“I’m sick!”

How the way one talks about their mental health diagnosis guides their journey to recovery

Isabelle Jacques, M.A., PhD student in sociology — University of Quebec in Montreal. In partnership with the Regroupement des ressources alternatives en santé mentale du Québec (RRASMQ)

Introduction

The majority of people who have received a mental health diagnosis (MHD) define themselves as sick people, as if they had received a diagnosis for a chronic physical disease. If the diagnosis as device is a useful tool for healthcare professionals, it takes on a much deeper meaning for the diagnosed, transcending its simple clinical function.

According to our study, these people will appropriate the diagnosis in a number of different ways. There is a link between moderate identification with the diagnosis of MHD and testimonies of recovery in which people regain power over their lives.

We believe it is important to better support people while they are being presented with a MHD and to bring some nuance as to what the diagnosis implies.

This involves guiding the person through a process of self-understanding, questioning the discourse in which they are identified as sick and presenting varied solutions (medical, therapeutic, alternative, spiritual, etc) that will allow them to have more tools with which to define themselves outside the identity of "sick person".

Background

Mental health diagnoses (MHD) can be studied through their clinical function, their administrative function and as communication tool between professionals. However, they can also be studied as an event that symbolically influences an individual’s life course.

In this study, Danilo Martuccelli’s (2015) sociology and reality systems that opposes effective and imagined limits of social constraint was used to reveal different types of individual identification with the dominant discourse on madness.

In modern western societies, the dominant discourse on madness portrays it as a “real disease”. However, the way individuals interact with these imaginary limits suggests different behavioural patterns that present a much more complex reality: individuals, in a constant opposition between “pathological mental” and the “problematic social” (Otero, 2012), do not define themselves systematically as “sick”.

Method

The analysis used conceptual categories (Paillé & Mucchielli, 2016) to reconstruct meaning based on an abductive approach. This approach combined deductive and inductive approaches in a back and forth between our conceptual framework, our corpus and the construction of new categories known as conceptualization.

A sample of 600 messages published in 2017 on Quebec online discussion forum *Revivre* was analyzed (qualitative data analysis with NVivo). The messages included questions, testimonies, requests for advice, calls for help and sharing on daily issues.

The *Revivre* organism is an online forum that offers a platform for individuals diagnosed with one or more of the following mental health disorders to connect with one another: depression, bipolar and anxiety.

Among the 600 messages published during the year 2017 (January to December), three subgroups were analysed:

- Bipolar disorder: 251 messages;
- Anxiety disorder: 310 messages;
- Depressive disorder: 137 messages.

Objectives

Aim: This study schematized different levels of identification with the diagnosis, its impact on recovery and its effects on coping.

Aim more specifically to:

1. Identify the types of diagnosis self-identification through speech patterns such as : “I’m sick”, “I have a disorder”, “I have a problem”, “I doubt”, “who am I ?”, “I’m not sick !”
2. Identify the nature of one’s problem (physicho-chemical, bodily, self, environmental) to understand the experience described by the forum participants and their ways of positioning themselves towards them
3. Identify the types of personal adaptations illustrating the self-understanding of diagnosed individuals and the aims and means used to adapt to the difficulties they have experienced (inspired by Robert K. Merton’s Typology of Deviance).
4. Theorize a typology of diagnosis that exhibits six figures of appropriation: resigned, expert, resilient, client, suffering and distanced. This typology aimed to illustrate the link between one’s relationship to their diagnosis and one’s positionality towards ways to get better.

Results

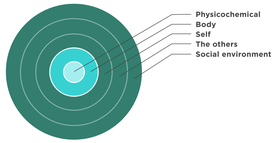
Types of auto-identification	Ways of interpreting the problem (causes)	Types of adaptation	
		Personal goals	Means considered (and accessible)
I am sick I have a disorder I have problems I am in doubt I am not sick Who am I?	**Physicochemical** (The brain functions independently, Bad genetics, Need of medication to reach goals, etc.) **Body** (The body acts independently, Sensations and thoughts foreign to oneself, Involuntary ideas, Uncontrollable emotions, etc.) **Self** (The person considers herself as responsible for her suffering, Ability or inability to..., Self-hatred, etc.) **The others** (Others have an active part in the experienced suffering, Passed trauma (abuse, victim of...), Relational issues, etc.) **Social environnement** (The ways society functions and its demands are blamed)	Being stable Understanding oneself Being happy Being accepted Being functional Being helped	Biomedical approach (medication, medical follow-ups) Psychosocial intervention (therapy) Alternative methods and lifestyle (sport, meditation, food, etc.) Self-medication (drug and/or alcohol consumption) Spirituality, meaning, self-help Escape and isolation Network, helping others, communication, healthy relationships Changing one’s life (moving, breaking up, changing jobs, etc.)

Results

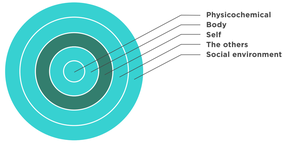
Link between diagnosis identification and adaptation to experience		
Types of adhesion	**Types of discourse**	**Findings**
Strong	« I am sick »	The means: biomedical approach (medication, access to professionals). Dependency to means. Cannot be delivered by oneself. The self cannot act. Healthcare professional expertise (the brain, molecules, etc.).
Moderate	“I have a disorder”	The means: come from varied sources. Independence from healthcare professionals, who are mostly considered as caregivers amongst other resources. Responsibility for recovery is shared between the individual, their support network and their access to different means.
Weak	“I have problems”	The means: come from varied sources. People who blame themselves for their failures or problems. No distanciation.

With or without diagnostic			
With or without diagnostic	**Types of discourse**	**Types of goals**	**Findings – styles of discourse**
With diagnosis	“I am sick” “I have a disorder”	To be functional To be stable To be accepted To be helped	The discourse used to talk about oneself takes on the shape of a description based on criteria from the DSM. “I have mood swings, delusional ideas, a loss in appetite and have hypersomnia”
Without diagnosis	“Am I sick?”	To be happy To understand oneself	The discourse of people without a diagnosis is harder to read: longer, with more suffering, less organized, less references to DSM criteria while talking about oneself. Hope that answers that might suggest a diagnosis. “Who am I ?”

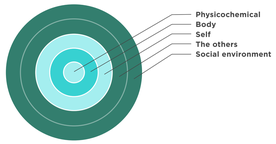
The typology present different ways of being affected by the diagnosis. Significantly present — Present — Absent



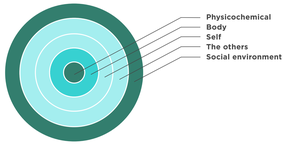
The resigned
The resigned consider themselves as having no way of acting upon their situation. They are limited to the fixed category of “sick” and are conformist. They depend on exterior means (medication, healthcare professionals support, etc.) that are part of a paternalistic model of healthcare and services.



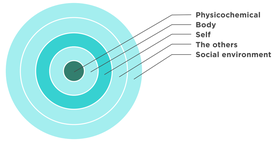
The expert
Experts do not consider that other ways of being are possible. However, they possesses the knowledge available about their “disease” and try as best as possible to “cope with it”.



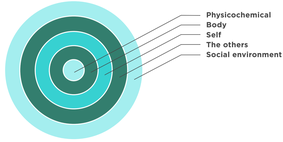
The resigned
Resilients adhere to more than one identity resource and consider themselves to be able to act in different contexts despite the difficulties encountered. They try to understand themselves through different resources and types of support available (using biomedical, psychosocial or other alternative approaches).



The sufferer
Sufferers are characterized by strong identity questioning. They do not find their place in society or try to understand themselves. They do not present a stable self-identification and their self- doubt limits their choice of action. They suffer, try to define themselves and the lack of answers paralyses them.



The clients
Clients do not adhere to the diagnosis. However, they use biomedical resources. Since they do not consider themselves as “sick”, they consider themselves as the sole person responsible for their difficulties and they suffer the weight of this responsibility. No distanciation.



The distanced
The distanced know the mental health system management. However, they no longer want to be identified with it. They define themselves in relation to the mental health diagnosis (MHD), but only by rejecting it. They want to define themselves on different terms, outside of the mental healthcare system. They feel relieved to take distance from it, but doubt and fear having a relapse. They negotiate between their past and their desire to discover new identity resources.

Conclusion

Findings

- The diagnosis frames the relation to one’s experience.
- The identification with one’s diagnosis transforms discourse on the self: identity affirmations of the type “I am.
- Strong identification allows for a distancing of the experienced difficulties, but limits the means used.
- A weak identification with one’s diagnosis shows the complexity of experiences, a greater variety of means, but brings on a stronger accountability towards oneself.
- An inadequacy between goals and means brings on a strong feeling of helplessness towards experienced difficulties.

Discussion

A strong identification to one’s diagnosis limits one’s ability to explore alternatives to the biomedical approach (medication and medical follow-ups) which leaves the individual with a feeling of hopelessness if these means fail. In contrast, the lack of identification to one’s diagnosis results in individuals who are more destitute and suicidal, because the responsibility to cope weighs entirely on the individual.
Speech patterns that promote optimal recovery show profiles of individuals who identify moderately with their diagnosis and who favour a variety of coping methods (medication, healthy relationships, sport, spirituality, etc.).
We conclude that consultation of individuals for their diagnosis must consider that one’s lived experience should not merely be presented as an “illness” to be treated. Health professionals must emphasize the complexity of life courses and the multitude of coping mechanisms one can take on the path to recovery.

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Contact

Researcher : Isabelle Jacques, M.A.
jacques.isabelle.6@courrier.uqam.ca

Partner: RRASMQ
www.rrasmq.com

UQÀM | Faculté des sciences humaines
Université du Québec à Montréal