Attitude Statements

An activity that helps challenge unhelpful attitudes to mental illness by looking at the impact of statements about people who experience mental distress.

Participants are introduced to myth-busting information, personal insights and the terms stigma and discrimination.

Conversations for Change

reTHiNK.org.nz

LIKE MINDS LIKE MINE®

Whakaitia te Whakawhiu i te Tangata

Attitude Statements

Objectives: To help youth challenge common stigmatising attitudes to mental distress and the effects of these attitudes

To increase empathy and understanding about people's mental health experiences in the context of stigma and discrimination.

Key messages:
- Mental distress is common and understandable.
- There is no one explanation for mental distress.
- Your behaviour makes a difference.
- Recovery is possible.

Recommended group size: Suggested maximum of 12 people per facilitator.

Part 1 **— Stigma and Discrimination card**
Time: 20+ mins (information and discussion).

Part 2 **— Attitude Statement cards**
Time: 50+ mins (5 mins then 10 mins small group discussion of the fronts & backs of cards, 20+ mins full group discussion and brainstorm).

Resources to have ready:

- Group Agreement and Places for Support brainstorm pages from the first activity.
- Stigma and Discrimination card.
- Attitude Statements card pairs (11 numbered pairs and one example set).
- Brainstorming paper.

Tips:
- Laminate the cards to use again.
- This activity can be a lengthy one if you use all of the cards and discuss them thoroughly. You may wish to use the cards most suitable to your group, and/or visit the activity again at a different time with the other half of the cards. We recommend you include the card discussing dangerousness, as this is an important message to encourage social inclusion.
- You can leave out the final self-harm card (11) if this feels appropriate to you.

Part 1 — Stigma and Discrimination card

Before you start

There is one A4 explanation card titled 'Stigma and Discrimination' along with 12 pairs of Attitude Statements cards (one is the example pair). A pair contains a) stigmatising statement and questions and b) education around the stigma and a personal quote (with koru design).

Introducing the activity

If this is done on a separate day from the 'Mental Illness Is' activity, remind everyone about the Group Agreement and Places for Support brainstorm pages.

Then read out the following, or introduce the activity in your own words:

"I'm going to read out a statement and I want to know what your thoughts are." Read out the front of the example card, "Teenagers all have issues, there's no point in getting support for them as they will grow out of it."

Ask the group: "Have you heard something like this before? What do you think about it? If a young person believed this idea, how might it affect them? If people who are around teenagers believed this idea, how might they behave towards teenagers?"

Say something like "This idea about teenagers, that they 'all have issues' is an example of a stigma about young people."

Ask:
- Who knows what stigma is?
- Who knows what discrimination is?

Display the 'Stigma and Discrimination' card.

Say something like:

"Stigma can be described as stereotypes (negative beliefs about people) and prejudice is agreement with the stereotypes."

"Discrimination can be described as 'unfair treatment based on someone belonging to a particular group which results in them being excluded from something — for example being unable to go to the doctor, not having a place to live, or finding it hard to get a job."

"Stigma leads to discrimination. Stigma is in our thinking and attitudes. Discrimination is the things we do that reflect the negative ideas we have about a particular group of people."

Ask:

1. What other kinds of stigma do young people face? (Answers may include: they can't be trusted, are emotional, difficult, don't make good decisions, or can't drive well.)
2. What kind of other groups face stigma and discrimination? (Look for answers like differently abled/people with disabilities, beneficiaries, people with mental health issues, minority groups, religions, ethnicities, cultures, different sexualities, gender diverse people and tangata whenua.)

Part 2 — Attitude Statement cards

Small group work:

Say: "Stigma and discrimination are big issues for people with experiences of mental illness/distress. We're now going to look at some ideas that are sometimes believed about people with mental health issues."

Divide participants into pairs or groups. Keep groups small (five or under) to support open and honest discussion.

Hand out the cards (one or two per pair/group) and say "Discuss the statement and questions with stigmatising statements on your card/s."

Move among groups to help encourage respectful conversations. After five to eight minutes say: "Now I'm going to give you another card to read and discuss."

Sharing the cards

Ask a member of each group to read out both the first statement and then their matching card to the larger group.

Questions for large group discussion

1. What would it be like hearing the statements on the front of the cards if you had your own experience of mental 'illness/distress'.
2. How might the attitudes (stigma) on the front of the cards lead to actions that discriminate against someone?
3. Where do we hear these unhelpful statements? Do you think the place and the person you hear it from makes a difference? For example, would it feel different if it was your doctor or your mum or your workmate saying these things?
4. Do you think the ideas on the front of the cards mean that people with mental distress are going to feel okay about themselves? If they hear these things, how likely will they be to ask for help?
5. Is it fair that people treat people with mental health issues badly, or don't give them the same opportunities as other people?
6. So what kind of things could we do or say if we hear negative attitudes like this? (Brainstorm these ideas on a piece of paper. You may choose to keep and display this brainstorm page as a reminder to your group about their ideas on this issue.)

Things that people could say:

To the person that might be affected

- Are you okay?
- That didn't seem fair.
- Do you want to talk about it?

To someone else saying something stigmatising or negative

- I don't think that attitude is very fair/accurate.
- I wouldn't want someone saying that about me.
- You're talking about some people I care about.
- I don't like that way of describing people.
- Hey, you don't know their story.
- Could we check the information you have about that?

7. Who should say these things? (Look for the answer that it is up to everyone to speak up. In addition, it may be easier for someone to speak up if they don't currently have a mental health struggle.)

Optional additional questions

1. Was there anything surprising about the information you read on the back of the cards?
2. The quotes on the back of the cards are from young New Zealanders — what difference did it make to you, to hear their perspective?

Finishing

If you are having a break before continuing with the next activities, it can be a good idea to remind participants about the Conversations for Change help card they received, and the Places for Support brainstorm page, which both list places where they can go to talk to someone.

Hints and help

A. Remember – there will be people in your group who have their own or family experiences of mental distress. Keeping conversations respectful is vital to make sure this is a useful and supportive group experience for them.

B. Some individuals in the group may have had experiences that seem to confirm negative stereotypes about people with mental illness/distress (e.g. my neighbour was dangerous or my aunt was 'weird'). It may be useful to ask the group about how young people as a group get judged, when adults think about all young people based on:

- one or two experiences with young people, or
- their most upsetting experience with young people, or
- sensational news stories about young people.

The message here is that just because an idea may be partially true in individual situations, it doesn't mean that it is useful to apply this belief to a whole group. Participants may like to reflect on stereotypes about other groups they are part of. There is evidence that people who face stigma and discrimination in other areas of their life are more likely to experience mental health distress.

Notes for facilitators

The following information is for you as a facilitator. Being familiar with it should help you feel more confident about supporting participants as they discuss the cards. Remember — it's okay to say when you don't know, and to encourage research from reliable sources. The numbers match the Attitude Statement card numbers.

1. Mental illness is really common. If there are 1 in 4 people experiencing it at any one time, how many of your friends, family and acquaintances might be experiencing it right now?

   At what point do we call something mental illness or mental distress, and at what point is it just part of being human, e.g. when traumatic or difficult things have happened or someone is managing a lot of stress.

2. Violence: One of the biggest mistakes is to think that people with mental illness are dangerous. People with mental illness are far more likely to be hurt by someone else than to hurt someone. This idea that they are dangerous often comes from the news. That's because one example of violence by someone with psychosis or schizophrenia can make a good headline and attract lots of attention.

   Mental health issues may also be highlighted in news stories as explanations for someone's violent behaviour, even if lots of other things are happening in that person's life which are also influencing their behaviour. Additionally, given how common mental health concerns are, a large number of those involved in any news story (the victims, family, Police officers, neighbours and bystanders) will also have mental health histories — but this is not mentioned!

   Often these negative ideas (stigma) about dangerousness are especially connected to people with experience of psychosis or schizophrenia. While it is always wise for a professional to be involved in assessing somebody experiencing psychosis, understanding what factors lead to violence is complex, and research shows other factors (like gender and previous acts of violence) are far better at predicting when violence might occur than if a person has a mental health condition (see Further Reading).

3. Most people recover from mental illness and can live great lives. Famous people who have experienced mental health conditions include: Demi Lovato, Tiki Tane, Prince Harry, Lady Gaga, Hayden Panettiere, Catherine Zeta-Jones, Abraham Lincoln, Amanda Seyfried, Selena Gomez, Carrie Fisher (Princess Leia from Star Wars), Elton John, Dwayne 'The Rock' Johnson, and John Kirwan, the ex-All Black prominently featured on the ads for the Depression helpline.

4. The community referred to in this card might be a sports club or extended family, or a cultural or faith-based community. It is vitally important that where faith and cultural beliefs are shared, these are treated respectfully by the facilitator. One area for further discussion is that young people may believe that leaders/elders/people in their parents' generation or in their community are not open to conversations about difficult issues like mental health or drugs or alcohol, and they may have had experiences that seem to support this idea. The discussion around this card may provide a valuable opportunity to examine this idea, and how a young person can test the waters to check out who might be helpful for them to talk to.

5. Addiction is complicated and has little to do

with willpower. Many social, psychological and physical dependency issues may combine to cause addiction. There is growing evidence which suggests misusing alcohol contributes to the development of mental disorders such as depression and the development of suicidal behaviours in young people (see Further Reading). Use of drugs, including marijuana (cannabis), LSD and P (methamphetamine) has been linked with a significantly higher likelihood of someone developing psychosis.

New Zealand research suggests early use of cannabis may particularly increase the risk of psychosis and lower someone's IQ. The increase in psychosis risk relates to the fact the brain is still developing up to the age of 25 (see Further Reading).

Methamphetamine (P) use can mimic the symptoms of psychosis and can trigger ongoing symptoms (see Further Reading). Peter's story, in the activity 'Turning Up the Volume', offers further opportunities to discuss this.

6. There are likely to be young people in your group who are experiencing, or have experienced, depression and anxiety. It's not always obvious who these people are; some people can present one way on the surface and have a lot of struggle and distress going on underneath. Sometimes other issues like truancy, aggression or drug and alcohol use can be related to a young person's struggles with depression or anxiety.

   Sometimes a person ends up struggling with what we call depression and anxiety after a big loss (grief), or because of other life circumstances such as bullying, abuse, loneliness, or feeling weighed down by expectations (see Further Reading). Alternatively, sometimes there is no direct or clear reason why the depression/anxiety started, and this may result in someone judging themselves harshly for having depression or anxiety.

7. Hearing voices can be a part of mental distress that people find scary and hard to understand. There are many famous people throughout history who have heard voices and understood these as spiritual guidance or similar. Some people hear voices as if they are very loud thoughts inside the head, while to others they sound as if they are spoken outside the body (see Further Reading). 'Turning Up the Volume' has more information about hearing voices.

8. Viewing mental health issues as a moral or character weakness may lead to people delaying getting support for themselves or for those they care about. Early intervention is associated with much better outcomes. It's more helpful to see it as a strength when people are willing to ask for help.

9. People of all shapes and sizes can experience eating difficulties. Eating difficulties are rarely 'simply' about food (see Further Reading). The activity 'Fresh Eyes' provides opportunities to talk further about this issue and the role our culture can play. Recovery is a combination of many things, including discovering or creating self-worth and motivation beyond our size, shape or weight, increasing self-compassion, and the ability to be okay with difficult emotions and circumstances.

10. Although the idea that past actions or ancestors' actions might contribute to mental health issues may be new for some facilitators, there are many people from lots of backgrounds who have come across this idea. For some people this idea can be a useful way of explaining what led to their mental distress. It helps them make sense of their situation or to get support or treatment for it — sometimes through traditional, cultural or faith frameworks.

    Some people experiencing depression have thought or felt "I deserve to feel this way" or "I don't deserve any better" or even "I am cursed". Given what we are coming to understand about epigenetics (the way your grandparents' experiences can influence what genes are switched on and off in you), the role drug use seems to have in triggering or worsening mental distress, and various spiritual and traditional views around the world, it is clear there is some scientific and cultural validity in the idea that mental illness can result from actions.

    You will note that in this activity the statement uses the word 'always'. We suggest that it is seeing this in black and white terms as the only possible contributor to mental distress that makes it unhelpful and potentially stigmatising. Another danger might be if people feel pressured into particular treatments or practices common in their community, particularly if these impact on their wellbeing or are significantly expensive.

11. Self-harm is a complex issue that is often judged as attention-seeking. Even for those using self-harm partially as a communication tool, isn't it of concern that harming their body is the way they communicate rather than using other ways of asking for support?

    Research suggests that self-harm is surprisingly common (see Further Reading). This area may be an important one for your group to discuss — however, feel free to leave it out if you are unsure about your ability to manage the resulting conversation.

The message on the front of this card may need to be shared with the whole group. If the conversation moves from stigma and self-harm to a specific example of self-harm, say something like: "I just need to stop you there … It's really important when we are talking about self-harm, that we don't talk about the details because I can't know what any of you have experienced in the past or what you might have going on at the moment. Can we talk about some safe places where you COULD have this conversation?" If someone mentions someone who is self-harming, say: "Thanks for bringing my attention to that. Can we touch base after the activity?"

If the conversation starts to open into a general conversation about suicide/self-harm say:

"I want to keep today's conversation on the mental health stigma topic — but I also don't want any of you going away with worries or concerns about the area of self-harm or suicide. What are some places we can go, if something in this conversation has brought stuff up for us?" (thelowdown.co.nz has a lot of safe information and stories on this topic. In addition, school counsellors or community mental health professionals may be able to facilitate a discussion on anxiety, depression, bullying, positive coping strategies and what to do when you are concerned about someone.)

Sometimes people divide those with self-harm behaviour into two groups: 'those who are serious' and 'those who are attention-seeking.' This division is not helpful. Self-harm is a risk factor for suicide and this behaviour needs to be treated seriously in all cases. This helps to avoid self-harm escalating for an individual or a group.

General suicide prevention message:

- Having passing thoughts of suicide is a really common human experience. If these thoughts start to hang around, or are very strong, they are our body and mind telling us that we need to get some support.
- When the type of support is a good fit for the individual, they can feel better. Often they can feel better surprisingly quickly.
- Thoughts of suicide are not something that a young person should deal with on their own, or only with the support of friends.

A common myth or idea is that if someone has attempted suicide, or is talking about suicide, that this means they will not take their lives. This is false. Talk of suicide, death, hopelessness, and suicide attempts are all indicators someone might complete suicide (see Further Reading).

Best practice guidelines (see Further Reading) suggest that an open group of young people is not the place to have in-depth discussions on self-harm or suicide. You will see the activity card mentioning self-harm has a warning on it for young people that you may wish to share with the group at large. Check out the second facilitators' video for more information.

Further Reading

Links to studies, articles, evidence and further information to support this resource can be found at www.rethink.org.nz/conversationsforchange