‘Acknowledge me as a capable person’: How people with mental ill health describe their experiences with general emergency care staff – A qualitative interview study

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ABSTRACT: People with mental ill health attend general emergency care more often than others for physical and psychiatric care needs. Staff in general emergency care report they lack knowledge and strategies to meet with and care for people with mental ill health. This study aimed to describe how people with mental ill health experience encounters with staff in general emergency care. We conducted individual semi-structured interviews with 11 people with mental ill health about their experiences in general emergency care and subjected the interview data to qualitative content analysis. Our results show the importance to people with mental ill health of being acknowledged as capable persons, and how this relates to their experiences of being recognized, ignored, or dismissed by staff in general emergency care. Even small, ordinary aspects of staff/patient interactions can have major impacts on a person’s recovery and well-being. The study is reported according to the consolidated criteria for reporting qualitative research (COREQ) guidelines.

KEY WORDS: emergency care, encounter, experiences, mental ill health, qualitative research, recovery.

INTRODUCTION

People with mental ill health rely on general emergency care (GEC) for both physical and psychiatric care, and they encounter GEC staff more often than others (Morphet et al. 2012). GEC is often the gateway to the healthcare system, playing a unique role in providing safe, high-quality acute care to everyone in the community (Australasian College for Emergency Medicine 2018). In this study, GEC refers to care provided by staff in general emergency departments (EDs) or prehospital emergency care (PEC), and GEC staff refers to healthcare professionals (registered nurses and physicians) involved in direct patient care. Several factors, including nursing staff, support recovery for people with mental ill health (Marynowski-Traczyk & Broadbent 2011). Recovery is essential in mental health, and the recovery model is the foundation of psychiatric care in many countries. Since mental health professionals can either support or hinder a person’s recovery (Waldemar et al. 2019; Wallström et al. 2020),...
we can assume that GEC staff also have the potential to affect a person’s recovery. Research in this area, however, is lacking. Because the patient’s perspective is central in recovery, a first step towards understanding how GEC staff can influence recovery is to explore how people with mental ill health experience their encounters with them.

BACKGROUND

Research on experiences in GEC among people with mental ill health is sparse and focuses mainly on people seeking care for self-harm, suicidal intentions, or other symptoms and signs of mental ill health (Schmidt & Umans 2020). This study adopts a broader perspective and includes people with mental ill health seeking care for physical and/or mental health reasons. In this article, the term mental ill health includes less severe mental health problems, symptoms meeting the criteria for a psychiatric diagnosis (European Commission 2005), and substance use disorders.

Research on GEC staffs’ experiences of caring for people with mental ill health is limited (Koning et al. 2018; Ryan et al. 2021). However, GEC staff often report their lack of knowledge and training as a major barrier to providing appropriate care for people with mental ill health (Chapman & Martin 2014; Holmberg et al. 2020; Jelinek et al. 2013; Marynowski-Traczyk & Broadbent 2011; Plant & White 2013; Weiland et al. 2011). The physical environment of the ED and short interactions due to time pressures further challenge the ability of GEC staff to meet patients’ emotional needs (Broadbent et al. 2014; Marynowski-Traczyk & Broadbent 2011; Weiland et al. 2011). GEC staff may also have negative attitudes to patients with conditions or behaviours they find emotionally challenging, such as self-harming (Rayner et al. 2019; Rees et al. 2014) and to consider mental symptoms less legitimate and a lower priority for care than physical problems (Rees et al. 2014). Although staff in GEC may lack strategies for meeting people with mental ill health (Jelinek et al. 2013), they still must make advanced assessments, including both physical and existential dimensions (Holmberg et al. 2020).

Registered nurses in GEC tend to have a biomedical focus (Holmberg and Fagerberg 2010), and their concept of recovery is bound to the dominant clinical notion of recovery: the patient free of symptoms and cured of disease (Marynowski-Traczyk & Broadbent 2011). In mental health, recovery can be understood as a unique personal process towards living well despite continuing mental ill health and the limitations it can impose (Anthony 1993). The goal of recovery as a personal process is not necessarily cured of mental ill health or return to a pre-illness state but instead that the person experience improved well-being and regain hope and believes in their own possibilities (Barker & Buchanan-Barker 2005; Davidson & Roe 2007; Marynowski-Traczyk & Broadbent 2011).

People with mental ill health are key stakeholders in the interventions and care they receive, but they report a variety of negative experiences and poor treatment from GEC staff, which they often attribute to stigma and discrimination (Clarke et al. 2007; Digel Vandyk et al. 2018; Harris et al. 2016; Owens et al. 2016; Vandyk et al. 2019; Wise-Harris et al. 2017). Those with frequent visits to the ED, which they perceive as necessary and unavoidable, describe staff as uncaring and impatient in their interactions (Wise-Harris et al. 2017), and those with self-harming behaviour report feeling judged, misunderstood, and generally excluded from decisions about their care (Lindgren et al. 2018). Other reported experiences of this group include being discharged from GEC without receiving treatment or having their concerns addressed (Digel Vandyk, 2018, Wise-Harris et al. 2017) and being treated with disrespect (Digel Vandyk et al. 2018).

To guide appropriate interventions and optimize GEC for people with mental ill health, we need to better understand their experiences with GEC staff and how these may influence their recovery process. The relational dimensions of the care encounter, which profoundly affect people’s experiences of acute care, their well-being, and their recovery process deserve much greater attention (Harris et al. 2016), and so do these patients’ perspectives. This study, therefore, aimed to describe how people with mental ill health experience their encounters with GEC staff.

METHOD

We used a qualitative design, conducting individual semi-structured interviews (Brinkmann & Kvale 2014) subjected to qualitative content analysis (Graneheim et al. 2017; Graneheim & Lundman 2004; Lindgren et al. 2020). The consolidated criteria for reporting qualitative research (COREQ) were used to report the study (Tong et al. 2007).

Context

This study was conducted in northern Sweden with publicly funded psychiatric emergency services open
during limited times of day and psychiatric consulting services available at the general ED. Swedish general EDs and PEC employ enrolled nurses/emergency medical technicians, registered nurses, specialist nurses, and (in EDs only) physicians.

Participants
Participants were recruited purposively through mental health professionals and advertisements in waiting rooms at mental health services (Brinkmann & Kvale 2014). Potential participants were informed about the study by mental health professionals. A few interested people contacted the authors themselves; the others allowed mental health professionals to forward their contact information. The authors, who did not know how many declined the first request, provided 12 interested recruits with more information about the study and its voluntary nature. Of these, 11 (7 women and 4 men) aged 23–86 years (median 49) participated, while one declined for an unknown reason. Self-reported diagnoses included emotionally unstable personality disorder, post-traumatic stress disorder, phobic personality disorder, anxiety, depression, schizophrenia, bipolar syndrome, obsessive-compulsive disorder, burnout, attention deficit hyperactivity disorder, and (for one participant) ‘unknown’. Participants’ numbers of visits to GEC ranged from one to three (n = 2), through four to seven (n = 4), to eight or more (n = 5). Their last visits were as recent as 1 week ago and as long ago as 16 years. Reasons for seeking GEC included cardiovascular disease, allergic reaction, suicidal intention, self-inflicted injury, anxiety, back pain, and bile, stomach, and intestinal disorders.

Data collection
The first author conducted individual semi-structured interviews from April to October 2019 (Brinkmann & Kvale 2014). Interviews were conducted in the participant’s home or at the university and lasted 29–104 min (average 60 min). No relationship was established before the study. An interview guide was used with five pre-defined open-ended questions such as ‘Can you tell me about your experiences of being cared for in general emergency care?’ and ‘Can you tell me about a meeting you experienced as positive/negative?’ The questions aimed to explore the participant’s experiences of their encounters with GEC staff. Follow-up questions were asked to encourage participants to clarify or develop their answers. Interviews were audio-recorded and transcribed verbatim.

Analysis
The qualitative content analysis involved a systematic interpretation of the textual and underlying content. An inductive approach was used to search for patterns, similarities, and differences (Graneheim et al. 2017; Graneheim & Lundman 2004; Lindgren et al. 2020). We first read through the interviews several times to get a sense of the whole. In the next step, we imported the transcripts to the analytic software MAXQDA (2020) and divided the text into meaning units relevant to the aim, which were condensed and labelled with codes. The first, second, and fourth authors discussed and reflected upon the codes and divided them into two domains: positive and negative encounters. We sorted similar codes into groups, then abstracted and interpreted them into subthemes, themes, and a main theme. For example, codes such as my perspectives were requested, my experiences were valuable, and staff cared about my answers were grouped, abstracted, and interpreted to form the subtheme feeling listened to, which was subsumed with related subthemes under the theme recognize me, which together with two other themes formed the main theme, acknowledge me as a capable person. All authors discussed the analysis until consensus was reached.

Ethical considerations
The project received ethical approval from the Regional Ethics Review Board (Dnr: 2017/284-31; 2019-00028), and the study was conducted according to the Helsinki Declaration’s ethical guidelines (World Medical Association 2013). The participants were informed about the study’s purpose, the advantages and disadvantages of participation, and their right to withdraw at any time, and they gave their informed consent. The authors acknowledged that the interviews could bring up unpleasant memories, and the interviewer observed participants’ reactions to identify such moments and respond as necessary. If needed, the interview could have been interrupted to give the participant opportunity to talk to the interviewer about the situation. However, this was never necessary during these interviews. The participants were also informed about the possibility of contacting the interviewer afterwards if the need arose. Nevertheless, while unpleasant memories may be difficult to face, participants may also value the opportunity to talk about their experiences to someone who is committed to listening attentively (Biddle et al. 2013; Lea Gaydos 2005).
RESULTS

The study resulted in seven subthemes abstracted and interpreted into three themes and one main theme describing how people with mental ill health experience their encounters with GEC staff (Table 1). Representative citations from the participants, identified by numbers, were included to illustrate the subthemes.

Acknowledge me as a capable person

The results show that encounters between people with mental ill health and GEC staff can be expressed by the main theme **Acknowledge me as a capable person**. The three themes recognize me, don’t ignore me, and don’t dismiss me represent different aspects of the main theme. People with mental ill health want to be recognized, listened to and acknowledged as capable persons with valuable knowledge about themselves. They do not want to be treated differently to others because of their mental ill health, or to be ignored or dismissed by GEC staff. These themes capture both positive and negative experiences, with examples from people who had had their needs met and felt cared for (recognize me), and from those who had not (don’t ignore me; don’t dismiss me). Small things, such as a kind gesture or a brusque tone, seemed to make a great difference, for better or worse, in these encounters.

Recognize me

The theme recognize me comprises the participants’ descriptions of collaborative and trustful relationships with staff who listened to them and valued their experiences and knowledge about themselves. Recognize me also encompasses the participants’ narratives about feeling a shared humanity with genuine and engaged staff who treated them as unique individuals.

Feeling listened to

The participants described experiences of feeling listened to and taken seriously by non-judgemental GEC staff. When staff reasoned with them, embraced what they said, and showed interest in their views and experiences, participants felt listened to, which made them feel valued and treated as equals.

They [the GEC staff] were present and focused, and it felt like they wanted an answer when they asked me questions. They cared about the answer and listened while still maintaining their professionalism. I guess that is a way to be treated as a person. (3)

The participants spoke of ‘competent’ staff who conducted thorough examinations, asked appropriate questions, and documented what was said in the medical record. Participants said that when they felt listened to, they gained confidence in the staff’s knowledge, skills, and decisions, which led to their developing trustful relationships and feeling they were in safe hands.

When you [staff] listen to me and process what I say, then you are the expert, and I listen to you... because I trust that you are the expert; you know best and also want the best for me. (5)

Feeling listened to made participants feel respected and empowered to make decisions about their care. They described it as collaborating with knowledgeable professional staff who valued the participants’ own self-knowledge. GEC staff who provided accurate and adequate information about treatments and measures and who presented choices were perceived to enable shared decision-making.

The participants described GEC staff who listened as being fully present. Staff who prioritized spending time with them, maintained eye contact, and sat down and showed genuine interest contributed to their feeling listened to and taken seriously. *When I feel like you are here, you listen to me, I am significant, and it is just those really small things that make a big difference*. (5) They considered it essential for staff to take the time to listen, to understand their situation in full, and especially to stay in their room with them, not just to perform measurements or monitor them. Participants who had not felt listened to or taken seriously described feeling relieved and grateful when they finally met GEC staff who listened to them and

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<td>Feeling listened to</td>
<td>Recognize me</td>
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<td>Feeling unheard</td>
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<td>Feeling mistrusted</td>
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TABLE 1 Overview of results by subtheme and theme
understood their needs. ‘I would have wanted to give him [the physician] a big bouquet because he saved my life’. (7).

Feeling unique
In this subtheme, participants reported encounters with GEC staff they perceived as genuinely interested in them. ‘It felt so genuine, not that it was his [the GEC staff’s] job to be there and act nice, but as if he really was interested’. (4) A genuine meeting was described as authentic and natural, often emerging immediately with compassionate staff. Participants described being met by GEC staff who were genuine, compassionate, warm-hearted, and kind made them feel cared for, supported, and safe. They also emphasized that ‘courageous’ staff, whom they perceived as personable and humane in the meeting, made them feel recognized as unique individuals. ‘... it becomes personal and... they do not generalize so that you are just one in the crowd’ (8). These staff members were considered approachable, open, and caring. The participants said it was helpful to have casual chats or small talk with staff about things other than their problems or their care. Sharing a laugh with staff who had a sense of humour could reduce tensions in the meeting. GEC staff who seemed optimistic and easy-going and who introduced themselves by name created a good atmosphere and made participants feel comfortable. ‘I think it is essential that they are easy-going, because if they are a little too serious when they enter, you can feel devalued without them saying anything’ (4).

Small gestures from staff such as expressing hope, making sure they were warm and comfortable, and peeking into the room now and then contributed to their feeling cared for. They also felt acknowledged by staff who gave them information and updates during long waits in the ED, arranged adequate follow-ups, and took preventive measures before sending them home.

Don’t ignore me
The theme don’t ignore me includes participants’ descriptions of feeling ignored by staff who did not acknowledge their perspectives or involve them in decisions about their care. It also includes narratives of feeling neglected by staff who were absent-minded or non-responsive in their treatment and their desire to be met by gentle staff who acknowledge them as competent persons.

Feeling unheard
The participants described feeling ignored by staff who neither listened to nor heard what they said, did not accept their views, or did not involve them in decisions about their care. Small gestures by staff such as avoiding eye contact, walking around the room, or gazing at the clock during the conversation contributed to participants’ feeling they were not listened to, which fostered feelings of being ignored, diminished, or thought stupid. GEC staff perceived as not listening, who dictated what their problems were rather than considering the patients’ own thoughts about their health issues, were described as absent-minded or authoritarian.

You want to have a conversation; that is what everyone wants. No one likes [it] when someone comes in and bosses you around and speaks on your behalf: ‘Now we will do this and this and this’. (7)

Participants also described times when they felt rejected by GEC staff, were not medically examined or assessed, and were sent home with continuing problems. They expressed the feeling that ‘you have to be dying’ (9) to get help. Participants described trying to bring relatives or friends with them to the ED to ensure they would get proper care or to dispute a physician’s decision and said it was challenging when their perspectives were not valued. They also described feeling unwelcome, insignificant, unworthy of care, and less important than other patients. The pre-existing negative thoughts and feelings they already struggled with were reinforced in such encounters, and they wondered whether it was even worthwhile for them to seek care. They expressed a desire to be trusted by GEC staff as competent people with valuable experiences and knowledge about themselves.

Feeling neglected
Participants in this subtheme reported an increase in their sensitivity to stress when GEC staff acted quickly and were in a hurry, particularly when they were struggling with their mental health. They were concerned about omitting important information when they perceived that staff had no time to listen. It was crucial to them to feel that staff had time, since they could not always express their needs quickly. However, participants appreciated GEC staff’s high workloads and efforts to do their best under prevailing conditions. Staff who seemed stressed were described as absent-minded and more impersonal in meetings, which could leave patients feeling neglected.
Now they are just going to hurry; now they are just going to send me away, they just want to get rid of me. Because this is what is triggered in my head; they just want to get rid of me, I am just difficult, I am worthless, I should not live. (6)

Participants noticed when staff went on ‘autopilot’ and were emotionally turned off and were hurt by those who were unpleasant, rude, harsh, or insensitive. GEC staff who were non-responsive or brusque were even more harmful when participants were experiencing mental ill health. Participants emphasized the importance of staff being careful and gentle in those situations.

Don’t dismiss me

The theme don’t dismiss me comprises the participants’ narratives of being treated differently to other patients. It includes participants’ descriptions of feeling judged by staff who underestimate their ability to understand their own health issues. It also encompasses experiences of staff who avoided asking or talking about mental ill health due to their own discomfort or in an effort not to complicate things.

Feeling judged

Participants felt they were not taken seriously when they sought care for physical health issues. They had experiences of GEC staff shifting their attention from the physical symptoms to their mental ill health or looking for psychosomatic causes. They know you have psychiatric problems, and then they classify you as “psychiatric” (9). According to the participants, staff often attributed their physical symptoms to anxiety and explained how anxiety felt and could manifest itself, even though these persons had lived with anxiety their entire lives. ‘It is as if [mental ill health] is the only thing that exists. You can enter with a broken arm, and they’ll still ask you if it’s just anxiety’ (8).

Participants experienced being talked to as though they were less knowledgeable and felt that staff underestimated their ability to understand what was happening. They also described becoming discouraged, doubting themselves, and beginning to think that the problem might be ‘all in their head’ after all, especially if a physician claimed this was the case. One participant said that some physicians wanted to be ‘Sherlocks and solve the mystery themselves’ and reacted as if patients had ‘stepped on their toes’ (10) by offering their own suggestions about the health issue.

Participants reported that GEC staff often mentioned their psychiatric diagnosis very early in the medical record, even when they had come for physical care. For example, notes on a patient being physically examined after a car accident began with, ‘The young woman with borderline...’ (5). Furthermore, participants seeking care for self-harm injuries described meeting judgemental GEC staff who pointed out that they ‘had themselves to blame’ or that ‘it was stupidly done’ (4). One participant reported having staff turn away from them and talk to their companion instead, making them feel they had been declared incompetent.

People [staff] must think that you are stupid because you bring someone with you; that is the idea you get: that you are unintelligent or that there is something wrong with you, which means they cannot address you directly. You get a thousand times sicker than you really are, and it is offensive... degrading. (6)

The participants feared being judged and were uncertain about how their care would be affected if they told GEC staff about their mental ill health. Based on previous negative experiences or stories from others about adverse treatment in health care, they sometimes chose not to disclose their mental health. When they did reveal their mental condition, they felt even more vulnerable and exposed, ‘as if you have taken down the protective shields that you normally have raised’ (10). Participants reported that any hostile treatment after they mentioned their mental ill health would raise their threshold for future disclosures and increase their sensitivity to their treatment. Participants also recognized that not mentioning their mental ill health might leave GEC staff unable to form a complete picture of their situation. Small things such as a glance, a word, or a sentence could make a big difference in how they felt treated and whether or not they would discuss their mental health.

Feeling mistrusted

Participants described encountering GEC staff who disbelieved them and suspected they were imagining things or making them up when they sought care for physical health issues. They reported feeling seen as hypochondriacs and having to seek care repeatedly, sometimes several times in a week, before getting any actual help. ‘She [the physician] also thought I was just acting, even though I was lying there and could barely breathe [from the pain]’ (7). Not being believed was experienced as diminishing; some participants described feeling insulted and angry; others said they...
Participants with frequent visits to the ED reported that staff commented on how often they were there and sometimes seemed tired of seeing them. Occasionally, they felt criticized for seeking care, which left them reluctant to interact with the staff. Small behaviours and gestures from staff such as questioning looks, offhand comments, jokes about their frequent visits, or lack of recognition and greeting despite previous meetings made participants feel insecure and uncomfortable. Such negative treatment could easily become etched into participants’ memories and reactions and raise their threshold for seeking care.

Feeling avoided
Some GEC staff were described as being cautious about or even avoiding talking or asking about mental ill health. The participants perceived this avoidance as a signal of their discomfort or wish not to complicate what could otherwise be construed as a simple situation. For example, they described GEC staff who focused on their diagnosis or wound but did not ask how they were feeling.

It is a rather strange experience to be sutured, for example, and one who sutured me said, ‘Well, you have a very good skin healing’. I guess she needed to talk about something to break the silence. There was not much I could add about that. (6)

One participant described feeling like an inconvenience when GEC staff who had been called in response to suicidal intentions were completely silent for the entire 30-minute ambulance trip. ‘It felt like I had called and taken someone else’s ambulance, someone who needed it more.’ (11) Participants assumed that staff lacked training and knowledge about mental ill health, making it difficult for them to communicate with staff and make themselves understood. Some participants said GEC staff should ask and talk about mental ill health to get the whole picture, make a reliable assessment, and provide more individual and optimized treatment. ‘If you do not have all the pieces of the puzzle, it is difficult to understand it... Dare to ask, and explain why.’ (10).

DISCUSSION
We aimed to describe how people with mental ill health experience encounters with GEC staff. Our results report the importance of people with mental ill health being acknowledged as capable persons, and how this relate to their experiences of being recognized, ignored, or dismissed by GEC staff. Previous research shows that GEC staff find it difficult to care for people with mental ill health, mainly due to their own lack of knowledge, training, and time. This study adds that it may not be that difficult or time-consuming to create decent and supportive encounters. Our results show that seemingly small things can make a significant difference, for better or for worse, in interactions between GEC staff and people with mental ill health. In mental health nursing, such small things have been noted to have an essential impact on a person’s sense of self and seem to be an effective, but barely visible, part of recovery-oriented care (Topor et al. 2018). The following discussion considers the results through the lens of recovery-oriented care.

Recovery-oriented care aims to empower people to be aware of themselves as the centre of the care they receive and includes listening to, learning from, and acting upon what’s important to them (Australian Government: The Department of Health 2010). Meaningful person–provider interactions may be the most significant aspect of emergency care in the experiences of people with mental ill health, who mainly want staff to listen to them, confirm their distress, and respect their needs (Clarke et al. 2007; Meehan et al. 2020). Being listened to is an essential component of meaningful interactions (Shipley 2010), although Kagan (2008) claims that listening is a ‘concept that can become obscured by its location as presumably commonplace, routine, and ordinarily embedded in person–person interactions’ (p. 110). Our results report experiences of feeling both listened to and unheard. These feelings were reinforced by seemingly small things that had either encouraging or discouraging effects on the participants. Encouraging things have been described as small but helpful gestures or acts of kindness that make the person feel recognized (Harris et al. 2016; Meehan et al. 2020). Signs of recognition include frequent eye contact, touching, speaking directly to the person, having a dialogue, and not interrupting (Cisna and Sieburg 1981). These things can make ‘an individual feel both more human and valuable, a person who means something for someone else’ (Borg &
However, according to Skorpen et al. (2015), staff seem not to pay enough attention to the significance of the small, ordinary-seeming aspects of their daily work that could have an extraordinary impact on someone in a vulnerable position. When they are genuine, small things such as gestures, actions and comments may support the recovery and well-being of people with mental ill health (Harris et al. 2016; Topor et al. 2018). The ‘genuineness’ of these small things seems to be decisive in their effect on the person (Topor et al. 2018).

Participants in our study reported feeling treated differently to others when seeking GEC for physical health issues. They felt they were not listened to and were met with prejudice and mistrust because of their mental ill health. Happell et al. (2016) also reported that people with mental ill health feel that they are not taken seriously and are viewed as incompetent, lacking in insight, and unable to make health decisions because of their mental ill health. Physical symptoms are often interpreted as reflecting mental rather than physical health, despite general awareness of the higher prevalence of physical health problems among people with mental ill health (Happell et al. 2016). Other studies have also reported people with mental ill health being labelled as ‘psychiatric’ regardless of their current health issue, being disbelieved, or having their medical concerns dismissed (Clarke et al. 2007; Wise-Harris et al. 2017). Our study adds that people with mental ill health want GEC staff to collaborate with them and acknowledge them as experienced people with valuable knowledge about themselves. According to Bird et al. (2014), redefining or rebuilding a positive self-identity that includes overcoming stigma and viewing oneself as more than just a diagnosis could be an essential part of recovery. This process can be supported by staff who are open to different dimensions of identity and treat the person as unique (2014). Slade (2013) suggests that to support recovery, staff need to be active in seeking leadership from the person and acknowledging that their own perspective is one way, but not the only way, to understand the person’s experience. According to Waldemar et al. (2019), equal collaboration, choice, and patients’ preferences are recovery-oriented principles reflected rhetorically in effective person–provider interactions. However, these principles often conflict with institutional procedures and may be overruled by competing demands (2019). Our findings suggest that to support recovery in people with mental ill health, GEC staff should acknowledge them as capable and resourceful persons and treat them as equal and unique. Staff must be able to listen without prejudice, treat the person with respect, and show genuine interest. Staff also need to know how small helpful things such as words, gestures or acts of kindness can make an important difference.

**Methodological discussion**

To ensure trustworthiness, we reflected on the credibility, dependability, and transferability of our method. We consider our sampling strategy and data collection method appropriate to the aim of the study, which strengthens its credibility. Participants’ ages and self-reported diagnoses varied widely, and the rich interview data revealed a variety of experiences, although women were overrepresented. We considered the possibility of recall bias in experiences reported 16 years later, but those experiences were likely very significant to have been remembered so clearly. Those older experiences did not stand out from the others, however, and were included equally in the study.

We have continuously reflected upon any preunderstandings that may have influenced the questions asked during the interviews and how we interpreted and analysed the participants’ statements. Including the research team in the interpretation was one way to increase dependability, as interpretation may vary between researchers. All authors collaborated on the study and discussed and reflected carefully on all parts of the research process. However, following Krippendorff (2013) and acknowledging that a text never entails just one meaning, we present our interpretation as the most probable meaning of the data. To show the connection between the data and the results, which aim to reflect the participants’ voices, we included quotations from different participants under each theme. With some exceptions, we chose not to specify in the results the occupational category of the GEC staff members discussed by the participants. This might be considered a limitation. Our intention, however, was not to compare patient experiences of different professions, but to shed light on the interpersonal encounter between two humans. GEC staff directly involved in patient care were therefore included equally to gain a more holistic understanding and maintain our focus on the participants’ experiences.
The different phases of the study, its context, and the selection of participants have been thoroughly described. It is up to the reader to decide whether the results are transferable to other contexts.

CONCLUSIONS

People with mental ill health want to be listened to, taken seriously, and acknowledged as capable persons with valuable knowledge about themselves. They do not want to be treated differently to others because of their mental ill health or to be ignored, judged, mistrusted, or dismissed. They wish to meet with staff who are genuinely interested, respectful, and willing to treat them as equal and unique. Small things seem to make a significant difference in the encounter and have the potential to either encourage or discourage the person and help or hinder their recovery. Thus, GEC staff need to know the significance of even a small, seemingly ordinary aspect of a routine interaction – a gesture, a look, a tone of voice, just one extra minute – that might easily be overlooked, but that could make a major difference to someone in a vulnerable position.

RELEVANCE FOR CLINICAL PRACTICE

It is important for GEC staff to develop their understanding of how small interactional things can contribute to meaningful person–provider interactions and support the recovery and well-being of people with mental ill health. It may also inspire GEC staff to know that meeting the needs of people with mental ill health with openness, empathy, and respect need not be difficult or time-consuming. However, questions remain regarding GEC staff’s perceptions of meeting and caring for people with mental ill health and we propose further research.

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ETHICAL APPROVAL

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