

**THE PSYCHIATRIC DIAGNOSIS DEBATE: A DISCURSIVE  
ANALYSIS OF THE PUBLIC COMMENTS MADE FOLLOWING  
ONLINE NEWS ARTICLES ABOUT THE DEBATE**

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## **ABSTRACT**

In May 2013 the American Psychiatric Association (APA) published the fifth version of the 'Diagnostic and Statistical Manual of Mental Disorders' (DSM-5). The DSM aims to provide a classification system and list of diagnostic criteria for 'psychiatric disorders' used by healthcare systems around the world. To coincide with this, the UK's Division of Clinical Psychology (DCP) released a position statement calling for a 'paradigm shift' away from psychiatric classification and conceptual systems based on a 'disease model' (DCP, 2013). This set the stage for the long-standing debate about psychiatric diagnosis and the dominance of the biomedical model to be played out in online news media, therefore opening up the debate to larger audiences in a context where readers were able to comment on the debate.

This study presents a Discursive Thematic Analysis (Braun & Clarke, 2006) of the online comments made by readers following one of the news articles. This analysis is used to map out and explore the range of arguments, constructions and positions in the responses to the article and the debate about psychiatric diagnosis and the biomedical model of mental distress. It also explores the broader discourses, assumptions, concepts, models and ideologies drawn upon in this talk. The study also presents an analysis of the news article and consideration of how the framing of the article relates to the responses observed in the comments section.

It is hoped that by examining the debate about psychiatric diagnosis and the biomedical model of distress this will further our understanding of the persuasive and powerful arguments that are available in support of these, how they are used and how they may contribute to the survival of psychiatric diagnosis despite well evidenced and articulated critiques, challenges and opposition.

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## **1. INTRODUCTION**

### **1.1 The debate about psychiatric diagnosis and the biomedical model of distress**

Psychiatric diagnosis is the process by which a qualified clinician, traditionally a psychiatrist, assesses an individual's experiences and behaviours and makes a decision as to whether these fit certain criteria and therefore warrant a diagnosis of psychiatric disorder. Although practitioners from other disciplines are increasingly being asked to diagnose, this process and the diagnostic and classification systems that facilitate it, originate from the psychiatric profession. However, psychiatric diagnosis is not only a system or tool drawn upon by those working in the profession, but is in fact a central framework which all other psychiatric practice is based upon. It is integral to psychiatry, as evident in Brown's (1990) statement that the critique of diagnosis is the critique of psychiatry. It is also a product of a biomedical approach to understanding mental distress which shall be discussed further here.

Historical and contextual accounts suggest that today's Western psychiatric classification and diagnosis systems originate largely in the ideas of influential German Psychiatrist, Emil Kraepelin in the 19<sup>th</sup> century (Bentall, 2004; Clegg, 2012). Kraepelin's ideas are also considered to have followed a trend in which classification and diagnostic thinking had begun to be applied to mental distress, for example by those such as Cullen, de Sauvages, Pinel and Kahlbaum (Clegg, 2012; Pilgrim, 2007).

Kraepelin proposed the existence of naturally occurring mental illnesses that he suggested were caused by disease processes within the brain or nervous system, thus presenting a biomedical understanding of distress. He argued that these conditions could be differentiated and categorised in a similar way to physical illnesses, which he and others sought to do. Thus began attempts to define and describe the various conditions, their aetiologies and presentations.

These foundations are arguably evident in the American Psychiatric Association's (APA) (2014) definition of psychiatric diagnosis as 'selecting those disorders from the classification (list) that best reflect the signs and symptoms that are exhibited by the individual being evaluated' (2014, para. 2).

Following the development of numerous classification systems from different traditions within psychiatry, it was the APA's 1952 Diagnostic and Statistics Manual (DSM) and the closely linked World Health Organisation's (WHO) 1949 International Classification of Diseases (ICD) which provided the first systematic categorization of mental illnesses. The DSM is now in its fifth edition as it was revised in 1968, 1980, 1994 and 2013. This system is widely found in use internationally, in both research and practice. ICD has had ten revisions, with an eleventh expected in 2015, and is used mostly in European countries.

Advocates of psychiatric diagnosis argue that these systems have advanced the care of people experiencing mental distress, that they enable an understanding of the prognoses of conditions and enable the most appropriate treatments to be selected. In the UK, mental health services are organised and based on this framework for understanding people's problems, and the funding of services is now largely determined by the diagnoses of those who come into contact with the service, for example, via the Payment by Results scheme. For individuals, the diagnoses they receive therefore allow them to access services, to apply for social and economic benefits and make health insurance claims in the US, as well as make legal insurance claims in many countries.

Further to this, the majority of research conducted, particularly the 'gold standard' random controlled trials, as well as national treatment guidelines such as the UK's National Institute for Health and Care Excellence (NICE) guidelines, are also dependent on these systems. As Harper (2013a) articulates, 'diagnosis has become institutionally embedded – the planning, funding and organisation of services is predicated on the diagnostic system' (2013a:79). Thus, in the UK and other Western countries, these psychiatric diagnosis systems and the biomedical understanding of distress they represent are the dominant frameworks in mental health services in Western world.



Despite its dominant position, psychiatric diagnosis and the biomedical model has been heavily contested, with criticisms and opposition coming from various directions including academics and researchers, those who use services, and those working within the psychiatric profession itself, as well as other disciplines such as sociology and clinical psychology. Johnstone (2013) argues that the debate surrounding psychiatric diagnosis has existed since the inception of psychiatry, although it is considered to have gained prominence in the 1960s and 1970s following the work of psychiatrists Thomas Szasz and R.D. Laing, amongst others (Crossley, 1998; Johnstone, 2013).

Szasz (1961) challenged the scientific basis of psychiatry and its use of a medical framework to attempt to understand mental distress. He argued that mental distress could not be approached in the same way as physical illness and disease because there was no physical evidence of pathology for mental distress.

Many others have gone on to support and further this critique by highlighting issues of validity and reliability in diagnostic systems. Boyle (1990) makes the argument that in medical diagnostic systems, a concept is created when patterns in symptoms are identified and then reliably associated with objectively measureable signs i.e. physical evidence of biological pathology. However, in psychiatric diagnosis, as Boyle (1990) points out, reliable patterns of symptoms do not exist and nor is there reliable evidence of signs that can be related to them, despite years of research. Instead, as evident in the process of creating the DSM and its multiple versions, committee boards are set up to discuss and attempt to reach some consensus on criteria and cut-offs, thus creating a diagnostic system based on 'intrinsically subjective criteria' (Johnstone, 2013).

This leads to the significant role of social values and norms in the creation and categorisation of psychiatric diagnoses. This is evident in how psychiatric disorders and behaviours considered dysfunctional and disturbing have changed over time. Thus, psychiatric diagnosis systems are argued to be culture specific,

value laden and influenced by what behaviour is deemed acceptable and not acceptable by a society.

One of the consequences of this subjective process, and a key criticism of psychiatric diagnosis, is that it lacks reliability. This is evident in the extensive overlap between categories (Bentall, 2004; Pilgrim & Bentall, 1998) and the inconsistency and poor inter-rater reliability in the judgements between clinicians e.g. Kirk and Kutchins (1994). This is also evident in the experience of many service users who report receiving a number of different diagnoses during their contact with mental health services.

Similarly, a further problem exists in the lack of specificity of categories, where two individuals with the same diagnosis may have no symptoms in common at all (Bentall, 2004; Pilgrim & Bentall, 1998). Service users are also often diagnosed with 'co-morbid' or 'dual' diagnoses when their experiences match criteria for more than one psychiatric disorder at the same time (Kessler et al., 2005). Johnstone (2013) considers this a consequence of diagnostic boundaries that have been 'artificially imposed' (2013:107).

A further key criticism of psychiatric diagnosis and the biomedical assumptions it is based upon is that this medicalises and pathologises normal and understandable responses to adverse experiences, circumstances and events (Rapley, Moncrieff & Dillon, 2011). This relates to Laing's (1961) early critique of the validity of schizophrenia, based on his clinical case studies of those living with the diagnosis. Laing (1961) concluded that schizophrenia was not a valid construct because it lacked meaning and ignored the link between people's distress and their experiences and relationships in life. Today, this argument continues to hold with many arguing that psychiatric diagnosis and a biomedical approach obscures social context, and does so at a time where the strongest evidence about causes of distress comes from research on social factors (Boyle, 2004), including trauma (Herman, 1997; Johnstone, 2007), abuse (Read, van Os, Morrison & Ross, 2005), poverty and discrimination (Harper, 2004). It is argued that instead of understanding the role of social, cultural and political causes of

distress, psychiatric diagnosis de-contextualises distress and relocates social problems to the individual (Rose, 1998).

Psychiatric diagnosis is argued to remove meaning from people's experiences and restrict understanding of their distress. Boyle (2007) also suggests that a reliance on psychiatric diagnosis not only limits research and understanding, but also ways of responding to human distress. As well as removing personal meaning and arguably a person's sense of agency and control, it is argued that further social exclusion, discrimination and stigma are just some of the consequences of receiving a psychiatric diagnosis (Johnstone, 2000; Read, Haslam, Sayle & Davies, 2006).

As a result of this research, there is a strong argument for alternative ways of understanding and responding to people's experiences of distress to take the place of psychiatric diagnosis. This was the major premise of the position statement released by the British Psychological Society's Division of Clinical Psychology (DCP) in May 2013. The statement called for a 'paradigm shift' away from psychiatric classification and conceptual systems based on a 'disease model' (DCP, 2013). It stated:

The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and ICD, in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations, consequently there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system which is no longer based on a 'disease' model (DCP, 2013).

Alternatives to the use of psychiatric diagnostic systems include Pilgrim's (2007) suggestion of 'working with particular presenting problems in biographical context, patient by patient, obviating the need for the label' (2007:541) and the use of formulation (Johnstone, 2013). Service user movements such as the Campaign for the Abolition of the Schizophrenia Label call for meaningful, ordinary language that is morally accepted and rooted in people's experience. A

social-materialist psychology of distress is also presented by The Midlands Psychology Group as an alternative to diagnosis and deficit- and individual-based understanding of distress.

Many authors writing on the subject conclude that there is still much work to be done here by researchers and practitioners to collaborate with service users to develop useful and acceptable alternatives. For instance, Johnstone (2013) states that formulation as an alternative is under-researched and has its own pitfalls and limitations.

Despite the vast amount of research on the subject and the increasing criticisms, psychiatric diagnosis and the biomedical model remain dominant frameworks in the understanding of mental distress. This has led many to ask why and how these frameworks have become and remain so dominant (Boyle, 2002; Harper, 2013a; Johnstone, 2000; Moncrieff, 2010; Pilgrim, 2007).

Harper (2013a) brings together many accounts of the institutional interests and social functions served by psychiatric diagnosis to demonstrate how multiple 'pillars of support', such as psychiatry and other institutions, the pharmaceutical industry, the media, the public and policy makers, all contribute to its persistence and prevent change (2013a:81). Harper (2013a) argues that progress requires further understanding of the strengths and weaknesses of these sources of support, in order to undermine and weaken them.

As discussed, it is clear that the subject of psychiatric diagnosis has generated extensive debate over a number of years, between those working in a range of disciplines and fields, as well as those who have experience of receiving a psychiatric diagnosis. As with many other contentious issues, the debate is well documented and there are various commentaries about it, from journal articles and text books to professional blogs and websites. It has clearly gained much attention within what could be described as the 'professional sphere' and from those who it affects directly.

However, when the DCP released the position statement to coincide with the publication of the fifth version of the DSM, this led the debate to enter wider public forums, particularly in the large amount of news coverage it attracted. Interestingly, a significant amount of interest from members of the public followed this, as judged by the volume of public comments made following online news articles on the subject.

As this is focus of the current research, it is therefore necessary now to turn to the psychiatric diagnosis debate in the 'public sphere' i.e. what do we know about how the debate is viewed, talked about and understood by members of the general public?

## **1.2. The debate in the media and public sphere**

### 1.2.1 The psychiatric diagnosis debate in the public sphere

An extensive literature review suggests there has yet to be any research conducted on how the debate about psychiatric diagnosis is represented or talked about in public forums. It is unclear how the debate is understood by members of the public, what responses there have been and who appears to be commenting on it. Therefore, the relationship between the public and the psychiatric diagnosis debate is unknown. There is also little research on public views and attitudes towards the use of psychiatric diagnoses and psychiatric classification systems (including the DSM), the use of mental health labels or views on the biomedical model underlying psychiatric diagnosis.

### 1.2.2 Public views and attitudes towards mental distress

In the absence of research as outlined above, it is worth considering the conclusions put forward by research in related areas. It could be argued that the research that most closely relates is that which focuses on public or 'lay' views and attitudes towards 'mental distress' or 'mental illness', the causes or 'explanatory models' that people hold and views on the helpfulness of interventions and services.

Within the UK and other western countries, there has been much research that investigates public 'attitudes' towards mental distress and those who have been labelled as having a mental health disorder. Much of this has been in the form of research that focuses on the stigma that surrounds mental distress. This research has predominantly reported negative attitudes being held by the public, for example, where people described as having a mental health disorder are viewed as difficult to talk to, unpredictable in their behaviour, and unlikely to recover (Angermeyer & Matschinger, 2003; Crisp, Gelder, Goddard & Meltzer, 2005; Wood, Birtel, Alsawy, Pyle & Morrison 2014). Other studies find that people are viewed as dangerous, childlike and unable to care for themselves (Hannigan, 1999; Link & Cullen, 1986; Link and Phelan, 2001; Nunnally, 1961; Steadman, 1981). These studies also find that when comparing attitudes across the mental health diagnoses it is schizophrenia which is associated with the most negative stereotypes, in comparison to anxiety and depression. However, the recent UK annual survey of attitudes towards mental health difficulties conducted on behalf of the Department of Health has demonstrated improvements in general attitudes as well as in understanding and tolerance of those with experiencing mental ill health, when compared to comparable data from 2008 (TNS, 2014).

When it comes to public views on the causes of mental distress and the interventions and treatment that are available, it should be noted that one of the most common objectives of research in this area has been to understand 'help-seeking' behaviour i.e. how public attitudes and understanding of mental distress support or prevent people from accessing mental health services. Much of this research is often then part of the rationale for 'mental health awareness' and 'anti-stigma' campaigns and efforts to improve the 'mental health literacy' of the general public.

It is also important to note that much of this research is based on the view that an understanding of mental distress by lay people in biomedical terms i.e. as a disease or illness, will improve attitudes, reduce stigma and in turn, increase the acceptability of accessing services. Thus, 'mental health literacy' is referred to in

many of these studies as the ability to identify mental distress as psychiatric disorders and mental illnesses (e.g. Rüscher, Evans-Lacko & Thornicroft, 2012). However, other research suggests that whilst accessing services may increase, the uptake of bio-medical explanatory models does not reduce stigma (Pescosolido, Martin, Long, Medina, Phelan & Link, 2010).

This privileging of a biomedical understanding of distress is evident in much of the research from Jorm and colleagues. For example, in a study of participant responses to vignettes, Jorm et al. (1997) find that the majority of participants attribute mental distress (referred to as depression and schizophrenia in the study) to socio-environmental factors. The authors however refer to this as an 'over-emphasis' and conclude that the mental health literacy of the population could be improved, particularly the over-emphasis on social environmental factors in schizophrenia. They also reported a difference in participants' beliefs about the causes of depression and schizophrenia, stating that genetic factors were more likely to be considered a cause for schizophrenia than depression, which the authors appeared to frame as a more encouraging result.

Similar results where 'lay' views favoured socio-environmental explanations of mental distress are also found by Pill, Prior and Wood (2001) in their investigation of 'lay attitudes' towards emotional distress and decisions to consult or seek help from health professionals. The authors stated that participants considered emotional distress to be outside of the boundaries of the 'clinical and treatable', and they reported 'an inability or an unwillingness' to view emotional distress as a symptom of psychiatric disorder or illness, which they also considered a barrier to accessing help (2001:217).

In relation to views towards interventions and services available, Pill et al. (2001) highlighted a tendency in participants to view emotional distress as best dealt with by the individual, with support from friends and family. They found that many participants stated they would not seek medical help for such problems and that GPs were viewed as not helpful. It was suggested by the authors that one of the reasons for this was that GPs were thought only able to offer anti-depressants which were considered by participants to be palliative rather than dealing with the

root causes, as well as being regarded with suspicion, as addictive and not effective. Together, these views were understood by the authors to be the key barriers in public 'help-seeking behaviour'.

Similar findings are also reflected in Pilgrim and Rogers' (1997) account of research they conducted on lay accounts of mental health. They noticed that although some respondents seemed to understand mental health in terms of its physicality and as situated within the body, they also noted an emphasis on social causes in particular. For instance, they observed that references to life events, family problems and economic hardship were made often, with genetic causes cited less often, and in the cases they were cited, they noted that they were usually referred to as an addendum. They concluded that because individuals viewed external stressors as out of their control, mental health was understood as 'the ability to cope or control things in everyday life', being 'balanced' and stable and achieved by striving for autonomy and on what they could control (1997:45). This included their own conscious actions, being self-reliant, building resilience and drawing upon resources such as support and positive feedback from others.

Pilgrim and Rogers (1997) also reported that respondents found it difficult to find the right terminology and spoke of the inexpressible nature of the subject area. They discuss whether this is related to mental healthiness being less tangible to construe without the outward signs and symptoms of physical health, which is identified as more easily articulated.

### 1.2.3 Public perceptions of psychology and psychiatry

Public perceptions and views of the 'psy' professions and the interventions they offer have also been the subject of research which may offer further insight into how the public respond to the psychiatric diagnosis debate.

Warner and Bradley (1991) analysed the responses of 120 undergraduate psychology students regarding their views of counsellors, psychiatrists and doctoral-level psychologists. They administered a multiple-choice test of training



requirements for the three professions and asked participants to rate the clinicians on 11 personal qualities, as well as their ability to treat 5 clinical cases. The study indicated that psychiatrists were preferred over psychologists for disorders considered more severe and for three of the remaining cases, counsellors were considered more appropriate than psychologists. The authors related this to the results regarding personal qualities which showed counsellors were rated more often as helpful, caring, friendly and good listeners over psychologists. It was also observed that psychiatrists were more often described as dealing with mental problems, studying the mind and behaviour. It was concluded that psychologists were viewed as less superior in terms of clinical expertise and personal qualities. The authors interpreted this in relation to the results showing participants had a poor understanding of clinical psychologists' training and type of treatment-focus.

Dempsey (2007) conducted a similar study investigating undergraduate students' views of clinical psychologists. After interviewing 15 of the participants about their views in more depth, Dempsey (2007) argued that perceptions were often drawn from information or understanding of other mental health professionals, particularly psychiatrists. This is consistent with other research which suggests that the public are less aware of what distinguishes clinical psychologists from other mental health professionals (Fall, Levitov, Jennings & Eberts, 2000; Von Sydow & Reimer, 1998).

Studies of the perceptions of psychiatry and psychiatrists have also been conducted over a number of years. The World Psychiatric Association (Sartorius et al., 2010) conducted a review of this literature in relation to concern about its public image by those working in the profession. The review indicated that the public hold mixed views about psychiatry and psychiatric treatment, with psychiatric treatment viewed as helpful in some studies but its quality and efficacy questioned in others. It was also viewed as harmful by respondents in other studies.

The authors reported that psychiatric medication in particular was viewed as having severe negative effects and its positive effects underestimated. A number

of perceptions (which the authors considered 'misconceptions') of psychiatric medication were reported to be prevalent in the general population. These included viewing medication as addictive, as sedatives without curing, merely drugging patients, invading a person's identity and being ineffective in preventing relapse. Similar views were found to be held by patients and relatives who also perceived medication as addictive, not targeting the cause of illness or providing a cure, inducing personality changes and suppressing normal feelings.

Psychotherapy was identified as the preferred treatment over psychiatric medication (by both the general public and patients and their relatives) when participants selected from a range of options, and the authors went on to argue that the effectiveness of psychotherapy was overestimated when considering scientific evidence for pharmacological treatment. The review also indicated that views of psychiatric treatment as ineffective are held by medical students, general medical practitioners and health professionals, with slightly more positive views of psychiatry observed in psychiatric patients and relatives. This review of the literature also provided further indication that members of the public are unaware of the difference between psychiatrists and psychologists.

#### 1.2.4 Positioning of public or 'lay' views

Based on some of the research discussed above, one could conclude that 'lay' views have frequently been positioned as incorrect, invalid and different when compared to 'experts' or 'professionals', particularly by those who understand mental distress within a bio-medical framework. This is demonstrated in this quote from Jorm (2000) who states, 'many members of the public cannot recognise specific disorders or different types of psychological distress. They differ from mental health experts in their beliefs about the causes of mental disorders and the most effective treatments' (2000:396). However, this assumes that all mental health professionals adopt the biomedical model of distress in their work, which is not the case. Pilgrim and Rogers (1997), for example, compare 'lay views' to health professionals who understand mental distress in terms of the 'biopsychosocial model'. They then go on to suggest that lay people's ideas

about the causation of mental healthiness and un-healthiness in fact 'mirrored the discourses of mental health professions and academic disciplines' (1997:45).

Pilgrim and Rogers (1997) also present an important alternative perspective on the positioning of 'lay' discourse that contrasts to other research discussed here. They present a critical view of 'lay beliefs' that are positioned as inferior and of lower status than 'expert' knowledge. Instead, they argue that lay people 'develop forms of knowledge that are legitimate and occasionally even superior to the current state of professional knowledge' (1997:39). They conclude that 'lay knowledge' is 'not merely a curious adjunct to/of expert constructions' but instead constitutes 'testimonies to the real material conditions in which individual perspectives and relationships are situated' (1997:47). This discussion was part of a larger one from Pilgrim and Rogers (1997) who went on to argue that an examination of differing perspectives within social science towards mental health problems benefits from a critical or sceptical realism, as this 'legitimizes an examination of all forms of knowledge including that produced by lay people' (1997:46). They emphasize the pertinence of 'lay knowledge' to the field of mental health considering the 'highly divided and contested' nature of the competing professional discourses in this field (1997:46).

It should be considered that much of this research on 'public' or 'lay' views and attitudes towards 'mental illness' has been conducted within a realist epistemological framework and empirical, positivist approaches that are uncritical of the biomedical model and use of diagnostic categories. Therefore much of what we can glean about the public's views on mental distress, and potentially psychiatric diagnosis, comes from studies of this nature. Although the epistemological stance of the present study will be different, the research discussed thus far has provided a useful insight into 'lay' accounts of mental distress that will likely be of relevance and use in the analysis and interpretation of public comments made about the psychiatric diagnosis debate.

#### 1.2.5 The psychiatric diagnosis debate in the news media sphere

A search of the academic literature shows that to date no formal research has been conducted on the representation of the psychiatric diagnosis debate in the news media, or in the media in general. This is unsurprising when we consider how rare it has been for this topic to feature in mainstream news. This forms part of the rationale for the current research as this coverage presents an opportunity to examine how the debate is constructed and represented in online news media (as well as how it is constructed and responded to by readers).

#### 1.2.6 News coverage of contentious issues

Considering the lack of research on news coverage of the psychiatric diagnosis debate, it is possible instead to gain a sense of how other contentious issues are reported in the news media, and how issues relating to medicine, health and science in general are covered.

Goldacre's (2008) criticisms of how the news media report on science-related topics provides some insight here. He argues that, particularly when it comes to science, news journalists are interested in 'breakthrough' one-off events, especially those that are, or can be framed as, new, unexpected and contradict what has previously been said. However, Goldacre (2008) points out that 'science itself works very badly as a news story ...because it does not generally move ahead by sudden, epoch-making breakthroughs. It moves ahead by gradually emergent themes and theories' (2008:236). Goldacre (2008) argues that science is reported through 'absolute truth statements from arbitrary authority figures... rather than descriptions of studies or evaluation of the quality of the evidence' and if motivated to claim they are presenting a 'balanced' account, will present two scientists disagreeing, 'one scientist will 'reveal' something, and then another will 'challenge' it' (2008:240).

Goldacre (2008) is also critical of the accuracy, interpretation and representation in the reporting of research studies on health and science issues, and argues the media promote the public misunderstanding of science as a result. Goldacre (2008) suggests that the news media present science as though it is 'temporary, changeable, constantly revising itself, like a transient fad' and that scientific

findings are therefore dismissible (2008:237). He argues that press releases are turned into stories by journalists who have no science background, that critical evaluation of events amount to reporting some brief information about the 'expert' from whom the content originated. He argues that the 'scientific content' of stories, such as the experimental evidence, is 'brushed over and replaced with didactic statements from authority figures on either side of the debate' (2008:308).

Stewart (2005) makes a similar argument after conducting a discourse analysis of news texts that report on a controversial research study. Stewart (2005) suggests that the use of authority figures, in this case, from the mental health field, is a key rhetorical feature of news discourse used to persuade readers of the objectivity of the report. This is argued to present an advantage for scientists' arguments when they are reproduced in the news, 'especially when contrasted with non-scientists' responses' (2005:155). Stewart (2005) suggests that this 'journalistic norm of objectivity' is partly responsible for the lack of investigation or comment on the quality of the scientific content being reported.

A similar conclusion is made by Leo and Lacasse (2007) in their examination of the way the news media report on the debate surrounding the efficacy of antidepressants. They highlight the lack of evidence that is quoted in support of what is written by the authors and question whether they have actively investigated the issues on which they report. Leo and Lacasse (2007) conclude that for some media outlets, the evidence is not important. They state that there are media outlets that publish press releases they receive and that there is a focus on getting information out to the public in a readable format rather than assessing the evidence.

Gaudiano and Herbert (2003) discuss news coverage of the 'anti-depressant placebo' debate, which they described as a new public interest story at that time and quoted headlines including "Maybe It's All in Your Head," "Make-Believe Medicine," "New Study of Brain Illustrates the Power of Placebo," "Antidepressants: Hype or Help?" and "Misguided Medicine: A Stunning Finding about Antidepressants Is Being Ignored".

Gaudiano and Herbert (2003) suggest that the news media took interest in this debate due to the prevalence of depression and anti-depressant use in the public, and because of the personal investment by many of the consumers in being informed about the issue and 'finding out the truth about this issue' (2003: web page). However, again, the question of how well the news media are able to do this is raised. In this case Gaudiano and Herbert (2003) conclude from one article in particular that, although a good amount of recent research evidence was discussed (showing the substantial placebo effect in antidepressant clinical trials), the author did not adequately appraise the research being presented, such as including alternative explanations for the findings being presented. They conclude that readers were therefore left misinformed. They view this particular debate as being about how large the difference is between the anti-depressant and placebo effect, and the mechanisms responsible for it, which felt this was not included in the news coverage and so were critical of the message that antidepressants are no more worthwhile than sugar pills. Gaudiano and Herbert (2003) criticized the 'media hype' on the topic of the power of the placebo and argue that the media should instead follow the debate and report on it responsibly.

This is consistent with Goldacre's (2008) observation that recent or 'new' research is privileged in news media and with his criticisms about the ability of news journalists to critically evaluate research they are reporting. Cotter's (2010) description of the commonly practiced, profession-specific writing rules that are observed in news language may provide more of an insight into why this might be. Cotter (2010) highlights these characteristics which include brevity, stylistic consistency, rhetorical accessibility, particular story structure, use of quotes and attribution. As Cotter (2010) points out, the objective of these newswriting principles and rules is both to aid reader comprehension and the writer in their task, and so one might conclude that this becomes a journalist's primary task, rather than presenting a comprehensive, critical and investigative account of an issue or topic.

The discussion above has begun to explore how certain topics are represented and covered in the news, demonstrating that they are often presented as one-off events, contradictory or controversial, new or unexpected, and that perceived authority figures are privileged and critical evaluation is minimal. To gain further understanding of why this is, it is useful to explore the concepts of news values and newsworthiness, which could be considered as key guiding factors in news production (Cotter, 2010).

### 1.2.7 News values

Within the study of journalism and news media, 'news values' are viewed as the criteria through which a story is judged to be 'newsworthy' i.e. worth being reported, therefore having a key influence in the selection and production of print news stories, consistent across news agencies and organisations. Whether it is to increase the number of papers being sold or times a news website is visited, this highlights the pressure on news producers (and therefore journalists and editors) to make their content as attractive to consumers as possible.

Bell's (1991) account and description of Galtung and Ruge's (1965) formative study of news values, outlines the following criteria considered to be core news values; negativity, recency, proximity, consonance, unambiguity, unexpectedness, superlativeness, relevance, personalisation, eliteness, attribution and facticity. With regards to the news value of 'negativity', Bell (1991) elaborates by saying that 'conflict between people, political parties or nations is a staple of news' and that war reporting is 'the ultimate of conflict news', as 'one of the earliest historical forms of news and a stimulus for the growth of news media' (1991:156). Similarly, 'bad news' is widely considered by both producers and consumers to be privileged in what is considered to be newsworthy. In a longitudinal study of the reporting of medical research in two British newspapers, Bartlett, Sterne and Egger (2002) found that good news and bad news were just as likely to have press releases written about them, but bad news was more likely to be reported in newspaper articles.

From her review of journalism textbooks, Cotter (2010) highlights a similar list of these values and concludes that a story is deemed newsworthy when it is 'unusual, timely, local or nearby, surprising, about change, conflict and people, has impact, evokes human interest, and conveys information' (2010:68). Cotter (2010) describes news values as 'one of the most important practice-based and ideological factors in understanding the focus and shape of news stories' and states that they 'function as guidelines for decision-making and are invoked, unconsciously or explicitly, at every step of the news process'(2010:67). Therefore those involved in the news production process, will have these criteria at the centre of their judgements and decisions. Cotter (2010) outlines the significance that 'news values' have for both the practice of journalism and the editorial outcomes at the level of the text, due to the central role these play in the decision-making process.

#### 1.2.8 News frames

Closely related to news values is the concept of 'news frames'. Within the social sciences, the concept of 'framing' has increasingly been used to investigate how an event or subject is portrayed in a text (Giles & Shaw, 2009). Entman (1993) describes the act of framing as 'to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described' (1993:52).

This act of shaping and presenting events and subjects in particular ways could be seen as a way in which journalists are able to ensure their story meets as many news values and journalistic norms as possible. Indeed, research has begun to identify a range of news frames that are used in news stories. For instance, the 'conflict frame' is commonly identified in news stories covering a wide range of subjects. The frame of 'risk', together with the 'conflict frame', is also particularly common in medicine and health news (Picard & Yeo, 2011). As this example shows, this corresponds with the news value of 'conflict' and demonstrates the overlap in some cases of news values and frames. Some authors also argue that certain news frames are used by journalists in a fixed,



uniform and even predictable way. These frames are described as highly formulated and represent a move away from creating interpretative and informative frames (Giles & Shaw, 2009).

An understanding of news values and news frames, and how these influence news production, is also useful when considering the representation of mental distress and 'mental illness' in the news, which has been the subject of much research over several decades.

#### 1.2.9 Mental distress and 'mental illness' in the news media

Research relating to 'mental health' and the media tends to focus on the media representations and portrayals of those who are described as having a 'mental illness', with much discussion on how this contributes to stigma and public perceptions (Anderson, 2003; Angermeyer & Schulze, 2001; Granello & Pauley, 2000; Link & Cullen, 1986; Sieff, 2003; Wilson, Lindsey & Schooler, 2000). For example, many studies in the past have reported that large proportions of mental health related news articles infer a relationship between having a mental health diagnosis and committing crime (e.g. Philo et al., 1994; Wahl, 1992; Ward, 1997), with others claiming that media representations reinforce or foster perceptions of unpredictability and dangerousness (Maclean, 1969; Miles, 1981) and feelings of fear (Monahan & Arnold, 1996; O'Mahoney, 1979; Wahl, 1992).

More recent research from the US however has indicated that stigmatizing language relating to mental distress in newspapers may be decreasing, as reports where crime is associated with mental health problems have been shown to be reducing (Vahabzadeh, Wittenauer & Carr, 2011). It has also been suggested that the media, and broadcast media in particular, are increasingly portraying those with mental health difficulties in more positive ways and that this has supported positive change in public attitudes (Mullins, 2014).

With regards to news frames in particular, Hazelton (1997) conducted a discourse analysis to explore the interpretative frames within which mental-health-related items were constructed in two Australian newspapers over the

course of a year. In doing so Hazleton (1997) highlighted that the majority of these items were framed within at least one of 5 semantic domains that were observed: bizarre and curious; medical-scientific marvels; moral tales; disorder, crisis, and risk; and lay wisdoms and common-sense remedies. The frame of 'disorder, crisis and risk' was the most frequently identified.

#### 1.2.10 Impact of news frames and representations on consumers

As discussed above, much of the research into media depictions of 'mental illness' also attempts to measure the impact of frames and portrayals in the media on public perceptions and attitudes towards those with mental health diagnoses.

Studies of the effects of news coverage and news framing on public perceptions often use survey methods to gather self-reports from the general public and deduce from this conclusions about public views and attitudes, which are then compared to large scale content analyses of newspaper stories on the subject e.g. Bauer (2005). Other studies compare the results of surveys to self-reports of media use. Philo (1996) and Philo, Secker & Platt (1994), for example, used focus groups and interviews and reported that of those participants who associated mental distress with crime and violence, 40% cited the media as a major influence on their views. Philo et al. (1994) also highlight findings that suggest media coverage can even exert a stronger influence than personal experience on people's perceptions.

Experimental studies are also conducted where the attitudes of participants are compared following exposure to different stimuli such as news stories. For example, Dietrich, Heider, Matschinger and Angermeyer (2006) compared the attitudes of participants who read a newspaper article depicting a person with mental health difficulties committing a violent crime, with the attitudes of those who had read a factual account of schizophrenia. They reported an increased likelihood of those who had read the newspaper article to refer to people with mental health difficulties as dangerous and violent. Studies like these often draw on theories such as priming theory, media effects theory and socio-cognitive

theories, and are often based on empirical approaches and methods grounded in realist epistemology.

Some researchers argue that, rather than directly influencing public perceptions, this media influence is dynamic and interacts with values and beliefs already held by people (McKeown & Clancy 1995), and with their personal experiences (Philo, 1996). Researchers argue that media messages, social beliefs and personal experience interact in a complex relationship. This is further explained by audience reception theory (Hall, 1993) which proposes that audiences do not just receive and digest meaning in a text, as intended by the author. Instead, individual audience members are viewed as actively involved in the interpretation of a text and the meaning they derive from it is dependent on their beliefs, views, values and experiences.

Research has also focused on how this impact on public concern can in turn influence social policy and measures which place further constraints on those with mental health diagnoses (Hallam, 2002; Wahl, 2003).

‘News framing’ research not only help us to understand how certain topics and issues are presented and covered in the news media but this also provides a form of analysis that will be drawn upon in the methodology of the study presented here. The analysis of the news coverage and framing of the psychiatric diagnosis debate has the potential to further our understanding of how the media’s representation of the debate may relate to responses to the debate.

### **1.3 Online news, interactivity and reader comments**

#### **1.3.1 History and context of the online news medium**

The emergence of the online news medium came at a time of innovation and change brought by the arrival of the internet and World Wide Web in the mid 1990’s and advances in new media technologies. This period saw a burst of new social media forms, communication and information technologies. By the end of

1995, large numbers of news organisations had created online editions (Boczkowski, 2005), and today all major news organisations have online editions, with many new online only news organisations also in existence, for example, The Huffington Post.

At present in the UK, it is estimated that 55% of the population now read or download news via online sources, compared to 20% in 2007, and it is thought that numbers of users will continue to increase (Office of National Statistics, 2013). The print industry in comparison however has experienced a steady fall in advertising revenue and circulation figures over the last six decades, as well as a failure to engage younger consumers (Boczkowski, 2005).

Boczkowski (2005) studied the emergence of the online news medium and contextualises its arrival with the changes taking place in the printed news industry. However, rather than online news being viewed as responsible for a decline in print readership, it is argued that this decline was already taking place and instead contributed to the efforts of news organisations to make the move to the online medium.

The priority of many news organisations in setting up online editions therefore became increasing reach and readership, which is arguably why online news sites were free to access, and mostly remain free today (Pauwels & Picone, 2012). Advertising became the major source of revenue for news websites and the objective of online news organisations became increasing online 'hits', visits and time spent on the website pages.

However, it has been argued that the advertising-only model is not sustainable and not sufficient to allow news providers to meet the costs of good quality journalism. Pauwels and Picone (2012) argue that 'taking the role of watchdog requires news companies and consequently their users to pay for, or rather to invest in, investigative and in-depth news reporting' (2012:549). This is evident in the introduction of pay walls by some online news organisations, such as The Times and plans by others such to generate income in a similar way.

### 1.3.2 Changes brought by online news

The development of the online news medium and the changes it has brought to the production and consumption of news has been the subject of much research. An increased number of people accessing online news at work has been observed in particular (Boczkowski, 2010) and with the increasing accessibility of the internet and advances in mobile technology, online news websites are becoming easier to access by many.

Studies of consumer patterns and usage of online news are able to use technology to track the specific characteristics of how it is typically accessed. For example, Castillo et al. (2013) observed that visits to news sites occurred mostly during weekdays and working hours. They also reported the tendency for readers to 'skim' pages for information and that this led to short 'dwell times'. Their study also highlighted significant increases in access, referred to as 'traffic bursts', which could be attributed to specific news developments.

A defining characteristic of online news is the interactive capabilities that it affords and with this it has brought major changes to the role of the user and their relationship to news content. Users are able to interact with the content itself by rating, 'liking' and recommending news pieces but are also able to share and send content to other potential consumers via email, messaging services or other online social media such as Twitter and Facebook (Agarwal et al., 2014). Castillo et al. (2013) refer to these forms of social media as 'propagation mechanisms', highlighting how the online environment affords users greater power and influence over the news as they influence the circulation and spread of news content. New media researchers describe this form of interaction that takes place between the user and the technology as 'medium' or 'content interactivity' (Chung, 2008; Stromer-Galley, 2000).

Another form of interactivity offered by online news is the capacity for users to interact with other users and the producers of the content via comments boxes, often found below the news story (Jönsson & Örnebring, 2011). Here, readers can express their views and opinions in relation to the news story, the issue at

hand or the comments made by others. This, together with other forms of 'user-generated content' such as videos and pictures are referred to as 'interpersonal' or 'human interactivity'. As Chung (2008) highlights, this not only facilitates communication among readers but also promotes 'back-and-forth conversations' between journalists and the audience (2008:659).

Most online news sites require users to create an online account or profile with the site before they are able to add a comment. Many feature separate but linked areas for staff replies and/or selected comments chosen by news staff as 'top picks'. Readers are also able to rate the comments made by others, for instance by clicking on an icon labelled 'recommend' or choosing between an 'agree' or 'disagree' icon. Comments can often then be sorted by readers according to these ratings or by how recently they were made.

Some argue that with the additional capabilities for interactivity, news audiences are no longer just recipients of news. Pauwels and Picone (2012) refer to the 'multi-directional communication environment' that has been created and Chung (2008) states that interactivity 'fundamentally challenges the traditional one-way directional flow of news by providing news audiences with increased choice options and even allowing them to participate in the production of information' (2008: 658). This increased user-choice and participation is one way in which news organisations are attempting to address the aforementioned challenges they face. As Santana (2011) puts it, 'newspapers are in the throes of figuring out new ways of holding on to existing readers while attracting new ones. One lure to readers is the promise of a more-participatory role - one newspaper publishers hope will encourage community dialogue while also building reader loyalty' (2011:67).

Considering the continuous advances and changes brought by the internet and technology, it is likely that the online news medium will continue to develop further ways that its users can interact with and engage with each other and the news. Those wishing to use the news as a forum for communication of ideas will need to be aware of this and the way that consumers use and interact with news.

### 1.3.3 User comments in online news research

Online and computer-mediated communication has been the subject of vast amounts of research over the past two decades. It is therefore unsurprising that the new forms of interaction enabled by online news have been the subject of much research, with a variety of aims and interests evident.

Brossoie, Roberto and Barrow (2012) used grounded theory to analyse reader comments following news articles about incidents of domestic violence in later life. They aimed to gain further insight into public awareness, understanding and views on the issue, but also to explore the impact of the news articles on these. Like the research being presented here, this study included an analysis of the news articles themselves in terms of incident details, story framing, and reporting style, which were then considered in relation to the themes and patterns observed in the comments. The authors reported a number of factors they believed comments were influenced by, which included: personal assumptions and perspectives about domestic violence, relationships, and old age; reporting style of the news items; and comments posted by other posters.

In terms of comments posted by others, numerous research studies focus solely on the quality of these and the impact they have on reader opinions and perceptions of issues discussed. For example, Anderson, Brossard, Scheufele, Xenos and Ladwig (2014) examined online comments and opinion formation following media coverage of an issue relating to climate change. In particular they looked at how 'uncivil' online interpersonal discussion may contribute to polarization of perceptions about this issue. They conclude that 'impolite and incensed' blog comments can polarize online users' views of the issue.

Research also examines the influence of reader comments on journalists and the user-reporter relationship. For example, after interviewing journalists, Santana (2011) reported that many participants found reader comments useful, for instance, in receiving feedback from readers, gaining ideas for new stories or altering their outlook on the newsworthiness of a story. However, it was also concluded that reader comments were largely viewed in negative terms by

journalists, with Santana (2011) stating that ‘many are troubled by their content and express their dismay over their newspaper’s endorsement of providing a forum for anonymous discussion, where emotions can run high and mudslinging is the norm’ (2011:76).

In relation to public engagement with political issues, Dahlberg (2001) refers to similar issues in online communication more generally, highlighting ‘a deficit of reflexivity, a lack of respectful listening to others, the difficulty of verifying identity claims and information put forward, the exclusion of many from online political fora, and the domination of discourse by certain individuals and groups’ (2001:para 1.).

The subject of ‘civility’ comes up in much of the research surrounding online news reader comments. Hlavacha and Freivogela (2011) argue that online news reader comments are frequently insensitive and rude. They explore this in relation to the ethical guidelines followed by news organisation and questions whether they should publish anonymous reader comments online whilst rejecting them for their hard-copy editions, highlighting a key difference between the online and print news forms.

Much of this research also highlights the view that ‘uncivility’ is largely related to the anonymous nature of the commenting facilities in online news sites. Reader (2012) explores this relationship and the arguments of those who call for this anonymity to be removed. However, Reader (2012) questions whether ‘anonymous discourse is a cause of incivility or a symptom of incivility’ (2012:507). Reader (2012) also introduces the views of commenters on the subject on anonymity, for instance, reporting a theme that it ‘allows people to speak truth to powerful institutions’, was ‘necessary for participants to express thoughtful minority opinions’, and concluded that the idea of removing this was opposed by the majority of participants (2012:503).

These findings are of interest to the research presented here as they highlight issues that will be considered in the analysis as well as potential features of online commenting behaviour that may be observed in the data.



## **1.4 Development of research aims and questions**

As discussed, psychiatric diagnosis is at the centre of a long-standing debate within the professional sphere and yet coverage and research of this debate in the news media is limited, as are insights into the general public's understanding of and views about the debate. However, an opportunity to investigate the news coverage and public response to the psychiatric diagnosis debate presented itself following the recent release of the DSM-5 and the DCP's position statement on the subject. Along with considerable news coverage of these two events and the debate also came substantial public participation, with one article in particular receiving 1,170 comments. Thus, this thesis aims to use this opportunity to examine the debate, not only how it is constructed and represented in online news media, but particularly how it is constructed and responded to by those commenting on the article.

In relation to the news coverage of the debate, this study aims to examine how this debate was framed and constructed in an online news article and how this may have influenced responses seen in the online comments made by readers following the article.

The study has a particular focus on mapping out the arguments, constructions and themes evident in the online comments. In doing so, it aims to identify how certain discursive constructions, devices and strategies have the effect of negotiating or managing criticisms of psychiatric diagnosis and the biomedical model of mental distress. The analysis will also explore the implicit assumptions, concepts, models and broader social, political or cultural discursive resources that are drawn upon in the arguments and constructions.

This has the potential to further our understanding of what might be happening in the debate and how psychiatric diagnosis and the medical model remain so dominant. This could inform and guide further efforts of those involved in the debate and campaigning for change, particularly those who wish to continue

communicating about and encouraging debate on these issues through the media.

It is hoped that by examining the debate about psychiatric diagnosis and the biomedical model of distress this will further our understanding of the persuasive and powerful arguments that are available in support of this model, how they are used and how this may contribute to the survival of psychiatric diagnosis despite well evidenced and articulated critiques, challenges and opposition.

#### 1.4.1 Research Questions

The research questions that follow the aims of this study are:

1. How was the debate about psychiatric diagnosis and the biomedical model of distress framed and constructed in an online news article about it?
2. How was the debate about psychiatric diagnosis and the biomedical model of mental distress constructed in people's comments in relation to a news article about it? Constructions of particular interest are those which have the effect of negotiating or managing criticisms of psychiatric diagnosis and the biomedical model of mental distress. What can this tell us about the range of arguments, constructions and issues that are common in talk about psychiatric diagnosis and the biomedical model of distress?
3. How are some of the arguments and constructions deployed in an interactional context? What, if any, discursive practices and rhetorical devices are used? What are the effects of these particular discursive practices and formulations and what might be the functions of these?

## **2. METHODOLOGY**

In the previous chapter I identified the research questions to be addressed in the study and the rationale behind the study. In this chapter I explain why a social constructionist epistemology and a Discursive Thematic Analysis were considered the best and most appropriate ways of answering the research questions.

### **2.1 Epistemology**

The present study, its design and the analysis are informed by a social constructionist epistemology. Social constructionism views reality, the sense we make of ourselves and the world, as constructed through the language and systems of meaning or discourses that are available to us.

In research that takes a social constructionist approach, phenomena and objects of study are therefore viewed as products of the contexts in which they exist. Research conducted from this position is concerned with how such objects, phenomena (and perceived knowledge of these) are constructed. It involves focusing on the construction and generation of knowledge through language and discourse (Gergen, 1985; Harper, 2012) and how this makes 'certain ways-of-seeing' and 'ways-of-being in the world' available (Willig, 2008).

Social constructionist epistemology differs from realist approaches as it assumes we cannot be in direct, unmediated contact with the world, as this is always filtered through our language, culture and history (Willig, 2012). This contrasts to a realist approach which assumes that data directly mirror reality and that knowledge can be created through the objective measurement of such data. In contrast, social constructionism posits that there is no one 'true' version of reality that can be observed, measured or discovered and challenges the universal knowledge claims made from realist positions. Instead, it focuses on how perceived knowledge of aspects of reality, such as ways of understanding the world and taken-for-granted knowledge claims are created (Gergen, 1985). It also assumes that a researcher's reading of data is dependent upon the

numerous contexts (social, cultural, professional, personal, political etc.) in which they are situated and presents one of many possible interpretations.

A further distinction is needed here as social constructionist epistemology can be distinguished according to how strongly a researcher positions themselves and their research as relativist. Researchers who adopt a relativist or 'strong' social constructionist position take the view that all we can claim to have knowledge about, 'know' or observe is use of language, as this is all that we have access to (Harper, 2012; Willig, 2012). Therefore, research of this kind does not speculate or make claims about phenomena outside of the observation of language use that might be considered as having caused or influenced the object of study, for example, emotions, cognitions, intentions. A common critique of this assumption within a relativist position is that it prevents one from taking a critical or moralistic position (Parker, 2002).

In contrast to this, it is also possible to adopt a social constructionist position that is less relativist, where it is argued that going 'beyond the text' and beyond language is necessary to consider the influence of 'broader historical, cultural and social contexts' (Harper, 2012:92). Willig (2012) posits that within these contexts are available discourses that can constrain and limit what can be said or done. This also allows the material, embodied nature of reality to be acknowledged within research. This position is referred to as 'moderate social constructionism' or 'critical realism', originating in the work of the philosopher Roy Bhaskar (Bhaskar, 1975).

Although the study draws heavily on Discursive Psychology (discussed further below), which is usually adopted within a relativist or strong social constructionist epistemology, the analysis also draws on what Potter and Wetherell (1995) term 'discursive resources'. This allows the study to explore the constructions of psychiatric diagnosis, the biomedical model and the debate in people's talk but also the social, cultural, political and material contexts within which they are made. For example, the influence of wider socio-cultural discourses such as medical discourse is considered. It will also be important to consider the practices and institutions through which mental distress is responded to in

society, and how these (and people's experience of these) might influence, make possible and limit what can be said or constructed by people.

Therefore 'critical realism' or 'moderate social constructionism' best describes the epistemological position taken in the present study. This is considered to be the most appropriate approach for answering the research questions as this approach considers language as central in understanding and making sense of phenomena. A social constructionist approach is consistent with the aims of the study to investigate the use of language in relation to the debate about psychiatric diagnosis and the biomedical model of mental distress, as well as to understand the possible effects of this language use. This epistemology informs the methods of analysis, assumptions about the data and what is thought can be achieved by the research.

## **2.2 Methods of analysis**

Having outlined the epistemological position of the study, it is now necessary to describe the methods of analysis adopted. This involves exploration of decisions made about the choice of methods, the strategy and process underlying their use (Denzin & Lincoln, 2000), as well as the theoretical perspectives which form the basis for the methodology of research (Crotty, 1998).

### **2.2.1 Discursive Thematic Analysis**

After considering the research questions and aims of the research, a Discursive Thematic Analysis (DTA) was chosen for the analysis of reader comments as it provided a way of exploring the constructions of psychiatric diagnosis, the biomedical model and the debate in their talk (see research question 2).

In their seminal paper on Thematic Analysis (TA), Braun and Clarke (2006) describe this as "a method for identifying, analysing and reporting patterns (themes) within data" (2006:79). Thematic analysis also allows a rich description of the content of a data set 'so that the reader gets a sense of the predominant or important themes', which can be particularly useful when previous research on

the topic is limited and views of participants are unknown (Braun & Clarke, 2006:83).

Thematic analysis was also chosen for its flexibility in how it can be applied from a number of theoretical positions, which Braun and Clarke (2006) cite as one of the advantages of this method. They argue that a TA is 'not wedded to any pre-existing theoretical framework, and therefore it can be used within different theoretical frameworks...and can be used to do different things within them (2006:81).

The analysis draws on theory from Discourse Analysis (DA), particularly Discursive Psychology, and is therefore considered a Discursive Thematic Analysis. The importance of outlining the theoretical basis of research when considering the choice of methods and how to use them is discussed by Harper (2013b) who suggests that the differences between qualitative methods regarding the nature of patterns being explored, their meaning and evidencing interpretative claims is 'less to do with procedural aspects of analysis' and 'more to do with reading a different theoretical literature' (2013b:21). It is also hoped that in doing so, this allows for further criticality, reflexivity and creativity which Chamberlain (2012) argues can be limited by the 'normalised adoption of specific methodologies' (2012:61). Chamberlain (2012) states that methodologies should not simply be selected 'off the shelf' but instead engaged with critically and the underlying epistemological assumptions or theoretical thinking behind the methodology explored.

A DTA approach was chosen over a DA as it provided a way of mapping out the range of arguments, positions and constructions that exist in the talk about the biomedical model of distress and psychiatric diagnosis. It provided an approach which would allow exploration and description of the broad patterns in how the debate and these issues were discussed (Braun & Kitzinger, 2001; Singer & Hunter, 1999; Taylor & Ussher, 2001). This would not have been possible using DA alone which typically requires focusing on a smaller selection of data and involves examining data with particular themes or talk in mind. Conducting a DTA made it possible to manage the large amount of data and the variation

within the data, particularly in terms of the topics and issues raised, whilst at the same time examine the talk within these themes and the discursive work being achieved within them. This would not have been possible if a TA alone was conducted and ensured the analysis was not limited to describing general patterns in the data at a content level.

### 2.2.2 Discursive Psychology

Discursive Psychology (DP) is a variant of discourse analysis that has ties with ethnomethodology, sociology and conversation analysis (Willig, 2013:127). This approach was part of the 'turn to language' in the 1970s and 1980s and the challenge to cognitivism that dominated psychology at the time (Willig, 2013:115). The assumptions that language and talk provided a means of accessing internal states and cognitions began to be challenged, as were the realist terms on which these assumptions were based. Discursive Psychology presented an alternative approach which emphasizes 'talk and texts as social practices' (Potter & Wetherell, 1994:48), and instead focuses on what functions and actions are performed in talk ('action-orientation'). This form of discourse analysis is interested in *how* these actions and functions are accomplished within particular interactional contexts, and in the use of a range of discursive practices, linguistic resources and rhetorical devices (Potter & Wetherell, 1994:48). It also explores their effects and consequences and the versions of reality, such as the objects, events and categories they construct (Potter & Wetherell, 1987). Willig (2012) refers to this focus upon 'discursive practices' as distinguishing DP from Foucauldian Discourse Analysis (FDA) which is described as focusing upon 'discursive resources'.

Such analysis is anti-cognitivist and non-individualistic and therefore does not speculate about motivations or intentions of speakers, as these, like other internal states such as cognitions and attitudes, are viewed as constructs of which we have no direct evidence (Potter & Wetherell, 1987). Edwards and Potter (1992) also state that although one is working with talk from individual speakers, the basic units of such analysis are not individuals. Instead, talk and descriptions are treated as the product of collective or collaborative processes.

Potter and Wetherell (1987), in their discussion of attitude research, outline three important foci in the use of this approach in research; the importance of examining context, which can help to clarify the action orientation of talk; an account of variability, where 'widely different kinds of accounts will be produced to do different things' (indicating the problem with notion of 'attitudes' that are stable across different contexts); and objects or issues in talk having multiple formulations or constructions that are created and talked about rather than there being one 'abstract and idealized' object that they refer to (1987:54).

The construction of fact and factual accounts within talk and texts has been of particular interest in this approach. Potter (1996) and Edwards and Potter (1992) describe various procedures and rhetorical devices that they observe in text and talk where factual accounts are constructed as well as undermined. Examples include footing, externalising devices, constructions of consensus and corroboration, category entitlement and extreme case formulation. A key question asked of the data is: 'how are accounts made to seem solid, factual and independent of the speaker', as if they are 'merely mirroring some aspect of the world?' (Potter, 1996:97). This form of analysis explores how a factual description can be undermined by rhetorical devices. In doing so, the actions and activities that are performed in the use of these accounts are examined.

In their discussion of the 'argumentative organization' of talk and texts, Potter and Wetherell (1994) also refer to this interest in how 'discursive versions are designed to counter real or potential alternatives' (1994:48). Potter (1996) offers a further useful distinction within these discursive accounts according to the 'rhetorical orientations' they take up: a 'defensive rhetorical orientation' is concerned with resisting discounting of a particular account whereas an 'offensive rhetorical orientation' is adopted when alternative descriptions are undermined.

Drawing on this theoretical framework in the analysis is particularly relevant considering the research is interested in talk and the range of arguments that occur within the context of a debate. This will guide the questions asked of the



data in the analysis and interpretative work that is done. The analysis will investigate how certain arguments are made and deployed in people's comments, the discursive practices and constructions used to do so, as well as the possible functions of these.

As discussed earlier, the analysis also focuses on the 'discursive resources' which are drawn upon and make possible the constructions and discursive actions that are observed in the data (Potter & Wetherell, 1994). Here, 'discourse' has a slightly different definition and is viewed as *constructive*, rather than *constructed* (as described earlier), in the sense that pre-existing discourses are drawn upon to make sense of phenomena and construct versions of reality. It is this form of discourse which FDA focuses upon.

As Willig (2013) points out, some discourse analysts view DP and FDA as 'distinct versions, or variants of discourse analysis that have grown out of different theoretical and disciplinary traditions' (2013:127). However, Wetherell (1998) argues that by exploring both discursive practices as well as discursive resources, the levels of analysis of interest in DA and FDA can be combined to present a fuller analysis.

### 2.2.3 Analysis of news article

As stated earlier, going 'beyond the text' is necessary to consider the influence of 'broader historical, cultural and social contexts' (Harper, 2012:92) and how the available discourses within these can constrain and limit what can be said or done (Willig, 2012). The news article to which the comments under analysis are attached is considered to be a significant context which constrains and limits what can be said in the talk. Therefore the article is analysed to facilitate further understanding and interpretation of what is observed in the DTA of the comments. The analysis of the news article is conducted by drawing upon literature which describes news values, news frames and practices, as discussed in the previous chapter. Although some of this literature focuses on the reporting of scientific research and science reporting, it is judged to be relevant and helpful for the purposes of this analysis.

## 2.3 Ethics

All data used in the analysis are publicly available via the internet. Permission to use both the user content and news article content for research purposes was sought and granted by Guardian News & Media Ltd (see Appendix 1).

Although the data are freely available, there are still important ethical considerations to be made in the use of it, particularly the use of online comments written by members of the public. As stated in the BPS (2013) 'Ethics Guidelines for Internet-mediated Research', the use of this data presents ethical issues relating to the public-private domain distinction and confidentiality and anonymity of data sources. Evans, Elford and Wiggins (2008) also refer to this issue of 'defining public and private space' and describe it as a 'prime concern for those who do not explicitly solicit the data that they use' (2008:329). However, it could be argued that the posting of comments on a news website is an example of one of the more public forums for communication over the internet, and thus the use of this for research less intrusive. I would argue that the ethical considerations to be made when gathering data in this way are different for data which is drawn from spaces such as internet chat rooms or other online groups which require membership, are smaller in size and could therefore be considered more private (Eysenbach & Till, 2000).

Further to this, the 'terms of service' are set out to users who create accounts on news websites, outlining the conditions of use and explanation of how the content they submit may be further used. In the case of the Guardian/Observer, the terms of service refer to user content and the organisation's licence 'to use, publish and/or transmit, and to authorise third-parties to use, publish and/or transmit your content in any format and on any platform' (see Appendix 2).

There are of course, ethical considerations that apply no matter how the data is generated in qualitative research and so the research draws on BPS (2013) guidance to ensure 'respect for the autonomy and dignity of persons; social responsibility; and maximising benefits and minimising harm' (2013:5). The study will not use the names, pseudonyms or identifiers that people have used in their

online 'profiles' and will remove any potentially identifiable information. Further to this, the potential negative impact on those who read the study when it is disseminated will also be considered and all possible attempts made to minimise this.

## **2.4 Procedure**

### **2.4.1 Data collection and sampling**

#### ***2.4.1.1 News article***

The data sample includes an online news article from the Guardian/Observer ('Psychiatrists under fire in mental health battle') published on 12<sup>th</sup> May 2013 prior to the release of the DCP's position statement and the release of the DSM-5 in May 2013 (Guardian News & Media Ltd, 2013).

#### ***2.4.1.2 Comments***

The data used in the main part of the study are the comments left by readers underneath the article above. This article attracted the largest amount of comments when compared to similar articles published around this time.

There were a total of 1,170 comments that were made in response to the article. Comments ranged in length, with some only a sentence long and others consisting of multiple paragraphs with commenters making multiple points. Some commenters appeared to make only a single comment and others were more active as they engaged in discussion with other commenters and/or were noted commenting on many occasions, often reiterating a point they made in an earlier comment. Commenters frequently wrote in response to a particular comment, by quoting or linking to it, and some left a comment that appeared in a more standalone fashion (often relating to the news article or the topics covered in it). On visiting the website, the most recent comments are visible (this is the default view, see Appendix 3) and often comments relate to these and a particular topic

being discussed. However it is possible to change the view of comment to show the earliest.

Together the comments totalled approximately 105,000 words across 280 pages when transferred to a Word document. After considering a number of factors, it was decided that the dataset would be reduced to a smaller selection of comments for the analysis. One of the reasons for this was to ensure enough time for the multiple elements of the research to be conducted and so that all research questions could be addressed. This decision was also reinforced during a pilot coding stage during the coding process in the DTA. Here it was noticed that codes and initial themes appeared to recur quite early in the analysis and after approximately 35-40 pages, very few new themes were noted. It was concluded that some saturation had been achieved which provided confidence that the analysis could be limited to a selection of comments rather than the whole corpus of data. A selection of 75 pages was therefore extracted for the analysis, from three different points across the data (pages 0-25, pages 100-125 and pages 200-225) to help capture any changes in the comments and to prevent any systematic bias in relation to the timing of comments. Within this selection of data, 286 comments were made and 114 different commenters were recorded, although it is possible that a person might have more than one profile.

Comments used as extracts in the analysis are presented with their comment number and an anonymised identifier indicating the commenter. This allows for comments from the same person to be identified. Where a new paragraph was used in a comment, this is preserved and where another comment is quoted, this is indicated by italics and speech marks.

#### 2.4.2 Analytic process

The DTA was conducted in line with stages often seen in thematic analysis and followed the six-phase approach outlined by Braun and Clarke (2006, 2012). The discursive analysis that was part of this drew on the theoretical framework that has been discussed above. This reflects Potter and Wetherell's (1987) view that

‘there is no *method* to discourse analysis’ ...rather ‘a broad theoretical framework concerning the nature of discourse and its role in social life’ (1987:175).

To begin with, all comments following the selected news article were transferred from the website into a plain text format in a Word document. Comments were numbered and assigned an identifier. The process of ‘familiarization’ then began. This involved reading through the selected data and making initial notes about particular comments or features within comments that were of interest or stood out in some way.

Following this, I began the coding process. The aim here was to break down the data to facilitate the search for patterns and themes in the text. This involved identifying and labelling features and parts of the data that were broadly related to the research questions. At this stage, coding was carried out at a ‘semantic’ level and codes remained descriptive and close to the content of the data (Braun & Clarke, 2012) (see Appendix 4 for example). Comments were read and re-read a number of times and multiple codes were often generated from the same comment or extract. After a period of time, I began to get a sense of connections and similarities between codes and some broad topics around which the codes clustered (Braun & Clarke, 2012) (see Appendix 5). Codes had also begun to repeat at this point. These initial themes and groupings were then transferred to an Excel spreadsheet which was used to continue the process of coding. Codes that could fit into these initial themes were added and new potential themes or groupings were created for those that could not.

Extracts from the data were then added to the corresponding codes in the spreadsheet. These included surrounding data so as to provide context for what had been written, as well as information about which comment was being responded to where this was indicated. Comment numbers were recorded as were the abbreviations of the commenter’s profile name. This provided a way of easily returning to the data in its original context as well as checking later in the process that potential themes originated from a range of commenters, rather than from the same person.

Following this, a process of reviewing and refining these initial themes began (see Appendix 6 for picture showing part of the process). An important part of this stage was referring back to the extracts to check the coding and re-name, move or discard codes where appropriate. This also allowed further refinement of the initial themes e.g. by collapsing similar themes or discarding those which had become redundant due to changes in coding. The names of themes were also refined as further interpretative work in relation to the research questions was conducted. The relationships and connections between these themes and sub-themes were also constructed at this point. This resulted in the formation of the following themes:

- Professional rivalry and self-interestedness
- Treatment, interventions and services for addressing mental distress
- Psychiatric medication as necessary
- Explaining, understanding and making sense of mental distress
- Descriptions of psychiatry profession/psychiatrists (positive/negative)
- Descriptions of psychology profession/psychologists (positive/negative)
- Psychiatric diagnosis as necessary

These themes went some way in providing a sense of what was talked about as part of the debate and what topics were particularly prominent. However, during the process of review and refinement, these themes and their sub-themes were further analysed by drawing on the theoretical literature described earlier in this chapter, to investigate how the debate was being constructed within these themes and what the effects of these constructions might be. This led to the development of four main themes that are discussed in the following chapter (see below). Notes, themes and relevant extracts were also recorded regarding

particular discursive practices, arguments and rhetorical devices that were common in the data, and again the possible functions and effects of these which are described in the analysis.

- Constructing the debate as professional rivalry and self-interestedness
- Constructing the debate as psychiatric intervention vs psychological intervention
- Negotiating and managing criticisms of the biomedical understanding of distress
- Psychiatric diagnosis constructed as necessary

To assess the quality of the analysis that is presented here, Spencer and Ritchie's (2012) criteria of contribution, credibility and rigour are each considered in a critical review of the study. This is included in chapter 4.

## **2.5 Position of the researcher**

Qualitative research is primarily concerned with meaning and interpretation (Willig, 2008) and it is the researcher who is at the centre of the activities which make these possible. Therefore, it is essential that a researcher remains aware of the impact of their own assumptions, values, interests and motivations on the process of conducting the research and the conclusions drawn from it. As Finlay (2003) points out, reflexivity is 'where researchers turn a critical gaze towards themselves' (2003:3) and demonstrate 'how the researcher and intersubjective elements impact on and transform research' (2003:4).

My interest in the subject area of this research developed whilst undertaking a professional doctorate in clinical psychology at the University of East London. During the process of training, I became much more aware of the critiques relating to the biomedical approach to understanding and addressing mental

distress. I became interested in ideas from critical psychiatry and critical psychology. This helped me to make sense of the discomfort I had experienced working in mental health services prior to training and at the same time surprised me as I began to question what I had previously assumed and taken as 'given'.

The influence of these ideas on me was reinforced during my experience of working on placements in services where biomedical frameworks were dominant. I saw people defined by the diagnoses they had been given and their experiences explained by a deficit or illness within them. As a result, the impact of a person's social circumstances on them was often ignored and unaddressed. Instead of acknowledging and addressing the impact of living in poverty, facing discrimination and prejudice every day, interventions in many settings centred around a person's 'compliance' in taking psychiatric drugs. Reliance on a medical understanding of distress meant that instead of bearing witness to trauma and abuse a person had experienced and helping them to make sense of their distress as an understandable and normal human reaction, these experiences were relegated to the past and reduced to 'triggers' of their illness.

I also became interested in the task of communicating these views and criticisms of the status quo, following many discussions in lectures about the challenges of doing this in contexts where biomedical explanations dominate and are 'taken for granted' (Burr, 2003), as well as my experience of conversations with friends and family members about this.

Together, my professional background, my views, values and interests have influenced my choice of research topic and the aims of this study. I aim to support future efforts in calling for change in the way we understand and tackle people's experience of distress, as well as support efforts to open up discussion about this outside of the academic and professional spheres. I hope to further our understanding about what might be contributing to the dominance and survival of the biomedical model of distress and the use of psychiatric diagnosis. Thus, the research is particularly interested in highlighting discursive practices, resources and arguments which are considered to have the effect of supporting and maintaining a biomedical understanding of mental distress and the use of



diagnostic categories. I am therefore not a neutral observer, but instead my interests, values and motivations will influence what I observe and construct in the research.

The decisions to adopt a social constructionist epistemology and draw on discourse analytic methods have also led to particular formulations of the research questions and have meant that data are viewed in a particular way with particular questions being asked. This will also have implications for what conclusions are drawn and how research can be applied. The use of a different approach and methodology would arguably have led to very different results.

Throughout the various stages of the study I aimed to continually reflect on my position and how I as a researcher may have been impacting on what was being investigated, the methods of doing so and what was being concluded from these activities. However, I have also taken steps to try to prevent the over-influence of these factors on the results produced by the study. I have made use of quality criteria to help me to produce an analysis that is rooted in the data and to ensure I am not forcing an interpretation on the data, even though many interpretations are possible. I will discuss the means by which I did this in chapter 4.

### 3. ANALYSIS

#### 3.1 Analysis of news article

The news article is reproduced here with line numbers in order to aid the analysis and presentation of the findings that are discussed below. Screen shots of the news article as it appeared on the news website are included in Appendix 7.

Figure 1: Article text content

1 [Headline] Psychiatrists under fire in mental health battle  
2 [Sub-header] British Psychological Society to launch attack on rival profession, casting doubt on  
3 biomedical model of mental illness  
4  
5 [Image of sad female]  
6 [Caption below image] British psychologists are to say that current psychiatric diagnoses such as  
7 bipolar disorder are useless. Photograph: Justin Paget/Fuse/Getty  
8  
9 There is no scientific evidence that psychiatric diagnoses such as schizophrenia and bipolar disorder  
10 are valid or useful, according to the leading body representing Britain's clinical psychologists.  
11  
12 In a groundbreaking move that has already prompted a fierce backlash from psychiatrists, the British  
13 Psychological Society's division of clinical psychology (DCP) will on Monday issue a statement  
14 declaring that, given the lack of evidence, it is time for a "paradigm shift" in how the issues of mental  
15 health are understood. The statement effectively casts doubt on psychiatry's predominantly  
16 biomedical model of mental distress – the idea that people are suffering from illnesses that are  
17 treatable by doctors using drugs. The DCP said its decision to speak out "reflects fundamental  
18 concerns about the development, personal impact and core assumptions of the (diagnosis) systems",  
19 used by psychiatry.  
20  
21 Dr Lucy Johnstone, a consultant clinical psychologist who helped draw up the DCP's statement, said  
22 it was unhelpful to see mental health issues as illnesses with biological causes.  
23  
24 "On the contrary, there is now overwhelming evidence that people break down as a result of a  
25 complex mix of social and psychological circumstances – bereavement and loss, poverty and  
26 discrimination, trauma and abuse," Johnstone said. The provocative statement by the DCP has been  
27 timed to come out shortly before the release of DSM-5, the fifth edition of the American Psychiatry  
28 Association's Diagnostic and Statistical Manual of Mental Disorders.  
29  
30 [Ad]  
31

32 The manual has been attacked for expanding the range of mental health issues that are classified as  
 33 disorders. For example, the fifth edition of the book, the first for two decades, will classify  
 34 manifestations of grief, temper tantrums and worrying about physical ill-health as the mental  
 35 illnesses of major depressive disorder, disruptive mood dysregulation disorder and somatic symptom  
 36 disorder, respectively.  
 37  
 38 Some of the manual's omissions are just as controversial as the manual's inclusions. The term  
 39 "Asperger's disorder" will not appear in the new manual, and instead its symptoms will come under  
 40 the newly added "autism spectrum disorder".  
 41  
 42 The DSM is used in a number of countries to varying degrees. Britain uses an alternative manual, the  
 43 International Classification of Diseases (ICD) published by the World Health Organisation, but the  
 44 DSM is still hugely influential – and controversial.  
 45  
 46 The writer Oliver James, who trained as a clinical psychologist, welcomed the DCP's decision to  
 47 speak out against psychiatric diagnosis and stressed the need to move away from a biomedical  
 48 model of mental distress to one that examined societal and personal factors.  
 49  
 50 Writing in today's Observer, James declares: "We need fundamental changes in how our society is  
 51 organised to give parents the best chance of meeting the needs of children and to prevent the  
 52 amount of adult adversity."  
 53  
 54 But Professor Sir Simon Wessely, a member of the Royal College of Psychiatrists and chair of  
 55 psychological medicine at King's College London, said it was wrong to suggest psychiatry was  
 56 focused only on the biological causes of mental distress. And in an accompanying Observer article he  
 57 defends the need to create classification systems for mental disorder.  
 58  
 59 "A classification system is like a map," Wessely explains. "And just as any map is only provisional,  
 60 ready to be changed as the landscape changes, so does classification."

### 3.1.1 News frames

The headline and sub-header set out a conflict frame from the outset with the use of words 'under fire', 'battle', 'attack' and 'rival', and the psychiatry and psychology professions are positioned at the centre of this conflict, as the two sides involved. This use of language continues throughout the article to present this as a strong frame, for example in the words 'fierce backlash' (line 12), 'provocative statement' (line 26) and 'attacked' (line 32). This is consistent with Picard and Yeo's (2011) finding that the 'conflict frame' is particularly common in medicine and health news. This frame, following Entman's (1993) description, arguably picks up on the disagreement between some of the members of the two professions as an aspect of the story and makes this much more salient to promote this particular definition or interpretation of the events.

### 3.1.2 New Values

The prominence of the conflict frame fits with the news value of conflict which Bell (1991) and Cotter (2010) outline as a key news value considered as contributing to the newsworthiness of a story. Additional news values described by Bell (1991) and Cotter (2010) also appear to be met within the article. The value of negativity is arguably met by the conflict frame. The value of recency is evident when considering the news article was published a few days prior to the release of the DCP's position statement and the publication of the DSM-V. The article refers explicitly to the timing and recency of the events in lines 12-13 and 26-17. The value of surprise and unexpectedness is also arguably present in the reference to the DCP's position statement as 'speaking out' (lines 17 and 47). Similarly, the value of change is evident in the use of the DCP's reference to the need for a 'paradigm shift' (line 14) and the description of the statement as a 'groundbreaking move' (line 12) as well as 'casting doubt' upon the 'predominantly biomedical model of mental distress' (line 15-16). The commonly practiced writing rules outlined by Cotter (2010) are also evident in the brevity of the article as well as the use of quotes and attribution throughout the article.

### 3.1.3 Science-reporting

The reference to the DCP's statement as a 'groundbreaking move' (line 12) is consistent with Goldacre's (2008) account of the tendency for news articles to report on science-related topics as if they are 'break-through', one-off events. Similarly, the new, unexpected and contradictory quality given to events described in the article is highlighted by Goldacre (2008) as particularly common in science-reporting. It could also be argued that as a result of this framing, the long-standing, gradually developing nature of the debate about psychiatric diagnosis and the biomedical model is omitted in this representation. This is highlighted by Goldacre's (2008) point that 'science itself works very badly as a news story ...because it does not generally move ahead by sudden, epoch-making breakthroughs. It moves ahead by gradually emergent themes and theories' (2008:236).

It could also be argued that the writer of the news article attempts to present a balanced account with the inclusion of quotes from a psychiatrist Simon Wessely and a clinical psychologist Oliver James, to represent both 'sides' of the debate. This could be considered consistent with Goldacre's (2008) suggestion that often news articles attempt to present a 'balanced account' by presenting two scientists disagreeing, 'one scientist will 'reveal' something, and then another will 'challenge' it' (2008:240). This also follows Stewart's (2005) argument that the use of authority figures is a key rhetorical feature of news discourse used to persuade readers of the objectivity of the report.

Goldacre (2008) argues that the focus on didactic statements from authority figures on either side of the debate can result in the 'scientific content' of stories, such as the experimental evidence, being 'brushed over'. Considering the emphasis in the article upon views and 'didactic statements' from figures on either side of the debate, as well as the brevity of the article, it could be argued that further detail and content about the reasons for the debate about psychiatric diagnosis and the biomedical model are therefore omitted.

The analysis of the news article is viewed as particularly important in the process of analysing and interpreting the comments that followed it, particularly as it is assumed the majority of commenters did not read the DCP position statement itself. The news article did not feature a web link to where readers would be able to access the statement and some commenters were noted as explicitly stating they had not read it or not read it 'in full'. The omission of such a link is discussed further in the next chapter. Within the next section, the news article is explored further by considering its relationship to each of the themes that are discussed.

### **3.2 Discursive Thematic Analysis**

In this section I present the main themes drawn from the discursive thematic analysis of the comments following the news article. The three super-ordinate themes to be discussed are:

- Constructing the debate as professional rivalry and self-interestedness
- Constructing the debate as psychiatric intervention vs psychological intervention
- Negotiating and managing criticisms of the biomedical understanding of distress

Extracts are presented to help demonstrate what was observed in these themes and sub-themes, and support further discussion. This involves analysis of the discursive elements of these themes and discursive strategies in the arguments being made. The framing of the debate in the news article is also discussed in relation to its role in influencing the talk and contributing to the theme.

The importance of considering context in discursive psychology is clear in the understanding of discourse as ‘situated’ within its context. Edwards and Potter (1992) state that ‘talk and texts are embedded in sequences of interaction’ (1992:3). Therefore it is not only the influence of the news article that is considered in the analysis but also the comments themselves. The importance of this was reinforced when it was noted in the analysis that a large proportion of commenters seemed to be responding to another person’s comment, rather than to the article or the DCP’s position statement. This was evident in comments where part of another comment was quoted or where a feature of the commenting facility is used to reference the commenter they are responding to.

Comments are therefore considered part of an evolving conversation and are not viewed as spontaneously generated, considering these layers of context. It is assumed that commenters are likely to have read parts of the news article, if not all, and that they may be responding to the most recent comments. It is also assumed some commenters may have read some of the comments and are adding a point they feel has been left out.

### **3.2.1 Theme 1: Constructing the debate as professional rivalry and self-interestedness**

#### 3.2.1.1 Criticisms as related to professional rivalry

A key theme developed in the analysis of the comments was the construction of the debate as being about a professional rivalry between the psychiatry and psychology professions. It is important to start by exploring the potential role of the news article in contributing to this theme. It is noticeable that within the article, 'psychiatrists' and 'British psychologists' are positioned as the key subjects at the centre of the debate, and indeed as 'rival' professions (see line 2). This may have prompted discussion within the comments about the relationship between the psychiatry and psychology professions, although people also appear to be responding to other comments which refer to this and may also be simply responding with their own viewpoint. A key element of the news article that is particularly relevant here is the framing of the debate as a 'battle' between the two professions. The framing of the debate as existing between the two professions, as if they are distinct, homogenous groups, is also achieved in a more implicit way throughout the article, for example in line 12-13, 26-28 and in the use of opposing quotes from a clinical psychologist and a psychiatrist towards the end of the article.

It could be argued that this contributed to the strong theme in comments where the two professional groups were described as rivals and as occupying opposing positions in reference to the issue being discussed. Commenters described the groups as 'arguing', 'fighting' and as engaged in 'ego-fights and petty squabbling', 'in-fighting' and a 'power struggle'.

For example, one commenter stated:

PID 163 ...i am baffled that these professionals are at each other's throats instead of seeing that they compliment each other in aiding a person to walk away from the brink of destruction.

I would urge them not to be insular from one another and be inquisitive and open-minded and accepting of the other's work. (You're not here to create your own pseudo-religious cults and beliefs. You're here to help people...

The term 'turf war' was also used often, with psychologists and psychiatrists said to be arguing over 'turf'. Therefore within the comments the debate was constructed as something taking place between the two groups, as attributable to the rivalry between them and ultimately to their own self-interests. One possible effect of this is that the significance of the debate is reduced, its legitimacy is questioned and the debate is closed down (one commenter even states that readers should 'leave them to their argument'). Discussion focuses on professional differences rather than the content of the argument.

Within the comments, the two professions were also constructed as if they were distinct, homogenous groups, as internally consistent, with little or no overlap between them. Commenters often went on to suggest that the professions should work together, 'co-operate' and put aside their differences for the benefit of the people they serve. Engaging in the debate was constructed as an activity that was not part of professionals' jobs and was not in the best interests of service users, as it distracted them from helping or supporting people, as demonstrated in comment 163. Again, this might have the effect of constructing the debate as unnecessary and even harmful.

#### 3.2.1.2 Criticisms as related to under-qualification and self-interestedness of psychologists

Within the comments that related to this rivalry, it could be argued that the criticisms of psychiatric diagnosis and the bio-medical model were also managed by pointing to the self-interests of psychologists and their lack of understanding or qualifications. Psychologists were constructed as less qualified than psychiatrists and therefore said to be lacking the required training or 'scientific' understanding required for speaking about the issues in the statement, as the following extracts demonstrate.



Kr 39 ... the statement by the psychologists is chiefly bitching and moaning that there are parts of the process that elude them due to a lack of scientific understanding. Psychiatrists know pretty well that drugs are not the be-all-end-all.

FP 181 I'd sooner trust a medically trained psychiatrist than someone with a psychology degree! Psychology is not a proper science. I have personal experience of people with bipolar and the only effective treatment is drug therapy.... Psychologists are, by and large, jealous of psychiatrists, probably because many of them would have liked to go to medical school but weren't good enough to get in!

There were also many instances in the comments where analogies were used to construct the psychology profession as lower in status than psychiatry, for instance by likening psychologists to astrologers, and psychiatrists to astronomers. Another commenter used a different analogy:

MS 173 this beat up is the equivalent of Physiotherapists declaring Orthopedic surgeons completely redundant

Psychologists were also described as unable to deliver particular interventions:

de 139 what next shut down the mental health services  
the truth is that the psychologists can not prescribe meds and if they are allowed to then they might change their views.

The constructions of psychologists as lacking qualification, unable to carry out particular interventions and as having lower status could be seen as having two possible functions: discrediting the criticisms from the DCP by suggesting they are unreliable or unsubstantiated and framing the criticisms as motivated by the profession's quest for higher status. The latter of the two is demonstrated above in comment 139, 181 and in the following comment:

wm 224 What is the agenda I wonder- Is IAPT under threat or something?

This could be described as a discursive strategy involving what Potter (1996) describes as an 'interest formulation'. This describes talk where 'issues of the stake or interest are drawn on in an attempt to undermine claims and accounts' (1996:122). Here, it could be said that the interest or stake of the psychology profession and their potential motivations in the debate are pointed to, and that this has the possible effect of undermining what was said. It could be argued that such constructions and arguments functioned to challenge the legitimacy of the DCP's criticisms and again construct the debate as unworthy of attention.

It could be said that within comments like these, there appeared to be an assumption of those who have the right to speak on the issue and those who don't. It seemed as though psychiatrists were being positioned as 'knowing best' and having significantly more right to speak about psychiatric diagnosis and understanding mental distress than psychologists, as if it was their 'territory'. This could be understood as an example of 'category entitlement', a discursive strategy described by Edwards and Potter (1992). Potter (1996) describes this as the way descriptions can be given authority by emphasizing or building up category memberships which imply particular knowledge entitlements. This is observed across the themes and shall be explored further.

### **3.2.2 Theme 2: Constructing the debate as psychiatric intervention versus psychological intervention**

A large proportion of the comments included reference to interventions and treatment for mental health problems. Within this broad theme, a number of sub-themes represent a range of arguments which seemed to function as justifying or supporting the use of psychiatric medication and construct psychological intervention as a poor alternative to this. Again, it is useful to first consider the news article and whether its content and framing of the debate influenced the dominance of this topic in the comments. The only mention of interventions

within the article was a reference to the DCP's position statement as 'casting doubt' upon 'the idea that people are suffering from illnesses that are treatable by doctors using drugs' in lines 15-17. Given this minimal mention of interventions, it is interesting that this topic featured so frequently in comments.

#### 3.2.2.1 Psychological interventions as ineffective compared to psychiatric drugs

A clear sub-theme within the comments was the construction of psychiatric drugs or medication as more effective compared to psychological interventions, or as the 'only effective' intervention. This was often accompanied by references to a biological origin or cause of mental distress, for instance in the following comment, one of many where psychiatric medication is constructed as the appropriate treatment for addressing 'underlying' biological mechanisms.

hg 193 Having spent 25 years with no intervention for my difficulties except psychological ones, I can say with confidence that if you have an underlying neurochemical problem that is not properly treated, the psychological interventions are very much less likely to work.

Kr 39 Psychiatrists know pretty well that drugs are not the be-all-end-all. But the fact is that the regulatory network of neurotransmitters can be derailed so dramatically that without drugs, no one will be able to bring them back into balance.

In their critique of some of the assumptions underlying the biological model of distress, Harrop, Trower and Mitchell (1996) highlight the assumption that if a biological process is observed in some way, it is assumed this preceded the distress rather than followed it and is understood to be a cause rather than an effect. They also point to similar flawed logic in the assumption that where biological changes are observed, only biological or chemical intervention can address this. This is evident in the comments above. However, Harrop, Trower and Mitchell (1996) argue that the way of treating mental distress does not depend on its origin, giving the example that many physical illnesses can be treated well by either medication or psychological treatments.

Comment 193 also demonstrates an observation that within many comments, psychological interventions were not included in this construction of appropriate, effective or 'proper' interventions. This may have had the effect of relegating psychological interventions to 'add on' or supplementary interventions which are more or less likely to work and depend on the use of psychiatric medication (as the next theme explores).

It was also common for commenters to distinguish between mental health difficulties according to their severity and to construct psychological interventions as inadequate for addressing mental health problems of the 'severe' type. This use of the 'severe-end device' is a familiar discursive strategy in justifying certain mental health interventions (Stevens & Harper, 2006) which was observed across themes. Psychologists were described as not working with those experiencing this form of mental distress and again, it could be argued they were excluded from those who had the right to pass comment about appropriate interventions, as the following comment demonstrates:

MS 173 while in SOME regards I agree with them... perhaps they should try actually LIVING with someone with bipolar or schizophrenia and seeing what a difference the RIGHT medications actually makes. they may change their tune.... they don't see the worst of it....and they aren't the front line.  
each has their role and responsibility....

#### 3.2.2.2 Psychiatric medication as stabilising symptoms

Within the discussion of interventions, a number of different arguments which seemed to have the effect of justifying psychiatric medication appeared to draw on reasons of pragmatism. One of these was the reference to the positive effects of psychiatric medication, particularly as 'stabilising symptoms' or bringing them 'under control'. This effect of psychiatric medication was also constructed as facilitating access to psychological therapy, as demonstrated in the following extract:

My 7 ...drugs can be incredibly helpful. Not everyone has the aptitude or life circumstances to stop everything and go into therapy for months or years. Sometimes even when people prefer therapy, drugs can be helpful in giving them back enough motivation or concentration that they can attend.

In comments similar to this, it was suggested that in order to use therapy, a person's symptoms must be first brought under control by psychiatric medication, thereby setting up a hierarchical relationship between psychiatric and psychological interventions. In this construction, the ordering of the interventions could not occur the other way around. A similar effect is noted in talk drawing on the concept of the biopsychosocial model, discussed in Theme 3.

In the reference to therapy requiring the 'aptitude' or 'life circumstances to stop everything' and as requiring 'months and years', this extract also highlights a theme that is discussed in more detail later where psychological interventions were constructed as inaccessible, and psychiatric medication presented as the solution for this (see 3.2.2.4).

### 3.2.2.3 Consequences of not taking psychiatric medication

A sub-theme that appeared to contribute to the construction of psychiatric medication as pragmatic and necessary was the reference to the consequences of not taking medication, which is evident in the following extract:

Gs 273 everyone is different. Just because psychotherapy was right for you and lithium was not does not necessarily mean this is the same for everyone. For some people coming off lithium could be a death sentence.

As the comment above exemplifies, many of the commenters referred to death as a consequence of not taking medication, with some implying suicide as the cause. It could be argued that psychiatric drugs were constructed as preventing

death and some commenters explicitly refer to drugs as 'life-savers'. Reference to 'life-saving' capabilities is another argument often made in support of psychiatric interventions such as psychiatric drugs and ECT (Stevens & Harper, 2006).

As discussed earlier, there was only a brief mention of psychiatric drugs in the news article and nowhere was it suggested that drugs have no place in supporting people experiencing mental distress. However, it is possible this was implied within the narrative of the news article, given the amount of discussion around the need for psychiatric medication and this theme in particular.

#### 3.2.2.4 Psychological interventions as unavailable and inaccessible

A further argument which may have had the effect of supporting the use of psychiatric medication involved the construction of psychological interventions as limited in availability, which is explored in the following extracts:

Jr 137 A decent psychiatrist doesn't work within one restricted model ... Many would recommend far more psychotherapeutic input if the resources were available.

mt 47 ...there is such a paucity of high quality therapies and management programmes for both psychiatric and pain conditions currently, that whilst statements such as the one made by the DCP are to be welcomed, there is so far to go before we can see mentally ill people living stable mentally healthier lives with a much reduced reliance on big pharma.

The first comment included here cites the lack of psychotherapeutic resources as the issue, stating that if it were not for this, psychological interventions would be recommended by psychiatrists. In the second comment, the lack of 'high quality therapies' is referred to and it is argued that this prevents a reduced reliance upon psychiatric medication. This, and the use of 'there is so far to go', has the effect of suggesting any change will be very difficult to achieve and demotes the

DCP statement as 'welcomed' but realistically unable to have much effect. These comments also might have the effect of suggesting that the lack of psychological interventions is a key factor in the dominance of interventions based on a biomedical understanding of distress.

A similar, related construction was also observed in the reference to psychological interventions as expensive compared to psychiatric medication. For example, one commenter simply stated:

TM 157 Pills are cheap (and lucrative for the manufacturer). Listening is expensive.

Another commenter discusses this issue in more detail:

MS 173 each has their role and responsibility....  
psychiatry and the bio-medical model is currently being applied far too widely and generously rather than as a specialty for handling acute cases.....BUT that is because our governments would rather pay for a prescription rather than months or years of therapy.....access to therapies for both physio and psychology is expensive and difficult to access....far more difficult than a prescription.....

This commenter not only constructs psychological intervention as expensive and therefore less available, but also describes this as 'months or years of therapy' and as seen earlier this gives weight to the argument it is difficult to access. In comments like this, psychiatric intervention is constructed as easy to access, quick and less expensive rather than as a long-term intervention.

It is of interest that both comments include elements of criticism towards psychiatric medication, referring to its over-use and the role of pharmaceutical industry in this. This highlights a strong pattern in the data where negative aspects of psychiatric medication, such as their over-prescription or adverse effects were acknowledged but at the same time it was concluded that these

were unavoidable considering psychological intervention did not provide a viable alternative.

What was striking about this was the subtle cynicism or fatalism in the way the unavailability of psychological intervention and the reliance on psychiatric medication was talked about. Instead of calling for more psychological interventions to be made available, psychiatric medication was constructed as if it was only option and as something that had to be put up with. This is interesting considering the recent 'National Audit of Schizophrenia' found consistently low numbers of service users being offered psychological interventions across Mental Health Trusts in England and Wales (NAS2; Royal College of Psychiatrists, 2014). This is considered a serious failing in mental health services across the UK yet it could be concluded from the comments that people do not feel it is possible to call for this to be addressed. It is possible the current funding cuts, austerity measures and the arguments for these may play a role here in implied suggestions of being 'realistic'. It could be argued that by constructing psychiatric and psychological interventions in this way, this again might have the effect of shutting down debate on the issues brought up by the DCP position statement.

#### 3.2.2.5 Both psychiatric and psychological interventions are needed

Related to the above, a strong sub-theme that also became apparent during the analysis was a suggestion that both psychiatric and psychological interventions are needed and this occurred across the themes described above. For example, in comment 7 discussed above, the writer after commenting on the helpfulness of psychiatric drugs, goes on to say:

My 7      Some people don't like therapy or are not reflective enough to be successful at it. Surely there is room for both drugs and psychological therapies in modern mental healthcare.

The extract below provides a further example of this:



Fc 164 ....I worked in mental health for 40 years and saw more than my fair share of psychiatrists who didn't listen.

However, there is no denying the efficacy of pharmaceuticals.

Treatment should be bespoke to each individual after carefully listening to their story.....It may be a mixture of several interventions and polarised views are not in the best interests of the person in front of you...

A similar observation was noted earlier in the analysis, in relation to the comparison of the psychiatry and psychology professions and the reference to the need for both these professions to exist and work together.

It could be argued that within this theme and throughout the sub-themes discussed above, a range of arguments were deployed in comments which may have functioned to justify or support the need for psychiatric medication. Potter's (1996) 'defensive rhetorical orientation' could be relevant here in describing what might be happening in these discursive accounts. Potter (1996) argued that in taking up this rhetorical orientation, speakers are resisting discounting of a particular account. It could therefore be inferred that the DCP position statement had been constructed as having suggested psychiatric medication should no longer be used or that psychological interventions should take the place of psychiatric medication.

This highlights an interesting process whereby the debate has developed and taken on new meaning in the comments. The news article said very little about interventions and yet it seemed this was brought to the debate by individual commenters highlighting this as an issue and taken up by others then responding to this. This may tell us something about the way debates play out in the context of online news comments and this shall be discussed later in the next chapter.

### **3.2.3 Theme 3: Negotiating and managing criticisms of the biomedical understanding of distress**

A key theme that was constructed during the analysis related to discussion about explanatory models and causes of mental distress which was particularly common within the comments. This could be seen as unsurprising when considering how prominent this aspect of the debate was in the news article. For example, very early in the article, in lines 2-3, the debate and criticisms from the DCP were introduced as 'casting doubt on biomedical model of mental illness'. After discussing the criticisms in relation to psychiatric diagnosis, the article again returns to the issue of the biomedical model in lines 14-16. The following themes demarcate the key patterns noted in discussions about the causes of mental distress. Particular attention is paid to the discursive work in the talk around this aspect of the debate, which arguably functioned to negotiate the criticisms of the biomedical model of distress.

#### **3.2.3.1 Constructions of the criticisms of diagnosis and biomedical model as reductionist and ignoring the role of biology**

Within comments that made reference to explanatory models, it was noticed that commenters frequently argued that mental distress was not caused solely by psychological, social or circumstantial factors. One of the ways in which commenters made this argument was through reference to their own experience of mental distress and their understanding of it:

we 134 My illness is not caused by trauma, and I object to the  
assertion that it must be. Besides which, the psychology department  
refused to treat me anyway because I was judged to be too ill and too  
much of a risk.

In many of the comments which stated that mental distress was not caused solely by psychological, social or circumstantial factors, it appeared as though commenters were suggesting that the criticisms from the DCP had stated the opposite:

j2 88 Beware of these straw man arguments that are presented by those who seek to be reductionist in favour of their own fields. The assertion that mental illness is purely psychological is just as laughable as that it is purely genetic.

wm 224 How reductive this debate is. Mental distress is not attributable to just one factor, and most working in the field have recognised this for years regardless of professional background. ... A false dichotomy is being set up here. What is the agenda I wonder- Is IAPT under threat or something?

In a similar way, criticisms of psychiatric diagnosis and the biomedical model were also constructed as ignoring or disputing the role of biology:

DH 107 Any half-decent psychiatrist knows that mental illness (or whatever you want to call it) manifests in a way which involves biological, psychological, and social factors, and acts accordingly. Sounds like these psychologists just want to pretend that the biological part doesn't exist, which is a ridiculous, indefensible position.

In some cases, for example comment 88, this construction of the criticisms could be viewed as part of a discursive strategy. The depicting of the criticisms in this way, and deeming them 'reductionist' could be considered a form of 'extreme case formulation' (Edwards & Potter, 1992; Pomerantz, 1986). By portraying the criticisms of the biomedical model in their extreme form, it is possible this allows or legitimizes some commenters to challenge this and justify the argument or view they are putting across.

However, as much as this may be interpreted as a clever discursive strategy in the debate, it could be argued that the prominence of this argument is unsurprising considering the news article might easily be read as anti-biological or dismissing the role of biology. This is particularly evident in lines 2-3, 15-16, 21-22, 47-48.

As discussed in chapter 1, the DCP statement (DCP, 2013) aimed to set out criticisms about an understanding of mental distress limited to a purely biological model, and clearly referred to its position on the role of biology. It stated:

This position should not be read as a denial of the role of biology in mediating and enabling all forms of human experience, behaviour and distress ... It recognises the complexity of the relationship between social, psychological and biological factors. In relation to the experiences that give rise to a functional psychiatric diagnosis, it calls for an approach that fully acknowledges the growing amount of evidence for psychosocial causal factors, but which does not assign an unevidenced role for biology as a primary cause, and that is transparent about the very limited support for the 'disease' model in such conditions (2013:2).

Considering the characteristics and role of news values discussed in chapter 1, the author of the news article may have purposefully framed the DCP's position statement in an extreme way. When using the news media to communicate to larger audiences, this highlights the importance of anticipating how a story might be framed and how this might facilitate particular arguments.

#### 3.2.3.2 Levels of explanations: reformulating the biological

A number of comments also appeared to draw on the idea that there are various levels involved in explaining mental distress and these were constructed as relating in a particular way to each other, with biology positioned as foundational. This is explored further using the following extract:

Kr 39 No, it isn't, and the statement by the psychologists is chiefly bitching and moaning that there are parts of the process that elude them due to a lack of scientific understanding.

Psychiatrists know pretty well that drugs are not the be-all-end-all. But the fact is that the regulatory network of neurotransmitters can be

derailed so dramatically that without drugs, no one will be able to bring them back into balance.

The talk about bereavement etc. misses that no one denies their influence. But their influence manifests on a biochemical level, quite simply because that is how we process any and all outside influence, whether it is mechanical, energetic (heat, radiation, light...) or emotional. When we hear something, we process it biochemically. When we see something, we process it biochemically.

One interpretation that could be made here is that Harre's (2002) theory of biology as an 'enabler' or 'mediating factor' of experience (and thus mental distress) is drawn upon towards the end of the comment, to construct the role of biology as involved but not 'causing' mental distress. However, at the same time the biological 'level' appears to be treated as foundational (in the words 'their influence manifests on a biochemical level'), whilst social, personal and environmental factors (reduced to 'bereavement etc.') are regarded as merely 'influences' upon the biological. It is implied that there is a hierarchy of these levels and the biological is the basic level of explanation. This could be considered a sophisticated foundationalist argument. This fits the 'dominant trend' described by Cromby, Harper and Reavey (2013) whereby biology is treated as 'more or less foundational but tacking on some discussion of social factors as contextual, or psychological factors as able to modify or ameliorate distress' (2013:91).

The extract below demonstrates a similar way in which this argument is made:

do 261 There is no doubt that abuse causes mental illness. The most extreme cases causing damage that likely cannot be reversed, like shown in those severely neglected Romanian orphans who suffered from R.A.D (reactive attachment disorder)

Why are they like that? Because their brains have failed to develop normally, neuro connections and chemical messages that allow genuine attachment have atrophied.

So, while mental illness might not start out as a biochemical problem that does not mean it does not become one.

The commenter at first states that abuse causes mental distress but after further explanation this is described as the cause of the damaged brain and biochemistry. Again, despite the acknowledgement of abuse, it could be argued that biological deficits are presented as the key mechanism responsible for mental distress and as the most relevant or significant factors in understanding mental distress.

The use of the 'stress-vulnerability' discourse is also drawn upon in a similar way to present this biological foundationalist argument, which is arguably a more familiar construction:

wm 224    How reductive this debate is. Mental distress is not attributable to just one factor, and most working in the field have recognised this for years regardless of professional background. The stress / vulnerability model, around for many years now, suggests an underlying vulnerability, possibly physical in origin, that can be triggered by stressors. Or my favourite(!) word - biopsychosocial- just about sums it up.

Here, the 'stress-vulnerability model' is used to suggest that 'for years' the social, personal and environmental factors have been acknowledged by those working in the field of mental health. It could be argued that biological or physical explanation is privileged here and social, personal or environmental factors are reduced to 'stressors' or triggers (Read, 2005). Boyle (2006) argues that this effect can be frequently observed in talk where the 'popular vulnerability-stress theory' indicates the importance of life experiences and traumas but this importance is mediated through an individual's prior biological vulnerability (2006:192). Boyle (2006) states 'at a stroke, social, environmental, and interpersonal events are simultaneously acknowledged and negated: we do not need to pay too much attention to the person's aversive social world, because the person is overly sensitive to it' (2006:192).

One might also consider the constructions above as separating out biological vulnerability and environmental stressors as if they are separate and distinct forces. Rose (2001) highlights this as the traditional dichotomising approach whereby divisions are made between nature (such as genes and biology) and nurture or the environment. Rose (1997, 2001) presents a critique of this assumption and argues instead that organisms and their biology are in constant interaction with their environment.

### 3.2.3.3 The biopsychosocial model: refuting bio-foundationalism

The extract above highlights another common discourse drawn upon in comments, the 'biopsychosocial model'. The following extracts demonstrate particular arguments that were made using this concept, which could be said to have the effect of refuting or dismissing the idea of bio-foundationalism.

sl 291 As a psychiatrist I believe we take a holistic approach, Known as the biopsychosocial model. This biomedical guff is out of date and simplistic. I care a lot about the narrative of my patients' lives and psychological models of illness are helpful. ... We should be working as a TEAM, psychologists!!

j2 88 This assertion that psychiatrists only consider the biological model is ludicrous and offensive. Throughout my training the emphasis was ""biopsychosocial"". That is that every individual's mental illness had biological, psychological, social and cultural determinants, and that these factors interact with each other.

As these comments demonstrate, the view that a biomedical approach dominates understanding and approaches towards mental distress was dismissed. It was argued that biology is not privileged in making sense of mental distress and that a purely biomedical approach is not adopted in practice. Instead, understanding distress in terms of biology is argued to be just one element of the biopsychosocial model. The biopsychosocial model is referred to as evidence of

this argument, either by adopting an approach based on this model or having trained according to this approach.

It could be argued that such comments indicate how the biopsychosocial model can be used to claim that social, personal and environmental factors are equally addressed along with biology. However, although these are constructed as if all interacting with one another, it could be argued that a hierarchy is often assumed, as evident in many of the comments explored thus far. As with the stress-vulnerability model, Boyle (2006) argues that the biopsychosocial model is used to 'maintain the primacy of biology while paying little more than lip service to social and psychological factors' (2006:192). Read (2005) similarly questions the assumed integration of perspectives implied by reference to the biopsychosocial model and argues there is instead a 'colonisation of the psychological and social by the biological', demonstrated by the 'ignoring, or vilification, of research showing the role of contextual factors such as neglect, trauma (inside and beyond the family), poverty, racism, sexism, etc. in the etiology of madness' (2005:597).

Cromby, Harper and Reavey (2013) suggest this assumption of a hierarchy is possible because the biopsychosocial model does not explain or clearly define how these proposed elements interact. The model is described as having little theory behind it and never having been clearly defined.

A similar observation was also made where commenters referred to multi-disciplinary team working, which arguably produced similar effects. For example, in comment 88 above, the commenter goes on to state:

j2 88 We practice in a complex matrix of contributing factors. We frequently practice in multidisciplinary teams in which psychologists, nurses, social workers and occupational therapists contribute to the understanding and treatment of patients on a equal footing.

It appears as though working in multidisciplinary teams functions as evidence of a multi-level approach that exists in addressing mental distress, and in doing so



refutes ideas of a hierarchy between these levels. One effect of this might be to suggest that the claims made by the DCP were unfounded or inaccurate.

#### 3.2.3.4 Current and future research as evidence of the role of biology

A familiar strategy in managing critiques of the biomedical model was also noted in the comments where commenters drew upon the argument that future research would provide evidence for the role of biology. For example, one commenter stated:

ia 14 I think sensible people in the field increasingly agree that serious mental illnesses (e.g. severe affective and psychotic disorders) are best understood as a combination of inherent vulnerabilities and environment. There's been some very interesting recent work with MRI and with statistically-based genetic epidemiology that points the way to a shared understanding -- as the understanding of physical bases becomes sophisticated enough to have something genuine to offer to the conversation.

It could be argued that by referring to the need for more research or the promise of evidence soon to be provided by recent advancements in technology, this manages the problematic nature of the evidence for the role of biology in distress. Boyle (2002) highlights this as a common argument used to justify the diagnosis of schizophrenia and argues that conclusive evidence and the full understanding of biological or genetic processes always lies just out of reach.

Similarly, it was also noted that commenters constructed the criticisms from the DCP as 'old' or out of date, as the following extract demonstrates:

Dh 109 I have read Szasz, and was persuaded that he had a point, for a while. Unfortunately, his sometimes well conducted polemic falters when held up against reality. And furthermore, it was written a long time ago, and our understanding of the brain, of genetics, of patterns of disease, and much more has come a long way in that time.

This comment could be read as suggesting the points raised by the DCP originated 'a long time ago' and draws upon the narrative of 'scientific progress' to undermine or dismiss the statement.

#### **3.2.4 Theme 4: Psychiatric diagnosis constructed as necessary**

During the analysis, it became apparent that references to psychiatric diagnosis were few and far between and much less common than the subjects highlighted in the themes above. Therefore although the themes above describe significant patterns in the data, this theme is included in the results due to the relevance of this to the research question and the study in general. The absence of talk about psychiatric diagnosis is considered a significant finding in the analysis as this was not expected. The reference to this in the news article also contributes to this conclusion as it was arguably brought up quite clearly in lines 6-7, 9-10, 17-18, 32-36, 42-44, 46-47, 56-57 and 59-60, and therefore responses to this were expected.

##### 3.2.4.1 Diagnosis as a necessary part of medical practice

It was observed in some comments that psychiatric diagnosis was constructed as necessary for deciding upon and prescribing treatments for mental distress, as well as providing a prognosis. In the comments below this appears to be supported by drawing upon a medical discourse and making comparisons to processes in physical health to construct psychiatric diagnosis as a necessary part of medical practice.

Cms 15 Who the hell wants to get rid of diagnosis'?

You can't treat any medical condition (mental or physical) without a precise diagnosis. You need a clear and accurate definition of any illness before you establish what the treatment plan will be for that patient. No diagnosis, no prognosis.

Jr 137 A decent psychiatrist doesn't work within one restricted model - "medical" or not. They form an opinion, based upon their medical training in diagnosis, of a patient's condition and then recommend treatments in terms of the available resources.

The second comment also demonstrates another use of the rhetorical device 'category entitlement' (Edwards & Potter, 1992). Edwards and Potter (1992) argue that category entitlements can be used to build up the 'facticity' of accounts. By referring to a 'decent psychiatrist' and their 'medical training', the commenter draws on the expertise and authority that this position is assumed to have. It could be argued this has the effect of constructing what is said as factual and therefore strengthens the argument.

The reference to medical practice and psychiatrists as associated with doctors working in physical health was also drawn upon, as demonstrated in the following comment:

crt 48 *You can't treat any medical condition (mental or physical) without a precise diagnosis.*

This is a common layman's belief, but simply not true. Ask any doctor. All doctors try to make diagnoses, preferably accurate ones, and all doctors must sometimes treat patients for whom they have no coherent diagnosis. This is as true for psychiatrists as for any other medical specialty.

Here, it appeared as though the problematic nature of psychiatric diagnosis was being constructed as to be expected by drawing on comparisons with doctors working in physical health. It could be argued this has the effect of constructing psychiatric diagnosis as unproblematic and dismissing criticisms of psychiatric diagnosis.

#### 3.2.4.2 Diagnosis as functional and beneficial for service users

Within the comments, it was also observed that psychiatric diagnosis was constructed as functional and as having benefits for service users. For example, the following comment refers to administrative and financial functions that diagnosis has:

Cs 183 there is the requirement to provide a diagnosis because that's required for all financial and administrative systems and this is what has to be addressed. Junk diagnosis but ensure people get what they need and work out how that's done without a tick box diagnosis, this is where it will get very difficult politically.

The commenter constructs the removal of the psychiatric diagnostic system as first requiring a new system to 'ensure people get what they need'. This fits with Harper's (2013a) argument that diagnosis has become 'institutionally embedded' (2013a:79).

Another commenter states:

th 182 Well I work as a counsellor and in my contract work I am required to provide a diagnosis.  
... Sometimes these diagnoses can help the person feel a bit safer because they can name what is happening to them.

Here, this commenter draws on a familiar argument that supports the use of psychiatric diagnosis. Another commenter similarly reflects on their own experience and constructs diagnosis as important in a context of having experienced unhelpful interventions.

hw 205 Drugs always made me worse, therapies just simply did not work, or so little i was kidding myself they ever did or ended up lying to make them feel better because you get bullied if you speak up about concerns! ... diagnosis is important, bloody important when you are

shunted back and forth between incompetent gp's, junior psychiatrists and psychologists who get angry with you because they always think their therapies "should" work or "have" worked, therefore you are just a freak if the outcome is different.

#### 3.2.4.3 Managing disagreement with diagnosis

The following extract is chosen for its relevance to the research question and as a further example of the theme across comments where commenters seem to be managing multiple views. This commenter highlights a practical solution they use to manage their disagreement and uncertainty about the use of psychiatric diagnosis:

th 182 Well I work as a counsellor and in my contract work I am required to provide a diagnosis. When someone comes in with grief it's an 'unspecified mental disorder'. I don't see grief as disorder. Grief is a natural part of life and sometimes we need support when it becomes unbearable. The word 'disorder' automatically pathologises any life challenge.

This is part of the medicalisation of emotional health. ...

... I cannot say based on my experience whether these diagnoses are appropriate or helpful or not. I can say that they don't seem to explain the whole story, which is what I think the DCP is attempting to address. Of course it's complicated. But for me, the most important quality required of a psychiatrist, counsellor, or psychologist aiming to help someone is to see their humanity, to see them as a whole person, unique, and to listen to what they have to say and to what their life story reveals about why they are there needing help.

This highlights an example of how objects or issues in talk can have multiple formulations or constructions that are being created and talked about rather than there being one 'abstract and idealized' object that can be referred to (Potter & Wetherell, 1987:54).

## 4. DISCUSSION AND CRITICAL EVALUATION

This chapter begins by considering the findings in relation to each of the research questions and how these findings might be understood in the context of relevant literature. This is followed by a critical review of the study which considers issues of contribution, credibility, rigour and reflexivity. The chapter ends by drawing conclusions about the implications of the study and final reflections and personal learning gained during the process of conducting this study.

### 4.1 Revisiting the research questions

This study aimed to explore how the debate about psychiatric diagnosis and the biomedical model of mental distress were constructed in people's comments in relation to a news article about it. Constructions of particular interest were those which had the effect of negotiating or managing criticisms of psychiatric diagnosis and the biomedical model of mental distress. The research aimed to better understand the range of arguments, constructions and issues that are common in talk about psychiatric diagnosis and the biomedical model of distress. The ways in which the findings of the study relate to each of the original research questions which reflect these aims are discussed below.

#### 4.1.1 Research Question 1

*How was the debate about psychiatric diagnosis and the biomedical model of distress framed and constructed in an online news article about it?*

The analysis of the news article highlighted the ways in which it was consistent with common news values and news frames. The framing of the debate as a conflict between the psychology and psychiatry professions was particularly prominent. This is arguably the result of journalistic and editing efforts of those involved in the writing of the article to ensure its newsworthiness and to attract as many readers as possible (Galtung & Ruge, 1965).

It also became apparent during the study that in emphasizing the events as a conflict and prioritising the traditional use of quotes from either 'side', the article dedicated less time to providing detail about the issue being discussed. It is also possible that in order to strengthen this newsworthy frame, the views being discussed were presented in a polarised and extreme way. This may have been why the DCP's acknowledgement of the role of biology in understanding mental distress was omitted from the article, and thus contributed to why there was such a strong theme in comments where this was challenged.

#### 4.1.2 Research Question 2

*How was the debate about psychiatric diagnosis and the biomedical model of mental distress constructed in people's comments in relation to a news article about it? Constructions of particular interest are those which have the effect of negotiating or managing criticisms of psychiatric diagnosis and the biomedical model of mental distress. What can this tell us about the range of arguments, constructions and issues that are common in talk about psychiatric diagnosis and the biomedical model of distress?*

The construction of the debate in people's comments became clear in the discussion of the four themes presented in the analysis. It was constructed as an argument taking place between professionals, as a result of a rivalry and their guild interests. The two professions were constructed as if they were distinct, homogenous groups and it appeared as though the debate was viewed as evidence that the two professions were not working together. It was also stated by commenters that engaging in the debate was not in the best interests of service users, as it distracted professionals from helping or supporting people.

Possible effects of this were that the debate was located as taking place between professionals. Such constructions might have served to not only position the debate as less relevant to non-professionals but also to discourage debate on the subject generally as it was often framed as distracting professionals from doing their jobs and unhelpful for service users.

The analysis of the news article led to the conclusion that it may have played a key part in the popularity of this theme in the comments due to the prominence of the conflict and rivalry frame around which the content of the article was structured.

The second major theme within comments was the construction of the debate as being concerned with psychological and psychiatric interventions. There appeared to be a range of arguments made within comments which arguably had the effect of justifying and supporting the use of psychiatric medication and were observed frequently in comments (to be discussed in relation to the research question 3). One could infer from the prominence of these arguments, that the debate and the DCP's criticisms were constructed or interpreted as if they were challenging the use of psychiatric medication and calling for psychological therapies to take their place. This appeared to be unacceptable to many commenters with a clear trend observed where psychiatric medication was deemed necessary, despite the negative drawbacks that were often highlighted at the same time.

The high proportion of comments which referred to interventions and functioned in defence of psychiatric medication was striking, particularly as this was mentioned only once in the news article. This could be understood in a number of different ways. This may relate to what the public find more relevant to them or easier to connect with and talk about. It is possible that members of the public may have more experience of being prescribed psychiatric medication, or know of friends or family members who have, than being given a psychiatric diagnosis. Thus, the debate about the use (or over-use) of psychiatric medication may be more familiar and something they are more able to comment on. This may be explained by audience reception theory (Hall, 1993) which proposes that audiences do not just receive and digest meaning in a text as intended by the author. Instead, individual audience members are viewed as actively involved in the interpretation of a text and the meaning they derive from it is dependent on their beliefs, views, values and experiences.



The unexpected prominence of talk about interventions and medication may also have been related to early comments which introduced the topic. It was noted that many comments, particularly early on, quoted the fourth comment that was left following the news article. This comment related the biomedical understanding of distress to the use of medication which they described as a short term solution to the problem that ignores root causes. Many commenters responded to this, some in agreement but also many who challenged this. The role of early comments in determining the patterns of talk in comments has been demonstrated by Ziegele, Breiner and Quiring (2014) in their analysis of 1,580 comments from two German news sites. This is discussed further in the discussion of the contribution and implications of the study later in this chapter.

The analysis highlighted particular patterns of talk and themes that were dominant in the comments but consideration also needs to be given to the lack of talk and debate about psychiatric diagnosis itself. It was concluded from the analysis that there was some talk about it with familiar arguments being raised both for and against the use of diagnostic categories in practice, for example diagnosis is needed for recommending treatment, giving a prognosis, therefore drawing arguments from medical discourse and practices (Georgaca, 2013). However, this was much less prominent when compared to the key themes constructed in the analysis. As discussed above, this may be a subject that the public have less experience of and are less familiar with and therefore did not feature as strongly in interpretations of the news article. Despite the references to some criticisms of psychiatric diagnosis in the second half of the article, the emphasis on models of explanation of mental distress may also have contributed to this.

Much of the discussion in comments also centred around explanations and causes of mental distress, particularly in relation to the role of biology. This is explored further when considering the final research question below.

#### 4.1.3 Research Question 3

*How are some of the arguments and constructions deployed in an interactional context? What, if any, discursive practices and rhetorical devices are used? What are the effects of these particular discursive practices and formulations and what might be the functions of these?*

The findings highlighted in chapter 3 highlighted a number of common discursive practices and rhetorical devices that featured in the talk described above.

Within the construction of the debate as relating to a professional rivalry, it often appeared as though the psychology profession was constructed as having lower status and that this related to their motivations behind the DCP's position statement. It was suggested this may have functioned as a discursive strategy to undermine the criticisms that were raised by the DCP, one that is referred to by Potter (1996) as an 'interest formulation'. The construction of psychologists as lacking qualification, medical training or 'scientific' understanding may also have served to challenge the legitimacy of the DCP criticisms. There also appeared to be an implicit suggestion here that certain people had the 'right to speak' on the subject and that this was restricted to psychiatrists and those with 'medical training'. This presented an example of the rhetorical device 'category entitlement' (Edwards & Potter, 1992) which was also observed in talk about psychiatric diagnosis where the expertise and authority that certain positions were assumed to have were drawn upon to construct what was said as factual and therefore strengthen the argument.

The 'severe-end device' (Stevens & Harper, 2006) was also identified in instances where psychological intervention was constructed as a poor alternative to psychiatric medication, owing to its inaccessibility and inability to support those with 'severe-end' forms of mental distress. This and talk of 'life-saving' effects is often observed in facilitating powerful arguments which support biomedical views and approaches, as described by Stevens and Harper (2006) in their study of professional talk where it served to justify psychiatric interventions. Psychologists were described as working with 'mild' forms of distress, rather than

those deemed serious or severe. This may have served to construct the criticisms of psychiatric diagnosis and the biomedical model as irrelevant when considering these more serious forms of distress. This is consistent with Harper (2013a) and Boyle's (2002) prediction of strong public and professional reluctance to acknowledge the problems with diagnostic categories and biomedical theories of mental distress due to the social functions these have and the long-standing assumptions they are based upon.

The rhetorical device that appeared across themes in the comments was the 'extreme case formulation' rhetorical device (Edwards & Potter, 1992). It was evident on a micro-level when analysing individual comments but also on a macro-level where collectively the constructions of the debate and issues within it were argued to have this effect. This could be seen in the construction of the DCP's criticisms as suggesting that psychological, social and/or circumstantial factors should be considered the only cause of mental distress and that biology plays no role in understanding mental distress. Extreme case formulation was also evident in the construction of the criticisms as suggesting that psychiatric medication should no longer be used or that psychological interventions should take the place of psychiatric medication. It could also be argued that the construction of the debate as taking place purely between the two professional groups to serve their own interests is also an extreme formulation, which may have had the effect of making the debate appear illegitimate.

Much of the discussion in comments also centred around explanations and causes of mental distress. Of particular interest to this study were the strong arguments which arguably served to negotiate and dismiss criticisms of the biomedical model of distress. These arguments appeared to acknowledge problems with a purely biomedical understanding of distress and reformulate the role of biology, whilst at the same time maintaining traditional notions of a hierarchy of levels, with biology constructed as foundational. These arguments drew on a range of rhetorical resources including the 'biopsychosocial model', the 'stress-vulnerability' and 'biology as enabling' theory. These were therefore described as new forms of biological foundationalism. This is reflected in Harper's (1999) argument about 'multifactorial accounts', that 'while appearing to

be liberal, open-minded, eclectic and flexible, they can also function in a conservative manner by relativizing challenges, and thus functioning to maintain current practice' (1999:135).

The DCP's criticisms of the biomedical model were also frequently argued to be reductionist themselves, and in favour of purely social and psychological understanding of distress. These constructions, particularly the latter, were considered less of a surprise due to the frequent references to this in the news article and the lack of clarity about the DCP's position on the role of biology.

## **4.2 Critical review**

To assess the quality of the research findings presented here, Spencer and Ritchie's (2012) criteria of contribution, credibility and rigour are each considered.

### **4.2.1 Contribution and implications**

Spencer and Ritchie (2012) refer to 'contribution' as referring broadly to the 'value and relevance of research evidence' (2012:229). Georgaca and Avdi (2012) similarly refer to the importance of providing 'new insights, enhancing existing research and generating new questions' (2012:157).

Harper (2013a) provided a rationale for analysing the 'pillars of support' that were described as contributing to the survival of psychiatric diagnosis. The public and the media were two of the six 'pillars' identified. This study has highlighted a number of strong arguments within comments in a public forum which arguably functioned to maintain and support the use of psychiatric diagnosis and the biomedical understanding of mental distress. The study also sheds some light on what makes these arguments so reasonable and difficult to challenge. In doing so, this has contributed to our understanding of how psychiatric diagnosis and the biomedical model of distress remain so dominant and unscathed by the criticisms and challenges that have been raised over the years. This relates to Georgaca and Avdi's (2012) argument about the power that exists in the dominance of certain discourses: 'there is a close mutual relationship between discourses and

practices; dominant discourses, which become taken for granted, support and enable social and institutional practices, which in turn maintain them' (2012:155).

The illumination of particular constructions and discursive practices which facilitate a number of possible effects is also of relevance to clinical psychologists who may benefit from anticipating these in their everyday practice. The study also provides a rationale for the need to develop our critical eye and our ability to notice the 'taken-for-granted' assumptions behind particular concepts, such as the biopsychosocial model and how their use can have particular effects.

It is hoped that by further understanding the persuasive and powerful arguments that are available in support of the biomedical model and psychiatric diagnosis, these can be anticipated in continued efforts by clinical psychologists to communicate with wider audiences about the debate and generate public interest. With regards to the use of online news media to do so, the study has implications for groups such as the DCP in how they go about this. The findings presented in this study suggest that it is necessary for 'media units' like those in the DCP to anticipate particular framings or representations that may be drawn upon in news articles. For example, framing the debate as a rivalry may have reduced the perceived significance of the debate to readers. The lack of clarity about the DCP's criticism in relation to the role of biology might also have led to strong arguments being made about this which distracted from what the debate was in fact about. It could be argued that this prevented further discussion and communication of the issues raised by the DCP. Therefore, it is crucial that any communication relating to this debate is clear that the criticisms are about the privileging of and reliance upon a purely biomedical understanding of distress, and the neglect of other ways of understanding and responding to this. More generally, it is recommended that any use of the news media by the clinical psychology profession includes the relevant 'hyper-links' to original documents and sources to facilitate clarity and prevent misrepresentations of what is being communicated.

Although some of the responses, constructions and arguments highlighted by the study were thought to have been influenced by the news article's representation

of the DCP's criticisms, some appeared to be less prompted by (and arguably less related to) either the DCP's position statement or the news article. The unexpected frequency of talk about interventions and psychiatric medication was discussed earlier in relation to audience reception theory. This has implications for traditional notions of being able to simply construct a report or statement and make this available for people to take in and digest, as if 'blank slates'. Instead, there is a need for consideration of ongoing debates and significant issues that relate to the subject of psychiatric diagnosis and the biomedical model, which people may bring to the debate or draw on in their interpretation of communication about it.

The findings also have implications for lay understanding of psychiatry and psychology. It appeared that interventions and treatment were of particular importance to commenters and they were able to broadly distinguish between the interventions typically offered by psychiatrists and clinical psychologists, which contrasts to the conclusions of previous research (Dempsey, 2007). The arguments highlighted in this study which justified and supported the use of psychiatric medication present a further contrast to the literature discussed in chapter 1, which highlighted strong public views about the negative effects and ineffectiveness of psychiatric medication (Pill et al., 2001; Sartorius et al., 2010). Although negative aspects of psychiatric medication were brought up in comments, there were a number of strong arguments made in defence of psychiatric medication and strong themes around medication as necessary despite this.

The construction of psychiatrists as having more expertise, more training and higher status than psychologists, particularly for treating 'severe' mental health difficulties, is arguably consistent with Warner and Bradley's (1991) findings. It is possible therefore that this represents a common view amongst the general public. The construction of psychological interventions as ineffective, unavailable and a poor alternative to psychiatric medication should also be noted, along with its contrast to previous research indicating a preference by members of the public for psychotherapy (Sartorius et al., 2010). This has implications for clinical psychologists as these views may be held by the clients, carers, family members

or professionals with whom we work. It is recommended that clinical psychologists remain aware of these constructions and be prepared for discussions on such subjects. It is also recommended that the clinical psychology profession increase efforts to better understand public views about and experience of psychological intervention through further research and evaluation. These findings also provide justification for further research into the public image of clinical psychology.

The use of online news media also requires further careful consideration of the nature of talk and interactivity in the comments sections which are now available on most news sites. It should be considered that many readers will read little of the article but instead read the comments and respond to these. Brossard and Scheufele (2013) argue that the nature of the discussion which develops following a news article can influence the way the news article and its subject is interpreted by readers. This therefore provides a rationale for finding ways to address this. A further recent study has indicated that comments and questions added by journalists in comments sections can improve discussion, keep it to topic and reduce incivility by asking questions of commenters (Stroud, Scacco, Muddiman & Curry, 2014). As discussed earlier, comments left early on in the timeline of commenting activity can have a significant impact on the direction of the talk (Ziegele, Breiner & Quiring, 2014). Thus, for those using the online news media to communicate in future, it may be useful to consider strategies such as adding comments in an attempt to influence the discussion.

#### 4.2.2 Credibility

Credibility is concerned with the 'defensibility and plausibility of claims made by research' as well as the 'ability to see how claims or conclusions have been reached' (Spencer & Ritchie, 2012:230). This is presented as a measure of quality in qualitative research which acts as an equivalent to 'interpretative validity' which is traditionally used to assess quantitative research.

As discussed in chapter 2, steps were taken during the analysis to try to prevent the over-influence of my role as researcher on the results that were produced. I

made use of quality criteria to help me to produce an analysis that was rooted in the data and to ensure I was not forcing an interpretation on the data, even though many interpretations are possible. In order to demonstrate this I used a variety of extracts throughout the presentation of the analysis to highlight examples of talk upon which I was basing the interpretations and claims being made. Additional extracts of data that were not included in the analysed sample are also submitted with the study (see Appendix 8 and 9) so that readers can further assess the plausibility of the findings. Interpretations and conclusions drawn from the analysis were also discussed in supervision sessions as a further way of checking and improving their plausibility. During these sessions there were times where particular interpretations and readings of the data were discussed and changed as a result of this. This also occurred during the process of reviewing and refining themes where the data was read and re-read to check that the themes were accurately reflecting the data.

#### 4.2.3 Rigour

Whereas attending to issues of credibility provides a more appropriate way of assessing interpretative validity in qualitative research, 'rigour' provides an equivalent to the concept of 'methodological validity' (Spencer & Ritchie, 2012:230).

One of the key aims in presenting this study has been to demonstrate the process in which it was conducted in order to highlight how the design of the research and choice of methods enabled it to meet its aims. Much effort has been made to articulate the rationale for the approach taken, choice of methods and other decisions made during the process to increase the 'defensibility' of the research (Spencer & Ritchie, 2012:232). As Georgaca and Avdi (2012) state, 'presentation of the research process should be transparent and situated, through the detailed explication of all the stages of the research process and the grounding of the analysis in extracts' (2012:157).

I have also endeavoured to make the process of analysis as transparent as possible in order to demonstrate the thoroughness of how it was conducted. The



various stages of the analysis were described in detail, including the generation of data, in chapter 2. Here for example, the steps taken during the selection and sampling of data were described to highlight the attempts to prevent any systematic bias in the analysis of the data. The description of the process of analysis was also documented with examples from the coding and theme generation stages (see Appendix 4 and 5). This is also accompanied by an account of what is assumed about the commenters and how they relate to the wider population. The limitations to this aspect of the research are discussed further below.

Reflexivity and reflection on the potential impact of the researcher on the study is also considered a key part of way of improving rigour in research, and this is discussed separately.

#### 4.2.4 Advantages and limitations of study

Thematic analysis is a useful way of working with large amounts of data to generate themes and identify patterns which can be particularly useful when previous research on the topic is limited and views of participants are unknown (Braun & Clarke, 2006). Due to the flexibility of thematic analysis it also allowed the study to draw upon discursive psychology and a social constructionist epistemology.

Crucially, the approach taken in the study enabled it to address the research aims, which were to explore how issues in the debate were talked about, constructed and the discursive effects of these constructions and discursive practices. The study was interested in social processes, therefore the use of naturally occurring talk was an advantage of the study and the use of a discursively informed thematic analysis provided a way of doing this.

One limitation of the study was that it was limited to the analysis of comments related to one news article and this is considered a constraint on the data. The study would have benefited from the inclusion of comments from multiple news articles originating from different news organisations as this would have

increased the credibility of the conclusions. By limiting the data to comments from the Guardian/Observer website, this presents a possible bias in the data when considering its readership.

According to the British National Readership Survey (NRS) (2013) the Guardian/Observer readership includes a high proportion of readers from the AB social grade (traditionally referred to as upper middle class and middle class), making up 59% of the readership, compared to 24% in the general UK population. Differences between age groups are small but a larger contrast is evident in relation to gender with more male readers (56%) than female (compared to 49% in the general population). The 'highest qualification' of readers also provides an indication of the readership with 65% having a degree or higher, compared to 23% in the general population. The newspaper is also regarded as liberal and left-wing in both its content and readership, with an Ipsos MORI survey in 2005 showing 48% of Guardian readers were Labour voters and 34% Liberal Democrat voters. Therefore it could be argued the findings may be heavily influenced by this sampling of the data and conclusions may potentially be specific to this kind of population. The choice of online news media and online comments as the focus of the study also presents a limitation as the findings are derived from talk limited to this setting and from people who have access to the internet.

Further to this, the use of this data meant it was not possible to know for certain the demographical information about the commenters, such as their gender, social class, whether they had a particular professional background or had experience of accessing services, or even in which country they lived. Therefore, the study was limited to working with the text only. The decision to select a sample of the data for analysis, rather than the whole corpus, is also considered a constraint of the study as despite the steps taken to prevent systematic bias, this cannot be certain.

#### 4.2.5 Generalisability

As Spencer and Ritchie (2012) highlight, there are many different views as to whether we can make claims of wider inference and transferability in qualitative research, with many authors suggesting this is problematic due to the context-specific nature of qualitative research.

Therefore, the study makes only tentative claims about the generalizability of its conclusions as it was confined to the analysis of responses to a particular news article. As discussed, the article provided a particular context which is considered heavily influential in the talk that emerged from it. The comments were also those made in an online setting, therefore representing only those people who have access to the internet and read the particular news website on which the article featured. However, it is hoped that the research goes some way in highlighting broader findings that could be generalised and might be expected from similar studies. For example, the findings related to the way the debate was covered in the news article and its role in influencing talk about the issues might well be generalisable to similar subjects communicated through news media. Conclusions about the arguments and constructions relating to psychiatric intervention and the biomedical model are also arguably generalisable to talk and texts elsewhere, for one, because many of these were familiar and were consistent with other research findings. The decision to analyse a large amount of comments, from a higher number of people, rather than a more in-depth analysis of a small selection adds to the confidence in the possible generalisability of the conclusions.

#### 4.2.6 Reflexivity

Reflexivity is 'the overarching principle of constructionist studies' and considered a key element of evaluative criteria, particularly for those studies conducted within a social constructionist epistemology (Georgaca & Avdi, 2012:157).

As discussed in chapter 2 and above in the discussion of credibility, my own beliefs, assumptions and values have been acknowledged as having influenced

the decisions involved in the development of this study and in the process of carrying it out. It has been acknowledged that these factors will have influenced my reading and interpretation of the data and I have not considered myself to be 'outside of the discourse' (Harper, 2003). What I saw in the data, how I coded this and constructed themes would all have been influenced by my assumptions, the concepts, frameworks and discursive resources I draw upon to make sense of the world around me. Thus, the themes are not described as having 'emerged' from the data as if they already existed, waiting to be discovered. As Braun and Clarke (2006) state, this would deny the 'active role the researcher always plays in identifying patterns/themes, selecting which are of interest, and reporting them to the readers' (2006:80). Instead, they are considered co-constructions and a product of a relationship between myself and the data. This is also reflected in Harper's (2007) argument that 'discourse analyses, like writing in general, are products of choices which the analyst makes within particular contexts with particular aims in mind' (Harper, 2003:79). I have therefore sought to declare my interests and beliefs in the interests of transparency about how these may have influenced and guided the research. I have also described the theoretical orientation taken in this study and its role in how it has been conducted.

As discussed earlier in this chapter, steps were also taken to minimise the impact of my assumptions, values and beliefs, particularly in the analysis. A further consideration to be made here is highlighted in Antaki, Billig, Edwards and Potter's (2003) evaluative criteria for discourse analysis, where they describe the risk of 'under-analysis through taking sides'. This describes 'the additional offering of the analyst's own moral, political or personal stance towards what the quoted speaker or text is saying' ('Under-Analysis Through Taking Sides', para. 15). Antaki et al. (2003) describe this as occurring when a researcher's desire to sympathise or censure is not accompanied by careful analysis and can lead to simplification of the analysis. Therefore much effort has been made to ensure detailed examination was achieved in the analysis, rather than the use of data to critically distance myself or indicate a dis-alignment with what was being described. This was crucial considering my personal views about the biomedical model and psychiatric diagnosis and my reading of critical psychiatry and critical psychology literature. I have also strived to remain aware of my own

assumptions, values, interests and motivations in order to stand back from these as much as possible during the analysis.

I have also been aware of the importance of describing the epistemological position I have taken in this study. This has informed choices made in relation to data collection, methods of analysis and has had implications for how the data was viewed and what was assumed could be achieved by the study. Willig (2012) argues that 'epistemological reflexivity', the extent to which a study 'clearly and unambiguously identifies its epistemological stance', is a precondition for any evaluation of research. Therefore attempts have been made to make this clear, particularly in chapter 2, to present the findings in a way that facilitates evaluation and to conduct the study in a consistent way in line with this epistemology.

### **4.3 Suggestions for further research**

As discussed, the study presented here has presented a challenge for the traditional idea that effective public communication can be achieved in the release of a report or position statement via the news media for audiences to receive and digest. Instead, the news media influences what is discussed and how it is framed, and readers interpret this by drawing on their beliefs, views, values and experiences. This may include experiences of and views about other related issues or debates which influence their interpretations and responses. Therefore further research in relation to these ongoing debates would be of benefit for our understanding of how best to communicate with larger audiences. For instance, this might include further understanding of the perceived roles of psychologists and psychiatrists, of debates about the widespread use of psychiatric medication and the availability of services and interventions. Further research that examines ideas of severity and distinctions between various forms of mental distress would also be of benefit.

Our ability to understand and anticipate how debates are played out in public forums would also benefit from further investigation into the influence of new media forms such as online news comments sections and other forms of social media such as Twitter and Facebook. As this study has demonstrated, debates

now often take place in more public spaces that are accessible and viewed by much larger audiences. 'Twitter' is another example of a space in which such debates take place and thus further research is needed to understand the nature of this form of communication and the implications it has for furthering and influencing debate.

Considering the limitations of not having demographical information about the commenters, it could only be assumed that the data used in the study originated from a variety of people including mental health workers, service users and people with friends or family members who have experienced mental health difficulties. As a result the study has been unable to comment on whether some arguments and constructions have come from particular groups. For example the arguments in which the role of biology in understanding distress was reformulated and defended may have been more likely to come from professional groups which rely on a biomedical model. Therefore, further research could expand on the present study by focusing upon talk from particular groups. For instance, focus groups could be conducted with members of the public who have not worked in mental health to investigate whether there are arguments, issues or views that are particular to them.

#### **4.4 Final reflections**

This study began with the premise that there are many problems with the use of psychiatric diagnosis systems and the dominance of the biomedical model approach to understanding and addressing mental distress. After conducting this study, I feel more aware of the complexities there are in communicating and sharing these criticisms with others. I am hopeful that as a result I am now more attuned to the constructions, discursive practices and resources that are available and facilitate certain arguments which will aid future attempts to share my views with others. I also feel more aware of the related issues that may be important to people which contribute to the way criticisms are received and particular conclusions made. I have been particularly surprised by the complexity that is added to the communication of these criticisms with larger audiences when mediated by the news media. My interest in the issues highlighted here has

grown throughout the completion of this thesis and I look forward to following the debate and contributing to it, particularly as it continues to evolve in the changing landscape of online media.

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## 6. APPENDICES

### Appendix 1: Permission from Guardian News & Media Ltd to use article and comments for research purposes

RE: Query re. public comments  
Philippa SWEENEY  
Sent: 31 March 2014 12:05  
To: Permissions Syndication [permissions.syndication@theguardian.com]

Dear Helen,

Many thanks for your email, I very much appreciate this. Thank you also for providing the reference which I will of course use.

Best wishes,  
Pippa Sweeney

---

From: Permissions Syndication [permissions.syndication@theguardian.com]  
Sent: 10 March 2014 14:30  
To: Philippa SWEENEY  
Subject: Re: Query re. public comments

Dear Pippa,

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Best regards,  
Helen

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----- Forwarded message -----

From: Philippa SWEENEY <u0739384@uel.ac.uk<mailto:u0739384@uel.ac.uk>>  
Date: 9 March 2014 11:04  
Subject: RE: Query re. public comments  
To: "userhelp@theguardian.com<mailto:userhelp@theguardian.com>"  
<userhelp@theguardian.com<mailto:userhelp@theguardian.com>>

Hi there,

Further to my email of 18th Feb, I would appreciate it if someone could let me know whether there are any requirements over the use of online comments on your website for research purposes. In



the case that there are no requirements or stipulations, it would be very useful to have confirmation of this.

Many thanks,  
Pippa Sweeney

---

From: Philippa SWEENEY  
Sent: 18 February 2014 12:06  
To: userhelp@theguardian.com<mailto:userhelp@theguardian.com>  
Subject: Query re. public comments

Hi there,

I would like to find out if there are any Guardian/Observer website policies or constraints regarding the use of public comments posted on your website for research purposes.

I am studying for a Doctorate in Clinical Psychology and for my thesis research I am hoping to investigate public views on the debate about psychiatric diagnosis. In May 2013 the Guardian and Observer published some thought-provoking articles about the release of the DSM-5 (Psychiatry's manual for classifying 'psychiatric disorder'). One article in particular prompted 1,170 online comments from readers on your website - therefore providing a unique opportunity to look at what some of the public views are on the matter.

I would like to use a qualitative research method (thematic analysis) to explore and look for patterns in these comments. This research would be closely supervised by a member of the staff team at University of East London (UEL) and registered with and approved by the UEL Research Degrees Sub-Committee (RDSC). I would ensure I attend to ethical considerations and follow the British Psychological Society's (2013) 'Ethics Guidelines for Internet-mediated Research'. The study would not use the names, pseudonyms or identifiers that people have used in their online profiles and will remove any potentially identifiable information.

I would be very grateful for any information you could provide on whether your organisation has any policies or requirements for the use of public comments in this way.

Many thanks,  
Pippa Sweeney

-----  
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### Appendix 3: Illustration of how comments are presented following news article (default view)

Order by Newest ▾Threads Collapsed ▾

1 2 3 4 ... 15 >

**MyChoiceMyWay** 18 May 2013 16:46 0 ↑

This is an interesting battle of the paradigms. However I'm feeling increasingly oppressed by all your attempts to impose your various paradigms on me! As a recovered survivor of mental illness I assert my right to choose my own paradigm - as I always have done. I analysed/interpreted/decided the causation of my mental illness - which was a component of the psychological, societal and biological. I chose the way that was right for me in treating each component.

I found benzodiazepines to be invaluable in aiding my recovery from severe anxiety state, depression and phobias. I self-regulated my dosage and at times I used them long term. I simply stopped taking them (with no problems whatsoever) when I decided I no longer needed them. I very occasionally still take a diazepam if I feel I need to.

I combined my self-medication with non-medical self-help techniques - including a self-help group, and elements of gestalt, primal, and narrative therapy.


I agree with MTSK87 : "Psychologists are refusing to have a broader view by denying the positive effects of pharmacutceutics and attempting to stigmatise them even further". Indeed most psychiatrists do "acknowledge the social and psychological aspects of mental illness alongside biological and organic theories". I know because I've worked with them at the Royal College Psychs.

I agree the DSM categories are far from perfect. In my self-help group we decided for ourselves what to include for our definition of "what depression feels like" - we were all different to some degree.

Debate is always good, and I welcome "Critical Psychiatry".However I find Lucy Johnstone as oppressive as the psychiatrists she criticises - in her attempt to impose her paradigm on everyone - including the survivors of mental illness!

I also have a degree in the social sciences - predominantly psychology.


Report

**Dryhtscipe** 17 May 2013 13:33 0 ↑

Pfeh, psychology and psychiatry.

Neither are proper sciences anyway. Neurology has important things to say on this subject, but nobody appears to be listening.

Report

**carolannomara** 17 May 2013 3:07 0 ↑

Guardian News & Media Ltd (2013)

## Appendix 4: Worked examples of coding

<p>12 May 2013 8:41am Recommend 12</p>	<p>Psychiatric drugs - make a difference</p>	<p>Psychologists (as therapists) - charge high prices - criticisms / debating and not doing their jobs</p>
<p>while in SOME regards I agree with them, they couldn't have used worse examples to support their biomedical models are useless proposition. perhaps they should try actually LIVING with someone with bipolar or schizophrenia and seeing what a difference the RIGHT medications actually makes. they may change their tune.... this beat up is the equivalent of Physiotherapists declaring Orthopedic surgeons completely redundant..... the fact is the physio only see's patients in the recovery stage.....and mild cases..... they don't see the worst of it....and they aren't the front line. each has their role and responsibility.... psychiatry and the bio-medical model is currently being applied far too widely and generously rather than as a specialty for handling acute cases.....BUT that is because our governments would rather pay for a prescription rather than months or years of therapy.....access to therapies for both physio and psychology is expensive and difficult to access....far more difficult than a prescription.....if an industry wants to make such claims they should back it up by lowering their prices and get down to doing their jobs.....then perhaps the prescribers wouldn't be in such a desperate position for the therapist to make such claims</p>	<p>Psychologists - unaware - ignorant of PPI's problems / experiences - physio's unqualified to criticize Psychiatry / unjustified - don't work with severe cases Both psy profess an approach needed - over-prescribed - specialty for acute cases / necessary for severe cases - cheaper than psy - easier to access</p>	<p>Treatment / Intervention - more than psychiatric drug - ψ is inaccessible, expensive</p>
<p>12 May 2013 8:43am Recommend 2</p>	<p>Psychiatrists practice inventing conditions Psychiatric diagnosis - problem of mis-diagnosis</p>	<p>Disparaging comments Psychiatrists - cause more probs than solve / try - invent conditions</p>
<p>12 May 2013 8:50am Recommend 11</p>	<p>Ref to news article - framing as 'battle' unhelpful BGP poster statement - attack / criticism of bio model</p>	<p>Explanatory models / understanding of mental distress - comparison to physical health - no. of components - not dichotomy with sides</p>
<p>12 May 2013 8:52am Recommend 11</p> <p>Most of these responses overlook the fact that a huge percentage of people never make it as far as seeing as psychiatrist or a psychologist. The mental health service is so woefully underfunded that you're lucky if you make it further than a prescription from your GP and maybe a session with a counsellor. Not to mention that so many GPs are completely unprepared for dealing with patients presenting with mental health issues. Some are still so old hat that they don't see mental health problems as real problems. I have lived in various parts of the country and even when in crisis, treatment has been a bungled affair. I'm thankful for drugs for at least stabilising me when the promised referrals have amounted to nothing. The whole system needs massive restructuring and proper funding. Psychiatrists and psychologists arguing like kids trying to one up each other in the playground isn't going to help anyone.</p>	<p>Psychiatric drugs - stabilising effect - helpful in absence of alternative MH services - need re-structuring &amp; proper funding Rivalry between psy professions - arguing - competing - at expense of helping people Use of metaphor - like kids in the playground</p>	<p>Treatment / Intervention - inaccessible / unaffordable - MH services - poor quality - GP's unprepared</p>

## Appendix 5: Initial themes and codes

Professional rivalry	<p>psychologists and psychiatrists fighting, quarrelling</p> <p>psychologists and psychiatrists haggling over terminology</p> <p>not in SU's best interests, at a cost to people's wellbeing</p> <p>at expense of doing their jobs</p> <p>at expense of not listening to service users</p> <p>arguing / rivalry related to own gain</p> <p>psychologist and psychiatrists not working together (this and rivalry as indication of psychologists and psychiatrists interested in own gain, self-serving)</p> <p>professionals should work together / co-operate rather than argue over turf</p> <p>psychologists and psychiatrists do work together (on same goal of challenging biomedical-only approach)</p> <p>psychologists and psychiatrists do work together (misrepresented by article)</p> <p>power struggle</p> <p>power struggle (psychiatrists holding power / status over psychologists)</p> <p>BPS taking on psychiatry (and psychiatry as powerful)</p> <p>rivalry not justified due to lower status of psychology profession</p> <p>rivalry relating to education</p> <p>comparison between prof groups relating to education and training</p> <p>are rivals but irrelevant as both as bad as each other</p> <p>as over dramatic</p> <p>the rivalry / battle frame as originating from news article / headline</p>
Treatment / interventions for mental	<p>medical treatment acceptable despite negative aspects</p> <p>psychological therapy vs. psychiatric intervention</p>

distress	<p>psychological intervention / therapy inadequate / ineffective on its own (without psychiatric tx) / not proper treatment (due to biological basis)</p> <p>relates/depends on severity (reference to distinction between mild and severe or internal/external MH difficulties)</p> <p>best/right treatment depends on individual / is different for different people</p> <p>best/right treatment should be tailored to individual</p> <p>both psychological therapies and medical intervention are needed</p> <p>variety of treatments needed</p> <p>best treatment is mix of psychiatric and psychological / compliment one another</p> <p>only psychiatric intervention/medication is prescribed</p> <p>Mental health services / psychological intervention under-funded</p> <p>psychology / therapy as too expensive / inaccessible</p> <p>therapy as poor quality, limited, restricted,</p> <p>lack of 'psychotherapeutic' / psychological</p> <p>psychology too reliant on CBT</p> <p>CBT as poor (therapy as poor quality, limited, restricted)</p> <p>CBT as a successful psychotherapy method</p> <p>biomedical interventions ineffective</p> <p>uncertain whether psychiatric intervention is helpful</p> <p>should promote / priority is social change (as prevention)</p> <p>should promote / priority is prevention</p> <p>change in circumstances</p> <p>changes / intervention at a social level are needed</p> <p>don't (but should) attend to social factors</p> <p>therapies as ineffective / having little effect</p>
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	<p>therapies as unhelpful / harmful</p> <p>psychologists try to avoid what is necessary/are passive</p> <p>therapy/psychological intervention/tx as inadequate</p> <p>psychiatric medication used because it is cheaper than / psychological therapy as expensive</p> <p>treatment can be the wrong one</p> <p>MH services/treatment as poor / needs attention and improvement (instead of/prevented by rivalry)</p> <p>quality of mental health services / treatment</p> <p>relaying experience of MH interventions / treatment / MH services</p> <p>problems get better without intervention</p> <p>alternative / diet / social / cognitive behavioural</p> <p>not needed (if have happy family background)</p> <p>coercive medical / hospital treatment as unethical</p>
Psychiatric medication	<p>medical treatment acceptable / necessary despite negative aspects</p> <p>do not cure but contain the disorder / needed despite limitations</p> <p>brings symptoms under control</p> <p>alleviates symptoms</p> <p>undesirable but necessary</p> <p>undesirable but necessary / better than alternative</p> <p>medicalisation / over medicated / over prescribed / over-use of</p> <p>as the only treatment available</p> <p>needed due to lack of alternatives</p> <p>as cheap option / preference / used due to / as less expensive</p> <p>easier option for people (than knowing about deeper self)</p> <p>use is related to pharma gain / profit</p>



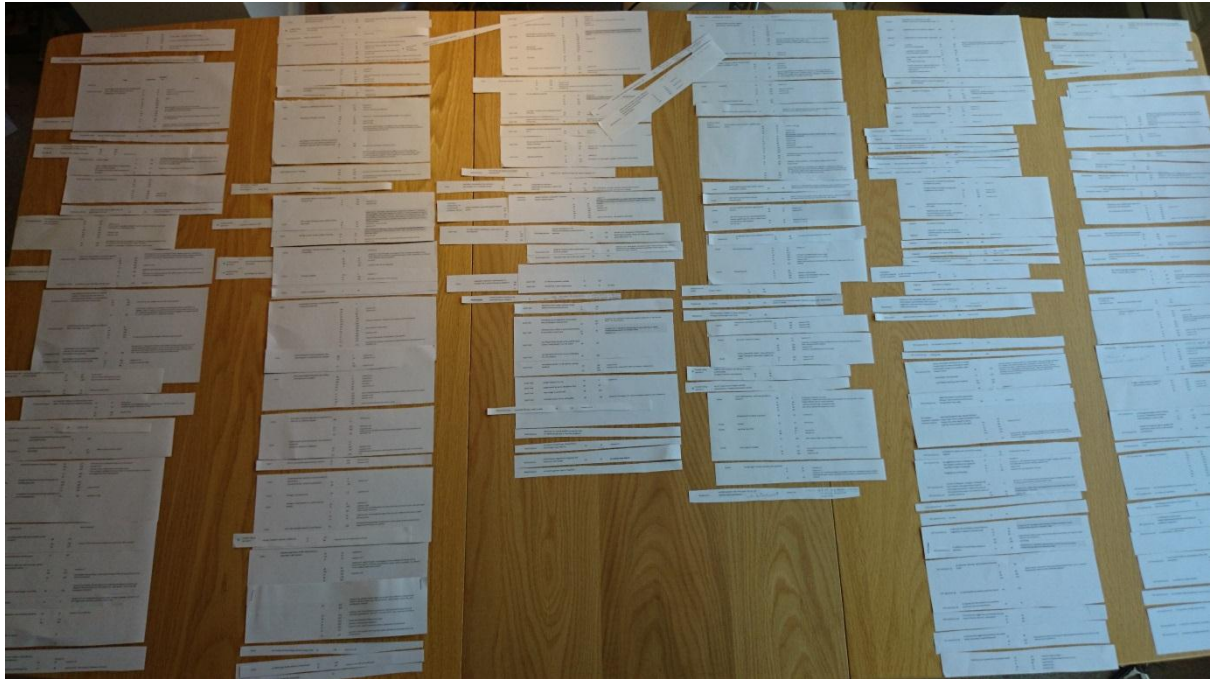
	<p>normalising use of medication in non-specific ways (challenging medicalisation)</p> <p>(necessary due to effect of social/environmental factors/stress on the brain)</p> <p>use of psych meds should not be used for social causes / medicalising? / not root cause?</p> <p>not appropriate for social causes / challenging life circumstances</p> <p>should only be used for acute / severe cases</p> <p>non-disease specific, can be used for multiple problems</p> <p>misdiagnosis can lead to wrong medication for years</p> <p>worsens distress</p> <p>harmful / unhelpful</p> <p>depends on cause of the problem/distress (internal or external), positive when causes is internal</p> <p>short term solution that ignores root causes</p> <p>prevents changes that are actually needed (to person's circumstances)</p> <p>negative effects</p> <p>administered too readily, without enough evidence/assessment/justification</p> <p>negative effects as unproblematic (just stop taking them)</p> <p>the only effective treatment</p> <p>as 'proper' treatment due to biological basis of difficulties</p> <p>can be helpful / effective</p> <p>(reliant on them for quality of life)</p> <p>(psych meds is proven to be effective / effectiveness demonstrated in research)</p> <p>evidence for life-changing, benefits</p> <p>life saving</p> <p>consequences of not taking psychiatric drugs</p>
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	<p>risk of non-adherence to treatment</p> <p>danger relying on as cure</p> <p>people would be worse off without them</p> <p>takes longer to work (cure)</p> <p>challenges about this are unfounded</p>
Causes / explanatory models of mental distress	<p>social / environmental stressors / significant life events</p> <p>not cuts / wealth (arguments against social factors)</p> <p>yes social factors but not cuts/poverty/wealth (money, wealth does not mean a person won't be affected by a MH problem)</p> <p>not the cuts</p> <p>intra-psychic</p> <p>biological changes as effects of distress (not cause) / enabling not causal</p> <p>made worse by social factors and psy intervention/dx</p> <p>not social / external / trauma</p> <p>(stress vulnerability model - stress reduced to 'trigger') biological vulnerability triggered by stress</p> <p>society's preoccupation with wealth, material possessions / concerns</p> <p>biological (brain, chemistry, genetic, abnormalities, thyroid, adrenals)</p> <p>physical illness, mis-diagnosed as mental illness</p> <p>not genetic</p> <p>no evidence for biological cause</p> <p>both social and biological</p> <p>biopsychosocial</p> <p>unclear</p> <p>recent developments, only now possible to research</p> <p>we know very little</p>

	<p>more research needed</p> <p>circular logic of drug treatment and causation</p> <p>poor sleep</p> <p>reference to neurological conditions (Dementia, ASD)</p>
	<p>biopsychosocial model as fact / correct</p> <p>majority agree with biopsychosocial model, sensible people in the field agree, to not use indicates lack of proficiency</p> <p>DCP statement, criticism of dx oppose biopsychosocial model</p> <p>MDT working as evidence of equal attention to biological, psychological and social</p> <p>psychiatry is not compatible with social or psychological understanding of MH</p>
Diagnosis	<p>as unproblematic part of psychiatric practice</p> <p>as necessary for recommending right/best treatments for patients (if mental illness not picked up/diagnosed, consequences are severe)</p> <p>necessary to provide prognosis</p> <p>required part of practice, necessary despite negatives</p> <p>necessary to provide definition of illness (but also not necessary, problems with being accurate not a problem)</p> <p>required as part of practice for financial and administrative reasons / has function (which makes change difficult)</p> <p>as based on medical training</p> <p>as unquestionable, authority of doctor</p> <p>for benefit of individual</p> <p>as validating</p>
Psychiatrist's practice	<p>work within biopsychosocial model / not just bio-medical</p> <p>doing the necessary (which psychologists try to avoid/are passive)</p> <p>diagnosis a necessary part of</p> <p>prescribe therapy as well as meds</p>

Psychologists practice	<p>listening</p> <p>passive</p> <p>refusing to treat due to risk / too unwell</p>
Disparaging descriptions of Psychologists	<p>hippy, fluffy</p> <p>educated but no personalities</p> <p>trying to be empirical, hanging onto coattails of psychiatry</p> <p>less educated than psychiatrists / lower in status than psychiatrists</p> <p>less competent than psychiatrists</p> <p>passive, not prepared to do difficult/nasty/forceful intervention that is necessary</p> <p>psychologists in BPS as mad</p> <p>as mad, having own mental health problems</p> <p>no better than psychiatry / just as bad</p> <p>self interest</p>
Disparaging descriptions of Psychiatrists	<p>empty of love, soul-less</p> <p>unpopular</p> <p>inflicting damage</p> <p>promoting nonsense / untrustworthy</p> <p>mental illness drs have more power over patients than physical health, can provide poor treatment</p> <p>experience of seeing psychiatrists poor</p>

## Appendix 6: Illustration of process for reviewing and refining of themes



## Appendix 7: Screenshots of news article

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

Guardian News & Media Ltd (2013)

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The Observer

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Psychiatrists under fire in mental health battle

British Psychological Society to launch attack on rival profession, casting doubt on biomedical model of mental illness

Jamie Doward

The Observer, Sunday 12 May 2013

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There is no scientific evidence that psychiatric diagnoses such as schizophrenia and bipolar disorder are valid or useful, according to the leading body representing Britain's clinical psychologists.

In a groundbreaking move that has already prompted a fierce backlash

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More on mental health

Are mental illnesses such as PMS and depression culturally determined?

Corrinne Burns: A growing number of psychiatrists suspect

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There is no scientific evidence that psychiatric diagnoses such as schizophrenia and bipolar disorder are valid or useful, according to the leading body representing Britain's clinical psychologists.

In a groundbreaking move that has already prompted a fierce backlash from psychiatrists, the British Psychological Society's division of clinical psychology (DCP) will on Monday issue a statement declaring that, given the lack of evidence, it is time for a "paradigm shift" in how the issues of mental health are understood. The statement effectively casts doubt on psychiatry's predominantly biomedical model of mental distress – the idea that people are suffering from illnesses that are treatable by doctors using drugs. The DCP said its decision to speak out "reflects fundamental concerns about the development, personal impact and core assumptions of the (diagnosis) systems", used by psychiatry.

Dr Lucy Johnstone, a consultant clinical psychologist who helped draw up the DCP's statement, said it was unhelpful to see mental health issues as illnesses with biological causes.

"On the contrary, there is now overwhelming evidence that people break down as a result of a complex mix of social and psychological circumstances – bereavement and loss, poverty and discrimination, trauma and abuse," Johnstone said. The provocative statement by the DCP has been timed to come out shortly before the release of DSM-5, the fifth edition of the American Psychiatry Association's *Diagnostic and Statistical Manual of Mental Disorders*.

The manual has been attacked for expanding the range of mental health issues that are classified as disorders. For example, the fifth edition of the book, the first for two decades, will classify manifestations of grief, temper tantrums and worrying about physical ill-health as the mental illnesses of major depressive disorder, disruptive mood dysregulation disorder and somatic symptom disorder, respectively.

Some of the manual's omissions are just as controversial as the manual's inclusions. The term "Asperger's disorder" will not appear in the new manual, and instead its symptoms will come under the newly added "autism spectrum disorder"

Are mental illnesses such as PMS and depression culturally determined?

Corrinne Burns: A growing number of psychiatrists suspect mental conditions are 'culture-bound syndromes' rather than exclusively biological

Clinical anxiety is becoming a worry

Mental illness: the claim that abuse is behind psychosis is irresponsible

New US manual for diagnosing mental disorders published


Do we need to change the way we are thinking about mental illness?

Vaughan Bell: news from the borders of mental illness

Medicine's big new battleground: does mental illness really exist?


Students stay silent about mental health problems, survey shows

Europe's best-kept secret



Find picturesque fishing villages, 8000 islands and sensational seafood

Dementia friends



Living with dementia: "The world has opened up for me"

Since Gina Shaw, a 62-year-old retired children's nurse, was diagnosed with Alzheimer's, she has been on a mission to make her native Liverpool a dementia-friendly city

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temper tantrums and worrying about physical ill-health as the mental illnesses of major depressive disorder, disruptive mood dysregulation disorder and somatic symptom disorder, respectively.

Some of the manual's omissions are just as controversial as the manual's inclusions. The term "Asperger's disorder" will not appear in the new manual, and instead its symptoms will come under the newly added "autism spectrum disorder".


The DSM is used in a number of countries to varying degrees. Britain uses an alternative manual, the *International Classification of Diseases* (ICD) published by the World Health Organisation, but the DSM is still hugely influential – and controversial.

The writer Oliver James, who trained as a clinical psychologist, welcomed the DCP's decision to speak out against psychiatric diagnosis and stressed the need to move away from a biomedical model of mental distress to one that examined societal and personal factors.

**Writing in today's *Observer***, James declares: "We need fundamental changes in how our society is organised to give parents the best chance of meeting the needs of children and to prevent the amount of adult adversity."

But Professor Sir Simon Wessely, a member of the Royal College of Psychiatrists and chair of psychological medicine at King's College London, said it was wrong to suggest psychiatry was focused only on the biological causes of mental distress. And in an accompanying *Observer* article he defends the need to create classification systems for mental disorder.

"A classification system is like a map," Wessely explains. "And just as any map is only provisional, ready to be changed as the landscape changes, so does classification."



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about mental health problems, survey shows



**Living with dementia: "The world has opened up for me"**

Since Gina Shaw, a 62-year-old retired children's nurse, was diagnosed with Alzheimer's, she has been on a mission to make her native Liverpool a dementia-friendly city

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**Ask the expert: what you need to know about dementia**

Clinical director Alistair Burns unravels the myths surrounding dementia and explains what to do if you think you or a loved one are at risk

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**Today's best video**



**Molly Ringwald: my struggle to have a child**

Hollywood actor Molly Ringwald performs for the Moth, the US-based not-for-profit storytelling organisation



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What you need to know – and what to do about it

312 comments

**Bio Star: Nothing Can**

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Guardian News & Media Ltd (2013)

## Appendix 8: Random selection of data not included in analysis for purposes of evaluation

dl – Ge:

*“The British Psychological Society is an utter joke.”*

This is very true. They are a clapped-out and self-serving bunch of charlatans. At least psychiatry is based in scientific method. The studies of neuropsychology, and recent developments in neurology, genetics and cognitive psychology put the contributions of people like Oliver James in proper perspective, James and his ilk pander to the latest middle-class fads and fancies and shun hard science. I'm glad they've made this pompous statement, as it will hasten their demise.

Ge – dl:

hear hear. You only have to read some report on the latest profound insights to emerge from one of their 'conferences' to know that they have nothing to offer. There are good people working in clinical psychology, working against heavy odds with huge caseloads. Oafs such as the BPS and various rent-a-quote buffoons don't help them in their work one bit

Gs – Ge:

*“What training in mental health do psychiatrists get after their MBChB?”*

Just a minimum of 6 years supervised specialist training in the subject plus the requirement to pass rigorous professional exams! Why do you comment on something you clearly know so little about??

sn – Ge:

*“No indeed. What training in mental health do psychiatrists get after their MBChB?”*

I'm a bit hazy on this but isn't it 2 years FY1 and 2, before specialising and training for about 9 years to become a consultant. Study for the RC exams. Many do postgrad qualifications and research degrees. So quite a lot really...

Not all Medics are MBChB- some are MBBS and there are other qualifications too....

Ge - Gs:

This comment was removed by a moderator because it didn't abide by our community standards. Replies may also be deleted. For more detail see our FAQs.

Ge - Gs:

It doesn't say much for their 'rigorous exams', (noted for their rigour, of course) does it if that's what all that study leads to?, if they think that will help? Five minutes - maybe ten if you're suicidal than you might get offered sectioning, or you might just get it anyway.

Ge – Gs:

Having now read further down the thread I see you proclaim yourself to be 'a consultant psychiatrist'. So, the answer to your pompous little question is, 'You tell me'.



## Appendix 9: Random selection of data 2

l3

Surely leading psychiatrists and clinical psychologists do not actually believe that the drugs prescribed to those with mental illness act as some sort of 'cure'. While it is true that drugs may be too readily prescribed and perhaps carelessly abused, the fundamental aim of the drug is to temporarily improve quality of life, one that may be terrifying and confusing for a person afflicted. These temporary treatments are coupled with cognitive and behavioral therapies that actually aim to tackle to root of the problem, whether its social, personal distress etc. Although, perhaps it is time to rethink what and how drugs are being prescribed when we do not yet have a complete understanding of the brain nor know the full extent of their effects.

Ny

This is just psychologists cynically using the stigmatisation of medication to promote their own career. This can lead to people being thrown between useless therapists unable to get needed medication. I know, I've been there.

je

Let's pray that both psychologists and psychiatrists (and psychoanalysts) burn forever in the fires of eternal pain.

Cs - je

that is not helpful, there are some really decent human beings who happen to be mental health professionals

hr - je

Better still: let's not.

S4

I am an experienced clinical psychologist, and I think that the way this argument is being couched is profoundly unhelpful. Unfortunately it seems to me that some psychologists are for some reason motivated to proselytise for explanatory accounts of pathology that do not include biological factors. This can then lead some to continue to apply this stance to problems that are so clearly neuro developmental in nature that it makes them look absurd (e.g autism). It is of course a truism that distress is connected to what happens to us and any decent mental health professional is aware of this. Unfortunately Lucy Johnstone's long standing preference for a highly visible form of anti psychiatric polemic can result in a defensive response from medical colleagues, who do not take kindly to being characterised as uncaring and, frankly, stupid or adequately trained. Johnstone will deny, and has denied, that this is her intention, but psychologically, it seems it is inevitable that the inference will be drawn.

This then leads to a process where the debate can take on the character of a guild war, as commented upon by Richard Bentall above, and the real, important, discussion gets lost in this. I get frustrated when I see articles like this purporting to represent the view of clinical psychologists as a group, when what they seem to be is a mixture of media interest in professional turf wars in combination with the stark views of a very visible and vociferous psychologist (Johnstone). She certainly does not speak for me and the DCP needs to be careful in engaging with a process that may set up an unhelpful and fruitless conflict at a time when we should be concentrating, post Stafford and Winterbourne, on getting services to a better place. This is where our efforts should be focussed. Psychologists and psychiatrists are both highly trained over a lengthy period, and as such should accept their joint accountability to work together to improve services, regardless of epistemological debates.