National Institute for Health and Welfare, in co-operation with Kela.

The OPI program is an outpatient group rehabilitation program that enables young people to attend psychiatric rehabilitation alongside vocational education. The target group comprised students aged 16–25 years studying in vocational schools who had a diagnosis of depression and/or anxiety disorder. The rehabilitation program represented a recovery based approach (Anthony 1993) to support students with mental health challenges to cope with their life situation and to accomplish their studies. The program consisted of 18 group sessions and 6 one-to-one sessions. The length of the program was 18 months including a 6 month follow up period. The program was cognitive-behavioral-therapy -oriented with solution-focused approach and led by two counselors. Two service providers offered altogether 8 courses during 2011–2013, each course had a maximum number of 12 participants. Referrals to the program were mostly made by the school health service, school social workers or community health services. Collaboration with the school - particularly with school social worker and school health service - played an important role in the OPI program. Besides screening for potential participants, they served as a link between the school and rehabilitation providing dialog and consultation between these two parties, in collaboration with the client. (Appelqvist-Schmidlechner et al. 2015.)

In investigating the program, both quantitative and qualitative research methods were used. The study on the feasibility and outcomes of the OPI program showed positive outcomes in quality of life, learning capacities and severity of depression among program participants (Appelqvist-Schmidlechner et al. 2015) The present study is based on the qualitative data collected in focus groups of program participants. Focus group was chosen as a method as it enables the uncovering of the unique cultural beliefs, values and motivations that affect one's health behavior and well-being (Krueger & Casey 2000).

Recruitment and participant selection

Altogether 80 students participated in the OPI program and were invited to participate in the OPI evaluation study that has been described in detail previously (Appelqvist-Schmidlechner et al. 2015). Written informed consent and obtained parental consent - in the cases of participants under 18 years old - was received from 70 participant. All of them were invited to take part in one focus group session to be organized in the end of the rehabilitation. Information about the study and the purpose of the focus group was provided. Of the 70 participants, 23 did not attend the focus group for various reasons. According to the program providers, some participants had dropped out the program earlier, some had personal reasons not to attend the session in this particular day and some were reluctant to participate in the focus group. Altogether 47 students (38 females and 9 males) participated in the focus group (5-7 participants in each focus group).

All study participants were students in two different vocational schools in Finland (16-26 years, mean age 19, SD 2,15), all with diagnosed depression and/or anxiety disorder. The anonymity of the participants was ensured for ethical reason. As a result, name, age or demographic data about those who participated in the focus group could not be collected.

Data collection

Eight groups of students aged 16–25 years diagnosed with depression and/or anxiety disorder who participated in the OPI program were interviewed during 2011–2013. The focus groups took place on the premises of the service providers during the last group session. Each focus group was facilitated by two female researchers (the first and second author); one leading the interview and the other supporting the facilitator by specifying questions about important issues, ensuring that all questions were exhaustively discussed and making notes if necessary. All interviews followed a similar structure with a primary focus to collect experiences on participating in the OPI program. The structure was developed by the first and second author and discussed within a project team (including professionals from Kela and the National Institute for Health and Welfare) providing support for the study. The interview started with the clarification of the purpose of the focus group, asking for permission to tape the interview, and then posing questions based on the interview guide. Interviews were semi-structured with following themes: Experiences of participating in the program, feelings about starting the program and about telling other people about it, perceived benefits and feasibility of the program, and experiences of integrating rehabilitation and school. In spite of the structured interview guide, the facilitators wanted to ensure the natural flow of the discussion and to avoid controlling the discussion too strictly. Consequently, despite of the fact that the primary focus of the group discussion was not the sense of otherness, this theme was very present and dominant in every group session, thus providing interesting data related to the subject of the present study.

The length of each focus group interview was from 40 minutes to 2 hours, typically 60–90 minutes. Following informed consent procedures, the interviews were recorded with the permission of the respondents and transcribed. The length of the recording was altogether 9 hours and 25 minutes (transcribed in 159 pages, single line spacing, font Times New Roman 12). To ensure confidentiality, all identifying information was removed and participants were assigned pseudonyms.

Ethical issues

The ethical approval for the study was granted by the ethics committee of The Hospital District of Helsinki and Uusimaa and the National Institute for Health and Welfare.
Written informed consent was received from all study participants or their parents if the participant was under 18 years. Information about the study and the purpose of the focus group interview was provided.

Both researchers that facilitated the focus groups were working at the National Institute for Health and Welfare in Finland as researchers and had previous experiences with this study method and interviewing young people. The researchers were not involved with planning or providing the program. The anonymity of participants was ensured for ethical reason.

Data analysis and reporting

Thematic content analysis (Braun & Clarke 2006) using an inductive approach was used to analyze the transcripts. The purpose was to identify, analyze and report patterns within the phenomenon of being labeled with a psychiatric diagnosis. Relevant expressions (sentences/paragraphs) for the aim of the study (sense of otherness) were identified and divided into meaning units. The procedure included the following steps: 1) data familiarization, 2) generation of initial codes, 3) searching for themes, 4) reviewing themes, and 5) defining and naming the themes. The raw data were systematized by the first author into different themes following the verification of the themes by the second author. The authors discussed then the themes until they reached agreement. The themes and examples of data extracts are presented in Table 1 and quotes illustrating the themes in the text. As the students participated in the focus group anonymously, the quotes are presented without detailed labels specifying, for example, the age of the participant at the end of each quotations.

Results

The data analysis discovered seven themes which were named as 1) Carnival of depression, 2) Stereotypes, 3) Shame, 4) Ethos of self management, 5) Overabundance of help, 6) Minimisation and lack of understanding, and 7) Power of peer support.

Carnival of depression

Humor was used as a method to deal with the condition of mental illness and to cope with public stigma. The expressions related to this was named as "Carnival of depression". A peer group with individuals in similar condition set frames for this "carnival". Students were joking about depression or depressed people in general, but they were also laughing a lot at themselves, as the following citations from the interview show:
Participant 1: I was a little bit afraid to come in, in the middle of the session, I thought fuck, there are at least ten totally strange people and I have to come in. I am brought out there. Hey, here you have a new one. And then they get one more weirdo.
[snickering]

Participant 2: Yippee! We got one depressed more!
[laughing]

Participant 1: Straight from Transylvania!

[laughing one's head of]

Participant 3: Let's put all the depressed here together, in the headquarters of depression.

Participant 2: Let's dump them all there [laughing] (Focus group 4)

Stereotypes

The study participants very often saw mental illness and treatment of mental disorders through culturally mediated stereotypes. Messages in the media and in the television influenced their attitudes. Themes in this category reflect how young people with a mental illness find psychiatric rehabilitation and, more generally, people with mental disorders.

The study participants did not exactly know what rehabilitation actually means. Images about mental health problems and rehabilitation came from stereotypes presented in films and media. However, they could not relate themselves with these stereotypes, as illustrated in the following quotes and examples of discussion:
"As I heard the word "psychiatric rehabilitation" I thought a while what it means and how it sounds and I thought I will be locked up in a hospital and I will be there in a room with soft walls with five other people wearing a straitjacket.

And I told her (school health nurse) that I don't know if I want to participate in this rehabilitation program. Because it felt like I am going to sit in a closed ward and have to explain why I feel myself a little bit depressed." (Female, focus group 6)

Participant 1: I think the word psychiatric rehabilitation is totally wrong to use. For people in our age it sounds like you are about to be locked up in a closed ward ....

Participant 2: For me, all drug addicts and alcoholics came to mind. (Focus group 4)

Participant 1: And I thought, hmmmm... rehabilitation...well well...,

Participant 2: You will be banded in your bed...

Participant 3: Look at these pictures, what do they tell to you...?

Participant 1. Do you hear voices? Do you feel something wringing your head?
[laughing] (Focus group 4)

Shame

Students were often concerned with the attitudes of peers or relatives about their condition. Many of them were ashamed and felt embarrassed about having mental health problems and participating in the rehabilitation. Worries about the reaction of peers were common. Telling about their participation in a rehabilitation program was difficult for most of the participants. It seemed that they protected their self-esteem by not disclosing their illness to others.
"Well, I still worry that they think I'm weird because I have this diagnosis and attend this kind of program..." (Female, focus group 1)

"..and my friends could talk something like, what kind of a fucking whacko she is, or something like that." (Female, focus group 8)

Some rather kept it as a secret, as illustrated in the quotation below.
"I definitely won't tell to my friends that I participate in a psychiatric rehabilitation program, that I'm in this kind of club for depressed people." (Female, focus group 7)

Some of the students were afraid they would disappoint their parents by telling about their condition. An example of discussion below describes the feelings of some study participants.
Participant 1: It's a little bit difficult to tell to your parents, suddenly you have to tell them that your child is depressed. Well, what?

Participant 2: It feels like you disappoint them

Participant 3: Yes, I felt the same (Focus group 4)

However, some study participants reported being able to talk openly about their illness with peers and relatives. These students had often relatives who had a history of mental illness, which normalized their condition.

Ethos of self management

Many study participants had a strong ethos of self management. This is not surprising considering the age of the study participants, being in the middle of the transition phase to adulthood and independence. As most of them lived no longer with their parents, they had the possibility to conceal their condition. Some of them did not want to burden their parents with their problems, as is shown in the following citation:
"This is my problem. They don't have to stress about it." (Female, focus group 4)

Many did not want to burden their friends and class mates with their mental health challenges, either. Many had this uncomfortable feeling like they would only ruin other's mood by telling about own bad feelings. Consequently, some of them tried to hide their bad feelings behind a "fake happy face".
Participant 1: That terrible embarrassment among other people if they heard about such problems.

Participant 2: Depression is still a kind of taboo...(Focus group 2)

Overabundance of help

Themes coded as "Overabundance of help " include negative perceptions directed toward peers and friends who were too keen to offer help. Many had faced overabundance of help, which was experienced as annoying by some study participants. The following are illustrations of these themes.
"So many think they are like Jesus ... I can heal you. Just talk to me". (Female, focus group 4)

"One friend of mine talked to me like I was 5 years old. That was so annoying." (Female, focus group 4)

Students didn't want to be treated as special cases by friends or teachers because of fear of stigma.
"And then somebody in the class, in front of the class, asked me if I'm ok and if I manage. And by doing that she made me look even more weirdo ". (Female, focus group 7)

Students didn't want other people to pity them. They wanted to be handled like other students, despite their diagnosis. They wanted teachers to take their diagnosis into account, but they didn't want to be treated as a special case.
"I have sent my teacher an e-mail and told that I want you to take this into account, but I don't want any special treatment or pity. I don't want to turn this into a big issue." (Female, focus group 2)

Minimisation and lack of understanding

Despite of the overabundance of help experienced by some study participants, many reported experiences of other people minimizing their condition, or lack of being understood by others. They reported having been misunderstood by teachers and peers, as well as by professionals. Some felt, that even mental health professionals did not take their condition seriously. The following citations present experiences with the public health care.

"I got this feeling that they minimised my condition. Then I started to cry uncontrollably and yelled them that fuck, I feel bad!" (Female, focus group 4)

"They told me that my condition is too good. Should I have a rope around my neck before they understand? I'm not suicidal and I don't want to be like that. I just want to have somebody to talk with. When I'm sitting all day long alone in my apartment staring at walls, well, it can't be that normal. (Female, focus group 4)

Due to numerous professionals providing help in the past, some of the study participants were tired to explain their condition and tell their story over and over again. They felt that peers, teachers and even psychiatric and mental health nurses could not really understand them despite their education and many years of working experience. Some of the study participants had a strong feeling of being misunderstood by all without the same condition.

"And then as I talked with a nurse, I don't think she really understood, even though she had studied this for ten years and more. But I think she can't REALLY understand me." (female, focus group 6)

Power of peer support

This theme reflects how the students with mental disorder felt a sense of belonging when interacting with others with similar condition. Group members were bonded through sharing a common problem. It was a relief for many to realize that others experience the same problems and are struggling, too. They felt connected, sharing a common problem and getting peer support. One main benefit of the group-based rehabilitation was the opportunity to laugh and cry together. Nobody needed to hide their bad feelings, but everybody had also the permission to laugh.

"It's so cool that even if we talk about rough things and cry together and something like that, but after a coffee break we can have fun and laugh together. I mean, you don't have to be sad all day, even if you...if you have just handled very deep stuff and talked about rough issues." (Female, focus group 2)

In groups with a good group cohesion, students had the experience of being understood by others, they were able to talk confidentially and openly. They felt more connected and less alone, reducing feelings of isolation.

"And also...you are not alone with this issue. And...well...it has been so good to talk with these people. They understand how you feel." (female, focus group 1)

Table 1. Themes		
Themes	**Coded for**	**Examples of data extract**
Carnivalisation of depression	Joking about depression in general Joking about depressed people Joking about oneself as a depressed person Joking about taking part in a rehabilitation program	*"Also my uncle is a nutcase"* *"...Let's put all the depressed here together, in the headquarters of depression..."* *"...Straight from Transylvania..."* *"... And then they get one more weirdo..."*
Stereotypes	Stereotypic images of depression and depressed people Stereotypic images of psychiatric rehabilitation	*"...They (people with mental health problems) walk in the street and mutter..."* *"For people in our age it sounds like you are about to be locked up in a closed ward ...".*
Shame	Shame in telling about one's depression Fear to disappoint the parents Worries about the reaction and attitudes of peers	*"I definitely won't tell to my friends that I participate in a psychiatric rehabilitation program, that I'm in this kind of club for depressed people."* *"It feels like you disappoint them (parents)"* *"...I have the feeling that my brother may think, that what...is my sister ok? Is she allowed to be among the people? Should she be locked up somewhere?"*
Ethos of self management	Unwillingness to burden other (parents, friends) Willingness to manage alone	*"They (friends) get embarrassed when I talk about my problems or about issues we are talking here. Then I got this feeling, I don't want to bother them..."Otherwise the feeling of others will be ruined."* *" This is my problem. They don't have to stress about it."*

Overabundance of help	Annoying friends offering help Too many parties offering help Turning one's condition to an too big issue	*"One friend of mine talked to me like I was 5 years old. That was so annoying."* *"All this fuss over me, I sit there alone with all these people, parents, school nurses and nearly the school cooks, too. Then you get the feeling, that well...here you are..."* *"And then somebody in the class, in front of the class, asked me if I'm ok and if I manage. And by doing that she made me look even more weirdo ".*
Minimisation and lack of understanding	Lack of understanding Minimisation of symptoms by others Exhaustion to explain one's condition	*"But I think she can't REALLY understand me."* *"...they minimised my condition."* *"I am so tired to explain everybody about all this.."..." It's so tiring."*
Power of peer support	Feeling of being understood Sharing a common problem Sharing different feelings	*"They understand how you feel..."* *"...you are not alone with this issue."* *"It's so cool that even if we talk about rough things and cry together and something like that, but after a coffee break we can have fun and laugh together*

Discussion

The study aimed to synthesize qualitative evidence related to experiences of otherness among students diagnosed with depression and/or anxiety disorder who participated in a psychosocial rehabilitation program. The themes described here highlight and explain how study participants experienced their illness, the reactions of other people to their condition and taking part in a rehabilitation program with peers in similar condition.

The present study showed that the sense of otherness due to a psychiatric diagnosis is related to stigma experiences, which may carry both negative and positive meanings (Link & Phelan 2010). The study participants had faced sense of shame, minimisation of their condition, lack of being understood by others and inappropriate way of providing support. On the other hand, in groups with peers with the same condition, they had experienced the possibility to share common thoughts and problems, to laugh and to make fun of themselves and to get peer support. The findings of the present study were in line with those of the study by Kranke and Floersch (2009), who interviewed adolescents with a mental health diagnosis and described their experiences of stigma in schools, finding both negative and positive meanings of stigma experiences.

In the present study, the presence of self stigma and label avoidance was particularly remarkable. Fear of social stigma strongly affected the student's willingness to participate in the rehabilitation program. Many felt embarrassed about having a mental health problem and they were worried about other people's reactions. During adolescence and young adulthood, concerns about opinions of others are common also among those without mental health challenges. It is understandable that young people with mental health problems experience these concerns even stronger. Young people with mental health problems commonly feel stigmatized and labeled experiencing multiple losses of identity, family, career choices, and educational and social standing at worst (Leavey 2005; Moses 2009). It is also known that they commonly are stigmatized by peers without mental health problems (O'Driscoll 2012).

Despite of the dominant presence of stigma experiences among study participants, not every student in this study experienced fear of stigma. Some study participants did not have difficulties to talk openly about their illness with peers and relatives. Previous studies have shown that stigma experiences among young people with mental disorders are not necessarily that common. In the study of Moses (2009), relatively low levels of stigma among adolescent recipients of mental health treatment was shown. The authors stated this to be related to the commonality of mental health symptoms during this age period or increased knowledge about mental health problems and the treatability of these problems. In the present study, those with previous experiences with mental health problems in the family seemed to face fewer difficulties with telling other people about their condition.

The diagnosis of depression / anxiety disorder formed a bond between the study participants, providing connection with others in similar condition, sense of belonging and being understood as well as peer support. Shared experiences of otherness deepened the social cohesion. The strategy of forming friendships with others in similar condition is called positive stigma avoidance strategy (Kranke & Floersch 2009). This is a strategy of managing stigma by producing a sense of belonging as well as normalizing behavior, feeling and experience. Group-based interventions - like the OPI program - have the opportunity to foster the group identity and to normalize the illness, reducing stress and self-stigma and supporting the recovery (Corrigan & Wassel 2005; Newbold et al. 2013). Further, group-based interventions have the possibility to provide opportunities to create and maintain friendships with individuals in similar condition. This is important as in this age period young people commonly choose friends based on similarity (Abound & Mendelson 1996).

The study participants used humor as a method in dealing with their mental illness. They were making fun of themselves and the peer group set frames for that. The "carnivalisation of depression" was perceived in using stereotypes, playing the fool and in lots of laugh with peers in similar condition. Previous studies have shown that the use of humor is a common method in coping with stress and it can be seen as a coping strategy, as a method to escape and/or avoid the reality (Crawford & Caltabiano 2011; Wu & Chan 2013). The term "Carnivalisation" is not found in the literature related to mental health issues, but it describes the phenomenon observed in this study better than the common term "humour" as it includes a stronger social aspect provided by the peer group. It also includes elements like atmosphere through humour and chaos, parody and personal satire, as described by Bakhtin (1968).

The study also showed up that the students did not have adequate information about mental disorders or psychiatric rehabilitation. Young people do not necessarily understand the meaning of the terms used by health care professionals or these terms may be experienced as stigmatizing. The perceptions were formed by stereotypic pictures from the media and television. It is known that media messages very often influence perceptions and form stigmatizing attitudes toward people with mental problems (Cutcliffe & Hannigan 2001;

Kranke et al. 2014).

Strengths and limitations

There are strengths but also several limitations of the study that have to be taken into account. The method used in this study fits for the purpose of the study. Qualitative research has the possibility to lend relevant insight into experiences of otherness as a young person with mental disorder. Group settings can trigger people to talk about things that they may not necessary talk about in individual interviews, enriching the data with group experiences and interpretations. Focus groups are seen as an ideal method for exploring people's own meanings and understandings of health and illness (Wilkinson 1998). However, as the sample was small, the results can not be generalized.

One challenge in facilitating focus groups is to get every participant to open up and engage in the discussion. Some were more dominant while other needed encouragement to speak. On the whole, the atmosphere during every focus group was open and friendly. Some groups were more talkative than the others. This impression was confirmed also by the counselors providing the program.

One weakness of the study is the small number of males among the study participants. Participants of the OPI program were mainly females and the voice of male students is underrepresented in the study. It is also to note, that not every participating in the feasibility study participated in the focus group interview. It is difficult to estimate, how this might have biased the results as the reasons for nonparticipating were various. Further, it has to be taken into consideration that the study participants were taking part in a group rehabilitation program. This has most likely had an influence on the themes that came up in the analysis, especially highlighting the meaning of peer support. The experiences of otherness among those without the possibility to participate in this kind of group-based rehabilitation program or those not having any kind of treatment would differ from these findings. This could be an interesting aim for future studies.

Implications for practice

The present study highlighted many interesting and important aspects for health care practitioners. First, as young people are known to be reluctant to seek help for their mental health problems, it is important to avoid minimisation of symptoms when dealing with a young person with a mental health concern. On the other hand, young people do not want to be handled like a person with a disability. Health care professionals can contribute to the positive experiences among young patients with mental illness with a person-centered approach, where the patients and their concerns are taken seriously. Young people with mental health problems want to be heard and respected like any other people.

Second, young people do not necessarily understand the terms used by the health care system. Service providers and mental health professionals have to pay more attention on how to reach those young people in need for help and how to lower the threshold for seeking help. Young people with mental disorders should be provided with adequate information about services that are supplied. Besides oral and written information, also an opportunity to visit the venue and professionals providing the service is recommended. Within the OPI program, this opportunity lowered the threshold to take part in the program.

Third, service providers should also be aware of the power of peer support in planning and developing mental health services for young people with mental illness. Connection with peers with similar condition has the opportunity to normalize the experience of the illness. This can have a positive impact on recovery. Further, young people with mental disorders should be used as experts by experience and be engaged in planning and developing mental health programs for their own age group.

Conclusions

The findings of the present study showed that the experiences of otherness among young people with depression and/or anxiety disorder are related to stigma experiences, which may carry both negative and positive meanings. Negative meanings were related, most of all, to shame and worries about the reaction of peers and relatives as well as to the lack of being understood by others. The positive feelings came out in interacting with peers in similar condition providing support, understanding and sense of belonging. Humor was used as a coping method of dealing with mental illness.

The present study provides a better understanding of the social identity of young people receiving support for mental health challenges, and it helps service providers to pay more attention on how to reach those in need of help, how to lower the threshold for seeking help and how young people with mental disorders should be supported.

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