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Simon Dunne

*Dublin City University, [simon.dunne@dcu.ie](mailto:simon.dunne@dcu.ie)*

Liam MacGabhann

*Dublin City University, [liam.macgabhann@dcu.ie](mailto:liam.macgabhann@dcu.ie)*

Michaela Amering

*Medical University of Vienna, [michaela.amering@meduniwien.ac](mailto:michaela.amering@meduniwien.ac)*

Paddy McGowan

*Dublin City University, [paddy@mcgowan.ie](mailto:paddy@mcgowan.ie)*

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## **“Making People Aware and Taking the Stigma Away”: Alleviating Stigma and Discrimination through Trialogue**

Dr. Simon Dunne, Dublin City University, Ireland, Dr. Liam MacGabhann, Dublin City University, Ireland, Prof. Michaela Amering, Medical University of Vienna, Austria, and Paddy McGowan, Dublin City University, Ireland.

simon.dunne@dcu.ie; liam.macgabhann@dcu.ie; michaela.amering@meduniwien.ac;  
paddymcgowan1@gmail.com

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### **Abstract**

Mental health stigma and discrimination is a major societal issue. Participatory approaches such as Open Dialogue may be effective in bringing about changes in such stigma and discrimination. Trialogue is an extension of such approaches to three or more sets of stakeholders in mental health systems. The current study explores stakeholders' evolving discourse concerning mental health stigma and discrimination over time through this approach and whether this approach may alleviate mental health stigma and discrimination. Through a prospective qualitative research design, individuals from seven participating communities throughout Ireland took part in interviews (n=42), focus groups (n=28) or Open Dialogue discussions (n=86) across three cycles of research. Thematic content relating to stigma/discrimination of individuals with mental health issues was purposefully analysed at each cycle using thematic analysis. The findings document the prevalence of avoidant approaches towards individuals with mental illness and their families in Irish society, resulting in negative effects of stigma and discrimination such as lowered levels of self-esteem, lower help-seeking behaviours, difficult interpersonal relations and fewer employment/educational opportunities. Trialogue Meetings evolved into a forum where myths surrounding mental illness were dispelled and more humane views of service users and service providers were established among relevant stakeholders and their social networks. The findings indicate that Trialogue Meetings may go some way to tackling stigma and discrimination through positive social contact, dialogue and education for relevant stakeholders in mental health systems. The findings also elucidate a culture of concealment of mental health issues in Ireland, leading to subsequent stigma and discrimination.

**Keywords:** Open Dialogue, Trialogue, community-based participatory approach, discrimination, mental health.

### **Introduction**

The stigma and discrimination of individuals with mental health problems and their families is increasingly recognised as a major issue in society today. In mental health contexts, stigma is an overarching term describing the negative characteristics of knowledge, attitudes and behaviours directed towards individuals affected by mental health problems (Thornicroft, Brohan, Rose,

Sartorius and Leese, 2009), while discrimination refers to unfair treatment which disadvantages such individuals in society (Thornicroft, 2006). Stigma negatively impacts upon the extent to which individuals with mental health problems use mental health services (Clement et al., 2015) and perpetuates patterns of self-stigma among such individuals (Ritsher, Otilingam and Grajales, 2003). A wealth of research has also demonstrated the negative effects which discrimination can have on individuals with mental health problems and their families, including fewer available job opportunities and increased levels of forced resignation (Sharac, McCrone, Clement and Thornicroft, 2010), greater difficulties in securing appropriate housing (Corrigan et al., 2003), negative interpersonal relations (Peterson, Pere, Sheehan and Surgenor, 2007) and lowered levels of self-esteem (Lysaker, Tsai, Yanos and Roe, 2009). In order to address such issues, public health interventions have been designed to reduce stigma and discrimination towards individuals affected by mental health problems (e.g. the recent “Time to Change” programme in England: Corker et al., 2013; Evans-Lacko, Henderson and Thornicroft, 2013). However, while these interventions have been successful in improving the public’s knowledge and attitudes towards mental health, they have been only partially effective in reducing discrimination towards individuals with mental health problems (Mehta et al., 2015). In order to address the future design of such interventions to impact discrimination, Mehta et al. (2015) have outlined the need for high quality research which explores the nature and context of such discrimination and which supports anti-discrimination policies towards individuals with mental health problems.

In this context, Open Dialogue approaches to research and development in mental health (e.g. Seikkula and Arnkil, 2006) may be effective ways of attempting to bring about change in relation to mental health stigma and discrimination. Open Dialogue approaches involve the application of shared dialogic processes to meetings between mental health service users and providers, where each individual participates in the conversation in their own way through a common language and mutual understanding around a chosen topic (Seikkula and Olson, 2003). Open Dialogue is a participatory method which is designed to bring people together in a temporary community environment centred on dialogic communication (See Seikkula and Olson, 2003 for further details). Sessions are typically facilitated by one or more individuals who implement a set of ground rules which are agreed in advance amongst participants. These include, but are not limited to, the following: all participants have equal status within the dialogue, the dialogue is based on give and take rather than one-way communication, an argument can be rejected only after it has been investigated and all participants are obliged to accept that others may have better arguments than their own (Gustavsen, 2001). Freire (1996) has suggested that the act of participating in such dialogue may help individuals to overcome dehumanising oppression, as dialogical processes enable human actors to become subjects instead of objects through the establishment of positive relations with other dialogical participants. Indeed, Open Dialogue has been found to strengthen relations between service users, service providers and mental health educators (Ulland, Andersen, Larsen and Seikkula, 2014) and enable the development of equitable policies in mental health services through accommodation of a range of diverse perspectives (MacGabhann, McGowan, Walsh and O’Reilly, 2010), thereby mitigating the effects of stigma and discrimination in these contexts.

Trialogue Meetings represent a particular form of Open Dialogue where three or more groups of individuals who deal with mental health systems are purposefully included as participants in the

conversation; these groups typically comprise service users, service providers and family members/friends (Amering, Hoffer and Rath, 2002). Anecdotal reports, two small-scale evaluations and one larger-scale evaluation across Austria, Germany and Ireland have indicated that engaging in Trialogue Meetings are positive and transformative experiences which improve relations between stakeholders in mental health contexts such as psychiatric institutions and wider community settings (Amering et al., 2002; Amering, Mikus and Steffen, 2012; Bock, Buck and Esterer, 2000; Bock and Priebe, 2005; MacGabhann, Dunne, Amering and McGowan, 2016; MacGabhann, McGowan, Amering and NiCheirin, 2012; Ruppelt, Mahlke, Heumann, Sielaff, and Bock, 2015; von Peter, Schwedler, Amering and Munk, 2015). However, systematic research is lacking in relation to the potential for Trialogue to ameliorate stigma and discrimination among service users, their family members and service providers. Following such ideas, the current research was designed to 1) explore Trialogue participants' evolving discourse relating to mental health stigma and discrimination over time, and 2) use this information to identify whether or not Trialogue Meetings have the potential to alleviate stigma and discrimination for individuals with mental health problems and their families.

## **Method**

### ***Design, Data Collection and Materials***

This paper describes a qualitative prospective study relating to stigma/discrimination of individuals with mental health issues in Ireland. Data was collected at three cycles across the seven-month study period in each participating community: 1) interviews after the first Trialogue Meeting and a central focus group which occurred after participants' first or second Trialogue Meeting (depending on their site), 2) a focus group after participants' fourth or fifth Trialogue Meeting, and 3) at the seventh Trialogue Meeting. In Cycle 1, interviews were structured around participants' experiences of key mental health issues such as knowledge of mental health issues, mental health stigma and experiences of participating in the initial Trialogue Meetings. Focus group data was also collected during this period at a facilitator workshop training day. These focus groups centred on participants' perspectives of the emerging story of Trialogue in each participating community up to that point. In Cycle 2, focus group data was collected at a second facilitator workshop training day after the fourth or fifth Trialogue Meeting had taken place, where participants discussed their experiences of Trialogue Meetings and the challenges which they had encountered up to that point. In Cycle 3, data was derived from the seventh and final set of Trialogue Meetings, which participating communities agreed in advance to use to discuss Trialogue's successes, failures and future sustainability. Further details relating to data collection at each cycle are also described in the data analysis section of this paper.

### ***Establishment of/Recruitment for Trialogue Meetings in Ireland***

In 2010, a research and development team in Dublin City University established a network of Trialogue Meetings in collaboration with seven local communities throughout Ireland (Cork, Mayo, Galway, Tipperary South, Donegal and two from Dublin) as a community-based Participatory Action Research project (Reason and Bradbury, 2008). These meetings were initiated at the request of individuals from each of these seven communities who had participated in a

mental health leadership service improvement programme in Dublin City University and comprised a group of mental health service users, service providers and carers. At least one individual from each participating community agreed to host seven monthly Trialogue Meetings in local community centres in their area over a one-year period and to collaborate with the research team in establishing, moderating and recruiting for these meetings. No specific disciplinary or professional background was required for facilitators; they simply had to have an interest in facilitating Trialogue Meetings and represent one of the main trialogue groups (service users, service providers, friends/family and/or carers). Members of the research team also represented a group of service users, service providers and friends/family members.

These individuals engaged in local recruitment methods (e.g. posters, flyers and social media advertisements) and identified suitable venues for Trialogue Meetings. This was facilitated and supported by a central project co-ordinator. The first Trialogue meeting in each community was scheduled to include members of the central project team, who answered questions and assisted in the moderation of Trialogue Meetings. Trialogue Meetings themselves centred on discussions of mental health issues in Ireland and were conducted in a spirit of anonymity, where participants were not required to indicate which mental health role they inhabited to other members of the group and were encouraged to “leave their hat [i.e. mental health perspective] at the door”. The topics discussed in the Trialogue Meetings themselves included people’s understanding of mental health, service users’ experiences of wellness, illness and stigma and the appropriateness of mental health services in Ireland.

### ***Data Analysis***

All qualitative data from Cycles 1-3 was purposefully analysed for content relating to the topic of stigma/discrimination of individuals with mental health issues in Ireland by the first author (an independent researcher who had no previous contact with participants). This analysis centred on the development of content relating to this theme across the three cycles of the study period and followed a deductive process of thematic analysis based on the model outlined by Braun and Clarke (2006). The analysis was validated by the second author who checked the quotes and themes for their consistency and coherence.

### **Results**

The following analysis documents the evolution of Trialogue participants’ discussions related to stigma/discrimination of individuals with mental health issues and the potential for Trialogue to tackle this stigma/discrimination across three cycles of the initial development of Trialogue Meetings in participating communities in Ireland. This thematic material is presented below for each cycle together with excerpts from participants’ discourse, and, where necessary, information on key developments in Trialogue. Ellipses have been inserted in square brackets in circumstances where quotations have been contracted for the purposes of length. For Cycle 1 and 2, participants are identified by data collection method and a corresponding number as follows: Interview Respondent 1 [IR.1], Focus Group 1 Respondent 1 [FGR1.1], Focus Group 2 Respondent 1 [FGR2.1]. For Cycle 3, each quotation has only a Trialogue Evaluation Meeting [TEM] identifier associated with it, in keeping with the spirit of anonymity of the Trialogue Meetings. Table 1

provides information of the mental health roles of participants from Cycles 1-3. Due to the option for anonymity, there was a substantial amount of missing data for participant details such as age and gender. However, from available data, females accounted for 59% and males accounted for 38% of overall participation rates and participation ranged across the lifespan, with 50% of participants aged 25 years or below. Participation rates varied from a maximum of 175 participants across all sites in the first set of Trialogue Meetings to a minimum of 54 participants in the sixth Trialogue Meetings during the summer months (with 86 participants in the final Trialogue Meetings of the study period).

Table 1: Mental health roles of Trialogue participants across the study period

<i>Mental health role</i>	<i>N</i>	<i>%</i>
Service user	63	20
Service provider	66	21
Family/carer	65	21
Community member	26	8
Service user/provider	19	6
Service user/family/carer	12	4
Service provider/family/carer	16	5
Family/carer/community member	18	6
Service user/provider/family/carer/community member	6	2
Other	12	4
Unknown	15	5

### **Cycle 1**

The Cycle 1 data combines material from 42 interviews (17 males and 25 females) with Trialogue participants who were purposefully targeted to ensure equal representation across seven participating sites, a focus group comprising 13 Trialogue facilitators from the seven sites and three members of the project team who attended a training day in Dublin City University (5 males and 11 females). All participants had facilitated either one or two Trialogue Meetings at this stage and represented a pre-defined homogenous group of individuals who had participated in the original leadership training programme, where they had received extensive training and experience in Open Dialogue communication.

### **Fearing the Unknown: The Prevalence of Stigma in Irish Society**

Stigma and discrimination of individuals with mental health problems were prevailing concerns among Trialogue participants. In this regard, participants suggested that Irish people tend to avoid

discussions of mental illness because of a range of factors such as negative media portrayals, disbelief that mental illness exists, their fears talking about mental illness and lack of education in the area.

*Through the media, people with mental health issues would be portrayed - would be like lunatics or crazy or psychos and that. They'd see the white coats and the detention centres, and so I think they think things like that still happen today. [IR.31]*

*People don't believe there are such things as mental illness, people mock [other] people for having mental illness; it's an Irish thing. It was always swept under the carpet. It's still a very big problem: the stigma around it. [IR.21]*

*I think some people, when they hear you have mental illness... It's like they are afraid to be around you, because they are afraid it's contagious, you know? And [they are afraid that] they would catch it or they are afraid they [would] get into situations in which they don't know how to react... So, they just turn a blind eye, or walk the other way, you know? [IR.6]*

*I think a lot of people are fearful and don't know if they're doing right or wrong by talking about it or by not talking about it. Maybe if there was more education on positive mental health – even in the schools 'cause we have education about every other forms of illness: diabetes and cancer, for example. [IR.22]*

Participants also described how such attempts to avoid mental illness often results in discriminatory practices in Ireland, which undercut the self-esteem of, and negatively impact upon multiple life domains of, individuals with mental health problems.

*When they see you, they avoid eye contact. They might cross the road or... They feel sorry for you, as they think you are a weak person, and that you're not as worthy a person as you would be if you didn't have a mental health problem, which makes you feel absolutely worthless, and lowers your self-esteem. [IR.16]*

*[Discrimination occurs] when you're not fitting [within] our normal structures and the accepted ways of living and being able to meet requirements. [An example of such] discrimination then would be a lack of flexibility within a work situation meeting the individual's requirements. [IR.25]*

*If you look at housing, if you look at education, if you look at employment, the stigma is right across the board, and we collude with that. [IR.9]*

From the perspective of Trialogue participants, when mental illness was talked about in Irish society, it often took the form of labelling and pigeon-holing of individuals with mental health problems, which could become a self-fulfilling prophecy.

*I feel the whole thing about labelling somebody; you are inclined to categorise them, and sort of pigeonhole them. It's kinda like taking away from their humanity, in a sense. It can be quite damaging, it can almost be a self-fulfilling prophecy in one sense. If you happen to get caught up in that label, you know, you can literally be caught there for life. [IR.5]*

As a result of these practices, society isolates individuals who are mentally ill and treats service users as if they are helpless.

*People are isolated from mainstream society, trust is taken away from people and decision-making is taken away from people and they're treated that they can't make up their own mind, they can't make their own decisions or they can't really look after themselves. And people don't believe that people can recover and it has become this massive catastrophic thing whereas it need not be. [IR.33]*

One participant even described how friends and family had a low tolerance for mental illness beyond an acute period.

*Generally, with low levels of mental distress, your friends and family and your society will accept it, but, if it gets beyond a certain point, and that point is different for each individual and in each community, you know, there is a switch that gets turned off and people no longer accept that your feelings are a valid response to your experience, you know? They talk about your emotions being inappropriate. [...] So sometimes you end up getting cast out of society, really. And, you're too upset then really to be able to work your way back in anywhere. [IR.18]*

Participants also identified that these discriminatory practices ultimately led individuals with mental illness to self-stigmatise themselves, a process which acts as a barrier to help-seeking behaviours for them.

*There's a certain shame attached to the illness. I suppose we can blame other people, but a lot of it starts with yourself: there is this self-stigma. I think this stigma is changing, but it is still very much there, a lot of people are very slow to go to help. [IR.36]*

In spite of these accounts, participants expressed hope that Trialogue meetings would break down the barriers of stigma among family members and wider networks through wider informed discussions about mental health issues.



*After going through 30 years of family not understanding, and thinking I'm sick and just seeking attention; if people like this sit in [a room] and listen to people who do suffer [with mental illness], it might just help them treat you differently. [IR.16]*

*[Triologue Meetings are] a very comfortable group environment where you can express your feeling towards mental health and learn new ideas in combating stigma, and, hopefully, creating new policies maybe towards the mental health sector. [IR.31]*

## **Cycle 2**

The Cycle 2 data comprises material from a focus group with 10 Trialogue facilitators and two members of the project team from six participating sites who attended a second training day in DCU following their fourth or fifth Trialogue Meeting (8 males and 5 females). At this point in the life of Trialogue in Ireland, one participating community branched off, as they had formulated their own process and methodology for Trialogue Meetings, and, consequently, did not attend this training day. With the exception of individuals from this group, the focus group participants were drawn from the same group who had attended the Cycle 1 focus group sessions.

### **A Humanising Process: Tackling Stigma through Trialogue**

At this stage, many participants identified that Trialogue Meetings had given them a chance to vent their frustrations with discrimination from the mental health services. Trialogue Meetings also began to evolve into a transformative education forum surrounding mental health issues.

*It was the first forum I've found to vent [or] even rant against the medical profession and what might be called abuse. And I've never spoken about [that] in a group before. I had spoken one to one and all that, so this was a great place - and I found that I was kinda surprised that I spoke so much about it. So, I would be curious as to how my participation will evolve as time goes on and as I let off steam. [FG2R.7]*

*We have had parents coming to the Trialogue who think that their children may have mental health difficulties, but don't know where to start, and actually come to the Trialogue just to try and learn about mental health, and I think that has been quite beneficial... You will see people calling [other] people aside at the end of the night that have spoken, and sorta asking them [questions]. They are getting a forum to explore what is going on, either in their own head, or a member's head within the family. [FG2R.5]*

According to participants, the process of participating in Trialogue Meetings also appeared to have a de-stigmatising effect on service providers, who began to see service users as human beings after having listened to their perspectives. As a result, Trialogue Meeting attendance was seen as an experience that could be used as regular training for service providers.

*It's been a really growth-ful experience for me, a freeing experience, a nurturing experience. It's really helped me as a professional. It's left me... I'm more and more seeing myself as another human being with other human beings. What can I do to communicate with them? [FG2R.8]*

*Oh, I have [been] saying to the doctor each time, the psychiatrist and all the disciplines, "Look you could use this as our [training] and some student nurses have come to it alright", and saying to them, "Look this is a great opportunity for you to get the service user perspective and staff perspective and relative perspective and your training". [FG2R.2]*

Similarly, one service user identified that hearing service providers communicate in Trialogue Meetings also served to tackle his own prejudices about service providers and humanise them.

*I found it good that there were professionals there, that it added something. [I discovered] that they were people [too] and [that] they were interested enough to listen to people's experiences. [...]It is actually changing my views; although I never really had any problems with nurses, it was doctors I had problems with... [laughter] But it is, it is a learning thing for me as well. [FG2R.6]*

### **Cycle 3**

The Cycle 3 data is drawn from qualitative data from the final Trialogue Meetings (n=86: 24 males, 18 females and 44 gender not recorded) which took place across the six remaining participating Trialogue sites. By prior agreement, these meetings constituted reflective discussions about the successes of Trialogue Meetings and were recorded with a notepad only in keeping with the spirit of anonymity of Trialogue. These meetings also represented the central research team's final involvement in the facilitation and organisation of Trialogue Meetings. At this stage, individuals from local communities took over the responsibility for Trialogue, engaging in ongoing local recruitment methods and organising all aspects of the running of Trialogue Meetings themselves.

#### **Creating a Collective Awareness: Deconstructing Stigma Through Trialogue participation**

Participants in the final Trialogue Meetings identified that the educational component of Trialogue enabled myths surrounding mental illness to be dispelled, thereby reducing stigma towards individuals with mental health difficulties.

*I came back because people were sharing and the Trialogue meetings were making people aware and taking the stigma way. You meet the most wonderful people who care and who want things to change. [TEM6]*

*The more you have this kind of conversation, the less stigma and the more understanding of all the different people’s stigma. Trialogue creates a collective awareness that takes down stigma and provides a joined-up understanding. [TEM4]*

Furthermore, participants outlined how Trialogue Meetings had the potential to effect change in mental health services through the generation of ideas and spreading of information to service providers. This was seen as particularly important, given the prevalence of shame surrounding mental illness in Ireland.

*These meetings are productive in terms of generating ideas that might lead to action and change. [TEM4]*

*As a professional, there’s a certain amount of information going out there now to other colleagues as a result of the Trialogue sharing. You are impacting on other colleagues, even if they’re not here. [TEM5]*

*If we all could just understand that we all experience this sense of isolation, shame, guilt... We are great in Ireland at shame and guilt; it binds us, it constricts us, it stops us being creative and interactive. We are so full of blame and negativity, so many people need to stand up and to say change starts with me. [TEM2]*

## **Discussion**

This is the first prospective qualitative study to document Trialogue participants’ discourse surrounding mental health stigma and discrimination over time and to explore the potential of Trialogue to alleviate stigma and discrimination for individuals with mental health problems, and their families. Mitigating stigma and discrimination was not the stated purpose of Trialogue Meetings, which were principally designed to bring about a shared understanding between mental health stakeholders on mutually agreed topics surrounding mental health issues through the process of dialogic communication. Nonetheless, the findings document how Trialogue Meetings may be useful as an education forum for relevant stakeholders in mental health systems and their social networks surrounding this salient issue.

Participants in Cycle 1 expressed their initial hope that Trialogue Meetings might lead to better education surrounding mental health issues in Ireland. In fulfilment of this hope, participants in Cycles 2 and 3 indicated that Trialogue Meetings had evolved into a forum where myths surrounding mental illness were beginning to be dispelled through dialogue and the sharing of different perspectives on mental health. The mental health education arising from Trialogue Meetings was also further disseminated by Trialogue participants to individuals in their social networks. While these findings need subsequent quantitative verification in order to demonstrate their veracity, they suggest that Trialogue Meetings may be effective means of increasing knowledge and dissemination surrounding mental health issues, in a similar fashion to public awareness and education campaigns which have been implemented to challenge discrimination

(e.g. Corker et al., 2013; Corrigan and Penn, 1999; Evans-Lacko, Henderson and Thornicroft, 2013; National Institute for Mental Health in England, 2004; Social Exclusion Unit, 2004).

An even more valuable outcome described by participants in the current study was that Trialogue Meetings actually diminished discrimination and stigma among participants. Specifically, the sharing of different perspectives through an open dialogical forum led to a more humane view of service users, and even service providers, among Trialogue participants. Furthermore, Cycle 3 participants indicated that participation in open dialogue between different stakeholders in mental health communities had a cumulative effect of reducing stigma and discrimination surrounding mental illness. As with the knowledge-generation outcomes described above, these findings require further quantitative validation in order to establish their authenticity. Nonetheless, they are particularly promising in light of the relative failure of public health campaigns to lead to reductions in stigma and discrimination in relation to mental health (Mehta et al., 2015). These findings also support the emerging picture that interventions to tackle stigma and discrimination surrounding mental health need to take place at a local or grass-roots level in order to sustain individual participation (Corrigan, Morris, Michaels, Rafacz and Rusch, 2012). Moreover, as other accounts have suggested (Dunne, MacGabhann, Amering and McGowan, 2016; MacGabhann, Dunne, Amering and McGowan, 2016), Trialogue Meetings are a potentially sustainable community-based participatory approach to research and development. In sum, Trialogue Meetings appear to have great potential for long-term improvements in stigma and discrimination surrounding mental health; a suggestion which warrants further systematic research.

The findings also describe a culture of concealment of mental health issues in Ireland characterised by subtle forms of stigma and discrimination. In Cycle 1, participants initially described the prevalence of stigma and discrimination surrounding mental health problems in Irish society. This took the form of labeling, self-stigma and shunning, with numerous resultant harmful outcomes on individuals with mental health problems and their families, such as lowered levels of self-esteem, lower help-seeking behaviours, difficult interpersonal relations and fewer employment and educational opportunities. While these findings mirror the broader research on patterns of stigma and discrimination and their deleterious effects (Clement et al., 2015; Corrigan et al., 2003; Lysaker et al., 2009; Peterson et al., 2007; Ritsher et al., 2003; Sharac et al., 2010), what is particularly striking about these findings was the suggestion from many participants that they related to Irish cultural attitudes of shame and guilt surrounding mental illness, which led to a culture of concealment of individuals with mental illness. These participants highlighted how Irish people were often uncomfortable with, and tended to avoid, discussions surrounding mental illness. Furthermore, they suggested that this avoidance of dialogue on mental illness may be related to an Irish cultural landscape where negative media portrayals, disbelief that mental illness exists, fears talking about mental illness and lack of education about mental illness are commonplace.

This notion of a “culture of concealment” has long been identified in a wide-range of academic research relating to mental health discourse in Irish society; from anthropological accounts to sociological and historical analyses (Herr, 1990; Lorenz, 1981; Scheper-Hughes, 1979). In a particularly prominent account of Irish discursive practices surrounding mental illness, Scheper-Hughes (1979; 2000) suggests that Irish values of self-discipline and mortification of the flesh contribute to negative cultural depictions of individuals who become mentally ill, whereby such

individuals come to be regarded as “soft” or “weak” characters who “give in” to mental illness and are subsequently hidden in societal discourse as a means of preserving these values. In line with such ideas, participants in the current study suggested that discriminatory practices relating to concealment typically occurred in Ireland when an individual with mental health problems was not seen to be fitting into “normal structures” and “accepted ways of living”, or when their periods of mental illness extended beyond an acute period. Participants described how such circumstances led individuals with mental health problems to be treated as if they were helpless, which had particularly harmful effects on their self-esteem. Furthermore, the culture of shaming and blaming individuals with mental health was highlighted by participants as a prevailing phenomenon with a markedly Irish character; where there was a history of concealing mental illness and avoiding dialogue on mental illness. In this regard, it should be noted that contemporary accounts suggest that Catholic notions surrounding the idea that suicide and mental illness is “sinful” or “wrong” still prevail in Irish society (McManus, 2010; O’Sullivan, 2010), which may also contribute to the culture of shame, guilt and blaming people with mental illness for their condition that was described by participants in the current study. These findings support the suggestion that public information campaigns and interventions which promote open dialogue and discussion surrounding mental illness may be necessary in an Irish context in order to circumvent this cultural predisposition towards concealing mental illness.

There are a number of strengths and limitations of the current research. Firstly, there were a diverse set of data collection methods at each cycle of the research process and participants were not purposively sampled at each cycle in relation to specific demographic characteristics (e.g. mental health role). Furthermore, although the focus groups in Cycles 1 and 2 comprised a pre-defined group of participants who were experienced in engaging in dialogue, these groups contained a large number of participants. In spite of these potential limitations, the variety of participants’ experiences and the robustness of the analysis process, whereby a researcher who was not involved in the data collection process independently examined the transcripts and field notes for thematic material, demonstrate the credibility and value of the findings. The current study also elucidates the potential Irish cultural pattern of concealment of mental health issues. While clearly documenting the mechanisms within which such cultural practices operate is beyond the scope of the current paper, these findings point towards a need for future interventions which tackle cultural biases that appear to be closely linked to stigma and discrimination surrounding mental health in Ireland. Tackling deep-rooted cultural prejudice is a very difficult task which requires careful government and health systems policies that support positive treatment of individuals who are discriminated and stigmatised (Aronson, 2012). Nonetheless, the current findings also suggest that Trialogue Meetings may go some way to supporting the development of such policies through de-stigmatising key stakeholders who may be involved in policy decisions. Finally, the current findings demonstrate the potential for Trialogue Meetings to alleviate stigma and discrimination for individuals with mental health problems and their families and lead to greater education for relevant stakeholders in relation to pertinent mental health issues.

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