Journal of Mental Health

ISSN: 0963-8237 (Print) 1360-0567 (Online) Journal homepage: www.tandfonline.com/journals/ijmh20

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To cite this article: Eva Biringer, Larry Davidson, Bengt Sundfør, Haldis Ø. Lier & Marit Borg (2016) Coping with mental health issues: subjective experiences of self-help and helpful contextual factors at the start of mental health treatment, Journal of Mental Health, 25:1, 23-27, DOI: 10.3109/09638237.2015.1078883

To link to this article: https://doi.org/10.3109/09638237.2015.1078883

Journal of MENTAL HEALTH

http://tandfonline.com/ijmh
ISSN: 0963-8237 (print), 1360-0567 (electronic)

J Ment Health, 2016; 25(1): 23–27
 DOI: 10.3109/09638237.2015.1078883

Routledge Taylor & Francis Group

ORIGINAL ARTICLE

Coping with mental health issues: subjective experiences of self-help and helpful contextual factors at the start of mental health treatment

Eva Biringer[1,2], Larry Davidson[3], Bengt Sundfør[2], Haldis Ø. Lier[1], and Marit Borg[2,4]

[1]Helse Fonna Local Health Authority, Haugesund, Norway, [2]Regional Research Network on Mood Disorders (MoodNet), Bergen, Norway, [3]Department of Psychiatry, Yale University School of Medicine, New Haven, CT, USA, and [4]Faculty of Health Sciences, Buskerud and Vestfold University College, Drammen, Norway

Abstract

Background: Self-help strategies and various contextual factors support recovery. However, more in-depth knowledge is needed about how self-help strategies and supportive environments facilitate the recovery process.
Aims: To explore what individuals who have recently been referred to a specialist Community Mental Health Center experience as helpful and what they do to help themselves.
Method: Ten service users participated in in-depth interviews within a collaborative-reflexive framework. A hermeneutic-phenomenological approach was used.
Results: Participants described a variety of helpful strategies and environmental supports. Four relevant main themes were identified: helpful activities, helpful people and places, self-instruction and learning about mental problems and medication and self-medication.
Conclusions: The process of recovery is initiated before people become users of mental health services. This study confirms that recovery takes place within the person's daily life context and involves the interplay of contextual factors, such as family, friends, good places, work and other meaningful activities. The coping strategies reported may represent an important focus for attention and clinical intervention.

Keywords

Mental health, recovery, coping, self-help, self-management, psychosocial

History

Received 22 December 2014
Revised 29 April 2015
Accepted 2 July 2015
Published online 14 October 2015

Introduction

The journey of recovery is typically described as subjective and unique and does not necessarily take place in the therapist's office but rather within the context of the person's everyday life (Borg & Davidson, 2008). It is a process that is comprehensive and involves individual, social (Mezzina et al., 2006; Schön et al., 2009; Slade et al., 2012; Topor et al., 2006, 2011), and material factors (Borg et al., 2009). Earlier research involving service users with severe mental problems showed that work (Borg & Kristiansen, 2008; Borg et al., 2013), meaningful activities (Salzmann-Erikson, 2013), positive life events (Davidson et al., 2006), and active self-help strategies (Deegan, 2005; Lam et al., 2011; Schrank et al., 2012) may all be crucial elements in recovery.

As one example of self-help strategies, Mayes recently described how her various methods of self-care took her mind away from her problems, increased her self-esteem, and made her feel hope and optimism (Mayes, 2011). In a narrative review, including 20 qualitative studies, Lucock et al. (2011) found that people used a wide range of self-help strategies in their everyday struggle to cope with their mental health symptoms. Creative activity, physical exercise, healthy living, structured routine and spirituality were all perceived as helpful (Lucock et al., 2011).

Most of the recovery research has been conducted in the United States and United Kingdom (Schön & Rosenberg, 2013; Slade et al., 2012). With the exception of evaluations of self-care groups and networks (Aglen et al., 2011), there has been limited research on everyday self-help or coping strategies in the Nordic context, but Borg & Davidson (2008) found that taking active roles, participating in social contexts, working and having regularity in activities, finding pleasure in ''small'' things, and having sources of motivation and hope were important for recovery. Further, the role of family, friends, carers (Mezzina et al., 2006; Schön et al., 2009; Topor et al., 2006), and work (Borg & Kristiansen, 2008; Borg et al., 2013) in recovery has been studied in the Nordic context. Most of these studies have involved participants who had severe mental health issues with long-term contact with mental health services. However, we argue that the questions of what is helpful and what people do to help themselves should also be asked before treatment because developed coping strategies represent important factors of resilience that may be very valuable for recovery. This is particularly true given that they are acknowledged and actively used by the service user and any professional helpers.

Correspondence: Dr. Eva Biringer, Helse Fonna Local Health Authority, P.O. Box 2170, N-5504 Haugesund, Norway. Tel: +47 52732700. Fax: +47 53491003. E-mail: eva.biringer@helse-fonna.no

Therefore, within a collaborative-reflexive framework, the present study explores what individuals who have recently been referred to a Community Mental Health Centre (CMHC) in Norway experience as helpful and what they do to help themselves in their daily struggle of dealing with mental health issues. This latter part includes what the individual does to feel better, strategies the person uses to overcome obstacles caused by mental health issues, and what he or she does to promote positive changes in life in the long run.

Methods

Setting

The study took place at a Norwegian CMHC that provides mental health services to four communities, covering a population of about 34 000 inhabitants. The CMHC has out-patient clinics, outreach teams doing home visits and two in-patient units for adults in addition to child and adolescent mental health services. Treatment at the outpatient clinic most often involves regular meetings with a health professional (psychologist, psychiatrist, mental health nurse, occupational therapist or social worker) in their office over a period of time. Most often, the first meetings are used to explore the service users problems, later the service user and the health professional work together to find solutions to the problems by means of specific psychotherapeutic approach, medications and counselling with regard to practical issues and life style changes.

Participants

Ten participants were recruited by their health professional at the CMHC at their first consultation. All participants provided written informed consent. The study was approved by the Norwegian Social Science Data Services (ref. no. 22920/2).

Participants ranged from 18 to 53 years of age (five out of the ten were younger than 30 years), four were female, and six were male. Mean time since they first sought help for their mental health problems was 2.6 years (range 0–7 years, two missing information). Three were inpatients and seven outpatients. All seven outpatients used the adult specialist ambulatory services for the first time, but two had previously been treated in the child and adolescent specialist services. Of the in-patients, one was admitted for the first time to a mental health institution, one had one previous stay at another CMHC, and one had several previous stays in psychiatric wards. At the time of the interview, the number of consultations by the seven who were attending the outpatient clinic ranged from 0–6 (mean 3), while the inpatients had a mean stay of 29 days on the ward. Self-reported mental health problems varied among the participants: several reported anxiety and depressive symptoms, one suffered from chronic bodily pain, two had psychotic symptoms, one reported alcohol addiction and anxiety, and one reported a combination of alcohol addiction and addiction to other substances.

Data collection and analysis

Acknowledging that the journey of recovery is subjective and unique and that the person's historical background and own pre-understandings are central, a hermeneutic-phenomenological (Giorgi, 2009; Laverty, 2003) and user-involved (Beresford, 2013) approach was chosen. Two of the researchers (MB, EB) who planned and performed the study had professional backgrounds in mental health care. Being aware of the danger of how their preconceptions and attitudes could affect questions asked and conclusions drawn, reflexive collaboration and exchange of ideas with service users was emphasized throughout the entire research process (Giorgi, 2009; Laverty, 2003; Moltu et al., 2013). The aims of user involvement in the present study were, within a reflexive-collaborative framework, to build trust and increased accessibility to the phenomena explored, and to provide support to the participants in terms of understanding what the study was about and the meaning of interview questions. To secure relevance and ecological validity of results, the semi-structured interview guide was developed and piloted with the ''expert-by-experience'' panel of MoodNet, a regional research network in western Norway (Moltu et al., 2013; Veseth et al., 2012). The panel included 12 co-researchers with lived experience of mental health issues. In addition, a co-researcher with lived experience (BS) actively took part in the interviews, analysis of results, discussions, and writing of the manuscript.

The individual in-depth interviews were undertaken at the CMHC, although all participants were invited to choose alternative places. Participants were asked open-ended questions about what they perceived as helpful and what they had done to help themselves in their everyday life. Interviews were audiotaped and transcribed ad verbatim.

We used a data-driven stepwise approach in line with thematic analysis to identify, analyse, and report patterns or themes in data (Braun & Clarke, 2006). Searching for patterns and meanings, the main author systematically coded all text material using N'Vivo 9.0 (QSR International Pty Ltd, Victoria, Austraila). During a two-day workshop in December 2013, three members of the research group (BS, MB, EB) reviewed these preliminary codes and refined them into a thematic map found appropriate by all members of the group. The coded material within the nodes ''What helps'' and ''Self- help'' was read and then analysed and discussed. As we were aware of the risk that the group members' own involvement and pre-understandings could impact interpretations based on the material and conclusions drawn, we aimed at having a reflexive dialogue in which the group members discussed various interpretations of data thoroughly before reaching a common understanding about constructs underlying the material and agreement about categorization of contents. During these discussions, the group members' pre-conceptions and interpretations about semantic and latent constructs underlying the material frequently was challenged by the other members of the group. To ensure internal validity of findings, the results were compared with the original transcripts and a few minor revisions were made.

Results

The participants all described an active and resourceful everyday life in which they had helpful and supportive people and environments. They described specific activities and

creative coping strategies that helped them alleviate inner pressure, forget problems, and gain inner peace. Through the analysis, the four following themes were identified: helpful activities, helpful people and places, self-instruction and learning about mental illness and medication and self-medication.

Helpful activities

Several participants went to work, were in education, or at least tried to keep up with their daily domestic tasks and routines. These activities helped them sustain their everyday healthy lives. Music, physical exercise, work, taking nature walks and other activities were often mentioned as having helped participants feel good and relieve symptoms and problems. Some spoke about how they deliberately used physical exercise in order to relieve inner pressure and reduce aggression, inner tensions, and sleep problems and to keep mental focus away from symptoms and everyday troubles.

> *P*10: I work out a lot . . . It's a good way to switch off . . . You sort of get started . . . I get rid of a bit of energy.

Some younger male participants mentioned computer games as a tool for keeping their focus away from their problems. One young man stated: ''Computer games . . . Yes they work! . . . because I go into a different world!''. Many participants listened to music in order to calm down and find inner peace. One participant composed her own music and used music as something she could fall back on when she was particularly depressed.

> *P*2: Music . . . I have always found peace in music . . . I make music myself, I sing, play guitar . . . I play most instruments. It has been something for me to fall back upon . . .

Several participants had regular contact with animals and used this contact as a source of comfort. A middle-aged woman who enjoyed long walks with her dog in the woods said she prioritized her dog above her own well-being. For instance, she once declined a place in a rehabilitation program because she did not want to leave her dog with strangers. Another woman with social anxiety and extensive cannabis use said the following about how contact with a horse helped her calm her feelings:

> *P2*: I have always really loved horses, because I've always felt more at ease around big animals . . . They don't judge you, they don't answer back . . . but at the same time they trust you.
> *EB*: Can you talk about your feelings when . . .
> *P2*: So much more than I manage to face people . . . Horses and dogs, they're like . . . you don't need to say anything either, for they like, they just look at you, and they kinda know . . .
> *BS*: Yeah . . . Also they appreciate that you are there . . .
> *P2*: Yeah, that you're there . . . just that you're there . . .
> *BS*: -Imagine if it was like that among us people as well . . .

Helpful people and places

Almost all participants felt that spending time with others, such as family or friends, or being in places that made them feel good was helpful.

> *P8*: It is good, you have to socialize with people, because there are people in the world and you can't sit in your room all the time.

Being in other places was also used as an alternative to settings with alcohol or drugs. For instance, one participant who had been abusing alcohol and drugs for some time found his regular twice weekly visit to the local church charity center a positive experience as the visit provided ''fresh air'' and a chance to talk to people. Going to places for social activities was also described as helpful. These included walks or to the gym, visiting friends or family and full- or part-time work. Being with others made them forget their problems, and the support and encouragement that others provided were useful in dealing with problematic issues. Talking to others about everyday challenges offered new insights, and solutions to problems were frequently illuminated.

Self-instruction and learning about mental health problems

Self-instruction techniques were used to keep negative thinking and problems at a distance.

For instance, a young man with psychotic experiences who felt that thinking positively was helpful in the long run used to repeat to himself like a mantra:

> *P10*: Today I am feeling good! . . . I am used to this. Today I am feeling good!

Several of the informants felt that seeking information and gaining knowledge about their conditions had been helpful in dealing with their problems. For instance, one of the participants, a man diagnosed with a bipolar spectrum disorder, had sought information through several sources and had managed to diagnose himself before his first contact with mental health care. The information he gathered had been useful as it helped him handle his mood swings, but it had also been useful in explaining his behaviour to his partner. He and several other participants had developed strategies that they used to prevent relapses based on their own experience. These included a regular lifestyle with sufficient and regular sleep, rest, and pauses and avoiding excessive work and stress. Regular meals and physical activity were also common strategies to avoid mood swings or worsening of symptoms:

> *P4*: It is actually quite important . . . Not running myself completely down . . . With sleeping and stress and drinking. It is those three things that are important. They dictate in a way fluctuations and mood, which, yeah, which go up and down.

Some participants described early warning signals; for instance, a woman who had had several psychotic episodes remarked:

> *P8*: I see shadows and things on the wall . . . [They] appear shaped like a man or just like light, how should I say it, circles or, yes . . . Then I think that I'm sick and should be [admitted].

Whenever she experienced these shadows, she immediately phoned her therapist and asked to be admitted to the ward.

Medication and self-medication

Several of the participants reported that they had occasionally used alcohol, cannabis, or other illegal drugs as ''self-medication'' in order to rid themselves of anxiety and inner tension. However, all these individuals felt that alcohol or drugs only provided temporary relief, as explained by a man with an addiction:

> *P6*: The bottle simply helps me . . . but it is only a temporary relief and after a while things get worse anyway.

Even if the participants were just about to begin treatment at the CMHC, some of the participants had been prescribed medication, for instance, by their general practitioner; however, medication was not a big issue in the interviews. A few informants said that medication helped them sleep, and one participant was surprised that she had become ill despite taking her anti-psychotic medication.

Discussion

This study revealed how service users recently referred to treatment were conscious about their roles as active agents in their own lives. The participants showed strength and creativity as well as self-determination in dealing with the issues that led them to seek care. Most had developed a variety of coping strategies in order to master daily tasks and actively joined activities or social events that made them feel better. Their agency in dealing with everyday challenges revealed that they had hope for recovery and a belief in the possibility of changing their lives and ways of thinking. These findings are in line with those from previous recovery studies saying that re-discovering personal strengths, competence and the experience of one's own mastery are sources of pleasure (Davidson et al., 2006) and highlight the importance of developing those parts of peoples' lives that take place outside their mental problem (Borg & Davidson, 2008; Davidson et al., 2006). This study from a Nordic context of people who are about to start treatment confirms the central elements in recovery, namely that recovery is holistic, strengths-based, focused on empowerment, and involves hope and meaning in life (Andresen et al., 2003; Davidson et al., 2005; Slade et al., 2012). These elements may be just as relevant to people at the start of the contact with mental health specialist services as they are to those who have used services for a long time or have come a long way in their work towards recovery. The participants showed an effective sense of social agency, that is, they seemed to view themselves as persons capable of choosing, initiating, doing and accomplishing things in the world they inhabited along with other people in various contexts (Davidson et al., 2006). This sense of social agency confirms the importance of the social dimension for recovery that has previously been shown (Mezzina et al., 2006; Schön et al., 2009; Topor et al., 2006, 2011).

The concept and perspective of resilience is useful when trying to understand the first phases of mental health issues, self-help strategies, and recovery as it shifts from the illness focus to the whole person in a life context. Common attributes of resilient people are sociability, self-efficacy and having a sense of meaning (Bromley, 2005), all of which were evident in the approaches and attitudes of the participants in the present study. Most of the participants had been referred to treatment for the first time and we believe that the information they provided about helpful places, people, activities, and self-instruction techniques represents valid knowledge (Rose et al., 2006) about coping and resilience factors from the perspective of persons who are in the initial phases of mental health service use. The study highlights an issue that may be self-evident for people in recovery but may not be so for professionals: The process of recovery may have already started before people have become users of mental health services.

The self-help strategies reported by the participants are consistent with findings from studies that have shown that activities help change physical, emotional and cognitive states (Lal et al., 2013) and that meaningful activities and lifestyle modifications are factors influencing recovery (Windell & Norman, 2013) in early phases of mental health distress. The activities specifically mentioned as relieving and helpful in the present study (physical exercise, listening to music, experiencing nature, being with animals and work) have also all been reported as helpful in earlier recovery research (Borg & Kristiansen, 2008; Borg et al., 2013; Davidson et al., 2006; Lal et al., 2014; Lucock et al., 2007) and in the Nordic context (Borg & Davidson, 2008). In addition, the participants' emphasis on a healthy and regular lifestyle and awareness of early triggers and warning signals are in line with earlier studies (Borg et al., 2009; Davidson et al., 2006; Suto et al., 2010; Veseth et al., 2012). Notably, the participants used coping strategies similar to commonly used therapeutic approaches: They experienced that certain activities and strategies replaced bad feelings with positive emotions and they deliberately kept their mental focus away from symptoms and problems by focusing on external objects and tasks and by thinking positively about their situation. These are examples of personal self-help strategies that therapists and service users should acknowledge and together build on in collaborative treatment processes. However, earlier reports from service users state that health care professionals seldom inquire about such personal strategies (Tooth et al., 2003).

Limitations

Through reflexive collaboration with service users during the entire research process, we aimed at expanding our understanding of the lived experience of the participants. This has provided a wider perspective in the research process (Rose et al., 2006). The process of engaging in an ongoing

reflexive analysis, is, however challenging (Finlay, 2002). Two of the researchers who planned and performed the study had a professional background within mental health care, and intersubjective elements may have influenced data collection and analysis. Further, the participants suffered from a wide range of mental health problems, and it may be that including a more homogeneous group would have allowed a deeper exploration of the lived experiences of the participants. We also emphasize that the sample was a convenience sample with a small number of participants included; however, the findings have a certain degree of transferability because the types of mental health issues explored are very common and the study was performed within the typical setting of a CMHC.

Conclusion

People who have just started treatment at a CMHC are trying to make sense of their lives and must be seen and met in this position. They are trying a variety of self-help strategies and environments that facilitate recovery. These developed coping strategies represent valuable personal resources that should be acknowledged and developed by the service user and therapist. As the study was conducted in the typical setting of a CMHC, findings may be relevant for many people struggling with mental health issues and clinicians working in mental health care.

Declaration of interest

This project has been financially supported by the Norwegian Extra Foundation for Health and Rehabilitation/Norwegian Council for Mental Health (grant no. 2010/2/0299) and the Regional Research Network on Mood Disorders in Western Norway (MoodNet).

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