Factual Television Documentaries and Mental Distress: A Narrative Analysis

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ABSTRACT

Introduction: The media is the main information source about mental distress and influences people's meaning-making. Overall, biomedical narratives of mental distress and portrayals of dangerousness have mainly been depicted. Print media is the most researched genre overall while in the realm of non-fictional television, news programmes have been explored the most. Studies have mainly utilised quantitative methodologies and there is a paucity of research on factual television documentaries (FTDs).

Method: A qualitative study which utilised a narrative analysis methodology was conducted to analyse portrayals of mental distress, dominant narratives, counternarratives and absent narratives in two FTDs broadcasted in the UK. Moving visual images were analysed in conjunction with spoken words.

Results: 'Anxiety' is portrayed as a 'condition' with ranges of severity. Psychosocial causes are purported and psychological therapy is portrayed as a means for 'patients' to learn how to manage 'anxiety' themselves. In contrast, 'psychosis' is portrayed as a mental 'illness' which can be triggered by stressful life events and substance use. People who experience 'psychosis' are portrayed as unpredictable and potentially violent, but also victims of negative media portrayals. Interventions such as medication and 'sectioning' are portrayed as necessary and humane. Dominant medical narratives were common to both documentaries, however, the Anxiety documentary also constructed a cognitive-behavioural subnarrative. Counternarratives of resistance/ challenges to interventions were constructed by people who access services (PWAS) in both documentaries. Problem saturated identities were constructed for PWAS in both programmes, and alternative identities were hinted at through visual images.

Conclusions: The study highlighted more differences than similarities in portrayals and narratives constructed for 'anxiety' and 'psychosis'. The potential impact of the documentaries and implications for clinical practice, research, service and policy development and public health campaigns are discussed.

ACKNOWLEDGMENTS AND DEDICATIONS

CONTENTS

1. INTRODUCTION

I first became interested in how the media portrays mental distress when a woman with whom I was working in a mental health setting told me she watched a factual television documentary (FTD) about 'Obsessive Compulsive Disorder' (OCD). The person identified strongly with a particular character, telling me she thought she was "just like them" – unable to dismiss obsessive thoughts and compelled to hoard. She told me she found the documentary helpful, as it normalised her experiences and educated her family, friends and partner about 'OCD', giving them a glimpse into her world, with the hope they would understand her better. It dawned on me the media was perhaps playing a bigger part in people's lives than I had previously appreciated, contributing to how they understood themselves and diagnoses. I became curious about what narratives about mental distress were available to people who access services (PWAS) and the general public in FTDs; henceforth this study was born.

1.1.   Terminology and Definitions

Throughout this thesis, scare quotes are used to emphasise my position in regards to constructs such as mental 'illness' and 'schizophrenia', such that they are not to be taken for granted and are socially constructed. The term 'mental distress' is used in the title and throughout the thesis as it pays respect to those who reject the notion of mental 'illness'. It also takes into account the criticisms of the medical model of mental 'illness' (e.g. Boyle & Johnstone, 2014). However, in my personal and professional experience, I am aware the term 'mental' also has negative connotations and is not agreeable to all people or used in all communities (Fenton & Sadiq-Sangster, 1996). It is also a term embedded in Cartesian understandings of distress, where mind and body are assumed to be separate entities. Rogers and Pilgrim (2010) point out the term 'mental distress' only alludes to the misery experienced by the person themselves and not of others in their relational contexts. Despite its shortcomings, I will use the term but not naively. I will also use the expression 'people who access services' or the

acronym 'PWAS'[1] rather than 'patient' or 'service user' in an attempt to move away from disempowering narratives associated with them. It is also more descriptive and value-free.

1.2. The Influence of the Media

The media is defined as, "the main means of mass communication (television, radio, and newspapers) regarded collectively" (Oxford Dictionaries), and has been shown to be the main information source about mental distress (Borinstein, 1992). Narratives presented in the media not only affect the meaning-making of PWAS (Conrad, 1997) but the mental health system, policy makers (Slopen, Watson, Gracia & Corrigan, 2007) and wider society. According to Lyons (2000), media portrayals of health/illness/disease influence people's ideas, attitudes and behaviours and generate and replicate meanings/metaphors.

1.2.1. Construction of 'Identity'

> "It should be acknowledged that all human beings are meaning-makers who create narratives about their lives and difficulties. Formulations differ from this kind of explanation by being strongly rooted in psychological theory and evidence. Given the widespread dissemination of psychological ideas in the media…this is a relative rather than an absolute distinction" (BPS, 2011, p. 7)

In the above quote, the Division of Clinical Psychology's formulation guidelines (BPS, 2011) advise Clinical Psychologists to recognise people are not devoid of any psychological ideas about their own distress and lives, as they are made available through the media. These ideas may influence the narratives people create about themselves, their experiences and 'identities'. Post-modern notions of 'identity' argue it is formed, perpetuated and revised through social processes (Berger & Luckmann, 1966). One's 'identity' maybe constructed and shaped "through the smooth absorption of a culturally proposed story" (Polkinghorne, 1996, p. 365). Narrative theories assume "…the stories that people tell and hear from others form the warp and weft of who they are and what they do" (Smith & Sparkes, 2006, p. 169). Narratives are "cultural resources" (Atkinson, Coffey & Delamont, 2003) people use to construct their own 'identities' and those of others. It is, therefore, of utmost importance for Clinical Psychologists to be

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[1] This term is preferred by people who form part of the "People's Committee" at the University of East London

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aware of and reflective about what narratives of mental distress are made available to PWAS and the wider public through the media.

1.2.2. Construction of the "Other" and Stigmatisation

Members of society come into contact with other people in their communities symbolically through stories presented in electronic and print media (Hartley, 1996). The construction of people's perspectives towards PWAS is therefore largely influenced by the media. Limiting and pathologising media narratives about PWAS may be restricting or even damaging for them and contribute to 'othering' (Foucault, 1977). The process of 'othering' draws a line between 'us' and 'them' and once this differentiation has been made, inclusion and exclusion of particular groups starts to occur. The result of this might be 'stigmatisation' of the supposed out-group (Lister, 2008).

'Stigma' is defined as "a social construction whereby a distinguishing mark of social disgrace is attached to others in order to identify and to devalue them" (Arboleda-Flórez, 2002, p. 25). Goffman (1963) argues 'stigmatisation' occurs in a social context whereby a person's integrity is tarnished by virtue of not conforming to societal norms. PWAS have blamed the media as a source of stigma (Read & Baker, 1996) and reported to be hurt and offended by media portrayals of mental distress (Dickerson, Sommerville, Origoni, Ringel & Parente 2002). PWAS also report people in their communities acting differently or even hostile towards them because of negative media portrayals about mental distress and some have found media coverage to have a negative effect on their own mental health (Mind, 2000).

Western mental health systems are dominated by psychiatric conceptualisations and practices which contribute to the stigmatisation of people experiencing mental distress. Historically, the biogenetic view of mental illness threatened the preservation of the Aryan gene-pool, and led to compulsory sterilisation and later, the murder of psychiatric patients by gassing and starvation (Johnstone, 2000). Nowadays, diagnostic labelling may contribute to stigmatisation (Link, Cullen, Frank & Wozniak, 1987); the label is thought to become associated with negative stereotypes, leading to discrimination and loss of status (Link & Phelan, 2001). Research has shown biomedical explanations of mental distress do not decrease

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'stigma' and may in fact exacerbate it (Phelan, 2005; Walker & Read, 2002; Pirutinsky, Rosen, Safran & Rosmarin, 2010; Read, Haslam, Sayce & Davies, 2006). Mehta and Farina (1997, p. 416) argue "viewing those with mental disorders as diseased sets them apart and may lead to our perceiving them as physically distinct. Biochemical aberrations make them almost a different species". Furthermore, biomedical explanations for diagnoses such as 'schizophrenia' are taken for granted by the media and presented uncritically, despite academic debates in this area (DCP, 2014). Despite this, media campaigns such as "Time to Change"[2] use the "mental illness is like any other illness" rhetoric in an attempt to decrease stigmatising attitudes towards people experiencing mental distress. The media both reflects and reinforces these taken for granted and deeply entrenched biomedical narratives about mental 'illness' which are offered by those in society who have the power to "direct it and govern it" (Foucault, 1973, p. 165).

1.3.   Relevance to Clinical Psychology

Consequently, it is in psychologists' interest to examine media portrayals. Policies such as "No Health Without Mental Health: implementation framework" (DoH, 2012) forms the wider context from which all mental health professionals should take interest in media portrayals of mental distress. Clinical psychologists could employ "cultural activism" (Lupton, 1999) in their work, by working with the media to democratise knowledge and create change within a wider societal context (Hagan & Smail, 1997). This begs the question how clinical psychologists can go about doing this. Pirkis, Blood, Francis and McCallum (2006) encourage professionals, PWAS, their families and policymakers to engage with media professionals to "minimise negative portrayals and maximise positive portrayals" (p. 536). Likewise, anti-stigma campaigners such as Thornicroft, Rose, Kassam and Sartorius (2007) call for interventions to improve public knowledge about mental distress. However, Harper (2009, p. 52) has argued the quest for more 'accurate' representations of mental distress is a "rather inflexible critical strategy, in which cultural prejudice is sought out and nominated for replacement by psychiatric truth" and it may actually lead to new stereotypes about mental

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[2] http://www.time-to-change.org.uk/mental-health-stigma

distress. Perhaps a more fruitful approach, would be for clinical psychologists to engage with the media and present social causes for mental distress and the effects of inequality (Cooke et al., 2014). However, before embarking on cultural activism, media portrayals of mental distress would need to be critically examined, so we can start to see what dominant narratives are presented as well as counternarratives and absent narratives. This would enable clinical psychologists to illustrate what dominant narratives about mental distress are presented in the media with a view to prompting debate among media professionals to enable them to challenge the status quo, should they wish to take up this position. It would prevent media professionals from taking the most powerful and prevalent narratives about mental distress for granted which would facilitate the empowerment of marginalised voices and narratives.

1.4.   Literature Review

1.4.1. Literature Search

A literature search was conducted using Google Scholar the following databases via EBSCO: Academic Search Complete, Communication & Mass Media Complete, PsycARTICLES and PsycINFO. Appendix 1 contains further details regarding the systematic search strategy.

1.5.   The Media and Mental Distress

People with a diagnosis of 'schizophrenia' are more likely to be victims of abuse than perpetrators (Brekke, Prindle, Bae & Long, 2001), yet they are frequently portrayed as violent and unpredictable in the media. Wahl (1992) reviewed research which examined depictions of mental 'illness' in the media from the 1950s to 1991 and concluded the media mainly depicted people who had labels of severe mental 'illness' and offered negative stereotypes (e.g. unemployable and violent). Even though the move to community care led to an interest in the role of media in depicting positive images of PWAS in the hope of reducing 'stigma' (Cross, 2004), research across different media forms in the 1990s continued to show negative depictions of those labelled with mental 'illness' (e.g. Philo, Seeker, Platt, Henderson, McLaughlin, & Burnside, 1994; Wilson, Nairn, Coverdale & Panapa, 1999) and critical representations were infrequent (Philo,

1996). However, Harper (2009) argues because an association between mental distress and violence has actually been found in some research studies (e.g. Hodgins, 2008), anti-stigma campaigners should engage in analysis and debate about why this maybe so. For example, they could look at contextual factors such as socioeconomic status and how this mediates mental distress and violence. Harper also highlights what we might be seeing in the media is an over-representation of violence due to its audience appeal, irrespective of its possible link with mental distress.

1.6.   Print Media and Mental Distress

Print is the most researched form of media in the arena of mental health. Negative depictions of mental 'illness' (e.g. themes of dangerousness towards 'others' and criminality) remain dominant in international print media (e.g. Coverdale, Nairn & Claasen, 2002; Whitley & Berry, 2013) with 'schizophrenia' most frequently associated with homicide (Nawkova et al., 2012). In the UK, violence towards others and other negative themes associated with mental 'illness' were also noted by Ward (1997) in their analysis of British newspapers. More recently, Clement and Foster (2008) specifically analysed depictions of 'schizophrenia' in newspaper articles in 1996 and 2005 using guidelines to assess 'poor quality' reporting such as the use of stigmatising language. There was no difference in the quality of reporting between the two time points however stigmatising language and stories of violence were more common in tabloid newspapers compared to broadsheets. Similarly, Goulden, Corker, Evans-Lacko, Rose, Thornicroft and Henderson (2011) conducted a longitudinal study of UK broadsheet newspaper articles between the years 1992 and 2008, utilising a content analysis methodology. They found there was an increase in the coverage of mental 'illness' over time, with increased reportage of explanations and people's experiences of mental 'illness'. Interestingly, when stories about understanding mental 'illness' were covered, they were dominated by psychosocial explanations rather than biomedical. The authors categorised story themes as 'good' or 'bad' news; with the former category including stories around understanding mental 'illness', people's experiences of mental distress, 'stigma' and mental health services, and the latter category focussing on stories about dangerousness, suicide and other negative descriptions. Stories about particular

diagnoses such as 'depression', 'anxiety', 'bipolar disorder' and 'eating disorders' mostly fell into the 'good news' category whereas stories about 'personality disorders' and 'schizophrenia' mostly fell into the 'bad news' category and their membership did not change over time. Thornicroft et al (2013) conducted a content analysis of English local and national newspapers between 2008 and 2011 to analyse whether an anti-stigma campaign was associated with changes in journalists' reporting of mental 'illness'. They found increased reporting of anti-stigma issues, but no significant decrease in stigmatising articles. In Canada, Whitley, Adeponle and Miller (2015) conducted a content analysis on newspaper articles over a 6 month period in 2010 and 2011. They found general articles about mental health were more positive and less stigmatising than articles featuring individuals diagnosed with mental 'illness', which featured themes of dangerousness. In the USA, Vilhauer (2015), also conducted a content analysis on a smaller sample of newspapers. The study specifically looked at the portrayal of 'auditory verbal hallucinations'. They found most articles portrayed them as signs of mental 'illness' and rather than experiences which can occur in the general population as well. They were also linked to violence, delinquency and suicidality. Most recently, Mellifont and Smith-Merry (2015) conducted a content analysis on Australian newspapers published between 2000 and 2015 to investigate how 'anxiety' disorders' are portrayed. They found the medical model to be most dominant, with medication being most frequently endorsed. Alternatives to the medical model were featured such as non-medical coping strategies, but these were less frequent.

Rather marginally, there are studies which have moved away from dichotomising media representations of mental distress as accurate/ inaccurate or positive/ negative, instead opting for an analysis of discursive resources and the construction of mental 'illness'. These studies have analysed print media outside of the UK, and criticised the privileging of biomedical explanations and other 'expert' knowledges of 'depression' (Rowe, Tilbury, Rapley & O'Ferrall, 2003; Leo & Lacasse, 2007). Nairn, Coverdale & Claasen (2006) examined the layouts, photographs and stories presented in New Zealand print media in 1997 and concluded the interrelationships between these aspects of the articles served to increase the sense of threat and violence posed by people labelled with a mental

'illness'. Exceptionally, Nairn and Coverdale (2005) analysed the perspectives of PWAS in New Zealand print media. Their voices constituted less than 1% of their entire sample. They depicted themselves as "normal, human and understandable" (p. 286), and talked about feeling stigmatised by media coverage of mental health. Bishop (2001) conducted a narrative analysis to explore narratives depicted in women's magazines about 'eating disorders' from the 1980s to the year 2000 in the United States. He concludes people diagnosed with 'eating disorders' are portrayed as selfish and perfectionistic. The 'disorder' is decontextualised and the role of family in the development of the problem is hardly discussed. The author argues magazines offer a "distorted picture" of the experiences of people with eating disorder diagnoses, divorcing the problem from consumerist discourses. Harper (2009) concurs print media portrayals of mental distress, "…are often embedded within discourses of consumerism, biopsychiatry and individualism…" (p.151).

In summary, the majority of research articles about print media portrayals are embedded in positivist epistemologies utilising quantitative content analysis methodologies, therefore, necessitating more qualitative research in this area. Further, examinations of portrayals of mental distress and other forms of media, such as television are needed (Thornicroft et al, 2013; Whitley & Berry, 2013).

1.7. Television and Mental Distress

1.7.1. The influence of television: empirical research

Television is arguably "the epicentre of public discourse about what it means to be a 'normal' citizen" (Cross, 2004, p.212) and is more likely to influence help seeking behaviours than other forms of media (Kato, Yamanaka, & Kaiya, 1999). Interestingly, television consumers do not think watching television has an effect on their own attitudes and beliefs about mental distress, but they do think it affects other people's attitudes, demonstrating the "third person effect" (Diefenbach & West, 2007). Television consumption has shown to be associated with negative 'attitudes' towards people diagnosed with a mental 'illness'. For example, Granello, Pauley and Carmichael (1999) found undergraduate students whose main information source about mental 'illness' was electronic media (defined as television, video and film), were more in favour of coercive

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interventions, social restrictiveness and social distancing in relation to people deemed 'mentally ill', compared to those whose main information source was university lectures, print media or through a work or familial relationship with someone diagnosed with a mental 'illness'. Granello and Pauley (2000) investigated the amount and type of television programmes watched by the same undergraduate students in their previous study. They found the more television watched, the more coercive interventions were favoured in comparison to sympathetic attitudes and community based care. The authors did not investigate the relationship between watching FTDs and 'attitudes' towards mental 'illness', but they did find watching news programmes was correlated with increased intolerance towards those labelled with mental 'illness'. Similarly, Diefenbach and West's (2007) study found television news consumption associated with a decreased desire to live next door to somebody deemed 'mentally ill'. Angermeyer, Dietrich, Pott, and Matschinger (2005) surveyed a representative sample in Germany and found increased television consumption was significantly associated with an increased desire for social distance from people diagnosed with 'schizophrenia'. This finding was supported by Diefenbach and West's (2007) study. However, the type of television programme was not investigated, therefore, it is difficult to decipher which television genre has the strongest association with negative 'attitudes'. Conversely, no overall significant association was found between newspaper consumption and desire for social distance from people with a diagnosis of 'schizophrenia', indicating television has greater influence than print media. Although the relationship between type of newspaper (tabloid, regional or broadsheet) has been found to be significantly associated with negative 'attitudes', with broadsheet newspaper readers having less desire for social distance than tabloid and regional newspaper readers, causal relationships cannot be inferred from these studies. Minnebo and van Acker's (2004) study challenged these findings as they found "perceived realism" of television images was more important than the amount or type of television consumed. Surprisingly, even direct experience of someone labelled with a mental 'illness' only slightly counteracted the influence of portrayals offered by television. Kimmerle and Cress (2013) found no association between television consumption and negative attitudes towards mental 'illness'. Interestingly, they did find limited knowledge about 'OCD' and 'major depressive disorder' was

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associated with negative attitudes about these problems, such as believing these diagnoses were linked to violence. In contrast, limited knowledge of 'schizophrenia' was associated with fewer negative stereotypes about people diagnosed with this 'disorder'. Among FTDs, Belson (1967) found viewers of a BBC FTD series, "The Hurt Mind" were more knowledgeable about treatments for mental 'illness' than people who did not watch the series and they held more positive views and sympathy towards people labelled with a mental 'illness'. Penn, Chamberline, & Mueser (2003) found a documentary about 'schizophrenia' reduced the likelihood of viewers blaming the person for their mental 'illness', however, the documentary did not affect the viewers' opinions on dangerousness or desire for social distance.

In summary, studies on the influence of FTDs is limited, but extrapolation from research on television generally indicates there is a strong correlation between media messages and recipient 'attitudes' and beliefs (Philo & Berry, 2004). However, studies of people's 'attitudes' should be approached with caution, given they remove variability and complexity typically present in dialogue (Harper, Tucker & Ellis, 2013).

1.7.2. <u>The Influence of Television: Theoretical Background</u>

Historically, mass communication theories assumed audiences are passive recipients of television messages, merely absorbing presented stimuli. This is otherwise known as the "hypodermic needle" perspective of the media where media messages from the dominant culture are 'injected' into consumer consciousness (Karpf, 1988). Moving on from stimulus- response theories, cognitive theories such as the Social Cognitive Theory of Mass Communication (Bandura, 2001) suggested television watchers learned not only through observation but were more likely to display behaviours themselves that were shown to be socially acceptable (i.e. they are reinforced rather than punished). This may also influence how television watchers learn to behave towards people labelled as mentally 'ill' (Stout, Villegas, & Jennings, 2004).

However, stimulus-response and cognitive theories erroneously assume a causal relationship between media output and human behaviour (Giles, 2003).

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Reconceptualising the media as having an "influence" on human behaviour (Gauntlett, 1995) enabled the complexity of the relationship between the media, contextual environmental factors and human behaviours to be taken into account. Cultivation theory (Gerbner, Gross, Morgan, Signorielli & Shanahan, 2002) posits increased television consumption leads to greater adoption of views and ideologies expressed on television. The theory adopts a systems approach which formulates television influence as the interaction between media institutions, the formation of media messages by these institutions and the long term effect of these two factors on society as a whole (Potter, 2014). Through processes of "mainstreaming" and "resonance", divergent societal values and cultures start to homogenise and meaning-making is influenced by both television messages and people's own real life experiences respectively.

However, television watchers are involved and active rather than passive viewers (Gunter, 1987), judging and critiquing representations they encounter (Hobson, 1988). Other theories have therefore privileged individual differences rather than the effects of the media or the influence of systems. Media Dependence Theory (Ball-Rokeach & DeFluer, 1976) postulates the degree to which the media constructs someone's reality is related to the person's dependence on the media to provide them with information about various subjects. According to this more psychological theory, the media enables self-reflection and construction of identity, directions on how to behave and avenues for leisure. Mikos (2014) proposes two processes by which audiences relate to films and television programmes; reception and appropriation. The former process involves the interaction of the television programme itself, the experience of the programme by the viewer combined with the meanings designated to it. Appropriation involves the application of the experienced television programme to everyday experience and "into viewers' sociocultural praxis" (Mikos, 2014, p. 410). Finally, Lupton (1999) argues a range of audience responses may occur in relation to the meanings presented in the media, including: 1) acceptance of meanings 2) "active negotiation" with meanings 3) rejection of meanings or 4) meanings being ignored due to lack of attention to them. However, the ability to decide whether to accept or challenge negative messages presented on television depends on the availability of more positive stories (Kitzinger, 1999). However, while these

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theories move away from assuming media consumers are passive subjects, the consideration of contextual elements of people's lives such as cultural and occupational backgrounds and how these influence meaning-making is almost absent. Theories such as Hall's circuit model (Hall, 1980) take into account the importance of people's contexts with regards to "decoding" media messages. It is therefore possible that multiple meanings are born out of interactions with the media. Giles (2003) calls for more qualitative research in the media psychology field, to capture the interpretative aspects of people's engagement with the media, which would in turn influence future theories and models.

1.8. Researching Non-Fictional Television

Challenges have been highlighted in regards to analysing television portrayals of mental distress such as the abundance of available texts, and difficulties in deciding which form (e.g. advertisements/ news bulletins) and genres to analyse (Harper, 2009). When analyses of non-fictional television programmes have taken place, they have generally grouped different media forms together rather than analysing them separately (e.g. Francis et al., 2004) and focused on what the 'accurate' way of reporting mental distress is, based on psychiatric conceptualisations of mental distress and pre-determined criteria situated in government values (which are closely linked to the former). The literature review revealed television news programmes were the most researched form of non-fictional television. I will briefly outline the research in this area, followed by a review of research on FTDs.

1.8.1. Television News Programmes

Portrayals of mental distress in televised news programmes have mainly been analysed outside of the UK. Francis et al. (2004) grouped Australian newspaper, television (news and current affairs programmes) and radio items together and analysed their content and quality. They found television programmes' main focus was mental health policy and programme initiatives followed by the causes, 'symptoms' and interventions for mental 'illness'. The authors reported the quality of television items was difficult to assess as full transcripts/ video recordings were not obtained. Francis et al. (2005) used the same methodology as the previously

mentioned study, but focussed on 'depression' and other mental 'illnesses'. They found non-specific mental 'illnesses' were the main focus of television programmes, followed by 'dementia'. These studies were largely descriptive and did not provide an in depth analysis of different media forms. Henson, Chapman, McLeod, Johnson, McGeechan and Hickie (2009) analysed news media in Australia between 2005 and 2007 using a content and frame analysis. They categorised types of news angles about mental health as positive, neutral or negative. Positive or neutral news angles were defined as those which normalised PWAS, whereas negative news angles were those which depicted them as different to the general population or a burden on society. They concluded the majority of news angles were positive or neutral, with fewer negative news angles than had been noted in past research. Interestingly, when PWAS represented themselves, they were rated as positive news angles, perhaps indicating they are less likely to perceive themselves as different to the general population. Henson, Chapman, McLeod, Johnson and Hickie (2009) analysed television news items related to young people and mental 'illness'. They concluded there were fewer positive news angles in relation to young people compared to adults with mental 'illness', however, similarly to adults, young people who represented themselves were rated as positive news angles. The construction of criteria to assess whether media portrayals are positive, negative or neutral begs the question how one decides which category a news portrayal belongs to. What constitutes a particular category at a given time is dependent on the sociocultural context in which the category is situated and the coders' perception and judgement of the material which is not value-free.

In the USA, Glick and Applbaum (2010) analysed a CNN news programme aired in 2007 called "Criminally Insane". Analysing the narrative development of the show, the researchers argued the show reflected and reinforced societal discourses, such as the biomedical view of mental 'illness' and the necessity of psychotropic medication. Furthermore, patients labelled as mentally 'ill' were portrayed as victims of a dysfunctional system where their compliance to medication was not overseen, thus, depicting the general population as victims of the system as well. Despite these critical insights, the researchers did not use a rigorous empirical methodology. Finally, Dubriwny (2010) analysed television

news bulletins about 'postpartum disorders' broadcasted in the USA from 2000 to 2007. The author argues the news bulletins leave hegemonic discourses about motherhood unchallenged, and offer limited perspectives on the postpartum period, by focussing on stories from white middle/ upper class women and 'experts' offering a biomedical view. The latter two studies highlight the need for richer and more diverse depictions of mental health in television news bulletins.

1.8.2. <u>Factual Television Documentaries (FTDs)</u>

FTDs perhaps offer a deeper understanding of mental health issues (Morris, 2006; Kimmerle & Cress, 2013) compared to other media genres, have a greater focus on social concerns (Corner, 1996) and hold an educatory role in society (Harper, 2010). FTDs may even have the power to decrease negative 'attitudes' towards PWAS, such as blaming the person for their problems (Penn et al., 2003). There may be an assumption that FTDs offer more 'truthful' depictions of mental distress due to their "real-world origins" (Nairn, 2007, p. 143) compared to other media genres. However, Henderson (1996) writes about the complexities in the FTD making process, which challenges this claim. These are namely, issues with privacy which may lead to the majority of filming taking place in a limited number of environments, such as hospitals; the power of medical professionals to a) prevent negative feedback being presented about the medical profession and b) deter PWAS from taking part through fear of them being stigmatised in the future. Other issues included self-selection and capacity of PWAS to give their consent. There is also pressure from more senior media workers to depict sensationalist material to prioritise audience preferences and economic pressures, which is echoed by media reporters in previous research (e.g. Matas, el-Guebaly, Peterkin, Green & Harper, 1985). The notion that FTDs present 'reality' and 'truth' is particularly slippery; rather, the finished product is a result of a complex process of negotiation between different stakeholders with competing agendas. Even where unconventional forms of documentary, such as video diaries are used, they will still be edited by media workers who may privilege particular narratives over others.

However, there exists a paucity of critical and empirical analyses of FTDs and how they portray mental distress despite their abundance on television (Morris,

2006). There are examples of analyses of non-UK documentaries about medicalisation and depictions of lay people in the context of cancer and health system changes (Hodgetts & Chamberlain, 1999) however, analyses of FTDs and mental distress remain limited. I will now discuss the commentaries and analyses found in the literature.

1.8.2.1.   *Factual television documentaries: previous research*

Cross (2002) offers a descriptive analysis of a UK BBC documentary called "Mad, Bad or Sad"; a video diary made by two people diagnosed with 'schizophrenia'. Birch (2012) offers a more in depth and formal analysis of the same documentary, and draws similar conclusions to Cross (2002). The analyses note the documentary challenges stereotypes of violence and shows the person behind the label of 'schizophrenia'. The people in the documentary use pejorative terms such as 'nutter' whilst drawing on their own attitudes before they were diagnosed with 'schizophrenia' to point out stigmatising attitudes of others (i.e. people without labels of mental 'illness'). They also criticise mental 'illness' labels and psychiatric care (e.g. medication and its side effects) and offer stories about how hearing voices or 'madness' are related to people's past life histories and emotional states. Cross (2004) continued his investigation of UK FTDs and how they depict people with 'schizophrenia' and consequences of community care by revisiting the same documentary mentioned earlier, and two others called "Panorama: Whose Mind is it Anyway?" and "Disguises: A Place of Safety". They were both broadcasted on terrestrial television channels. He argued the shift in television broadcasting to populist in the 1990s meant voices of PWAS started to be heard, however, "claims to plausibility and authority depend as much on what speakers look like as on what they say" (Cross, 2004, p. 204) and people with 'schizophrenia' were frequently shown as unkempt and 'mad', thus, drawing on visual cues which rely on historical and lay representations of 'madness' (Nairn, 2007). Other themes in these documentaries included dangerousness, unpredictability, the need for the mentally 'ill' to be controlled with medication, internalisation of labels by people and community care impinging on public safety. Harper (2008; 2010) commented on UK FTDs since the year 2000 and noted a shift from sensationalised depictions of mental distress to sympathetic and positive ones by showing the existential struggles faced by both celebrities

and marginalised groups. However, he argues, in the process, FTDs have been too focussed on depicting positive messages, celebrity experiences and biomedical explanations, and lacked reflection on issues of gender, race and alternative understandings of mental distress. Other dominant narratives in FTDs noted by Harper (2009) include the relationship between creativity and mental distress, and how this narrative curiously diminishes when the sufferers of mental distress appear to be from working class backgrounds compared to those with celebrity or middle class status. Somewhat contradictory, Harper (2009) does also argue British documentaries show varied perspectives of mental distress whilst at the same time positing, "factual television…seems to contribute to Western culture's general distrust and rejection of social explanations of distress in favour of medical…ones…" (p. 150).

Li (2012) conducted a single media case review of an Australian documentary on suicide and 'depression'. Using a textual analysis, he found the term 'depression' was not defined and was unproblematically framed within a medical context, leaving little room for autonomy in people's 'recovery' journeys. Although the study examined the documentary critically, they did not analyse visual data or other documentaries. Most recently, Anderson et al (2015) performed a content analysis on 64 FTDs about substance use disorders broadcasted in the USA between the years 1991 and 2008. They concluded drug use has become more medicalised over time, leading to substance users being depicted as "patients", which was deemed a more positive and sympathetic portrayal by the authors than "junkies". However, this medicalisation is not purported equally among different racial and socioeconomic profiles; for example, white middle class people who used substances were more likely to be offered a medical explanation for their substance use compared to minority groups and those from lower socioeconomic backgrounds, whose substance use was depicted as a criminal matter.

In summary, the literature reviews highlight print media is the most researched genre with regards to mental health portrayals. While television news programmes have also been analysed, these studies have mainly taken place outside of the UK and far fewer studies have focussed on FTDs. Analyses of FTDs are, therefore, few and far between and Harper (2008, p. 173) has argued,

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"the development of more sophisticated textual analyses, then, might be the next stage for organisations and individuals seeking to critique media images of distress". This gap in the research, combined with the power documentaries hold due to their supposed educatory role and inclusion of PWAS more than other media genres, puts them in an insurmountable strong position to be investigated further.

1.9. The Current Study

Previous research on media portrayals of mental distress have privileged the categorisation of portrayals through the use of quantitative research methods such as content analysis. Therefore, media narratives, which contain diverse messages and meaning, are lost through quantitative methodologies (Goulden et al., 2011). Generally, the views of PWAS are rarely presented in the media (Wahl, Wood & Richards, 2002) and are largely superseded by stories from their friends, parents and lawyers (Nairn & Coverdale, 2005). Various hypotheses have been suggested for this stark exclusion. The same authors argued it may reflect an assumption that PWAS are unskilled or lacking in credibility. Conversely, professional and 'expert' knowledge holds more weight than lay knowledge or the knowledge of PWAS. 'Expert' knowledge is privileged in society (Foucault, 1970) and promoted in the media through a discourse of "mental health literacy" (Jorm, 2000). However, Coverdale et al. (2002) have argued, "media depictions would be more positive should individuals with a mental 'illness' be directly quoted or enabled to present their own stories" (p. 698). Similarly, Morris (2006) posited, "the more that media depictions of mental health issues are shaped by those who best understand them, the greater the opportunity that attitudes and awareness will be changed for the better" (p. 188). Therefore, the proposed study aims to investigate how mental distress is portrayed in the UK media, and what narratives are constructed, with a particular focus on documentaries, which historically have included the voices of PWAS (Henderson, 1996) more than other media genres.

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1.9.1. Why Now?

The timing of the proposed study coincides with recent controversies about the publication of the DSM-5 (APA, 2013), which received extensive media attention (e.g. Doward, 2013) and formed a context for revived academic debate about the medical model of mental 'illness' and psychiatric technologies (e.g. Welch, Klassen, Borisova, & Clothier, 2013). Amidst the debate, the British Psychological Society's Division of Clinical Psychology issued a position statement calling for a paradigm shift in the way mental distress is conceptualised (BPS, 2013). Previously, criticisms of the medical model of mental 'illness' had been prevalent among movements comprised of people with lived experience of mental health difficulties (Whitley, 2012) and some academic circles (e.g. Johnstone, 2000). The DSM-5 is of great relevance to the upcoming revisions of the diagnostic system used in the UK, i.e. ICD-10 (WHO, 1992), as DSM-5 and ICD-11 groups held joint meetings and academics argued "the new edition of ICD can and must do better – learning from the DSM-5's mistakes rather than perpetuating them" (Frances & Nardo, 2013, p. 2). Therefore, debates surrounding the DSM-5 and the upcoming ICD-11 form the wider sociocultural context within which the study is situated.

1.10. Research Questions

- How is mental distress portrayed in contemporary UK factual television documentaries?
- What are the dominant, counternarratives and absent narratives in the documentaries?

2. METHOD

This chapter highlights the epistemological position of the research and reasons for choosing a qualitative narrative approach. The chapter also outlines the data collection procedures, ethical and legal aspects, transcription procedures and the analytic steps taken. The evaluative criteria used for the research are also introduced.

2.1. Epistemology

The epistemological position of the study was social constructionist (Berger & Luckmann, 1966), within which there are multiple positions. Drawing on Burr (2003), social constructionism posits knowledge is constructed and mediated through social practices and emerges out of particular cultures and societies at particular times. Claims to absolute 'truths' or 'reality' are not taken for granted. However, the study does not deny entities such as 'mental distress' do not exist, rather there is an awareness these entities are constructed differently by different people, cultures and institutions (Harper, 2012). I also recognise my own assumptions and contexts interact with the data and affect the interpretations made. The study took a moderate social constructionist position (less relativist) in order to not only examine the narratives in the data but also go beyond this and study the wider sociocultural contexts in which these narratives emerged (Willig, 2013). Taking this positon also allowed the study to avoid the criticisms associated with "naïve social constructionism" such as extreme relativism (Pocock, 2015) which invokes problems related to morality and lack of acknowledgement of material and physical aspects of people's existence such as embodiment.

2.2. Rationale for Conducting a Narrative Analysis

A narrative qualitative approach allows the naïve realist assumptions of quantitative research to be challenged (Yardley, 2000) and for research in the area of the media and mental distress to be enriched. A qualitative approach fitting with a more moderate social constructionist position, which allows the examination of both spoken and visual narratives in unison, is narrative analysis (Keats, 2009).

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In line with the narrative turn, visual moving images are being interpreted to understand how and why they are produced and how they are understood by different audiences (Riessman, 2008). Visual research in psychology has traditionally focussed on how research participants create or interpret visual images to gain a deeper understanding of their experiences (e.g. Reavey, 2011; Bell, 2002, Esin & Squire, 2013) rather than investigating documentary materials such as television programmes. While some researchers have outlined detailed steps for analysing visual data (e.g. Gleeson, 2011; Rose 2000), these have privileged the analysis of themes and coded categorisations of visual data rather than narratives.

Documentary films are typically comprised of multiple voices and events which, during the editing process, are developed into narratives by the film makers with a potential audience in mind (Ellis, 2012). As such, adopting a narrative analysis methodology allowed different aspects of the documentaries to be analysed closely. Furthermore, narrative analysis broadens the number of issues that can investigated compared to other qualitative approaches, such as 'self' and culture and the relationship between them (Weatherhead, 2011).Finally, the chosen methodology allowed the richness and complexity of the data to be retained.

2.3.   Definition of 'Narrative'

There are numerous definitions of 'narrative', however, the following definition fits with the visual as well as the spoken nature of the data:

> "…a narrative is…a set of signs, which may involve writing, verbal or other sounds, or visual, acted, built or made elements that similarly convey meaning. For a set of such signs to constitute a narrative, there needs to be movement between signs, whether this occurs in sound, or reading, or an image sequence, or via a distinct spatial path, that generates meaning… Narrative must also carry some particular, rather than only general, meanings" (Squire et al., 2014, p. 5)

This definition was used during the analysis of the documentaries to search for narratives amongst the data.

2.4.   Data Collection

I used the Television and Radio Index for Learning and Teaching (TRILT) database to find documentary films broadcasted in British media. The database claims to be "...the best source of UK television and radio broadcast data available on the web…"[3] and was also recommended by the University of East London's Psychology and Arts and Digital Industries subject librarians. The inclusion and exclusion criteria for documentaries were as follows:

Inclusion criteria:

- Mental distress was the main focus of the documentary
- The documentary focussed on a particular mental 'illness' or diagnosis
- Documentaries were broadcast on UK digital television channels (i.e. BBC1, BBC2, BBC3, BBC4, ITV, ITV1 + 1, ITV 2, ITV 2 + 1, ITV3, ITV3 + 1, ITV4, ITV4 + 1, More4, More4 + 1, Channel 4, Channel 4 + 1, E4, E4 + 1, FilmFour, Channel 5, Channel 5 + 1)
- Documentaries were broadcast in all regions of the UK
- Documentaries were broadcast before February 2014

Exclusion criteria:

- Mental distress was not the main focus of the documentary
- The documentary was not focussed on a particular mental 'illness' or diagnosis
- The documentary was only broadcast in specific regions of the UK (e.g. on BBC2 Northern Ireland only)

2.5.   Justification for Inclusion and Exclusion Criteria

According to the research questions, documentaries which focussed on any particular mental 'illness' or diagnosis were included in the analysis. The search terms 'mental illness', 'mental distress' and 'mental health' were used to search for listings of relevant documentaries in the TRILT database. The database featured detailed synopses of each documentary which allowed me to determine

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[3] See the following webpage http://bufvc.ac.uk/tvandradio/trilt/

whether they met the inclusion criteria for the study. Freely available UK terrestrial channels with the largest percentage of audience share[4] were included in the TRILT database search. Satellite and cable channels were excluded as they were only available to fee paying customers, thus limiting viewership. Documentaries which were broadcast in specific regions of the UK (e.g. on BBC Wales) were also excluded, as this would have again limited viewership. Documentaries which were broadcast up to and including February 2014 were considered, as at the time of research board registration, this was the most current time period.

2.6. Sample Size

Drawing on Hodgetts and Chamberlain's study, I limited the analysis to two documentary films, which allowed me to "explore the richness and complexity…" (Hodgetts & Chamberlain, 1999, p. 321) of the narratives presented. Furthermore, Potter and Wetherell (1987) have argued sample size does not determine the success of a study, rather, sample size should be guided by the research questions. Analysing the narratives from two documentary films were deemed sufficient to answer the proposed research questions.

2.7. Ethical Aspects

> "The inherent ethics of narrative research lies in the resolute honesty of the researcher's reflexivity, which states clearly the biases, aims, and positioning of the knower and the circumstances under which the knowledge was created, with the researcher taking full responsibility for what is written. From this point of view, the report is not ''about'' the participants but ''about'' the researcher's meaning making" (Josselson, 2007, p. 549)

The above quote reinforced my awareness of the importance of being a transparent and reflexive researcher who remained consistently aware of how my actions and interpretations may affect those reading the study. For example, the people who took part in the documentaries might be concerned about how audiences judge them, and their reputations and self-worth might be affected by this (Ellis, 2012). It was also important to reflect on how the study may affect

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[4] The Broadcasters' Audience Research Board publishes weekly, monthly and annual figures of television viewership. "The Viewing Report" published annual figures for 2013 viewership and was downloaded from http://www.barb.co.uk/trendspotting/analysis/annual-viewing-report?_s=4

other readers who have experienced similar difficulties to the people featured in the documentaries, along with their family members and professionals working in the mental health field. I was therefore particularly concerned about the potential implications of working from a social constructionist stance. Trahar (2009) has argued postmodern paradigms question assertions about 'truth' and this might be experienced as disrespectful by the very people researchers aim to be respectful of. During my interpretations of the data, I was therefore wary of being respectful towards people who may hold modernist perspectives about mental distress.

The study was registered with and granted approval by the University of East London. Ethical approval through the University of East London or the NHS was not required as the documentaries were in the public domain and clinical data was not collected or analysed, nor were participants recruited to the study.

2.8.　Legal Aspects

Copyrighted works, such as documentary films, are protected from unlawful activity under the Designs, Copyrights and Patents Act (1988). There is a 'fair dealing' exception under Sections 29 and 30 of the Act whereby limited extracts of work can be copied and analysed for research purposes, provided there is acknowledgement. However, as the thesis would be made freely available through the university repository and library, permission[5] to use the documentaries for research purposes was sought and granted from the relevant production companies who were also the copyright holders. A copy of the e-mail addressed to the production companies/ copyright holders can be found in Appendix 2. I have not included their replies due to confidentiality.

2.9.　The Sample

I sought to analyse two of the most recently broadcasted documentary films which satisfied all of the inclusion criteria. Appendix 3 outlines the list of documentaries considered for analysis, which were found on the TRILT database. The three part "My Secret Past" documentary series broadcasted on Channel 5 in December 2013 met all of the inclusion criteria. Two of the most recently broadcasted documentary films from this series were entitled, "Jennifer

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[5] This was advised by the University of East London guidelines on Copyright Frequently Asked Questions webpage: http://www.uel.ac.uk/lls/services/copyright/faq/

Ellison: My Post-Baby Breakdown" and "Louis Smith: Living with ADHD". The production company did not grant permission to analyse these documentaries due to challenges associated with the gaining copyright permission. I then contacted another production company (also the copyright holders) who produced two documentaries which met all the inclusion criteria. They were entitled "Bedlam: Psychosis" and "Bedlam: 'Anxiety'" and broadcast on Channel 4 in November 2013 and October 2013 respectively. They formed part of a four-part documentary series called "Bedlam". On the Garden Productions website, the documentary series is described as a factual series and with the following description, "tackling mental illness and stigma head-on, a new 4 part documentary series with exclusive access to Britain's most famous psychiatric institution: The South London and Maudsley."[6] This amounted to two hours of documentary film which was transcribed and analysed.

2.10. Transcription

> "A transcript is a text that "re"-presents an event; it is not the event itself. Following this logic, what is re-represented is data constructed by the researcher for a particular purpose, not just talk written down" (Green, Franquiz and Dixon, 1997)

The above quote argues the transcription process is not simply recording what is heard, in the absence of context, but an interpretative act which produces data for a particular purpose. It is also a political act (Roberts, 1997) which cannot be easily separated from analysis (Riessman, 1993). Murray (2008) has argued transcriptions prepared for narrative analyses should include emphases, exclamations and pauses. I therefore adapted Banister, Burman, Parker, Taylor and Tindall's (2011) transcription scheme to incorporate these different aspects of talk (see appendix 4). This adapted transcription scheme not only allowed me to analyse expressive aspects of language, but also remain close to the intended meanings of characters in the documentaries and the filmmakers. The moving visual images were not transcribed into written words, rather, screen shots of images were taken so as not to restrict the interpretation of moving images from verbal transcriptions.

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[6] This quote can be found on the Garden Production webpage
http://www.thegardenproductions.tv/series.html

2.11. Approach To Analysis

Riessman (1993, p. 54) argued there is "no standard set of procedures" in narrative analysis. The focus of the analysis depended not only on the research questions, but also the content of the data collected (Murray & Sargeant, 2012). I took an open and curious stance in relation to the data as a story analyst (Smith & Sparkes, 2006). The analytic steps outlined below were not necessarily carried out in sequential order. Figure 1 offers a visual representation and brief summary of the analytic steps outlined below.

2.11.1.   Analytic Steps

1. Multiple viewings of documentaries were made to familiarise myself with the data (Hodgetts & Chamberlain, 1999). Through initial note taking, I identified the plot synopses (ibid)[7] and characters (Davis, 2008)[8].

2. I converted the documentary films on the DVDs into mp3 files and uploaded them to Express Scribe Transcription Software where I transcribed the spoken words.

3. Each documentary consisted of component parts – shots, scenes and sequences, each defined as follows, "the shot is a section of film exposed during a single take. A scene is comprised of one or more shots occurring within one time and place. A sequence is composed of a group of scenes having dramatic unity" (Oumano, 1985, p. 160). I privileged the existing editorial structure of the documentaries and divided the transcripts according to the documentary scenes. I watched each scene in turn whilst reading the corresponding transcripts repeatedly.

4. Documentaries contain many competing voices which are organised by the narrative during the editing process (Ellis, 2012). I identified the voices deployed in each scene, including the inner voices of characters (Frank, 2012, p.34). In the spirit of polyphony, I was aware these "may sometimes be contradictory or conflicting" (Martindale, 2015, p. 42). The voices of characters were featured in different contexts such as in conversations between characters (constituting 'small stories' e.g. Georgakopoulou, 2006), interviews and through explanations.

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[7] These can be found in appendix 5
[8] Details of which can be found in appendix 6

5. Drawing on Positioning Theory (Harré & van Langenhove, 1999), attention was also paid to how the characters positioned themselves, took up positions and were positioned by others. Positioning is understood as, "a way in which people dynamically produce and explain the everyday behaviour of themselves and others" (ibid, p. 37) and positions are made available through societal discourses (Hollway, 1984). Specifically, this analytic step drew on modes or categories of positioning, to make explicit the types of positioning undertaken in the documentary.

6. According to Squire et al. (2014) narrative researchers use still and moving images to gain access to overall stories. Furthermore, moving images have a supportive function; they help viewers understand a film's narratives and can bring about expectations about what will happen next in a story (Mikos, 2015). Therefore, drawing on Rose (2001) adapted by Riessman (2008), the moving images in each scene were "interrogated". I studied how component parts such as shots were arranged and asked about the story they suggested, in unison with the spoken words.

7. I identified which narratives and subnarratives were dominant (White & Epston, 1990) by drawing on Jones' (2002) conceptualisation which defined them as **"powerful and prevalent storylines" (p.125) which may be prevalent in academic and clinical literature, as well as journalism and popular culture. In the current study, I drew on dominant cultural narratives about 'anxiety' and 'psychosis' in these areas, and engaged in "reflexive consideration" (Jones, 2002, p. 141) to understand how my own assumptions and interests affected my interpretations of the narratives. I identified counternarratives (Squire et al., 2014) and related subnarratives using two methods proposed by Jones (2002). One method looks for "moments when the participants themselves orient to telling a counter-narratives" (p. 136) and the second method requires the analyst to use their own knowledge as "…an interpretative resource" (p.136). The former method looks for "…those instances where participants overtly disagree with another statement, use words or phrases such as 'taboo', 'I know I shouldn't' or 'I know most people wouldn't agree' or characterise themselves as rebellious" (p. 128) or phrases such as "people always say… but I know…" (p. 129- 130) or "I shouldn't be telling you that" (p.130). Characters may also "…briefly orient to the dominant cultural

storyline and then… resist it" (p.131). Although the study did not interview participants, the study looked for moments where characters featured in the documentary showed disagreement, resistance or rebelliousness. Absent narratives were identified, by searching for threads that were implicit but not pursued (White, 2000).
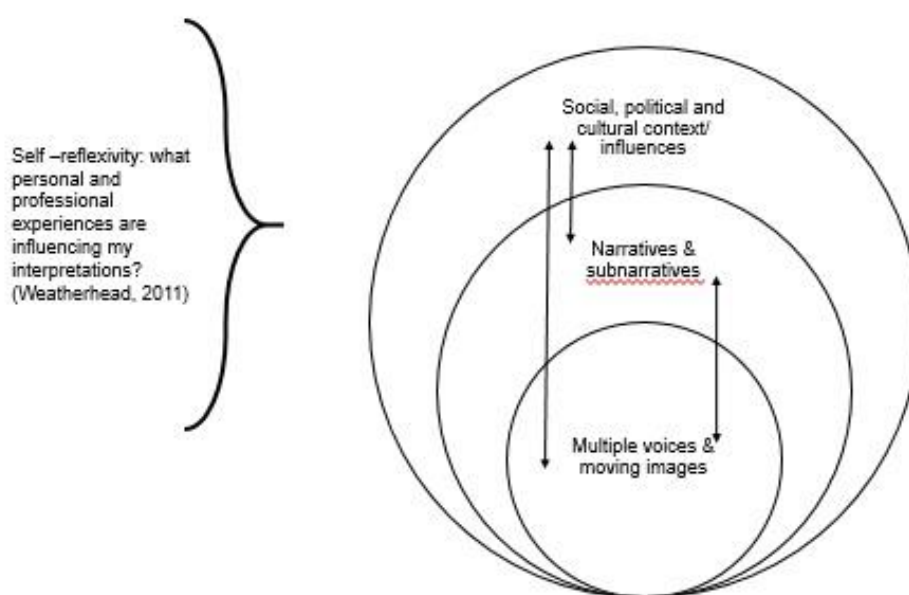

Self –reflexivity: what personal and professional experiences are influencing my interpretations? (Weatherhead, 2011)

Social, political and cultural context/ influences

Narratives & subnarratives

Multiple voices & moving images

Figure 1: A visual representation and brief summary of the analytic steps

2.12. Personal Reflexivity

It is recognised that different people will have different interpretations and attach different meanings to the same films (Mikos, 2014). I represent one of the thousands of viewers watching the documentaries, with my own assumptions, identities and personal and professional narratives which interact with, shape and influence my interpretations of the moving images and spoken words presented in the documentaries (Murray, 2008; Weatherhead, 2011). The interpretations presented in this thesis re-present additional narratives or re-tellings about the narratives presented in the documentaries. This re-telling has been influenced and shaped by my assumptions and other aspects relating to personal reflexivity, such as "…values, interests, beliefs, political commitments, wider aims in life and

social identities..." Willig (2013, p. 10). I have attempted to maintain reflexivity throughout the conception of the study, as well as throughout the analysis, write-up and discussion by having continuous and reflective discussions with my supervisors and colleagues, and by keeping a reflective diary (see appendix 7). It seems timely to reflect upon and make explicit particularly pertinent assumptions and values which I believe may have influenced my readings of the data and other aspects of the research. I am a clinical psychology trainee who has worked in mental health services and/or research since 2007. During the past decade I have moved from taking a positivist and reductionist stance towards mental distress to taking a more a moderate social constructionist position. I particularly value psychological understandings of mental distress which take into account people's social, political, cultural and economic contexts. As such, I take a critical stance towards privileging the chemical imbalance theory of 'mental illness'. I can trace where my assumptions about mental distress started to change. Having studied Psychology and Cognitive Neuroscience at undergraduate level and worked as a research assistant at an institution which largely privileged psychiatric and biomedical understandings of mental distress, I was eager to learn more about mental 'illness', prevention and treatments. I enrolled on a postgraduate degree programme in mental health, where I was introduced to postmodernism, social constructionism, narrative and systemic therapies. I was eager to take my new learning further, and enrolled on the Professional Doctorate in Clinical Psychology at the University of East London. However, it is not only my educational and occupational background which has shaped my more critical assumptions in relation to the mental 'illness' paradigm, but also my experience of seeing loved ones being labelled as mentally 'ill' and prescribed life-long medication with severe side effects. Their distressing experiences were only ever understood by professionals in the context of biomedical narratives, and opportunities for understanding how their life circumstances had impacted on their emotional wellbeing were absent. However, I do not disagree with the use of psychiatric technologies such as diagnoses or medication if a person finds these practices helpful.

In summary and as illustrated in figure 1 above, personal or self- reflexivity influenced my interpretations of the data and therefore the choice of dominant

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narratives, counternarratives and absent narratives outlined in the following analysis sections. Reflexivity also influenced which moving visual images were interrogated and included in the thesis. Inclusion of the wider social, political and cultural contexts which were hypothesised as influences for the narratives constructed in the television documentaries are based on my engagement with relevant literature and knowledge acquired from research studies and degrees/ training courses I have undertaken. Further reflections on personal reflexivity are made in the discussion chapter.

2.13. Evaluation of Study

The validity and quality of the research was assessed using flexible criteria suggested by Yardley (2000, p. 215) - "sensitivity to context; commitment and rigour; transparency and coherence; impact and importance". These criteria are drawn upon in the discussion chapter.

3. ANALYSIS OF BEDLAM ANXIETY DOCUMENTARY

3.1. Dominant Narratives

3.1.1. <u>The Right Way To Think and Behave Narrative</u>

3.1.1.1. *Subnarrative: The cognitive-behavioural paradigm*

Throughout the documentary, the cognitive-behavioural paradigm of 'anxiety' prevails. Simon Darnley's voice is mostly deployed to construct this subnarrative. For example, in scene 8, his voice is deployed to construct a subnarrative about the cause and maintenance of 'anxiety':

> [Scene 8, lines 125-128] Simon Darnley: The news is <u>full</u> of <u>bad</u> stories about us being attacked, about paedophiles about people being murdered. Negative stories are put forward constantly to us which increases our perception of danger.

Simon Darnley pays lip service to the cultural context implicated in 'anxiety'; he reduces its impact on people to intrapsychic cognitive factors, i.e. 'perception'. Visually, Simon is filmed driving into work and an aston of his job title is shown while he talking:

<u>Image A</u>

This tells a story of a busy clinician with 'expert' status, who is able to give the audience a professional and trusted view on the topic. His voice is deployed again in scene 15, where causation and maintenance are revisited in more detail, specifically in the context of Helen and James' experience of 'intrusive thoughts':

> [Scene 15, lines 455-462] Simon Darnley: …but if somebody thinks oh my god does does that mean I'm some sort of child killer? Am I likely to do

that? They may start going a different way or really worried about it. If I <u>act</u> on that thought it gives credence to the thought, <u>has</u> validity, it has some sort of meaning. [Music] So with intrusive thoughts, once you get one which gives you 'anxiety', if you <u>act</u> on that 'anxiety' and do anything about it it's more likely to carry on.

Visually, Simon is stood in a clinic room wearing a professional identity badge which reinforces his 'expert' status visually:

Image B

In these extracts, Simon Darnley positions himself as an expert on 'anxiety' and 'intrusive thoughts' and positions the people who experience emotional distress as passive recipients of negative stories who respond to their 'thoughts' in an incorrect way. This in turn positions himself as having the right to 'correct' their thinking and behaviour. This could be seen as an act of "moral positioning" (Harré & Van Lagenhove, 1991). 'Patient' voices are deployed in the documentary to reinforce this subnarrative. For example, James' voice is deployed straight after Simon Darnley's voice in scene 15, where his personal idiosyncratic experience of 'OCD' incorporates the voices of CBT 'experts', such as Simon Darnley's:

> [Scene 16, lines 464-473] James: I just I get intrusive thoughts…then like the thought (2) of incest might pop into your head for some reason…you think shit I'm I'm a freak I'm abnormal why would I have this thought no one else has these thoughts.

James positions himself as a victim of 'intrusive thoughts' as well as a moral person who is so opposed to incest that thoughts of it cause him to question his

own sense of 'normality'. He positions other people as normal compared to himself, as he assumes they do not have the same experience as him.

As James is talking there are numerous cutaway shots to visual images of the path leading to James' family home and the house itself, interspersed with images of children while he is talking about having 'intrusive thoughts' about incest:
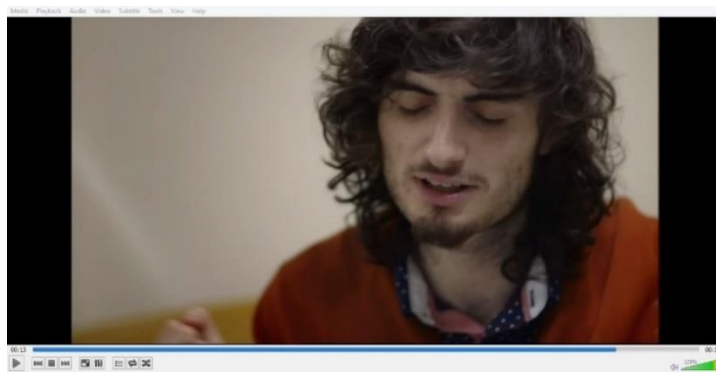

Image C

Image D

Image E

Image F

Image G

Image H

Image I

Image J

The images of James show him putting his head into his hands, perhaps to convey his despair and distress. The inclusion of still images of children dramatise and accentuate his experience of thoughts of incest; the shots are shown in quick succession, conveying the intrusive nature of James' experiences. The visual images of the pathway leading eventually to James' house conveys transition, perhaps to 'recovery'.

Finally, the subnarrative continues to be constructed in the treatment phase of the storyline, with the therapy being shown 'in action' through a series of behavioural experiments and in-vivo exposure work. The narrator's voice is deployed to guide the audience through these techniques, and draws on cognitive-behavioural ideas about what treatment aims to do:

> [Scene 12, lines 271-272] …Today she's doing a practical experiment confronting her fear head on...

> [Scene 28, lines 732-734] ...James has reached a critical point in his treatment. Anna is going to challenge his fears around the toilet in the most extreme way.

3.1.1.2. *Subnarrative: From irrationality to rationality*

The documentary constructs a subnarrative about Helen and James' journeys from 'irrationality' to 'rationality'. In scene 6, Helen's interviewer bases his question on a rational paradigm to intentionally position her as 'irrational':

> [Scene 6, lines 108-113] You're you've been with us that whole time so if you said have I done anything to that man, we could tell you no
>
> Helen: Yeah, it would help a little bit but not probably not absolutely, no. There's no ration, it's not rational at all like that, you know I can't just explain it away to myself.

Helen's inner rational voice has perhaps been shaped and developed through encounters with medical and psy-professionals, however, she stands firm in her position that although she is able to 'be rational', she is not able to maintain this position permanently. Shortly after this scene, the narrator moves irrationality into the realm of treatment, in unison with the storyline, and deliberately positions Helen in her absence as 'irrational':

> [Scene 11, lines 252-254] Helen is being treated for an irrational fear that she's harmed people, specifically that she's put strangers in rubbish bins.

The narrator's voice draws on language used by the medical and psy-professions (i.e. "irrational fear"), to persuade the audience of their positioning of Helen. An 'expert' voice is then introduced in scene 12, to articulate and label a process of moving from irrationality to rationality, i.e. "insight":

> [Scene 12, lines 297-303] Simon Darnley: At <u>some</u> point that person will have insight to say I <u>know</u> this is stupid but… it <u>feels</u> real and it <u>feels</u> dangerous but actually it's not and they <u>feel</u> responsible and it feels that the fact is real but it's not…

Simon Darnley positions himself as an expert on "insight" which is constructed as the development of the ability to realise what is 'reality' and what is not, and

listening to your inner rational voice rather than your feelings. In positioning himself as an 'expert' on rational thinking and behaviour, he positions the patients in the documentary as irrational and in need of therapy to rectify this deficit. Moving visual images of Simon Darnley walking through a natural environment reinforces natural and 'normal' ways of thinking. Again, the aston reminds the audience of Simon Darnley's status in the mental health system, and his level of expertise on 'anxiety' to persuade the audience of his point of view:

Image K

In the treatment phase of the documentary, the narrator's voice is deployed to guide the audience through the interventions used by the staff on the unit to move 'patients' to a place of 'rationality':

> [Scene 14, lines 404-406)] When a patient starts to obsess the therapists are trained not to give reassurance. It risks turning something completely irrational into something real.

The narrator (therefore, the documentary makers) take an objective and scientific stance towards the 'patient' characters. They are positioned as different and exotic because of their 'irrationality'; this creates emotional distance between those experiencing 'anxiety', and those who are not. The use of the word 'patient' draws on traditional doctor-patient roles, or a more modern form of that, the patient-therapist dyad. This positions the therapists as having the right not to give reassurance to the patients. At the end of the documentary, the narrator's voice is deployed to demonstrate that James had started thinking rationally and gained "insight":

[Scene 28, lines 778-781] We've been told the key to making people better here was when they finally got insight. When they saw their greatest fear was just a fear and <u>not</u> a reality. It felt like maybe James had got to that point.

Helen is not afforded the same privileged position, and there is an element of surprise expressed by the narrator about Helen's outcome; that she had managed to return to work despite "still struggling with her thoughts" (Scene 31, line 830). This surprise perhaps rests on the assumption that people must make a 'full recovery' in order to be a productive member of society. This maintains Helen's position as 'irrational' and lacking in "insight", despite her transition to 'normal' activities, which is discussed below.

3.1.1.3. *Subnarrative: Therapy makes people 'normal'*

The documentary constructs a problem saturated and dysfunctional subnarrative about the characters' loss of 'normality' due to 'anxiety' and their retrieval of 'normality' through engagement in a therapy programme. It draws on wider narratives of what it means to be a normal human being, based on Western values (e.g. being employed, in a relationship and sociable). Multiple voices, such as Simon Darnley's, are deployed to portray James as 'abnormal' pre-therapy; someone who is dependent, a 'loner' and, in some sense, a 'failure' as he is unable to live by societal expectations:

[Scene 9, lines 166-169] Simon Darnley: He's dropped out of university, he's he's lost a lot of friends [music stops] and basically been <u>stuck</u> at home with his Mum in a very isolated situation where he's just spent a lot of his life around that toilet.

This problem saturated subnarrative about James is thickened by the deployment of Penny's voice, who portrays him as a 'loner' growing up:

[Scene 10, lines 218-223] He kept himself very much to himself. Um, he'd play on his own for hours absolutely hours and you ask him what he was doing and he'd say he was playing in his head and with hindsight now I thought to myself I wonder if that was particularly normal, whether it was a portent of things to come.

Playing in one's head could be construed as 'normal' behaviour of a child (i.e. imaginative play), however, in the context of this subnarrative, it is construed as abnormal behaviour and a sign of future difficulties. Footage of James as a child is shown just before Penny's voice is deployed. Initially it shows him crying and standing next to a paddling pool where another child is playing. The footage shows James splashing the water in the pool and interacting slightly with the other child:

Image L

The documentary then jumps to a close up shot of James' head while Penny talks about how he played in his head:

Image M

This image is followed by another moving image of Penny walking through a field while she questions whether James' behaviour was 'normal':

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Image N

These images tell a story of James being an 'abnormal' child who found it difficult to play with other children, instead preferring to remain in his own world. Penny walking in a relaxed manner through a vast field acts as a stark contrast to the uncomfortable close up of James, and conveys 'normality' in contrast to 'abnormality'.

Scene 13 shows James and his mother arguing over James' struggle to complete his university work due to his "condition" (Narrator, Scene 13, lines 351). Penny seems to draw on hegemonic societal narratives about the importance of employment and men being breadwinners during her criticism of James:

> [Scene 13, lines 360-368] Penny: Well you're stupid that's why because they want you to do year two but that's up to you! You're gunna end up not even going back to university /
>
> James: / Why why
>
> Penny: / Well because I'm sick of this, you'll be a student till you're <u>fucking</u> thirty! Christ James /
>
> James: / xxx
>
> Penny: / I didn't ask, do you know I've been out earning my living / xxx

Penny positions herself as a productive person who earns her own living, and at the same time positions James as a poor student who is not living up to the expectations of his university. When Penny accuses James of being stupid, an image of Eeyore, a donkey character from Winnie the Pooh, in the form of a stuffed toy is shown. The reference to Eeyore, a famously melancholic and

depressed character, is perhaps symbolic of James' distress but also draws attention to his immaturity, as he has not achieved what is expected of young men in society:

Image O

The documentary then cuts to image P, while Penny prophesises that James will not go back to university. This natural and colourful image juxtaposes the previous gloomy image and offers hope of James returning to university, and becoming a productive and 'normal' person:
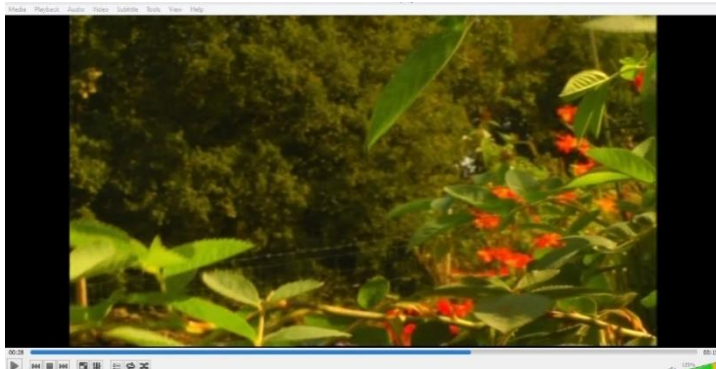

Image P

Moving images of James dancing on grass are then shown, as Penny shouts, "you'll be a student till you're fucking thirty!" This thickens Penny's story about James being unproductive and perhaps having his priorities wrong in life i.e. he prefers having fun rather than working:

Image Q

Furthermore, throughout scenes showing the therapy in action, attempts to 'normalise' James are made, for example working on reducing the amount of time he spends in the toilet. The narrator's voice is deployed to explain this part of the therapy process. The narrator positions himself and most of the audience as 'normal' and James as 'abnormal', by using a 'him' and 'us' dichotomy:

> [Scene 10, lines 242-246] Narrator: …She's set him a target of 7 minutes, the average time most of us spend in the loo.

James himself appears to be recruited into this narrative, perhaps giving it more validity. For example, he justifies going to lunch because "a normal person would" (Scene 9, line 214) and thinks he is abnormal because he has thoughts of incest (see extract above from scene 16). At the end of the documentary, a restoration of 'normality' is created for James; the audience are informed by the narrator he returned to university.

Similarly, Helen is portrayed as behaving 'abnormally' pre-therapy; she is described as a "virtual recluse" by the narrator (Scene 12, lines 269-270) because she does not leave the house or attend work for two years and has suffered a relationship break-up. At the end of the documentary, Helen explains how her therapist has taught her a normal way of being, "what I should do and what I shouldn't do" (Scene 27, lines 726-727). Visual images show Helen meeting up with a friend outside her previous place of work while the narrator's voice-over explains she has returned to work and hopes to rekindle her relationship with her ex-boyfriend – all indications of a return to normality:
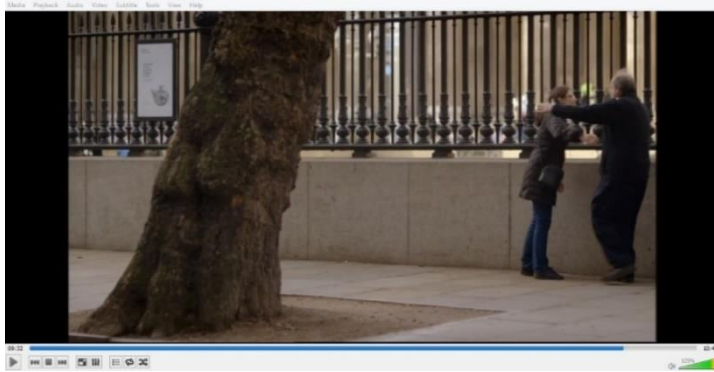
47

Image R

Finally, Arron's restoration to 'normality' is denoted by him sharing his experiences with his support network which is something he did not do previously because he was scared of people seeing his "craziness" (Arron, Scene 7, line 118). The narrator explains Arron still experiences 'anxiety' but "it doesn't dominate his life anymore" (Scene 31, lines 835-836). Moving images show Arron travelling on a train, perhaps symbolising his discharge from the therapy programme and his journey towards 'normality':
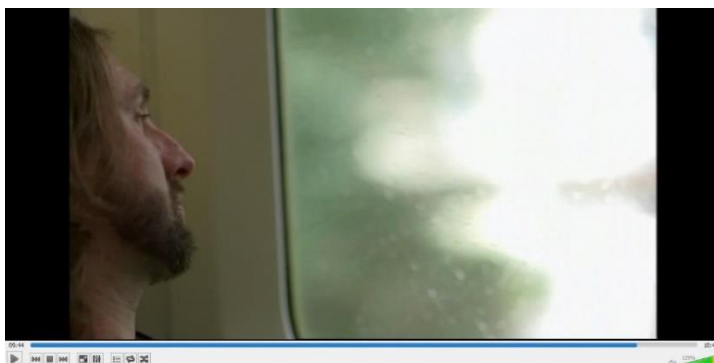
Image S

3.1.2. Medical Narrative

A medical narrative takes root in the name of the documentary – "anxiety". The narrative is constructed in unison with the cognitive behavioural subnarrative. For example, in scene 3, the narrator's voice is deployed to explain what 'anxiety' is:

> [Scene 3, lines 46-48] It's a condition all of us experience at some point in our lives but imagine if you woke up one day to find your 'anxiety' had taken on a life of its own.

'Anxiety' is normalised, by saying anybody can be affected by it. However, it is also decontextualised by portraying it as coming out of the blue and medicalised by calling it a 'condition'. It is portrayed as reaching a point where it can become uncontrollable, insinuating the need for professional help. At the same time as the narrator's voice, moving images of a man (who we later come to learn is Leon) putting on a rubber gloves and a table of rubber gloves are shown:

Image T

Image U

The images start to build a story of sterilisation and 'anxiety', but given the lack of information about Leon at this point in the documentary, the images are used as a resource to engender curiosity to keep the audience watching. These images also construct a visual narrative of exaggerated behaviour, which supports the exposition that 'anxiety' can become uncontrollable and more extreme. Furthermore, Simon Darnley's voice is also deployed to normalise 'anxiety', however, he also alludes to a process of entering a 'tipping point' thus constructing a medical narrative where there is a clear dichotomy between 'health' and 'illness':

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> [Scene 8, lines 131-133] Simon Darnley: This could happen to any one of us at any one time. We're all on a scale, each <u>every</u> single one us could be tipped over.

The documentary then moves onto 'anxiety' related diagnoses, specifically 'OCD' which is used synonymously with 'condition' and 'anxiety'. The construct 'OCD' appears to be endorsed by James, Simon Darnley and Penny, giving it validity. 'OCD' is portrayed as a lifelong, relapsing condition by Penny. The voice of the psychiatric profession can be heard in her voice:

> [Scene 13, lines 376-379] …because he's relapsed before that it would be completely unrealistic of me to think this is the cure of to end all cures and he'll be all right because OCD never goes away…

A medical narrative is therefore constructed by the documentary, in unison with a psychological narrative about mental distress. The medical narrative serves to pathologise and medicalise the characters' experiences. The documentary also adopts the medical positioning of people who access mental health services, by calling them 'patients'.

3.1.3. 'Anxiety' Can Be Overcome With Willpower Narrative

'Anxiety' is portrayed as a 'condition' that can be removed through willpower. Numerous voices are deployed to construct this narrative, in the context of a storyline which features past treatment failures, a build-up of suspense about whether the 'patient' characters will overcome their problems or not, finally ending with triumph over adversity. In scene 13, the narrator's voice is deployed to tell a story about James' past treatments, while empathising with Penny's position:

> [Scene 13, lines 346-349] …As a teenager she watched him go in and out of various psychiatric institutions each time he came out James would feel <u>better</u> until his OCD took hold once more.

The narrator portrays 'OCD' as a powerful entity which can be alleviated with psychiatric interventions, but not fully. The responsibility of removing 'OCD' completely is soon placed on the individual, through the deployment of Penny's voice. Penny says she is sure James will "beat this…he's got to learn to manage it" (Scene 13, lines 373, 379). Penny positions James as having a duty to gain

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control over the 'OCD', with the assumption he has the power to do so. Furthermore, James pressurises himself to get rid of the 'OCD' and also constructs it as something he can suddenly decide to take control of:

> [Scene 13, lines 383-385] I just now I feel like it's it's been with me long enough and er cause if I don't get get on top of it now then that's it really…

As the plot moves along, Helen and James' journeys at the residential unit feature set-backs or 'relapses' in their treatment which creates uncertainty about their destinies and perpetuates suspense among the audience:

> [Scene 14, lines 424-426] Helen: The weeks up until now I've been doing well so (3) and then maybe it's just evening out (2) I don't know (2) yeah not so good.

> [Scene 24, lines 664-667] Narrator: After a major relapse at Christmas, James has returned to the 'anxiety' unit. He has just 4 weeks of treatment left. He can't seem to beat the OCD bully that's controlling his 'anxiety'.

In the above extract, Helen appears to have been recruited into the willpower narrative, and so when she experiences a set-back, she appears puzzled and downhearted. Furthermore, James' is positioned as a victim and powerless, in the face of a powerful aggressor, the personalised "OCD bully". Towards the end of the documentary, further pressures to overcome 'anxiety' (such as practising and repeating techniques) are placed on James and Helen by their therapists:

> [Scene 25, lines 686-696]: Anna: I don't have a sense there's lots more information we can give you it's actually about you now taking what you've learnt and doing doing doing and practising practising practising /

> James: / I know I know

> Anna: / Repeating repeating repeating. It's not us sort of being mean or harsh it's about saying let's kind of switch gear now so it really becomes something that you're you're kind of erm you've absorbed everything and you're applying it

> James: Uh huh.

Anna's voice appears to draw heavily on cognitive-behavioural principles that a person becomes their own therapist by the end of their treatment as well as the willpower narrative which allows her to position James as responsible for overcoming his 'anxiety'. James appears to listen to her and agree, taking up the position of a responsible 'patient'. Similarly, Helen also appears to internalise the pressure placed on her by the therapist, who tells Helen, "it's about you kind of having that confidence because it's kind of (.) really up to you now" (Scene 27, lines 721-723), leading to Helen positioning herself as solely responsible for beating the 'anxiety' and having the power do so:

> [Scene 27, lines 727-730] Helen: That's it you know it's entirely up to me now to to implement what I've learnt and not be doing I shouldn't be doing what I'm doing still but somehow I can't sort of get over the last hurdle of it (.) yeah

The deployment of Helen's voice thickens the uncertainty about her ending until the narrator's voice is deployed to mark her overall treatment success, as well as for James and Arron, due to them "…learning how to deal with the 'anxiety' and then staying on top of it" (Narrator, scene 31, lines 828-829). However, Leon is not given the same privileged portrayal or narrative closure (see counternarratives and absent narratives sections below).

3.2. Counternarratives

3.2.1. Victim Versus Patient

In scene 1, James' voice is the first one deployed, after being invited by the interviewer into a conversation about what the toilet means to him:

> [Scene 1, lines 2-14] So, James, what does the toilet (2) mean when you see it?

> James: Um (2), I, eh, if I'm, no, if I'm being perfectly honest, it's sort of like, um almost like a (2) I was going to say enemy, but more like a torture really, it sort of like um, I've had such a, for like as long as I can remember, since even before my parents got divorced, like when I was you know 5 years old, like I've had a really difficult relationship with it, which sounds ridiculous, it's just an 'effing toilet, but, even the xxx design of the loo looks

> slightly comical, but, I like I sort of <u>hate</u> it it's sort of like a big wanker or like [laughter] like like a monkey on my back or something that yeah I so I yeah

In the above extract, the protagonist is the toilet. It is personified and given meaning beyond its status as an inanimate object. James positions the toilet as the main source of his emotional distress – a problem that will not go away. He persuades the interviewer and audience he has had a lifelong difficult relationship with it. Unusually, the 'aggressor' in James' account is an inanimate object rather than a person. Initially James positions the toilet as his nemesis and then re-positions himself as a tortured victim. James orients the audience to the counternarrative, by saying, "…which sounds ridiculous, it's just an 'effing toilet…". His inner rational and critical voice can be heard in this line, which has perhaps been shaped by his family, professionals and/or wider society. This is an alternative formulation or narrative to the cognitive-behavioural and medical narratives about James' problems and 'patient' position which are constructed throughout the rest of the documentary. The deployment of this counternarrative is an anomaly; it does not fit with other narratives in the documentary and is perhaps deployed in the first scene because it provides a striking beginning to the documentary and is used as resource to keep the audience watching. James is filmed next to the toilet while he talks about his relationship with it:
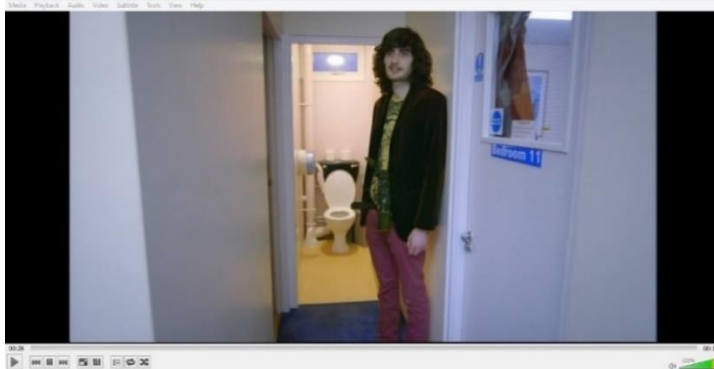

Image V

When he orients the audience to his counternarrative, James is taken out of the frame and only the toilet can be seen:

<u>Image W</u>

This brings to the fore the absurdity of James having a difficult relationship with an inanimate object, and perhaps aligns the documentary with James' inner rational voice.

3.2.2. <u>Distress Evoked By Treatment</u>

At specific points in the documentary, emotional distress arising from CBT techniques such as in-vivo exposure is evident. The documentary does not offer a commentary on these instances through the narrator, however, they are clearly present from the deployment of other character's voices. James' emotional distress from his psychological treatment is apparent at the beginning of the documentary, where little context is given:

> [Scene 3, lines 37-49] James: Oh my <u>God</u>. Oh my God, oh my God, oh my God, oh my God, oh my <u>God</u>
>
> Anna: As you said just keep going, stand up

Despite James' verbal expression of distress, Anna's powerful position as his therapist enables her to encourage him to tolerate it. James appears to take up the position of a compliant patient. As the plot moves along, and more context is given, in scene 28 we learn that James was in treatment at this point in the documentary, however, it is portrayed by the narrator as an example of his 'condition' rather than distress resulting from treatment. In scene 17, James meets with Anna in a consulting room where "…the therapy continues to be about <u>confronting</u> the fear…" (Scene 17, narrator, lines 494-495). Anna printed off articles of famous sex offenders for an in-vivo exposure exercise. Visual images show James with his head in his hands followed by him crying whilst clutching an

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article. These images convey the high levels of distress he experiences when "confronting the fear":

Image X

Image Y

The documentary perhaps deploy these visual images for entertainment value, and their stance towards the distress evoked by therapeutic techniques remains neutral. Similarly, during a depiction of Arron, he talks about how therapy causes him 'anxiety':

> [Scene 4, lines 50-52] I-I feel a bit anxious cause part of my therapy at the moment is tackling opening and closing drawers and doors only once…

Arron appears to explain a therapeutic process akin to exposure and response prevention (ERP), where people are encouraged to refrain from carrying out rituals so as to expose themselves to 'anxiety' which, in theory, they will become habituated to. However, the documentary appears to deploy this segment of speech to give voice to Arron's 'abnormal' behaviours of repeatedly opening and closing drawers rather than to expose the distress he experiences from therapy.

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3.2.3. Resistance to Treatment

The depictions of Leon's reluctance to work alongside the therapist's point of view can be seen as an act of resistance[9]:

> [Scene 20, lines 573-578] Interviewer: And what are you using that this disinfectant down there what what how often are you using that and for what? Leon: Don't tell the therapist this [laughter] She'll say have you been using that disinfectant? It isn't my main thing I don't use disinfectant that much
>
> [line 583] Narrator: At fifty-five he was older than most patients
>
> [line 585] Narrator: And didn't seem as desperate to change

In the above extracts, Leon appears to resist the therapist's attempts to terminate his use of disinfectant; he privileges his own assessment of the normal amount to use over the assessment of the therapist. Drawing on the therapist's voice, he also resists her right to question him and let us know she is focusing on something that is of little concern to him. The interviewer positions himself as a pseudo-therapist or authority figure who has the right to enquire about Leon's behaviour. This could be seen as an act of forced self-positioning (Harré & van Lagenhove, 1991) where Leon is forced to position himself in order for the documentary to have information to base their positioning of him. The interviewer's questions position Leon as non-compliant with treatment. Leon's response indicates he is fearful the interviewer will report back to his therapist and he also appears to downplay his disinfectant use, which provides information for positioning him as non-compliant with treatment and lacking in self-awareness. Visual images in this scene reinforce the evidence for his positioning; Leon is shown to be in possession of disinfectant and numerous plastic gloves:

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[9] According to Wade (1997, p. 25), resistance is defined as, "…any mental or behavioural act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence or oppression (including any type of disrespect), or the conditions that make such acts possible…"
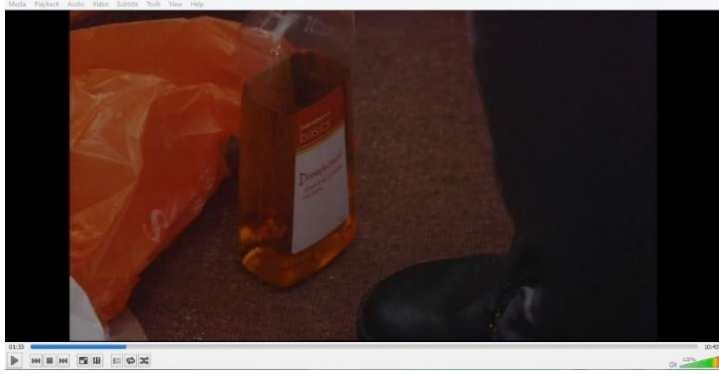
Image Z

Image AA

Through the voice of the objectifying narrator, Leon is portrayed as a lacking motivation to change which is understood in the context of him being older than other 'anxiety' sufferers. This, in turn, positions the other characters as more driven to engage with the treatment programme and change their behaviours

3.3.   Absent Narratives

3.3.1. Absence of Therapy Name and Associated Terms

The words "cognitive-behavioural" are not mentioned once during the documentary, and scenes of CBT in action, like Arron's ERP and James' in-vivo exposure, are not labelled as such. This is puzzling considering the documentary clearly endorses CBT and providing the name of the therapy would enable interested viewers to request it more easily from their healthcare provider. This absence could be for a number of reasons. It creates an air of mystery about the therapy and may keep the audience intrigued. Secondly, the film makers may have assumed it unimportant or irrelevant for the audience to know what it is. They may have also wanted to avoid confusion or distraction from the main

storylines among the audience. Finally, it could be that overly technical language is excluded to make the documentary more accessible to a lay audience. The use of the colloquial term "practical experiment" (Narrator, Scene 12, line 271) rather than the technical term "behavioural experiment" (Westbrook, Kennerley, Kirk, 2007, p. 19) could be evidence for this hypothesis.

3.3.2. Leon's Lack of Narrative Closure

Narrative closure indicates a conclusion or resolution at the end of a story and "…occurs when the protagonists have solved all the problems with which the narrative has saddled them" (Carroll, 2007, p. 7). Helen, Arron and James are all afforded narrative closure in scene 31 (where the narrator explains their treatment successes and return to 'normality'), unlike Leon. Leon is not included in the final scene of the documentary and is not presented as a success story like the other characters are. Leon's voice is last heard in scene 21, where the documentary makers deploy his statement about 'madness':

> [Scene 21, lines 589-591] You know this Shakespeare thing which said madness creeps in little by little. It does! [Laughter]

Given the earlier portrayals of Leon, the deployment of his voice where he talks about 'madness' serves to push the boundaries of his portrayals to that of 'madness'. This portrayal is reinforced by only half of Leon's body and not his face being shown throughout the documentary (image AB). Although Leon may have requested anonymity, this has been achieved in other ways in other television programmes such as filming the person from the back or blurring over their face. A beheaded body communicates at some level a person who has lost his mind. As Leon positions himself as an expert on 'madness' in this extract, it gives validity to the portrayal, as Leon himself comments on the process of how it can happen i.e. "little by little".

Image AB

Numerous hypotheses can account for why Leon's storyline stops at 'madness' and narrative closure is omitted. Perhaps his resistance to psychological treatment simply does not fit into the "therapy makes people normal" subnarrative and, therefore, he is omitted from the ending. Perhaps the documentary makers only wanted to provide romanticised happy endings, and Leon's storyline jeopardised this aim. Treatment 'failure' is rarely talked about among professionals (Spellman & Harper, 1996) and a parallel process may have occurred in the documentary. If this is the case, it begs the question - why was Leon included in the documentary in the first place? The documentary places the responsibility of 'recovery' in the hands of 'anxiety' sufferers, through the construction of the "anxiety can be overcome with willpower" narrative. Leon's voice may have been deployed as implicit evidence for this narrative - he does not have the impetus or willpower to change and as a result, does not overcome his 'anxiety'.

3.3.3. Family Dynamics and 'Anxiety'

The documentary lacks a narrative about family dynamics and 'anxiety', despite Penny's critical comments towards James and his recurrent 'relapses' on return to his home environment where his family live from psychiatric hospitals. By focussing on people's 'conditions' and ignoring the wider contextual factors influencing their distress, the documentary endorses a more medicalised and individualised narrative about 'anxiety' and does not offer alternative and enriching narratives. The documentary perhaps reflects the move away from implicating families in the aetiology and maintenance of mental distress, out of fear of blaming them.

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3.3.4. Absent Identities

The amount of personal information the audience learns about the characters is unequal. For example, we learn about James, Helen and Arron's occupations, but we do not learn about Leon's. Furthermore, visual images of Leon with important people in his life are not shown and possibilities for identities other than 'patient', 'mad' or 'victim' are not apparent. The documentary does, however, show visual images of Arron (image AC) and Helen (image AD) with other people, who could be their friends, family or partner:
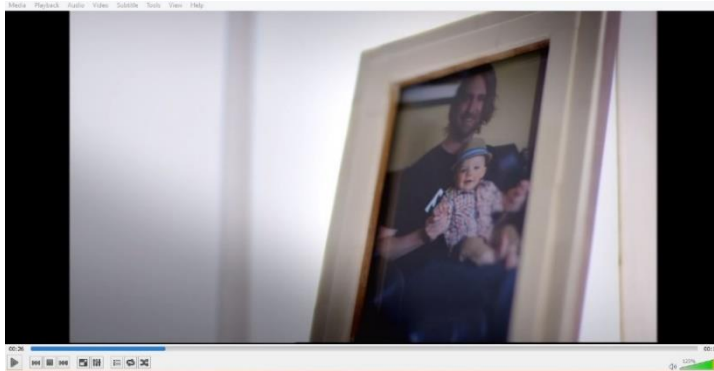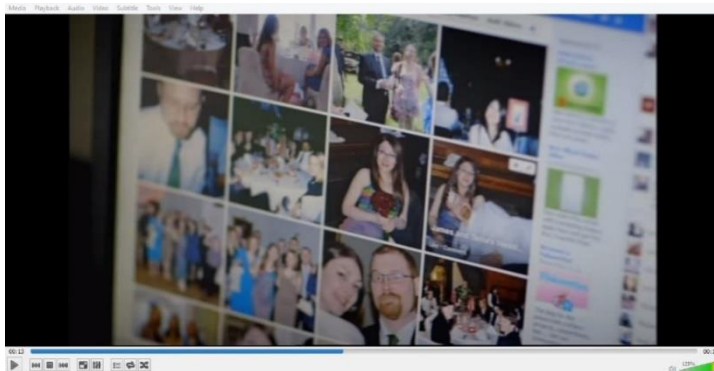

Image AC

Image AD

Photographs in James' room are also shown:

Image AE

However, the documentary does not provide a platform for their multiple identities to be storied. For example, stories about their relationships with these people, what other roles they have in their lives and what these relationships say about what they value in life are not included in the documentary.

4. ANALYSIS OF BEDLAM PSYCHOSIS DOCUMENTARY

4.1. Dominant Narratives

4.1.1. <u>Medical Narrative</u>

4.1.1.2. *Subnarrative: Dichotomy between normality and abnormality*

In scene 4, Jim's voice is deployed to define a line between normality and abnormality. He positions Tamara as a 'patient' in her absence, an example of the "deliberate positioning of others" (Harré & van Lagenhove, 1999, p. 27) and in doing so, he positions himself as a more powerful person, with the right to decide whether Tamara's experience of bed bugs is 'normal' or 'abnormal' and, ultimately, whether she is mentally 'ill' or not:

> [Scene 4, lines 58-63] Jim Thurkle: She has um persistent delusional disorder and the persistence is about bed bugs and she brought a small tube with some bed bed bugs in it so there is no <u>doubt</u> that there are bed bugs in her flat but what the patient imagines is that the bed bugs are behind her eyes and in places that is physically impossible for them to be.

Jim Thurkle's position of authority is also established visually by the professional work setting he is filmed in, his identification badge and aston:

<u>Image AF</u>

The narrator then extends this subnarrative beyond Tamara to other people who access services in the community. They are labelled with 'psychosis' and the audience is given an explanation about what this means:

[Scene 4, lines 65-67] Narrator: …It means they can lose contact with reality, hear voices, suffer hallucinations or delusions.

The narrator positions the imagined audience as naïve and uninformed about mental 'illness'. In doing so, the narrator positions himself as an educator in mental health literacy. The explicit assertion of authority at this point in the documentary perhaps gains the audience's trust in the narrator early on. This allows subsequent assertions made by the narrator to be trusted; his voice can then be heard over moving images of Tamara walking down a corridor towards her flat, which are reminiscent of, and carry meaning associated with long, daunting corridors in psychiatric institutions such as asylums and long stay psychiatric hospitals:
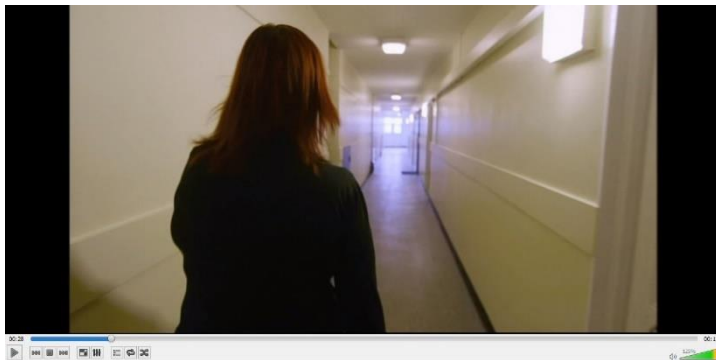
Image AG

Showing this familiar image during the voiceover from the narrator, has the effect of associating 'psychosis' with psychiatric institutionalisation, perhaps suggesting the continued need for control of mentally 'ill' people, which is discussed below. In addition to 'persistent delusional disorder' and 'psychosis', the psychiatric diagnoses 'schizophrenia' and 'paranoid schizophrenia' also feature in the documentary. These diagnoses are also portrayed as unproblematic terms and reified as existing entities that can be identified. In subsequent scenes, Lloyd's voice is deployed to persuade the audience of the validity of mental 'illness'. Lloyd is a voice hearer who, unlike Tamara, appears to accept being labelled as mentally 'ill', as the interviewer deliberately positions Lloyd:

[Scene 7, lines 126-128] Interviewer: Was that your illness [music stops] < Lloyd: Yeah that was the illness yeah > What was it telling you to do?

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Lloyd also positions Martha, the voice he hears, as a "schizophrenic voice", indicating his agreement with diagnostic labels:

> [Scene 13, lines 344-345] Err I've I did a bit of the video reports and I've tried to capture some of the schizophrenic voices xxx.

4.1.1.3. *Subnarrative: Life events trigger mental 'illness'*

In scene 14, Dr Gallo, Lloyd's psychiatrist, co-constructs a subnarrative with the interviewer about Lloyd's pathway to mental 'illness'. Lloyd's life experiences, such as a relationship break-up and bereavements, are constructed as triggering a 'first episode of schizophrenia':

> [Scene 14, lines 358-369] Dr Gallo: Err he first became ill in during 2007. At that time I don't know exactly but he was thirty seven, thirty eight <Interviewer: So nothing before that?> No nothing that we are aware of. Um there were you know stressful quite significant life event, it was erm d'you know the separation from from his er girlfriend and the following year it was the the death of his mother

> Interviewer: So before there was no no mental health issue is that unusual?

> Dr Gallo: No no no you can have first episode of a schizophrenia in people who are sixty years old or so. It can happen.

Dr Gallo's response depicts the course of schizophrenia as variable, with the possibility of it occurring at any time over the life course. This extends the medicalisation narrative across the life span. Due to editing procedures, it is unclear whether Dr Gallo was asked a question at the beginning of the scene and, therefore, how Dr Gallo was positioned by the interviewer, in the lead up to Dr Gallo's story about Lloyd. However, we see that Dr Gallo positions himself as an 'expert' in Lloyd's life story and the development of his mental 'illness'. In the latter part of the interview, Dr Gallo is positioned as an 'expert' in mental 'illness' by the interviewer, and Dr Gallo takes up this first order positioning unquestioningly. The interview takes place in a clinical setting whilst on the move, which depicts Dr Gallo as a busy clinician and supports the exposition that he is an expert in the field of mental 'illness':

Image AH

4.1.1.4. *Subnarrative: The link between substance use, mental 'illness' and physical health problems*

      The voices of the narrator and Dr Gallo are deployed to support a medicalised narrative about the role of substances in the aetiology and maintenance of mental 'illness'. Tamara's use of speed, an amphetamine drug, is introduced as a storyline in scene 9. Her use of speed is portrayed as an 'addiction' and a causal link is made between speed and the onset of her 'delusions' by the narrator:

> [Scene 9, lines 251-253] Keeping Tamara well is complicated by her long term addiction to speed. It's likely to have been the trigger for her delusions.

A visual image of Tamara looking dishevelled and tired reinforces the portrayal of Tamara as a 'speed addict':
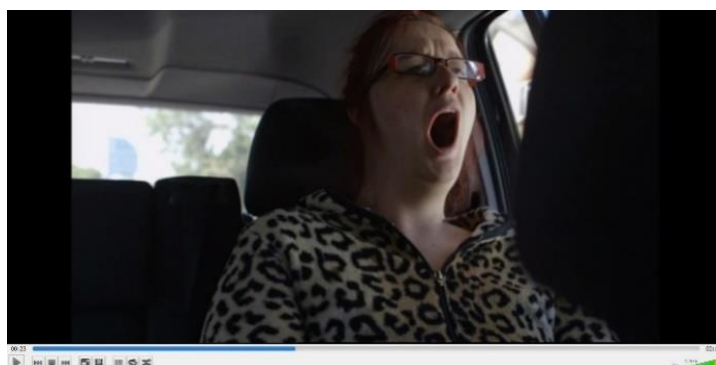
Image AI

Alcohol use is medicalised in different ways to speed. Firstly, excessive alcohol use is linked to worsened anxiety 'symptoms' by Dr Gallo:

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[Scene 14, lines 376-378] His anxiety symptoms have deteriorated as well markly. One of element of playing a part in this has been he increased use in alcohol.

During this segment of speech, Dr Gallo's voice is played over an extreme close-up of Lloyd's face which is not unusual in television images of people labelled with mental 'illness' and may signify isolation from other people (Rose, 1998). This close up might also allow Lloyd to be placed in the gaze of the audience where they are permitted to scrutinise the 'other':

Image AJ

Secondly, the interviewer and Dr Gallo co-construct a medicalised self-medication narrative to explain Lloyd's relationship with alcohol:

[Scene 14, lines 379-381] Interviewer: So is the drinking is that him medicating himself?

Dr Gallo: Yes…

A moving image of Lloyd lighting and smoking a cigarette is shown at the same time, perhaps signifying Lloyd's self-medication with tobacco as well as alcohol:

Image AK

The end of the documentary emphasises the harmful effects of alcohol on people's physical health by depicting Lloyd in hospital with pancreatitis. Here, Lloyd's alcohol use is constructed as 'binge drinking' and it is linked to physical health problems and mortality by the narrator, Dr Gallo and the interviewer:

> [Scene- 22, lines 806-607] Narrator: He developed pancreatitis, a condition often caused by alcohol abuse and sometimes fatal

> [Lines 808-814] Dr Gallo: He was <u>binge</u> drinking I mean clearly he's got a problem with alcohol you know. A <u>serious</u> condition what we would hope is that he gets better you know that he go he goes through this but er again the you know his physical illness are very very very severe indeed

> Interviewer: Could he die?

> Dr Gallo: Yeah, yeah

In the extracts above, the narrator positions himself as an 'expert' in the relationship between substance use and mental 'illness', while Dr Gallo is positioned as an 'expert' by the interviewer – a position which he takes up. Using an 'expert' voice has the effect of persuading the audience of the medicalised perspectives on the link between substance use, mental 'illness' and physical health problems. This brings certainty and 'truth' to the topics being addressed.

4.1.2. <u>Moral and Control Narrative</u>

Particular voices and events are deployed to construct narratives about the necessity of compulsory and coercive interventions in the face of antisocial behaviour such as substance use, unpredictability, potential violence and lack of compliance with obligations associated with being a psychiatric 'patient'.

4.1.2.1. *Subnarrative: Control of substance use*

The documentary endorses two different ways of controlling speed and alcohol use, based on their different constructions discussed earlier. Tamara's use of speed is problematised further in the documentary by Jim Thurkle. He draws on Tamara's voice to persuade the audience about her speed 'addiction' by saying Tamara herself knows she has a drug problem. Tamara is positioned as the disagreeable party in their separate discussion about which drugs are helpful, thus positioning Jim Thurkle and his colleagues as amenable and willing to work with Tamara. In this positioning process, Jim Thurkle is explicit about what he believes his duties, and those of his colleagues, are in relation to Tamara's drug use, in order to justify their continued attempts to control her life choices:

> [Scene 10, lines 282-286] Jim Thurkle: She knows she's got a drug problem but she also believes with her heart that it helps her and the drugs she chooses would not be ones that we think do help her but she disagrees with that fervently. We have I think we still have a duty to work with that.

Moving visual images of Tamara walking away are shown while Jim Thurkle's voice is played, reinforcing the portrayal of Tamara as disagreeable and unwilling to engage in a narrative about speed being the wrong drug of choice for her:

Image AL

In contrast to ongoing attempts to eliminate Tamara's speed use altogether and replace it with professionally endorsed substances i.e. psychotropic medication, attempts to control Lloyd's alcohol use involved discussing its harmful effects:

> [Scene 14, lines 381-382] Dr Gallo: …we discuss about the harmful effect of alcohol…

Dr Gallo appears to position himself as having a duty to inform his 'patients' about the negative effects of alcohol use, however, beyond this advice giving, the responsibility it placed on the individual to take his advice and make changes in their behaviour.

Both Dr Gallo and Jim Thurkle take up the duty of attempting to change their patients' substance use which they believe to be problematic. The audience are drawn to empathise with them, as they are depicted as hard workers who have a difficult task on their hands.

4.1.2.2.   *Subnarrative: Necessity of Coercive and Compulsory Interventions*

Tamara is deliberately positioned as unpredictable in her absence by the narrator. In Tamara's case, this is portrayed as the changeability of her 'mental state' (i.e. the presence or absence of psychiatric symptoms) and behaviour (i.e. whether she is behaving 'normally' or not). Jim Thurkle is positioned by the

narrator as having no choice but to monitor Tamara frequently, because of this declared unpredictability:

> [Scene 9, lines 223-224] Narrator: Tamara is one he needs to visit several times a week. She, can change by the day

Tamara is also positioned as one of many patients, which has the effect of distancing the audience from Tamara as a person and creating an objective and depersonalised stance towards her as 'the other'. The narrator also stories the documentary team's experience of Tamara as unpredictable:

> [Scene 17, 578-579] Narrator: Whenever we arrange to meet, you can never be quite sure which Tamara was going to turn up

Tamara is visited regularly by Jim Thurkle and is considered for another hospital admission when she presents as more distressed than usual in scene 19, despite Tamara being very clear that going into hospital would not be helpful for her. Similarly, in the storyline about Rosemary, she is deliberately positioned in her absence as mentally 'ill' in two ways by the narrator. She is assigned a psychiatric diagnosis of 'paranoid schizophrenia' (Scene 6, line 105; Scene 8, line 212; Scene 16, line 511) thrice throughout the documentary and positioned as a 'psychotic patient' (Scene 8, line 214) by the narrator. This repeated labelling of Rosemary by the documentary perhaps emphasises her supposed differences and 'others' her more than other characters. She is also deliberately positioned in her absence as recalcitrant and difficult to engage by the narrator because she does not perform obligations expected of 'psychotic patients', i.e. taking medication and maintaining contact with their care coordinator. Furthermore, Rosemary's reluctance to engage with the system is portrayed as her "struggling to accept her mental illness" (Narrator, Scene 23, lines 897-898). The deployment of Jim Thurkle's voice sandwiched between the narrator's assertions adds uncertainty about Rosemary's 'mental state', perhaps with the aim of persuading the audience of the necessity to carefully monitor Rosemary's 'symptoms' and behaviours. Jim uses medicalised language in conversation with the interviewer to maintain his 'expert' position in the construction of Rosemary's level of 'risk' to herself:

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[Scene 8, lines 211-219]: Narrator: It's now been 5 weeks since Jim's seen Rosemary, a woman with paranoid schizophrenia. She stopped taking her medication. The most common cause of relapse amongst psychotic patients.

Jim Thurkle: I-I don't know what condition she's in or whether she's near to a-a complete relapse and what her mental state is. Those are ongoing risks for her.

Interviewer: Are you a bit concerned?

Jim Thurkle: Yeah yeah.

The visual images during this speech segment attempt to draw empathy for Jim from the audience. He is shown to search for Rosemary in vain. These images are interspersed with an image of Jim Thurkle being interviewed, where there is an aston of his job title, reaffirming his professional and expert status which gives weight to this narrative:

Image AM

Image AN

Image AO
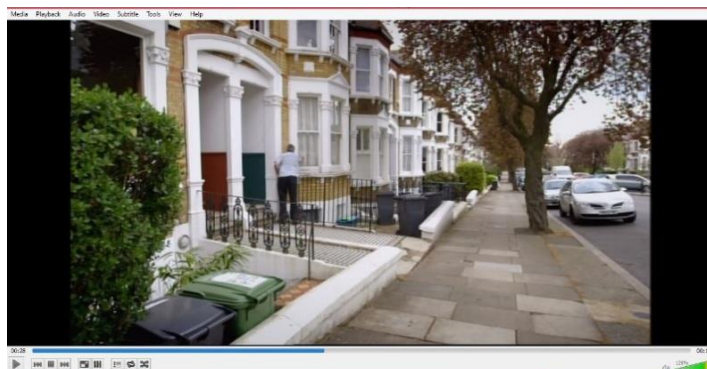
Image AP

In scene 15, Rosemary's 'risk' to others becomes a prominent feature of the storyline through the re-deployment of Jim Thurkle's voice:

> [Scene 15, lines 440-444] When this happened last year just prior to coming into hospital she was knocking on the doors of the next door neighbour who has two young children. She was disturbing the man upstairs by doing the same kind of thing.

In the above extract, Jim Thurkle positions Rosemary as disruptive and deviant. He includes small children in his story to persuade the audience of the level of risk Rosemary poses to the public. However, his story is taken out of context – we do not know the circumstances surrounding Rosemary's past behaviour and again she is deliberately positioned in her absence. We do not hear Rosemary's side to the story, thus, she does not have the privilege and opportunity to engage in second order positioning. Eventually, in scene 16, Jim Thurkle's voice is deployed again to justify Rosemary's subsequent compulsory admission to a psychiatric hospital:

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[Scene 16, lines 521-523] … ultimately our assessment is that she doesn't have capacity and that she could be an awful lot better in terms of her mental health. We've tried <u>all</u> the other alternatives.

Jim Thurkle uses the collective term "we" to include the voices of his colleagues. This has the effect of creating a more powerful collective voice which holds more weight in the justification of detaining Rosemary in hospital again. Jim Thurkle asserts he and his colleagues have the right to detain Rosemary against her will. This can be seen as an act of "moral positioning" (Harré & van Lagenhove, 1999, p.21), where Jim Thurkle attempts to make his position, and the position of his colleagues, understood within their roles as mental health professionals and the legal context of the Mental Capacity Act (2005).

Another voice which is deployed to justify the control of 'mentally ill' people is that of Ray, Lloyd's father. The narrator tells the audience that Ray had no choice but to take Lloyd to a psychiatric hospital because he was hearing voices (it is unclear whether the admission was voluntary or involuntary). Thus, the role of controlling people diagnosed with mental 'illness' extends to family members. Lloyd explains he started to have problems with the police around the time he started hearing voices. Ray's decision and justification to take Lloyd to hospital appears to draw on stigmatising narratives about unpredictability and fear of violence from people who hear voices, which understandably fostered a worried response:

[Scene 7, lines 119-120] Ray: I was terribly worried about him you know / what I mean?

[Lines 168-177] Ray: … It <u>did</u> [worry me] at first because I thought well you never know do you, I don't know you know /

Lloyd: / Yeah if you take notice of the voices.

Ray: You know I don't know if he takes notice of them [the voices] so it could be anything couldn't it. I didn't ever want them say well get up and hit your dad over the head or kill your dad < Lloyd: Yeah, it doesn't work like that > But you know what I'm saying I know it sounds silly but you you would have had no chance would ya?

Ray looks for validation from the interviewer and his audience, and seems to aim to persuade others of his predicament (Riessman, 2008). Lloyd does not take Ray's first order positioning for granted, and instead resists it by pointing out people can act dangerously in response voices if they pay attention to them. Ray chooses not to engage with Lloyd's point of view about voice hearing, and instead continues to speak about Lloyd as if he is not part of the conversation and to position Lloyd as powerless and potentially dangerous in the context of a hypothetical scenario where Lloyd may have experienced commanding voices with violent content. Lloyd's counternarrative to this subnarrative is discussed further below. Where Lloyd's resistive voice interrupts Ray's, the visual images remain focussed on Ray's face perhaps to position the audience's attention on Ray's voice rather than on Lloyd's, which has the effect of reducing the power of Lloyd's counternarrative:

Image AQ

At the end of the documentary, the narrator's voice is deployed to finalise the position of the documentary makers in regards to coercive and compulsory interventions. Further, the narrator praises community care as humane and normalising:

> [Scene 23, lines 900-902] Narrator: …it seems to make sense what community care was all about. Treating those who are mentally ill with humanity, as people like us.

Visual images of 'normal' families in the park and outdoors are shown in unison to create a visual narrative about what it means to be a 'normal' citizen:

Image AR

Image AS

These images are in stark contrast to the earlier images of Tamara, Rosemary and Lloyd, who are mostly filmed alone and indoors. These contrasts enable "normalising judgements" (Foucault, 1977) to take place among the audience, reinforcing support for the narrative that community care and its associated technologies (i.e. coercive and compulsory interventions) are necessary to control and redeem the mentally 'ill' from their unpredictable, potentially violent and non-compliant behaviours and in the process, keep the public safe and undisturbed.

Finally, Rosemary carries more of the aforementioned negative constructions than her counterparts and is the only character in the documentary who is depicted as being 'sectioned' multiple times. As Rosemary is the only character from a black and ethnic minority (BME) background in both documentaries, this depiction perhaps points to wider issues in the mental health system pertaining to race.

4.2. Counternarratives

4.2.1. Resistance to Medicalisation

Tamara consistently resists medicalised narratives of mental distress. The opening scene of the documentary features Tamara being interviewed. It is a lively introduction, which throws the audience straight into meeting Tamara for the first time. Tamara's story begins with her laughing, and accepting the interviewer's invitation to explain what is going on for her whilst at the same time constructing Tamara's irrationality as the focus, simultaneously taking the gaze away from her living environment:

> [Scene 1, lines 5-13] Interviewer: What's Bertie the bed bug?
>
> Tamara: [Laughing] Bertie the bed bug. Do you know that's a bed bug's name. One of them's called Bertie. We've got like a whole family of them. 'Cause they thought I was seeing stuff cause I was sitting in a public hallway because I couldn't sit in my flat no more so they said that I was mad like sort of um mental, mentally not mentally able to cope on my own and that they had to section me on a section 3. They concluded was that I'm paranoid about bed bugs.

Naming a bed bug and laughing about it perhaps protected Tamara from the emotional pain of living in such poor living conditions. Tamara attempts to persuade the audience about the existence of bed bugs is apparent through her use of the collective term "we've". She tells a story about sitting in a public hallway because she felt unable to stay in her flat due to bed bugs. She juxtaposes this to what 'they' said (which we later find out refers to the mental health professionals involved in her care). She recalls how 'they' interpreted her experiences- they thought she was hallucinating, mad, not able to cope and paranoid about bed bugs. As a result she was admitted to psychiatric hospital against her will. There is a jump cut made after Tamara states "section 3", perhaps to indicate a passage of time in Tamara's story. It is possible she actually said more than is depicted in this scene and so it is not clear whether Tamara ends the story here, or whether it is an ending created by the documentary makers. Nevertheless, the crux of Tamara's story is that the

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conclusions of professionals were not only different to her own but, in fact, ignoring the reality of the material conditions in which she lived.

How Tamara is presented visually in this scene, perhaps tells a different story about her, and discredits her position. Tamara is initially shown to conduct fairly 'normal' activities such as bringing the shopping into her flat and putting make-up on, conveying Tamara as a 'normal' person, who does 'normal' activities like everybody else. Then while Tamara is being interviewed, there is a cutaway shot to image X, which interrupts the continuous filming of Tamara:

Image AT

Given the lack of context afforded to Tamara at this point in the documentary, and the contrast to earlier moving images of Tamara carrying out 'normal' everyday activities, the documentary makers perhaps attempt to persuade the audience that Tamara is a more peculiar and unusual character than initially thought. This serves to discredit Tamara's counternarrative, while at the same time paying lip service to the views of PWAS.

Tamara also resists being positioned as mentally 'ill' in conversation with the interviewer in scene 11. The interviewer draws on a prominent narrative about people being scared of 'mentally ill people' who live in the community, and Tamara resists both first order positions as a mentally 'ill' person and as somebody who is fearful of people with mental 'illness':

> [Scene 11, lines 307-311] Interviewer: A lot of people are scared of mentally ill in the community aren't they
>
> Tamara: Yeah, I'm not 'cause I know they're not I've been in hospital with them, they're not they're not, they're harmless really

Tamara's voice is played over an extreme close-up image of her face (image AU). This has the effect of objectifying and portraying her as unfamiliar (Rose, 1998) and as discussed earlier, allows Tamara to be placed in the gaze of the audience where they are permitted to scrutinise her as the 'other':
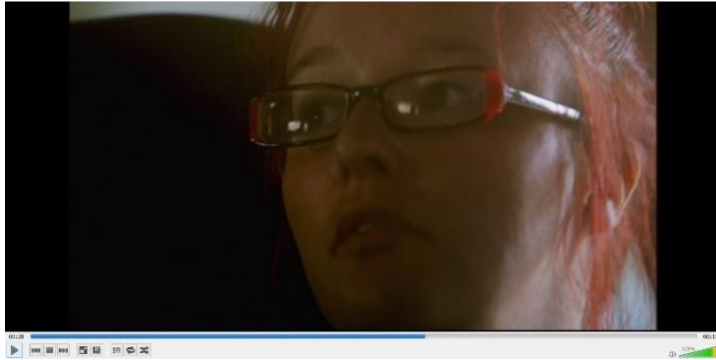

Image AU

Furthermore, the medicalisation of Tamara's experience of bed bugs obscures the impact of social factors on mental wellbeing. Indeed, Tamara resists the idea of hospital admission, and is assertive about what she feels she needs - new accommodation, not hospital admission:

> [Scene 19, 651-661] Tamara: And this place is just getting worse now
>
> Jim Thurkle: Well I'm quite worried about you at the moment
>
> Tamara: No I ain't going into no hospital I'm fine / in that aspect
>
> Jim Thurkle: / you don't wanna to go there
>
> Tamara: Oh no, oh no. I wanna move out of here
>
> Jim Thurkle: I know
>
> Tamara: That's what I want. I want to live a normal life and I living a normal life is in a normal property. No bugs that attack you and have sore lips with it because of it

Jim Thurkle positions himself as a caring professional by saying he is worried about Tamara, but she takes this self-positioning as a cue for another hospital admission. She is clearly aware of the powerful position Jim Thurkle holds and instantly resists this. Tamara's repetition of "oh no" emphasises how strongly she feels about not going into hospital again and stresses the need for a different kind

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of intervention in accordance with her non-medicalised counternarrative about bed bugs. Tamara continues to resist the medicalised narrative about bed bugs, and the more she does this, the more Jim Thurkle exercises his power:

> [Scene 19, 689-695] Tamara: Bed bugs are not mental, they are visible they are here in reality. It's not mentally, I'm not seeing things, they are here
>
> Jim Thurkle: I'm sure Dr Werner will want to have that discussion with you
>
> Tamara: So no mental er health er health hospital will help me.

The legitimisation of the voice and power of psychiatry, and implicitly the law (specifically the Mental Health Act, 1983), can be heard in Jim Thurkle's voice. Tamara appears aware of the possible consequences of Jim Thurkle's proposition, and resists the hospital admission that might be offered to her as intervention, or even forcibly imposed.

Again, extreme close-ups of Tamara's face form a large part of the visual images during scene 19 (images AV and AY), whereas Jim Thurkle's face is filmed at a distance. At times the moving images of Tamara's face are unfocussed and watching becomes uncomfortable and disorientating for the viewer. Image AX shows Tamara's feet fidgeting; the combination of these with extreme close ups of her face and the unfocussed lens portray Tamara as 'mad' and out of control of her limbs. Drawing on stereotypical and familiar visual narratives of madness further serves to discredit Tamara's counternarrative, while lending support to the dominant medical and moral and control narratives:.
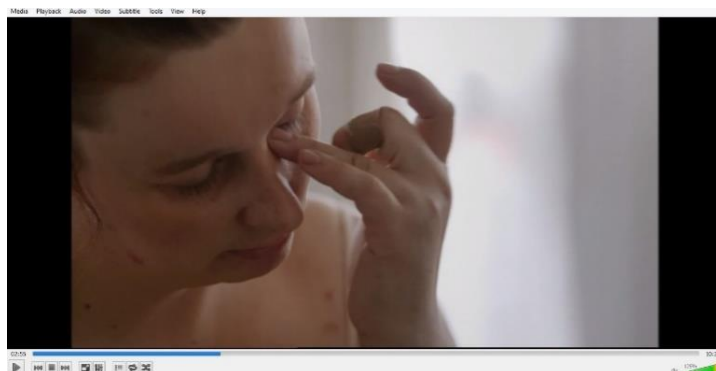
Image AV

Image AW

Image AX

Image AY

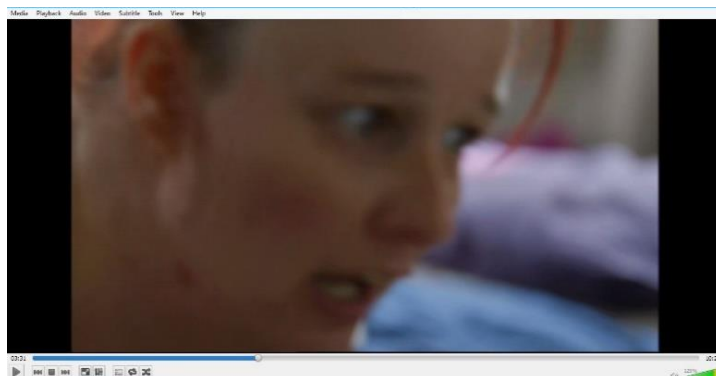Furthermore, Tamara's resistance of the medical narrative throughout the
documentary is simultaneously discredited and positively connoted. Tamara's
dissenting voice is deployed as an example of someone who does not let mental
illness "beat her down" (Scene 11, line 320). Her resistance is, therefore,
portrayed by the narrator as fighting a mental 'illness', rather than challenging the
medical narratives of mental distress.

Lloyd is also resistive of the medical narrative. Although he is portrayed as accepting of the mental illness label, he orients the audience to a counternarrative about Martha, the voice he hears. He is shown to converse with Martha throughout the documentary film, and appears to have a deeply personal relationship with her:

> [Scene 7, lines 204-207] Lloyd: Looking forward to having a good chin wag with her. I haven't been on me own for ages you know [laughter] I know I must seem crazy. Stop laughing [laughter] stop laughing

However, Lloyd's acceptance of being positioned as mentally 'ill' combined with his personal relationship with the voice and heavy drinking leads to him being portrayed as "struggling to come to terms" with his mental 'illness' (Scene 12, lines 322-323) and being "unusually open about his illness" (Scene 12, line 339) by the narrator. This nuance clearly presents itself as a conundrum for the documentary film makers; leading them to conclude Lloyd is in limbo in regards to his mental 'illness' which leads him to drink alcohol to cope with the 'illness' and he is somewhat peculiar for speaking out about his relationship with Martha.

4.2.2. Substance Use as a Coping Strategy

Tamara offers a counternarrative to the medicalised and problematised addiction narrative about speed offered by the narrator, Dr Werner and Jim Thurkle (see dominant narratives section above). Surprisingly, given the portrayal of Tamara as unstable, Tamara's counternarrative about speed remains consistent in different contexts. In a psychiatry appointment with Dr Werner, Tamara argues it is a coping mechanism for the mental distress she experiences:

> [Scene 10, lines 267-272] Dr Werner: Oh it's it's a bit more than than I thought it used to be a little bit less is that right?

> Tamara: Yeah but what's the point giving up. Takes my pain away. Right let's talk about medication now 'cause I'm not talking about speed no more that's just / not what I have to deal with

Dr Werner positions Tamara as a 'patient' in their conversation, thus giving him the right to enquire about and comment on her use of speed. Dr Werner's expert

position is reinforced by visual images of him in a clinical setting; one image features an aston of his job title:

Image AZ

However, Tamara challenges Dr Werner's powerful position, and changes the subject to medication. When Tamara is interviewed at home away from the clinic, she appears more open about her reasons for using speed. Tamara does not draw on a medicalised or problematised addiction narrative, but instead stories her relationship with speed as 'reliance'. She argues that speed helps her function, and relieves the mental distress associated with her social circumstances, i.e., losing her children into care:

> [Scene 10, lines 274-280] I don't get out of my bed if I don't have my speed. I don't do shopping, I don't do <u>nothing</u> with myself so as long as I've got my speed. I rely on my speed on a lot of <u>stuff</u>. I've lost my kids into foster <u>care</u>, yeah, they're in foster care now. I just can't cope anymore so with the speed it numbs my <u>pain</u> <u>inside</u> and when I'm normal, I get upset about the kids definitely 'cause I do miss 'em.

Tamara positions herself as caring mother, by saying she cannot cope without her children and the pain associated with losing them. Tamara repeats the predicament she is in with regards to her children, perhaps to persuade the audience of how harrowing this experience is for her, and possibly seeking to engender empathy for her use of speed.

Whilst Tamara explains how she lost her children into foster care, there is a cutaway shot to a collage of photographs (image BA):

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Image BA

This image appears to support Tamara's positioning of herself as a caring mother who struggles to be without her children. The image tells a story about Tamara previously having a family life, a dog, children and a partner. This visual image also forms part of an absent but implicit narrative about other aspects of Tamara's life and identity, which are not the focus of the documentary.

Similarly, Lloyd also constructs his alcohol use as a way of coping with difficult experiences, and attempts to persuade the audience that he uses alcohol to feel stable within himself. He does not view drinking alcohol as problematic per se, but does problematise excessive drinking:

> [Scene 14, lines 386-389] Lloyd: It's because I don't feel stable that's why and drink helps me to stabilise meself but the problem with that is, is once you drink too much, if I had 3 pints it will be fine, but I don't, I have 6 pints or something, you know, or 9 pints.

Interestingly, the narrator and interviewer both support this counternarrative for Lloyd, but not for Tamara. The narrator draws a link between the stigma associated with having a diagnosis of 'schizophrenia' and Lloyd's experience of worry to empathise with Lloyd's use of alcohol as a way of coping. The narrator, therefore, positions Lloyd as a victim of stigmatising views about mental 'illness' in society, who uses alcohol as an understandable coping strategy:

> [Scene 14, lines 391-393] Narrator: Lloyd was all too aware of what the schizophrenic label meant. He locked himself away and drank through the worry. It was his way of dealing with it…

Lloyd is shown to close and lock his front door, which constructs a visual narrative of him isolating himself and literally locking himself away:

Image BB

It perhaps also symbolises the social distance and barriers that exist between people deemed mentally 'ill' and those who are not. The interviewer also supports the counternarrative and presents it to Ray, Lloyd's father. Ray considers the interviewer's view, and then resists it:

> [Scene 26, lines 937-941] Narrator: I guess the drink helps you forget about the voices dunnit
>
> Ray: Well I suppose it does dunnit but then what happens tomorrow then what you drink again and then the day after that what you do then. Bollocks innit.

Therefore, the documentary provides a platform for counternarratives about substance use, but also resists them, by emphasising the harm it can bring to the person.

4.2.3. Challenges to Coercive and Compulsory Interventions

Jim Thurkle's voice is deployed throughout the documentary to construct a narrative that coercive compulsory interventions, such as detaining people in hospital against their will, are humane and necessary. However, there are moments during the documentary where he briefly alludes to disagreements with this position; one where he brings into question whether 'sectioning' is ethical, on the basis that people have a right to make their own choices in life:

[Scene 16, lines 519-520] Jim Thurkle: …There's a bit of me that thinks why are we going to this length when she is leading the life she chooses…

Jim does not hold a questioning position for very long; he reverts back to his duties and obligations as a social worker, drawing on professional language, such as "assessment" and "capacity", to persuade the audience of the necessity of Rosemary's 'section'. He also alludes to a counternarrative about the difficult personal impact of this particular aspect of the work:

[Scene 16, lines 568-575] Interviewer: Do you always feel comfortable um with what you've done?

Jim Thurkle: I don't always feel comfortable no not at all but I know there are situations where there is <u>no</u> alternative and today was one example of that. There is a bit in of Rosemary that knows she's not well. Quite often that's the the telling point in assessments like this where the person themselves votes with their feet.

The interviewer strategically questions whether Jim Thurkle is comfortable with these aspects of his work, and through second order positioning, Jim Thurkle re-positions himself as uncomfortable but right in his decisions to detain somebody against their will. Jim also draws on a biomedical model of mental distress, where a patient's unwillingness to comply with obligations and duties set for them by legal and mental health systems are seen as signs of 'illness', and further evidence for compulsory hospital detention. There is an extreme close-up of Jim Thurkle's eyes at the beginning of the above extract:
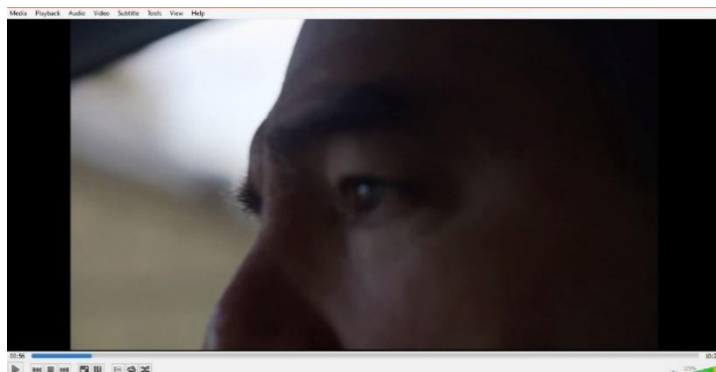

Image BC

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This perhaps evokes the audience's curiosity about what Jim is thinking after the event of Rosemary's sectioning process. Or, perhaps as Jim is questioning the status quo, the gaze is turned to him, rather than the psychiatric practice he is questioning. The audience are therefore invited to scrutinise Jim, rather the practice he questions temporarily. Equally, the interviewer scrutinises Jim as a person with his leading question.

4.2.4. Negative and Stereotypical Narratives Exacerbate Mental Distress

Lloyd's voice offers a counternarrative to the frequently depicted negative and stereotypical narrative linking 'schizophrenia' to violent behaviour:

> [Scene 7, lines 197-204] Lloyd: … And you hear a lot about schizophrenics on the news, that he was schizophrenic and he murdered someone and stuff like that
>
> Lloyd: They're going soon
>
> Interviewer: What do you mean things like that make you feel paranoid / about going out
>
> Lloyd: / It makes me feel yeah worse in case I could do that you know.

The interviewer initially assumes that Lloyd might be afraid of people diagnosed with 'schizophrenia' as they are reported to be murderous in the news. The voice of the psychiatric profession can be heard in the interviewer's voice, as he uses medicalised language such as "paranoid". Lloyd, however, does not use the same medicalised language as the interviewer and instead uses the general term, "worse", to describe how he feels in response to these media stories. Lloyd's move away from medicalised to folk language perhaps normalises his response and makes his feelings more accessible to the audience. Due to Lloyd positioning himself as mentally 'ill', he appears to have internalised this narrative about 'schizophrenia'. Therefore, it is not surprising Lloyd feels "worse" about himself. The initial segment of speech is played over visual images of Lloyd sat in his kitchen speaking to the voice:

Image BD
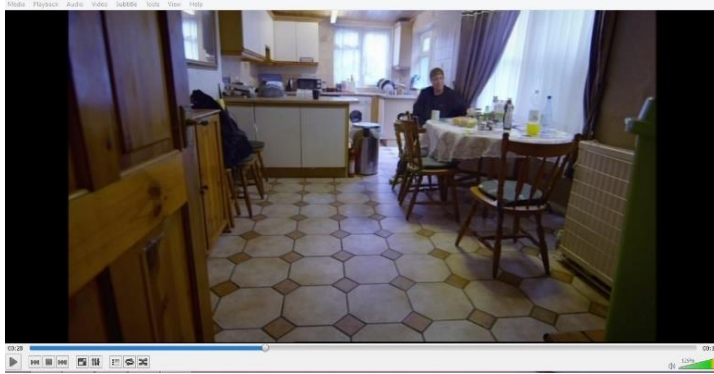
The sound then focusses in on what he says to the voice. Lloyd says "they're going now". This has the effect of reminding the audience of Lloyd's 'madness', and places more importance on this than Lloyd's counternarrative.

4.3. Absent Narratives

4.3.1. Social Inequalities and Mental Distress

Throughout the documentary there are visual images of social housing:

Image BE

Image BF

Image BG

However, a verbal narrative about the meaning of these visual images is not given. It could be argued that the documentary makers are purely providing an observation of the housing environments of the characters in the documentary. Regardless of whether it is intentional or not, in showing these images, the documentary hints to a profound and subjugated narrative. The absence of this verbal narrative in the context of these visual images, combined with a strong pro-biomedical and psychiatric perspective, serves to maintain a neutral stance towards poverty and mental distress while elevating the medical model of mental distress and its associated interventions and technologies.

4.3.2. Absence of Explanatory Narratives for Psychiatric Terms

Psychiatric terms such as 'schizophrenia' and 'paranoid schizophrenia' are not given explanatory narratives, whereas 'persistent delusional disorder' and 'psychosis' are. The former three terms are all implicitly associated with 'psychosis' (also the name of the documentary episode) without any direct explanation as to how they all relate to it. The terms are either used interchangeably with 'psychosis' or 'psychosis' is implied as an umbrella term.

4.3.3. Absent Identities

The audience learns very little about the 'patient' character's interests, aspirations and backgrounds. As discussed in the counternarrative section 4.3.2, image BA tells a story about different aspects of Tamara's identity. Through other visual images, we see Tamara lives with cats and enjoys being with animals, however, these images are less frequent than those portraying her as 'mad', and a verbal narrative about Tamara's interests is not offered:

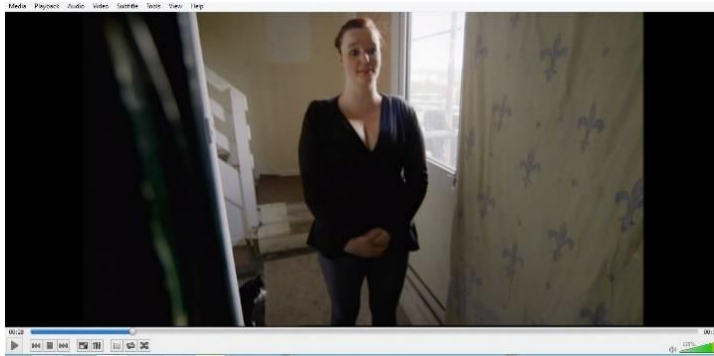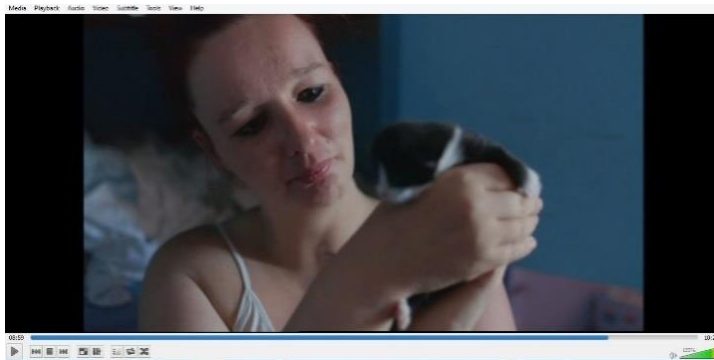Image BH

Image BI

Sadly, information about Rosemary's relational contexts are totally absent from the documentary, unlike Lloyd and Tamara, who we hear have family members, partners and children (however, the documentary does include Rosemary's admiration of the royal family and music). The lack of relational contexts serves to portray Rosemary as a 'loner', which 'others' her even further.

5. DISCUSSION

The beginning of this chapter reviews the findings from the analysis in the context of the research questions, wider social, political and cultural contexts, as well as previous research findings. The potential impact of the documentaries is discussed before moving onto the critical review and implications for clinical practice, research, service and policy development and public health campaigns.

5.1. Revisiting the Research Questions: Summary of Main Findings And Initial Discussion

5.1.1. <u>How Is Mental Distress Portrayed In Contemporary UK Factual Television Documentaries?</u>

In the Bedlam Anxiety documentary, 'anxiety' is undefined, reified and portrayed as a condition, of which there are two kinds; a type which everybody experiences during their lives and another more extreme type which is uncontrollable, sudden and in need of professional treatment. Initially, the documentary portrays 'anxiety' as a curable condition, however, as the plot moves along, it is portrayed as manageable by sufferers themselves through willpower and engagement in a particular type of psychological therapy. Although the therapy is not named in the documentary, they point to CBT. A psychological formulation of the causes of 'anxiety' is purported by the documentary; 'anxiety' is portrayed as arising from an increase in people's perception of danger in the context of hearing negative news stories (Freeman & Freeman, 2008). One specific anxiety related diagnosis is featured in the documentary – OCD which is portrayed as a lifelong, relapsing condition by a family member. This has been substantiated by research (e.g. Bloch et al., 2013), but the 'prognosis' of 'OCD' may depend on factors such as severity (Skoog & Skoog, 1999). Intrusive thoughts are portrayed as a component of 'OCD', which can lead to 'anxiety' if the person assigns meaning to them or acts on the 'anxiety' that they induce (Salkovskis, 1999). 'Anxiety' sufferers are portrayed as 'patients' who are different, exotic, abnormal and irrational before they engage in a therapy programme. As the plot moves along, the characters are portrayed in a more positive light - they are shown to overcome their problems by engaging in a therapy programme with an eventual return to 'normality' and/or 'rationality'. However, one character who does not

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engage in the treatment programme is portrayed as lacking in motivation to change and 'mad'. In the Bedlam Psychosis documentary, 'psychosis' is portrayed as a mental 'illness' with a set of identifiable 'symptoms'– loss of contact with reality, hearing voices, hallucinations and delusions, in unison with the ICD-10 criteria (WHO, 1992). Three specific 'psychotic disorders' are featured in the documentary: 'Persistent Delusional Disorder', 'Schizophrenia' and 'Paranoid Schizophrenia'. As suggested in the literature, stressful life events such as bereavement and relationship break-ups are portrayed as triggers of mental 'illness' (Bebbington et al., 1993), as well as substance use. 'Schizophrenia' is portrayed as an 'illness' which can develop at any point along the life-span. This portrayal is substantiated by previous research (e.g. Howard, Rabins, Seeman & Jeste, 2000). Finally, these diagnoses are presented as unproblematic terms and reified as existing entities that can be identified and controlled using coercive and compulsory psychiatric interventions such as 'sectioning' under the Mental Health Act (1983), hospitalisation and medication. 'Psychosis' sufferers are 'othered' and portrayed as 'patients', 'ill', 'mad', 'loner', potentially violent, but also victims of negative media narratives which portray them as violent. The violence portrayals are depicted despite a causal relationship between criminality and 'schizophrenia' being difficult to demonstrate empirically (Gelder, Mayao & Cowen, 2001). Other portrayals include recalcitrant, unpredictable, difficult to engage, 'risky', disruptive, deviant, addict and "binge drinker". 'Psychosis' sufferers are portrayed as fighting mental 'illness', unaccepting of it or struggling to come to terms with it.

5.1.2. <u>What Are the Dominant, Counternarratives and Absent Narratives In The Documentaries?</u>

5.1.2.1. *Bedlam anxiety documentary: dominant narratives*

The documentary constructed a dominant "right way to think and behave" narrative, which was constructed of three subnarratives – "the cognitive behavioural paradigm", "from irrationality to rationality" and "therapy makes people normal". The former subnarrative drew on traditional "second wave" CBT ideas to explain the causes of and maintenance processes involved in people's experiences of 'anxiety'. The theories of leading mental health professionals in

CBT (e.g. Salkovskis, 1999) are drawn upon by the 'expert' characters. The treatments featured in the documentary, such as behavioural experiments and in-vivo exposure are also defining features of CBT (Westbrook, Kennerley & Kirk, 2007). Given the documentary was created and broadcast during a particular social and economic context where cognitive-behavioural accounts and therapy for 'anxiety disorders' dominate the UK mental health arena (e.g. NICE, 2005; NICE, 2011) and are sanctioned by the state through the Improving Access to Psychological Therapies (IAPT) initiative it is not surprising this particular paradigm features heavily and takes precedence over other psychological paradigms. The "from irrationality to rationality" subnarrative indicates an adoption of Western society's post-enlightenment value base which embraces scientific, logical and rational thinking (Ife, 2012). Rationality is also a value of CBT (Procter, 2008), and so the documentary further aligns itself with the underlying philosophies and values of CBT, as well as its technologies. The documentary constructs stories of anxiety sufferers returning to a rational state of being, which enforces an essentialist view of human nature, where the humanist individual is seen as a unitary rational subject (Henriques, Hollway, Urwin, Venn & Walkerdine, 1998). This reinforces the idea that "the end result of therapy is a self which is more self-aware and detached, a self which can monitor itself in a rational way and detect emerging difficulties" (Bracken & Thomas, 2008, p. 94). Social norms are also reinforced by the documentary through the "therapy makes people normal" subnarrative which draws on hegemonic narratives of maleness (Connell, 2005) and capitalist British values of prosperity and productivity[10], while psychological therapy is constructed as a means to achieving them. This not only reflects but also reinforces the UK government agenda of 'normalising' people diagnosed with mental health problems so they can enter into employment (Layard, 2004) – having an occupation being the pinnacle of 'normal' social behaviour.

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10 As stated in David Cameron's newspaper article: "I strongly believe that our values form the foundation of our prosperity. The Western model of combining vibrant democracy with free enterprise has delivered great progress and prosperity… promoting our values is a key way to economic success – and that's why we will stick to our long-term economic plan of cutting the deficit, cutting taxes and backing businesses and families to get on in life" Downloaded from https://www.gov.uk/government/news/british-values-article-by-david-cameron

The documentary constructed a "medical narrative" by drawing on a continuum narrative of mental distress which assumes 'anxiety' is experienced by all people, but some may reach the severe end of the spectrum and threshold for a diagnosable 'anxiety disorder' (Beck, 1976). However, the adoption of this narrative only normalises mental distress to a certain extent, before being colonised by the medical model and entering 'disorder' territory. Furthermore, the documentary's inclusion and use of medical language such as 'anxiety', 'OCD', 'relapse' and 'condition' and the positioning of characters as 'patients' constructs a medical narrative in unison with the psychological cognitive-behavioural subnarrative. This is perhaps reflective of the close relationship between CBT and the medical model (Bohart & House, 2008), where medical terminology is adopted by the former and organises its treatment manuals. Similarly, research in Australia has also shown news articles about 'anxiety disorders' to be dominated by the medical model (Mellifont & Smith-Merry, 2015). However, in the current study, psychological therapy is privileged for 'anxiety' whereas Mellifont & Smith-Merry's study emphasised the use of medication, perhaps indicating differences in how 'anxiety' is treated in the UK and Australia.

The final dominant narrative of the documentary, "anxiety can be overcome with willpower", which adopts the assumption that change can happen when people "…release powers from within themselves to make a difference to their circumstances" (Hagan and Smail, 1997, p. 258), enables the documentary makers to create an entertaining story about 'overcoming adversity' while at the same time endorsing psychological therapy as a means to reaching this end.

5.1.2.2. *Bedlam anxiety documentary*: counternarratives

The first counternarrative, "victim versus patient", provides an alternative subject position for 'anxiety' sufferers, i.e. 'victim' in a difficult relationship instead of 'patient' with internal deficits. It also draws attention to complex relational dynamics implicated in mental distress, rather than intrapsychic processes such as 'irrational thinking'. Psychodynamic narratives or formulations of 'transitional objects' (Winnicot, 1953) and 'projection' of unwanted thoughts and feelings onto inanimate objects (Freud, 1936) offer frameworks for understanding how people's relationships with objects in their environments might impact on their emotional

wellbeing. However, due to the lack of research in these areas (Jarvis, 2004) and the dominance of medical and cognitive-behavioural narratives in the context of an evidence-based climate, these narratives or formulations remain subjugated and allow the documentary to re-position characters as 'patients', thus re-aligning the documentary with more traditional Western narratives of mental distress.

The second counternarrative was "distress evoked by treatment". The study of adverse effects arising from psychological therapies and stories of 'failure' have been given less attention than positive effects and 'success' (Barlow, 2010; Spellman & Harper, 1996). This status quo is reflected in the documentary through a variety of ways, such as the absence of commentary by the narrator about the distress evoked from treatment. This neutrality might indicate an endorsement of the "no pain, no gain" idea, conceptualised as an "…American modern mini-narrative: it compresses the story of a protagonist who understands that the road to achievement runs only through hardship" (Morris, 2005, para. 13). This "mini-narrative" is advocated in CBT (e.g. Barnes et al., 2013), where short-term discomfort is seen as acceptable in the context of longer term gains. The documentary, therefore, subjugates the "negative effects" subnarrative, which 'anxiety' sufferers allude to in the documentary, in the context of success stories being privileged.

The final counternarrative – "resistance to treatment" depicts Leon's reluctance to engage in the therapeutic programme. The documentary lacks curiosity about Leon's resistance and instead he is construed as 'mad' and lacking in motivation to change. This perhaps reflects how Clinical Psychology and related 'psy' professions view people's reluctance to comply with interventions offered as a further sign of pathology or at the very least it is perceived negatively, rather than a "healthy self-protective process that is to be respected…" (Mahoney, 1988, p. 306) or an indication of "living creatively" (Afuape, 2011, p. 37). Furthermore, the documentary also makes a connection between older age and lack of motivation to change, which perhaps draws on and reinforces the "you cannot teach an old dog new tricks" (Ekdawi & Hansen, 2010, p. 142) societal narrative. This societal narrative allows the documentary's assertion that older people are unamenable to psychological therapy, and uses it as the sole explanatory framework for resistance to treatment.

5.1.2.3. *Bedlam anxiety documentary*: absent narratives

The first absent narrative, "absence of therapy name and associated terms" excluded or simplified the name of the therapy (CBT) and associated terms such as the names of CBT techniques. This perhaps indicates a negotiation made by the documentary makers to balance 'expert' and technical knowledge/language with making content comprehensible to lay viewers. This negotiation reflects the "dumbing down" of television content in the context of increasingly profit and ratings focussed environment (Henley, 2006). This may have allowed the dominant CBT paradigm to be presented as 'the truth' rather than one of many paradigms within the UK clinical psychology profession. It also presents the treatment featured in the documentary as the only treatment for 'anxiety' and does not represent the multitude of treatments available, both within the NHS and private sector.

The second absent narrative "Leon's lack of narrative closure" is linked to the portrayal of Leon as lacking in motivation to change and 'mad'. Lack of narrative closure has been found to be 'the norm' and prevalent in programmes where people are depicted as 'mad' (Rose, 1998; 2000). This perhaps "…adds weight to the idea that representations of madness on television are chaotic and resist the fixity of anchors" (Rose, 2000, p. 260). Although the lack of narrative closure might be also be due to a post-modern cultural context where concluded narratives are no longer essential (ibid).

The third absent narrative, "family dynamics and anxiety" is perhaps indicative of the documentary's choice to ignore literature on the impact of familial relationships on people's mental wellbeing, which has been well documented in the psychodynamic domain (Milton, Polmear & Fabricus, 2004) and in the area of "expressed emotion" (Brown, Monck, Carstairs & Wing, 1962). Expressed emotion refers to emotional over-involvement, hostility and critical comments from family members towards a person diagnosed with a mental health problem, and it has been associated with poorer outcomes among people diagnosed with 'anxiety disorders' (e.g. Chambless & Steketee, 1999). The documentary's choice to exclude such salient narratives in psychological literature is perhaps reflective

of the psy-professions' reluctance to blame parents for their children's mental distress (Coulter & Rapley, 2011).

The final absent narrative of the Anxiety documentary was "absent identities". The occupations of all PWAS are mentioned apart from Leon's. Identities other than being 'mad', 'patient' and 'victim' are also hinted at by the documentary through visual images AC, AD and AE. Therefore, problem saturated identities (Gergen, 1991) are more prominent, and the scope for more enriched and positive descriptions of people who experience 'anxiety' are severely restricted. This not only reinforces a 'them and us' divide between 'anxiety' sufferers and society, but it also offers limited subject positions for people who experience mental distress and avenues for recovery, other than through psychiatric services.

5.1.2.4. *Bedlam psychosis documentary: dominant narratives*

The documentary constructed a dominant medical narrative, which was constructed of three subnarratives – "dichotomy between normality and abnormality", "life events trigger mental 'illness'" and "the link between substance use, mental 'illness' and poor physical health". The former subnarrative was constructed through the documentary's uncritical use of psychiatric diagnosis and medical language. Previous research has shown the biomedical view of mental illness to dominate news programmes (e.g. Glick and Applbaum, 2010). The fact that the documentaries are organised and labelled according to nosological psychiatric categories is the first indication of endorsement of classification systems, which delineate people's behaviours, experiences and emotions into normal or abnormal categories. Despite criticisms surrounding the validity and reliability of the diagnostic construct "schizophrenia", for example, which has been highly contested by many researchers (Bentall, 2003; Boyle, 2002; van Os, 2009), the use of psychiatric diagnosis in the documentary prevails, and Lloyd's voice is deployed to persuade the audience of the validity of mental 'illness' and diagnostic labels. The "life events trigger mental illness" subnarrative assumes life events can trigger a mental 'illness' at any age. The subnarrative draws on the biopsychosocial model (Engel, 1980), which attempts to integrate biological, psychological and social factors in the aetiology of mental distress. Even though

people's social circumstances are implicated in mental distress, they are, "…relegated to the role of 'triggers' of an underlying genetic timebomb…it is a colonisation of the psychological and social by the biological" (Read, 2005, p. 597). Contextual factors are, therefore, medicalised, and not seen as stressful enough in their own right (Boyle, 2011). Furthermore, the documentary does not challenge or question this aetiological position, and in doing so, reinforces the status quo. The "the link between substance use, mental 'illness' and physical health problems" subnarrative draws on a dominant narrative in research literature that people diagnosed with 'psychotic illnesses' are heavy substance users (e.g. Mueser, Bennett & Kushner, 1995; Kumari and Postma, 2005). The documentary problematises and medicalises speed and alcohol use, but in different ways. Speed use is portrayed as an 'addiction' and a trigger for mental 'illness'. This portrayal draws on empirical evidence linking amphetamine misuse with the onset of 'psychotic symptoms' (Paparelli, Di Forti, Morrison & Murray, 2011) and prominent narratives in academic literature such as the "secondary psychiatric illness model" (Mueser, Drake & Wallach, 1998) which postulates substance misuse plays a causal role in the development of mental 'illness'. On the other hand, Lloyd's alcohol use is medicalised by drawing on the "self-medication hypothesis" (Khantzian, 1985; 1997) which postulates people choose specific substances to alleviate particular psychiatric 'symptoms'. Furthermore, the documentary links excessive alcohol use among people diagnosed with mental 'illness' to poorer mental and physical health outcomes. It is likely the 'expert' characters have drawn on medical studies claiming the same (e.g. Duke, Pantelis & Barnes, 1994; Drake, Osher & Wallach, 1989). The documentary, on some level, endorses unhelpful ideas and stereotypical views about people diagnosed with 'schizophrenia' leading unhealthy lifestyles and, therefore, being responsible for their worsened mental health and increased mortality rates (e.g. Brown, Birtwistle, Roe & Thompson, 1999). This may engender self-blame among people diagnosed with 'psychotic illnesses', and create stigmatised attitudes towards them.

The second dominant narrative, "moral and control narrative", encompassed two subnarratives: "control of substance use" and "necessity of coercive and compulsory interventions". The former subnarrative is constructed via the

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deployment of 'expert' voices who explain their attempts to change their patients' substance use behaviours. These attempts are made understandable in the context of the documentary's assertions about the link between substance use, mental 'illness' and physical health problems. The depiction of attempted control of substance use is also reflective of the British government's stance. "Healthy Lives, Healthy People" White Paper (DoH, 2010) sets out a strategy for substance use to be controlled and treated to avoid people entering and re-entering the criminal justice system and to improve health outcomes. They also suggest placing responsibility on public health professionals to "…work locally to prevent people from taking harmful drugs, to reduce the drug use of those already taking drugs, and to help people to be drug free, recover fully and contribute to society" (ibid, p. 43). The explicit positioning of health professionals in this way allows the position of agents of social control to taken up by the 'experts' in the documentary and for this to be endorsed by the documentary itself.

The latter subnarrative was "necessity of coercive and compulsory interventions". The construction of the characters as 'other', unpredictable, recalcitrant, difficult to engage, a risk to themselves and other people, potentially violent, disruptive and deviant, serves to increase the sense of threat about people with 'psychosis' and justifies the use of coercive and compulsory interventions. Indeed justifications pertaining to risk to self and others are used in clinical practice to apply such interventions (Szmukler & Appelbaum, 2008). These constructions draw on a number of historical and deeply entrenched narratives in wider society, the mental health profession itself and the media about people labelled with 'psychotic disorders'. These narratives not only form the wider context of the documentary, but are also reinforced by the documentary itself. The narrative that people diagnosed with 'psychotic disorders' are prone to violence (Harper, 2004) is still salient today, and its endorsement by the general public has significantly increased[11]. Drawing on previous literature, the association with violence is also constructed in the mental health profession by researching and concluding an

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[11] Attitudes to Mental Illness 2010 Research Report prepared for Time to Change (2013) downloaded from https://www.mind.org.uk/media/463374/118308-attitudes-to-mental-illness-2012-report-v6.docx

association between 'schizophrenia' and violence towards others (e.g. Hodgins, 2008). Depictions and themes of violence and 'schizophrenia' and related diagnoses dominate content in print and televised media (e.g. Cross, 2004; Nairn et al, 2006). However, as previous studies of media content have shown criticisms of community care (e.g. Rose, 1998), the documentary offers a more positive narrative about this being humane, normalising and a solution to the risks posed by people. This perhaps suggests a shift in public consciousness about community care, or represents the ideology and influence of the South London and Maudsley NHS Foundation Trust who worked in close partnership with the documentary makers[12]. Finally, Rosemary was found to carry more of the aforementioned negative constructions and be detained in hospital multiple times compared to her counterparts. Her more 'othered' treatment is perhaps reflective of how people from BME backgrounds are treated in the mental health system. For example, they are more likely to experience compulsory detainment in hospital (Bowl & Barnes, 1990) than people from non-BME backgrounds.

5.1.2.5.   *Bedlam psychosis documentary: counternarratives*

The "resistance to medicalisation" was constructed via the voices of 'psychosis' sufferers in the documentary. Stressful material and social circumstances are emphasised by Tamara, and she is outwardly critical of the medicalisation of these experiences. Similar resistances to the dominant medical approach have been documented among other people such as Jacqui Dillon: "as far as I am concerned, I am not sick. What my abusers did to me was sick. I have had a perfectly natural, human response to devastating experiences" (Dillon, 2009, p. 190) and in a BBC documentary called "Mad, Bad or Sad" (Birch, 2012). Although Tamara is given a platform to make her voice heard, she is simultaneously portrayed as 'mad' and a 'fighter' of mental 'illness', thus re-situating her experiences within the medical paradigm. Similar portrayals have been found in earlier documentaries (Cross, 2004). In the same vein, Lloyd's demonstrates a personal relationship with the voice he hears and in this sense he resists the medicalisation of this experience as a meaningless, pathological

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[12]http://www.slam.nhs.uk/media/bedlam-on-c4/behind-the-scenes/a-producers-view

'symptom'. Professional voices have argued hearing voices is a personal experience and functional for the voice hearer (Escher, 2009) rather than a sign of disease. However, Lloyd is portrayed as 'struggling to come to terms' with his mental 'illness' rather than somebody who is able to align himself with medical narratives, while at the same time drawing on alternative ones. Perhaps these findings reflect how alternative narratives outside of the medical model of mental distress remain marginalised in psychiatry, clinical psychology and society, despite calls for a paradigm shift from both professionals and people with lived experience of mental distress (DCP, 2013; Johnstone, 2000). Previous research has also found alternative narratives about mental distress to be few and far between in the media (Philo, 1996; Harper, 2009).

The "substance use as coping strategy" counternarrative is also constructed via the voices of 'psychosis' sufferers, and it is also well documented (e.g. Lobbana et al., 2010; Spencer, Castle & Michie, 2002). The documentary appears to support the counternarrative for alcohol use more than speed. This perhaps reflects the social acceptance of using alcohol in the UK whereas speed is classed as an illicit grade B drug (Misuse of Drugs Act, 1971). The different legal contexts may also explain why Lloyd's alcohol use is portrayed as "binge drinking" whereas Tamara's use of speed is portrayed as an "addiction". It may also explain why different approaches to controlling these substances are depicted in the documentary. However, medicalised accounts which focus on harmful effects, 'self-medication' and 'addiction' are given prominence in the documentary, reflecting a subjugation of the voices of people who have lived experience of combined mental distress and substance use.

The "challenges to coercive and compulsory interventions" counternarrative is constructed by Jim Thurkle. His voice questions the ethical grounds of coercive and compulsory interventions.. However, this counternarrative is not held for very long before 'sectioning' is justified by drawing on paternalistic and 'capacity-best interest' frameworks (Szmukler & Appelbaum, 2008). Criticisms of these interventions are marginalised both inside and outside of the mental health

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system, but groups such as Speak Out against Psychiatry[13] aim to campaign against them.

The next counternarrative was "negative and stereotypical narratives exacerbate mental distress". This was constructed via the deployment of Lloyd's voice, who explains how the dominance of media stories about 'schizophrenia' and associated violent acts exacerbate his mental distress and bring uncertainties about himself. These negative experiences have also reported among other PWAS. For example, 34% of people who were surveyed by Mind reported to feel more anxious or depressed and 22% said they felt more isolated and withdrawn because of media portrayals (Mind, 2000). However, due to the audience appeal of linking 'schizophrenia' and violence, this narrative remains dominant in the media, despite PWAS speaking out about its negative impact on their own mental wellbeing.

5.1.2.6. *Bedlam psychosis documentary: absent narratives*

The documentary also comprised of three absent narratives: "social inequalities and mental distress", "absence of explanatory narratives for psychiatric terms" and "absent identities". The first aforementioned absent narrative is implicit in the visual images of social housing shown throughout the documentary. The relationship between poverty, social inequalities and mental distress is well-established in academic literature (e.g. Murali & Oyebode, 2004) but is obscured by 'stress-vulnerability' explanations of mental 'illness' which are invariably in both research and clinical settings. This parallel process is noted in the documentary, where a medical narrative of mental 'illness' is privileged. The second aforementioned absent narrative refers to the lack of explanations and definitions for 'schizophrenia' and 'paranoid schizophrenia' unlike the terms 'persistent delusional disorder' and 'psychosis'. These terms are also used interchangeably with 'psychosis' and this process has previously been found in other texts such as journal articles and book chapters (Boyle, 2006). Boyle

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[13]A politically active group who campaign against compulsory treatments and psychotropic medication http://speakoutagainstpsychiatry.org/

argues this has the effect of transferring the assumptions associated with 'schizophrenia' and its variations onto the word 'psychosis'. This serves to strengthen medical narratives of mental distress. Finally, similarly to the Anxiety documentary, "absent identities" reveals the lack of alternative identities made available about 'psychosis' sufferers other than, for example, being 'ill' or 'mad'. The occupational statuses of PWAS are not mentioned, unlike the Anxiety documentary. Even though visual images hint to identities such as 'animal lover', these are not storied verbally and Rosemary's relational context is totally absent. Thin descriptions about people serve to reinforce 'othering' of people labelled as 'mentally ill', with Rosemary arguably being the most 'othered' character in the documentary.

5.2. Contrasts, Comparisons and Further Discussion

The Bedlam documentaries are an extension of archaic ways of thinking about mental distress, reinforcing the "neuroses-psychoses" distinction which became prominent in the mid-1970s (Bentall, 2003). This distinction has allowed 'anxiety' to be constructed as amenable to psychological intervention and 'psychosis' as a biological 'illness' which is "beyond therapy" (Kingdon & Turkingdon, 2005, p. 89). This persists despite the move towards conceptualising 'psychosis' as on a continuum with 'normal' experiences (Johns & van Os, 2001) and recommendations to offer psychological treatments for 'psychosis' (NICE, 2009). Perhaps at a more unconscious level, the different constructions of 'anxiety' and 'psychosis' allow both the unwanted 'irrational' and 'mad' parts of the audience to be projected onto the 'other' (Boyle, 2002). However, Thomas (2012) argues the British media (specifically the BBC) are unwilling to challenge dominant psychiatric narratives about mental distress because they are worried about offending the psychiatric institution.

There have been recent calls for 'anxiety' and 'psychosis' to be understood and treated in the same way, but they were published post-Bedlam (e.g. DCP, 2014). However, according to Johnstone (2000):

> "…ideas arise within, and are shaped by, historical, social and political contexts, and are supported or opposed by groups or individuals

(consciously or unconsciously) in accordance with their own desires and interests" (p. 212)

Including the breadth of psychological accounts in the media not only poses a threat to the psychiatric profession, but also to pharmaceutical companies who have a financial interest in upholding biomedical narratives of mental distress (Lewis et al., 2001). It remains to be seen whether more psychological narratives of 'psychosis' start to be included in documentaries in the future, given a recent backlash from clinical psychologists who have called for more 'balance' in the media (Bentall, 2016).

The Psychosis documentary shows mental health professionals working hard to control substance use, keep the public safe and mentally ill people 'well'. It places part of the responsibility of community care on 'patients', who disrupt the system when they fail to fulfil their obligations as psychiatric patients. The documentary endorses the use of coercive and compulsory interventions in the context of these failings. On the other hand, the Anxiety documentary does not include subjects of safety, coercive and compulsory interventions and substance use. This is reflective of 'schizophrenia' and related diagnoses being linked to violence, deviancy and heavy substance use, unlike 'anxiety' diagnoses.

Finally, 'patients' who do not comply with the therapeutic programme or community care are designated as 'mad' in both documentaries. Drawing on social learning theory, the audience may come to believe those who do not comply with the obligations they have given, will essentially be punished and tarnished as socially undesirable. This leaves little room for other ways of being outside of an obedient member of society who does not question or challenge dominant systems and practices.

5.3.   The Potential Impact of the Documentaries

According to the Bedlam media report[14] published by the South London and Maudsley NHS Foundation Trust, the Anxiety documentary was the second most watched documentary in the Bedlam series after Crisis, with approximately 1.6 million viewers. It also had the highest number of tweets (8,786) with the hashtag 'Bedlam'. The Psychosis documentary followed with approximately 1.2 million viewers and 5,277 tweets using the hashtag 'Bedlam'. The report also published Channel 4 research which looked into the attitudes of approximately 400 viewers of the documentaries. 79% of the sample believed the series portrayed people who experience mental distress in a positive light compared to usual media depictions, while a similar proportion of viewers (80%) felt the series brought a new perspective about mental distress. However, the report does not expand on what these perspectives are. The 'true' impact of the documentaries cannot be discerned from such a survey - the characteristics of the sample are not presented, it is unknown whether it is representative and baseline perspectives before watching the documentaries are not stated. Finally, according to the same report, only one media source, the notoriously satirical magazine, Private Eye, took a critical stance in relation to the Bedlam series arguing it was the modern day equivalent of "the notorious 'freak shows' at the original hospital". The media report is otherwise dominated by reports of extensive and positive media coverage in social media (e.g. Twitter and Facebook), print and online.

Below are some hypotheses of what the potential impact of the documentaries might be. These warrant further study by an independent body with no affiliations to the production company, Channel 4 or the NHS trust which was involved in the making of the documentary to reduce bias. The Psychosis documentary may contribute to the public perception of mental distress as an 'illness' which warrants medication, coercive and compulsory interventions to protect the public. It is possible the documentary could also influence a rise in these types of interventions. The documentary offers a range of perspectives about substance use, and this might be confusing for viewers who identify themselves as mentally

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[14]Bedlam media report downloaded from
http://www.slam.nhs.uk/media/255994/bedlam_media_report.pdf

'ill' or have experiences similar to those depicted in the documentary. However the documentary may deter people from using speed and drinking excessive alcohol. In the realm of "locus of control" (LOC) research, it has been suggested people who experience 'psychosis' are more likely to have an external locus of control (Harrow, Hansford & Astrachan-Fletcher, 2009). This means they perceive other people such as doctors to be in control of their health and this is linked to poorer 'recovery'. The documentary may reinforce people's external locus of control as the 'patients' are portrayed as reliant on mental health professionals. This may impede their 'recovery' further. In the context of the Anxiety documentary, purporting the "anxiety can be overcome by willpower" narrative has been criticised as "magical voluntarism" (Smail, 2004) and "positively cruel" (The Midlands Psychology Group, 2014, p. 6) for people who experience mental distress. This is because people are assumed to have resources *within* themselves, rather than having access to resources *outside of* themselves (Smail, 1996), which are distributed unequally among different social groups. The documentary may therefore lead people to blame themselves for not being able to "get over" experiences of 'anxiety' by themselves or even through the help of a therapist. Finally, the viewers may come to believe psychological therapy (or specifically CBT) is a panacea for 'anxiety', and ignore wider social, cultural and political factors affecting people's ability to cope with mental distress.

5.4. Critical Review

5.4.1. Evaluation of Quality

As discussed in the methods chapter, I will draw upon Yardley's criteria for good qualitative research: "sensitivity to context; commitment and rigour; transparency and coherence; impact and importance" (Yardley, 2000, p. 219).

5.4.1.1. *Sensitivity to context*

As well as remaining close to the data itself, I was also sensitive to the theoretical context of the research by reviewing the theories included in the introduction chapter. Sensitivity to the specific socio-cultural contexts of the characters, their interviewers and the production team was not possible, as the study did not take the form of traditional narrative interviews. This is a limitation of studying

documentary material. In order for sensitivity to context to be increased in this domain, researchers studying documentary material could interview the production team and seek permission from copyright holders to contact characters in the documentary. This would not only allow the researcher to understand their socio-cultural contexts, but also gain their perspectives on the interpretations made. However, this may pose legal issues pertaining to issues of confidentiality.

5.4.1.2. *Commitment and rigour*

I participated in prolonged engagement with the topic, not only as a researcher but also as a television consumer. I have read literature outside of the mental health arena such as film theory and media texts, listened to podcasts such as BBC Radio 4's "All in the Mind" and continued to watch new documentaries on mental distress which were broadcast post-Bedlam. In addition to this, I have kept abreast with new research published on the topic, and engaged in debate about medicalised narratives of mental distress in social media spaces such as Twitter and with colleagues. I have developed competence and skills in narrative analysis by attending workshops, reading books and research articles, as well as seeking advice from more experienced narrative researchers such as my supervisor. Immersion in relevant data, theoretical and empirical, is demonstrated in the introduction chapter.

Although the sample only included two documentaries, they underwent a thorough and in-depth investigation. This allowed the research questions to be answered fully. The analysis also took place at both verbal and visual levels which took into account the complexity of the data. One limitation is music was not analysed due to the vast "interpretive space" (Pollak, 2008, p. 94) already opened up by analysing moving visual images.

5.4.1.3. *Transparency and coherence*

I had tried to make the re-telling of the narrative presented in the documentaries meaningful to the reader by using language and expressions that are easily accessible to those with and without experience in the mental health field. The methods chapter demonstrates the good fit between my research questions, the epistemological position of the study and the methods and analysis utilised.

In regards to transparency, I have included transcribed excerpts of the documentaries in the analysis chapter, sample of transcriptions with coding in appendix 8 and the analytic steps are explained fully in the methods chapter. Full transcriptions of the documentaries are not published in the thesis due to copyright restrictions. Finally, due to my critical perspective on medicalised narratives of mental distress, as described in the personal reflexivity section in the methods chapter, I was aware of how this may influence my reading of the documentaries. I actively sought out non-medicalised narratives to ensure my value base did not unduly influence my interpretations. Nonetheless, the research was influenced by professional interest in the topic which is outlined in the introduction.

5.4.1.4.   *Impact and importance*

The impact and utility of the research study are highlighted in the following sections which look at theoretical, practical and sociocultural impact (Yardley, 2000) and the implications for clinical practice, research, service and policy development and public health.

5.5.   Theoretical, practical and sociocultural impact

The research study enriched understandings of portrayals and narratives of mental distress in the UK media by analysing factual television documentaries which have traditionally been a neglected genre in research studies. Previous research studies have privileged quantitative methodologies, particularly content analysis, whereas the current research study utilised a qualitative approach which allowed diverse media messages and meanings to be explored. The study also offered a clear and coherent method to analyse television documentaries which may encourage more researchers to analyse this genre in the future.

With regards to practical impact, the research study is of relevance and interest to a large and diverse pool of people including media professionals, policy makers, mental health professionals including clinical psychologists and psychiatrists and PWAS. The study may therefore influence the beliefs and actions of many people from different background and professions. The study may encourage documentary makers to question their beliefs and biases about

mental distress which could influence the narratives and portrayals put forward in their future documentary proposals.

Finally and with regards to sociocultural impact as discussed in the introduction, PWAS have blamed the media as a source of stigma and reported to be hurt, offended and negatively affected by media portrayals of mental distress. The current study validates these reports by highlighting the particularly negative portrayals of people who experience 'psychosis', which may help PWAS and other interested parties to challenge stigma in television documentaries as well as other media genres.

5.6. Implications

5.6.1. Implications for Clinical Practice

Calls for clinical psychologists to work with the media are not new (e.g. Cooke, 1999). More recently, Whomsley (2014) has argued:

> "Clinical psychologists together with other health care professionals have an important part to play in engaging with the media: to put forward their understanding of the area in which they have expertise; to question findings that they consider inaccurate; to help to shape the narrative" (p. 11)

However, psychologists may encounter barriers such as lack of time to dedicate to media engagement and no formal training in this area (Kaslow, 2015). The British Psychological Society do offer media training courses and workshops, however to my knowledge, there are no specific Good Practice Guidelines published by the British Psychological Society or Division of Clinical Psychology to guide clinical psychologists in this area. The creation of these guidelines would be a helpful place to start. I also would argue factual television documentaries and other media genres such as magazine articles are highly influential and creative platforms which necessitate engagement with clinical psychologists, PWAS and other mental health professionals who are keen to challenge limiting, medicalising and stigmatising narratives of mental distress. Some examples of these narratives include the dominant medical narratives found in both documentaries analysed in the current research study, and the "negative and stereotypical narratives exacerbate mental distress" counternarrative found in the

Psychosis documentary. These stakeholders should take a proactive role in media work, by approaching and joining with media professionals to construct alternative and dialogical narratives of mental distress which introduce other ways of being (e.g. other than being a psychiatric 'patient' as constructed by both documentaries in the current study) and other ways of dealing with mental distress (e.g. other than taking medication as constructed by the Psychosis documentary in the current study). This would enable people to take up their preferred subject position and empower them to choose ways of coping that works for them.

It is also important for clinical psychologists to not only influence the verbal narratives of mental distress, but also still and moving images in print and televised media. For example, the "Get the Picture" Time to Change campaign[15] has made alternative still images available to journalists, rather than the overused "head clutcher shot" (i.e. an image of somebody with their head in their hands) which campaigners have argued was a stigmatising image which portrayed mental health issues as despairing, hopeless and bleak. The use of social media has also been suggested (Betton, Borschmann, Docherty, Coleman, Brown & Henderson, 2015) and could be more influential than mass media for particular social groups. For example, creating and sponsoring online social media videos on websites such as Facebook might be a more effective way of targeting and engaging younger people than news bulletins and factual television documentaries.

However, it is also the media's responsibility "to question what is a legitimate source" (Karpf, 1988) and seek out commentary from clinical psychologists who take up positions outside of dominant CBT and psychiatric schools of thought which have been privileged in the Anxiety and Psychosis documentaries analysed in the current research study. Finally, clinical psychologists could reduce the effect of media narratives on their clients in individual, group and community level clinical work. Narrative therapy (White & Epston, 1990) could

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[15]http://www.time-to-change.org.uk/getthepicture

help clients identify what narratives exist in society and contribute to their mental distress, and reduce the extent to which they internalise these narratives.

5.6.2. Implications for Research

Further research of factual television documentaries is warranted given print media continues to dominate the research arena and the current study is novel. The current study only investigated portrayals and narratives about 'anxiety' and 'psychosis' but further research is needed to investigate other constructions. The impact of the documentaries (or other media) on the general public and people with lived experience of mental distress could be studied more rigorously. This could done using a qualitative approach where participants are interviewed as part of a focus group before and after watching the documentaries. This would also avoid problems associated with survey methods (Harper, Tucker & Ellis, 2013) which have dominated research studies so far. Future research would also benefit from analyses of gender, race and class differences in media narratives of mental distress as there has been little research in this area to date. The current study did make note of a finding pertaining to race in the Psychosis documentary, but as this was not the main focus of the study, this requires further investigation.

5.6.3. Implications for Service and Policy Development

Commissioners and service leads should be encouraged to reflect on their wider socio-cultural contexts in which their decision making processes occur, as their assumptions about mental distress may be shaped by dominant media narratives such as "the necessity of coercive and compulsory interventions" narrative constructed in the Psychosis documentary. This would ensure mental health services are commissioned and led on the basis of the needs of people who access these services, rather than on potentially unhelpful assumptions shaped by the media about the people they aim to serve. Clinical Psychologists could engage in policy development (Patel, 2007) to influence and shape ideas already in circulation about the importance of challenging media portrayals (e.g. DoH, 2012). However, media portrayals of mental distress also shape and inspire government policies (Clark, 2004; Hallam, 2002). Organising a national conference (Diefenbach, 1997) for mental health professionals, commissioners, policy makers, PWAS and media professionals would allow stakeholders to

engage in dialogue about media narratives and mental distress with a view to tackling stigmatising portrayals and influencing media output and policies on mental distress.

5.6.4. Implications for Public Health Campaigns

Clinical psychologists are in a strong and influential position to create and deliver public health campaigns which aim to normalise mental distress and include the voices of those who have found paradigms outside of the dominant medical model helpful. These campaigns would also form the wider context of future FTDs, and simultaneously influence media narratives. FTDs made in conjunction with clinical psychologists could also be constructed as part of public health campaigns.

6. REFERENCES

Afuape, T. (2011). *Power, Resistance and Liberation in Therapy with Survivors of Trauma: To Have Our Hearts Broken*. Hove, England: Routledge.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Anderson, T.L., Scott, B.L. & Kavanaugh, P.R. (2015). Race, inequality and the medicalization of drug addiction: an analysis of documentary films. *Journal of Substance Use*, 20(5): 319-332.

Angermeyer, M.C., Dietrich, S., Pott, D. & Matschinger, H. (2005). Media consumption and desire for social distance towards people with schizophrenia. *European Psychiatry*, 20:246–250.

Arboleda-Flórez, J. (2002). What causes stigma? *World Psychiatry*, 1(1): 25-26

Atkinson, P., Coffey, A. and Delamont, S. (2003). *Key themes in qualitative research: Continuities and changes*. Walnut Creek, USA: AltaMira Press

Ball-Rokeach, S. & DeFleur, M. (1976). A dependency model of mass media effects. *Communication Research*, 3:3-21

Bandura, A. (2001). Social cognitive theory of mass communications. In J. Bryant & D. Zillman (Eds.) *Media effects: Advances in theory and research*. (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

Barlow, D.H. (2010). Negative effects from psychological treatments: A perspective. *American Psychologist*, 65(1):13–20.

Barnes, M., Sherlock, S., Thomas, L., Kessler, D., Kuyken, W., Owen-Smith, A., Lewis, G., Wiles, N & Turner, K. (2013). No pain, no gain: depressed clients'

experiences of cognitive behavioural therapy. *British Journal of Clinical Psychology*, 52:347–364.

Bebbington, P., Wilkins, S., Jones, P., Foerster, A., Murray, R., Toone, B. and Lewis, S. (1993). Life events and psychosis initial results from the Camberwell collaborative psychosis study, *British Journal of Psychiatry, 162:72-79.*

Beck, A. T. (1976). *Cognitive Therapy and the Emotional Disorders.* London, England: Penguin.

Bell, S. E. (2002). Photo images: Jo Spence's narratives of living with illness. *Health: An interdisciplinary journal for the social study of health, illness and medicine*, 6(1): 5-30

Belson, W. (1967). The Impact of Television: Methods and Findings in Program Research. London, England: Crosby Lockwood.

Bentall, R. (2016). Mental illness is a result of misery, yet we still stigmatise it. *The Guardian.* Retrieved from URL http://www.theguardian.com/commentisfree/2016/feb/26/mental-illness-misery-childhood-traumas

Bentall, R.P. (2003). *Madness explained: Psychosis and human nature.* London, England: Penguin.

Berger, P. L. and T. Luckmann (1966). *The Social Construction of Reality: A Treatise in the Sociology of Knowledge.* New York: Anchor Books

Betton, V., Borschmann, R., Docherty, M., Coleman, S., Brown, M. & Henderson, C. (2015). The role of social media in reducing stigma and discrimination. The British Journal of Psychiatry, 206:443-444.

Birch, M. (2012). Mediating mental health: contexts, debates and analysis. Surrey, England: Ashgate Publishing

113

Bishop, R. (2001). The Pursuit of Perfection: A Narrative Analysis of How Women's Magazines Cover Eating Disorders. *The Howard Journal of Communications*, 12:221-240.

Bloch, M.H., Green, C., Kichuk, S.A., Dombrowski, P.A., Wasylink, S., Billingslea, E., Landeros-Weisenberger, A., Kelmendi, B., Goodman, W.K., Leckman, J.F., Coric, V. & Pittenger, C. (2013), Long-term outcome in adults with obsessive-compulsive disorder. Depression and Anxiety, 30:716–722.

Bohart, A.C. & House, R. (2008). Empirically supported/ validated treatments as modernist ideology, I: Dodo, manualisation, and the paradigm question. In R. House & D. Loewenthal (Eds.), *Against and for CBT: Towards a constructive dialogue?* (pp. 188-202). Ross-On-Wye: PCCS Books.

Borinstein, A.B. (1992). Public attitudes towards persons with mental illness. *Health Affairs*, 3:186–196.

Bowl, R. & Barnes, M. (1990).Race, racism and mental health social work: implications for local authority policy and training. *Research, Policy and Planning*, 8:12-18.

Boyle, M. & Johnstone, L. (2014). Alternatives to psychiatric diagnosis. *The Lancet,* 1(6): 409-411.

Boyle, M. (2002). *Schizophrenia: A scientific delusion?* (2nd ed.). London, England: Routledge.

Boyle, M. (2006). From schizophrenia to psychosis – paradigm shift or more of the same? Presented at The Annual Conference of the BPS Division of Clinical Psychology, London.

Boyle, M. (2011). Making the world go away, and how psychology and psychiatry benefit. In M., Rapley, M. Moncrieff & J. Dillon (Eds.) *De-medicalising misery:*

Psychiatry, psychology and the human condition. (pp. 27-44). Basingstoke: Palgrave MacMillan.

Bracken, & Thomas, (2008) Cognitive therapy, cartesianism, and the moral order. In R. House & D. Loewenthal (Eds.), *Against and for CBT: Towards a constructive dialogue?* (pp. 86-101). Ross-On-Wye: PCCS Books.

Brekke, J.S., Prindle, C., Bae, S.W. & Long, J.D. (2001). Risks for individuals with schizophrenia who are living in the community. *Psychiatric Services*, 52:1358–1366.

British Psychological Society (2011). *Good Practice Guidelines on the use of psychological formulation.* Leicester, England: British Psychological Society.
Brown, G.W., Monck, E. M, Carstairs, G.M. & Wing, J.K. (1962). Influence of family life on the course of schizophrenic illness. *British Journal Preventative and Social Medicine*, 16:55-68.

Brown, S., Birtwistle, J., Roe, L. & Thompson, C. (1999). The unhealthy lifestyle of people with schizophrenia. Psychological Medicine, 29:697-701.

Burr, V. (2003). What is social constructionism? In V. Burr (Ed.), *Social constructionism* 2nd ed. (pp. 1-27). London, England: Routledge.

Carroll, N. (2007). Narrative closure. *Philosophical Studies*, 135:1–15

Chambless, D.L. & Steketee, G. (1999). Expressed emotion and behavior therapy outcome: a prospective study with obsessive-compulsive and agoraphobic outpatients. *Journal of Consulting and Clinical Psycholog*y, 67(5):658-65.

Clark, J. (2004). Mad, bad and dangerous: the media and mental illness. *Mental Health Practice*, 7(10):16-19.

Clement, S. & Foster, N. (2008). Newspaper reporting on schizophrenia: A content analysis of five national newspapers at two time points. *Schizophrenia Research*, 98:178–183.

Connell, R.W. (2005). *Masculinities.* Cambridge, England: Polity Press

Conrad, P. (1997). Public eyes and private genes: Historical frames, news constructions, and social problems. *Social Problems*, 44:139-154.

Cooke, A. (1999). Clinical psychology, mental illness and the media. *Clinical Psychology Forum*, 128:7-11. Leicester: British Psychological Society.

Cooke, A., Gilchrist, A., Goodbody, L., Harper, D., Kinderman, P., Lea, L., Marsh, I. & McGowen, J. (2014). A response: So what do we need to do? *Clinical Psychology Forum,* 256: 22-25.

Coulter, C. & Rapley, M. (2011) 'I'm just, you know, Joe Bloggs': The management of parental responsibility for first episode psychosis. In M., Rapley, M. Moncrieff & J. Dillon (Eds.) *De-medicalising misery: Psychiatry, psychology and the human condition.* (pp. 158-174). Basingstoke: Palgrave MacMillan.

Coverdale, J., Nairn, R. & Claasen, D. (2002). Depictions of mental illness in print media: a prospective national sample. *Australian and New Zealand Journal of Psychiatry*, 36:697–700.

Cross, S. (2002). Hearing Voices: Mental Illness and Cultural Recognition. The Journal of Global Communications and Culture, 2(3/4):69-78.

Cross, S. (2004). Visualising madness: mental illness and public representation. *Television and New Media*, 5:197-216.

Davis, E.M. (2008). Risky business: Medical discourse, breast cancer and narrative. *Qualitative Health Research,* 18(1):65-76.

Department of Health (2010). *Healthy Lives, Healthy People: Our strategy for healthy lives in England.* London, England: The Stationary Office

Department of Health (2012). No Health Without Mental Health: implementation framework. London, England: The Stationary Office.

Designs, Copyrights and Patents Act (1988) Retrieved from URL http://www.legislation.gov.uk/ukpga/1988/48/pdfs/ukpga_19880048_en.pdf
Dickerson, Sommerville, Origoni, Ringel & Parente (2002) Experiences of stigma among outpatients with schizophrenia. *Schizophrenia Bulletin,* 28(1):143-155.

Diefenbach, D.L. & West, M.D. (2007). Television and attitudes toward mental health issues: cultivation analysis and the third-person effect. *Journal of Community Psychology*, 35(2):181-195.

Diefenbach, D.L. (1997). The portrayal of mental illness on prime time television. *Journal of Community Psychology*, 25(3), 289-302.

Dillon (2009). Jacqui Dillon. In Romme, M., Escher, S., Dillon, J., Corstens, D. & Morris, M. (Eds.) *Living with voices: 50 stories of recovery*, (pp. 188-193). Ross-on-Wye, PCCS books.

Division of Clinical Psychology (2013). *Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift*. Leicester: British Psychological Society.

Division of Clinical Psychology (2014). *Understanding psychosis and schizophrenia. Why people sometimes hear voices, believe things that others find strange, or appear out of touch with reality, and what can help.* Leicester, England: British Psychological Society.

Doward, J. (2013). Psychiatrists under fire in mental health battle. *The Guardian.* Retrieved from URL

http://www.theguardian.com/society/2013/may/12/psychiatrists-under-fire-mental-health

Drake, R.E., Osher, F. & Wallach, M.A. (1989). Alcohol use and abuse in schizophrenia: a prospective community study. *Journal of Nervous and Mental Disease*, 177(7):379-441

Dubriwny, T.N. (2010). Television news coverage of Postpartum disorders and the Politics of medicalization. *Feminist Media Studies*, 10(3):285-303.
Duke, P.J., Pantelis, C. & Barnes, T.R. (1994). South Westminster schizophrenia survey. Alcohol use and its relationship to symptoms, tardive dyskinesia and illness onset. The British Journal of Psychiatry, 164(5):630-636

Ekdawi, I. & Hansen, E. (2010). Working with older people in contexts of difference and discrimination. In G. Fredman, E. Anderson & Stott, J. (Eds.), *Being with older people: A systemic approach*. London, England: Karnac Books.

Ellis, J. (2012). Editing, narrative and separation. In J. Ellis (Ed.), Documentary witness and self revelation (pp. 64-78). London, England: Routledge.

Engel, G.L. (1980). The Clinical Application of the Biopsychosocial Model. The *American Journal of Psychiatry*, 137(5):535-544

Escher (2009). Making sense of voices: The relationship between the voices and the life history. In Romme, M., Escher, S., Dillon, J., Corstens, D. & Morris, M. (Eds.) *Living with voices: 50 stories of recovery*, (pp. 54-63). Ross-on-Wye, PCCS books.

Esin, C. & Squire, C. (2013). Visual autobiographies in east London: Narratives of still images, interpersonal exchanges, and intrapersonal dialogues. *Forum: Qualitative Social Research,* 14(2), 1

Fenton, S. & Sadiq-Sangster, A. (1996). Culture, relativism and the expression of mental distress: South Asian Women in Britain. *Sociology of Health and Illness*, 18(1): 66-85.

Foucault, M. (1970). *The Care of the Self: The History of Sexuality, Volume 3.* Trans. Robert Hurley. London, England: Penguin.

Foucault, M. (1973). The psychiatric cure, in LaGrange, J. (Ed.) *Psychiatric power, lectures at the College de France 1973-1974.* Basingstoke, England: Palgrave MacMillan.

Foucault, M. (1977). *Discipline and punish: The birth of the prison.* London, England: Penguin

Frances, A.J. & Nardo, J.M. (2013). ICD-11 should not repeat the mistakes made by DSM-5. The British Journal of Psychiatry, 203:1-2.

Francis, C., Pirkis, J., Blood, R. W., Dunt, D., Burgess, P., Morley, B., Stewart, A. & Putnis, P. (2004). The portrayal of mental health and illness in Australian non-fiction media. *Australian and New Zealand Journal of Psychiatry*, 38: 541–546.

Francis, C., Pirkis, J., Blood, R.W., Dunr, D., Burgess, P., Marley, B. & Stewart, A. (2005). Portrayal of depression and other mental illness in Australian nonfiction media. *Journal of Community Psychology*, 33(3):283-297.

Frank (2012). Practicing Dialogical Narrative Analysis. Retrieved from URL http://www.sagepub.com/sites/default/files/upm-binaries/41823_2.pdf

Freeman, D. & Freeman, J. (2008). Paranoia the 21st-century fear. Oxford, England: Oxford University Press.

Freud, A. (1936). *The ego and the mechanisms of defence.* London, England: Hogarth.

119

Gauntlett, D. (1995). Moving experiences: Moving Experiences: Understanding Television's Influences and Effects. London: John Libbey

Gelder, Mayao & Cowen (2001). *Shorter Oxford Textbook of Psychiatry*. Oxford, England, Oxford University Press.

Georgakopoulou, A. (2006). Thinking big with small stories in narrative and identity analysis. *Narrative Inquiry* 16(1):122–130.

Gerbner, G., Gross, L., Morgan, M., Signorielli, N. & Shanahan, J. (2002). Growing up with television: Cultivation processes. In J. Bryant, & D. Zillmann (Eds.), *Media Effects: Advances in Theory and Research (*pp. 43-68*)*. Mahwah, NJ: Lawrence Erlbaum Associates.

Gergen, K.J. (1991). *The saturated self*. New York: Basic Books
Glick, D. and Applbaum, K. (2010). Dangerous noncompliance: a narrative analysis of a CNN special investigation of mental illness. *Anthropology & Medicine*, 17(2):229–244.

Giles, D. (2003). Media Psychology. New Jersey, USA: Lawrence Erlbaum Associates.

Gleeson, K. (2011). Polytextual thematic analysis for visual data – pinning down the analytic. In Reavey, P. (Ed), *Visual methods in psychology: Using and interpreting images in qualitative research* (pp. 314- 330). Hove, England: Psychology Press

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. London, England: Penguin Books.

Goulden, R., Corker, E., Evans-Lacko, S., Rose, D., Thornicroft, G. & Henderson, C. (2011). Newspaper coverage of mental illness in the UK, 1992-2008. *BMC Public Health*, 11:796.

Granello, D.H. & Pauley, P.S. (2000). Television viewing habits and their relationship to tolerance toward people with mental illness. *Journal of Mental Health Counselling*, 22(2):162-175.

Granello, D.H., Pauley, P.S. & Carmichael, A. (1999). Relationship of the Media to Attitudes Toward People With Mental Illness. *Journal of Humanistic Counselling, Education & Development,* 38(2):98-110.

Green, J., Franquiz, M., & Dixon, C. (1997). The myth of the objective transcript: Transcribing as a situated act. *TESOL Quarterly*, 31:172-176.

Gunter B. (1987) *Television and the Fear of Crime*. London, England: Libbey.

Hagan, T. & Smail, D. (1999). Power-mapping –I. Background and basic methodology. *Journal of Community and Applied Social Psychology,* 7:257-267.

Hall, S. (1980). Encoding/Decoding In Hall, S., Hobson, D., Lowe, A. & Willis, P. (Eds.) *Culture, Media, Language.* (pp. 117-128), London, England: Taylor & Francis

Hallam, A. (2002). Media influences on mental health policy: long-term effects of the Clunis and Silcock cases. *International Review of Psychiatry,* 14:26-33.

Harper, D. (2004). Storying policy: Constructions of risk in proposals to reform UK mental health legislation In B. Hurwitz, V. Skultans & T. Greenhalgh (Eds.) *Narrative Research in Health and Illness.* (pp.397-414), London, England: BMA Books.

Harper, D. (2012). Choosing a qualitative research method. In D. Harper & A.R. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (pp. 83-99). Chichester, John Wiley & Sons.

Harper, D., Tucker, I. & Ellis, D (2013). Surveillance and subjectivity: Everyday experiences of surveillance practices. In K. Ball & L. Snider (Eds.), *The surveillance industrial complex: A political economy of surveillance* (pp. 175-190). Oxon, England: Routledge.

Harper, S. (2008). Understanding mental distress in film and media: a new agenda? *The Journal of the Royal Society for the Promotion of Health,* 128(4), 170-174.

Harper, S. (2009). Madness, power and the media. Basingstoke, England: Palgrave Macmillan.

Harper, S. (2010). Freaks, geniuses or biological citizens? Discourses of mental distress in British television documentaries. *Jump Cut: A review of contemporary media.* 52.

Harré, R. & van Langenhove, L. (1991). Varieties of positioning. *Journal for the Theory of Social Behaviour*, 21(4): 393-407.

Harré, R. & van Langenhove, L. (1999). *Positioning theory*. Oxford, England: Blackwell Publishers

Harrow, M., Hansford, B.G. & Astrachan-Fletcher, E.B. (2009) Locus of control: Relation to schizophrenia, to recovery, and to depression and psychosis – A 15 year longitudinal study. *Psychiatric Research*, 168:186-192.

Hartley, J. (1996). *Popular reality: Journalism, modernity, popular culture.* London: Arnold.

Henderson, L. (1996). Selling suffering: mental illness and media values. In G. Philo (Ed.), Media and mental distress (pp. 18-37). Essex, England: Addison Wesley Longman.

Henley, P. (2006). Anthropologists in television: A disappearing world? In S. Pink. (Ed.), *Applications of anthropology: professional anthropology in the twenty-first century* (pp. 170-190). Oxford, England: Berghahn Books.

Henriques, J., Hollway, W., Urwin, C., Venn, C. & Walkerdine, V. (1998). Introduction to section 2: constructing the subject. In J. Henriques, W. Hollway, C. Urwin, C. Venn & V. Walkerdine (Eds.), *Changing the subject* (pp. 91-118). London, England: Methuen & Co.

Henson, C., Chapman, S., McLeod, L., Johnson, N., & Hickie, I. (2010). Room for improvement: mixed portrayal of young people with mental illness on Australian television news. *Australian and New Zealand Journal of Psychiatry*, 44:267-272.

Henson, C., Chapman, S., McLeod, L., Johnson, N., McGeechan, K & Hickie, I. (2009). More us than them: positive depictions of mental illness on Australian television news. *Australian and New Zealand Journal of Psychiatry*, 43:554-560.

Hobson, D, (1988). *Crossroads. The drama of soap opera*. London, England: Macmillan.

Hodgetts, D. and Chamberlain, K. (1999). Medicalization and the depiction of lay people in television health documentary. *Health*, 3(3):317–333.

Hodgins, S. (2008). Violent behaviour among people with schizophrenia: a framework for investigations of causes, and effective treatment, and prevention. *Philosophical Transactions of the Royal Society B: Biological Sciences*, *363*(1503), 2505–2518.

Hollway, W. (1984). Gender difference and the production of subjectivity. In J. Henriques, W. Hollway, C. Urwin, L. Venn and V. Walkerdine (Eds.), *Changing the subject: psychology, social regulation and subjectivity*. London, England: Methuen.

123

Howard, R., Rabins, P.V., Seeman, M.V., Jeste, D.V. & the International Late-Onset Schizophrenia Group (2000). Late-Onset Schizophrenia and Very-Late-Onset Schizophrenia-Like Psychosis: An International Consensus, *American Journal of Psychiatry,* 157:172–178.

Ife, J. (2012). *Human rights and social work: Towards rights based practice.* Cambridge, England: Cambridge University Press.

Jarvis, M. (2004). *Psychodynamic psychology: classical theory and contemporary research.* London, England: Thomson.

Johns, L.C. & van Os, J. (2001). The continuity of psychotic experiences in the general population. *Clinical Psychology Review*, 21(8):1125–1141.

Johnstone, L. (2000). *Users and abusers of psychiatry: A critical look at psychiatric practice.* London: Routledge

Jones, R.L. (2002). "That's very rude, I shouldn't be telling you that": older women talking about sex. *Narrative inquiry*, *12*(1):121–143.

Jorm, A.F. (2000). Mental health literacy: public knowledge and beliefs about mental disorders. The British Journal of Psychiatry, 177:396-401.

Josselson, R. (2007). The ethical attitude in narrative research. In D. J. Clandinin, *Handbook of Narrative Inquiry: Mapping a methodology (pp.537-566).* London, England: Sage publications.

Karpf, A. (1988). Doctoring the media: The reporting of health and medicine. London, England: Routledge.

Kaslow, N.J. (2015). Translating psychological science to the public. *American Psychologist.* 70(5):361-371.

Kato, T., Yamanaka, G., & Kaiya, H. (1999). Efficacy of media in motivating patients with panic disorder to visit specialists. *Psychiatry and Clinical Neurosciences*, 53(4):523–526.

Keats, P.A. (2009). Multiple text analysis in narrative research: visual, written, and spoken stories of experience. *Qualitative Research*, 9:181-195.

Khantzian, E.J. (1985). The self medication hypothesis of addictive disorders. American Journal of Psychiatry, 142:1259–1264.

Khantzian, E.J. (1997). The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. Harvard Review of Psychiatry, 4:231–244.

Kimmerle, J. & Cress, U. (2013). The effects of TV and film exposure on knowledge about and attitudes toward mental disorders. *Journal of Community Psychology*, 41:931-943.

Kingdon, D. & Turkingdon, D. (2005). Cognitive therapy of schizophrenia. New York: Guilford Press.

Kitzinger, J. (1999). A sociology of media power: Key issues in audience reception research. In G. Philo (Ed.) *Message received*. (pp. 3-20). Harlow: Addison Wesley Longman.

Kumari, V. & Postma, P. (2005). Nicotine use in schizophrenia: The self medication hypotheses. *Neuroscience and Biobehavioral Reviews*, 29:1021–1034

Layard, Richard (2004) *Good jobs and bad jobs Centre for Economic Performance occasional papers*, CEPOP19. Centre for Economic Performance, London School of Economics and Political Science, London, UK.

Leo, J. & Lacasse, J.R. (2007). The media and the chemical imbalance theory of depression. *Sociology*, 45:35-45.

Lewis, S., Baird, P., Evans, R. G., Ghali, W. A., Wright, C. J., Gibson, E. & Baylis, F. (2001). Dancing with the porcupine: rules for governing the university-industry relationship. *Canadian Medical Association Journal,* 165(6):783-785.

Li, T.C.W. (2012). The girl least likely – A linguistically informed media case review. *Advances in Mental Health,* 10(2):190-194

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. (1987). The social rejection of ex-mental patients: understanding why labels matter. *American Journal of Sociology, 92*:1461-1500.

Link, B.G. & Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27:363-385.

Lister, R. (2008). Inclusive Citizenship, gender and poverty: some implications for education for citizenship. *Citizenship Teaching and Learning*, 4(1): 3-19.

Lobbana, F., Barrowclough, C., Jeffery, S., Bucci, S., Taylor, K., Mallinson, S., Fitzsimmons, M. & Marshall, M. (2010). Understanding factors influencing substance use in people with recent onset psychosis: a qualitative study. *Social Science and Medicine*, 70(8):1141–1117.

Lupton, D. (1999). Editorial: Health, illness and medicine in the media. *Health,* 3:259-262.

Lyons, A.C. (2000). Examining Media Representations: Benefits for Health Psychology. *Journal of Health Psychology,* 5(3):349–358.

Mahoney, M.J. (1988). Constructive metatheory: II. Implications for psychotherapy. *International Journal of Personal Construct Psychology*, 1:299-315.

126

Martindale, B. (2015). Widening the dialogue: psychoanalysis and open dialogue. *Context*, 138:41-44.

Matas. M., el-Guebaly, N., Peterkin, A., Green, M. & Harper, D. (1985). Mental illness and the media: an assessment of attitudes and communication, 30(1):12-17.

Mehta, S. & Farina, A. (1997). Is being "sick" really better? Effect of the disease view of mental disorder on stigma. *Journal of Social and Clinical Psychology*, 16(4), 405-419

Mellifont, D. & Smith-Merry, J. (2015). The Anxious Times An Analysis of the Representation of Anxiety Disorders in The Australian Newspaper, 2000–2015. Asia Pacific Media Educator, 25(2):278-296.

Mental Capacity Act 2005. (2005). London: The Stationary Office.

Mental Health Act 1983. (1983). London: The Stationary Office.

Mikos (2014). Analysis of film. In U, Flick (Ed.) *The SAGE handbook of qualitative data analysis* (pp. 409-424). London, England: Sage.

Milton, J., Polmear, C. & Fabricius, J. (2004). A short introduction to psychoanalysis. London, England: Sage.

Mind (2000) Counting the cost: a survey of the impact of media coverage on the lives of people with mental health problems. London, England: Mind Publications.

Minnebo, J. & Van Acker, A (2004). Does television influence adolescents' perceptions of and attitudes toward people with mental illness? *Journal of Community Psychology*, 32(3), 257–275.

127

Misuse of Drugs Act (1971). Retrieved from URL
http://www.legislation.gov.uk/ukpga/1971/38/pdfs/ukpga_19710038_en.pdf

Morris, D. (2005). Belief and narrative. *The Scientist*. Retrieved from URL
http://www.the-scientist.com/?articles.view/articleNo/16332/title/Belief-and-
Narrative/

Morris, G. (2006). *Mental health issues and the media. An introduction for health
professionals*. Oxon, England: Routledge.

Mueser, K.T., Bennett, M., Kushner, M.G., 1995. Epidemiology of substance use
disorders among persons with chronic mental illnesses. In A.F. Lehman, & L.
Dixon (Eds.), *Double Jeopardy: Chronic Mental Illness and Substance Abuse*.
(pp. 9) New York: Harwood Academic Publishers.

Mueser, K.T., Drake, R.E., Wallach, M.A. (1998). Dual diagnosis: a review of
etiological theories. Addictive Behaviours, 23(6):717–734.

Murali, V. & Oyebode, F. (2004). Poverty, social inequality and mental health
Advances in Psychiatric Treatment, 10(3):216-224.

Murray, M. & Sargeant, S. (2012). Narrative psychology, in Harper, D., and
Thompson, A.R. (Eds.), *Qualitative research methods in mental health and
psychotherapy*. Chichester, England: John Wiley and Sons.

Murray, M. (2008). Narrative psychology. In J.A. Smith (Ed.), *Qualitative
psychology a practical guide to research methods* 2nd ed. (pp. 111-133). London,
England: Sage.

Nairn, R.G. (2007). Media portrayals of mental illness, or is it madness? A review.
Australian Psychologist, 42(2):138-146

Nairn, R., Coverdale, J.H. & Claasen, D. (2006). What is the role of intertextuality in media depictions of mental illness? Implications for forensic psychiatry. *Psychiatry, Psychology and Law*, 13(2):243–250

Nairn, R.G. & Coverdale, J.H. (2005). People never see us living well: an appraisal of the personal stories about mental illness in a prospective print media sample. *Australian and New Zealand Journal of Psychiatry*, 39:281–287.

National Institute for Health and Clinical Excellence (2005). *Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder.* London: National Institute for Health and Clinical Excellence.

National Institute for Health and Clinical Excellence (2009) Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care (update). London: National Institute for Health and Clinical Excellence

National Institute for Health and Clinical Excellence (2011). *Generalised anxiety disorder and panic disorder in adults: management.* London: National Institute for Health and Clinical Excellence.

Nawková, L., Nawka, A., Adámková, T., Rukavina, T.V., Holcnerová, P., Kuzman, M.R., Jovanović, N., Brborović, O., Bednárová, B., Zuchová, S., Miovský, M. (2012a). The picture of mental health/illness in the printed media in three Central European countries. *Journal of Health Communication*, 17(1):22-40.

Oumano, E. (1985). *Film forum: thirty-five top filmmakers discuss their craft.* New York: St Martin's Press.

Paparelli, A., Di Forti, M., Morrison, P.D. & Murray, R.M. (2011). Drug-induced psychosis: how to avoid star gazing in schizophrenia research by looking at the real cause. *Frontiers in Behavioural Neuroscience*, 5(1):1-9.

Patel, N. (2007).The Prevention of Torture: A Role of Clinical Psychologists? *International Journal of Critical Psychology, Counselling and Psychotherapy, 7(4):229-246.*

Penn, D., Chamberline, C., & Mueser, K. (2003). Effects of documentary film about schizophrenia on psychiatric stigma. *Schizophrenia Bulletin*, 29(2):383–391.

Phelan, J.C. (2005). Geneticization of Deviant Behaviour and Consequences for Stigma: The Case of Mental Illness. *Journal of Health and Social Behaviour,* 46: 307–322.

Philo, G. & Berry, M. (2004). Bad news from Israel. London, England: Pluto.

Philo, G. (1996). *Media and mental distress.* Essex, England: Addison Wesley Longman

Philo, G., Seeker, J., Platt, S., Henderson, L., McLaughlin, G., & Burnside, J. (1994). The impact of the mass media on public images of mental illness: Media content and audience belief. *American Journal of Public Health,* 89:1339-1345.

Pirkis, J., Blood, R.W., Francis, C., McCallum, K. (2006). On-screen portrayals of mental illness: extent, nature, and impacts. *Journal of Health Communication*, 11:523–541.

Pirutinsky, S., Rosen, D.D., Safran, R.S., & Rosmarin, D.H. (2010). Do medical models of mental Illness relate to increased or decreased stigmatization of mental illness among orthodox Jews? *Journal of Nervous and Mental Disease*, 198:508–512.

Pocock, D. (2015). A philosophy of practice for systemic psychotherapy: the case for critical realism. *Journal of Family Therapy,* 37:167–183.

Polkinghorne, D. (1996). Explorations of narrative identity. *Psychological Inquiry*, 7:363-367.

Pollak, A. (2008). Analysing TV documentaries. In R. Wodak & M. Krzyzanowski (Eds.) *Qualitative Discourse Analysis in the Social Sciences*. (pp. 77-94). Basingstoke: Palgrave Macmillan.

Potter, W.J. (2014). A Critical Analysis of Cultivation Theory. *Journal of Communication*, 64: 1015-1036

Potter, J. & Wetherell, M. (1987). Discourse and social psychology: Beyond attitudes and behaviour. London, England: Sage.

Proctor, G. (2008) CBT: The obscuring of power in the name of science. In R. House & D. Loewenthal (Eds.), *Against and for CBT: Towards a constructive dialogue?* (pp. 241-256). Ross-On-Wye: PCCS Books.

Read, J. & Baker, S. (1996). Not just sticks and stones: a survey of stigma, taboos and discrimination experienced by people with mental health problems. Leeds: The Mental Health Charity. Retrieved from URL http://disability-studies.leeds.ac.uk/files/library/MIND-MIND.pdf

Read, J. (2005). The bio-bio-bio model of madness. *The Psychologist,* 18(10):596-597.

Read, J., Haslam, N., Sayce, L. & Davies, E. (2006). Prejudice and schizophrenia: A review of the "Mental illness is an illness like any other" approach. *Acta Psychiatrica Scandinavica*, 114: 303-318.

Reavey, P. (2011). Visual methods in psychology: Using and interpreting images in qualitative research. Hove, England: Psychology Press

Riessman, C. K. (1993). *Narrative analysis.* Newbury Park, USA: Sage.

131

Riessman, C. K. (2008). *Narrative methods for the human sciences*. London, England: Sage Publications.

Roberts, C. (1997). Transcribing talk: Issues of representation. *TESOL Quarterly*, 31:167-171.

Rogers, A. & Pilgrim, D. (2010). Stigma revisited and lay representations of mental health problems. In A. Rogers & D. Pilgrim (Eds.), *A sociology of mental health and illness* (pp. 25-43). Maidenhead, England: Open University Press.

Rose, D. (1998). Television, madness and community care. *Journal of Community & Applied Social Psychology*, 8:213- 228

Rose, D. (2000). Analysis of moving images. In M.W. Bauer, & G. Gaskell (Eds), *Qualitative researching with text, image and sound* (pp.243-262). London, England: Sage.

Rose, G. (2011). Visual methodologies an introduction to the interpretation of visual materials. London, England: Sage.

Rowe, R., Tilbury, F., Rapley, M., & O'Ferrall, I. (2003). About a year before the breakdown I was having symptoms: sadness, pathology and the Australian newspaper media. *Sociology of Health and Illness*, 25(6): 680-696

Salkovskis, P.M. (1999). Understanding and treating obsessive compulsive disorder. *Behaviour Research and Therapy*, 37:S29- S52.

Skoog, G. & Skoog, I. (1999). A 40 year follow-up of patients with obsessive-compulsive disorder. *Archives of General Psychiatry*, 56:121-127.

Slopen, N.B., Watson, A.C., Gracia, G. & Corrigan, P.W. (2007). Age Analysis of Newspaper Coverage of Mental Illness. *Journal of Health Communication*, 12:3– 15

Smail, D. (1996). *How to survive without psychotherapy*. London, England: Karnac Books

Smail, D. (2004). Psychotherapy and the making of subjectivity In P. Gordon & R. Mayo (Eds.). *Between Psychotherapy and Philosophy*, (pp 130-140). London & Philadelphia: Whurr.

Smith, B., and Sparkes, A.C. (2006). Narrative Inquiry in psychology: exploring the tensions within. *Qualitative Research in Psychology*, 3(3):169-192

Spellman, D. & Harper, D.J. (1996). Failure, mistakes, regret and other subjugated stories in family therapy, *Journal of Family Therapy,* 18: 205-214.

Spencer, C., Castle, D. & Michie, P.T. (2002). Motivations that maintain substance use among individuals with psychotic disorders. *Schizophrenia Bulletin*, 28(2):233–247

Squire, C., Andrews, M., Davis, M., Esin, C., Harrison, B., Hyden, L-C. & Hyden, M. What is narrative research? Starting out. In C. Squire, M. Andrews, M. Davis, C. Esin, B. Harrison, L-C. Hyden & M. Hyden (Eds.), *What is narrative research?* London, England: Bloomsbury Academic.

Stout, P.A., Villegas, J. & Jennings, N.A. (2004). Images of mental illness in the media: identifying gaps in the research. *Schizophrenia Bulletin*, 30(3):543-561.

Szmukler, G. & Appelbaum, P.S. (2008). Treatment pressures, leverage, coercion, and compulsion in mental health care. *Journal of Mental Health, 17*(3):233-244.

The Midlands Psychology Group (2014). *The draft manifesto.* Leicester, England: British Psychological Society.

Thomas (2012). English Madness: Vox Populi. Retrieved from URL http://www.madinamerica.com/2012/02/english-madness-vox-populi/

Thornicroft G, Rose D, Kassam A, Sartorius N. (2007). Stigma: ignorance, prejudice or discrimination? *British Journal of Psychiatry*, 190:192-193.

Thornicroft, G., & Henderson, C. (2013). Newspaper coverage of mental illness in England 2008-2011. *The British Journal of Psychiatry*, 202, s64-s69.

Thornicroft, A., Goulden, R., Shefer, G., Rhydderch, D., Rose, D., Williams, P., Thornicroft, G., & Henderson, C. (2013). Newspaper coverage of mental illness in England 2008-2011. *The British Journal of Psychiatry*, 202, s64-s69.

Trahar, S. (2009). Beyond the story itself: narrative inquiry and autoethnography in intercultural research in higher education. *Forum: Qualitative Social Research*, 10(1:30) Retrieved from URL http://www.qualitative-research.net/index.php/fqs/article/view/1218/2653

van Os, J. (2009). A salience dysregulation syndrome. *British Journal of Psychiatry*, 194:101-103.

Vilhauer, R.P. (2015). Depictions of auditory verbal hallucinations in news media. *International Journal of Psychiatry*, 61(1):58-63.

Wade, A. (1997). Small acts of living: Everyday resistance to violence and other forms of oppression. *Contemporary Family Therapy, 19(1):23-39.*

Wahl, O.E., Wood, A. & Richards, R. (2002). Newspaper Coverage of Mental Illness: Is It Changing? *Psychiatric Rehabilitation Skills*, 6(1):9-31

Wahl, O.F. (1992). Mass media images of mental illness: A review of the literature. *Journal of Community Psychology*, 20:343-352.

Walker, L, and Read, J. (2002). The differential effectiveness of psychosocial and biogenetic causal explanations in reducing negative attitudes toward mental illness. *Psychiatry: Interpersonal and Biological Processes,* 65(4):313-325

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Ward, G. (1997). *Mental health and the national press*. London, England: Health Education Authority.

Weatherhead, S. (2011). Narrative analysis: An often overlooked approach. *Clinical Psychology Forum*, 218:47–52.

Welch, S., Klassen, C., Borisova, O. & Clothier, H. (2013). The DSM-5 Controversies: How should psychologists respond? *Canadian Psychology*, 54(3):166-175.

Westbrook, D., Kennerley, H. & Kirk, J. (2011). *An Introduction to Cognitive Behaviour Therapy: Skills and Applications.* London, England: Sage.

White, M. (2000). Re-engaging with history: The absent but implicit. In M.White (Ed.), *Reflections on narrative practice* (pp. 35-58). Adelaide, South Australia: Dulwich Centre Publications.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton & Company

Whitley, R. & Berry, S. (2013). Trends in Newspaper Coverage of Mental Illness in Canada: 2005-2010. *Canadian Journal of Psychiatry*, 58(2):107-112.

Whitley, R. (2012). The antipsychiatry movement: dead diminishing or developing? *Psychiatric Services*, 63(10):1039-1041.

Whitley, R., Adeponle, A. & Miller, A.R. (2015). Comparing gendered and generic representations of mental illness in Canadian newspapers: an exploration of the chivalry hypothesis. *Social Psychiatry Psychiatric Epidemiology*, 50:325–333.

Whomsley, S. (2014). The representation of mental health in the media. *Clinical Psychology Forum*, 246:53-55. Leicester: British Psychological Society.

Willig, C. (2013). Conceptual preparation: From recipes to adventures. In C. Willig (Ed.), *Introducing qualitative research in psychology* (pp. 3-14). New York, USA: Open University Press.

Wilson, C, Nairn, R., Coverdale, J., & Panapa, A. (1999). Constructing mental illness as dangerous: A pilot study. *Australian and New Zealand Journal of Psychiatry,* 33:240-247.

Winnicot, D, W. (1953). Transitional objects and transitional phenomena; a study of the first not-me possession. *International Journal of Psychanalysis*, 34(2):89-97.

World Health Organization (1992). *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. World Health Organisation.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15:215-228.

7. APPENDICES

7.1. Appendix 1: Literature Search

The following databases were used to search for peer-reviewed articles: Academic Search Complete, Communication & Mass Media Complete, PsycARTICLES, PsycINFO (all via EBSCO) and Google Scholar. The reference sections of articles were also scanned. Relevant articles were picked according to the following inclusion and exclusion criteria:

Inclusion criteria

- Representations/ portrayals of mental health problems/ diagnoses (excluding autism and learning disabilities)
- Representations/ portrayals of mental health problems/ diagnoses (excluding autism and learning disabilities)
- Stigma and mental distress related articles
- English language
- Print media, televised news programmes and television documentaries
- Peer reviewed

Exclusion criteria

- Book reviews
- Social media, fictional television, radio
- Portrayals of physical health
- General mental health 'topics'
- Media influence in causing/ perpetuating mental 'illness' e.g. eating disorders
- Portrayal of mental health research
- Non-English language

Searches via EBSCO

(NB. not all articles are cited in the main body of the report)

Search number	Date	Search terms	No. of articles generated	No. of relevant articles
1	Up until January 2015	Media & mental health	458	60
2	Up until January 2015	Media & mental illness	224	118
3	Up until January 2015	Media & mental distress	2	0
4	Up until January 2015	Media & mental disorders	169	47
5	Up until January 2015	Media & mentally ill	43	12
6	Up until January 2015	Media & psychiatric disorders	2	0
7	Up until January 2015	Media & psychological disorders	2	0
8	Up until January 2015	Media & psychological distress	1	0
9	Up until January 2015	Television & mental health	129	26
10	Up until January 2015	Television & mental illness	76	6
11	Up until January 2015	Television & mentally ill	23	4
12	Up until January 2015	Television & psychiatric disorders	4	1

13	Up until January 2015	Television & mental distress	0	0
14	Up until January 2015	Television & mental disorders	0	0
15	Up until January 2015	Television & psychological disorders	0	0
16	Up until January 2015	Television & psychological distress	0	0
17	January 2015 – February 2016	Media & mental health	63	3
18	January 2015 – February 2016	Media & mental illness	27	3
19	January 2015 – February 2016	Media & mental distress	0	0
20	January 2015 – February 2016	Media & mental disorders	0	0
21	January 2015 – February 2016	Media & mentally ill	0	0
22	January 2015 – February 2016	Media & psychiatric disorders	0	0
23	January 2015 – February 2016	Media & psychological disorders	0	0
24	January 2015 – February 2016	Media & psychological distress	0	0

25	January 2015 – February 2016	Television & mental health	0	0
26	January 2015 – February 2016	Television & mental illness	6	0
27	January 2015 – February 2016	Television & mentally ill	0	0
28	January 2015 – February 2016	Television & psychiatric disorders	4	0
29	January 2015 – February 2016	Television & mental distress	0	0
30	January 2015 – February 2016	Television & mental disorders	0	0
31	January 2015 – February 2016	Television & psychological disorders	0	0
32	January 2015 – February 2016	Television & psychological distress	0	0

7.2. Appendix 2: E-mail to Copyright Holders/ Television Production Companies

NB: Permission was granted from The Garden Productions LTD (who were also the copyright holders) for all of the actions proposed below apart from publishing screen shots in the academic journal article.

Dear XXX,

Further to our telephone conversation, I am writing to request permission to transcribe and analyse XXX documentaries for my thesis featured in Table 1, which forms part of my Professional Doctorate in Clinical Psychology. The title of my thesis is Factual television documentaries and mental distress: a narrative analysis.

[Table 1 – list of documentaries inserted]

There exists a paucity of research in the area of non-fiction television, especially among factual television documentaries, despite them having an educatory role and providing rich visual information. My proposed study aims to analyse how mental distress is portrayed in factual television documentaries. It also aims to analyse the prominent, alternative and absent or marginalised narratives in factual television documentaries. In order to conduct my proposed research, it would be necessary to:

* Transcribe both the spoken words and visual images presented in the documentaries
* Conduct a narrative analysis on the transcriptions which is a type of rigorous and coherent qualitative analysis
* Include quotations from the documentaries in my written thesis
* Aim to publish the thesis in a peer-reviewed academic journal

As with all doctorate and PhD theses, they are made available to public through the British Library, university repositories, and online. I would greatly appreciate your help in obtaining permission to go ahead with the above. As the documentaries are no longer available online, I would also greatly appreciate DVD copies of the documentaries, in order to proceed with my proposed research.

I look forward to hearing from you soon.

Yours sincerely,

Candice Joseph
Trainee Clinical Psychologist
Doctorate Programme in Clinical Psychology
School of Psychology
University of East London

7.3.   Appendix 3: TRILT search

Documentary name	Date broadcasted	Length	Channel	Meets inclusion?
Fit to Rule Learning Zone	12/02/14 (repeat)	30 minutes	BBC2	No - Specific diagnosis/ 'mental illness' not main focus
Watch Over Me	04/02/14 & repeats	60 minutes	BBC1	No - Broadcast in Northern Ireland only
999: What's your emergency	27/01/14 & 28/01/14	65 minutes	More 4	No- Specific diagnosis/ 'mental illness' not main focus
The Queen's Mother in Law	19/01/14 & repeat	65 minutes	More 4	No- Mental distress is not main focus of programme
Football's Suicide Secret	14/01/2014	60 minutes	BBC 3	No- Main focus is taboo of 'mental illness' in football (particularly suicide and depression)
Failed by the NHS	13/01/2014	55 minutes	BBC 3	No- Main focus is lack of treatment for young

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				people with 'mental illness' in NHS
Dirty Britain	12/01/2014	60 minutes	ITV4	No- Mental distress is not the main focus of the programme
Tubular Bells: The Mike Oldfield Story	11/01/2014	60 minutes	BBC 4	No- Mental distress is not the main focus of the programme
Jennifer Ellison: My Post-Baby Breakdown	31/12/2013	50 minutes	Channel 5	Yes - specific diagnosis/ mental health problem is main focus
Louis Smith: Living with ADHD	30/12/2013	50 minutes	Channel 5	Yes - specific diagnosis/ mental health problem is main focus
Kerry Katona: My Depression Diaries	29/12/13 & repeats	55 minutes	Channel 5	Yes - specific diagnosis/ mental health problem is main focus
Karaoke Nights	29/12/2013	55 minutes	Channel 4	No- Mental distress is not the main

				focus of the programme
Bedlam Breakdown: Older Adults	21/11/2013 & repeat	60 minutes	Channel 4	No- Specific diagnosis/ 'mental illness' not main focus
Bedlam Psychosis	14/11/2013 & repeat	60 minutes	Channel 4	Yes - specific diagnosis/ mental health problem is main focus
Bedlam Crisis	07/11/2013 & repeat	60 minutes	Channel 4	No- Specific diagnosis/ 'mental illness' not main focus
Bedlam Anxiety	31/10/2013 & repeat	60 minutes	Channel 4	Yes - specific diagnosis/ mental health problem is main focus

7.4. Appendix 4: Transcription Scheme

Adapted from Banister et al. (2011):

(.) Pause

(2) Two second pause

xxx untranscribable

(xxx) indistinct/ doubtful transcription

Word underline emphasis

! exclamation/ excitement in voice

Where an interruption by another speaker is brief it is placed in parentheses <>

Other interruptions and overlapping talk are marked with /

[laughter] Laughter

[whispering] Whispering

[whispering xxx] untranscribable whispering

[crying] or [cry] Crying or cry

[clapping] Clapping

7.5. Appendix 5: Plot Synopses

Bedlam Anxiety Documentary

Part 1: Introducing "the most anxious people in the country"

The beginning of the documentary introduces the 'patients' - James, Arron, Leon and Helen, their 'abnormal' behaviours and part of James' treatment. Sandwiched between these sequences, the narrator's voice is deployed to bring meaning to them, labelling the patients as the most anxious people in the country. The setting of the documentary is introduced by the narrator – a residential unit running a therapy programme.

Part 2: Hope of a cure

The documentary sets up a hope for a 'cure' and introduces the basic premise of the treatment – changing the way people think by changing the way they behave. James and Helen's problems are detailed further by deploying Simon Darnley, James, Penny and Helen's voices.

Part 3: Treatment initiation and struggle

Snippets of James and Helen's treatments are shown (e.g. behavioural experiments) and the struggles they face to 'defeat' their problems (e.g. relapses and set-backs). The audience are left in suspense, wondering whether they will overcome their problems or not.

Part 4: Successful treatment

At the end of the documentary, the 'patients' have been through a transformative process and some are shown to be very grateful to the staff. All but one of the 'patients' are depicted as making a 'recovery'. The documentary has also been through a transformation; they change their position on the idea of a 'cure', instead, advocating continued management of 'anxiety' by the 'patients' themselves

Bedlam Psychosis Documentary

Part 1: Introducing the 'mentally ill'

The documentary introduces the audience to Tamara and Lloyd - characters who represent what psychosis and mental 'illness' are. Their diagnoses, psychiatric 'symptoms' and circumstances leading to their first hospital admissions are revealed.

Part 2: Management of mental 'illness'

The idea of 'care in the community' is introduced as an alternative to detaining people in asylums. Jim Thurkle's job role is introduced in the context of the care in the community model – he has the task of keeping 'patients' mentally well, which allows them to keep their independence. For example, he is shown to continually chase Rosemary, the third 'patient' in the documentary because she refused to engage with him and escort Tamara to a psychiatric review appointment. Tamara and Lloyd's use of substances are revealed, as are the challenges faced by mental health professionals in the context of their patients' behaviour.

Part 3: 'Relapse'/ crisis point

Rosemary's reluctance to engage with Jim Thurkle leads to her being detained in hospital. Tamara is considered for a hospital admission when she appears to be

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in a distressed state, however, when re-visited by Jim Thurkle and Dr Werner she is perceived as calmer and permitted to stay at home. Lloyd becomes difficult to track down, and eventually his psychiatrist Dr Gallo finds out he has been admitted to intensive care with pancreatitis. The condition is linked to Lloyd's binge drinking, and the audience are left in suspense, wondering whether Lloyd will survive or not.

Part 4: The system works

The end of the documentary depicts Tamara as 'well' and happy. Rosemary is back at home after her hospital admission and reports to be feeling better. Lloyd is still in intensive care but is in a stable condition. The events depicted in the end of the documentary serve to support the position that psychiatric care in the community is a caring and effective system for managing people with 'psychosis'.

7.6.   Appendix 6: Character Information

<u>Bedlam Anxiety Documentary</u>

The characters featured in the background of the documentary are the camera person and interviewers. The main characters in the documentary are the 'patients' – James and Helen. Supporting characters include two further 'patients' - Arron and Leon. Other supporting characters include Penny (James' mother), Simon Darnley (Head of Anxiety Disorders Residential Unit), Anna (James' therapist) and Helen's therapist (name unknown). Other characters which are talked about by the characters include Helen's ex-boyfriend (mentioned by the narrator) and Leon's therapist (mentioned by Leon). The narrator is a male character and the storyteller in the documentary.

<u>Bedlam Psychosis Documentary</u>

Similarly to the Anxiety documentary, the characters featured in the background of the documentary are the camera person and interviewers. The main characters include the 'patients' – Tamara, Lloyd and Rosemary and Tamara and Rosemary's social worker – Jim Thurkle. Supporting characters include - Dr Fidel Gallo (Lloyd's psychiatrist), Dr Tom Werner (Tamara's Psychiatrist) and Ray, Lloyd's father. Other characters which are talked about by the characters are Martha (the voice Lloyd hears), Lloyd's late mother and ex-girlfriend (mentioned

by Dr Fidel Gallo) and Tamara's two children (mentioned by Tamara). Again, the narrator is a male character and the storyteller in the documentary.

7.7.   Appendix 7: Reflective Diary Extracts

Example Diary Extract:

Watching Rosemary get 'sectioned' roused feelings of sadness – I wonder how she felt about it and how the consent process worked re filming. It's a shame they weren't able to engage Rosemary in other ways (or maybe they chose not to include other events?) and ended up portraying her as 'difficult to engage'. It seems medication and hospitalisation are the only two interventions they have offered to Rosemary. This reminds me of other people I know who have only been offered medication and not been given the chance to story what has happened to them through psychological therapy – but again maybe she was offered this in real life but the documentary didn't show it?

7.8.   Appendix 8: Transcription With Coding

Initial coding example:

Leon – keeps audience intrigued/ curious

Author
Narrator: "Didn't seem as desperate to change"
• Portrays Leon's beliefs as irrational and as obsessions
• Switch from normality (veganism) to abnormality (obsessions about being contamination by dead organisms)
• Portrays how unusual Leon is – he is older than other patients and doesn't seem to want to change

Author
Voiceover: telling a story about Leon rather than with him. Portrays madness, lack of agency and control

Author
Resistance

Author
Inner voice of therapist

Author
Leon appears to resist the therapist's attempts to terminate his use of disinfectants. He has an alternative narrative about his amount of disinfectant use.

Author
Medicalises Leon's experiences by using the word "obsessed". Portrays him as irrational and abnormal.

Author
Portrayed as different to other patients

Author
Portrays Leon as strange and unusual for not wanting to change/ be normalised by the therapy

571 Narrator: Over time his beliefs have spiralled out of
572 control |
573 Interviewer: And what are you using that this disinfectant
574 down there what what how often are you using that and
575 for what?
576 Leon: Don't tell the therapist this [laughter] She'll say
577 have you been using that disinfectant? It isn't my main
578 thing I don't use disinfectant that much|
579 Narrator: He's obsessed by the idea of being
580 contaminated by anything that's dead even an insect |
581 Interviewer: So about a week's worth or less
582 Leon: Oh it's only about a day's worth
583 Narrator: At fifty-five he was older than most patients |
584 Leon: I'll dump this in the recycling bin
585 Narrator: And didn't seem as desperate to change|
586 Leon: Get rid of these

Finding and analysing narratives example:

266   Dr Werner: Yeah, how much do you spend these days?

267   Tamara: Seventy a week

268   Dr Werner: Oh it's it's a bit more than than I thought it

269   used to be a little bit less is that right?

270   Tamara: Yeah but what's the point giving up. Takes my

271   pain away. Right let's talk about medication now 'cause

272   I'm not talking about speed no more that's just / not what I

273   have to deal with

274   Dr Werner: / Right yeah let's skip that out yeah

275   Tamara: I don't get out of my bed if I don't have my

276   speed. I don't do shopping, I don't do nothing with myself

277   so as long as I've got my speed. I rely on my speed on a

278   lot of stuff. I've lost my kids into foster care, yeah, they're

279   in foster care now. I just can't cope anymore so with the

280   speed it numbs my pain inside and when I'm normal, I get

281   upset about the kids definitely 'cause I do miss 'em.

282   Jim Thurkle: She knows she's got a drug problem but she

283   also believes with her heart that it helps her and the

284   drugs she chooses would not be ones that we think do

Author
He goes along with Tamara's wishes.

Author
Tamara: "I rely on my speed"
- Cuts to Tamara at home
- Tamara offers an enriched narrative about her use of speed to persuade the audience about the necessity of the drug in her life.
- She stories her relationship with speed as reliance. She argues it helps her cope with everyday activities such as getting up out of bed, shopping; numbing the pain she feels from losing her children into foster care
- She draws a distinction between being 'normal' and 'not normal' in relation to being on speed or not.
- She positons herself as unable to cope, but also as a caring mother, as she gets upset about not having her kids and misses them.
- Counternarrative – not medicalised- does not identify with addict label – takes into account her social context and could be seen as a way of coping with her situation

Author
Repeats this statement to persuade audience of how harrowing this experience is for her

Author
Jim: "She knows she's got a drug problem"
- Positions Tamara as a drug addict by persuading audience this is how Tamara sees herself (even though Tamara offers a counternarrative to this dominant one)
- Story about disagreement between health professionals and Tamara regarding their positions on speed – Tamara thinks it helps her, professionals don't think it helps her

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