Social Science & Medicine 289 (2021) 114364

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Discussing mental health difficulties in a "diagnosis free zone"

Elina Weiste [a,*,1], Melisa Stevanovic [b], Taina Valkeapää [c], Kaisa Valkiaranta [c], Camilla Lindholm [d]

[a] University of Helsinki, Faculty of Humanities, P.O. Box 24, 00014, University of Helsinki, Finland
[b] Tampere University, Faculty of Social Sciences, 33014, Tampere University, Finland
[c] University of Helsinki, Faculty of Social Sciences, P.O. Box 24, 00014, University of Helsinki, Finland
[d] Tampere University, Faculty of Information Technology and Communication Sciences, 33014, Tampere University, Finland

ARTICLE INFO

Keywords:
Conversation analysis
Diagnosis
Mental health
Stigma
Normalization

ABSTRACT

Being identified as "mentally ill" is a complicated social process that may be stigmatizing and socially problematic, as a mental illness diagnosis determines the criteria for what is considered normal. This has given rise to a number of anti-stigma campaigns designed to create awareness of the way stigmas affect people with mental health difficulties and to normalize those difficulties in society. One such campaign is the "diagnosis-free zone", which declares that those with mental health difficulties should not be categorized on the basis of their diagnosis; rather, they should be encountered as full individuals. In this paper, we investigate how mental health difficulties are discussed in Clubhouse communities, which adhere to the "diagnosis free zone" programme. The findings are based on conversation analysis of 29 video-recorded rehabilitation group meetings, in one Finnish Clubhouse, intended to advance clients' return to the labour market. The analysis demonstrated that members referred to their mental health difficulties to explain the misfortunes in their lives, especially interruptions and stoppages in their careers. By contrast, staff members disattended members' explanations and normalized their situations as typical of all humans and thus unrelated to their mental health difficulties as such. In this way, the discussion of mental health difficulties at the Clubhouse meetings was implicitly discouraged. We propose that the standards of normality expected of a person not suffering from a mental health difficulty may well be different from the expectations levelled at participants with a history of mental problems. Therefore, instead of considering cultural expectations of normality to be a unified domain, effective anti-stigma work might sometimes benefit from referring to mental-health diagnoses as a means of explicitly tailoring expectations of normality.

1. Introduction

Being identified as a person with a "mental illness" is a social process (e.g., Guifoyle, 2001; Watts et al., 2005). From a social constructionist perspective, "mental illness" exist not in the symptoms displayed by individuals but in changing cultural categorizations of what is considered normal and deviant behaviour (Horwitz, 2013). In these categorizations, language-use plays a central role. Constructing certain traits or behaviours as constituting a mental health difficulty occurs "through the uses of varieties of institutionalized forms of speech" (Wahlström, 2018). This study adopts a conversation analytic view and studies interactions in which mental health difficulties are discussed by staff members and individuals identified with such difficulties at a community rehabilitation centre.

Previous conversation analytic research on psychiatry has investigated the way professionals solicit clients' talk about their problems, monitor clients' interactional behaviour, take decisions regarding their mental state and suggest treatments (e.g., Angell and Bolden, 2015; Kushida and Yamakawa, 2020; Roca-Cuberes, 2016; Savander et al., 2019; Thompson and McCabe, 2018). Often, these actions orient to the moral and normative character of what the clients' talk may convey. For instance, in his seminal paper, Bergman (1989) demonstrated that

* Corresponding author. University of Helsinki, Faculty of Humanities, P.O. Box 24, 00014, University of Helsinki, Finland.
E-mail addresses: elina.weiste@ttl.fi (E. Weiste), melisa.stevanovic@tuni.fi (M. Stevanovic), taina.valkeapaa@helsinki.fi (T. Valkeapää), kaisa.valkia@gmail.com (K. Valkiaranta), camilla.lindholm@tuni.fi (C. Lindholm).
[1] Permanent Address: Finnish Institute of Occupational Health P.O. Box 40 00032 Finnis Institute of Occupational Health, Finland

https://doi.org/10.1016/j.socscimed.2021.114364
Received 15 December 2020; Received in revised form 21 August 2021; Accepted 1 September 2021
Available online 2 September 2021

psychiatrists' seemingly innocent and affiliative utterances inviting clients to disclose their personal feelings and troubles in fact conveyed strong moral assumptions. Bergman concluded that while discrete topicalization of clients' behaviour was indeed affiliative, it also functioned as a means of highlighting some deviant or morally questionable behaviour. From the client's perspective, such discreetly probing utterances can easily be heard in moral terms, but, due to their indirectness, they may be difficult to resist (Bergmann, 1989). By addressing clients' personal experiences, professionals may also intrude into their epistemic domain and claim knowledge that violates clients' right to privileged access to their own mind and experience (Angell and Bolden, 2015; Weiste, 2015). This may invoke resistance, which can lead to an escalating cycle of pressure and disagreement that is difficult to bring to a close without either the client or the professional losing face (Quirk et al., 2012). Thus, in these conversations within psychiatric institutions, clients' understandings of their problems and even their social identities, i.e., the social categories and attributes that are related to them (Goffman, 1963), may become challenged and redefined. Outside psychiatry and other "helping institutions", such challenging of an individual's self-understanding may be even more prevalent. One negative example of such a process is stigmatization.

Stigmatization occurs when individuals experience a contradiction between their own perception of their social identity and the way it is perceived by others in a social situation (Goffman, 1963). Moreover, in stigmatization, individuals with "blemishes of individual character" inferred from a known record (e.g., mental illness) apply existing stereotypes to themselves (Goffman, 1963: 4) and therefore feel incapable of achieving personal goals (Corrigan et al., 2016: 11). Furthermore, stigmas affect not only those identified with mental health difficulties but also mental health professionals. It might be expected that such professionals display more positive attitudes towards mental health difficulties than do the general population. Nevertheless, mental health professionals are noted to hold surprisingly negative attitudes, which contributes to the discrimination against individuals considered to be "mentally ill" (e.g., Loch et al., 2013; Nordt et al., 2006). Even more challenges are encountered in working life. According to the national Finnish mental-health barometer, 62% of respondents agreed that employees could lose their jobs, position and reputation if their employer and co-workers discovered that they were suffering from mental health problems (FMHB, 2019). Thus, it is unsurprising that every second (51%) respondent reported that they would not disclose their mental health difficulties at the workplace (FMHB, 2019).

Another social process into which people identified with mental health difficulties are drawn is normalization. In research on recovery from chronic illnesses, normalization is often seen as a process in which individuals are enabled to resume their pre-illness roles and find ways to live "a normal life" while coping with symptoms and disabilities (Joachim and Acorn, 2000). In this view, normalization is seen as a management strategy among those with such conditions. From a professional standpoint, supporting clients' ability to satisfy cultural expectations of normality is often seen at heart of mental health promotion (see, e.g., Barry, 2019).

Normalization can also be seen as an interactional matter. According to Goffman (1963), in interaction, people present themselves as "normal" to save "face", i.e., the social value they claim for themselves in encounters with other people. Other people are expected to engage in this "face-work" to preserve the face of their interlocuter and ensure the continuity of social interaction (Goffman, 1967). When considered as a social action, normalizing occurs by labelling an action or utterance "normal" or "commonplace" or by interpreting it in an ordinary way (Svinhufvud et al., 2017). In helping interaction, such normalizing actions are utilized to affiliate with clients and suggest that their problems are normal and not unique. However, there is often a tension between the views of professionals and clients on whether the problem should be considered "normal" (Svinhufvud et al., 2017).

Stigmatization and normalization are thus two distinct but dialectically intertwined processes: a person who is considered "normal" does not carry a stigma, while a person who has a stigma is viewed as "abnormal". Both components of this dialectical relation can be seen in a number of anti-stigma programmes that aim, on the one hand, to create awareness of the way stigmas affect people with mental health difficulties, and, on the other hand, to normalize mental health difficulties in society (Corrigan, 2004). Nevertheless, the processes of both stigmatization and normalization are means through which society categorizes individuals, thereby conveying to its members what is expected of a person in order for them to satisfy the standards of normality (Goffman, 1963: 2). However, it is precisely in this respect that the role of a mental health diagnosis is dilemmatic. What difference does it make if an existing mental health diagnosis is taken as the starting point for defining the standards of a "normal life"?

The local community centres of the Clubhouse organization are committed to reducing the stigma surrounding mental health difficulties (Hänninen, 2012; Phillips, 2012). A central means for achieving this is the so-called "diagnosis-free zone". The idea behind the "diagnosis-free zone" is that no one should be categorized on the basis of their diagnosis; rather, they should be encountered as full individuals. According to Clubhouse standards, no one at the Clubhouse is expected to discuss their diagnoses or illness histories unless they specifically wish to do so (Hänninen, 2012). However, some earlier research has suggested that such discussion performs important functions: selective disclosure of one's mental health diagnosis has, for instance, been suggested as a strategy to reduce self-stigma (Mensing, 2010). Conversely, research has also shown that not talking about mental health diagnosis can reinforce stigmatization (Paananen et al., 2020). Thus, to better understand the dialectical nature of stigmatization and normalization, and its exploitation in development of anti-stigma programmes, more research is required on the way mental health difficulties are discussed by both individuals identified with mental health difficulties and mental health professionals.

In what follows, we aim to investigate this in the context of Finnish Clubhouses, which are so-called "diagnosis free zones". Our analysis is guided by the following questions: 1) how do Clubhouse members design their talk on mental health difficulties and what functions do these utterances serve? 2) How do staff receive and respond to utterances in which members refer to their mental health difficulties?

2. Materials and methods

The data analysed in this study are drawn from one Finnish Clubhouse. The Clubhouse model is a global concept involving local community centres that offer people with mental health difficulties a sense of belonging, opportunities for social relationships and support in obtaining employment, education and housing (Hänninen, 2012). One central goal of Clubhouse activities is to advance clients' return to the labour market (McKay et al., 2018). In order to develop clients' work competence, Clubhouses arrange rehabilitation groups where clients can, with the support of staff and peers, take steps toward competitive employment (Pirttimaa and Saloviita, 2009). Thus, one aim of the Clubhouse is to provide a safe environment for clients to practice their work-related skills. A Clubhouse is a membership organization open to

anyone with a history of mental health difficulties; those individuals who participate in activities at the Clubhouse are thus its members (Hänninen, 2012). The paid staff work alongside members in all functions of the house and encourage them to achieve their full potential (Hänninen, 2012). Thus, their role more closely resembles that of a "tutor colleague" than that of a mental health professional.

The data analysed in this study consist of video-recordings of 29 weekly meetings of a rehabilitation group at the Clubhouse, collected from September 2016 to August 2017. Each meeting lasted from 30 to 60 min, amounting to a total of 22 h and 40 min of interaction. The group focused on topics related to working life, and the aim of the group was to practice work-related skills. The meetings involved 2–10 members and 1–3 staff members. As the group was voluntary and open to all members of the Clubhouse, the participants varied: some members were present at almost all the meetings in the data corpus; some participated only once. The staff members were trained in social work, and their work experience ranged from six months to several years.

The study was conducted in accordance with the Declaration of Helsinki, and research ethics approval was obtained from the Southern Finland Clubhouse Association. Research permits were issued by the board of directors at the relevant Clubhouse. Informed, written consent was obtained from all participants, and they were advised of their right to withdraw their consent at any point during the study. The anonymity of the participants has been carefully ensured by altering the participants' names and other identifying details in the text.

The data were analysed by means of institutional conversation analysis (CA) (e.g., Arminen, 2005; Heritage and Clayman, 2010). Conversation analysts inductively investigate recordings of naturally occurring interactions to uncover the practices of interaction through which the meanings of social actions are produced. According to the CA view, every turn of talk performs social actions (such as asking, evaluating, accounting or agreeing). The main idea is to investigate the function of these actions in a given moment of social interaction (Schegloff, 2007). Institutional CA builds on this basic view and explains how sequences of social actions contribute to achieving the goals of the institution in question (Arminen, 2005; Heritage and Clayman, 2010).

In the analytic procedure of this study, the interaction during the meetings was first transcribed according to CA conventions (Schegloff, 2007, Appendix). Next, the video-recordings were viewed several times, and segments of interaction in which Clubhouse members referred to their mental health difficulties or diagnosis, one way or another, were identified. Thereafter, we began to work with the collection of data segments in a data-driven way, comparing the categories and patterns identified in a single data segment against every new segment of data. Finally, focusing on the ways participants received and responded to contributions at the group meetings, we performed a more specific analysis of the manner in which mental illnesses were handled in the talk of Clubhouse members, on one hand, and of the responses to that talk by Clubhouse staff, on the other. The data extracts presented in this paper are drawn from across our dataset on the basis of their capacity to demonstrate, in a clear and accessible way, how members referred to their mental health difficulties and staff members responded to them.

3. Results

When discussing a range of issues related to their life-situations, work, social relations and roles at the Clubhouse community, the participants rarely referred to their mental health difficulties. From our dataset of 22 h and 40 min of interaction, we identified only 21 such cases. These segments of talk were found in specific interactional environments where discussing one's personal life became relevant (the group members where asked, for instance, to describe their work history or work-related goals). Most of the time, the group discussions concerned less personal topics, such as planning the Clubhouse "Transitional work" programme (see e.g., Valkeapää et al., 2018). When referring to their mental health difficulties, the Clubhouse members attempted to render their situation understandable, providing explanations for behaviour that deviated from social norms, as well as for misfortunes and adversity in their personal life, especially regarding interruptions and stoppages in their careers. By contrast, staff members disattended these members' explanations (Mandelbaum, 1991), thereby creating an implicit assumption that discussion of mental health difficulties was discouraged at Clubhouse meetings. In a few cases, the participants also explicitly established a shared view that discussing one's mental health difficulty publicly was unadvisable.

In the following, we present three types of cases where members refer to their mental health difficulties and staff members respond to them. Each type of case is illustrated with a data extract. Lastly, we show one data extract in which the participants explicitly discuss "not talking about mental health difficulties" publicly, creating a shared view that speaking about one's mental health difficulty is inadvisable.

3.1. Implicitly setting the interactional 'rule' of not discussing one's mental health difficulties at Clubhouse meetings

When discussing their mental health difficulties, Clubhouse members disclosed their personal information and first-hand experiences. Previous research has demonstrated that the recipient of such reported experiences has a normative obligation to affirm the nature of the experience and its meaning and to affiliate with the stance of the teller (Heritage, 2011). In our cases, no such affiliative responses were provided. Instead, staff members either 1) blatantly disattend to the members' explanations, i.e. the staff member's turn was clearly unconnected to the prior turn in which the explanation was offered (Mandelbaum, 1991: 100), 2), subtly ignored such explanations, i.e. the staff member elicited talk about some other aspect of the member's turn that focused the talk away from the mental health difficulty (Mandelbaum, 1991: 105), or 3) normalized the members' situations as being typical of all humans (Svinhufvud et al., 2017) and thus unrelated to their mental health difficulty.

3.1.1. Mental health difficulty as an explanation is blatantly disattended by staff members

Four (out of 21) cases in our data included a mental health difficulty explanation that was blatantly disattended by staff members (see Mandelbaum, 1991). In these cases, the staff member's next turn was clearly unconnected to the immediately prior turn.

The first extract provides an example of such talk. In the extract, the group members (two staff members and five group members) have been discussing the skills required in working life using a list of skills projected on a screen. Thus far, the staff members have emphasized one bullet point, the importance of initiative. Some of the group members have raised doubts about their ability to work independently and to know which tasks they are expected to perform. In the first three lines, the staff member provides an example of what initiative could mean in practice.

Extract 1.

01 SM1: sehän on sitä oma-aloitteisuutta että sä kysyt
it's initiative that you ask
02 mitä mä nyt teen mitä mä nyt voisin
what do I do what could I do now when I
03 tehdä mul on tunti täs viel aikaa.
still have an hour left.
04 (3.0)
05 Bea: ja sit sen oman jaksamisenki huomaa täälä
and then you can notice your own strength here
06 Klubitalolla ja oman oma-aloitteisuuden
at the Clubhouse and your own intiative
07 huomaa iteki et miten pystyy niikun,(0.2)
notice yourself how you can like, (0.2)
08 **mul oli masennuksen jälkeen kun mä aloin toipumaan**
I had after the depression when I started to recover
09 **mä olin hirveen arka tekemään mitään (0.2)**
I was so terribly shy about doing anything (0.2)
10 tääl kannustettiin sit tekemään jotain ja
here I was encouraged to do something and
11 sit mä aloin ottamaan vähän vastuuta
and then I started to take a little responsibility
12 ja vähä oma-alotteisuuttaki alko tulemaan ja tämmöstä,
and started to get some initiative or so,
13 (17.0)
14 SM1: **kello on nyt kaheksaa minuuttia vaille yks** (.)
the time is now eight to one *(.)*
15 siin on nyt seuraava lista tämmönen
there is next this kind of list
((continues to go through the skills needed at
the Clubhouse))

In lines 1–3, the staff member defines initiative as the ability to actively ask what one is expected to do and thus contribute proactively to the matter in question. In this way, she presents initiative as a normative good that group members could, and should, also possess when working in the Clubhouse community.

In line 5, one of the members, Bea, takes a turn and makes a general observation about how working in the Clubhouse community can help members notice and evaluate their ability to take the initiative (lines 5–7). After that, she switches the talk to herself. Bea refers to her depression (line 8) and describes it as an explanation for her being "so terribly shy about doing anything". This kind of extreme-case formulation (Pomerantz, 1986) has often been observed in self-disclosures

where a person reports personal information as evidence of a significant change in their life (Antaki et al., 2005). Bea describes how her ability to take responsibility (line 11) and initiative (line 12) has improved due to the support provided at the Clubhouse. Thus, she takes a retrospective look at her depression and evaluates the usefulness of participation at the Clubhouse in her process of recovery.

After Bea's turn, everyone in the group remains silent for an exceptionally long time (line 13). During the gap, all group members sit motionless with lowered gazes. SM2 smiles and looks at the participants and then at the slide on the screen. Eventually, in line 14, SM1 (sitting at the back towards the camera) takes a turn in which she blatantly ignores Bea's prior utterance and continues with the counselling agenda. By mentioning the time that is left in the meeting, she indicates the need for haste if they are to address all the issues on the agenda.

In sum, although Bea refers retrospectively to her depression and positively evaluates the role of the Clubhouse in her recovery, her turn is blatantly ignored, i.e., left without the expected response, and the conversion is shifted away from discussion of Bea's mental health difficulty and her recovery from it.

3.1.2. *Mental health difficulty as an explanation is subtly disattended by staff members*

In addition to blatantly disattending members' turns of talk, staff members also subtly disattended members' explanations by focusing the talk away from their illnesses with follow-up questions that topicalized some other aspect of the talk (see Mandelbaum, 1991). There were six such cases in our data. Extract 2 provides one such example.

The extract is taken from a group meeting aimed at allowing group members to share experiences and thoughts on work. Prior to the extract, some group members have taken turns describing their study and work experiences. One of the group members has mentioned that he was unable to work because of his mental health difficulty, and his turn is left without a response. In the first line, another member, Tua, takes a turn and begins to share her experiences.

Extract 2.

01 Tua: no mä voin jatkaa (.) no ni mä oon kyl
so I can continue (.) erm well I've indeed done
02 pakkaushommii tehny ja (.) sitten totani (.)
some packaging jobs and (.) then erm (.)
03 mul on siivousalan koulutus kyllä että
I have training in the cleaning sector
04 tota mut- (.) mutta mutta mä olin,
erm bu- (.) but but I was,
((removed 3 lines talk about the title of the training))
08 Tua: **mul oli silleen (0.2) mullaki on sairaus**
I had (0.2) I also have an illness
09 **mä sairastuin ni sitte** tota niitä hommii niinku
***I got ill so then** erm those jobs erm*
10 (.) mä oon jotain siivoushommii tehny kyllä
(.) I've done some cleaning jobs
11 mutta vähäsen tehny siivoushommii mutta (.)
but just a few cleaning jobs but (.)
12 mutta mutta (.) sittei niinku vaan enää
but but (.) then I just didn't
13 saanu niit hommii et vähän aikaa olin,
get those jobs so for some time I was,
14 SM2: **kauanko sä niitä pakkaushommia teit?**
how long did you do those packaging jobs?

In line 1, Tua takes a turn beginning with the statement that she has worked in some packaging jobs and acquired formal training in the cleaning sector. She uses the particle *kyl* (translated as "indeed"), which is typically used when trying to provide reassurance and reduce some negative implications of a given context (Hakulinen et al., 2004: 1609). In addition, the faltering production of her turn, such as hesitation (*erm*, lines 1, 2, 4), pauses (lines 1, 2, 4), and half-formed and repeated words (line 4), can imply that there is something socially problematic in her talk (Lerner, 2013). In line 8, Tua continues to describe her past experiences but then switches to the present tense and refers to her illness. Tua does not specify her illness, but, by using the particle *-kin* (translated as "also"), she connects her turn to the prior talk of another group member and implies that she has the same kind of illness. Such vague references to "having an illness" or "getting an illness", in which the diagnostic category is not specified, were typical in the members' talk (cf. Weiste et al., 2018). Next, Tua uses the illness as an explanation for her limited work experience, regardless of her formal training (lines 10–11), and for her eventual inability to secure any work (lines 12–13). When discussing her career, Tua also downgrades the description: she first describes having had "some" cleaning jobs (line 10), then "just a few" cleaning jobs (line 11), and finally her failure to find any work (lines 12–13).

In line 14, the staff member ignores Tua's explanation by asking a follow-up question about her packaging job (which Tua referred to in lines 1–2). In this way, he guides the discussion in a particular direction, disattending the member's illness and troublesome experience. Thus, in addition to declining affiliative engagement with Tua's experience, the staff member departs from the topic at hand and addresses another agenda (see Heritage, 2011).

3.1.3. Mental health difficulty-related experiences are normalized by staff members

Staff members also responded to members' reference to their mental health difficulties by normalizing (e.g., Svinhufvud et al., 2017) the situations as typical of all humans and thus unrelated to mental health difficulty as such. We found eight such cases in our data. Extract 3 provides a case in point. In the extract, the participants have been discussing issues related to self-esteem when applying for a job. In the first lines, one of the members, Ben, takes the stance that one should be indifferent to others' opinions when making life-decisions. After that, another member, Mea, takes a turn and refers to her illness as an explanation for her troublesome behaviour.

Extract 3.

01 Ben: et ei pitäis yhtään välittää mitä muut ajattelee,
so you shouldn't care what other people think,
02 SM1: nii,
yes,
03 Ben: puheista tai jengistä tai mist tahaansa.
what they say or people or anything.
04 Mea: mä oon kans ajatellu et onks- £ooks(h) mä mitään(hhe)
I've also thought that a- £am I(h) nothing(hhe)
05 et et tavallaan et pohtinu sitä£ (0.2) ei pitäis
I've in a way pondered that£ (0.2) you shouldn't
06 liikaa miettiä näit asioita mut joskus käy sillee et
think about those things too much but sometimes it just happens
07 (0.2) **se on vaan sitä sairautta nimenomaan.**
(0.2) ***it is just precisely this illness.***
08 SM1: **tai se on just mitä kaikki muutkin tekee,**
or it is just what all people do,
09 SM2: **kyllä sitä kaikki muutkin miettii.**
all people think about it.
10 SM1: tekee enemmän tai vähemmän.
they do more or less.

In line 4, Mea designs her talk as a response to Ben's turn by indicating that she *also* has considered this kind of self-criticism. Nevertheless, she presents an opposing view: While Ben asserted that one should be indifferent to the views of others, Mea states that she indeed criticizes herself ("I've thought that I'm nothing", line 4). She also uses a so-called smiley voice and produces one-sided laughter particles interpolated within her words, practices that Potter and Hepburn (2010) have noted mark some trouble in the interaction. Next, she makes her problematic way of thinking explicit and states that this is something "you should not think about too much" (lines 5–6). She also states that this thought "just happens" sometimes, reducing her own responsibility for such behaviour (Weiste et al., 2018). Next, she refers to her illness as an explanation for such undesirable behaviour. Similar to Extract 2, Mea does not specify her illness with a particular diagnostic category; rather, she discusses it in general terms. However, she uses the demonstrative pronoun *sitä* (*that*), which implies that the reference is adequately known among the participants (Etelämäki, 2009).

In line 8, the staff member takes a turn, and, by continuing with conjunctive particle *tai* (*or*), expresses an alternative option (Hakulinen et al., 2004: 1098). Thus, the staff member challenges the member's explanation by normalizing her experience (Svinhufvud et al., 2017). She claims that the member's problematic thoughts are unrelated to her illness and, instead, are experiences common to all people. In line 9, the other staff member also strongly agrees, repeating the same view. In this way, the staff members address the member's problem and offer support (Svinhufvud et al., 2017), but they leave her explanation unvalidated and close down the talk on topics related to mental health difficulties.

In sum, the Clubhouse members referred to their mental health difficulties when explaining their problematic behaviour and adversities in working life. In this way, they rendered their situation understandable and more socially acceptable. Addressing these issues was, however, often marked with hesitation and other features that indicate some trouble in the interaction. In such delicate moments of interaction, in which a person struggles to disclose personal information, the recipient is expected to affiliate with the stance of the teller (Heritage, 2011). Nevertheless, in their subsequent turns of talk, the staff members redirected the talk without affirming the nature of the experience and its meaning to the member. By doing so, they created an interactional 'rule' in which discussion of mental health difficulty was implicitly discouraged at the Clubhouse meetings.

3.2. *Creating a shared view that discussing one's mental health difficulty publicly is inadvisable*

In addition to implicitly discouraging members from discussing their mental health difficulties at Clubhouse meetings, the staff members also affiliated with members' views that disclosing one's mental health difficulty leads to negative social consequences (for instance, when applying for a job). In this way, the participants established a shared view according to which publicly revealing one's mental health difficulty was inadvisable. There were only two such cases in our data, one of which is presented in Extract 4, below (see the next page).

Here, the participants are discussing short-term and long-term goals related to their life. Prior to the extract, one of the members, Ida, has expressed the wish to demonstrate her ability to achieve future goals like education and employment, despite the challenging issues in her past. Related to Ida's description, a staff member raises the example of a popular Finnish rap-artist (Cheek) who has publicly discussed his bipolar disorder. The staff member states that such public disclosures from successful and popular individuals might bring hope and comfort to those with similar illness who are feeling desperate and distressed. Starting from line 1, another Clubhouse member, Teo, comments on the staff member's account.

Extract 4.

01 Teo: kyl noist on hirveesti saanut semmost
those (disclosures) have really given kind of
02 hyväksyntää itsehyväksyntää noist (0.2)
acceptance self-acceptance (0.2)
03 ollu aika paljon julkisuudes just
there have been many in the spotlight
04 **kakssuuntasii tullu esiin just**
bipolar has come up
((removed 4 lines in which Teo lists public
figures with bipolar disorder))
09 **kyl sitä saa semmost (0.2) voimaa siitä.**
that gives you a kind of (0.2) new strength.
10 SM1: mmm.
mmm.
11 Teo: sit mä jotenki ajattelen niin kierosti et
then in some way I think in such a twisted manner that
12 helppohan noiden nyt on sanoo heh heh niinku kertoo
it is all very well for them to say heh heh like talk
13 itestään kun ne on julkkiksii
about *themselves because they are famous.*
14 [heh heh
15 [((all joins the laughter))
16 Teo: et ne vaan saa lisää töitä(h) kun ne kertoo
so they only get more work(h) when they tell
17 SM1: nii heh heh
yeah heh heh
18 SM2: positiivista huomioo.
positive attention
19 SM1: nii nii nii heh heh
yes yes yes heh heh
20 Teo: **sit se ite omal kohal ni @en mä nyt voi kertoo**
then in my case @I really cannot tell
21 **kellekää@,**
anyone@,
22 (1.5)

23 SM1: niinku jotenki (0.2) siin on ehkä se että kun on
so in a way (0.2) it might be that when you're
24 tommonen huippusuosittu tyyppi
such an extremely popular person
25 artisti vaikka ja se hän on saanut
for example an artist and he has earned
26 ne propsinsa sinne kymppiin etukäteen
the maximum points beforehand
27 ennen kun se niinku tavallaan,
before he kind of,
28 SM2: kertoo,
tells,
29 SM1: nii paljastaa jotain semmosta itestään
yeah reveals that type of issue about himself
30 **et jos mietitään et minä lähtisin nyt**
so if we imagine that I were to
31 **paljastaa jotain semmosta ittestäni niin**
reveal that type of issue about myself then
32 **mun propsit tip[puis(h)niinku heh**
my points would fall(h) like heh
33 Kia: [heh heh
34 SM2: nii
yeah
35 SM1: ja tapahtuuko näin et sit sitä varmaan niinku
and would it end up being that you're probably like
36 pelkää just jonkun työsaannin kannalta tai
worried about how to get work or
37 tuoskimpa Cheekin työt loppuu tohon noin että,
I guess Cheek's work won't end there so,
38 SM2: nii
yeah

Teo confirms the staff member's statement that disclosures by public figures can have a positive influence, which in his case appears in terms of self-acceptance (line 2) and strength (line 9). By recognizing the staff member's example and commenting on it with reference to his own experience, Teo highlights his status as a person with mental health difficulties (cf. Heritage and Raymond, 2005). Next, however, Teo changes the perspective. He describes how revealing a mental health difficulty is unproblematic (lines 11–13) and can even be advantageous (line 16) for celebrities because of their position. During his turn, Teo produces a laugh (line 12), which can be understood not only as a

pre-indicator of the appropriate laughability of the account (Jefferson, 1979: 80), but also as a way to problematize the previous accounts (Haakana, 2001), which display only the positive effects of the stories that celebrities share. The laughter is joined by the others at the end of the turn (line 15), highlighting a mutual understanding of Teo's assessment (Kangasharju and Nikko, 2009). In line 18, both staff members also agree with Teo verbally, emphasizing the positive attention celebrities receive when discussing their mental health difficulties. To underline the difference between the position of public figures and himself, Teo explicitly states how he "really cannot tell anyone" (lines 20–21), which, at this point, challenges the staff member's account of the hope-raising effect of the example.

After a silence (line 22), SM1 orients towards Teo's previous turn. SM1 describes the favourable preconditions that protected this celebrity when discussing his mental health difficulty (lines 24–27; "he has earned the maximum points beforehand"). Furthermore, SM1 provides a counter example: if she revealed her similar condition, her "points would fall" (lines 30–32) and she would be afraid of losing job opportunities (line 36), contrary to the case of the popular artist (line 37). Similar to Teo, SM1 also laughs during her turn, but here only one Clubhouse member, Kia, joins the laughter, while the others remain silent.

Although SM1's turns display understanding of Teo's experience, they also contain problematic features. First, when referring to mental health difficulty, SM1 uses the indirect form "that type of issue" (lines 29, 31), which, on one hand, indicates that everyone knows what she is talking about, but, on the other hand, explicitly displays how to avoid openly discussing mental health difficulties, thus treating it as a delicate topic. Second, the narration is presented in the first person (I), where SM1 positions herself as a person with a mental health difficulty and who thus sees at first hand that revealing this difficulty would be harmful to her. By doing so, she negatively evaluates her own social status (how many "points" she would lose). Previous research has demonstrated that this type of self-deprecating turn is used when managing interactional trouble (Speer, 2019). In other words, SM1 validates Teo's experience of being incapable of publicly revealing his mental health difficulty– this is truly something that this staff member would not do either.

In sum, the implication in Extracts 1–3 that staff members avoid discussing mental health difficulties at Clubhouse meetings is made partially explicit in Extract 4: publicly discussing one's mental health difficulties is unpropitious due to its negative social consequences, especially in working life.

4. Conclusions and discussion

In this study, we explored the way mental health difficulties are discussed in Finnish Clubhouses, which are so-called "diagnosis free zones" designed to combat the stigma of mental health problems. The analysis showed that members referred to their mental health difficulties to explain the misfortunes in their lives, especially interruptions and stoppages in their careers. By contrast, staff members disattended discussing members' mental health difficulties and normalized their situations as being typical of all humans and thus unrelated to the mental health difficulties as such. In this way, they created an assumption that discussion of mental health difficulty was discouraged at Clubhouse meetings. The participants also established a shared view that disclosing one's mental health problem was inadvisable in public. Thus, it seems that the mental health professionals' strategy of rejecting diagnoses in order to normalize mental health difficulties increased the social difficulty of members discussing their mental health problems.

When Clubhouse members discussed their mental health difficulties, they disclosed personal information about their first-hand experiences. Previous research has shown that the recipient of such a reported experience is normatively obligated to affirm the nature of the experience and its meaning and affiliate with the stance of the teller (Heritage, 2011). In our data, the staff-members failed to provide such affiliative responses, instead disattending the member's experience or normalizing the situation as being typical of all humans. This may be problematic, as a non-affiliative or absent response to self-disclosure may damage the social cohesion among participants (Farber, 2006). Furthermore, this type of response can lead a person to feel rejected and unwilling to share more personal thoughts (e.g., Vinogradov and Yalom, 1990; see Logren et al., 2019). In terms of the group context, research has demonstrated that counsellors should facilitate and specifically invite participants to discuss their own personal experiences in relation to the experiences of other group members (Weiste et al., 2020). Such affiliative responses among peers could provide social support through reciprocity and instigate self-reflection (Logren et al., 2019).

Notably, the Clubhouse members in our data often used vague references to their mental health difficulties, rarely referring to explicit diagnostic categories. This differs from the findings of Weiste et al. (2018) in the context of psychiatric assessment interviews. There, clients utilized diagnostic categories in their talk in several ways, displaying their knowledgeability of psychiatric terminology. Therefore, the vague illness references used by both Clubhouse members and staff members might support the conclusion that discussing mental health difficulties is challenging for clients in this specific "diagnosis free" context.

The infrequent use of diagnostic categories (or references to mental health difficulties) may also be related to the institutional aim of the Clubhouse model. Rather than examining the client's mental state and working through personal issues by talking (as in psychiatric clinics), the aim of the Clubhouse is to provide a "workplace evocative" environment for practising work-related skills. It could be that by disattending or normalizing members' references to their mental health difficulties (Extracts 1–3), the staff members orient themselves toward a professional identity whose role is to implicitly educate members not to discuss their mental health difficulties in the "workplace". In Extract 4, this orientation becomes explicit when a staff member adopts the identity of a "person with mental health problem" and affiliates with a member's claim concerning the negative social consequences of public disclosure of mental health difficulty. Such disclosure could result in "falling points" in the eyes of other people and fears over how to obtain work.

Discussing mental health difficulties can also be a face-work resource (Goffman, 1959), as, in psychiatric treatment discussions, a medical condition may not be a client's only potentially discrediting attribute (Weiste et al., 2018). For example, Hansen et al., (2014) have argued that the inability to work may be experienced as even more discrediting in contemporary society than having mental health difficulties. This is critical in the context of the Clubhouse model, in which one of the key aims of rehabilitation is to support members' participation in working life (Hänninen, 2012). In work-related discussions, the possibility to refer to their mental health difficulties can provide Clubhouse members with an understandable and socially acceptable explanation for adversities in their careers. Thus, in order to help Clubhouse members save face, it would be important to respond to such explanations with an expression of social acceptance, thereby allowing them to maintain their self-presentation as socially responsible individuals who would have participated in working life had they not become ill.

Our study nonetheless contains certain limitations. First, the relatively small number of references to mental health difficulties in our sample means that our findings may not be representative of all the ways in which mental health problems are discussed in the context of Clubhouse rehabilitation. Second, as our data are drawn from a very specific context, our results cannot be uncritically applied to other mental-health rehabilitation contexts. Third, our methodological approach, conversation analysis, contains a significant inherent limitation in that it precludes speculation on the way Clubhouse members themselves experienced staff members' responses to their references to mental health difficulty. Nevertheless, what the conversation analytic approach does allow is the inspection of adjacent turns-of-talk to examine how the previous turn has been understood by the participants (see Sacks et al.,

1974). In this way, we hope to have provided a more nuanced understanding of the nature of talk on mental health difficulties in a "diagnosis-free zone" in the continually changing context of moment-by-moment social interaction.

As observed at the beginning of this paper, a psychiatric diagnosis can serve as an important normalization resource. It helps a person provide socially acceptable explanations to those aspects in their life that might otherwise be embarrassing to disclose to others, such as the lack of a presentable career. Considering stigmatization and normalization as two opposite, yet dialectically intertwined, processes, both of which inform programmes and campaigns to improve the position of the "mentally ill" in society (Corrigan, 2004; Corrigan and O'Shaughnessy, 2007), it is essential to discuss the perspective from which "normality" is to be conceptualized and defined. The standards of normality expected of a person without a mental health difficulty may well be crucially different from those expected of individuals with a history of psychological problems. Thus, instead of considering cultural expectations of normality to be a unified domain, effective anti-stigma work might sometimes benefit from explicitly tailoring expectations of normality with reference to mental health diagnoses.

Credit author statement

Elina Weiste, Melisa Stevanovic, Camilla Lindholm. Conceptualization; Elina Weiste, Kaisa Valkiaranta, Taina Valkeapää . Data curation; Elina Weiste, Melisa Stevanovic, Kaisa Valkiaranta, Taina Valkeapää . Formal analysis; Elina Weiste, Melisa Stevanovic, Camilla Lindholm. Funding acquisition; Elina Weiste, Melisa Stevanovic, Kaisa Valkiaranta, Taina Valkeapää . Investigation; Elina Weiste, Melisa Stevanovic, Camilla Lindholm. Methodology; Camilla Lindholm. Project administration; Elina Weiste, Melisa Stevanovic, Taina Valkeapää . Validation; Elina Weiste, Melisa Stevanovic, Taina Valkeapää . Roles/Writing – original draft; Elina Weiste, Melisa Stevanovic, Writing – review & editing.

Acknowledgments

Research for this study was supported by the Academy of Finland [grant no. 307630] and the University of Helsinki.

Appendix

Transcription symbols

[	overlapping talk
(.)	micropause
(0.0)	pause (length in tenths of a second)
.hh	audible in-breath
hh	audible out-breath
-	truncation
∘	whisper
:	lengthening of a sound
↑	rise in pitch
,	level pitch
.	pitch fall

References

Angell, B., Bolden, G.B., 2015. Justifying medication decisions in mental health care: psychiatrists' accounts for treatment recommendations. Soc. Sci. Med. 138, 44–56.
Antaki, C., Barnes, R., Leudar, I., 2005. Self-disclosure as a situated interactional practice. Br. J. Soc. Psychol. 44 (2), 181–199.
Arminen, I., 2005. Institutional Interaction. Ashgate, Aldershot.
Barry, M.M., 2019. Concepts and principles of mental health promotion. In: Barry, M., Clarke, A., Petersen, I., Jenkins, R. (Eds.), Implementing Mental Health Promotion. Springer, Cham, pp. 3–34.
Bergmann, J.R., 1989. Veiled morality: notes on discretion in psychiatry. Discourse in professional and everyday culture 5, 23–46.
Corrigan, P.W., 2004. How stigma interferes with mental health care? Am. Psychol. 59 (7), 614–625. https://doi.org/10.1037/0003-066X.59.7.614.
Corrigan, P.W., O'Shaughnessy, J.R., 2007. Changing mental illness stigma as it exists in the real world. Aust. Psychol. 42 (2), 90–97. https://doi.org/10.1080/00050060701280573.
Corrigan, P.W., Bink, A.B., Schmidt, A., Jones, N., Rüsch, N., 2016. What is the impact of self-stigma? Loss of self-respect and the "why try" effect. J. Ment. Health 25 (1), 10–15. https://doi.org/10.3109/09638237.2015.1021902.
Etelämäki, M., 2009. The Finnish demonstrative pronouns in light of interaction. J. Pragmat. 41 (1), 25–46. https://doi.org/10.1016/j.pragma.2008.09.005.
Farber, B.A., 2006. Self-disclosure in Psychotherapy. Guilford Press, New York.
FMHB, 2019. Finnish mental health barometer. The National Congress of Mental Health in Finland, Helsinki. https://www.mtkl.fi/toimintamme/julkaisut/mielenterveysbarometri2019/.
Goffman, E., 1959. The Presentation of Self in Everyday Life. Doubleday, New York.
Goffman, E., 1963. Stigma and social identity. In: Blaikie, M., et al. (Eds.), The Body: Critical Concepts in Sociology. Routledge, London, pp. 116–145.
Goffman, E., 1967. On face-work. Interaction ritual 5–45.
Guilfoyle, M., 2001. Problematizing psychotherapy: the discursive production of a bulimic. Cult. Psychol. 7 (2), 151–179.
Haakana, M., 2001. Laughter as a patient's resource: dealing with delicate aspects of medical interaction. Text Talk 21 (1/2), 187–219. https://doi.org/10.1515/text.1.21.1-2.187.
Hakulinen, A., Vilkuna, M., Korhonen, R., Koivisto, V., Heinonen, T.R., Alho, I., 2004. *Iso Suomen Kielioppi* [The Comprehensive Finnish Grammar]. Finnish Literature Society, Helsinki.
Hansen, H., Bourgois, P., Drucker, E., 2014. Pathologizing poverty: new forms of diagnosis, disability, and structural stigma under welfare reform. Soc. Sci. Med. 103, 76–83. https://doi.org/10.1016/j.socscimed.2013.06.033.
Heritage, J., 2011. Territories of knowledge, territories of experience: empathic moments in interaction. In: Stivers, T., Mondada, L., Steensig, J. (Eds.), The Morality of Knowledge in Conversation. Cambridge University Press, Cambridge, pp. 159–183.
Heritage, J., Clayman, S., 2010. Talk in Action. Interactions, Identities, and Institutions. Wiley-Blackwell, Chichester.
Heritage, J., Raymond, G., 2005. The terms of agreement: indexing epistemic authority and subordination in talk-in-interaction. Soc. Psychol. Q. 68 (1), 15–38. https://doi.org/10.1177/019027250506800103.
Horwitz, A., 2013. The sociological study of mental illness: a critique and synthesis of four perspectives. In: Aneshensel, C., Phelan, J., Bierman, A. (Eds.), Handbook of the Sociology of Mental Health. Springer, London, pp. 57–78.
Hänninen, E., 2012. Choices for Recovery: Community-Based Rehabilitation and the Clubhouse Model as Means to Mental Health Reforms. Report 50. The Finnish Institute for Health and Welfare, Tampere.
Jefferson, G., 1979. A technique for inviting laughter and its subsequent acceptance/declination. In: Psathas, G. (Ed.), Everyday Language: Studies in Ethnomethodology. Irvington, New York, pp. 79–96.
Joachim, G.L., Acorn, S., 2000. Living with chronic illness: the interface of stigma and normalization. Canadian Journal of Nursing Research Archive 32 (3), 37–48.
Kangasharju, H., Nikko, T., 2009. Emotions in organizations: joint laughter in workplace meetings. J. Bus. Commun. 46 (1), 100–119. https://doi.org/10.1177/0021943608325750.
Kushida, S., Yamakawa, Y., 2020. Clients' practices for resisting treatment recommendations in Japanese outpatient psychiatry. In: Lindholm, C., Stevanovic, M., Weiste, E. (Eds.), Joint Decision Making in Mental Health. Palgrave, London, pp. 115–140.
Lerner, G.H., 2013. On the place of hesitating in delicate. In: Hayashi, M., Raymond, G., Sidnell, J. (Eds.), Conversational Repair and Human Understanding. Cambridge University Press, Cambridge, pp. 95–134.
Loch, A.A., Hengartner, M.P., Guarniero, F.B., Lawson, F.L., Wang, Y.P., Gattaz, W.F., Rössler, W., 2013. The more information, the more negative stigma towards schizophrenia: Brazilian general population and psychiatrists compared. Psychiatr. Res. 205 (3), 185–191. https://doi.org/10.1016/j.psychres.2012.11.023.
Logren, A., Ruusuvuori, J., Laitinen, J., 2019. Peer responses to self-disclosures in group counseling. Text Talk 39 (5), 613–647. https://doi.org/10.1515/text-2019-2042.
Mandelbaum, J., 1991. Conversational non-cooperation: an exploration of disattended complaints. Res. Lang. Soc. Interact. 25 (1–4), 97–138. https://doi.org/10.1080/08351819109389359.
McKay, C., Nugent, K.L., Johnsen, M., Eaton, W.W., Lidz, C.W., 2018. A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. Adm. Pol. Ment. Health 45 (1), 28–47.
Mensing, B., 2010. Stigma Reduction Techniques/campaigns for Practitioners in a Rural Community Mental Health Practice. Dissertation. Minnesota State University.
Nordt, C., Rössler, W., Lauber, C., 2006. Attitudes of mental health professionals toward people with schizophrenia and major depression. Schizophr. Bull. 32 (4), 709–714. https://doi.org/10.1093/schbul/sbj065.
Paananen, J., Lindholm, C., Stevanovic, M., Weiste, E., 2020. Tensions and paradoxes of stigma: discussing stigma in mental health rehabilitation. Int. J. Environ. Res. Publ. Health 17 (16), 5943. https://doi.org/10.3390/ijerph17165943.
Phillips, S.M., 2012. The Clubhouse model and community psychology. In: Walker, C., Johnson, K., Cunningham, L. (Eds.), Community Psychology and the Socio-Economics of Mental Distress: International Perspectives. Palgrave, Hampshire, pp. 222–237.

Pirttimaa, R., Saloviita, T., 2009. Transitional employment and its effects in Finland *Psychiatric*. Rehabilitation Journal 32 (3), 231–234. https://doi.org/10.2975/32.3.2009.231.234.

Pomerantz, A., 1986. Extreme case formulations: a way of legitimizing claims. Hum. Stud. 9 (2), 219–229.

Potter, J., Hepburn, A., 2010. Putting aspiration into word: 'laugh particles', managing descriptive trouble and modulating action. J. Pragmat. 42 (6), 1543–1555.

Quirk, A., Chapin, R., Lelliott, P., Seale, C., 2012. How pressure is applied in shared decisions about antipsychotic medication: a conversation analytic study of psychiatric outpatient consultations. Sociol. Health Illness 34 (1), 95–113. https://doi.org/10.1111/j.1467-9566.2011.01363.x.

Roca-Cuberes, C., 2016. Diagnosing as an interactional achievement in psychiatric interviews. In: O'Reilly, M., Lester, J.N. (Eds.), The Palgrave Handbook of Adult Mental Health. Palgrave, London. https://doi.org/10.1057/9781137496850_11.

Sacks, H., Schegloff, E.A., Jefferson, G., 1974. A simplest systematics for the organization of turn taking for conversation. Language 50, 696–735.

Savander, E., Weiste, E., Hintikka, J., Leiman, M., Valkeapää, T., Heinonen, E., Peräkylä, A., 2019. Offering patients opportunities to reveal their subjective experiences in psychiatric assessment interviews. Patient Education and Counselling 102 (7), 1296–1303. https://doi.org/10.1016/j.pec.2019.02.021.

Schegloff, E.A., 2007. Sequence Organization in Interaction: a Primer in Conversation Analysis, vol. 1. Cambridge University Press, Cambridge.

Speer, S.A., 2019. Reconsidering self-deprecation as a communication practice. Br. J. Soc. Psychol. 58 (4), 806–828. https://doi.org/10.1111/bjso.12329.

Svinhufvud, K., Voutilainen, L., Weiste, E., 2017. Normalizing in student counseling: counselors' responses to students' problem descriptions. Discourse Stud. 19 (2), 196–215. https://doi.org/10.1177/1461445617691704.

Thompson, L., McCabe, R., 2018. How psychiatrists recommend treatment and its relationship with patient uptake. Health Commun. 33 (11), 1345–1354.

Valkeapää, T., Tanaka, K., Lindholm, C., Weiste, E., Stevanovic, M., 2018. Interaction, ideology, and practice in mental health rehabilitation. Journal of Psychosocial Rehabilitation and Mental Health 6, 9–23. https://doi.org/10.1007/s40737-018-0131-3.

Vinogradov, S., Irvin, D.Y., 1990. Self-disclosure in group psychotherapy. In: Stricker, G., Fisher, M. (Eds.), Self-disclosure in the Therapeutic Relationship. Plenum, New York, pp. 191–204.

Wahlström, J., 2018. Discourse in psychotherapy: using words to create therapeutic practice. In: Smoliak, O., Strong, T. (Eds.), Therapy as Discourse. The Language of Mental Health. Palgrave, London. https://doi.org/10.1007/978-3-319-93067-1_2.

Watts, R.J., Felson Duchan, J., Kovarsky, D., 2005. Diagnosis as Cultural Practice. Mouton de Gruyter.

Weiste, E., Peräkylä, A., Valkeapää, T., Savander, E., Hintikka, J., 2018. Institutionalised otherness: patients references to psychiatric diagnostic categories. Soc. Sci. Med. 207, 71–79. https://doi.org/10.1016/j.socscimed.2018.04.048.

Weiste, E., 2015. Describing therapeutic projects across sequences: balancing between supportive and disagreeing interventions. J. Pragmat. 80, 22–43. https://doi.org/10.1016/j.pragma.2015.02.001.

Weiste, E., Tiitinen, S., Vehviläinen, S., Ruusuvuori, J., Laitinen, J., 2020. Counsellors' interactional practices for facilitating group members' affiliative talk about personal experiences in group counselling. Text Talk 40 (4), 537–562. https://doi.org/10.1515/text-2020-2068.