

**“Through the Looking Glass”  
Young People’s Discrimination of Peers with Experience of Mental  
Illness<sup>1</sup>**

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<sup>1</sup> This research was initiated in 2004 and was framed around experience of ‘mental illness’. The authors feel that the debates around constructions of mental experiences have moved on significantly since this time and would advocate for a shift to the holistic understandings provided by the framework around experience of ‘mental distress’. The importance of this shift will be noted in the discussion section, but the results and analysis will be presented inline with the original development of the research in terms of experience of ‘mental illness’.

## **Abstract**

Through a qualitative thematic analysis of material from focus groups with young people in Auckland, the authors demonstrate the role of knowledge and perceptions of mental illness in discriminating against young people with the experience of mental illness. The young people talked of mental illness in traditional terms, with a medicalised knowledge of mental illness and stereotyped perception of people who experience mental illness, but there was also evidence of more encouraging understandings around how to respond to friends with experience of mental illness. The implications of this research are considered for challenging knowledge and perceptions that undermine counter-discrimination work whilst building on those that support social inclusion for young people with experience of mental illness.

## Introduction

It has become widely recognised in recent times that the mental health of young people is a burgeoning concern. As mental disorders look set to become the greatest global burden of disease by 2020 (Murray and Lopez, World Health Organisation, 1996) the consistently high prevalence and onset rates for young people (for example, see National Institute of Mental Health, 2006) and their reported underutilisation of mental health services (for example, see Sawyer et al, 2000), reinforce the need for greater attention in this area. An important focus to research in this area has been on young peoples' perceptions of mental health and well being (Gordon and Grant, 1997) and mental distress and illness (Secker et al 1999), primarily within a health promotion perspective.

The stigma and discrimination associated with mental illness are now well recognised as barriers to well being, recovery and social inclusion (Mason, 1996) and the nature of the experience of stigma and discrimination is well documented (Mental Health Foundation, 2004). It would be informative to complement this growing body of knowledge on the experience of stigma and discrimination with an insight into the perceptions of those who, purposefully or otherwise, stigmatise and discriminate against people with experience of mental illness.

This paper provides a summary of exploratory research conducted by *Vibe* – a central Auckland community action network for young adults living with experience of mental illness operating as a Like Minds Like Mine initiative at the Mental Health Foundation. The network was established in 2000 and, whilst also providing a forum for socialising between members, especially operates to develop and implement projects within youth communities to counter discrimination faced by young adults with experience of mental illness. At the end of 2003, *Vibe* decided that more understanding was needed to progress such projects. Thus, in 2004 the group carried out a research project to explore how young people *without* experience of mental illness perceived young people *with* experience of mental illness. The themes identified will be of use to those developing projects to reduce discrimination in youth communities around experiences of mental illness.

## Methods

This research was funded as part of 'Vibe', a community action network for young adults living with experience of mental illness operating as a Like Minds Like Mine initiative at the Mental Health Foundation of New Zealand. In determining how best to counter stigma and discrimination associated with mental illness, the group decided to explore the stigmatising and discriminatory attitudes amongst young adults who aren't living with the experience of mental illness.

Focus groups were delivered in two Auckland tertiary institutions during 2003, with one female and one male facilitator. Eight groups were conducted with a total of 33 participants, who gave informed and signed consent to participating. The age range was from 18 – 25 years old, and 14 of the 33 participants were female. 7 of the participants identified as Asian, 2 as Pacific Islanders, 1 as New Zealand Maori, 3 as 'other', and the majority (20) as New Zealand European.

The young adults were asked about their understandings of mental illness in general, their knowledge of the causes of mental illness, where they got their information on mental illness, their perceptions of people living with a mental illness, and how they interact with people living with a mental illness.

All of the focus groups were audio taped and transcribed. The facilitators and members of the Vibe group then analysed the transcriptions to elicit major themes around mental illness and discrimination. The research was qualitative and used a general inductive approach.

## Results

The analysis of the participants' responses uncovered four themes that emerged frequently in the focus groups. There was a shared understanding of 'common knowledge' of what mental illness is and what its causes are, with some strongly identified sources of information underpinning that knowledge. There were also a common history of encountering people with experience of mental illness, and participants spoke of childhood experiences both candidly and honestly. Both the knowledge of mental illness and history of encountering it can be seen as influencing the perceptions the participants had of those with experience of mental illness. These perceptions were most evident in the ways that participants discussed their interactions with young adults living with the experience of mental illness.

To provide more detail on these four areas and the richness and intricacies of how these young adults view mental illness and those who experience it, the following will summarise the discussions held in the focus groups and provide interpretative analysis of how these areas relate to each other and can be seen to influence the stigma and discrimination of young adults living with the experience of mental illness.

### 1. Knowledge: "from depression to schizophrenia"

Participants' understandings of mental illness were primarily based on a familiarity with the diagnostic labels of mental disorders. However, their familiarity came across as broad and vague; often listing multiple diagnoses and at times confusing them with intellectual, learning and behavioural disorders:

*"There's a wide spectrum of mental illnesses"*

*"Bipolar, manic depressive, OCD"*

*"Wide range from depression to schizophrenia"*

*"I mean mental illness, shit, handicap basically"*

*"I mean I'm probably mentally ill because I've got dyslexia"*

Along with this almost interchangeable use of labels, there was also some confusion as to the prevalence of mental disorders. Only one person recalled the Like Minds Like Mine campaign's message of '1 in 5 people', with other guesses ranging from '1 in 3' to '1 in 10'.

Causes of mental illness were identified in three areas. Most commonly it was understood as a response to psychosocial life events, especially those from childhood:

*"Depressing things happen and you get depressed"*

*"Could be any number of things I guess, divorce maybe, losing a family member or friend, trauma, emotional trauma"*

*"I think it's to do with your upbringing"*

*"I think past experiences that have gone wrong . . . in your childhood"*

*"Maybe family, job, study, stress, I think the most cause is stress"*

To a lesser extent, but still strongly represented, was an emphasis on the role of alcohol and other drugs:

*"Pregnant mothers taking alcohol and drugs"*

*"Too many drugs, acid can alter your brain chemistry and do damage"*

*"Definitely drugs"*

*"People who use large amounts of marijuana over time are not all there"*

*"Yeah, schizophrenia and stuff, too much drugs"*

An infrequent cause raised was the influence of genetics:

*"Something wrong at birth, horribly wrong"*

*"I think it's something you get when you're born"*

*"Some people, it's like from birth"*

*"It's a hereditary thing"*

*"Maybe their parents, their grandmother or father, one of them has this problem"*

There was also an understanding that these three factors were interrelated in their influence on people's experience of mental illness:

*"Partly drugs, genetic, forced learned behaviour"*

Interestingly, within this knowledge about mental illness there was only one comment that could be seen as demonstrating an understanding of recovery:

*"[it's] something you can deal with, it doesn't mean your life is over"*

Although one other person perhaps came reasonably close:

*"the person can be occasionally weird, but then they are ok"*

The source for much of this knowledge of mental illness was mass media, particularly television and the Like Minds Like Mine advertising campaign:

*"How movies and media etc portray mental illness is often how people get their preconceptions"*

*"Certainly the TV ads are a bit of an eye opener, when they show people like John Kirwan . . . no one would have thought there was anything wrong with him but there obviously is, I get a lot out of those ads"*

The other major source of information was the variety of school programs that addressed mental health issues. These appeared to have two approaches; *proactive* attempts at education within a broad health studies approach, and *reactive* responses often triggered by a suicide within the school:

*"[Mental health education] would only happen at schools that maybe had students in the school suffering from it"*

*"Yeah, every time there was, well, there was a couple of suicides while I was there, and you know they tried to bring it up after all that happened, to prevent all the depression"*

*"They just didn't shut up about it, we were just bashed with it"*

A small number of people found their knowledge through others:

*"Just random conversations you have with people, you pick up, yeah, just word of mouth you pick up new things"*

Finally, two people specifically saw relationships with people with experience of mental illness as enhancing their understanding:

*"Only recently understood it more through a personal acquaintance . . . you learn from those people"*

*"I have [learnt] a little bit 'cos my friend's had depression and stuff, but not much"*

To summarise then, the knowledge represented in the talk was situated in discourse from the mass media and targeted educational sources. There was little to suggest an awareness of how their personal interactions with their own or others' experience of mental illness could positively inform their understandings.

## **2. Encounters: "they got so much shit"**

Most participants could relate some interpersonal connection to people with experience of mental illness, mainly from early school days:

*"[We] all knew about the special needs class at school or kids with behavioral problems or were just difficult and needed more attention"*

*"We'd joke about being a special needs kid to others at school, we were never really educated about what their disabilities were or interacted with them"*

*"[We] were taught to stay from people who are different or with mental illness, you might catch it off them"*

These memories of segregation and social exclusion appear to be replicated and reinforced in contemporary interactions with people with experience of mental illness:

*"Bullying, teasing, sort of kicked out of the group"*

*"Yeah, I'd say people are sort of scared of difference so they sort of tease them"*

*"Yeah I would say cos they're a bit different from most people they would sort of get teased a bit more and everyone sort of picks on them"*

*"Like when we see a person who is mentally retarded we don't really go down & analyse why, what his life, what he's going through and how he's coping, we see him and then we forget about him, so we don't really give a good thought of what he's going through or what we can do to help"*

## **3. Perception: "he's normal pretty much, but it's hard to say, they all look normal"**

The perception of young people with experience of mental illness was a convoluted mixture of the diversity of their knowledge and personal encounters. There was a ubiquitous sense that mental illness is in everyone, despite 'normal' appearances:

*"I thought they were no different to anybody else, appearance wise you don't see any difference"*

*"I think a lot of people don't realise they have it"*

*"There are different levels of mental illness, some people are worse than others, so it's probably depending on how mentally ill someone is, it's hard to explain, but some people are worse than others, it can be common for some and not for others"*

*"I guess everyone could suffer from some sort of mental illness, maybe not seriously but certainly part of it is there"*

*"I think everyone gets depressed at some stage, I don't think you'd class it as mental illness until it goes on to a deeper sort of depression, I was depressed yesterday when I got a couple of really bad marks [laughter] but I got over it"*

This notion that mental illness is in all of us with varying thresholds was problematic for some:

*"I don't know when things became a mental illness . . . I feel uncomfortable to say someone has a mental illness, that they have crossed this line"*

With no external signs of mental illness, whether or not someone has "crossed this line" seemed to hinge upon a mastery of the internal world:

*"Someone can not control their mind, doesn't really know what they're doing sometimes  
- Don't really know how to control themselves"*

- *It's to do with their emotions; they can just lose it at any time*
- *It can also be seen as a deficiency, that you're not able to control yourself or what you are doing*
- *It can also be like a nervous breakdown*
- *I think when people have that sort of problem then they become emotional, as emotion is everything rather than they don't really have their mind, what they do rather than think"*

There were strong underlying notions that experiences of mental illness were indicative of someone not in control. For some, this lack of control was associated with an emotional weakness, and a weakness with without sympathy:

*"People can think that those with mental illness are just being dramatic"*

*"A lot of people are unsympathetic, like 'get over it, everyone else deals with this stress why can't you' like 'if you can't do it then you're a sissy'"*

*"[They're] too emotional, they start crying over small things  
- really very sensitive  
- it's not their fault for being so silly"*

With a combined loss of mental / emotional control and a pervasive sense of personal weakness, there is an emphasis on a need for individual resilience:

*"They get frightened, they don't know what to do, they just run away, and they go and do something to themselves, they think 'oh I'm not good enough' and they do something to themselves, basically it depends on what kind of a person he is, if he's nice and strong maybe he'll rebel, but if he's a weak person maybe he'll break down"*

Alongside the recognition of 'nice and strong' resilience, there was a stronger re-telling of the familiar stories of the reactions of people with experience of mental illness:

*"If you go out with someone & you play a practical joke on them & they go schiz's & start hitting you or whatever, you don't really want to go out with them do you, because you were just joking, they didn't know how to handle the situation, some people have different thresholds and if that threshold is crossed they go overboard"*

*"Needs to be more understanding of what [mental illness] is and how it affects people, like people can be like normal one minute & then completely lose it the next and people are like 'Whoa! They're psycho', but really it's, you know, something that you can't control"*

*"What people can be capable of doing, if they have a certain mental illness, it's like, someone could have a mental illness and get really depressed and handle it by going out and beating someone up, but then they get all depressed 'cos they've just been beaten up and it's like, goes full circle"*

*"There's a fear that if you're in a psychiatric hospital they will probably attack you with a knife, but probably that's not what would happen"*

Underpinning this perceived threat is a suspicion of the concealed experience of mental illness:

*"A lot of the time they're normal, they can hide it, over a period of time they've learnt how to control it to a point, you can get that odd occasion when they want to lash out, see it on the news every day"*

This concealment was seen to be compounded by a need for denial and secrecy:

*"- There's a hesitancy to admit you have a mental illness or disability  
- It's a hidden illness"*

*"- Most people hide it  
- They don't want to be put in a box"*

It is also recognised that there are some specific issues that young people face that contribute to a desire to hide their experiences of mental illness and appear normal:

*"- [Mental illness is] possibly more common for younger people, who are more malleable & affected by what people say*

*- For young people there's no one you can turn to*

*- You rebel against your parents, you don't want to be rejected by your friends, even going to a counselor is not ok for some people, it's like you shouldn't have any problems"*

The higher prevalence, the peer pressure and the negating of problems combine to create complexities for the young person with experience of mental illness:

*"Yeah that's where [mental illness] usually starts, like even anorexia, bulimia, anything usually happens when you're a round teenagers or secondary school"*

*"- It seems to onset at our age and then things can improve, get better as you mature, like eating disorders*

*- High image pressure amongst peers"*

*"It is so important for young people to be accepted"*

*"Some fields of study like law are really highly competitive and stressful and a lot of people are unsympathetic"*

To summarise, the perception of young people with experience of mental illness by their peers covers a diverse collection of perspectives, from a ubiquitous continuum of experiences that all young people have, to an alarming portrayal of somewhat feeble people who cross the line into silliness at best and violence at worst. Aspects of being young were seen as contributing to the experience of mental illness and in particular the reasons for hiding the experience from your peers.

Interestingly, none of the perceptions expressed any positives around experience of mental illness, with the possible exception of:

*"It's cool to be quirky and unique, being a bit crazy is cool!"*

#### 4. Interactions: "easier to not say something than say something wrong"

The way participants perceived young people with experience of mental illness had its biggest impact on interpersonal communication amongst peers:

*"It's a hard topic to bring up, if they talk about it then sweet but then a lot of them wouldn't"*

*"Lack of knowledge I guess, don't know what to say, don't know what's right or wrong, the PC way, easier not to say something than to say something wrong"*

- *Yeah it's harder to talk to someone about something you don't fully understand yourself, so how can you approach them when you don't know*
- *Can't really start a conversation when you can't keep it going*
- *They could take it the wrong way too, they could blow up in your face, much easier to say nothing"*

With little common understanding on which to base a conversation, and that all pervasive fear of volatility, the barriers to communication begin to form. These barriers are reinforced with the predetermined perception of young people with experience of mental illness that ensures that they are rarely even approached:

- *People have special needs when it takes time and effort to interact and have that conversation with them, they can be socially isolated because of this . . .*
- *People get tired of having to deal with mental illness – do you still have that problem?!"*

*"Go & try talking to them & they want talk to you, they'll just keep to themselves"*

*"Like there's a group here that are obviously mentally handicapped, whatever, that all hang out together, it's just obvious they are"*

- *It's just the way they've grown up – they've never really associated with, for lack of a better term, a normal person (laughter)*
- *Maybe they've been told it's best that you don't hang out with a normal person"*

In contrast to these barriers, the participants felt that knew, in theory, how they'd respond to a young person disclosing their experience of mental illness:

*"If they need help, just give them help and don't tease them about it, just treat them how you want to be treated"*

*"I'd comfort them, but I wouldn't know what to say or how to cope . . ."*

- *I'd be glad they could tell me about it*
- *I'd make more time for those friends & try to be more understanding, knowing that things can be more difficult for them "*

*"Go up & talk to them, make friends with them, don't make them feel alone"*

In actioning these intentions, communication was central again, particularly in the context of an existing relationship:

*"[I'd] ask them a lot of questions, if I ask anything you don't want you don't have to tell me, but I would want to ask them so I can help them out, they can tell me anything, it's better if they're your friend, 'cos then you know not to say the wrong thing"*

*"I think what they need is they need lots of attention, and they need you to be patient so I think that's the most important thing you should do for them without professional understanding, that's the best thing you could do for them, I think people need to understand them, what they're going through"*

Several people spoke of people they knew with experience of mental illness and some of the issues they had in these friendships:

*"I know a girl who has this problem too . . . she's pretty cool, but sometimes when she's down she's hard to talk to, like with her on the phone or when you go and see her, I don't know, I don't know how to describe . . . like even though you may want to help her, but you don't know how, just take her out and try and have fun, try to pull her up"*

*"My friend was like quite overweight and she was like the social outcast, 'cos you know, no one likes to hang out with the fat kid or whatever, for the last four years she's been cutting herself and just being like in a huge depression and down and stuff, she's at uni' this year & she's you know, tried to overdose on her depression medication and stuff 'cos she's feeling really really bad and you just don't know what to say to them, she like talked to me about it, but she felt she couldn't go to her mum about it, I mean she went to a school counselor about it but there's only so much they can without, you know, breaking their confidentiality"*

*"Yeah I've got a friend at the moment and she has mental illness, even if she doesn't think she has, ever since we were in high school she's always had these panic attacks and there's always something wrong with her, she's always been sick, everyone's always said 'oh hypochondriac' . . . it was just the way she was but people always teased her and talked about it, but not to the point of not being friends and stuff, you know, they just got sick of her always being sick"*

Again the difficulty in talking about the experience of mental illness is clear in these friendships and the problems of knowing what to say. Even with an established friendship the experience of mental illness can be seen as exerting additional pressures on the relationship, which is compounded when there is no connection:

*"If there is some I didn't know that well and they were needy I know that I can't look after that person as well as concentrating on the rest of my friendships  
- It's natural that if you identify some one that has a mental illness then you probably see them as being a bit of an effort  
- People that are not being positive, are needy, or could never have a good time . . . no one wants to hang around with people like that"*

The role of communication in both creating barriers to exclude and potential pathways of connection can be seen to be essential to the consideration of countering discrimination amongst young people with experience of mental illness.

## Discussion

The participants in this research talked openly and frankly about mental illness - their knowledge of it and their perceptions of and encounters with those who experience it. The insight this gives into contemporary understandings of "discrimination in action" from the perspective of those who do the discriminating can inform the continuing development of strategies to counter discrimination associated with mental illness.

To summarise the themes presented in this paper, the knowledge about mental illness along with perceptions of and encounters with people who experience mental illness can be seen to combine and reinforce the discrimination experienced by young people with experience of mental illness.

Young people's knowledge about mental illness appears to be used ambiguously, with a haphazard use of diagnostic labels, a blurring of mental and intellectual disorders and guesstimates of prevalence levels, which show either a lack of clarity about this information, or possibly a lack of concern about clarity. It could be that this traditional medical knowledge is being simplistically re-presented and done so with a post-modern shrug of ennui. This appears to be also the case for the recurring discussions about the sources of mental illness, which are predominately cast in terms of biological causation or etiology, with a 'continuum' of mental experience and an unspecified threshold that signals the end of normality and the start of 'mental illness'.

The absence of discussion on the role of social and environmental inequities, or cultural or spiritual factors on mental health and illness situates the knowledge firmly within traditional western discourses of pathological disease that are inevitable within individuals. The strength with which this perspective was reinforced could explain the lack of 'recovery' concepts within the talk.

The knowledge of mental illness and its causes has roots in the participants' experiences, particularly through childhood, adolescence and into young adulthood. The early school days saw the differentiation of 'others' into segregated education streams (possibly blurring intellectual and mental disorders). Once people are cast as different, then disregard and degradation are used to establish and maintain distance. This discriminatory process continues through to young adulthood, and becomes generalised as a justification system for discrimination toward those perceived as 'different'.

The process of differentiation and distance is strengthened by familiar themes, and the representations in the talk of the fear of danger and physical violence associated with mental illness are indicative of their wider hegemony within society. Even though it is clear that these tales are spurious (given their basis in stereotypes and conjecture), the 'mental menace' theme was prevalent through most discussions.

Perhaps the most significant aspect of the talk to emerge was the importance of communication, both as a discriminatory tool but also as a potential counter-discriminatory tool. Firstly, the manner in which communication is utilised to exclude and discriminate against young people with experience of mental distress is two fold. The perceived awkwardness and effort in initiating conversation is seen as excessively prohibitive and futile in any case as the conversation would not be desired by the young person with experience of mental illness. So even if you did want to talk to *them*, they wouldn't want to, or know how to, talk to *you*!

However, when the people discussed how they they'd react to a friend disclosing an experience of mental illness, many alternatives were provided to the discrimination that permeate the rest of their talk. The primary response would be to talk with their friend and in doing so offer help or friendship. Communication was seen as the most important thing in responding to a friend with experience of mental illness, as help in itself or as a means to help, or as a way of providing social inclusion.

Importantly within the talk about communication, the participants constructed its use both to discriminate and not discriminate as natural and inevitable, thereby rationalising and justifying its role. The barriers that (non)communication created and maintained were seen as just as immutable as the communicative response that a friend's disclosure would merit. Communication then plays a pivot role, with a potential for both discrimination and social inclusion.

There is significant potential for this research to inform counter-discrimination work, particularly amongst young people. A primary focus would be on increasing social responsibility amongst young

people. While mental illness is constructed as a pathological experience that is internal, inevitable and individually accountable, the sense of responsibility towards people with experience of mental illness will be diminished. If people are absolved of their responsibility towards others (as 'they' are perceived as abnormal and in part to blame for their abnormality) then discrimination is permissible (since 'they' clearly are different and should be treated as such). To reverse this situation, the factors that underpin this deficit in social responsibility need to be challenged and replaced.

There may be benefits from providing young people with a different framework for understanding these experiences, shifting the focus from mental 'illness' to more holistic notions such as mental 'distress'. Hegemonic medical conceptualisations of people's experiences as an "illness" need to be balanced with alternative theories for understanding people's experiences as distressing but understandable responses to lived experiences. In line with much international research (see Health Education Authority, 1997; Read & Harre, 2001), this would help to reconstruct the individualistic, pathological and deterministic notions of people's experiences that could be underlying much of the discrimination articulated in participants' talk. Indeed, the medical model, which underlies these articulations, has been shown to reduce social responsibility (Ministry of Health, 2003). Broadening understandings of distress beyond a medical discourse thus potentially increases people's sense of micro, meso and macro social responsibility. The adoption of a holistic perspective to distress may also be more appropriate for the bi-cultural context in New Zealand.

Addressing the language used within the participants talk, particularly around diagnostic labels, it appears that "a little learning is a dangerous thing". Whether it is ignorance or indifference, it is clear that current knowledge needs to be given a meaningful context. As the language is currently used to define difference and establish barriers, there is a need to not only clarify existing terms, but to locate them within broader understandings and critical issues. The common diagnostic labels in use need to be *correct*, in terms of their use by medical professions (i.e. DSM IV) but also need to be *corrected* in relation to alternatives to traditional labelling, such as can be found amongst recovery discourse. The 'little learning' needs to be accurate and built upon to make it a less 'dangerous thing'.

Whilst outside the scope of this research, it is clear that the discrimination toward people with experience of mental illness started at a young age and within schools. This has implications for how educational structures are (or have been) instrumental in establishing divisions based on differences. How this has been, or can be redressed are complex, but this research suggests there is a need for integration, mutual respect and compassion. There is also potential to pursue this issue through a 'whole school' approach to mental health promotion in schools that enhances inclusion, diversity, openness, and support, alongside proactive education around mental wellbeing, which would help to breakdown patterns of discriminatory behaviour. There may also be benefits from challenging the effect of these experiences on young adults – that at one time in their lives mental illness (and intellectual disability) were shown to them as different does not justify perpetuating that viewpoint. Discrimination that occurs in the present day, but is informed by the past, would need challenging on the basis of both current behaviours and historical attitudes.

The perception that mental illness creates a lack of control that could result in unpredictable aggression was articulated by many of the participants, but with important caveats. The talk was not first hand experience, or even second experience – the danger and violence had never happened to them or anyone they knew. Moreover, the stylistic nature of the talk strongly suggests that they are re-presentations of media related stories, blending sensationalised news stories and popular fiction stereotypes and myths. The importance for challenging discrimination is to not only question the validity of this association between mental illness and violence, but to also address the motivation for drawing upon this discourse and the manner in which it is used to discriminate against others. If the perception of danger is a device used to justify discrimination, attention should be directed at the justification as much as the device itself.

There were more positive themes within the talk, particularly in the discussion of a friends' disclosure of mental illness. Whilst discrimination is evident, and predominates, more inclusive and supportive perspectives were also articulated in the talk about young people with experience of mental illness. There are two ways in which this could be capitalised on. Firstly, it is clear that communication is a crucial component, and people without experience of mental illness would benefit from a 'language' in which to connect with others. This could range from the literal words needed to make that first approach or be a broader understanding of the things that work best for people with experience of mental illness. Subsequently there would need to be an attempt to align

this positive hypothetical understanding with behaviour – moving from knowing what to do in theory to actually doing it in practice. Working with the incongruence between belief and action, along with providing alternative communication strategies could help to overcome strengthen non-discriminatory behaviour. The second approach may be to build on young people's existing awareness of aversion to peer pressure by reframing mental illness in popular terms of creativity and 'alternatives to mainstream'.

## Conclusion

This research has explored young people's perceptions of peers with experience of mental illness and suggested how these can perpetuate discrimination. Through an inductive analysis, several themes were evident in the semantic content of their talk about knowledge, encounters, perceptions and interactions regarding young people with experience of mental illness. In summary, there was understanding of people's experiences as a psychosocial response, yet a consistent use of a medical discourse that pathologised experiences by constructing them as internal and deterministic. Consequently there lacked notions of recovery or positive experiences, and instead existed strong perceptions of people as having latent danger and unpredictability. In turn they felt their purported intentions to be supportive were thwarted by an inability to communicate safely with people experiencing illness, which was used to justify their exclusion and seclusion despite an articulated awareness of discrimination issues through negative pressures to be 'normal'.

The majority of participants' perceptions seemed to stem from school experiences and mass media; suggesting these as key areas for influence. Possible means for development of anti-discrimination work with young people within such means were extracted from the above themes. In particular we suggested introducing holistic models of illness as an alternative and valid means for understanding people's experiences. In doing so it is suggested that people's misperceptions of experiences as pathological and uncontrollable could be alleviated. Moreover if people's illness is re-emphasised as an understandable response to life experiences, the fear associated with these experiences as unpredictable and 'weird' can be diluted. Recognising the explicit role of contextual influences in people's illness may also increase a sense of social responsibility that encourages behaviours that are more supportive and less discriminatory.

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