The Discursive Construction of Mental Health Problems in Irish Print News Media

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Mary Farrelly

This thesis is dedicated to the memory of Gerard and Esther Farrelly, my parents.

Acknowledgements

Table of Contents

List of Tables

Abstract

The manner in which various media formats report events and topics that are considered newsworthy is an important site for making discourse visible. Discourses construct realities and are revealed in how objects are spoken about. The aim of this study was to gain a more sophisticated understanding of the way in which 'common sense' understandings were employed in establishing knowledge about mental health problems and the resultant production of power through an examination of how mental health problems are constructed in Irish newspapers. This study reports on 123 news items collected over a one month period from five Irish newspapers. The methodological approach adopted was discourse analysis, based on a Foucauldian understanding of discourse, emphasizing the ubiquity and inter connectedness of knowledge and power.

The findings suggest that mental health problems were discursively constructed in Irish newspapers enlisting discursive categories of hiddenness, visibility, crises and risk, devastation, illness, psychosocial causation, recovery and professional treatment. These discourses operated to produce an understanding of mental health problems and mental distress as being an individual, biomedically defined phenomenon, beyond the control of the individual, dangerous and devastating to the person, others and society, constructing mental health problems as outside the locus and control of people who experience them, producing a need for the government of mental health. These 'common sense' understandings of mental health problems reinforce the superior status of psychiatric knowledge as the legitimate means of both making mental distress visible and as a means of response. Association with physical illness was frequently used to legitimize and de-stigmatize mental health problems. Competing recovery and psychosocial discourses were appropriated by the use of psychiatrically oriented language and by association with psychiatric structures. Representation of social factors related to causation was limited to proximal factors obscuring macro structures that are implicated in the creation and perpetuation of inequality, social deprivation and isolation. Critical discourses that challenge the legitimacy of biological explanations and psychiatry were largely absent.

"People know what they do; they frequently know why they do what they do; what they don't know is what they do does" (Foucault 1983, p.187).

Chapter 1 Introduction, background and overview of the thesis

1.1 Introduction and background to the research question

The experience of mental distress is one of the most significant public health issues in modern society. The World Health Organisation (2008), based on findings from community epidemiological studies, estimates lifetime prevalence rates of mental disorders in adults as being from 12.2-48.6%. Even if these statistics and the basis for defining mental health problems are contested, it is clear that mental distress is a major issue for society, for those who experience it, their relatives, friends and those who work in the 'psychiatric industry', providing services and commodities. A fundamental tenet of modern, 'progressive' mental health care is maintaining people and provision of services outside of institutions in the community. *A Vision for Change* (Government of Ireland 2006) Ireland's current mental health policy, identifies the community as a valuable resource in helping people recover from mental health problems and the extent to which this support exists or can be harnessed is contingent on prevailing societal beliefs, attitudes, knowledge and understandings about mental health and mental health problems. A central concern in society has been the stigma that is widely accepted as being associated with having a mental health problem. A recent study exploring experiences of discrimination associated with having a mental health problem in Ireland, provided accounts of discrimination in employment, personal relationships, business, finance and health care with participants describing being discounted, discredited, mocked, shunned, inhibited and constrained (Lakeman *et al.* 2012).

Concerns about stigma are generally predicated on its effects on individuals, as being a barrier to social integration and the extent to which it constrains help seeking behaviour. Modern approaches to treatment and care for people with

1

mental health problems emphasize the importance of social integration being not only an indicator of positive mental health but an essential element of recovery from mental health problems. Stigma is viewed as something that can create barriers for people with mental health problems in society and interfere with integration and acceptance. With community care being the dominant, preferred care option of late, people experiencing mental health problems are living and recovering in the community and it is generally accepted that negative attitudes towards and ignorance about the nature of mental health problems in the general population can result in stigmatising practices resulting in a further psychological burden and making recovery and integration problematic. Negative attitudes in society towards mental health problems may make those experiencing mental distress reluctant to seek help and thus delay potential alleviation of distress.

Concerns about stigma and the rights of those considered to have a mental health problem are clearly a major concern and have driven research and practice aimed at investigating and influencing societal attitudes. A major area of this research has been how mental health problems are depicted and represented in various media sources with concerns about 'negative' depiction and its influence on attitude formation. These approaches are frequently underpinned by a realist understanding of mental health problems which construct them as conditions which exist as a trans-cultural aspect of illness that have been discovered through developments in scientific medical knowledge and conceptualisation (Wrigley 2007). Resistance to these dominant understandings, emanating from the work of Michel Foucault, anti-psychiatrists such as Thomas Szasz and R.D. Laing, post-psychiatrists Pat Bracken and Phil Thomas and movements critical of the coercive and dominant nature of psychiatry, problematize mental health problems as social constructs. 'Mental health problems' can be understood as occupying a social space between the individual experience of mental distress and the shifting and conflicting social constructions of what is considered normal and abnormal human behaviour, emotion and cognition. This study while acknowledging the role of media in attitude formation is concerned with the broader issue of how meanings

2

about mental health problems are constructed. It is underpinned by an understanding of social reality as constituted in discourse and the resultant production of power and knowledge that has important and pervasive effects on society and on the individual. 'Mental health problems' are understood as constructed in discourse and deconstruction is important in revealing understandings that are taken for granted. Discourse is produced in many sites, and media have become an important site in which meanings are constructed. This study is concerned with the way in which mental health problems are constructed in discourse using Irish newspapers as the site for scrutiny.

1.2 Mental health problems as objects of discourse

The field of mental health is a "space of contestation, struggle and resistance" (McDaid and Higgins 2014, p.1). What we call 'mental health problems' are contested, evidenced in the historical and cultural variance in how we understand and respond to mental distress. Over time 'mental health problems' have been variously understood as human weakness, as vice, as punishment, as a sign of possession, as a form of deviance, as biological malfunction, as psychological malfunction, as a response to adverse social circumstances and as social constructs. The attribution of a 'mental health problem' has been used to legitimize the incarceration, torture, medication, stigmatisation and deprivation of freedom of vast groups of individuals. Contemporary western understandings of mental health problems are dominated by health and psychiatric discourses, that are underpinned by an of ideology of bio determinism and are represented as the result of scientific progress and as a more humane approach to human distress than historical punitive methods. The conventional and official history of 'madness' conceptualises current understandings of mental health problems as the result of a series of improvements in scientific knowledge, what Turner (1987, p.60) refers to as: "a prime example of this liberal interpretation of history as the history of freedom and rationality". From this perspective "the prejudice and irrationality of the Middle Ages was eventually replaced by science which adopted an increasingly

liberal and humane approach to the insane" (Turner 1987, p.60). This understanding is contested.

Resistance to the psychiatric discourse comes from a variety of sources. Service user and critical discourses emphasize the centrality of individual experience and human rights. Sociological discourses emphasize the role of society in creating distress and the role of social processes in constructing realities. Foucault's major work on 'madness', *Madness and Civilization* (1965) charts the position of 'madness' in society from the Middle Ages to the end of the classical age (1660-1900) in Europe. In it he analyses key shifts in the historical status of madness from the Middle Ages and Renaissance, when it was understood as tragic human experience, through to the Great Confinement in the mid-seventeenth century when it was associated with a lack of productive activity and unreason, to the Age of Enlightenment at the beginning of the 18th century when it became the object of medical science (O'Farrell 2005; Foucault 1965). Foucault considered that power was constituted through accepted forms of knowledge, scientific understandings and what is considered 'truth'. His 'method' was to problematize 'taken for granted' social objects by investigating their construction in social discourse. This, combined with his consideration of the development of disciplinary power, biopower and later governmentality, provides an epistemological lens through which to examine the trajectory of mental health problems in Irish society and develop an understanding of the discourses that exist in the current context. While Foucault's ethical project, problematizing disciplinary practices that exert power on the individual in seeking to modify their behaviour (O'Farrell 2005), was wider than the subject of mental health, his examination of the way in which power/knowledge is produced about mental health problems provides "a theoretical foundation to enable an analysis of 'mental illness' not bound by the individual mental state or human flesh" (Brennan 2014a, p.11). From his perspective "Scientific concepts are not neutral descriptions of patterns of behaviours, but on the contrary that they produce through discursive activity the behaviour which they seek to describe" (Turner 1987, p.61). Given the significance

4

of power/knowledge in how society responds to the issue of mental health and the implications that this has for people who experience mental distress, a consideration of the discourses that constitute meaning about 'mental health problems' is important in attempting to understand the dispersion of power and its effects at particular junctures.

1.3 Media as a disciplinary site

Media are important social sites in which knowledge and meanings are constructed. Their central purpose is the communication of information in a mediated form to large groups of people in society. In the 18th century Beccaria alluded to the political importance of the public consumption of printed material asserting that: "Only printing can make the public as a whole and not just a few persons depositories of the sacred code of the laws" (Beccaria 1764, cited in Foucault 1977, p.96). Two hundred years later at the opening broadcast of Ireland's first national television station in 1961 the then President, Eamon de Valera said: "I must admit that sometimes when I think of television and radio and their immense power, I feel somewhat afraid" (Morash 2010, p.172).

The importance and role of print media as more than simply a means of conveying information and its complex functions are revealed in a consideration of its history in Ireland and elsewhere. The history of printing in Ireland dates back to the mid-16th Century (Morash 2010). By the year 1550 printing presses had been established in parts of Europe and in 1551 the earliest known Irish book was printed in Ireland, *The Boke of Common Praier* by a printworks which was established on foot of a grant by an Act of the Privy Council in London after Henry VIII had declared himself King of Ireland in 1541. Morash (2010) suggests that while the motivation of Gutenberg in choosing the Bible to print in Europe was as a response to market demand, in Ireland no such market existed. The establishment of printing in Ireland under state control and the choice of material to be printed (religious doctrine, proclamations and declarations by the government) was an attempt by the British

sovereign power to indoctrinate and provide rules to govern the conduct of the Irish colony. Foucault postulated that the breakdown of feudal institutions and the formation of territorial administrative states in parts of 16th century Europe raised many challenges in relation to government (Hindness 1996). "One important consequence of the weakening of feudal ties was that matters of individual conduct could no longer be regarded as regulated by networks of personal dependence and reciprocal obligation" (Hindness 1996, p. 107). Therefore, the government of oneself and who could legitimately claim to govern that government assumed a significance at a time when new systems of administration were emerging. Morash emphasizes the socio-political and disciplinary function of printing in making visible the authority of the state in the context of Ireland as a colony:

> The point in printing a proclamation or ordinance was a public display of the technological prowess of the administration. In a society in which the press was tightly controlled, a printed proclamation, whatever else it said, always made one clear statement on behalf of the colonial administration to the population as a whole: we have the technology to do this (and you do not) (Morash 2010, p.6).

Since then dispersion of mediated information has expanded alongside technological developments which have made media ubiquitous and pervasive. Definitions of media have changed and evolved alongside technological developments. Media which was once understood as "an identifiable cluster of different forms of public communication with a certain institutional identity" (Mc Quail 2010, p. 13), which mainly referred to print (newspapers and books) and broadcast (television, radio and film) has become more difficult to define. Media now incorporates a vast array of 'new' media including social media and digital forms of 'old' media. For the purposes of this thesis I am adopting a broad definition of media as 'forms of mass public communication' but have focussed mainly on newspapers, magazines, television, radio and film in reviewing previous research, as they have been the main areas investigated.

Foucault considered that the body has become a site for disciplinary control through operation of disciplinary power by apparatuses of state such as medicine, the law, the education system and psychiatry. He argued that these disciplines "define the limits of behaviour and record activities, punishing those bodies which violate the established boundaries, and thus rendering bodies productive and politically and economically useful" (Lupton 2003, p.25). For example, psychiatry and legal systems have functioned to produce mental health problems as mental illnesses. As media has become ever more accessible and mental health problems have become more the focus of open discussion, with more ostensible acceptance of the testimonies of people who have experienced mental health problems and their relatives, media has assumed increased importance not only as a means of communication for apparatuses of state but as an apparatus of discipline in its own right, as a site in which meaning is constructed. In the words of teenagers writing about a school mental health campaign: "Fortunately, the lamp of the media is shining more and more light on mental health…." (Burke, O'Sullivan and Nestor 2009, p.10). As Cramer (2007, p.409) argues "in a postmodern age with declining emphasis on the institutional disciplinary powers of school, church, and even the family, popular culture may assume increased importance in the regulation and/or production of moral standards".

While the part that media play in creating meaning cannot be precisely measured, the extent of consumption by the public and the extent to which media have been shown to be concerned with mental health issues offers insight into its pervasiveness. In relation to print news media for example, globally more than half the world's adult population read a newspaper, mainly in print form but increasingly in digital form, representing more readers and users than total global users of the internet (World Association of Newspapers and News Publishers 2013). In Ireland it is estimated that as many as 84.2% of the population read a newspaper at some time during the week with 51% reading a daily paper and 48.4% reading a morning paper (Joint National Readership Survey 2009-2010). More recently readership rates of print newspapers have declined but online readership

7

compensates for this (Joint National Readership Survey 2013). The portrayal of mental health issues in media is widespread, and a substantial body of research indicates that popular media is an important source of knowledge for the public about 'mental illness' (Dietrich *et al*. 2006; Angeryer *et al.* 2005; Penn, Chamberlin and Mueser 2003; Granello, Pauley and Carmichael 1999; Thornton and Wahl 1996; Daniel Yanklovich Group Inc. 1990).

Based on the assumption of an association between attitude and behavior, a large body of research has been concerned with attitude formation, suggesting that exposure to negative coverage of mental health problems leads to the formation of negative attitudes. Cultivation theory is concerned with the effects of television viewing on the formation of attitudes and perceptions of social reality (Gerbner *et al* 1986). Some research suggests that the more television an individual watches the more likely they are to express opinions and hold views similar to those represented on the television (Stout, Villegas and Jennings 2004, Gerbner *et al* 1986) and similarly research into newspaper coverage suggests that negative coverage of mental illness tends to lead to the formation of negative attitudes (Dietrich *et al* 2006; Angeryer *et al* 2005).The perceived importance of media in influencing meaning is highlighted in the current Irish mental health policy document, *Vision for Change*, which suggests: "A robust challenge needs to be mounted to all discriminatory practices and media misrepresentations of mental health problems" (Government of Ireland 2006, p.36). While the formation of attitudes is generally thought to be a complex interaction of knowledge, experience and personality, Hazelton (1997, p.88) suggests that:

> "While there is no necessary uniformity to audience response, and reading entails more than the passive and uncritical absorption of messages, the discursive structuring of media texts and the selection of language and imagery work to entice audiences into certain interpretations of an issue, while simultaneously closing off, or denying the legitimacy of others".

Based on such assumptions a large body of research has focussed on the quality of portrayal, identifying positive or negative depictions, with more recent research concerned with 'balanced', 'accurate' portrayal of mental 'illness' and people with mental health problems and adherence to national and international 'best practice guidelines' that generally centre on accepted language and terminology that themselves form part of discursive practice. 'Good' journalism is understood as 'accurate' journalism, performing a public service. This is reflected in the sentiments of Joseph Pulitzer in an address at the founding of the Columbia University School of Journalism in 1912:

> What is a journalist? Not any business manager or publisher, or even proprietor. A journalist is the lookout on the bridge of the ship of state. He notes the passing sail, the little things of interest that dot the horizon in fine weather. He reports the drifting castaway whom the ship can save. He peers through fog and storm to give warning of dangers ahead. He is not thinking of his wages or of the profits of his owners. He is there to watch over the safety and the welfare of the people who trust him.

Generally research into media coverage has identified that mental health problems tend to be portrayed in a negative manner, are associated with violence and criminality and that people with mental health problems are portrayed as having little agency and conforming to stereotypical images. There is relatively little published research in Ireland on media and mental health problems. Those that are published (O'Connor and Casey 2001; Meagher *et al* 1995) appear to suggest that mental health problems are treated in a more 'positive' or 'benign' way by news journalism in Ireland than in other countries. Over the past 20 years, in response to research that indicates negative portrayal and the assumption of its effect on societal attitudes and behaviour, many countries have developed initiatives to govern and regulate media reporting on particular groups that are viewed as marginalised or vulnerable in some way. Among these are people with mental health problems. Equality legislation, broadcasting regulation and guidelines on reporting are examples of efforts to regulate or influence the way in which people or issues are depicted. This is viewed as a good thing and recent research into media coverage of mental health problems or suicide has used adherence to

guidelines as a standard against which to judge the quality of reporting with adherence viewed as a positive indication of progress. However, closer critical examination of such legislation and guidelines reveal that while ostensibly they are well intentioned, in that they attempt to improve reporting of mental health problems by regulating the language used, moving from the use of derogatory and pejorative language, they replace one discourse with another, by promoting the use of the medicalised language of diagnosis. They convey the meaning that prevailing scientific discourses that represent mental health problems as 'illnesses' are the appropriate, positive and legitimate way in which to understand and talk about mental health problems. Underlying these assertions is an assumption that there is a 'reality' that is there to be captured. As discourse is pervasive it is accepted that new discourses emerge and are unavoidable, however there is a choice in the selection of alternative discourses.

The manner in which mental health problems are represented and understood has important consequences for those who experience them and while acknowledging that attitude formation is influenced by media representation and is a complex process that involves integration of more than just one source of experience, the issue of how meaning is made has wider implications beyond individual attitudes. The consideration and analysis of discourse is important in gaining an understanding of meaning, knowledge and power in relation to mental health problems from a socio-political position. Media are recognized as a significant social site where meaning is constructed, forming societal understandings of what constitutes 'mental health problems' and constituting notions of causation, appropriate responses and treatments.

1.4 A personal perspective

Discourses analytic studies, based as they are on an understanding of the world as socially constructed, are by definition inextricably influenced by the identity and perspective of the researcher. Researcher identity concerns issues such as the

world view of the researcher and their perspective on the topic of the research and need to be acknowledged to demonstrate the place of the researcher in the research. I am a psychiatric nurse and a mental health lecturer who has worked in a variety of roles in the Irish health system both in mental health care, regulation and in nurse education over the past 30 years. My interest stems from a variety of perspectives. I have witnessed and been part of a considerable amount of change in relation to the way in which health services are delivered, in relation to locations, treatments, personnel, and developments in the legal, regulatory and policy frameworks that govern health and mental health. This has made me interested in the impetus for change, the way in which something which is accepted as normal, usual and good at one point in time is unacceptable and bad at another, and the reasons stated for that change. Having worked in community and in-patient settings and having been responsible for making decisions about the meaning of people's thoughts, emotions and behaviours, whether someone was 'mentally ill' or not, whether someone needed to be 'admitted or detained' or not, whether someone could live in a hostel or not, has caused me to reflect on the arbitrary nature of the 'labels' that people are given and give themselves when they experience distress and the differing ways in which people experience and understand their lives and have their lives experienced and understood. Alongside this, was my experience of changes in policy, regulation and legislation and the impact they have on how work is done and what got to be called 'mental illness', 'care' and 'treatment' and the coexisting ostensible logic and illogic. So I come to this research with questions about the nature of human existence, the nature of 'mental health problems' and the forces that operate in determining how we understand them.

This coincides with an interest in media. As an avid media consumer I am aware of 'inaccuracy', 'bias' and framing in the reporting of subjects of which I have some knowledge, for example nursing and health policy. My professional work has in the years before commencing this study mainly been around the development of a clinical career pathway for nurses and midwives and part of this has involved efforts

11

to develop and promote advanced-level practice both among the professions and in the wider population. I have been in a position therefore to observe from two perspectives media coverage of nursing and advanced level roles, as someone who is endeavouring to get a message into the media and as a consumer and observer of what is portrayed. The selective nature of what is portrayed and the perspective from which it is reported is interesting, as is the role of public relations as a major influencer and mediator between the information and the message. The narrative produced for the public is not a passive reporting of 'facts' but is influenced by a complex series of processes and factors and therefore presents a 'position', when it purports to present the 'facts'. For example, news print and to some extent broadcast media, when reporting on Advanced Nurse Practitioners (ANPs) tend to focus on the part of the role that is an 'extension of practice' the piece that is taken over from doctors in the main. However, the 'extension' of practice in an ANP's role is only a part of the role, there are other equally important elements, not least, the advanced nursing practice piece which provides an expert level of 'nursing care' that is important for clients and also important in the development of competence in other nurses. However, in endeavouring to promote awareness of such posts, and based on an understanding of the perspectives that tend to influence publication, advice from public relations companies will be to focus on the 'newsworthy' aspects of the post. So issues such as 'waiting times' and 'medical substitution' tend to be emphasized in press releases rather than other aspects of the posts that are arguably equally important. This has made me question my relative acceptance of the reporting of other topics, such as economics or crime, where my knowledge is, in the main, derived from media sources. While I acknowledge that these are only some of the many influences on how an issue is framed in media, I offer this as an example of how my thinking has developed on the subject.

My initial interest related to the 'accuracy' of media depiction and centred on *'how mental health problems are portrayed and represented in Irish print news media'*. This led me to review previous research nationally and internationally in the area.

Much of the research done in the area of mental health problems, media and stigma (though not all) has centred on the assumption of a relatively uncomplicated relationship between portrayal, depiction and stigmatisation; that assumes that negative coverage leads to negative attitudes, that lead to stigmatising behaviours, that lead to negative experiences for people who experience mental health problems (Morgan and Jorm 2009; Vogel, Gentile and Kaplan 2008; Dietrich *et al* 2006; Angeryer *et al* 2005; Diefenbach and West 2007; Penn, Chamberlin and Mueser 2003; Granello and Pauley 2000; Granello, Pauley and Carmichael 1999; Thornton and Wahl 1996). These assumptions inform conventional rhetoric in the area and importantly health and social policy. Research that has stemmed from this perspective, that considers language as representational rather than constructive, has tended to focus on negative versus positive categorizations of coverage, associations of mental illness with particular states (criminality, violence for example). It examines 'what' is said. While this is no doubt informative, it provides a relatively superficial, simplistic picture of the relationship between mental health problems and media content, and does not sufficiently analyze the processes that underpin the production of knowledge in media or the power relations embedded in these processes. Olstead (2002, p.622) suggests that:

> most research to date has focussed on revealing what the media say about mental illness as opposed to investigating how it is constituted in text. In doing so, previous studies have failed to make the connection between strategies of reporting and power.

So while I initially started examining media coverage of mental illness from the perspective of '*is this factually correct?*' it became increasingly difficult to reconcile this approach with my understanding of the complexity of multiple 'realities' that convey and refer to mental health problems. Therefore my approach to this research is underpinned by an understanding of mental health problems as being discursively constructed. This implies that it is important to not only examine what 'is' said, but also 'how' it is said, and involves a consideration of dominant understandings conveyed in order to gain insight into the operation of power/knowledge.

13

1.5 The research question

The research question for the study was: 'how are mental health problems discursively constructed in Irish print news media'? The aim was to gain a more sophisticated understanding of the way in which 'common sense' understandings are employed in establishing knowledge about mental health problems and the resultant production of power through an examination of how mental health problems are constructed in Irish newspapers.

The objectives of the study were to:

- Identify the discourses and points of resistance present in relation to mental health problems,
- Identify institutions or groups that are made visible or obscured by identified discourses,
- Reveal techniques employed in constructing mental health problems and the potential effects this has on the individual.

The selection of terminology for the topic under investigation warrants consideration particularly given the position of the research in a social constructionist tradition that emphasizes the importance of language in constructing meaning. The terminology used to denote the phenomenon that is under investigation is contested. A variety of terms are commonly used including 'mental illness', 'mental health problem', 'mental disorder' or 'psychological or mental distress', each invoking particular discourses. Attempting to find neutral terminology to refer to the topic of what is commonly referred to as 'mental health problems' is futile, as whatever terms are selected are "semiotically loaded" with particular meaning and associations with particular discourses (Parker 2008, p. 40). It is impossible to use words that are neutral as the very nature of language is to convey meaning and language not only conveys meaning, but also constructs it and therefore is not and cannot be made neutral. In the main, throughout the thesis I have selected the term 'mental health problem' to denote the phenomenon that refers to mental distress and which is also commonly referred to as 'mental illness', 'mental disorder', 'madness', 'insanity'. I acknowledge the problematic nature of

the term, connoting as it does the medical discourse (Parker 1992) when attempting to investigate construction. Where historically and contextually relevant other terms are used and in some cases these are placed in single inverted commas to indicate this.

1.6 Summary

What are understood as mental health problems are a significant social challenge and the way in which they are understood in society has important implications for individuals who experience mental distress. Portrayal of mental health problems is ubiquitous in media and research has demonstrated negative portrayal and influences on attitude formation. This has significant effects on both those who experience them and their families and also for others involved in the 'mental health industry'. Having a mental health problem is commonly understood as stigmatizing and contemporary discourses that construct mental health problems as 'illnesses' are frequently understood as 'positive' representation.

The approach adopted in this thesis suggests an understanding of meaning as socially constituted. I have argued that mental health and mental health problems are important issues in and for society and the way in which they are understood and constituted varies. A variety of competing discourses contend in constituting the experience of mental distress across time and cultures and making these visible assists in challenging 'taken for granted' ideas. Ideas for example about appropriate means of talking about mental distress, what causes it, what are normal and abnormal expressions of distress and how and who should respond to people who experience it. In order to do this it is necessary to examine the way in which these discourses surface and media as forms of mass public communication are suitable sites. Scrutiny and examination of discursive construction assists in illuminating common sense and taken for granted understandings, allowing for consideration of different ways of thinking about a phenomenon and revealing the operation of power/knowledge in the foregrounding of some understandings over

15

others. Media as forms of mass public communication have an important role to play in meaning making thus warranting their scrutiny in a consideration of discursive construction.

1.7 Outline of the thesis

This chapter has contextualized the study by providing a background to my interest in the area, a justification for undertaking the study and the development of the research question. Chapter two presents an overview of previous research on media representation and portrayal of mental health problems. Chapter three describes and justifies the methodological approach adopted and provides details of how the research was operationalized. Chapter four provides an overview of the context in which the research was undertaken in relation to approaches to mental health and the development of mental health care in Ireland. Chapters five, six, seven and eight present the findings of the study, outlining the various discursive constructions revealed in the portrayal of mental health problems in Irish newspapers. Chapter nine discusses the findings in the context of previous literature and theory relating to discourse and mental health problems and closes the thesis by discussing final conclusions, implications and limitations of the study.

Chapter 2 Media and mental health problems-a literature review

2.1 Introduction

This chapter aims to provide an overview of research relating to the portrayal, representation, depiction and construction of mental health problems[1] in media. Although I have chosen to focus on newspapers articles for this study, I have considered research on various media sources in this review as many different forms of media converge to construct meaning. Literature on media and mental health problems can broadly be seen to answer a number of questions. A major area of research has been concerned with how 'mental illness' is portrayed and represented in various media sources with newspapers, magazines, television, and film being the most prevalently researched, this being termed 'portrayal research' (Stout, Villegas and Jennings 2004). Research in this area has been largely based on review of content and a focus on 'what' is being said, with some more critical studies looking at 'how' it is being said (Olstead 2002). 'Impact' research has been concerned with the impact of media portrayal on the knowledge and beliefs of the public, mostly adult populations with some studies looking at particular groups such as children or college students (Stout, Villegas and Jennings 2004), the dominant concern being the extent to which media coverage contributes to the formation of beliefs and attitudes that stigmatize people who have a mental health problem. Based on the assumption that media messages impact on public attitudes, behaviour and thus stigmatization of those with mental health problems, a further body of research has been concerned with investigating whether public attitudes and knowledge can be improved by targeted information campaigns.

These approaches reveal fundamental differences in understandings of the ontological and epistemological underpinnings of the human world and mental

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[1] I use the term 'mental health problems' generally except where the research referred to uses other terms.

health. Portrayal, depiction and impact research that is concerned with stigma and 'accurate' depictions and manipulation of media messages to improve the perception of mental health problems, locates mental health problems as a reality, and language and media as a reflection of that reality. Another body of research, emanating from social constructionism, positions mental health problems as socially constructed and language and media as constitutive rather than reflective, and therefore implicated in construction of meaning. What gets reported on or represented is understood as a socio-political act with socio-political effects. Whether adopting a realist or constructionist understanding of mental health problems and the social world, both research orientations have something to contribute to an understanding of the relationship between media and mental health problems and this review is concerned not only with the findings of the studies, but with gaining an understanding of the way in which the area has been approached.

Studies of depiction and portrayal of mental health problems have been undertaken in a wide variety of countries (UK, Austria, USA, Canada, Australia, New Zealand, Jamaica, Ireland and Czechoslovakia), across a variety of media sources (newspapers, magazines and film), and genres (news, entertainment, drama and documentary), with some studies focusing on a single media source and others focussing on a variety of sources. Much of the research has tended to be concerned with eliciting the nature of content with reference to positive or negative images of mental health problems, and more recently this has moved to a concern with the extent to which journalists (particularly print news media) adhere to good practice guidelines on reporting issues of mental health and suicide. Studies have mostly been concerned with the explicit content of media with more critical approaches being concerned with the processes that contribute to the generation of media reporting and the underlying discourses revealed in the way mental illness is constructed in media. This review will discuss the literature on media and mental health problems with reference to the extent of media coverage, portrayal in various media sources, the presence of dominant voices, who is

represented in news items, strategies used to depict mental health problems and the impact of media depiction.

2.2 The presence of mental health problems in media

Media coverage of mental health problems is widespread, and research has highlighted the extent of coverage in various media sources. Reported rates of coverage vary, influenced by differences in sampling strategies, media sources researched, societal trends, cultural differences or episodic events. In Ireland studies have identified an average of between 0.65 (O'Connor and Casey 2001) and 1.04 (Meagher *et al*. 1995) articles in newspapers per day pertaining to mental health and illness and an average of 133 per month dealing with suicide (Cullen 2006). In Australia a large-scale national study that investigated non-fiction items in newspapers, television and radio items related to mental health and illness reported an average of 11.9 items per day in newspapers, 3.4 on television and 21.4 on radio (Francis *et al*. 2004). As much as one-third of television programmes in the United States has been found to contain mental illness content (Diefenbach 1997; Wahl and Roth 1982). Wahl and Roth (1982) reported that 1 in every 11 television programmes contained a person with mental illness, the equivalent of 420 shows a year leading the researchers to suggest that there may be one (or more) person with a mental illness being presented for viewers every day of the year. A United Kingdom study of television portrayal identified that 4% of television programmes contained mental illness content (Rose 1998) and a recent analysis of television drama over a three month period indicated that 74 episodes in 34 programme contained metal illness stories with 434 references to mental health (Philo, Henderson and McCracken 2010). Signorielli (1989) reporting on a sample of prime time network drama in the United States covering a period from 1969-1985, concluded that 20% of all prime time programmes made reference consistently to mental illness and 3% of major characters had a mental illness. Particularly high reference has been reported in children's media with one study on Disney animated films identifying that 85% of a sample of Disney animated feature films had verbal references to mental illness (Lawson and Fouts 2004) and a New Zealand study of

children's television finding that 46.1% of programs contained one or more reference to mental illness (Wilson *et al.* 2000).

While research indicates that mental health problems have a significant presence in media another way of judging the presence of mental health problems in media portrayal is by considering proportionality, the relative presence of mental health problems compared to their prevalence in and effects on populations. A study which reviewed reporting of research on mental disorders on the *British Broadcasting Corporation* (BBC) website and in the *New Scientist* magazine concluded that reporting of mental health related research is disproportionate to the disease burden. The study found that cancer research accounted for twice as many items despite mental disorders accounting for 65% more of the Disability Adjusted Life Years (DALYs) (Lewison *et al.* 2012). Even allowing for a comparatively disproportionate presence, given the ubiquity of mental health problems in media sources, it is fair to conclude that media consumers have a large exposure to media content on mental health problems and that this exposure is likely to influence their understanding of mental health problems, the formation of attitudes and influence their behaviour both in relation to their own mental health and others. Also, if we understand mental health problems as constructed in discourse, the extent of media coverage of mental health problems suggests that media is an important part of that social process.

2.3 Portrayal of mental health problems

A large body of research has been concerned with the way in which mental health problems are portrayed in various media sources. A considerable body of research indicates that mental health problems are portrayed in a negative manner in mass media, both in news and entertainment, print and broadcast. Negative portrayal is characterised by an association of mental health problems with violence and aggression, depiction of negative stereotypical images, comic representation, use of pejorative or negative colloquial terms to convey mental health problems,

association of mental health problems with loss of control and lack of self agency and depiction of mental health problems in general terms that does not differentiate between conditions.

Research undertaken by the *Glasgow Media Group* indicates that, both in fiction and non-fiction media, print and television media, depictions of mental illness are overwhelmingly related to harm to others (Philo, McLaughlin and Henderson 1996), with one study identifying as much as 45% of drama programmes portraying people with mental illness as dangerous (Philo, Henderson and McCracken 2010) despite research that suggests that only a small proportion of violent crime is committed by those experiencing mental health problems and that people with mental health problems are more likely to be victims of crime than perpetrators (Stuart 2003). An analysis by Crepaz-Kay (1996) of media reporting of an inquiry into homicides and suicides in England and Wales that indicated a very small minority of homicides are carried out by those who are mentally ill or who have had contact with the mental health services, demonstrated that even when presented with factual information, media reported sensationalised, inaccurate information suggesting that those with mental illness are a great source of danger to the public and should be institutionalised. This is borne out by other studies that have identified that mental illness is frequently portrayed in print and broadcast media as being related to violence, dangerousness and loss of control (Mc Ginty *et al*. 2014; Philo, Henderson and McCracken 2010, Billic and Goergaca 2007; Coverdale, Nairn and Claasen 2002; Nairn, Coverdale and Claasen 2001; Wilson *et al.* 1999a,b; Allen and Nairn 1997; Philo, McLaughlin and Henderson 1996; Signorielli 1989; Wahl and Roth 1982), in an almost exclusively negative light (Nawakova *et al.* 2009; Huang and Priebe 2003; Wilson *et al*. 1999a;b; Scott 1994, Barnes 1993) and conforming to stereotypical images (Scott 1994; Barnes 1993). Mental illness is likely to be mentioned in relation to forensic issues (Coverdale, Nairn and Claasen 2002; Meagher *et al.* 1995; Scott 1994), particularly schizophrenia (Francis *et al*. 2005). One study of network prime time programmes in the United States found that people with mental health problems were portrayed as being nearly ten times more violent

than the general population and 10-20 times more violent than the mentally ill in the US population (Diefenbach 1997).

Nairn, Covedale and Claasen (2001) considered the discursive resources employed in newspaper coverage of the disclosure of a psychiatric patient's health information by a psychiatric nurse (on the grounds that the patient was potentially dangerous and subsequently went on to seriously assault a child) and the subsequent report by the New Zealand Privacy Commissioner. They suggested that mental illness was conveyed by systemic elements, which imply that mental illness is a unitary condition. This suggests to readers that characteristics and behaviours of those specified may be common to all sufferers of mental illness and evoke similar responses. This study was interesting in that the researchers used source materials in the analysis, giving an insight into the process of reporting and the transformation of legal opinion into news. They concluded that while there were no inaccuracies in reporting, the relatively neutral legal document (the Commissioner's report) was transformed into a very negative stigmatizing depiction of mental illness.

Hazelton (1997) explored how messages about mental health and illness, mental health policy, psychiatry and mental health related topics were constructed and conveyed by the Australian print news media. He suggested that of five semantic domains (bizarre and curious, medical scientific marvels, moral tales, disorder crises and risk, lay wisdom and common sense remedies) the domain of disorder, crises and risk theme dominated. This may have reflected the particular timing of the study, which was undertaken in 1994, during which police in Victoria fatally shot a number of people with mental health problems and a period when Australian mental health services were being re-oriented to community care and de-institutionalisation in line with Government policy. News items tended to report on exceptionally unusual incidents involving people with mental illness or reported to have mental illness either as perpetrators or victims, and tended to trivialize private

experiences of psychiatric disturbance and emotional distress. He suggested that a scientific medical discourse was privileged and that crises imagery and alarmist demography were employed, emphasizing the potential for disorder, crises and risk in the institutional versus community care debate.

Other studies have identified that people with mental illness have tended to be represented on television in relation only to their mental illness without reference to other aspects of their lives such as family connections or work (Wahl and Roth 1982). They are also portrayed as being less likely to be employed outside the home and if employed likely to be seen as failures (Signorielli 1989) and to have a negative quality of life and a negative impact on the community (Diefenbach 1997). The use of sensational headlines and pejorative terms has been noted, with what one author termed 'tabloid terminology', using terms such as 'evil psycho' and 'schizo' (Barnes 1993), with tabloid newspapers being more sensational or negative in tone than broadsheets (Nawakova *et al.* 2009; Meagher *et al.* 1995; Scott 1994). Studies on children's television have identified the use of pejorative terms related to mental illness, like 'looney', 'crazy' and 'bonkers' to describe eccentric behaviour or loss of control (Wilson *et al.* 2000; Philo, McLaughlin and Henderson 1996) with characters either being portrayed as comic or evil (Wilson *et al.* 2000). Other research has identified the use of terms such as 'maniac', 'crazed' and 'lunatic' to denote out of control violence towards others in the absence of any indication that the perpetrator had a mental illness (Philo, McLaughlin and Henderson 1996). Olstead (2002, p.629) noted the "ideological polarization" in portrayals of people with mental illness in Canadian newspapers, suggesting that people with a mental illness are constructed as 'Them' and others as 'Us'. This tendency for news media to create polarized groups, where 'we' are associated with what Hartley (1992) terms the 'Wedom' and 'others' are assigned to the 'Theydom', facilitates the media function of creating a sense of belonging for the target community, the readers or viewers. More recent research commissioned by *SHIFT*, a UK Department of Health initiative to combat stigma and discrimination, that considered a three month period of television drama suggested that three themes

dominated in depicting people with mental health problems, 'dangerous outsiders', 'tragic victims' and 'mental illness as a normal feature of human life'. The research suggested that while 45% of television drama was considered 'sympathetic', 63% contained pejorative references to mental health problems (Philo, Henderson and McCracken 2010). Factors predictive of negative portrayal in newspapers have been identified as presence in a tabloid newspaper and reports about psychosis (Nawka *et al.* 2010).

Some research reports what are considered to be 'positive' depictions. A study investigating news print media representation of the de-institutionalization programme in Jamaica identified that all reporting over a 26 month period was positive. The positive position adopted by the newspaper was supported by articles countering fear through expert knowledge (positive views of local medics), appeals to reason (provision of statistics and international trends in de-institutionalization) and through lay scientific education (research findings to show how community treatment is working was provided in a lay-friendly manner) (Whitely and Hickling 2007). A recent study of television news coverage of mental illness in Australia, found that portrayals tended to be neutral or positive and that 'experts' and politicians tended to describe people with mental illness as 'one of us', with 55% of items classified as positive and recovery oriented (Henson *et al.* 2009). Similarly a large scale study that reviewed a sample of non-fiction media across radio, television and newspaper found most coverage to be of good quality (Francis *et al*. 2004).

Although not large in number, relatively small scale and confined in relation to the range of media investigated, Irish studies have tended to report 'positive' depictions. Two studies that evaluated the content and tone of articles in a wide variety of Irish newspapers suggested that most articles (over 68% in both) were positive or neutral tone (O'Connor and Casey 2001; Meagher *et al*. 1995). A study which explored the representation of suicide in Irish print media (Cullen 2006)

examined all Irish newspapers and periodicals over a 12 month period and concluded that most media items relating to research discussed suicide in terms that were primarily incidental or clinical rather than as a broader social issue and that 18% of the articles contravened guidelines on the reporting of suicide in the media. Suicides tended to be reported in relation to depression, bereavement and analysis of trends. Numerous media items failed to adhere to guidelines, 18% of items used the term 'commit suicide' which is considered inappropriate due to connotations of sin and crime. Language used often conveyed a message that suicide was outside the norm and somewhat ridiculous or shameful. The findings suggested that terminology emphasized the 'sadness' of suicide', strong moral judgments were evident, sensationalist language tended to be used, and that some items conveyed a message that suicide is undertaken by selfish people. A study of four Irish contemporary films identified that while the portrayal of psychiatrists was generally "sympathetic and involving" and that portrayals of states of psychological distress was generally unflinching, there was a paucity of portrayals that did not involve dissocial or violent behaviour (Kelly 2006, p.77).

'Positive' depictions warrant careful consideration as they tend to suggest a relatively uncritical, simplistic understanding of portrayal as conveying just one polar message rather than taking into account the complexity of language, images and the interaction of media with society and the consumers. Johnson (2008) notes that in recent years attempts have been made to provide more 'positive' representations of mentally ill people by representing them as 'heroes', 'celebrities' or 'normal everyday people'. For example, he questions the widespread approbation accorded to a United States comedy series, *Monk*, which features a detective who has obsessive convulsive disorder (OCD). This comedy is widely accepted as progressive by advocacy organisations for its progressive depiction of a person with a mental illness. The detective's condition is central to the plot of the program and is presented as assisting rather than inhibiting his work as a detective. The programme is supplemented by online material such as the website which offers 'factual' information on OCD and self-assessment tests for users to assess

their level of OCD, including competitions encouraging website viewers to divulge their 'Monk-ness' or obsessive compulsive behaviour, and the association of the program with branded cleaning products. This is understood by Johnson as encouraging engagement with associated techniques of governmentality through the framing of social and political issues in terms of individual personality and identity. Johnson suggests that the portrayal of the detective in 'Monk' demonstrates how, through 'positive' representations of persons with mental illness which articulate madness as a valuable facet of identity, difference, rather than being excluded, is cultivated as a useful social and economic resource. Johnson (2008, p. 30) suggests that "The new style of public sensibility toward the mad draws on the discursive resources of other social movements associated with identity politics, speaking the language of "diversity", "anti-discrimination", "equality", "liberation" and even civil "rights"". Johnson suggests that 'positive' representations be considered cautiously as they mediate "contemporary conceptions of identity by positively framing the cultivated desires for individualizing diagnoses and therapeutic management" (p.31). These serve to extend and legitimize control practices by "celebrating therapeutic modes of cultivating and understanding identity" (Johnson 2008, p.31). Evoking Foucault's caution against viewing de-institutionalization and the move from the criminalization of madness to medicalization as being the result of progressive politics, Johnson cautions against viewing contemporary anti-stigma trends as an indication that there is a move towards freedom from discrimination and social control. The integration and acceptance of 'madness' as a useful characteristic and a facet of identity serves to further reinforce the medicalization of existence. While ostensibly presenting such representations as positive and progressive and serving a de-stigmatisation agenda, discourses of surface liberalism mask discursive practices that reinforce dominant biomedical ideologies.

Literature that suggests more positive depiction of mental health problems in media have tended to equate good quality reporting with a judgement of the 'accuracy' of information portrayed (for example Pirkis *et al*. 2008; Francis *et al*.

26

2005) and the use of 'expert' opinion as a positive contribution to accuracy. When media items focus on causation and treatment of mental illness in what are ostensibly well meaning attempts to portray 'reality', biomedical discourses are privileged. Some studies have equated 'inaccuracy' with references to social causative factors alone and not 'comprehensive bio-psycho-social' causative factors and reference to 'alternative' or herbal remedies not tested by research (Francis *et al*. 2005). Positive portrayal of Electro Convulsive Therapy being equated in one study with accuracy and reason (Kellner 2008). Numerous studies identify the dominance of biomedical discourses (Lewison *et al.* 2012; Bilic and Georgaca 2007; Hazelton 1997) and that this has increased over time (Clarke and Gawley 2009). A recent study which reviewed reporting of research on mental disorders on the *British Broadcasting Corporation* (BBC) website and in the *New Scientist* magazine concluded that content that related to mental disorders placed an emphasis on biological research, brain function, genetics, physical environment causes, pharmacological and biological treatments and interaction between mental and physical disorders, with both sources rarely reporting on psychological interventions. The study suggested that some disorders were over represented such as Alzheimer's disease, addiction and sleep disorders when compared with disorders that are more prevalent and carry a higher disease burden such as depression. The authors concluded that mental disorder is represented as essentially neurobiological in origin (Lewison *et al.* 2012).

Conrad (2001) suggests that the presentation of scientific information, linking genetics and mental illness, in news print media has tended to be framed by 'genetic optimism'. Journalists tended to overstate positive results from research literature and understate research that either provides negative or disconfirmation of previous findings. While this study found that the scientific accuracy of stories relating genetics factors with causation of mental illness was generally good, Conrad concluded that the 'genetic optimism frame' distorted the meaning of some of the findings, over-representing the importance of genes in the causation of mental illness. When interviewed for this study journalists identified this as

problematic but pointed towards editorial pressures to have sensational, or eye catching bylines, which negative stories or stories that did not confirm previous results failed to satisfy. They also identified that if the original story was overplayed, this made it more difficult to report contradictory findings. 'Definitiveness' is viewed as an important component of news stories, and therefore reporting of the "vicissitudes of science" (Conrad 2001, p.238) is incompatible with this requirement.

As a response to research that indicates negative depiction and based on an understanding of media reporting of mental health problems as impacting on societal attitudes and contributing to stigmatizing attitudes and in part in response to a concern about contagion in relation to suicide and self-harm, codes of practice in the form of media guidelines to journalists and for media generally have proliferated in the 1990s and 2000s, (for example Department of Health, Australia and Hunter Institute of Mental Health 2014; Ministry of Health, New Zealand 1999; Schizophrenia Ireland 1999; Bodywhys no date, Irish Association of Suicidology and Samaritans no date). Their publication has been accompanied in some countries by the establishment of media watch agencies that monitor and intervene when breaches of guidelines are identified, for example the SANE *Stigma Watch Campaign* in Australia and the *Headline Media Monitoring* Programme in Ireland. A large scale government funded project in Australia that compared media (newspaper, television and radio) coverage of suicide and mental illness before and after the introduction of *Reporting on Suicide and Mental Illness* (a campaign and resource to provide guidance to media professionals reporting in these areas) found that the quality of reporting improved after the introduction of the guidelines (Pirkis *et al.* 2008). The guidelines emphasize the importance of what they defined as 'appropriate' use of language relating to suicide, non-prominent placement, avoidance of use of photographs of the location or person and mention of the method of suicide.

The use of such guidelines as a benchmark for good practice in relation to depiction and portrayal of mental illness in media is problematic. The rationale underpinning attempts to improve media reporting about mental health problems is centred on alleviation of stigma through 'positive' or 'realistic' representations. Guidelines frequently emphasize the importance of providing 'factual' information derived from 'expert' sources, mainly psychiatrists and mental health professionals, which support a biomedical understanding of mental illness (Holland *et al* 2008). The problematic nature of equating particular frames as 'positive' or 'negative' is exemplified in a recent study which produced an instrument to assess mental illness stigma in print media, *Picture of Mental Illness in Newspapers* (PICMIN) (Rukavina *et al.* 2012). The instrument was developed based on a search of print news media that grouped terms as either neutral or labelling and headlines and content as either de-stigmatizing, neutral or stigmatizing. Aside from the difficulty with adopting an understanding of stigmatization as a unilateral phenomenon generated by use of terminology, rather than as a complex, social process (Holland 2012), from a social constructionist perspective no language is considered neutral as it conveys particular meaning. This is evident in the description of one of the criteria in the PICMIN tool in the de-stigmatizing category which is described as "Headings about stories on individuals who have overcome *mental illness* (including celebrities *confessing* the have *mental illness*)" (my emphasis). De-stigmatization is equated with an understanding of mental health problems as *'illnesses'* and the notion of someone *'confessing'* produces connotations of sin, shame and criminality. Another example can be found in a *Guide for Journalists and Broadcasters Reporting on Schizophrenia* published by *Schizophrenia Ireland* which stresses the importance of 'accurate' reporting and states that:

> "Schizophrenia is a serious mental disorder which interferes with a person's ability to recognise what is real, manage his/her emotions, think clearly, make judgments and communicate. Schizophrenia is usually described as a psychotic illness (1999, p.2).

These assertions, which define 'good' and 'positive' practice and reporting, produce particular understandings of mental health problems as illnesses that are contested.

Depictions that could be viewed as negative and stigmatizing, by the use of pejorative terminology for example, may on the other hand represent more liberating understandings. Holland *et al.* (2009) identified elements in newspaper coverage that would not comply with good practice guidelines, such as the use of pejorative and colloquial terminology, but that nevertheless challenged dominant understandings of mental illness. They concluded that though this portrayal was more supportive of a view of people as having self-determination, using language of those activists who declare that they have 'reclaimed' the language of 'madness, it would be counted as negative in research that used adherence to guidelines as a benchmark of good quality reporting. Guidelines themselves are discursive. Helpful as they are in addressing some of the more obvious issues in relation to the portrayal of mental health problems in media, adherence to guidelines is simply just that, adherence to guidelines[2]. Research that equates this with positive portrayal misses the point of the centrality of discourse and language and its role in constructing meaning. Anti-stigma campaigns and studies concerned with stigmatizing portrayals that focus on the use of derogatory language and the inappropriate use of psychiatric terminology, demonstrate "a form of linguistic essentialism" locating the problem with the use of the terminology rather than with psychiatry's colonization of everyday life with the use of diagnostic language (Holland 2012, p.224). Holland (2012) suggests that efforts to de-stigmatize mental health problems, more urgently deployed in recent times given the increasing capacity for psychiatry to diagnose increasing numbers of people, focus on stigma as a problem residing in the failure of knowledge and acceptance in society rather

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[2] The contingent and contextual nature of 'positive depictions' is exemplified in commentary by an organization concerned with media images of nurses, The Truth About Nursing (http://www.truthaboutnursing.org) which reports on media coverage of nursing. The US series 'Nurse Jackie' is generally reviewed as delivering 'positive' and 'realistic' depictions of nurses as peers of doctors and autonomous practitioners, with the protagonist 'Nurse Jackie' being applauded for her unconventional *'clinical virtuosity'* ignoring details of her actions such as stealing drugs, having sex with the pharmacist while on duty so she can get drugs, and flushing the severed ear of a rapist down the toilet.

than deconstructing psychopathology. Anti-stigma campaigns that focus on improving the knowledge of the community about the 'true' nature of mental health problems, obscure psychiatry as part of the problem (Bracken and Thomas 2005) and as such can function as effective disciplinary techniques, more pervasive because of their perceived innocuousness (Johnson 2008). While the elicitation of 'positive', 'negative', 'accurate' and 'inaccurate' portrayal has been a central theme of research in the area, another concern has been the presence or absence of particular voices.

2.4 Dominant voices

The affiliation or position of those who contribute to or produce media is an important component of discourse. Some studies have identified the dominance of particular groups in media items that represent 'truth' about mental health problems in levels of 'expert' opinion sought or items written either by or from the perspective of 'experts'. Some research has characterised 'expert' involvement as a contribution to the veracity or authenticity of the information contained in the media item. Relatively low levels of 'expert' involvement have been noted in some studies (Scott 1994), with only 5.5% of articles authored by mental health professionals and 26.8% seeking the opinion of a mental health professional in an Irish study of newspaper portrayal (Meagher *et al.* 1995). Articles in which psychiatric opinion was sought in this study were reported to be significantly less likely to be sensational and more likely to be supportive in tone. A later Irish study found higher levels of articles written by mental health professionals (12.5%) (O'Connor and Casey 2001) and nearly half (46%) of articles sought the opinion of mental health professionals, although this study identified that psychiatrists were less likely to write items than other mental health professionals. The authors of these two studies identified the low numbers of psychiatrists writing media articles as an issue for concern, the latter pointing to the "erroneous portrayal of psychiatrists as applying an exclusively 'medical' model" (O'Connor and Casey 2001, p.71). This study was undertaken in 1999 a time when internationally and in Ireland the advocacy and service user agenda was gaining recognition with people who had

experienced mental health problems being defined as 'experts by experience' in some discourses. This, however, is not reflected in the study as there was no consideration of people with mental health problems in the analysis framework used for the study. The only people who were considered as being possible authors of news items were journalists and health professionals. The category 'opinion of mental health professionals sought' excluded anyone else as having a legitimate opinion, particularly those who have experience of mental health problems like sufferers or relatives. Those defined as 'experts' form part of discourse.

Hazelton (1997) suggests, in his study of Australian newspapers, that scientific knowledge is glorified. Other research, on the depiction of depression in Australian newspapers, found that though there was a pre-dominance of 'expert' voices that while both biomedical and psychosocial explanations for causation were present, both place the agency outside that of the person, rendering them powerless (Rowe *et al.* 2003). A study of a CNN special investigation programme focussing on mental illness concluded that "The show simultaneously reflects and reinforces the existing cultural model for mental illness as a biological disease amenable to, above all, pharmacological therapy" (Glick and Applbaum 2010, p.242). This prevailing biomedicalization with a growing presence of psychosocial understandings of mental health problems, reflects the trends in western society in how mental illness is viewed though Rowe *et al.* (2003, p.693) note that "Those with a stake in maintaining the dominance of the biomedical discourse occasionally make concessions to alternative positions, in order to sustain that position of dominance". This is evident in the widespread acceptance of the 'multi-disciplinary team', which purports to offer care from a bio-psycho-social perspective but which is led and controlled by the psychiatrist, legitimized by mental health legislation.

Reflecting a general orientation towards acknowledging the importance of the lived experience of people who have or have had a mental health problem, some research has been concerned with whether people with mental health problems

have contributed to or written media items. Coverdale, Nairn and Claasen (2002) identified that in only 4.8% of newsprint items in New Zealand people with mental illness were 'given voice' or quoted. More recent research has identified elements of 'talking back', where news stories reflecting a 'post-psychiatry' position were identified and in which ownership of mental illness and its associated terminology was apparent, including stories which challenged the medicalisation of mental illness and challenged those stigmatising practices and attitudes through the use of humour and drama (Holland *et al* 2009). However, other research suggests that even when people with mental health problems contribute to or author a media item their view is supportive of expertise and is likely to be qualified by a health professional (Rowe *et al* 2003). Such reports tend to be descriptive rather than explanatory (Coverdale, Nairn and Claasen 2002) and it is more likely that a middle class person will get to speak (Olstead 2002). Hallam (2002), investigating how media reports of two tragedies involving people with schizophrenia were reported on in newspapers, suggests that many of the reports were heavily influenced by campaigners for better care and attention for people with mental illness and demonstrated how this contributed to an unbalanced policy debate around care provision.

2.5 Strategies adopted to depict mental health problems

Some research has gone beyond portrayal and depiction and sought to investigate the processes involved in media production and the effect this has on how mental health problems are portrayed. The communication source defines and constructs an issue, deciding which elements to include, to emphasize and what words to use (Schmitz, Filippone and Endelman 2003). News framing is a "dynamic cultural process that reflects decisions made by journalists, editors and broadcast news producers about what is newsworthy" (Blood and Holland 2004, p.325). This process has obvious implications for the reader's understanding of the issue and the formation of opinions, attitudes and behaviour in this regard but also for how meaning is constructed about particular phenomena.

Henderson (2007, 1996) considered factors which influence media representations of mental illness in television production processes of 'non news' programming (soap operas, comedy, drama and documentary) in the UK by interviewing a range of production staff. She argues that television representations of mental illness are the result of a complex process of negotiation among the production team which is concerned not necessarily with 'accurate' depictions of mental illness but with pressure to achieve high audience ratings (Henderson 1996, p.18). Even with a television programmes such as *Brookside* which attempted to reflect demographics and to realistically portray social issues, the message needed to be packaged to appeal to audiences. In general production team members perceived that their aim was to entertain rather than to educate and that adhering too rigidly to the facts and figures brought programme too close to public education, which may be perceived by audiences as 'lecturing' rather than' entertaining' (Henderson 1996, p.19). So while ostensibly one soap opera could be seen to be more socially responsible in aiming to air current social issues, these were framed by the necessity of entertainment. How particular issues were dealt with was also perceived as being influenced by the requirement to set the narrative at a sufficiently quick pace to hold the interest of the audience. For issues like mental health problems, this requirement for narrative pace is at odds with the reality of some mental health problems (Henderson, 1996, p.21) and she suggests that decisions concerning character and storyline development are driven by audience preferences, concerns around entertainment value, assumptions about audience needs and the need for 'dramatic' storylines rather than any concern regarding responsible or realistic reporting of mental illness (Henderson 2007). This might suggest that while fictional programmes privilege entertainment over realism, non-fictional documentary type programmes present a more realistic 'truth'. On the basis of interviews with producers of documentary television that covered mental illness issues, Henderson (1996) suggests that what was portrayed was influenced by access to people who had experienced mental illness and the control that medical staff exerted in allowing access to them. Medical staff were seen by

producers to be acutely aware of their responsibilities with regards to allowing access to interviewing and filming mentally ill patients, due to concerns about informed consent and subsequent stigma associated with disclosure, positioning them as 'gatekeepers'

Cross (2004) suggests that the growth in populist television, which gives more voice to marginalised groups and the move to community care for people with mental illness has provided the public with more and differentiated access to representations of mental health problems in so much as people who suffer mental illness are given voice, and thus shown. This, he argues, calls for a consideration of the 'visual' images of madness that viewers are presented with. In examining differences in representations of mental illness across a range of TV current affairs formats and the ways they mediate visual representations of mental illness, Cross identified images used in documentary television that reflect images in art that depict mental illness, like wild unkempt hair, bloodshot staring eyes, unpredictable outpourings and utterances, that provide visual images of madness and construct people with mental illness as 'different' to us. "These are stereotypical conceptions that make it clear how madness is seen: as visible differences of appearance and behavior that demarcate a symbolic boundary between "us" and "them"" (Cross 2004, p. 199). Cross asserts that contemporary images of madness are routed in past images and that images of madness as difference remain remarkably constant. He argues that visual techniques employed in documentary programmes construct people with schizophrenia as dangerous to others and in need of coercive management with the default form of treatment notably medication. Others provide more ambiguous images that present people with mental illness as being 'like us', engaging in similar pursuits and possessing the same feelings and needs. With the growth of community care and the decline segregation of the mentally ill, it is more difficult to recognize 'the mentally ill' thus causing concern and fear (Cross 2010; 2004). Visual and other depictions of symptoms and behaviour patterns can also act in a self-fulfilling way, so that people with a mental illness

identify with the depiction and act accordingly. Some suggest this can have a positive effect in relation to help-seeking (Schmitz, Fillippone and Edelman 2003).

In a study of television portrayal of mental illness in prime time television in the United Kingdom Rose (1998) suggested that people portrayed as having mental illness were filmed differently than those who were portrayed as not having a mental illness. Close up shots were used for those who were mentally ill and they were more often shot alone, signifying isolation from others. Other studies have identified techniques or strategies used in media to convey a particular message. Glick and Applbaum (2010) undertook an analysis of an episode of a CNN 'Special Investigations Unit' aired in 2007 in the United States that focused on crime prevention and mental illness. They suggested that the way in which information was presented in the programme, the timing of quotes from people with mental illness who had committed crimes and how these were structured in relation to the commentary by the presenter, demonstrated a semiotic technique 'poetic parallelism' which reverses normal emphasis in language by allowing what comes later in a text to influence earlier material. Sentences spoken by a person with a mental illness who had committed a crime were presented out of context which served to reinforce stereotypical understandings of mental illness. This pattern has the potential to influence viewers' interpretation in an unconscious way. The authors conclude that the narrative development of the program depicts the mentally ill as victims of an inadequate health system that fails them by failing to ensure that they comply with treatment, resulting in them harming others in the community through acts of violence. This creates the implicit impression that the solution to violence by the mentally ill is adherence to pharmacological treatments. Other research has identified that even in supposedly 'factual' media sources like newspapers, reporting of suicide does not reflect national statistics and that suicides by certain groups, and by certain methods are over represented in coverage (Niederkrotenthaler *et al*. 2009).

Allen and Nairn (1997), in a study of a 'factual', 'educative' style series of articles in an Auckland newspaper, identified a journalistic strategy that led reader to draw on the commonsense understanding that those with a mental illness are dangerous. They suggest that this journalistic strategy is employed, in the use of stories about people with mental illness, to engage the reader to become a co-creator of meaning of the text, to lead them to draw on their existing stereotypes of dangerousness and validate them, thus making them more committed to the constructed understanding. Nairn, Coverdale and Claasen (2006) suggest that intertextuality[3] is used to ignore the finding that there is no increase in homicides by persons with a mental illness as a consequence of de-institutionalization, and to suggest that the promotion of patients' rights poses a public safety threat. Such research has contributed to an understanding of the influence media production processes have on the meanings produced about mental health problems. Another large area of research has centred on the perceived impact media depictions have on consumers' attitudes, opinions and behaviour.

2.6 The impact of media depictions

People affected by mental health problems have good reason to be concerned about the way in which societal attitudes might be influenced by media as this has potential to affect their interaction with others and the way in which they are treated in society. A major area of research has been concerned with the consequences of media depictions and has focused on the impact such depictions have on the attitudes of the public towards people with mental health problems, a logic that has driven some mental health awareness campaigns that have attempted to present 'positive' messages in media in the hope of affecting attitudes and help seeking behavior. Some of the debate in reception studies has centred on tension between theories that emphasize the capacity of audiences to actively interpret and process media messages therefore not be overly influenced by

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[3]Intertextuality - the accumulation of meaning across different texts, where one image makes reference to another or has its meaning altered by or is dependent on being understood in the context of another (Hall 1997)

negative images and those theories that support the belief that the media creates audience beliefs (Miller and Philo 2001). Social representation theory provides a theoretical framework for how we understand the world and Moscovici (1963) describes two key processes, anchoring and objectification through which members of a social group come to understand a new phenomenon 'Anchoring' refers to how individuals identify characteristics of the phenomena that are familiar, ground the new phenomena within already familiar terms and representations. 'Objectification' refers to how abstract concepts translate into concrete images integrating the perceived essence of a phenomenon into the common knowledge of the social group (Moscovici 1963, p.251). The pervasiveness of media as a source of information is accepted in contemporary society and Hartley suggests that electronic and print media perform an important socio-cultural function as societies become more complex:

> In modern, complex, fragmented societies no one can hope to know the other members of their community directly. The only real contact with others is, paradoxically, symbolic, and rendered in the form of stories, both factual and fictional, in electronic and print media (Hartley 1996, p.207).

According to this theory, the portrayal of people with mental health problems as being violent, comical and vulnerable potentially contributes to public understanding by making associations between the phenomena that are accepted as 'real' (a basis for anchoring) and then generalised (objectification).

Much of the research in this area has been underpinned by 'cultivation theory' developed by Gerbner and Gross in the late 1960s (Bryant and Mirion 2004). Cultivation theory takes account of the ubiquity of television and media and proposes that the more exposure an individual has to a media source the more they are likely to hold views and opinions based on the version of social reality portrayed in the media source. Through research that investigated the content of television programmes Gerbner points to the highly selective nature of what is represented as reality, in relation to for example, age profile, social class and ethnicity, as well as factors such as the level of violence in society (Gerbner *et al* 1986). Television

provides a particular version of reality different, according to research in this tradition, to the 'real' reality. Cultivation analysis investigates the opinions and views held by consumers of media in relation to factors such as perceptions of violence in society and the motivation of others, purporting an association between these and levels of television exposure.

For example, studies have demonstrated an association between high levels of television viewing with negative views of individuals with mental health problems (Granello and Pauley 2000, Gerbner *et al* 1986). A large scale project in Germany suggested that the desire for social distance from people with schizophrenia increased continually with the amount of television consumption (Angeryer *et al*. 2005). This study also suggested, in relation to newspapers, that regular readers of tabloids or regional newspapers expressed a higher desire for social distance than those who read broadsheets. Similarly Diefenbach and West (2007) suggest that as television viewing increases so do beliefs that locating mental health services in residential neighbourhoods will endanger the residents. Providing information in the form of a documentary about schizophrenia has been shown to result in more benign attitudes although not in relation to perceived dangerousness (Penn, Chamberlin and Mueser 2003). Granelllo and Pauley (2000) identified significant and positive associations between television consumption and intolerance of mental illness. A study that reported on student attitudes and desire for social distance, found that the group who had read an article linking mentally ill people with violent crime displayed an increased likelihood to describe a mentally ill person as dangerous and violent than those who had read a more informative article which used violence associated terms less frequently (Dietrich *et al*. 2006). Vogel, Gentile and Kaplan (2008) found a positive correlation between television consumption and perceptions of stigma in relation to mental illness, which negatively predicted public attitudes towards seeking professional mental health services. Investigating public attitudes towards the criminally insane Steadman and Cocozza (1977) suggest that when asked to recall media stories about people who were criminally insane, the public mentioned stories about offenders who did not

fall into any of the legal categories for criminal insanity, indicating a tendency towards conflation of criminality and dangerousness with mental health problems. Particular types of media have been suggested to be more influential than others in affecting public attitudes. Individuals who indicated that their primary source of information about mental illness was electronic (television, movies and videos) held more authoritarian attitudes and were more in favour of social restrictiveness than those whose information came from other sources (Granello, Pauley and Carmichael 1999).

Importantly the World Health Organisation (WHO 2000) reports research that suggests that some forms of media coverage of suicide are significantly associated with an increase in rates of suicide particularly among young people. A study of suicide rates in the United States over the period 1948-1983, comparing them with media coverage of celebrity suicide, suggested a correlation between the amount of publicity given to these suicides and the rates of suicide, with the greater publicity being associated with increasing rates (Stack 1987). Also important is the suggested impact of media reporting on the formation of social policy. Patterson (2006), in an analysis of reporting of two murders carried out by individuals who were mentally ill, suggests that the way in which newspapers represent mental illness, through reporting of such events, can have an impact on social policy by apportioning blame to the mental health and social care system, thus influencing public opinion and consequently political action. This is particularly important when one considers the centrality of social policy and public influence to the allocation of public funds and the protection of individual rights. In general research suggests that 'negative' media coverage contributes to 'negative 'attitudes towards people with mental health problems (Mogan and Jorm 2009; Thornton and Wahl 1996).

Notwithstanding debates on the complexity of attitude formation, at the most manifest level, given the pervasiveness of media and the widespread coverage of

issues pertinent to mental health it is reasonable to assume that media plays a part in social understandings. A report on public attitudes towards mental illness in the USA found that for a majority of respondents, television and news programs (87%), newspapers (76%), radio news (75%) and magazines (74%) were a source of information on mental illness (Daniel Yanklovich Group Inc. 1990) with other studies reporting similar findings (Dietrich *et al*. 2006; Angeryer *et al*. 2005; Penn, Chamberlin and Mueser 2003; Granello, Pauley and Carmichael 1999; Thornton and Wahl 1996). Considering the relative influence of various forms of textual communication, attitudes displayed by the general public towards mental health problems and people who experience them are unlikely to be influenced by research published in academic journals or the relatively low proliferation of informative publications produced by special interest groups; it is much more likely that attitudes are influenced by popular media which is readily available and accessible and to which they are exposed daily (Wahl 1998).

However other factors are implicated in attitude formation such as various elements of personal experience. Familiarity with mental health problems has been shown to result in more positive attitudes. Various types of prejudicial attitudes (for example authoritarianism, the belief that a paternalistic mental health care system should make decisions for people with mental health problems and benevolence, the belief that mentally ill people are child-like and innocent) lead to discriminatory behaviours (desire for social distance) and are influenced by familiarity with mental illness (Corrigan *et al*. 2001). Brockleman, Chadsey and Loeb (2006) undertook research that suggests having a friend or student with mental illness was predictive of positive perceptions of students with mental illness among faculty members. The more familiarity a person has with mental health problems, either through becoming informed through media sources or by knowing someone with mental illness, the less likely they are to hold prejudicial beliefs and therefore behave negatively towards people with mental health problems. Cultivation theory stems from research in a positivist tradition that presumes on one hand the existence of a stable reality and on the other the possibility of

41

accurately measuring attitude and opinion. Research from a social constructionist
position involves a wider consideration of consequences as related to the
relationship between the creation of knowledge and the distribution of power and
the likely impact that has on the individuals and groups concerned.

2.7 Summary

Portrayal of mental health problems is widespread across media sources and
research in the area emanates from a variety of perspectives. Although analysis of
discourse is the specific aim of only some specific research activity, a consideration
of assumptions underpinning other types of research contributes to an
understanding of how mental health problems and media are positioned in society.
Media form an important part of the way in which certain 'truths' are constructed
about mental health problems and is frequently cited as a source of information for
the public. A major area of research has been concerned with the manner in which
mental health problems have been portrayed and depicted in various media sources
and suggests that portrayal of mental health problems is largely found to be
negative, that mental health problems are associated with violence, that people
who experience mental health problems are portrayed by negative stereotypical
images and in comic representations, that pejorative, negative colloquial terms are
used and that mental health problems are associated with loss of agency and that
general depictions are utilised that do not differentiate types of mental health
problems. Research that has identified pejorative and stigmatising representation
has informed the development of good practice guidelines for journalists and media
professionals, resulting in the emergence of a body of research that focusses on
adherence to guidelines. Such research is predicated on the assumption of a
straightforward relationship between attitude formation, stigmatising behaviour
and negative media portrayal and is justified by research that indicates correlations
between consumption of particular media and negative attitudes towards people
with mental health problems. This research has centred on the identification of
'positive' and 'negative', 'accurate' and 'inaccurate' depictions frequently enlisting
biomedical and expert discourses in defining what is constituted as 'positive' and

'accurate ' depiction. However what is constituted as 'positive' or 'accurate' depiction forms part of discourse and reinforces particular discourses. A focus on the 'accuracy' of depiction contributes to a realist understanding of mental health problems as existing independently of social discourse. Another body of research has specifically considered media as a discursive site and has identified that mental health problems are frequently conflated with risk, criminality, violence, lack of personal agency and biomedical understandings by media processes. Such research offers insight into the formation of knowledge and the operation of power in the ways in which mental health problems are positioned in media and society. The next chapter provides details of and a rationale for the selection of the methodological approach and details of how the research was conducted.

Chapter 3 Methodology and method

3.1 Introduction

This study is informed by social theory and underpinned by a social constructionist approach, enlisting a Foucauldian understanding of discourse. Foucault suggested that power relations are produced in the way in which subjects are located in discourse as natural, inevitable, logical and thus normalized. Problematizing such ideas is at the core of deconstructing the social practice of creating meaning. Cheek (2004) emphasizes the importance of understanding that, in 'doing' discourse analysis and in making explicit the researcher's understanding of discourse and discourse analysis, which supports the scholarship and integrity of the research, the researcher is excluding other understandings of discourse and discourse analysis. Therefore I am exploring "one possibility" for understanding discourse and discourse analysis (Cheek 2004, p.1142). This chapter describes the approach and its ontological and epistemological foundations and outlines the rationale for the selection of discourse analysis. The Foucauldian approach to discourse analysis is described and the key Foucauldian concepts of genealogy, power/knowledge, discursive practice and governmentality are explained and their relevance to this study considered. I then describe the research design and method adopted.

3.2 Philosophical underpinnings

Research approaches are underpinned by assumptions about the nature of existence, what can be known, ontology, and the nature of knowledge, epistemology, how it can be known. Research approaches can be differentiated by locating them as either qualitative or quantitative. The quantitative paradigm, associated with the natural word and underpinned by a positivist understanding of the world as being capable of being known objectively and making claims for the establishment of causal relationships, predictions and generalizability. The qualitative paradigm, associated with the social world is underpinned by understandings that emphasize subjectivity, personal experience and the existence of multiple realities (Taylor 2001). Another way of differentiating world views is by

locating them as modernist or post-modernist. The modernist world view which favours science, truth, progress and grand narratives which are rejected by post-modernism which emphasizes plurality and multiple realities. The terms post-structuralist and post-modernist are frequently used interchangeably to refer to intellectual propositions that shape research approaches that privilege no single method or paradigm (Cheek 2000, Denzin and Lincoln 1994). Post-structuralism emerged as a response to structuralism. Structuralism emphasized the importance of the scientific scrutiny of structure and relationship between elements in understanding the world. Post-structuralism challenges the notion of structure and fixed principles and emphasizes the importance of deconstructing not only the subject but also the knowledge systems used to understand the subject (Alvesson 2002). While both post-modernist and post-modern thought unite in valuing "plurality, fragmentation and multi-vocality" (Cheek 2000, p.6) post-structuralism is more often enlisted when discussing epistemology and method and is concerned with the exploration of representation of reality in texts (Cheek 2000), while post-modernism is concerned with wider cultural and social issues (Alvesson 2002).

Research undertaken from post-modernist and post-structuralist perspectives is underpinned by a number of assumptions. Central to post-modernism and post-structuralism is the notion that there is no one single 'reality' but that multiple realities exist, that 'the truth' not only cannot be captured in research, but that it does not in fact exist. Discourse is central and language is viewed as constitutive so that 'natural' objects are understood as discursively produced. Grand narratives and theoretical frameworks that purport to provide overarching explanations for phenomena are viewed suspiciously in favour of multiple voices and realities. Power and knowledge are linked inextricably and knowledge is not viewed as innocent or neutral (Alvesson 2002). This study, attempting as it does to understand how mental health problems are constructed in news print media is a study of text and as such is located in a post-structualist paradigm of constructionism

3.2.1 Constructionism

Constructionism is defined as:

> A theoretical orientation emphasizing that we do not have any direct access to an objective, independent reality but by trying to describe it we create a particular version of it. 'Reality' is always filtered through the perspective taken and the language used (Alvesson 2002 p.178).

Social constructionism is an approach which questions any notion of objective or essential 'truth' and asserts that 'truth' should be considered as the product of power relations, acting in someone's interest and never neutral (Lupton 2003; 1994). All knowledge is viewed as a product of social relations. Epistemological claims made in this tradition consider that knowledge generated by research is partial, situated and relative (Taylor 2001). Knowledge is viewed as a product of social relations and as such subject to change. The emphasis is on subjectivity as a process, the individual is produced discursively rather than understood definitively. This approach is underpinned by the notion that there is no 'true' reality that exists that can be described, understood or captured but that multiple 'realities' exist and that they are constructed by discourses that "constitute them in specific contexts according to particular relations of power" (Hall 1997, p.185). While not new in sociological theory, social constructionism has only relatively recently been applied to analyze concepts of health and illness and the way in which they are produced in social relations and the social influences on the production of scientific knowledge in the field (Lupton, 2003).

While social constructionism as an approach can be applied to any field of health, it is perhaps in mental health that it has particular significance. Lupton (2003, p.12) states that:

> The social constructionist approach does not necessarily call into question the reality of disease or illness states or bodily experiences. It merely emphasizes that these states and experiences are known and interpreted via social activity and therefore should be examined using cultural and social analysis.

In the case of physical illnesses, while their understanding in the social world is frequently questioned by social theorists, their existence as illnesses is rarely if ever questioned. Whereas in the field of mental health, the existence of 'mental illness' has been questioned by people such as Thomas Szasz, R.D. Laing and others, who problemtatize the medicalization of human distress. Problematizing mental health problems does not mean denying the existence of the phenomenon of mental distress, it seeks to examine the way it is manifest and understood in the social world and the forces that influence this. Foucault (2001, p.171) said that:

> ...some people have interpreted [my] analysis as a form of 'historical idealism', but I think such an analysis is completely different. For when I say that I am studying the 'problematization' of madness, crime or sexuality, it is not a way of denying the reality of such phenomena. On the contrary, I have tried to show that it was precisely some real[ity] existent in the world which was the target of social regulation at a given moment. A given problematization is not an effect or consequence of a historical context or situation, but is an answer given by definite individuals. You can only understand why this kind of answer appears as a reply to some concrete and specific aspect of the world.

These and other emergent discourses problemtatize biomedical colonization and the domination of what we have come to know as 'mental health', and the production of the 'mentally ill' person as a social process.

Language is central to social interaction, so social constructionist research is concerned with language. The positivist or 'realist' view of language is that it represents reality (Potter and Wetherell 1987). Language from this perspective is neutral in that it does nothing to influence or shape that which it describes it simply reflects it. From a constructionist view language is far from neutral, it conveys a particular view, language 'constructs' reality, it shapes the event or phenomena that it describes. Language is not understood as being representational, as transporting meaning or as a mirror of reality, but as constructive. The traces of social relations are found in a wide variety of places, in conversations, in official documents, in literature, in art, in drama and increasingly in mass media. Film, television, print and social media are all important sites for topics to be spoken and

written about and thus provide texts which can be examined. The social constructionist perspective suggests that media not only reflects social reality but plays a part in actively constructing it. Text is not simply a 'reporting of facts' which can be viewed as 'truthful' or 'real', rather it is a 'construction' which chooses to use one word or words over others to convey a message, and in doing so constructs 'a' reality or realities rather than 'the' reality.

3.2.2 Discourse analysis

Discourse analysis refers to a broad range of research approaches, from a variety of disciplines (psychology, sociology, linguistics, anthropology, literary studies, media and communication studies and philosophy) that are concerned with the study of 'discourse' in a variety of forms (Potter and Wetherell 1987). Discourse theory integrates insights from linguistics and hermeneutics with those from social and political science in an understanding of language as both being influenced by and influencing political action (Torfing 2005, p.5). Discourse theory can be understood in the context of particular definitions and understandings of discourse. There is no definitive or unifying definition, the particular orientation of a discourse analysis approach is dependent on the understanding of 'discourse' adopted by the researcher in relation to the research question. Taylor (2001) suggests that the differing approaches to discourse analysis can be described in four main areas, research that adopts: a focus primarily on the language itself, its regularities and variability (for example semiotics); a focus on language in use and in interaction (for example conversation analysis); a focus on the language related to a particular topic or activity (for example relating to a particular occupation or group of people); and a fourth approach, the study of language and related practices in the constitution of aspects of society and people in it. This study is located in the fourth of those approaches as it is concerned with wider social context in which meaning is produced relating to mental health problems. Central to discourse analysis is the particular definition of discourse adopted. Parker (1992, p.6) defines discourse as "a system of statements which constructs an object". In Foucauldian Discourse Analysis: "Discourse is defined as an empirical collection of practices" that

include…"all kinds of linguistically mediated practices in terms of speech, writing, images and gestures that social actors draw upon in their production and interpretation of meaning" (Torfing 2005, p.7).

Fundamental to this approach to discourse analysis is a focus on the analysis of power in social relations (Lupton 1992). Discourse analysis investigates the construction and function of discourses, the way in which discourses are constructed, the consequences of the particular construction and what is gained by it (Potter and Wetherell 1987). Discourse analysis sets out to reveal the 'taken for granted', the knowledge underlying ways of talking and analyses the way this produces the object. Parker (1992, p.7) suggests a method for analysing discourses: "When we look at discourses in their historical context, it becomes clear that they are quite coherent, and that as they are elaborated by academics and in everyday life they become more carefully systematised". He suggests that by deliberately systematising different ways of talking about a subject, it can be better understood and that once discourses are so articulated the dynamics of tensions between them and their effects on the world can be looked at (Parker 1992, p.6).

> A strong form of the argument would be that discourses allow us to see things that are not 'really' there, and that once an object has been elaborated in a discourse it is difficult not to refer to it as if it were real. Discourses provide frameworks for debating the value of one way of talking about reality over other ways. Types of person are also being referred to as the objects of the discourses.

Discourses therefore construct the object, by allowing it to be referred to in a particular way that makes it seem natural or normal to talk about, the object is shaped and understood thus, because of the discourse, and not because this is the way the object 'really is' and discourse analysis provides a means to deconstruct that.

Discourse analysis has been applied to a wide variety of social phenomena and in the discipline of healthcare has been used to consider topics such as AIDs (Clarke 2006, Lupton 1994), cancer (Wilkinson and Kitzinger 2000), attention deficit hyperactivity disorder (Clarke 2011), death (Walter, Littlewood and Pickering 1995),

older people (Mc Closkey and van den Hoonaard 2007), sexually transmitted diseases (Pryce 2001) and single parenthood (Carabine 2001) for example, providing valuable insights into how particular states are framed by discourse, how professional practices and dominant discourses are not neutral or self-evident and the functions of these knowledges and practices and their consequences for those invested and society in general (Georgaca 2014). In the area of mental health, the nature of which is arguably more contested than conditions that are understood as 'physical', and which is among the many states that attract stigma, discourse analysis has a particular relevance. Discourse analytic research has been used to examine a number of areas related to mental health and mental distress including service users' experiences and understandings, discursive practices engaged in by professionals, clinical categorization and the analysis of public texts such as media and official documents (Georgaca 2014). This study adopts an approach to discourse analysis influenced by Foucault's notions of discourse and power/knowledge.

3.2.3 A Foucauldian approach

The difficulty in operationalizing a Foucauldian approach is well documented (for example, O'Farrell 2005; Carabine 2001) and efforts to describe Foucault's modus operandi in the context of methodology and method have proven elusive. This emanates in part from Foucault's stance in not being prescriptive and not making claims to the possession of any particular 'truth' or method, his practice of changing and redefining concepts, and debates and uncertainty in secondary literature about the nature of his work as academic, political or literary (O'Farrell 2005). He describes his books as 'a kind of tool box which other can rummage through to find a tool which they can use however they wish in their own area," (Foucault 1974, cited in O'Farrell 2005, p.50). The tension that emerges for me and others is in trying to satisfy doctoral academic requirements and demonstrate a rigorous approach, while adopting an approach that resists structured guidance on methodological procedures (Graham 2005). Kendall and Wickham (2004, p.143) describe the Foucauldian framework as "an approach rather than a methodology, a

predisposition to look at certain questions rather than others" and assert that "…
precise methodological tools are not on offer: rather we are given an approach and
a set of phenomena to look out for". Foucault inquired into a number of disciplines
including, psychiatry, psychology, criminology, linguistics, economics, biology and
medicine utilizing two main approaches, archaeology and genealogy. This study
utilizes Foucault's genealogical concept as a guiding methodology and as a
theoretical framework. I will attempt to articulate the methodological approach
through a consideration of the Foucauldian concepts of genealogy, discourse and
power/knowledge.

3.2.3.1 Genealogy

Foucault's work centred on the production of knowledge through systems of
discourse and he suggested that analysis of discursive practices reveal power
relations at play and disclose how an object is formed in and by the discourse.
Foucault used history as a tool to examine different orders. According to Foucault,
experience and knowledge are ordered in different ways, but that these attempts
are always limited and should be challenged and that no system is unproblematic,
should be taken for granted nor should be considered a universal truth or
universally applie d. The examination of how "each historical period orders
knowledge and constructs concepts according to certain rules" (O'Farrell 2005,
p.63) makes it possible to deduce rules that underlie current practices. It is
necessary not just to recognize the different orders but to identify the principles
that give rise to them. So the recognition of different orders and the examination
of their intersections and divergences are central to Foucauld's methods (O'Farrell
2005). He was interested in "the rules and practices that produced meaningful
statements and regulated discourse in different historical periods" and how
knowledge and meaning was produced in discourse (Hall 1997, p.44). Foucault's
'method' was to examine historically over time major institutions that exerted
influence over groups of people thereby uncovering discursive formations and
ultimately 'discontinuities' in how certain objects or phenomena were/are
understood at a given time. It is an examination of these discontinuities that gives

light to the way knowledge or meaning of what it is to be human can be understood. "Foucault's basic strategy in both archaeology and genealogy is to retell the history of a discipline or institution or practice" (Prado 2000, p.25).

> Foucault is everywhere concerned with exhuming the hidden, the obscure, the marginal, the accidental, the forgotten, the overlooked, the covered-up, the displaced. His subjects for investigation are whatever is taken as most natural, obvious, evident, undeniable, prominent and indisputable.

His 'method' or 'approach' then is to: "impugn the commonplace, to query accepted knowledge" (Prado 2000, p.53). Prado (2000, p.33) suggests that in emulating Nietzsche's inversion of the particular over the universal, Foucault inverts interpretative significance of the marginal over the ostensibly central, the constructed over the supposedly natural and the importance of the accidental over the allegedly inevitable. Foucault's work has been broadly divided into his early works, which were considered archaeologies, and later works genealogies (Prado 2000, p.25).

His archaeological work centred on a comparison of the different discursive formations over different periods in history in relation to a particular subject, demonstrating differences and contingencies (Gutting 2013). His genealogical works emanated from the archaeological historical investigations, go beyond them to explain changes in systems of discourse with reference to changes in social power structures (Audi 1999). Genealogy: "carefully exposes the tiny influences on bodies that, over time, produce subjects defined by what they take to be knowledge about themselves and their world" (Prado 2000, p.36). Understandings of mental distress are formed in discourse and have significant influence on how individuals make sense of their experience and how society responds to them. This study adopting a genealogical approach is concerned with the discursive practices that produce power/knowledge about mental distress through an examination of discourses produced in newsprint coverage of mental health problems. Discourse is a central concept in Foucauldian understanding of power/knowledge, Foucault saw the 'self' as being produced or constructed by the technologies that are meant to

shape it and as such "Foucault's point is that "the subject" is a product of discourse rather than being prior to the discourse" (Prado 2000, p.57).

3.2.3.2 Discourse

Discourses are "practices that systematically form the objects of which they speak" (Foucault 1972, p.49) and "a device through which knowledge about the subject is developed and the subject constituted" (Carabine 2001, p.288). Foucault perceived that the object is constructed by the discourse, as the discourse shapes what can be said or thought about the topic, it 'rules in' and 'rules out' what is legitimate to be said or done in relation to the topic (Hall 1997). Foucault viewed discourse as *a 'body of knowledge'* and his conception moved discourse beyond language and closer to the concept of discipline (Mc Houl and Grace 1993), to include behaviour and practice. Discourses can be elicited and identified through an examination of various texts (written, visual, oral, architectural), behaviors, practices across time and become discursive formations when they relate to the same topic and support the same agenda or strategy (Cousins and Hussain 1984 cited in Hall 1997, p.44). Behaviour and practice however are made visible and communicated by language. So while the aim of this study is not to study language, behaviour and practice as communicated in linguistic text (in newsprint) is the object of scrutiny. Applying this understanding of the constitutive and productive nature of discourse to this study, mental health problems are understood as being constructed by the various different practices which are represented in text and in speech. Reporting on mental health problems in media in certain ways creates a particular picture, type and understanding of mental health problems. So the meanings about mental health problems are constructed in and by discourse. These discourses have effects, particular consequences, which in themselves are powerful. For example, by talking about mental health problems and enlisting particular discourses, this produces a particular truth that has implications for how mental distress is understood and responded to by society. Discourses are also productive in that they interact with and are mediated by other discourses and they " 'hook' into

normative ideas and common-sense notions"….to produce potent and new ways of conceptualizing the issues or topic" (Carabine 2001, p.269).

3.2.3.3 Power and knowledge

Central to the approach to analysis adopted in this study is a Foucauldian understanding of power, power relations, knowledge and science. He questioned long-standing assumptions that positioned knowledge and science as pure and theorized science as one of many practices of knowledge, operating in relation to social, economic, political and thus intrinsically enmeshed with power (O'Farrell 2005, p.96). Foucault employed genealogical analysis to trace discourses historically through examination of a variety of sources to uncover the relationship between knowledge, power and discourse. Central to Foucault's understanding of power is his emphasis on the distinction between notions of power that emphasize its oppressive nature and the incapacity of individuals to resist, what he would term 'dominance', and his understanding of power as relational, dispersed and productive.   Foucault's notion of power considered that power "is exercised rather than possessed" meaning that it is not simply the possession of an oppressor or governing group and used to dominate those who are subordinate, but that power is an effect of the strategic position of the dominant group, and is manifested, extended, transmitted in the relations of both the oppressors and those who are perceived as not having power, free subjects (Foucault 1977, p.26). So the Foucauldian conception of power is that it is not the domain of one group, it is not something that is exercised simply by one over the other, but that it emerges in the tension of resistance between groups and resistance is a necessary condition for the operation of power. Power can only exist if resistance is possible. Foucault considered that power is dispersed, in that it exists at every level of society not merely the domain of the state and that it is productive in that it generates particular types of knowledge and order (O'Farrell 2005). He understood the operation of power and knowledge as inextricably linked, "no form of knowledge emerges independently of power and (that) the exercise of power produces certain

types of knowledge," (O'Farrell 2005, p.101) resulting in the term power/knowledge.

Foucault's theorisations of power developed over time with three configurations of power, disciplinary power, biopower and governmentality being described across texts. Disciplinary power was described in most detail in *Discipline and Punish* (Foucault 1977), with reference to how the human soul was conceived and came to be the focus of attention, rather than the physical body in the punishment of crimes. This is fundamental to understanding the development and operation of discursive practices, like psychiatry, and their ways of establishing orders of 'truth' or the construction of 'reality' in society (O'Farrell 2005). He set out to "try to study the metamorphosis of punitive methods on the basis of a political technology of the body in which might be read a common history of power relations and object relations," (Foucault 1977, p.24). In *Discipline and Punish* Foucault charts a change in how criminals were dealt with in the mid to late seventeenth century, from a system which centred on the mortification of the body through physical and corporal punishment, where criminal acts were seen as an offence against the monarch, to one where criminal acts began to be viewed as offences against society and which used incarceration to protect society, to encourage deterrence and to rehabilitate the individual. This change represented a change in emphasis from viewing crimes as an offence against the authority of the sovereign to a threat to the authority of society (Prado 2000). Accordingly prisons and judicial systems developed and disciplinary techniques were contrived to administer this system. These changes however were not inevitable. At the time when penal reform was being mooted as a rejection of sovereignty, at the critical juncture when change began three 'technologies of power' co-existed. Sovereign power, where punishment was ceremonial and served to make visible the power of the king represented the old way, monarchical law. Juridical punishment, punishment as a sign, a coded set of representations which requalified individuals as subjects by using punishments that by being related to the crimes, served as signs that would be recognized by the citizens. The coercive institution which had punishment as a

technique for the coercion of individuals and which centred on the prison as an institution and emphasized training and punishment (Foucault 1977, p.131).

Foucault challenged the notion that these changes took place as a result of humanitarian concerns or notions about social causes for the production of deviance, although he does allow that they may have in part originated from humanitarian intentions. He asserted that

> The true objective of the reform movement ..... was not so much to establish a new right to punish based on more equitable principles, as to set up a new 'economy ' of the power to punish, to assure its better distribution, so that it could be neither too concentrated at certain privileged points, nor too divided between opposing authorities; so that it could be distributed in homogenous circuits capable of operating everywhere, in a continuous way, down to the finest grain if the social body (Foucault 1977, p.80).

Foucault suggested that while the juridical system was the most logical to prevail given the writings of penal reformers of the time and the symbolic and representational nature of the punishments, the prison dominated and became the focus for dealing with criminals. This fundamental change in the system of dealing with crime represented according to Foucault a 'discontinuity' and the course that followed was not inevitable or logical but something that should be examined analysed and considered as it gives insight into the operation of power (Foucault 1977). The examination of 'discontinuities' (a juncture where several courses are possible, but one prevails) involves a consideration of what political, economic and social forces are at play in society at the time. Foucault challenged notions about the progressive nature and superior status of science as a way of understanding the world, positioning science as only one particular configuration of knowledge among others (O'Farrell 2005).

He purported that what happened was that a whole new understanding of the person emerged that opened up new possibilities for the control of the individual in the interests of disciplining to produce a productive citizen. Central to his argument is the construction of the soul, which he saw as a shift from a pre-modern to a

modern conception of self (Prado 2000, p.57). The person came to be viewed as a subject with a soul and was judged as such rather than as a being who committed crimes. Foucault (1977, p.16) considered that "If the penalty in its most severe form no longer addresses itself to the body, on what does it lay hold? ….. since it is no longer the body, it must be the soul". This opened up the possibility that the person with a soul could have a conscience, and self-determination; that they could be changed and more importantly that they could change themselves. This is achieved by the self being imbued with the 'right' beliefs and affective states through discipline (Prado 2000, p.57). Foucault quotes the French penal reformer of the mid 1700s Servan who said, "A stupid despot may constrain his slaves with iron chains; but a true politician binds them even more strongly by the chain of their own ideas; it is stable at the point of reason that he secures the end of chain; this link is all the stronger in that we do not know of what it is made and we believe it to be our own work" (Foucault 1977, p.103) The disciplinary practices that were developed were designed not only to discipline the subject but to instill in them self-discipline that would perpetuate.

> If what subjects are made to believe works as well as actually watching them, instilling certain additional beliefs can make control complete. In other words, subjects can be made to watch themselves. What follows is a shift in emphasis from the enforcement of rules and regulations to the inculcation of norms through disciplinary techniques. The avowed objective is to normalize individuals, to rehabilitate wrongdoers, to train productive members of society. What actually occurs is that new subjects are manufactured who carry within them the norms that constitute self-surveillance (Prado 2000, p.64).

The punishment of the body changed to become the confinement of the body and the manipulation of the mind and soul. "From being an art of unbearable sensations punishment has become an economy of suspended rights" (Foucault 1977, p.11). This represented a change of view as to the nature of personhood.

> In the old system, the body of the condemned man became the king's property, on which the sovereign left his mark and brought down the effects of his power. Now he will rather be the property of society, the object of useful appropriation (Foucault 1977, p.109).

The developed techniques detailed in *Discipline and Punish* that discipline individuals, do not only do so by compelling and forcing, but by enabling the production of truth and knowledge which produce a soul that can be constrained. Foucault (1977, p.11) suggested that "As a result of this new restraint, a whole army of technicians took over from the executioner, the immediate anatomist of pain: warders, doctors, chaplains, psychiatrists, psychologists, educationalists; by their very presence near the prisoner, they sing the praises that the law needs; they reassure it that the body and pain are not the ultimate objects of its punitive action". These disciplines are implicated in the development of discursive practices; scientific disciplines and institutions that regulate the knowledge and therefore the individual by defining orders of truth about what constitutes truth and reality in society at a given time (O'Farrell 2005). According to Foucault "Recourse to psychology-pharmacology and to various physiological 'disconnectors' even if it is temporary, is a logical consequence of this 'non-corporal' penalty" (Foucault 1976, p.11). Discipline, (at work in education, medicine and military), "increases the forces of the body (in economic terms of utility) and diminishes these same forces (in political terms of obedience)" and according to Foucault developed and dispersed "in response to particular needs: an industrial innovation, a renewed outbreak of certain epidemic diseases, the invention of the rifle or the victories of Prussia" (Foucault 1977, p.138). Knowledge and power are inextricably linked, "power produces knowledge" and "there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations" (Foucault 1977, p.27). It is this interaction of power and knowledge that are at the core of this study. Mental health problems are constituted in a social, economic and political discursive space which produces knowledge and at the same time effects the knowledge produced. A consideration of the discourses present in media representation aims to make visible the conditions of possibility for the production of knowledge and truth about mental health problems.

Foucault suggested that the disciplinary practices originally conceived around criminality and the prison and the notion of 'the subject' that was so constructed

went on to become central to the creation and sustainment of other institutions which required to shape and control the behaviour of large groups of people in the interests of economic productivity and political obedience, satisfying the needs of government. "In every age the way in which people reflect, write, judge, speak (right down to the street and to the most everyday conversations and writing) and even the way people experience things and react with their feelings; all of their behavior is governed by a theoretical structure, a system which changes with ages and societies-but which is present in all ages and societies" (Foucault 1966, p.514 cited in O'Farrell 2005, p.56).

Foucault describes three technologies of surveillance used in the exercise of disciplinary power in the institutions: hierarchical observation, normalizing judgment and the examination. Hierarchical observation, refers to mechanisms that seek to coerce by means of observation through facilitation of visual and/or auditory access by those in charge over those with less authority "..an apparatus in which the techniques that make it possible to see induces effects of power, and in which conversely, the means of coercion make those on whom they are applied clearly visible" (Foucault 1977, p.171). Observatories were developed during the classical age and together with the telescope, the lens and the light beam were part of a new physics and cosmology emphasizing light and visibility (Foucault 1977, p. 171). Observatories followed a military camp layout and this model was continued in other institutions such as schools and hospitals. The basic premise being the maximization of visibility. He evoked the physical structure of the 'panopticon', a circular physical structure designed by Jeremy Bentham and used in prisons to maximize the visibility of prisoners in an efficient way by making the viewer invisible, in coining the term 'panopticism'. The effect he said was to, "induce in the inmate a state of conscious and permanent visibility that ensures the authentic functioning of power" (Foucault 1977, p.201). As well as other institutions, hospitals were built in this manner to maximize the visibility of patients in the interest of observation. Large wards and central observation points, and the circular area with a 'central nurses station' is still the preferred model for wards

today. Pyramidal structures of observation organized grades of workers in a hierarchical manner with each grade supervising those beneath them facilitating large numbers of people to be subject to surveillance and the disciplinary gaze. The power of hierarchized surveillance of the disciplines is both indiscreet, in that it is by definition everywhere, and is constant in its supervision of those who are entrusted with supervising and discreet in that it functions silently (Foucault 1977).

Normalizing judgment refers to assessment through comparison with a norm derived from a favoured paradigm. Deviations are punished and corrective by nature, encouraging and forcing adherence to the norm. The norm represents what exists in the great institutions like medicine, military, church and belonging to the norm is reinforced by sanctions for deviation. "It measures in quantitative terms and hierarchizes in terms of the abilities, the level, the 'nature' of the individual (Foucault 1977, p.183). In doing so establishes the 'normal individual' and makes possible classification according to the norm making categorization possible.

The examination is the administration of test for the 'good' of the individual and is the process which makes it possible to qualify, classify and punish individuals. The examination makes visible the individual rather than the sovereign and as such the individual becomes subject to the 'gaze', through the combination of hierarchical observation and normalizing judgment. "It is the examination which, by combining hierarchical surveillance and normalizing judgment, assures the great disciplinary functions of distribution and classification" (Foucault 1977, p.192).

Foucault moved on from the centrality of discipline in the exercise of power in *The History of Sexuality* (Foucault 1976) to develop the notion of biopower as a technology of power exercised on populations. Foucault used the term, biopower to refer to the emergence of particular social processes to satisfy the needs of the modern state. New sciences were recruited to regulate populations and individuals

to confront the challenges of urbanization and the needs of industrial capitalism. By this he was referring to the growth of knowledge and practices related to public health, hygiene, sexuality and reproduction which operated to make the individual an object of power and knowledge under the gaze of the disciplines. Biopower, the power over life, health and reproduction (as opposed to the sovereign power over death) operates in two key ways; the regulation of bodies *en masse*, the 'bio-politic' through the collection of data about populations, and 'anatamo-politics' and the regulation of the individual body by the internalization of rules and ideas of modern science (Hyde, Lohan and McDonnell 2004).

Foucault went on to describe 'governmentality' a third configuration of power which describes the way in which individuals in liberal societies self-govern by internalizing the rules of conduct. It is "the rationlisation of systematization of a particular way of exercising political sovereignty through the government of people's conduct" (O'Farrell 2005, p.107). Rose (1998, p.11) argues that the growth of the 'psy' disciplines (psychology, psychiatry, psychotherapy, psychoanalysis) is linked with changes in the exercise of political power in the latter part of the nineteenth century. This discontinuity he argues has transformed individual conceptions of personhood, who and what we are and how we should act. Rather than being scientific disciplines that can legitimately make claim to objective knowledge, existing independently of the person, they emerged in relation to particular social economic and political circumstances and as "intellectual technologies" that "make up" the person (Rose 1998, p.11).

3.3 Rationale for selection of the research approach

As highlighted in chapter two, a large body of research on representation of mental health problems in media is limited to manifest content, which provides important descriptive information, but only surface meanings and cannot make assumptions about symbolic or latent meanings in text (Lupton 1992). Potter and Wetherell (1987) argue that certain analytic strategies (from both positivist and naturalistic

paradigms) have tended to undermine and diminish variances in people's accounts. Restriction is placed on responses through forcing the selection of a limited number of options (for example in questionnaires structured interviews or content analysis). This limits variation and avoids ambiguity. Gross categorization, the allocation of accounts to broad categories, further diminishes variation. In approaching the issue of media and mental health problems I had first to reflect on which world view resonated with my beliefs about mental health problems and their meaning in society. While not denying or undermining the human experience of mental distress, I understand mental health problems as being socially constructed in that knowledge and practice related to them is socially determined. In adopting this understanding, I therefore consider that how we talk and write about mental health problems is important as this is influenced by socially available discourses and that this in turn shapes how the experience of mental distress is understood and treated in society. For example, representing mental health problems as illnesses has particular consequences for people who experience mental distress but also for many other individuals and groups in society. This requires a methodology which facilitates in-depth consideration of language and social context to produce an analysis of the function and consequence of the discourse. Lupton (1992, p.146) suggests that "Discourse analysis has the potential to reveal valuable insights into the social and political contexts in which varied discourses about health take place". Analysis of how knowledge is produced in relation to mental health problems and the how the individual is governed in that context through the techniques and procedures of the discourse, is central to the aims of this research. Using a Foucauldian lens means approaching data analysis with an understanding of power as being constituted in discourse and examining surfaces of emergence to understand how the discourse is produced. Deconstructing mental health problems in this way, through an examination of dominant discourses and the conditions for their production, may enable the emergence of other useful ways of understanding the experience of mental distress (Georgaca 2014).

This study utilized a discourse analytic approach underpinned by Foucauldian concepts of power, knowledge and discourse in the constitution of the order of social 'reality' to consider the issue of mental health problems and their construction in Irish newspapers. While the experience of mental distress exists, the social attribution of it is always contextual and thus it is both an ontological and epistemological concern (Pilgrim 2014b). Knowledge about mental health problems is produced in discourse and so we need to consider both what 'it' is and how we come to make sense of 'it'. Some discourses are privileged over others and the tensions between competing discourses reveal power relations. Discourses are revealed in the way a subject is spoken about or written about, for example in news media, and investigation of the ways in which discourses are used reveals the operation of power relations at a given time. "It is not merely a question of recognizing that different orders are possible, but one must search for the very principles that give rise to particular ways of constructing order, one must search for those systems which make it possible to actually see that an order exists" (O'Farrell, 2005, p.58). Identifying dominant discourses involves a problematisation of commonplace assumptions about a topic, an analysis of the way in which 'taken for granted' assumptions are presented and deployed as an effect of power. Examination of discourses employed in the construction of mental health problems provides an insight in to the way knowledge and power are produced about mental health and the effects of this. Kendall and Wickham (1999, p.49) suggest that:

> ....we can say that power is a strategy, a strategy that maintains a relation between the sayable and the visible. The visible is always in danger of exhaustion because it is completely determined by the sayable; the problem is one of how visibilities, being completely receptive, in contrast to the spontaneity of the sayable, are inexhaustible.

A consideration of constructions of mental health problems in newspapers (the sayable) will illuminate constructions of mental health problems (the visible) in contemporary Ireland.

Foucault employed analysis and commentary of selected but extensive ranges of texts over a wide range of periods and countries in his works. Carabine (2001,

p.280) suggests that it is relevant to: "use genealogy to provide a 'snapshot' of a particular moment without resorting to tracing its history, and that this will tell us something about discourse/power/knowledge". This study considers the construction of mental health problems by looking at print news media in Ireland at a particular juncture, a period of one month. In doing so it contributes to contemporary understandings of knowledge/power at a particular time and can contribute a genealogy of the way the topic is constituted (Carabine 2001). Discourse analysis in the Foucauldian tradition offers a methodological frame through which to examine the conditions of possibility for the emergence of discourses and counter-discourses, power and resistance. Such studies can "open up our contemporary regime of the self to critical thought" (Rose 1998, p.2).

3.4 Operationalizing a discourse analytic method

This study is underpinned by a Foucauldian approach to discourse analysis and operationalized by a structure articulated by Potter and Wetherell (1987) and a method of analysis outlined by Carabine (2001) and Lupton (1992). Potter and Wetherell provide a framework through which to work on the 'doing' of a discourse analysis in a ten stage process. As their process is geared towards research that uses text from interviews, I have adapted it to fit with my study of text and so have made it an eight stage process, omitting the interview and transcription stages, as outlined here:

Stage 1. Research question

Stage 2. Sample selection

Stage 3. Collection of records and documents

Stage 4. Coding

Stage 5. Analysis

Stage 6. Validation

Stage 7. The report

Stage 8. Application

I will describe and justify the method adopted for the study by referring to stages one to six, stages seven and eight being made explicit in chapters five, six, seven and eight which present the findings and chapter nine which discusses the findings and provides the conclusion and implications of the study.

3.4.1 The research question

The research question for the study was: 'how are mental health problems discursively constructed in Irish print news media'?

The aim of the research was to gain a more sophisticated understanding of the way in which 'common sense' understandings are employed in establishing knowledge about mental health problems and the resultant production of power through an examination of how mental health problems are constructed in Irish newspapers.

The objectives of the study were to:
- Identify the discourses and points of resistance present in relation to mental health problems,
- Identify institutions or groups that are made visible or obscured by identified discourses,
- Reveal techniques employed in constructing mental health problems and the potential effects this has on the individual.

3.4.2 Sample selection

Discourse analytic studies potentially use a wide variety of textual material as data. The selection of the particular source of data is dictated by the researcher's theoretical assumptions about discourse and the subject area being addressed (Taylor 2001, p.25). My research question was concerned with the processes involved in the social construction of mental health problems and the associated operation of knowledge and power. I selected news reporting in print newspapers as a means to do this. A consideration of discourses of mental health could concentrate on a variety of texts for consideration, including legislative and policy documents, academic texts, literature, art or historical records. I have reviewed

academic literature in the field (in chapter two relating to mental health problems and media) and in chapter four provide a historical overview of the development of understandings of mental health in Ireland. Theoretical literature was used to contextualize and inform data analysis and the study findings.

Media encompasses an ever increasing number of forms of mass communication including television, radio, newspapers and with technological innovations social and digital media has become a particularly significant form of 'new' media consumption. So the options for scrutiny included film, television or radio, factual or fictional, newspaper or magazines, and the wide variety of social media now available. The selection of one media source was made to facilitate in-depth analysis of a data set. Research into 'new' media formats such as digital media indicates that rather than replacing 'old' media formats such as newspapers, television and radio, it has the effect of converging these formats and thus enhances consumption (English 2013). I selected newspapers due to their widespread public prominence and because of the authority which they are afforded due to their rhetoric of factuality (Walter, Littlewood and Pickering 1995). This makes them suitable as a site which both reveals and constitutes discourses that are widely engaged with by the general public and therefore important in contributing to public discourses of mental health.

Newspaper readership rates are high in Ireland with an estimated 87.3% of the population reading any newspaper in the week and 56.4% reading a daily newspaper at the time of commencement of the study (Joint National Readership Survey 2009). Since then readership rates of print newspapers have declined but online readership compensates for this (Joint National Readership Survey 2013). Newspapers both in print and digital formats continue to be an important element of social interaction. In 2009 there were 167 newspapers published in Ireland including broadsheets and tabloids, published at daily and weekly intervals. The available population of Irish Newspapers at time of data collection is outlined in Table 1.

Type of Newspaper	Number	
National	Daily morning	7
	Daily evening	2
	Sunday	10
	Weekly	1
Regional		86
Free distribution		61
Total		167

Table 1. Newspapers published in Ireland in 2009 (Joint National Readership Survey 2009)

Pragmatism dictates that the selection of a specific and limited range of newspaper material for investigation was necessary so that a reasonable claim for an exhaustive investigation could be made (Kendall and Wickham 2004). A variety of sampling strategies are used in research on media content, each with merits and constraints. Sample selection can be made on the basis of broadness and inclusivity or specificity and uniqueness (Taylor 2001, p.25). For investigation of newsprint, access to news items can be achieved digitally or manually. Manual selection is where a specified time range is selected and a sample of the papers are read with certain inclusion criteria in mind). This can be done by one or more researchers or by a commercial press cutting agency. The presence of more than one researcher or an external reader creates a concern about uniformity of approach and reliability, but this can be addressed to some extent with secondary checking. This sampling strategy is potentially more inclusive than digital extraction as it does not pre-determine what will be included, only in the broadest sense, however it necessarily limits the number of data sources that can be included.

The other way in which samples have been obtained is by using searches of electronic databases using pre-determined key words related to a subject, in this instance, mental health problems. This has the benefit of allowing access to a much larger sample, but limits the data collected to that which is pre-determined by the key words chosen. While selection of keywords can be inclusive and wide ranging, there is the potential to miss subtle or vicarious reference to mental health problems with this method.

I selected a manual scrutiny of selected newspapers on the basis that I wanted to make decisions about inclusion of news items on sight of them rather than pre-determining selection with key words and risk missing important items that might not have been anticipated by the pre-determined terms. Selecting terms commonly used to connote mental health problems, such as depression, schizophrenia, and mental illness may have limited the selection to articles that reflected a biomedical discourse, for example.

Given this approach a pragmatic decision needed to be taken to identify a specified number and range of publications for scrutiny. I undertook a preliminary study in October 2008 to explore possibilities in the research design and I reviewed newspapers over a 7 day period. A cross section of newspapers (15 issues of 5 newspapers) were selected to reflect regional distribution, socio economic status of readership and weekly spread to include a national daily broad sheet, a national daily tabloid, a Sunday paper, and a regional weekly paper. The newspapers included were:

- *The Irish Times* (national broadsheet, daily Monday to Saturday)–6 copies
- The *Irish Daily Mirror* (national tabloid, daily Monday to Saturday)–6 copies
- The *Irish Sunday Mirror* (national Sunday tabloid) 1 copy
- The *Sunday Independent* (national Sunday broadsheet)–1 copy
- The *Longford Leader* (regional weekly)–1 copy.

Each paper (including supplements and magazines) was read in detail for any mention of mental health problems and related issues. This included medically diagnosed states denoted as mental illness e.g. schizophrenia, behaviors that are seen as symptoms of mental illness like suicide, deliberate self-harm and experiences that are associated with mental illness like or hearing voices or 'feeling depressed'. Included also were treatments (medications, talking therapies), structures (mental hospitals, community care, voluntary organizations) and professionals (psychiatric nurses, doctors, psychologists) associated with dealing with mental health problems and any words that were associated. Articles were

extracted and marked in order to identify their source, date and position in the newspaper. From this initial review it was possible to initially code articles into three main categories based on how mental illness was referred to:

1. Articles in which mental health problems were the main subject/topic of the article,

2. Articles in which the central concern/topic were issues other than mental health problems, but which referred to mental health problems indirectly,

3. Articles in which mental health problems were referred to obliquely in the article through the use of words that were related either colloquially or otherwise.

The range of articles collected confirmed that the in-depth reading of each newspaper was useful and that focussing on articles in which mental health problems or associated issues were the main area of concern were the most fruitful in terms of depth of coverage as my interest was with depth of information. It also confirmed that sufficient material could be sourced from the specified archive of newspapers so I decided to use the same newspapers for the main study. These are a national daily broad sheet, *The Irish Times* which has the 2nd highest readership, an estimated 9.6% of the population, a national daily tabloid the *Irish Daily Mirror* with an estimated readership of 5.5% of the population, a weekly regional paper the *Longford Leader* and two national Sunday papers, the *Sunday Independent*, with an estimated readership of 28.6% of the population and the *Irish Sunday Mirror* with a readership of 4% of the population (Joint National Readership Survey 2011) (Table 2).

Title of Newspaper	No. of issues in March 2009
The Irish Times	26
Irish Daily Mirror	26
Sunday Independent	5
Irish Sunday Mirror	5
Longford Leader	4
Total	66

Table 2. Sample of newspapers included in the study

They represent a cross section of broadsheet and tabloid newspapers that are most widely read by the Irish population. While the *Irish Independent* was the daily newspaper with the highest daily readership, I chose *The Irish Times* as the daily newspaper, as the Sunday edition of the Independent frequently covers in greater depth news items from the previous week and therefore was likely to pick up main news items from the daily editions of the same newspaper.

The Irish Times was established in 1859 and while it would have traditionally been the newspaper aligned with a protestant ethos and a unionist political orientation, today it is considered a newspaper of the middle classes and adopts a progressive, liberal position while maintaining more conservative centre right position on economic issues. It is published six days a week, Monday to Saturday. The *Irish Daily Mirror* is the Irish edition of a British tabloid newspaper established in 1903 which was traditionally and continues to be politically aligned to the British Labour party. It would be considered to have a largely working class readership. The *Sunday Independent* is the Sunday edition of the *Irish Independent* and has the widest circulation of any Sunday newspaper in Ireland. The *Independent* newspaper was established in its current form in 1905 and traditionally emanated from a nationalist political ideology. Currently it occupies a more populist position, with a centre right orientation in relation to economics. The *Longford Leader* is a regional newspaper established in 1897 and published weekly on Wednesday and would have a readership confined to County Longford and surrounding areas and contains mainly content related to local regional issues.

The sample therefore was a prospective sample of the above newspapers, and I commenced data collection in the month of March 2009. The following inclusion criteria were decided based on information gained in the preliminary study:

1. Only articles that were written in the English language were included, as the researcher is not sufficiently fluent in any other language (Irish or Polish) to allow for analysis,

2. All items were included in which the central subject was mental health problems,

3. Small adds, property pages and property supplements, were excluded as no relevant data was found in the preliminary study in these sections.

The decision to select a particular archive in discourse analysis is influenced by the nuances of the research question. My research question concerned the discursive construction of mental health problems in Irish newspapers and as such could have been addressed based on a sample at selected at any particular time. Justification, therefore, for the particular time is arguably less relevant than provision of contextual information about events preceding and coinciding the time period. In 2009, mental health practice in Ireland was at an important stage in time with a number of significant events exerting influence . A new *Mental Health Act* had been published in 2001 and was in the process of being fully enacted, and a new mental health policy, *'A Vision for Change',* was published in 2006 (Government of Ireland 2006). This policy was developed in the context of a variety of critical discourses that resist dominant understandings of mental health problems as illnesses including service user, recovery and discourses that emphasize the centrality of meaning in human experience. *'A Vision for Change'* recommended that the approach to mental health care be re-orientated to a 'recovery' orientation, placing emphasis on service user involvement in service planning, delivery and evaluation. Also, importantly, it recommended completing the closure of the major mental hospitals and the sale of their lands, the revenue from which (in a time of economic prosperity and rising property prices) was to fund the further development of community mental health services. Then, in 2008, came an economic recession that saw property prices fall dramatically with major cuts in Government spending. This provided an interesting time at which to consider the way meaning about mental health problems was made and the discursive conditions under which particular meanings were made possible. The sample size was not decided on at the commencement of data collection, but as the articles were extracted and read and analysis proceeded, it became clear that the one

month period elicited a sufficient number of substantive articles (123) to undertake an in-depth analysis.

3.4.3 Collection of data

Each copy of the selected newspapers was read closely and articles that met the inclusion criteria were extracted and retained. One hundred and twenty three news items were retrieved. This included items from a special supplement concerning mental health services in one of the newspapers that was sponsored by the *Health Service Executive* (HSE), the state agency responsible for health care provision in Ireland. This was unanticipated, an exceptional once off supplement, not typical of the usual newspaper content. It was included on the basis that it formed part of the newspaper coverage of mental health problems.

3.4.4 Coding

Potter and Wetherell (1987, p.167) suggest that 'coding' is undertaken in order to "squeeze an unwieldy body of discourse into manageable chunks" as a means of preparing the data for more intensive analysis. This first step is preliminary and separate to data analysis unlike in content or thematic analysis where the categorization is part of the analysis (Potter and Wetherell 1987). Each news items was given a unique number, and its source and date recorded for reference. To facilitate organization and analysis of the data, I created a database with fields relating to the article reference, publication title, authorship, aspects of mental health problems and sources referred to. This facilitated data retrieval and organization of the news items in particular groups such as by publication type or topic if required. This database was further developed as analysis proceeded to include domains of meaning elicited from the news items.

3.4.5 Data analysis

In *Discipline and Punish* Foucault (1977) states that his study obeys four general rules which offer insight into his modus operandi. He suggests not focusing entirely on only the negative or repressive effect (of the punitive mechanisms) alone, but to consider all possible effects therefore regarding the complex social function of the subject. He advises that one analyses the subject not only as a consequence of legislation or as an indicator of social structure, but as having their own specificity in the exercise of power, regarding the subject as a political tactic. Instead of treating the history of subjects germane to your subject (in *Discipline and Punish* the history of penal law and the history of the human sciences) as separate but overlapping and mutually influential, look for a common source or single process from which they derive, for example the technology of power. Investigate the influence of power relations in the production of the subject (Foucault 1977). This requires the researcher to adopt a 'naïve' approach, taking nothing for granted and reading beyond ostensible content by considering the social and political context to identify particular discourses and their likely effects.

The process of 'doing' data analysis is difficult to articulate, particularly in a linear fashion as it is an iterative process that requires moving between the data and analysis repeatedly to confirm or refute emerging systematic patterns (Potter and Wetherell 1987). Approaches articulated by Carabine (2001) and Lupton (1992) offer guidance on how to practically execute this process. They suggest focusing on two dimensions, textual and contextual. The textual dimension focuses on the micro elements of discourse, the language and its structure, elements such as grammar, rhetorical devices, content and overt meaning and macro elements such as topics and themes. The contextual dimension relates the social, political and cultural context in which the discourse is located and its function in producing an ideological effect (Carabine 2001; Lupton 1992).

Each article was read, re-read and examined to identify the ways in which words and phrases were used to create meaning about mental health problems. Kendall and Wickham (2004, p.133) suggest that:

> ..the less gifted researcher should not shy away from some of the more conventional procedures of qualitative research to see if a hypothesis will standup. It is worth trying to generate categories from fragments of data. It is worth counting instances of a phenomenon.

Some quantitative analysis was done initially, sources of news items, terms used to describe mental health problems were recorded, and affiliation of people quoted and those writing was noted and quantified. Preliminary themes, categories and objects were identified through coding and the database developed was used to organise this information. I noted the general orientation of articles. News items that related to similar topics were coded, grouped and read together to distinguish meaning for example those that related to mental health problems in children, those that reported on mental health services, those that related to causation. Data were read and re-read to identify particular ways of talking about mental health problems. Particular attention was paid to textual strategies and rhetorical devices employed to construct meanings as factual, authoritative and natural, indicating favoured understandings. Discourses drawn upon to construct mental health problems were identified. This identified that mental health problems were written about in a number of ways:

- being on the increase
- being devastating to the person
- impacting on others
- being caused by societal stressors
- being an individual problem
- being outside the control of the person
- being related to harm to self and others
- descriptions of services being provided
- being biological in origin
- being hidden

- requiring identification

- identifiable through diagnosis.

Then the data and the preliminary analytic descriptions were scrutinised to identify inter-relationships between discourses and to consider absences and silences. This required a consideration of theoretical, academic and policy documents relating to mental health to identify contemporary discourses of mental health problems relating this to discourses identified in the data (Carabine 2001). The functions and consequences of these discursive practices in the production of power/knowledge were then considered.

3.4.6 Validation and rigour

Rigour is approached differently in research from a post-modern perspective than in that from a positivist tradition, the difference centering on ontological and epistemological claims as to the existence of a true reality and the extent to which something can be fully known. Some qualitative approaches suggest validation of the findings by review of the data by external experts or participants in the study, however concordance or non-concordance by others may relate to individual similarities or differences in paradigms, experiences, backgrounds or biases "rather than do justice to the empirical material" (Alvesson 2002, p.70). As discourse analysis makes no claims to objectivity the burden in relation to rigour lies with making the research process and analysis visible to the reader, so they can make their own evaluation. So in achieving rigour the researcher is attempting not to demonstrate reproducibility, they are simply attempting to be transparent. A number of strategies have been suggested to enhance rigour in discourse analytic studies. The presentation of empirical data in the study supports the accountability of the claims being made to the empirical materials (Hepburn and Potter 2004). I have included extracts of newspaper articles alongside my analysis in the findings chapters to illuminate analytic decisions made. Presenting the findings in the context of previous research facilitates assessment of coherence (Hepburn and Potter 2004). Chapter two presents a summary of previous research on media and

mental health problems and the findings are discussed in the context of previous research and theoretical literature in the findings and discussion chapters. Potter and Wetherell (1987, p.171) suggest that fruitfulness is the most powerful criterion of validity, and refer to it as "the scope of an analytic scheme to make sense of new kinds of discourses and generate novel explanations". The presentation of findings and subsequent discussion will provide the reader with an opportunity to make a judgment as to whether this has been achieved.

3.5 Summary

This chapter has outlined and justified the methodology and methods adopted for the study. The aim of the study is to gain a more sophisticated understanding of the way in which 'common sense' understandings are employed in establishing knowledge about mental health problems and the resultant production of power by examining newspaper reporting. The study is underpinned by a post-modern, post-structuralist approach to understanding the world which emphasizes the importance of plurality and multiple realities and rejects grand narratives and the claims of science to a privileged position in relation to truth. The methodology enlisted to do this is discourse analysis adopting a Foucauldian understanding of discourse that considers the regulatory effect of discourse on the individual through the operation of power/knowledge. The way in which mental health problems are understood in society has widespread implications for those who experience mental distress. It also has implications for others involved such as relatives, health workers and those involved in the 'industry' of psychiatry and for society at large as we are all implicated in and affected by how human experience is understood. Discourse analysis provides a framework through which to analyze a phenomenon, which illuminates the way in which an object is constructed by the way it is written about. It provides a means through which to make visible 'taken for granted' ideas about a subject, revealing the operation of power/knowledge and opening up space for challenges to ways of thinking. Newspapers form part of disciplinary structure. They are an important social site in which knowledge and meaning is constructed particularly due to their authoritative position and a perception of them as

reporting the 'true' story. This, their ubiquity, and the extent to which they refer to mental health problems make them a suitable site for scrutiny in attempting to gain an understanding of the formation of meaning. This study considered news coverage of mental health problems in a sample of five newspapers over a one month period in 2009. This elicited 123 news items for which the central theme was mental health problems. These were coded and analyzed for textual and contextual dimensions to identify the ways in which words and phrases were used to create meaning about mental health problems. The findings of the study are presented in chapters five, six, seven and eight and the next chapter, chapter 4 provides an overview of the context in which the research was undertaken in relation to understandings of mental health and the development of mental health care in Ireland.

Chapter 4 Mental health in Ireland-history and context

4.1 Introduction

A variety of discourses converge to construct meaning about mental distress, each one underpinned by different assumptions, methodologies, values and priorities, some dominating at different times (Bracken and Thomas 2010). This chapter aims to provide a background to these discourses by exploring the historical development of how 'mental health problems' have been understood in Irish society and in doing so contextualizes the period in which the study was undertaken and provides insight into the various discourses that have contributed to the current order. The aim is not to provide a totalising history but to explore important historical junctures in relation to mental health care in Ireland and to contextualize current understandings through a consideration of competing discourses.

The manner in which what we call 'mental health problems' in Ireland today are understood requires a consideration of the trajectory of institutionalization of those considered 'insane' and the social and economic milieu in which these structures and practices emerged and developed (Brennan 2014a; b). Foucault argued against assumptions that underpin continuity as a tool for historical explanation, such as the rationality of progress, totalising explanations, constancy of objects or categories and the primacy of scientific endeavour in discovering the 'real' world (O'Farrell 2005). He considered insanity to be a socially constructed phenomenon produced in the discontinuity at the dawn of the modern era as a result of discursive practices and structures produced by the requirement of social norms and the state needs for economic productivity through the government of citizens. He rejected explanations that positioned psychiatry as a result of scientific discovery and progress. The time at which this study was undertaken, 2009, followed the publication and implementation of a new and purportedly reforming *Mental Health Act* (2001) and a new mental health policy, *A Vision for Change,*

(Government of Ireland 2006), both of which heralded a fundamental change in approaches to mental health problems in Ireland. It was also a year which, following a period of unprecedented economic prosperity, was immediately preceded in 2008 by an economic crisis that had begun to have massive impacts on personal and public finances.

Brennan (2014a) suggests that there have been three significant points of substantial change in the recent trajectory of Irish insanity, the establishment and expansion of the asylums in the mid 19th century which led to a mass institutionalisation of individuals considered insane, the commencement of de-institutionalization from the mid- twentieth century and the closure of mental hospitals in the twenty first century. I will use these three points to provide a historical account of the various understandings of mental health problems and some of the events that occurred alongside. I will also consider the juncture at which mental health problems became a focus for medical concern and critical discourses that have emerged to resist psychiatry as a discursive practice.

4.2 Institutionalization

In pre-Christian Ireland illness in general was seen as the result of an intervention by a malign deity as punishment for a wrong doing (Robins 1986). This reasoning was also applied to behaviour that was exhibited by those affected by what we now call mental illness, mental disorder or mental health problems. When "faced with strange, irrational and disturbed behaviour, early societies in the absence of any other explanation, could see it only in `the hand of God or some evil spirit' " (Robins 1986, p.5). Robins refers to the 'madman's wisp' which was a ball of straw, that had the power to cause mental illness, which the druidic priest would throw at those who had angered him. The ancient Irish language had different words for 'fools', 'idiots' and 'madmen' (Robins 1986) and the Brehan laws, which were codified in 432 A.D. and remained in effect until 1603 formally recognized this difference between idiots, fools and lunatics, each classified as a distinct group,

with differing legal rights and obligations (Scheper-Hughes 1979). At this time those considered as fools, idiots or lunatics were cared for in their own homes by relatives or permitted to wander freely in society. Monasteries provided some shelter for a small number of wandering lunatics. Their rights, as defined by the Brehan laws appeared to be determined by the extent to which they were capable of work or be useful or amusing to society (Robins 1986). Up to and and during the Middle Ages in Ireland and across Europe, no special provision was made for those considered to be insane, with the first asylums being built in Europe in the 15th century (Commission of Inquiry on Mental Illness 1966).

In Ireland, the 17th and early 18th centuries saw the emergence of Protestant ethics following the reformation and British colonization. The Protestant ethic placed emphasis on the obligation of the individual to behave and conform, and behaviour that did not conform was viewed as a rejection by the individual of acceptable social standards, a matter of deliberate choice. This coincided with the closure of the monasteries which hitherto had provided shelter for the 'mad'. The 'insane' were more visible than before and an annoyance to others. Critical historians see the mass confinement that occurred across Europe at this time as being linked to a wider containment of social deviancy and a consequence of societal needs for productivity and order at a time of urbanization, industrialization and the rise of professional disciplines in the early nineteenth century (Rogers and Pilgrim 2005). Torry and Miller (2001, p.132) report that in 1824 a visitor observed that "on most public roads in the South of Ireland fools and idiots (melancholy spectacles of humanity!) are permitted to wander at large, and in consequence of this freedom have acquired vicious habits, to the annoyance of every passenger". Ireland, governed by Britain, was viewed as a place needing control and structures needed to be put into place to contain those viewed as not conforming to society's norms. Finnane (1981, p.18) notes that "Confronted with the evidence of social disorder, over-population and an ailing economy, reforming politicians, political economists and social observers, rising professionals, philanthropists and humanitarians of various persuasions and motivations all sought to bring order to

Ireland, to foster the condition in which the transition to a prosperous agricultural society could be effected". The requirements of colonial government coincided with economic needs to produce both the problem (indigence and social deviance) and the solution (institutional confinement).

Foucault viewed the confinement of the poor and insane in the context of a shift in society at the time from the predominance of sovereign power, which was no longer sufficient in efficiently regulating the behavior of the people, to the development of new techniques of social control. The Great Confinement marked the point at which madness ceased to become a personal concern and became a problem of the city (Foucault 1965; 1977). Central to the exercise of 'disciplinary power' necessary to regulate the behavior of individuals and to produce docile and productive bodies was the organization of architecturally designed institutionalized spaces to house the vagrant poor and insane (O'Farrell 2005; Foucault 1977). In Ireland, an Act of 1634 made provision for the establishment of 'Houses of Correction[4]' which were to stem the numbers of roving people that were creating a nuisance for society and threatening social order. These Houses of Correction represented a tidy solution to society's problem and were the first step in the establishment of order. Later Houses of Industry were established by a series of statutes commencing in 1703 with the establishment of the first House of Industry located in Dublin's St. James's Street followed by more throughout the country. Beggars, fortune tellers, minstrels, those who refused to work, gypsies and insane persons, were incarcerated in the houses of correction and industry which were staffed by keepers who were not paid by the Government. This meant that the keepers relied on money from the inmates, of which the insane had least, resulting in the latter receiving little nurturance (Robins 1986). While the insane were not necessarily the primary target of these initiatives, the nature of their behaviour and lifestyle meant that they were treated in a like manner. The Poor Law Act of 1838 was one of a series of acts aimed at addressing social instability in Ireland due to

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[4] The Act was entitled *'An Act for the Erecting of Houses of Correction, and for the Punishment of Rogues, Vagabonds and Sturdy Beggars, and Other Lewd and Idle Persons'.*

the widespread poverty it firmly established workhouses as the pivotal structure of the poor relief system.

If the establishment of institutional structures were important techniques in the operation of disciplinary power, so too was the organization of people within them (Foucault 1977). As the Houses of Correction and later the Workhouses and Houses of Industry became increasingly full of the insane, the need for their further segregation became an issue for politicians who raised concerns about conditions for those who were deemed to be insane. Some workhouses and institutions made some provision for them, but they existed in sufficient numbers, and their condition was such that their welfare became a concern for politicians resulting in the publication of a number of reports. While social order was no doubt important to British politicians eager to establish order in Ireland, parliamentary reports of the time provide evidence of humanitarian concerns of politicians regarding the suffering of the mentally ill and their treatment in their homes, communities and institutions (Williamson 1970). Regardless of motivation, the result was that large groups of people, the poor and destitute, were confined in what have been described as desperate conditions in workhouses, prisons and other institutions, and among them were those, who by virtue of judgments as to the normality of their behaviour, were considered to be mad, insane, lunatics. While the institutions provided the means of gathering the people together to facilitate surveillance, the establishment of abnormality or the process of 'normalisation' (a technology of surveillance) was an important step in segregating those who posed a threat to the social order. This movement, which was happening in parallel in Europe, began the separation of the 'mad' from other groups of people deemed to be unreasonable and located 'madness' firmly in the gaze of science (O'Farrell 2005).

The origins of the mental health care system we have today in Ireland lies in the mass incarceration in asylums of those considered to be insane in the 18th and 19th centuries. In Ireland, a Parliamentary Committee of 1804, investigating the needs

of the aged, infirm and poor, concluded that greater provision needed to be made for the insane at the public expense (Robins 1986) and in 1817 the *Report of the Select Committee to Consider the State of the Lunatic Poor in Ireland* (House of Commons, p.3) considered that the provision in establishments for the 'mentally deranged' was "inadequate for the reception of the Lunatic Poor" and "by no means calculated for the restoration to sanity, or even for the safe custody and care of the unhappy persons who were suffering under so dreadful a malady". They recommended the establishment of four or five District Asylums, additional to those already established in Dublin and Cork each with a capacity for 120 to 150 lunatics. This report commenced the process of setting up regional asylums for the insane in Ireland and provided the origins of centralized, state provision of institutional care for people with mental health problems in Ireland, significant remnants of which still remain in institutional structures, systems and power dynamics (Brennan 2014a).

Finnane (1981) observes that the segregation of the insane in Ireland began quietly. While initially it was estimated that only 100 beds would be necessary to house the 'idiots' and 'troublesome lunatics' that were wandering the roads and in the houses of industry, once established, the asylums expanded out of all control over the following two hundred years and became institutions of great social significance and an indispensable part of social order (Finnane 1981). St. Patrick's Hospital was the first asylum in Ireland, established in 1745 from funds donated by Jonathan Swift on his death. The notion of segregation was clear in a letter of the then Lord Mayor, William Foynes to Swift. In it he said: "First, I would have a spot of ground fixed on, that should be in good open air, free from the neighbourhood of houses; for the cries and exclamations of the outrageous would reach a great way, and ought not to disturb neighbours: which was what you did not think of when you mentioned a spot in a close space, almost in the heart of the city" (Reynolds 1992, p.3). St. Patrick's Hospital, (not in keeping with the vision of Swift) only catered for those who could pay, only taking in the poor insane to act as servants to the richer inhabitants (Robins 1986). The 1800s saw an extensive building programme that

established asylums throughout Ireland. The Richmond Asylum was the first publicly funded asylum in Ireland and was established in 1815 and between then and 1966, 23 asylums were established in Ireland (Commission of Inquiry on Mental Illness 1966).

Admission to the asylums in the late 1700s and up to the mid 1800s required the establishment of 'insanity' based on categorization systems that were vague, all-encompassing, applied inconsistently and were based on social problems, until the passing of the Dangerous Lunatics Act of 1838 (Brennan 2014a). Admission to the asylums could still be made by application to the particular asylum, but this act provided for ordinary citizens to make an allegation of insane behavior (there was no requirement of proof). The person could then be arrested and brought before two Justices of the Peace and required to undergo a medical examination and if judged to be insane, gaoled and then committed to the district asylum (Walsh 2005). Those incarcerated in the asylums were categorized as either lunatics (the mentally ill) or idiots (those with what we now call an intellectual disability).

The rates of admissions to the asylums grew exponentially, necessitating the building of auxiliary asylums and extensions to the existing asylums causing the Inspectors of Lunatics in their 1902 report to refer to increasing insanity as: "this vast brooding evil which causes so much misery", asserting that: "If this rate were to continue, to follow up a no doubt somewhat fanciful idea, though one not altogether devoid of interest, computation shows that in 170 years from this, the population of Ireland would consist of exactly an equal number of sane and insane" (Report of the Inspectors of Lunatics, 1902, cited in Torrey and Miller 2001, p.143). A census of insane persons under care showed an increase from 1,584 (0.21 per 1,000 total population) in 1828 to 4,297 (0.53 per 1,000) in 1844 and they were to continue to increase (Torrey and Miller 2001). The asylums, which were originally meant to house modest numbers, grew beyond all expectations and by 1900, in the space of 100 years, the lunatic poor of Ireland had been housed in asylums with

21,000 people, representing 0.5% of the population, incarcerated in district asylums (Walsh and Daly 2004).

The mass confinement of the insane in the 18th and 19th century across Ireland, Great Britain and Europe raises questions as to whether this reflected a 'real' increase in madness or whether other factors were at play. Reasons given for the apparent rise in insanity vary. The rise in life expectancy as a result of better nutrition and the decline in mortality from infectious diseases such as smallpox, cholera, typhus and tuberculosis and thus increases in population meant that more people were living longer including those 'afflicted with insanity' (Walsh and Daly 2004). The growth of industrialization meant that rural, subsistence living left no one to care for the insane in families as had been the tradition. However, Ireland was different in a number of ways. Firstly Ireland's mass confinement was more thoroughly executed and completed earlier than that of England (Brennan 2014a; b; Walsh and Daly 2004). Ireland's institutionalization of the 'mentally ill' far exceeded that of England, Scotland and Wales. This occurred at a time of a decline in the population (Brennan 2014 a; b) when other state backed, centralized social provision was absent (Finnane 1981) and without religious involvement which was the norm for the indigent poor and sick (Brennan 2014a). Reasons given for the rise in institutionalization in the UK and Europe concern the new market economy which produced social deviance that the existing means of poor relief was ill-equipped to deal with due to the demand of capitalism for wage labour (Rogers and Pilgrim 2010) producing the problem of indigence. The industrialization reason did not work for Ireland, with much of the population still living in rural settings at subsistence level, industrialization developed much later in Ireland. Some explanations emphasized a 'real' rise in madness arising from a variety of factors such as maternal nutritional deficiencies following the potato famine and other associated factors, however rates of insanity in other countries effected by famine did not rise in the same way (Walsh 2012).

> As far as Ireland is concerned the evidence that the famines of the late 1840s led to more schizophrenia is, at best, equivocal. The apparent

increase in the number of those schizophrenic was in the context of an increase in lunacy generally and the increase observed in Ireland was manifest throughout Europe and North America in jurisdictions where there were no major famines (Walsh 2012, p.14).

Other reasons postulated were heredity, the relatively high rates consanguineous marriages and increase in alcohol consumption. The high rate of emigration meant that people who had previously being accommodated and cared for at home were made destitute by their relatives' departure is supported by observations of particularly high rates of incarceration in counties which were particularly affected by emigration (Walsh 2012). The unsettled and highly volatile political environment in which people lived and the extreme poverty and deprivation in which much of the growing population lived is also postulated as a cause (Torrey and Miller 2001). The slightly lower death rate in Irish asylums relative to England, perhaps due to the prevalence in English asylums of general paralysis caused by syphilis led Irish officials to declare that:

> the apparent excess of insanity in Ireland over that of England is due to the absence of general paralysis. Strange as it may appear, the apparent preponderance of insanity in this country may be largely due to the virtue of its inhabitants (Drapes 1894 cited in Walsh and Daly 2004, p.24).

Walsh and Daly (2004, p.26) suggest that confinement in Ireland satisfied "twin polarities of social convenience and humanitarian impulse". Without consciously setting out to do so the establishment of the asylum system created a reliable economic entity, a source of employment in Ireland at a time of extreme poverty, the dependence on which led to resistance to the development of alternative approaches to mental illness. While the asylums provided a solution to the social problems that were rife at a time of extreme poverty, compounded by the potato famine of 1845, they also importantly contributed greatly to the local economy and provided much needed work and at a time when secure employment was much needed and valued (Brennan 2014a; b). The asylums became "sites of social intervention" used by families to manage crises, in a symbiotic relationship that satisfied the needs of the families and the needs of the asylums for inmates and

thus survival (Brennan 2014b, p.12). Brennan (2014a; b, p.12) suggests that "while there was no proactive programme of patient recruitment, a push-pull dynamic developed between families seeking intervention and asylums in need of patients" and the rate of incarceration continued to rise, leading to a situation where in 1956 Ireland had the highest rate of mental hospital utilization in the world at 710.34 per 100,000 of population, higher than the USSR and the USA.

The 17th century saw the beginning of the incarceration of people considered to be poor, socially deviant and indigent in Ireland and across Europe and people considered to be 'insane' were included in that mix. Social, political and economic factors such as famine, industrialization, colonization and religion converged to produce a situation in which people who exhibited particular behaviors came to be institutionalized and defined as 'insane'. Once established the institutions developed social significance as places of work, sites of detention, arbiters of normality and places of sanctuary and sustenance and were the disciplinary space in which madness was produced.

4.3 Discipline and medicalization

As well as the establishment and organization of disciplinary space the organization of activity was important in the operation of 'disciplinary power', involving practices such as the establishment of timetables, group activities and correct ways of operating to produce a productive and docile individual (Foucault 1977). The establishment of the early asylums in Ireland were influenced by the 'moral treatment' movement. This movement, with its origins in what was widely accepted as the reforming work of William Tuke in the York *Retreat* in England and Phillippe Pinel in *Bicetre* in Paris is considered by Scull (1989, p.278) to be "a decisive epistemological break in the history of Western responses to madness". In Tuke's *Retreat* in York punishment and incarceration were replaced by education, kindness, gentle but firm control and encouragement, instruction and emphasis on moral guidance and family norms. In *Bicetre* in Paris Phillipe Pinel unchained the

mentally ill and argued for employment, occupation and humane treatment (Turner 1987). 'Moral treatment' emphasized moral, social and psychological dimensions to mental illness and treatment entailed social engagement, hard work and the establishment of 'good' habits, moral improvement and order. Pinel and Tuke were and still are regarded by some as pioneers of reform, replacing tyranny of punishment with kinder and more humane treatment (Robins 1986).

The new regimes introduced by Tuke and Pinel, were considered by Foucault as a product of the social context of the time. In 1780 Paris was subject to an epidemic which was generally thought to emanate from an infection in the *Hopital Generale* and institutions were perceived as being in need of hygienic purification alongside moral purification (Turner 1987). Foucault considered moral treatment in the context of societal concerns about contagion emanating from the houses of interment and argued that the regimes of moral treatment inspired by Tuke and Pinel replaced physical coercion with a more subtle form of social coercion on the individual, "a gigantic moral imprisonment" (Foucault 1965, p.278). With its emphasis on moral discipline, the new system, by creating anxieties of the conscience, was thus a more efficient and economic system than the old system (Turner 1987; Foucault 1965). Moral treatment as espoused did not transfer from the *Retreat* to State-run hospitals in United Kingdom (Rogers and Pilgrim 2005), and while this ideology was ostensibly adopted in Ireland conditions for the insane remained poor. It is reported that while early admissions to the asylums were limited to those who were 'curable', amenable to the particular type of 'treatment' offered; the growing need for the accommodation of 'chronic patients' and the need for income from patients' labour were soon to dominate the operation of the asylums (Williamson 1970).

The early asylums in Ireland were governed by lay administration, 'moral managers', and employed physicians to attend to the inmates. Rather than understanding the growth of medical influence as a consequence of 'discovery' of

scientific fact that already existed, Foucault argues in *The Birth of the Clinic* (1973) that particular conditions of possibility existed to produce a medical understanding of the body. Psychiatry and medicine of the mind originated in the space created by the incarceration of those considered insane in the asylums (Porter 2002; Bracken and Thomas 2001). Foucault considered that the focus on the body as a biological entity represented an epistemological rupture, in which the body became a site of power by entering the field of knowledge, creating a meta-narrative of biological reductionism. He suggested that: "In fact, this supposed empiricism is not based on a rediscovery of the absolute values of the visible, nor on the pre-determined rejection of systems and all their chimeras, but on a reorganization of that manifest and secret space that opened up when a millennial gaze paused over men's sufferings" (Foucault 1973, p.xii-xiii). He describes the period as: "the period in which illness, counter-nature, death, in short, the whole dark underside of disease came to light, at the same time illuminating and eliminating itself like night, in the deep, visible, solid, enclosed, but accessible space of the human body" (Foucault 1973, p.241). Thus medicine and psychiatry are understood as political, operating as part of a disciplinary state and elevated beyond their possibilities into all areas of human life through a biologization and application of the clinical 'gaze' to the human body. Foucault (1973, p.39) said that:

> ....by linking medicine with the destinies of states, they revealed in it a positive significance. Instead of remaining what it was, 'the dry, sorry analysis of millions of infirmities', the dubious negation of the negative, it was given the splendid task of establishing in men's lives the positive role of health, virtue, and happiness; it fell to medicine to punctuate work with festivals, to exalt calm emotions, to watch over what was read in books and seen in theatres, to see that marriages were made not out of self-interest or because of a passing infatuation, but were based on the only lasting condition of happiness, namely, their benefit to the state.

He purported that the 'gaze' of medicine, "the reductive discourse of the doctor", makes the individual visible in a particular way that closes down other possibilities and is afforded unwarranted legitimacy as a natural scientific reality rather than being understood as a political act that produces power/knowledge and has effects and consequences (Foucault 1973, p.xi). Medicine moved beyond a methodological

function to have ontological importance, concerning an individual's being as an object of knowledge (Foucault 1973, p.244).

A biomedical approach to mental health problems emphasizes the primacy of the natural sciences in understanding causation of mental health problems and locates their treatment in medical practice providing the ideological basis for psychiatry. The basis of this understanding is that mental health problems are caused by neuro-biological factors which are either genetically determined or acquired. While modernist achievements of physical medicine are generally accepted, psychiatry's achievements are not and a biological basis for mental health problems is contested (Bracken and Thomas 2001). Biomedical understandings were suggested as far back as when Hippocrates (460-377BC) provided an explanation of distressed human behaviour, categorizing illnesses according to cause implicating the effect of bile and phlegm on the brain:

> Men ought to know that from nothing else but the brain come joys, delights, laughter and sports, and sorrows, griefs, despondency, and lamentations. …….. And by the same organ we become mad and delirious, and fears and terrors assail us, some by night, and some by day, and dreams and untimely wanderings, and cares that are not suitable, and ignorance of present circumstances, desuetude, and unskillfulness. As long as the brain is at rest, the man enjoys his reason, but the depravement of the brain arises from phlegm and bile, either of which you may recognize in this manner: Those who are mad from phlegm are quiet, and do not cry out nor make a noise; but those from bile are vociferous, malignant, and will not be quiet, but are always doing something improper. If the madness be constant, these are the causes thereof (Hippocrates 400BCE, translated by Adams 2014).

The emergence of biological understandings of particular behaviours is suggested as emerging at a time when the Ancient Greeks were becoming aware of internal conflicts regarding motivation of human behavior, such as debates regarding reason versus desire, and conflict between the individual and societal demands (Ducey and Simon 1975 cited in Read and Saunders 2010, p.22) providing an explanation for behavior which exonerated the individual from responsibility. While more recent biomedical understandings of mental health problems derive their legitimacy from research that implicates defects in brain anatomy and chemistry, research into hereditability and genetics and the relief of symptoms derived from

psychopharmaceutical agents (all of which are contested), the dominance of biological causation theory flourished in the Victorian era in the absence of such science (Pilgrim 2014a).

When a lunacy inspectorate was established in 1846 in Ireland to regulate the asylums the first two inspectors were doctors. According to Robins:

> "..the two inspectors set out to consolidate the medical influence on the development and operation of the asylums. Neither had any special experience or understanding of insanity to boost their authority, but little scientifically based knowledge existed at this time" (1986, p.92).

Nevertheless the inspectors' view was that it was important that the asylums evolved on strictly medical principles. The asylum rules of 1843 enshrined in policy medical control over the treatment of patients by placing the asylum manager in a subservient position to that of the physician (Brennan 2014a). Asylums became an integral part of medical progress and were viewed as a humane way to treat and manage the mentally ill (Rogers and Pilgrim 2005). This established the link between medicine and mental health problems that endures and is the origin of the biomedical orientation of current psychiatric services. Care in the asylums was provided by untrained keepers or attendants (males) and nurses (females) whose main functions related to the smooth functioning of the institution and the organisation and observation of the patients (Sheridan 2008). The attendants, keepers and nurses were required to work under the supervision of the medical superintendents. In Ireland, the first training programmes were established in 1894 and in 1921 the General Nursing Council registered the first nurses on the supplementary Register for Mental Nursing (Sheridan 2008). This and the introduction of training programmes for doctors by the Medico-Psychological Association consolidated the medicalisation of mental health care requiring as it did the routinization of the management of the insane under the medical model through the provision of programmes of care (Finnane 1981).

Foucault considered that 'madness' was produced in the medicalisation of hospitals and asylums as one of the mechanisms of disciplinary power and describes 'technologies of surveillance' that enabled that power to be exercised. The 'examination', a technique in the exercise of disciplinary power, where information about people is obtained and used to produce knowledge to be used by the disciplines (psychiatry, psychology, sociology) combines surveillance and normalising judgement to transform people into objects of knowledge and power (O'Farrell 2005). The asylums provided a space which made the 'examination' possible. Foucault (1977, p.185) describes the routines of medicine in the hospital.

> One of the essential conditions for the epistemological 'thaw' of medicine at the end of the eighteenth century was the organization of the hospital as an 'examining' apparatus. The ritual of the visit was its most obvious form. In the seventeenth century, the physician, coming from outside, added his inspection to many other controls-religious, administrative etc; he hardly participated in the everyday administration of the hospital. Gradually, the visit became an ever more important part of the functioning of the hospital.

This, according to Foucault had two consequences: firstly it resulted in the physician gaining authority over the existing staff relegating them to a subordinate role in the execution of 'the examination', and secondly it produced the 'nurse' who was in need of training and thus produced a 'corpus of knowledge' derived from "a domain of objects perpetually offered for examination" [the inmate], transforming the hospital into the "physical counterpart of the 'medical' discipline" (Foucault 1977, p.186). Foucault linked the segregation of the insane with the segregation of the lepers in Europe, the decline in which left institutional structures to be filled and a legacy of medical monopoly on the definition and treatment of deviance. While Ireland did not have a legacy of leprosy (Brennan 2014a), the Workhouses and Houses of Industry established to segregate and deal with the indigent poor, commenced the segregation project. Madness was created and became the domain of medicine, not on the basis of any superior scientific understanding as to the nature of human distress, but by virtue of contingent factors at play in societies experiencing fundamental change that resulted in particular economic and governmental needs.

While the medicalization of madness was conventionally understood as evidence of scientific progress, early 'treatments' carried out in the asylums, while physical in nature including the use of bromides, paraldehyde, psychosurgery, shocks, cold baths and spinning, were aimed at calming patients rather than any pretense at cure and were not derived from any scientific basis. Nevertheless the biological hypothesis was pursued and developments in brain imaging and biochemistry permitting examination of brain structure and neurochemistry, studies examining hereditability and most recently the mapping of the human genome have resulted in a widespread understanding of mental health problems as having a biological basis. Electro-convulsive therapy was introduced in the 1940s and in the 1950s this was augmented by the 'discovery' of the psychoactive potential of drugs used for other conditions (then rebranded anti-psychotics and anti-depressants) and their subsequent vigorous synthesis and marketing by pharmaceutical companies (Rogers and Pilgrim 2010). Foucault (1965, p.250) considered that the result of medicalization of insanity was that:

> Madness no longer exists except as seen. The proximity instituted by the asylum, an intimacy neither chains nor bars would ever violate again, does not allow reciprocity: only the nearness of observation that watches, that spies, that comes closer in order to see better, but moves ever farther away, since it accepts and acknowledges only the values of the Stranger. The science of mental disease, as it would develop in the asylum, would always be only of the order of observation and classification. It would not be a dialogue.

This he considered meant that the basis for the establishment of judgments about sanity and insanity was rendered invisible, inviolating it from debate or scrutiny.

If the development of moral treatment and the medicalisation and 'creation' of psychiatry as a discipline was viewed as more humane and progressive than previous understandings of 'insanity', and evidence of the inevitability of developments in science, so too was the de-institutionalization of the 'mentally ill'.

4.4 De-institutionalization

In the early to mid-twentieth century in Europe and the United States, mental health policy began to re-orientate towards de-institutionalisation and community based care. In Ireland, as early as 1927, the *Commission on the Relief of the Sick and Destitute Poor, including the Insane Poor,* critical of the overcrowding in the mental hospitals (which had been renamed in 1924) recommended the treatment of those with acute mental illness in general hospitals (Irish Free State 1927). However, it was to be 40 years later, in 1967, that the first of these opened in Waterford (Walsh and Daly 2004) and the initiative continues with the most recent unit opening in Beaumont Hospital in Dublin in May of 2014, almost 100 years later.

From a high of 21,720 in 1956 mental hospital occupancy in Ireland has continued to decline, with 2,401 (0.05% of the population) in-patients in Irish psychiatric units and hospitals in 2013 (Daly, Walsh and Moran 2014; Walsh and Daly 2004). While some of the fall in numbers can be accounted for by the de-designation of elderly and intellectually disabled patients in some hospitals so that they were no longer classified as psychiatric patients and deaths of long stay residents (Walsh 2004) the legislative framework which permitted it was the establishment of the 1945 *Mental Treatment Act.* Until then admission to the hospitals was under judicial jurisdiction legislated for by the Dangerous Lunatics Acts of 1838 and 1867. The 1945 Act although considered inadequate to guide modern mental health care, was considered revolutionary for its time, providing as it did for the first time for the treatment of patients on a voluntary basis in hospitals. Under the 1945 Act, patients could be admitted to psychiatric hospitals as voluntary, temporary (involuntary) or as a person of unsound mind, with specific rules regarding rights and processes of admission and discharge relating to each status. Decisions about admission and discharge lay with doctors and "this served to further consolidate the medical dominance of mental hospitals" (Brennan 2014b, p.15). However, the provision for voluntary admission and the requirement for review of 'temporary patients' led to a decline in the numbers of people resident in mental hospitals.

The *Report of the Commission of Inquiry on Mental Illness* in 1966 (p.xiv). expressed

optimism as to the future of mental health care and confidence in scientific

methods of understanding and treatment mental health problems:

> In the last few decades, psychiatric knowledge and methods have
> undergone a profound advance; and further progress no doubt lies in the
> not too distant future. There has been no similar period of time in the past
> which has seen such a marked improvement in therapeutic practice. The
> change has been due in part to the therapeutic possibilities opened up by
> the many pharmaceutical discoveries of recent times; but it has also come
> from a deeper understanding of the aetiology of mental ailments and of the
> needs of the mentally ill.

The *Commission* recommended the development of in-patient services through

establishment of short-term units in general hospitals and community based

services, such as day hospitals, out-patient clinics and domiciliary visiting with the

cost of the maintenance of psychiatric hospitals and in-patient care frequently

referred to. While comprehensive in its focus, the recommendations of the report

were not implemented nationally (Brennan 2014a).

The next major shift in mental health policy in Ireland was outlined in *The

Psychiatric Service-Planning for the Future* (Department of Health 1984) which

outlined a plan for major changes in mental health services, many of which had

been recommended in the previous report. The change in the delivery of in-patient

services from large psychiatric hospitals to units in general hospitals was perhaps

the most major change planned. In addition, the policy document recommended

that services were to be fully sectorized and special services were to be set up for

specific groups within the spectrum of mental illness. Generally, there was to be

more emphasis on rehabilitation of the mentally ill and a relocation of the services

away from the traditional mental hospital into mainstream medical care and

especially the community. It also provided detail as to the infrastructure required

to facilitate the shift, but importantly resource implications were not explicitly

stated. The 1980s in Ireland was a period of recession and high unemployment and

the necessary funding for the development of the infrastructure required to develop the comprehensive community services required by *'Planning for the Future'* were not made available. The recommendations of *Planning for the Future* were not comprehensively implemented either. A small number of home-based teams were created and some nurses and psychologists trained as cognitive behavioural therapists, addiction counsellor and psychotherapists, but the existing occupational structures remained unchanged and in the main they continued in traditional roles, using new skills as an adjunct to the dominant biomedical treatment system. However, admission rates to psychiatric hospitals slowly decreased and the development of community services was more comprehensive in some areas than in others. Some psychiatric units in general hospitals were established and hostels, day centres and day hospitals were established in many areas, however the full range of structures required to facilitate the shift to community based care as an alternative to in-patient care did not take place.

A variety of factors are implicated in the change in focus from institutionalized care to community orientation globally and in Ireland. Rogers and Pilgrim (2005, p.174) suggest that "The reasons thought to be responsible for deinstitutionalization are multiple and contested, and implicate a complex set of inter-relationships between the medical profession, public morality, the State and political economy". Discovery of the major tranquillizers for use in psychosis in the 1950s is frequently cited as facilitating the move from institutional to community based care for the mentally ill by virtue of their, if not 'cure ', at least treatment for psychosis. This rationale is problematic for a number of reasons. Not only had numbers in mental hospitals started to decrease prior to the introduction of the anti-psychotics, but the rate of decrease did not accelerate following their introduction, indeed in some European countries bed use increased (Rogers and Pilgrim 2005). This explanation also fails to account for the de-institutionalization of those not suffering from psychotic illnesses such as those with mental handicap who were also incarcerated in mental hospitals (Rogers and Pilgrim 2005). However the use of such drugs produced more docile patients who, while they could live in the community, would

still be under the control of psychiatrists and medical influence was not disturbed (Hyde, Lohan and McDonnell 2004).

Research highlighting the role of the institution in contributing to social withdrawal and passivity among patients, termed 'institutional neurosis' by Russel Barton (1959), and the work of Erving Goffman (1963) in describing 'total institutions', along with concerns regarding mistreatment of patients in asylums challenged the legitimacy of the asylum as a place or system to deal with mental illness in the mid twentieth century (Hyde, Lohan and McDonnell 2004). Scull (1977) argues that after the Second World War the impetus for decarceration emanated from the growing cost of the asylums, with increased unionization and labour costs. The emergence of the anti-psychiatry movement and the work of psychiatrists such as Thomas Szasz and R.D. Laing who considered psychiatry a coercive instrument of oppression and denied its legitimacy in constructing mental distress as illness, and Foucault's views on psychiatry as a disciplinary practice, provided an ideological platform for mental health survivor groups (Hyde, Lohan and McDonnell 2004). However, they appear to have had limited impact on psychiatric practice and the psychiatric services in Ireland (Brennan 2014a).

Changes in psychiatry itself and conceptualizations of mental health problems are also implicated in the move to community models of care. The further development of more formal classification systems for mental disorder, with the inclusion of psychiatric disease for the first time in the World Health Organization's *Manual of International Statistical Classification of Diseases, Injuries, and Causes of Death* (ICD-6) in 1949 and the publication of the first *Diagnostic and Statistical Manual* (DSM) by the American Psychiatric Association in 1952, meant that criteria for admissions to mental hospitals were more 'scientifically' defined leading to a more consistent approach and continuing the medical monopoly. The development of psychological conceptualizations of mental disorder emanating from the work of Sigmund Freud (1856-1939), Aaron Beck (1921-), Albert Ellis (1919-2007) and Carl

Rogers (1902-1987) for example and sociological understandings of the impact of social circumstances on mental health emanating from the work of Emile Durkheim (1951) and later Brown and Harris (1978) for example challenged the psychiatric monopoly, which nevertheless survived by movement into new locations and production of the concept of the multidisciplinary team. Brennan (2014a, p.7) argues that professional practice migrated from the asylums, "in the absence of a critical evaluation of the usefulness of psychiatry to these areas of social life". In tandem with a partial and unevenly distributed shift to community care, professional discourses continue to be dominated by a biomedical model that has adapted to and been complimented by rather than disturbed by psychological and social theories.

Rogers and Pilgrim (2005) argue that the asylums, providing as they did semi-permanent or permanent accommodation and treatment, acted as a form of social control; and thus while disabling for their residents they provided society with a neat solution to the management of a socially troublesome group of non-conformist people. These functions were still required when de-institutionalisation began. The development of acute units in general hospitals, together with hostels in the community for people with enduring mental health problems, provided a revised form of institutional care, retaining the centrality of in-patient treatment, supported by new legal measures to ensure coercive control over community based patients. The expectations placed on the acute units, they argue, are unrealistic as the new units cannot replicate the old functions (Rogers and Pilgrim 2005). They also argue that the movement of in-patient psychiatry to acute units in general hospitals represented an opportunity to improve the professional standing of psychiatry, viewed as a relatively low–status specialty. This professional interest, together with families who were troubled by psychiatric patients led, they say, to: "a confluence of interests [that] emerged in final quarter of the twentieth century to retain hospital focus to mental health work, despite the run-down of the asylum system" (Rogers and Pilgrim 2005, p.185).

The most recent Irish mental health policy document *A Vision for Change* commenting on progress in relation to development of community based services suggests: "It is also questionable whether the spirit of the community-oriented model has been fully implemented, that is, whether the main provision of care has fully moved from in-patient settings to the community" (Government of Ireland 2006, p.56). While in-patient services were contracted, the large psychiatric institutions continued to require funding, and additional funding to develop the community services was not provided. Brennan (2014a) suggests further factors responsible for the failure to more fully implement '*Planning for the Future'* lies in political unease at the potential for job losses, the economic reliance on the asylums for local economies the vested interests of professional groups, mainly psychiatrists and psychiatric nurses for occupational security at a time when Ireland was in recession. He goes on to suggest that it was only in 2006, a period of time in which Ireland had almost full employment was the political impetus to close the large asylums enshrined in government policy. The full move to community oriented mental health care is still underway in Ireland. Almost all of the large psychiatric hospitals have closed down and those considered to require acute in-patient mental health care are accommodated in in-patient units in general hospitals.

In the same way as moral treatment and medicalization is frequently represented as progressive and the inevitable product of scientific development, so too is de-institutionalization and community care. However, what is represented as a major re-orientation is arguably a re-location given the prevailing ubiquity of the discursive practices of psychiatry in defining normality and abnormality and what gets to be called 'mental illness'. Bracken and Thomas (2001, p.726) ask "If psychiatry is the product of the institution, should we not question its ability to determine the nature of post-institutional care?" Foucault's notion of power emphasizes the ubiquity of resistance and being targeted by a professional discourse is a necessary condition for the production of resistance (Hyde and Lohan, McDonnell 2004, p.32). While biomedical models have prevailed in the organization of services for people with mental health problems, evident in the

99

predominance of psychiatrists as the gatekeepers of the naming and defining of mental distress and in the extensive and sometimes exclusive use of medication only as a means of alleviating suffering, a range of discourses have emerged that challenge the legitimacy of psychiatry as a way of understanding and responding to human distress from both within professional groups and from people who experience or have experienced mental distress.

4.5 Critical discourses

Discourses critical of psychiatry have stemmed from a variety of perspectives. Some question the epistemological underpinnings of psychiatry that position mental health problems as problems of biology. The anti-psychiatry movement centred on questioning of the existence of 'mental illness' and the legitimacy of the state in providing 'treatment'. Thomas Szasz argued that the use of the word 'illness' in relation to mental distress was nothing but a metaphor and is mistakenly afforded primacy as a means of understanding the phenomenon. His (and others) views are supported by a questioning of the scientific legitimacy of research that suggests a biological basis for mental health problems. Research has suggested differences in brain anatomy of people diagnosed with schizophrenia for example, and this is contested by arguments in relation to cause and effect as similar brain structures have been observed in people who have experienced trauma, emphasizing the impact of environmental stressor on the biology of the brain (Read *et al* 2001). Theories about neurochemical causation have emerged from extrapolations of observations of the effects of particular medications on symptoms, for example in the case of the monoamines and depression. The legitimacy of such claims is also questioned on a number of levels. Firstly symptom relief is not synonymous with cure and the association with causation erroneous, for example Moncrieff (2009) argues that while Asprin relieves headaches, nowhere is it suggested that headaches are caused by a lack of Asprin. Secondly in relation to depression an equivalent amount of research indicates equal success for placebos (Kirsch and Sapirstein 1998; Moncrieff, Wessley and Hardy 1998). The

massive increases in the prescription of Selective Serotonin Re-uptake Inhibitors [5] (SSRIs) worldwide accompanied by increases in the incidence of depression do not support the extravagant claims made for their efficacy and for depression as a chemical imbalance (Moncrieff 2009). Thirdly the shifting nature of diagnostic categories and the absence of specificity regarding treatment conflicts with the prominence and gravitas afforded to pharmaceutical treatment. With every revision of the ICD and DSM disorders are reclassified to include or exclude particular aspects of behavior and emotion and many psychiatric drugs are used for a variety of 'disorders'. This is particularly relevant to the use of antipsychotic drugs for the myriad of states that are categorized as 'psychotic disorders'.

The optimism and hope that accompanied the 'discovery' of the original antidepressants and antipsychotics in the 1950s and subsequent new and more refined SSRIs and second generation and atypical antipsychotics has been overtaken by challenges to their efficacy, questioning of the quality and ethical integrity of the research that suggests positive outcomes and widespread recognition of the pervasive, disabling and sometimes irreversible and catastrophic nature of their side effects by mental health activists from both professional and lay positions (Thomas, Bracken and Timimi 2012; Whittaker 2010; Healy 2009; Moncrieff 2009; Double 2006). Similarly studies which have made claims for the efficacy of Electro Convulsive Therapy (ECT) as a treatment for depression have been reviewed in light of its adverse effects and review of medium and long-term benefits concluding that research offers minimal support for its effectiveness in the treatment of schizophrenia or depression beyond the treatment period (Read and Bentall 2010).

The anti-psychiatrists discussed above question the existence of 'mental illness' and emphasize the role of psychiatry as a form of social control. They tend to present

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[5] Anti-depressants which increase the amount of the neurotransmitter Serotonin in the brain, for example Prozac

binary distinctions between for example biology and social science, individualism and collectivism, freedom and coercion, physical illness and mental illness which are challenged by post-structural thought which exposes the way in which such distinctions obscure political, ethical and conceptual complexities (Bracken and Thomas 2010). The work of Foucault contrasts with that of the anti-psychiatry movement in not positioning any particular perspective as 'good' or 'bad' but rather undeserving of any particular privileged claim to superior knowledge. The *Critical Psychiatry Movement*, a movement that formed in the late 1990s and which is made up of mainly psychiatric professionals, is more aligned with Foucauldian thought than that of the anti-psychiatrists in that it seeks to work from inside the profession in questioning its ideological basis rather than denying any jurisdiction for psychiatry in the business of mental distress (Bracken and Thomas 2010). Critical psychiatry questions the validity of classification systems, the role of biological science in psychiatry, the associated de-contexualization of experience and the coercive power afforded psychiatry and the associated implications for civil liberties and human rights. The movement provides a forum for the consideration of other ways of understanding human experience and ways of improving treatment and care. The terms post-modern psychiatry and post-psychiatry have been coined to describe similar movements that aim to move beyond the conflicts between psychiatry and anti-psychiatry and their assumptions of 'correct' ways of understanding human experience, to emphasize the importance of social and cultural contexts, value based approaches and minimize the controlling and coercive nature of psychiatry and offer the potential to "opens up spaces in which other perspectives can assume a validity previously denied them" (Bracken and Thomas 2001, p.727).

Resistance has also emerged from people who have experienced mental health problems. Variously referred to as service users or survivors, groups have proliferated and organisations such as *Survivors Speak Out, Intervoice, the Hearing Voices Network* and *Mad Pride* have been influential in providing visibility and political fora for people who have been users of mental health services.

Ideologically, in terms of understanding mental distress, the orientation of many of these groups (although not homogenous) has been to emphasize that there are many different ways of understanding mental distress and to emphasize the centrality of the individual experience, the primacy of individual rights and the involvement of service users in all aspects of mental health service planning and delivery. The *Hearing Voices Network*, an international group, developed from the work of Marius Romme and Sandra Escher with people who hear voices, emphasizes the relevance of meaning and the importance of multiple ways of understanding the experience. The *Hearing Voices Network Ireland* has recently been founded, with self-help hearing voices groups established in a number of regions.

The notion of 'recovery' and the recovery movement has emerged from the work of Mary Ellen Copeland and others in the 1980s, based on the publication of studies and personal narratives by people who had been diagnosed with what was understood as severe mental illness, describing their experiences in recovering meaningful lives (Jacobson 2003). This focus on recovery as an internal individual process has led to the inculcation of the concept into mental health services and the organizational/societal conditions that may facilitate recovery (Mental Health Commission 2008). The concept of recovery offers a more optimistic understanding of the experience of mental health problems and the possibilities for people so diagnosed. It emphasizes the importance of personal meaning, person-centred services, mobilizing personal resources, service user operated services or peer support, respect for expertise by experience and social inclusion allowing for a multiplicity of perspectives (Mental Health Commission 2008).

The pervasiveness and persistence of the biomedical model, on which psychiatry is based, in the face of multiple resistances to the ontological basis from which it derives legitimacy demonstrates the manner in which: "the medical authority of the psychiatric profession functions as a power long before it functions as knowledge," (Foucault 2006, p.3). Bracken *et al* (2012) argue that psychiatry has operated and continues to operate from a 'technological paradigm' that privileges and is

preoccupied with categorization, causal logic and the identification of specific aspects of treatment demanded by evidence based medicine that is associated with physical medicine. They suggest, based on the results of meta analyses of studies relating to the efficacy of technological interventions, that success is derived from non-technical aspects of psychiatric care and suggest not an abandonment of scientific endeavour in the field of mental health but a "healthy scepticism for biological reductionism, tolerance for the tangled nature of relationships and meanings and the ability negotiate these issues in a way that empowers service users and their carers" (Bracken *et al* 2012, p.433). It is in the context of these various competing discourses that mental distress is understood in Ireland presently.

4.6 The current context of mental health care in Ireland

The deinstitutionalization of mental health care that began in the mid-twentieth century with the publication of the 1945 Act, has almost been achieved in so much that the large mental hospitals have been closed and the majority of care is being delivered in community based settings. The *Mental Health Act* 2001 is the current legislative framework for mental health care in Ireland. Provision in the Act is made for enhanced rights for people detained in mental health services with the enhancement of powers for the Inspector of Mental Hospitals and the establishment of Mental Health Tribunals for review of detention orders. This brings Ireland in line with the European Union requirements in relation to human rights but critics deplore the continued provision for legitimized coercive treatment allowed for on the Act. Current mental health policy in Ireland emphasizes the need for an inclusive approach to mental health care which privileges the rights and in-put of people with mental health problems. The main recommendations in *Vision for Change* centre on development of a holistic person-centered approach to mental health problems, with improved access to health promotion, integrated multi-disciplinary service provision and care planning, integration and participation in community life for service users, re-configuration of services and development of comprehensive community mental health teams (Government of Ireland 2006).

The involvement of service users in the planning and delivery of services is a central recommendation and the *National Service User Executive* is a body set up to inform the *National Health Service Directorate* and the *Mental Health Commission* on issues relating to user involvement and participation in the planning, delivery and evaluation of services (Government of Ireland 2006). The involvement of service users as advocates is another recommendation facilitated by the establishment of the *Irish Advocacy Network.* This change in emphasis has been influenced by discourses of individual rights, service user and recovery.

While *A Vision for Change* espouses this ideology, the structures it proposes, in the main, support rather than challenge the status quo. Despite liberal rhetoric espoused in policy, Ireland's current legislative framework continues to uphold the medical profession as the caretakers of mental health care as it places the consultant psychiatrist at the head of the multi-disciplinary team. This has occurred despite growing research linking psycho-social factors to the causation of mental health problems and growing questioning of the efficacy of the medical model as way of understanding mental distress. While psycho-social models of care have been embraced to some extent in parts of the Irish psychiatric services, this has been fragmented and structures remain unchanged. For example the *Mental Health Act* 2001 continues to require the person deemed Inspector of Mental Health Services to be a consultant psychiatrist (Government of Ireland 2001). Location of care may have changed from large psychiatric institutions to day centres, day hospitals, patients' homes and other community locations, but service structures and treatment modalities continue to centre on diagnosis and treatment with psychobiological therapies. Full reform of the service has not taken place as envisaged in *A Vision for Change.* Critics suggest the lack of a detailed implementation plan and adequate resources are responsible for this. Even in a time of economic prosperity mental health services in Ireland were not resourced sufficiently to develop. Funding for mental health services has reduced from 13% of overall spending on health in 1984, to 7.2% in 2006 and 5.4% in 2013, with some

allocated funds left unspent during in recent years (Faedo and Normand 2013). At a more fundamental level, the issue of mental distress and mental health is confined to the realm of health and illness and dealt with through legislation and policy in the health arena, rather than understood as a wider social issue

4.7 Summary

This chapter has charted the trajectory of events that have contributed to the construction of meanings about mental health problems from the commencement of institutionalization to the current context in Ireland. While the institutionalization of the 'insane' in Ireland was more widespread and completed earlier than in Great Britain and Europe, it occurred in the context of particular social, economic and political events and forces, the effect was similar. People considered to be insane were isolated from the rest of society and 'insanity' became a bio-medical concern. Despite the move to de-institutionalise mental health care biomedical understandings have prevailed and have expanded to accommodate psychological and social discourses. Critical discourses have emerged from a variety of sources that resist prevailing understandings, both questioning the legitimacy of medicine to respond to mental distress and the validity and nature of the responses. Contemporary mental health legislation and policy, while ostensibly incorporating some of these perspectives, nevertheless perpetuates biomedical understanding in the establishment of responsibilities and structures. It is in this context that this study was undertaken. The following four chapters outline the findings of the study on how mental health problems were discursively constructed in Irish newspapers.

Chapter 5 Constructing hiddenness and constructing visibility

5.1 Introduction

This chapter and chapters six, seven and eight present the findings of the study. Each chapter refers to two discursive categories. The findings are presented in relation to the various discursive practices enlisted in representing mental health problems in news items, the resultant power/knowledge produced and the likely effects of this. The sequencing of the findings is not meant to suggest the dominance or subordination of any particular element of the discourses, and while they are grouped together their overall inter-relatedness is acknowledged. This first section of this chapter provides some quantitative descriptive analysis of the data in relation to the distribution of the news items according to newspaper authorship and background of those quoted in the articles and it then presents the findings in relation to the discursive construction of hiddenness and visibility. Chapter six presents the findings in relation to the discursive construction of crises and risk, and devastation, chapter seven the discursive construction of illness and psychosocial causation, and chapter eight the discursive construction of recovery and treatment. The findings are summarized in the final section of chapter eight. Throughout extracts of data are presented to exemplify identified discourses that form discursive strategies[6] and a list of the articles is provided in Appendix 1.

The aim of the research was to gain a more sophisticated understanding of the way in which 'common sense' understandings were employed in establishing knowledge about mental health problems and the resultant production of power. The objectives of the study were to:

- Identify the discourses and points of resistance present in relation to mental health problems,

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[6] To differentiate reference to news items that were part of the data for the study from reference to other literature, and in the interests of explicating sources, in-text citation for news items will be in the form of title of article, publication, date, page number.

- Identify institutions or groups that are made visible or obscured by identified discourses,

- Reveal techniques employed in constructing mental health problems and the potential effects this has on the individual.

5.2 Descriptive findings

The sample consisted of 66 newspaper editions over a 31 day period in March 2009 which elicited 123 news items that had mental health problems as a central theme. This represents an average of 3.9 items per day. The significance of this rate of coverage needs to be considered in the light of the 59 news items which were in a 'once-off', 'extraordinary' mental health supplement to one of the Sunday newspapers. Without this supplement 64 news items would have had mental health problems as a central theme. Table 3 gives details of the distribution of articles according to the newspaper.

Newspaper	Number of articles	% of total
Sunday independent	74 (59 in mental health supplement)	60 (47)
Irish Times	30	24
Irish Daily Mirror	13	11
Longford Leader	4	3
Sunday Mirror	2	2
Total	123	100%

Table 3. Distribution of articles according to newspaper

A consideration of the terms used to refer to mental health problems and the particular mental health problems that were referred to in the articles contributes to an understanding of the meanings attached. Mental health problems were frequently referred to as generic entities, unitary conditions, undifferentiated from each other. 'Mental' being the most commonly used prefix with 'illness', 'problem', 'difficulty', 'issue' and 'disorder' attached, the term 'psychiatric illness' was also used. This concurs with previous research on newspaper coverage that identified that mental health problems were represented as unitary or undifferentiated states (Francis *et al.* 2005; Nairn, Coverdale and Claasen 2001). When mental health problems were referred to generically, they were sometimes qualified by reference

to severity, 'mild', 'moderate' and 'severe' or length, 'long-term', and 'enduring'. When particular mental health problems were specified or the focus of an article, suicide, depression, anxiety, and addiction were the most frequently mentioned with eating disorders, deliberate self-harm, psychosis, schizophrenia, personality disorder, post-traumatic stress disorder, bi-polar disorder, obsessive compulsive disorder mentioned less frequently. Other mental health problems, acquired brain injury, attention deficit hyperactivity disorder, kleptomania and dementia only received single mentions. Although information on prevalence of health problems in Ireland is lacking (Tedstone Doherty *et al*. 2007; Department of Health and Children 2006), data from well-being surveys, in-patient reports and international prevalence data, suggest that disorders of mood and anxiety are more commonly reported and identified than psychotic disorders in Ireland and in the western world (Daly, Walsh and Moran 2007; Tedstone Doherty *et al*. 2007; World Health Organization 2001). When general adult mental health was being referred to there was no specification of 'adult' as a population group, but other groups were specified, adolescents, young people and children, the travelling community, gay, lesbian and transgender people, deaf people, people with an intellectual disability and people who have committed a crime.

A consideration of authorship and sources in news items contributes to an understanding of the construction of mental health problems by identifying whose perspective is represented. Table 4 gives details of the authorship and Table 5 provides details of the affiliation of people quoted in the news items. Numbers are provided to give an indication of the relative presence and absence of particular groups.

Authors	Number of news items
Anonymous (in *HSE* supplement)	45
Journalist	41
Anonymous (main newspapers)	7
Medical doctor	6
Psychologist	4
Person with a mental health problem	3
Psychiatric nurse	3
Editor	2
Friend of person with a mental health problem	2
Relative of person with a mental health problem	2
Counsellor	1
Occupational therapist	1
Speech and language therapist	1
Psychiatrist	1
Fashion worker	1
Transition students	1

Table 4. Authorship of articles included in the study[7]

People quoted	Number of news items	%
Service providers *Health professionals* (36) • Doctor 11 (5 psychiatrists) • Psychologist 10 • Psychiatric nurse 4 • Occupational therapist 2 • Social worker 2 • Speech and language therapist 1 • Other 6 *Civil and public servants* 8 *Representatives of voluntary agencies* 9 *Others* 2	55	45
Relative/Friend of person with a mental health problem	18	15
Person with a mental health problem	15	12
Politician	9	7
Legal	5	4
Peer/service user organisation	3	2
Other	4	3

Table 5. People quoted in news articles [8]

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[7] The total number exceeds the number of news items as some authors were assigned two affiliations.
[8] Not all news items quoted or revealed sources enlisted.

Most articles in the main parts of the newspapers and their supplements were written by journalists. As previously mentioned, one of the newspapers had a supplement sponsored by the *HSE* which reported on developments in service provision that were in line with the mental health policy document 'Vision for Change' (Government of Ireland 2006). While most of the articles in this supplement were anonymous, in that there was no stated author, the content and attribution of the supplement would indicate that they were either written by or based on information provided by staff or representatives of the *HSE*. The relatively small number of professionals who were authors of articles in the main sections of the newspapers were either medical doctors, psychologists or psychiatric nurses. Only three articles were written by people with mental health problems and four were written by friends or relatives of people with mental health problems.

Category entitlement, a common rhetorical strategy which operates by including reference to others, a person considered to be an 'expert', as a way of corroborating and conferring gravitas on the view expressed, was frequently used to convey an opinion or argument (Potter 1996). Health service providers' voices dominated, with 45% of articles quoting a service provider. Psychologists, doctors and psychiatrists being the most frequently referred to or quoted professional occupation. Psychiatric/mental health nurses, occupational therapists, social workers, psychotherapists and other associated professional groups were mentioned but in small numbers. Civil and public servants engaged in mental health service delivery, politicians and staff of various voluntary agencies with an interest in mental health also featured. Of the 123 articles, 12% quoted or referred to information from people with a mental health problem and 15% referred to relatives or friends. Three articles quoted representatives of peer or service user organizations and three quoted information from judiciary and legal sources. The dominance of service providers and professionals in the data is influenced by the inclusion of the *HSE* supplement on mental health services. In articles written by or quoting professionals the content tended to represent their views as expert and

authoritative in relation to causation, cure and response. Across all news items, the items written by or quoting people with mental health problems tended to be limited to a focus on descriptions of their experience of mental health problems, complaints about lack of services, and enlisted biomedical frameworks of understanding. People with mental health problems, quoted or writing, were exclusively people who experienced what are understood as 'neurotic disorders' such as depression, deliberate self-harm, obsessive compulsive disorder, addiction, rather than what are termed the 'psychotic' or 'serious' mental health problems. People diagnosed with schizophrenia or psychoses were less visible and when present were spoken about by others rather than having their own voice.

This low level of involvement of people with mental health problems in the reporting of news pertaining to mental health problems is not new, with previous research identifying an absence of their voice and suggesting that when quoted or referred to their input tended to be superficial, qualified by and supportive of 'expert' views, and limited to particular social classes, mainly middle class (Rowe *et al*. 2003; Coverdale, Nairn and Claasen 2002; Olstead 2002) with some studies not even considering service users as a group for consideration in the authorship of articles (O'Connor and Casey 2001; Meagher *et al*. 1995). Varying levels of 'expert' involvement have been noted in previous research, with some identifying low levels (Scott 1994), and others identifying higher levels of involvement (Henson *et al*. 2009). O'Connor and Casey (2001) report in their sample of Irish newspapers that 46% of articles used health professionals to provide an expert opinion.

Some studies of media content consider the visual impact of the text and accompanying images as they are considered to convey discourse as well as the textual content. As part of data analysis I included fields in my database relating to the positioning of the articles in the publications and details of any accompanying images. Of the 123 articles the majority (69%) were located in supplements with 31% of the articles located in the main sections of the newspapers. This high level

in supplements is influenced by the inclusion of the *HSE* supplement in the sample. Articles in the main section of the newspapers were, with only one exception, positioned in the body of the newspaper and not on the front page. Analysis of the accompanying images revealed that in the *HSE* mental health supplement the images were dominated by pictures of *HSE* mental health service staff. In other publications people who were quoted or writing the articles were frequently pictured.

The next section of this chapter will discuss how mental health problems were constructed as hidden and how visibility was constructed in repairing hiddenness.

5.3 Constructing hiddenness

Mental health problems were constructed as being hidden, secret and elusive to define. Mental health problems were written about as being hidden, by virtue of being kept hidden and secret by people who experience them and their families, hidden due to elusiveness of definition and hiddenness was understood as not coming to the attention of 'the authorities'. Hiddenness was constructed as normative, it was taken for granted that people would want to keep their mental health problems a secret, invoking discourses of shame and societal stigma. Mental health problems were written about as difficult to define for a variety of reasons. This hiddenness was constructed as problematic due to a risk of danger to the person and as a barrier to receiving help.

5.3.1 Secrecy, stigma and shame

Secrecy about mental health problems was depicted as normative. It was taken for granted that people who have mental health problems do not wish to talk about them and want to keep them secret and hidden. News items that reported on the experiences of people who experienced mental health problems presented contrasts between a public outward manifestation of themselves and their lives and

an alternative private secret self that was known only to their close relatives and friends. In an item describing a man who suffered post-traumatic stress disorder and died by suicide the man's wife is quoted:

> A lot of people were surprised because he was still very good humoured, he was holding down a job, it was only people who saw him in his home, and there weren't many of those, who knew how bad he was.

And later in the article:

> They were the perfect couple, travelling the Australian Outback together, writing guidebooks. Only Catherine knew how John wept in his sleep at night, unable to cope with the horrific things he had seen in the morgue in Saigon. (I saw John go downhill as the demons from his Vietnam service ate away at him. Sunday Mirror. 22 March, 2009, p.26).

A contrast is presented between an outward appearance of well-being and happiness and a secret, hidden, experience of distress. Similarly in a news item that reported on the case of a man who was reported to have a mental health problem and had been prosecuted for sexual assault, the journalist, who was also a friend, stated:

> I and other close friends at the time guarded this secret (that he had a mental health problem) well and kept up the front that he was recovering from malaria. (Eugene is not a sex criminal, he should not be locked up. Sunday independent. 15 March, 2009, p.33.)

Secrecy is reinforced by the complicity of his friends. Referring to a previous period when he was understood to have a mental health problem and before he committed this crime, the perceived stigma of having a mental health problem is understood by his friends as greater than that of having an infectious disease.

A book review of a novel about a psychiatrist and his patients and which was stated as drawing on the author's personal experience of depression and addiction reported:

> It is human nature to shy away from vulnerability; we mostly avoid the things that might throw the slightest terrifying chink of light on our pain-even dark books.

> Well, this particular dark book strides over to the window and wrenches
> open the curtains on alcoholism, mental illness, self-hatred and sexual
> assault…. (Balm for troubled souls, but who will help the helper? Sunday
> Independent, Living Supplement. 8 March, 2009, p.14)

Secrecy and hiddenness are presented as so normal as to be a part of human nature and a normal, inevitable reaction to human distress and suffering. Metaphors of light and darkness are used to support the argument for the naturalness of secrecy about mental health problems. Similar metaphors of light and darkness were employed to describe openness about mental health problems in a headline which describes a programme about suicide as: 'Bringing suicide out of the dark corners of Irish Society' (Sunday Independent Living Supplement. 15 March, 2009, p.2). The privileging of secrecy is exemplified in an item about a celebrity who had recently spoken in public about his experiences of depression, it was stated that he 'made no secret of his depression' (TV Bill in clinic for depression. Irish Daily Mirror. 12 March, 2009, p.3.). An alternative way of expressing this could have been to write that he spoke about his depression, but instead it states that he did not keep his depression secret, thus constructing depression as an experience that might be deserving of secrecy or more normatively kept secret. So even when a person talks about having a mental health problem and is open about it the suggestion is that secrecy is the normative response and that they are going against the norm.

Hiddenness was justified by enlisting a stigma discourse. Mental health problems are widely acknowledged as attracting stigmatizing attitudes and behaviours. Erving Goffman (1963, p.3) described stigma as an "attribute that is deeply discrediting" and which is generated in social processes that mediate between judgments about what is normal and attributes of particular groups in society. The attribution of stigma requires the assignment of stereotypical attributes to a particular group, the formation of prejudice, agreement with beliefs in relation to that group and the performance of discriminatory behaviours based on those beliefs (Corrigan and Watson 2002). Research into the stigma associated with mental health problems has centred on the impact on the person and the behaviour of others in society. Stigmatizing attitudes and behaviours include

possession of negative attitudes, paternalism, increased desire for social distance and discriminatory practices. Stigma impacts on those with mental health problems in a wide variety of ways including internalization of negative societal values, consequently, diminishment of self-esteem and inhibition of help-seeking behaviour and importantly causing people to be reluctant to acknowledge the possession of a mental health problem (Corrigan and Watson 2002, Corrigan and Kleinlein 2005). Self-stigma, "the prejudice which people with mental illness turn against themselves" (Corrigan and Watson 2002, p.16) and the anticipation of discrimination contribute to the dominance of secrecy in the construction of mental health problems.

Rogers and Pilgrim (2010, p.36) refer to the pervasive nature of stigma, where the "non-patient also expects the diagnosed person to be expecting social distance". This was evident in reports that spoke about a lack of dialogue and openness about mental health problems as emanating from people's reluctance to admit what they perceive to be weakness. Discussing business people and professionals who have 'fallen on hard times', a news item on businessmen who experienced economic hardship due to the recession described them as follows:

> "These are the type of people who are the least likely to call for help. Why? Because everything in their background makes them feel they should be self-reliant. Because of their own activities, backgrounds or personalities they have been lauded as successful and have given the impression that they are wonderfully secure in what they have done in their lives," he (businessman who founded charity *Turning the Tide of Suicide*) said. (Lifeline needed for those at risk of suicide. Sunday Independent 15 March, 2009, p.26)

Eating disorders were depicted as being kept secret in an article that reported on websites that promote anorexia and bulimia that encourage people who have them to keep their 'illness' a secret (The weight game. Sunday Independent Life Magazine 29 March, 2009, p.12.). Another feature on anorexia, carrying the

headline 'Anorexia's open secrets', referred repeatedly to secrecy about the problem but made the case for more openness and 'exposure'.

> ..so little awareness, indeed so much secrecy, seems to surround eating disorders.

> ...so much of it is shrouded in secrecy. These secrets need to be exposed and dealt with. There are too many people in Ireland suffering for this level of silence to continue. (Anorexia's open secrets. Irish Times Health Plus Supplement. 10 March, 2009, p.8.)

A report on a transition year school project undertaken by teenagers to address the issue of bullying stated: 'Mental illness is often portrayed as something to be ashamed of' (Bullying and Mental Health. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.10.). An article written by a journalist of her own experience, described growing up with a mother who had a diagnosis of schizophrenia described the shame experienced by a young child in relation to the behaviour of her mother.

> My shame came from her flamboyance, her moth-eaten fur coat and hat thrown over torn and filthy clothes, her feet and neck black from never being washed.

> From what I could see of her personality, she was a quiet, gentle woman, but when the voices in her head were getting too loud, or her behaviour too erratic, the guards would come, and her personal shame became public property for various neighbours, some concerned and kind, others cruel and jeering.

> My shame came from the times I'd witnessed her being dragged into a squad car by big burly gardai to be brought to the local psychiatric hospital. Some of the villagers loved to gather at a safe distance to watch the chaotic screaming scene and cheer as she walloped the hell out of whatever officer had the bad luck to let go of her arms. (I was always ashamed of my mother, but not now. Sunday Independent. 23 March, 2009, p.18.)

Shame was located here with the mother, 'her shame,' and the daughter, 'my shame' by association, and related to public displays of behaviour that were considered bizarre and unusual, but also to the treatment of that behaviour. This is part of the condition that gives rise to the shame. The visibility of the mental health problem is the reason for desiring its hiddenness.

News items that depicted mental health problems as being kept hidden tended to focus on the actions of individuals in avoiding stigma rather than referring to any sophisticated consideration of societal attitudes towards mental health problems or human distress. Stigma was acknowledged as residing in society but the solution was located with the individual who was required to be open about their problems. A number of articles reported on a documentary that concerned the topic of suicide from the perspective of families of people who died by suicide:

> Ireland has long preferred to hide its suicides away, not least because up until recently it was a sin in the eyes of the Catholic Church and victims couldn't be buried on consecrated ground. (Bringing suicide out of the dark corners of Irish society, Sunday Independent Living Supplement. 15 March, 2009, p.2.)

The producer, who has produced other programmes on mental hospitals and suicide, was described as having:

> ….produced moving and acutely observed films on various unseen aspects of Irish life (The Hospice and The Asylum are among his forays into veiled territories), is continuing his excavation of the stories behind the statistics with I See A Darkness, a three-part documentary series focusing on suicide. (The world is not enough. Irish Times, Weekend Review. 14 March, 2009)

The programme was described as: 'conveying the darkest of truths' and suicide was described as ' the darkest of mysteries' (Powerful testimonies used to shed light on suicide. Sunday Independent, Living Supplement. 15 March, 2009, p.3.). Stigma was specifically mentioned in an editorial entitled 'The health of our youth':

> Mental illness carries a stigma in our society. And young people are reluctant to acknowledge their difficulties. (The health of our youth. Irish Times. 28 March 2009, p.15.)

This is also the view of an official of Grow, a leading mental health organization,

> Very often young people find it hard to talk about mental health and to get help where and when they need it. Young people can often feel a sense of stigma in relation to some of the difficulties they may be experiencing. (GROW promotes positive mental health in Co. Longford. Longford Leader. 20 March, 2009, p.2.)

Two loci of stigma were referred to, stigma residing in society and experienced by individuals, however the individual is made prominent as the site for change. Young people 'find it hard to talk', whereas this could be otherwise stated as societal conditions are not conducive to being open about difficulties.

Stigma theory emphasizes the importance of a 'sign' or 'signifier' that marks someone as possessing particular characteristics that are, or come to be, negatively evaluated by others and society. Visibility is a defining factor in the stigmatization process, so it makes sense that someone who experiences mental distress and who fears being stigmatized by being marked as 'mentally ill' would desire invisibility. However the 'problem' of hiddenness was dealt with in newspaper discourses by a call for more visibility. Numerous articles called for more visibility through more awareness and vigilance to identify those who are experiencing mental distress. In an account of a young man who died by suicide a metaphor of the veil is used rhetorically to evoke the notion of secrecy and hiddenness.

> The young apprentice electrician had no history of depression, he was out-going and funny and grabbed life with both hands. Sadly Jonathon was secretly carrying the weight of the world on his shoulders and hid behind a veil of smiles.
>
> He was a normal man who suffered in silence. There are thousands more like him in Ireland and that's something Rob (a friend) hopes to change. (People need to realise they are not alone Irish Daily Mirror. 26 March, 2009, p.24.)

Hiding mental distress is normalized by the writer who speculates that the practice of keeping suffering hidden is widespread and this is stated unquestionably. But the state of hiddenness is problematized by his friend who wants to change this through fund raising for an awareness campaign. Hiddenness is problematic because it means that someone might not get help and thus harm themselves.

Mental health promotion campaigns frequently use 'confessional', 'coming out' stories in media, with celebrities speaking about their experience of mental health

problems as a means of alleviating stigma, a counter-discourse or resistance to the stigma discourse. A study of news items from 1990-2000 found an increase in celebrity exemplars when compared with news items from 1980 (Clarke and Gawley 2009). A number of news items related to celebrities who were reported to have mental health problems (TV Bill in clinic for depression. Irish Daily Mirror. 12 March, 2009, p.3, Coughlan: Church to blame for Ireland's drinking. Sunday Mirror. 22 March, 2009, p.27.). Referring to the well-known actor and presenter Stephan Fry, one news item stated:

> Nowadays, we see intellectuals such as Stephan Fry explaining that he is bipolar, a severe mental illness, and this helps us to understand that these people are not 'mad'. (We're still not so understanding. Sunday Independent. 29 March, 2009, p.35)

The surface meaning here presents a positive image of mental health problems, legitimising them by association with intelligence and celebrity challenging notions of social incompetence commonly ascribed to people with mental health problems (Rogers and Pilgrim 2010). But ambivalence is revealed in the isolation of 'them' from 'us'. The fact that legitimization is required suggests that mental health problems are in need of legitimization, and that people can only be redeemed by another positive characteristic and association with someone of high status. People with mental health problems are isolated as 'these people', different to 'us', but acceptable if they are 'intellectual' like Stephan Fry, invoking the 'mad genius' discourse.

5.3.2 Deficient definition and identification

Some articles constructed hiddenness by suggesting that there were a lot of 'hidden' mental health problems that had not come to the attention of the health services. News items that referred to difficulties defining and identifying mental health problems constructed 'hiddenness' as problematic and worked to repair 'hiddenness' by offering particular mechanisms for establishing 'visibility'. News items represented mental health problems as definitely existing, this was not called into question, but elusive to define due to a variety of causes including inept

professionals, inadequacy or unavailability of services and difficulties in differentiation between various mental health problems and between what is considered normal human experience and 'abnormal' mental illness. Referring to obsessive compulsive disorder (OCD), an article stated:

> American research indicates that people with OCD see three to four doctors and spend more than nine years seeking treatment before they receive a correct diagnosis.
>
> OCD is difficult to diagnose and people suffering from the disorder are often secretive about their symptoms or lack insight into their illness. It's even difficult to describe the condition.
>
> Other studies have found that it takes an average of 17 years for people to obtain appropriate treatment from the time OCD begins. OCD has been misdiagnosed as depression, bipolar disorder, ADHD, autism and schizophrenia. Getting proper diagnosis and appropriate treatment can take even longer in Ireland, according to (psychologist and adviser to OCD organisation). (Cycle of obsessive thoughts. Irish Times. Healthplus Supplement, 13 January, 2009, p.7.)

Reasons for it not being recognized are given as:

1. it is difficult to diagnose correctly,

2. many doctors may not recognize it,

3. it is difficult to describe,

4. people keep it a secret,

5. people who have it don't understand that they have it.

The explanations provided for the invisibility of OCD function to support the existence of an objective reality, a diagnosis called OCD, a 'proper diagnosis'. Other possible descriptions or interpretations of distress and behaviour are denied expression. The imperative to be diagnosed is privileged, with warnings of the difficulties in getting a diagnosis and advice to self-diagnose. Diagnosis is only problematized in so much as it is difficult to get it right, the blame lies with the 'condition' or the 'practitioner', there is no questioning of the ideological basis for the diagnostic framework. The elusiveness of diagnosis was similarly referred to in relation to post-traumatic stress disorder (PTSD):

It took Dervla two years to discover she was suffering from post-traumatic stress disorder (PTSD). (How trauma brought Derval to tranquillity. Sunday independent Living Supplement, 15 March 2009, p.14)

The 'condition' which is presented unquestionably as real, is waiting to be discovered. This draws on a biomedical discourse, with use of words such as 'suffering' and 'disorder' linguistically locating mental health problems in the domain of physical illness.

The recognition and discovery of mental health problems was also a subject for attention in relation to children and adolescents.

She (Professor of child psychiatry) believes families can play a vital role in recognising symptoms of depression in children and young people.

"The difficulty for parents is recognising if this behaviour is just a normal phase of teenage life or something a bit more serious: has the young person got a mental health problem like depression, which is quite common in adolescents? The teaching is that depression is more common among young women but young men do find it very difficult to communicate around those sort of feelings, so my view is that depression is under-diagnosed in young men." (Huge increase in children treated for self-harming. Sunday Independent. 29 March, 2009, p.8)

While difficulties in definition are suggested, the difference between what is normal and what is a 'mental health problem' is written about as a problem of recognition rather than a problem with the classification system. While the difficulty in differentiation between 'normal' human experience and depression is acknowledged the article goes on to warn that there is more of it out there than is recognized, it is 'quite common'. Depression is discussed as a real entity existing but hidden and waiting to be discovered. Differences in incidence are accounted for as relating to a difficulty in expression by young men, obscuring any other gender related issues that might account for variations in mental distress. Families are enlisted in the process of identification by provision of increased surveillance.

5.3.3 Hidden from services

Hiddenness was also written about in the context of not coming to the attention of health services and frequently accompanied by complaints about lack of resources and calls for more service provision. Two articles that reported on a conference that focused on self-harm reported:

> While A& E departments deal with about 11,000 cases of self-inflicted injury every year, health professionals believe that the true rate is much higher because many cases never come to the attention of the health services. (State's first Self-Injury Awareness Day. Irish Times, 2 March, 2009, p.6)

> and

> There are about 11,000 presentations to casualty departments across the State each year according to figures compiled by the National Suicide Research Foundation. However, experts say this figure represents only a small proportion of actual self-injury, the majority of which does not come to the attention of health or social service providers. (Thousands treated for self-inflicted injuries feel that causes are ignored. Irish Times. 3 March, 2009, p.11.)

These accounts make a claim that there is more self-injury happening than is being brought to the attention of particular services and use rhetorical strategies to legitimize the claims being made. 'Health professionals' and 'experts' are stated as holding the belief. The assignation of a view to a professional grouping suggests expertise and knowledge over and above what the ordinary person would have and lends legitimacy to the argument. 'They' are also referred to as plural, so more than one health professional holds this view, using consensus to bolster the case for there being more hidden self-injury. Latour and Woolgar (1986) refer to a 'hierarchy of modialization' to describe a continuum of rhetorical resources that are used to modalize statements as factual. Here in the first extract, 'believe', the assertion used, is weaker than an assertion that something 'is', but stronger than 'I guess' for example. This allows the statement to be made but also allows for challenges to be accommodated as the hypothesis is unprovable as the 'true rate' can never be known. The second extract asserts that it is 'the majority' of self-injury that does not come to the attention of the services. Two issues are interesting here, no rationale is given for these assumptions about the existence of unrecognized self-harm and importantly 'coming to the attention of the health

services' is presented unproblematically as legitimizing their existence and being desirable and important.

Anorexia and OCD were also written about as being under recognized. An article that reported on the launch of a book based on a research study that investigated the impact friends have on teenagers' body image, reported that the researcher concludes, on the basis of the narratives that she reports in her book, 'there are an awful lot of people out there with undiagnosed eating disorders' and the research is reported as highlighting 'the prevalence of undiagnosed eating disorders' (Friends influence body image. Irish Times Healthplus Supplement. 17 March, 2009, p.1).

Similarly in relation to OCD:

> He (person with OCD) is keen to point out that OCD is much more common than people think and it can affect ordinary individuals. (Cycle of obsessive thoughts. Irish Times, Healthplus Supplement. 13 January, 2009, p.7)

Suggesting that there are a lot of undiagnosed or unrecognized mental health problems in existence was a claim frequently made to support the need for more services, more funding for existing services and for the creation of particular types of services. News items relating to depression, youth mental health, suicide, OCD, anorexia and self-harm employed arguments about the existence of the 'disorder' or 'condition', criticizing services and legitimizing the development of new services. For example;

> Pieta House, a Dublin based organisation which provides support and counselling to those affected by self-injury, estimates the real number of people affected may be closer to 60,000 a year. (Thousands treated for self-inflicted injuries feel that causes are ignored. Irish Times. 3 March, 2009, p.11.)

Describing the take up of a new community based drop in service for young people the centre's programme manager is quoted:

> "We knew there were lots of hidden needs out there, but it's much more than we anticipated." (A place to piece life back together: dropping in to Jigsaw Galway. Irish Times, Weekend Review. 28 March, 2009, p.3.)

Hiddenness was defined by reference to whether the 'person with a mental health problem' comes to the attention of the 'services', so the 'mental health problem' exists only in relation to the 'services' and the existence of the 'hidden problem' is used to legitimize claims for the existence and expansion of the 'service'. The 'service' needs to find more 'mental health problems' in order to survive.

The 'problem of hiddenness' was dealt with by arguments for greater visibility. The mechanisms for constructing 'hiddenness' as a problem suggest a preferred means of establishing visibility. Hiddenness was constituted in a number of ways, as the individual not wanting to make their mental health problem known, as being a problem of definition (achievement of a diagnosis) and as not coming to the attention of the mental health services. The 'problem' of societal stigma was obscured by arguments for more definition and openness when it could be positioned in the context of societal attitudes towards mental distress. This places the responsibility for 'repairing' hiddenness with the individual, by being open about their mental health problem, and on others to be vigilant and to 'watch out for it'. The suggested means by which mental health problems were to be made visible and legitimized was by being 'noticed' by 'experts', 'services' and given a name, the mechanism for having them noticed was the achievement of a diagnosis. This reinforces the legitimacy of dominant biomedical discourses that privilege definition, diagnosis, biological determinism and individualistic understandings of human distress. It privileges a particular way of defining mental distress as 'mental health problems', suggesting that this is the only means of addressing distress and getting help. Also by talking about mental health problems as 'states' that can be 'discovered' and 'defined' it reinforces the 'real' existence of a phenomenon, 'a mental disorder', that exists, and is waiting to be discovered. 'Hiddenness' is thus a necessary condition for establishing 'visibility' in a particular way, a particular type of visibility, by being named and defined by mental health services. This produces a need for mental health services. The way in which visibility was constructed is presented in the next section.

5.4 Constructing visibility

The notion of hiddenness as normative but problematic produces a need for visibility. As a response it reveals the very 'thing' that was the reason for secrecy. The problem of definition links 'hiddenness' with 'visibility' by providing a mechanism for establishing visibility. Discursive practices that emphasize a need for greater awareness, visibility, surveillance and scrutiny make visible preferred mechanisms for establishing a particular way of understanding mental health problems. Greater awareness of mental health problems, combined with vigilance and improved mechanisms for establishing diagnosis were written about as desirable as a means of establishing increased visibility.

5.4.1 Awareness, surveillance and identification

The need for more awareness of mental health problems was the subject of a number of articles and was written about unproblematically as desirable. Greater visibility was reported as being achieved by a variety of actions, increased awareness and identification of mental health problems among the public, by professionals and by individuals themselves, effectively making them more visible. News items focused on the means of establishing greater visibility through surveillance in families, among friends and by establishing new groups, sites and mechanisms for the practice of surveillance. The need for more awareness was reported in relation to a range of mental health problems for example depression, self-injury, eating disorders, and general mental ill health, was generally presented alongside reports on the 'hiddenness' of mental health problems and frequently accompanied by warnings of the danger of mental health problems not being recognized and arguments for additional service provision and increased funding of services to avert tragedy.

Raising awareness in relation to suicide was the subject of a number of news items, with the implication being that more awareness and openness about depression would mean that people would seek help and thus not resort to suicide. For

example, reporting on the suicide of a young man, who on the surface was not depressed, a sub-headline stated, 'Pals launch campaign to raise suicide awareness', reporting on publicity and a fund raising campaign that the man's friends were running to encourage young people like him to seek help rather than harm or kill themselves (People need to realise they are not alone. Irish Daily Mirror. 26 March, 2009, p.24.). Other articles reported on similar media campaigns aimed at raising awareness among different groups (Bringing suicide out of the dark corners of Irish society. Sunday Independent, Living Supplement. 15 March, 2009, p.2; Powerful testimonies used to shed light on suicide. 2009, 15 March, p.3.). Making people aware was suggested as a response to averting risk of suicide. A regional newspaper advertised a training course:

> Just ten places now remain in a training course aimed at creating a greater awareness of suicide and help prevent it from occurring. (Suicide prevention project in Rooskey. Longford Leader. 27 March, 2009, p.3)

Young people joined in the call for greater awareness and surveillance in an article that reported on Dail na nOg (The National Youth Parliament) who made recommendations in relation to mental health stated their recommendations were:

> 1. A structured SPHE (social , personal and health education) course for senior-cycle students, incorporating positive mental health awareness and the development of an accompanying online support service. 2. Mandatory mental health awareness workshops in all school on symptoms, supports and effects of mental health issues; 3. A nationwide awareness campaign to promote positive mental health, aimed at reducing the numbers of suicides among young people. (Teenagers take issue with mental health. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.10)

Each recommendation privileges awareness of mental health problems over other possible responses. News items that discussed raising awareness frequently called for increased vigilance on the part of friends and family to 'watch out' for signs of mental health problems in their loved ones. An article on alcohol consumption and mental health in the *HSE* sponsored supplement on mental health urged surveillance by professionals and friends.

> Professionals and friends need to identify individuals who are using alcohol to treat underlying problems such as stress, anxiety or depression in order

to offer alternative approaches to managing mental health problems. (Addressing the issue of alcohol. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.14.)

Specific groups were identified as being at particular risk, or having propensity to have hidden mental health problems and thus in need of special attention in relation to awareness and surveillance. An item, referred to previously in relation to how hiddenness was constructed, which reported on an increase in self-harm among children and adolescents, urged parents to watch their children:

> She (Professor of Child Psychiatry) believes families can play a vital role on recognising symptoms of depression in children and young people. She will also discuss what parents can do if their children are showing signs of depression or suicidal tendencies.
>
> "Parents may feel overwhelmed, afraid to intervene for fear of making a bad situation worse. But they can help greatly by noticing and attempting to communicate with their young person," she says.
>
> "…parents should seek help if their child's behaviour changes markedly at home, at school or in their social relationships."
>
> "The difficulty for parents is recognising if this behaviour is just a normal phase of teenage life or something a bit more serious; has the young person got a mental health problem like depression which is quite common among adolescent?" "The teaching is that depression is more common among young women but young men do find it very difficult to communicate around those sort of feelings, so my view is that depression is under-diagnosed in young men", she added. (Huge increase in children treated for self-harming. Sunday Independent. 29 March, 2009, p.8.)

This report does rhetorical work to enlist support for its contention regarding the need for surveillance. The notion of there being a difficulty, making a distinction between a 'normal phase of teenage development' and 'a serious mental health problem' provides an imperative for surveillance and identification. It conveys urgency and provides legitimacy for the diagnosis of mental health problems. Statistics are used in two ways; statistics relating to diagnosis of depression among young women are used to constitute a need for surveillance and a lack of statistics (less diagnosis among young men) is dealt with by suggesting it is hidden as they don't communicate their feelings, suggesting that mental health problems like depression are common among this group. Foucault recognized the family as one of a number of sites for the exercise of disciplinary power. Commenting on the

'levels of application' of discipline as a type of power he states: "...one day we would show how intra-familial relations, essentially in the parents-child cell, have become 'disciplined', absorbing since the classical age external schemata, first educational and military then medical, psychiatric, psychological, which have made the family the privileged locus of emergence for the disciplinary question of the normal and the abnormal" (Foucault 1977, p.215-216).

A vivid description of surveillance was provided in a news item focusing on the treatment of Josef Frtizl, (an Austrian man who imprisoned his daughter for 24 years in a cellar in their house and physically and sexually assaulted her, fathering seven children with her, and murdering one of the children she bore him). It stated that because of fears that he may kill himself as his mental health had deteriorated since the verdict and life sentence imposed, prison authorities had intensified their 'suicide watch'. This involved, assigning an elderly cell mate to "watch over him", and alert them to any changes in his behaviour, increasing the routine checks through the peephole in his cell and daily contact with a psychiatrist who is an expert in the suicidal behaviour of prisoners especially those convicted of sex offences. This psychiatrist is reported to have kept a 'watchful eye' on Fritzl during the trial, 'observing every gesture'. The prison vice-president stated that:

> "We have established a close-knit surveillance network around Fritzl. But I cannot go into much detail because he reads the newspapers and we don't want him to know the details of what we're doing," he said. Fritzl's elderly cellmate has been told to observe him closely and to sound the alarm if there are any marked changes in his behaviour. A psychiatrist who was assigned to Fritzl before the trial is also in daily contact with him. Patrick Frottier, an expert on the suicidal behaviour of prisoners, in particular convicted sex offenders, kept a watchful eye on him throughout the trial, observing every gesture. He is now overseeing an intensive therapy programme with Fritzl, and has avoided all contact with the media for fear it would compromise the treatment.

He went on to say that video surveillance of him was out of the question as:

> "If we were to watch him round the clock, that would show no regard for his human dignity. Fritzl may have a dark side but at the end of the day he is

still a human being." (Authorities are in red alert for Fritzl suicide. Sunday Independent, 22 March. 2009, p.21.)

Extensive description is provided of the means, the actors and a variety of terms are used to describe the way he was being observed and more is hinted at that cannot be reported on. This description of his surveillance, using the concern of suicide as a reason, enlisting the help of a fellow patient and the establishment of a surveillance network evokes the idea of the panopticon as a disciplinary structure. Constant electronic surveillance is ruled out as a challenge to his dignity, suggesting that intermittent human surveillance is somehow more ethical. The stated reason for the surveillance, to prevent him from killing himself and the surveillance is privileged. What is interesting here is that surveillance is presented as the principle response to his mental distress, while surveillance is described comprehensively, the 'intensive therapy programme' receives only a cursory mention.

In the mental health supplement to the Sunday Independent, which focused exclusively on mental health in Ireland and was sponsored by the *HSE*, specific groups were targeted as requiring particular attention and as having mental health problems that are sometimes hidden or unrecognized, and thus is in need of special surveillance. For example, adolescents as aforementioned, gay and lesbian people (Working it out-gay and lesbian mental health. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.13.), deaf people, (Deafhear.ie Sunday Independent. Your Health Your Life Supplement. 22 March, 2009, p.13.), people with cancer (Support and cancer. Sunday Independent Your Health Your Life Supplement, 22 March, 2009. p.12.), the travelling community (Travelling community-mental health. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.14.), and prisoners (Joined up services for prisoners with psychotic illnesses. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.22). An article on gay and lesbian mental health discussed the impact that concealing their sexual identity, homophobic bullying and negative reactions to coming out can have on the mental health of gay and lesbian people.

> 'Reach Out', the Government's strategy for suicide prevention, identifies gay and lesbian people as a group vulnerable to depression, self- harm and suicidal behaviour because of their experience of stigmatisation and marginalisation in Irish society. (Working it out-gay and lesbian mental health., Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.13.)

Similarly deaf people were targeted for specific mention.

> Deaf people are at an increased risk of having mental health problems for three main reasons: the cause of the deafness may instigate neurological, sight or other problems; there may be significant language delay; and deaf people have extremely limited access to appropriate mental health services. (Deafhear.ie Sunday Independent. Your Health Your Life Supplement. 22 March, 2009, p.13.)

Among the reasons given for an increased risk for deaf people of having a mental health problem is the absence of mental health services, the absence of a treatment facility is given as evidence of increased risk of developing the problem and not other explanations, for example, the social isolation that might be experienced by someone who cannot hear. In these two accounts what could otherwise be understood as human reactions to adversity are treated as pathological, evidence of mental health problems. Specification of particular groups for scrutiny expands the scope of surveillance, bringing more people to attention, more opportunities for surveillance and more opportunity to identify mental health problems.

Younger age groups also came under the professional lens. Screening of children from age eight was urged in a news item that reports on a study into the neuropsychological development of female sufferers of anorexia. It is stated:

> The report's authors say school children could be screened at the age of eight to identify signs that make them more vulnerable to risk factors such as size zero fad and the cult of the super-thin celebrity. (Anorexia linked to brain growth in the womb. Sunday Independent. 29 March, 2009, p.18.)

Surveillance is suggested as being carried out by professionals, not just for particular behaviours that might be indicative of mental health problems but for more nebulous 'signs that make them more vulnerable to risk factors'. A psychosocial discourse coincides here with a biomedical discourse in constituting

causation of anorexia. Even younger age groups were brought into 'mental health' view with children from age zero to three being the focus of a news items that described an initiative to address mental health in infants and toddlers.

> Infant Mental Health (IMH) is a field dedicated to understanding and treating children aged zero to three. IMH training has long been recognised as a necessary component of developing skills and expertise in remediating mental health problems during infancy and toddlerhood. Over the past four years, the North Cork Child, Adolescent and Family Psychology Service has observed a growing number of referrals for infants and toddlers with social and emotional difficulties.

> Ms Matacz adds: "Today, it provides the beginnings of a pathway for infant mental health training at primary, secondary and tertiary levels."

> "This service promotes the development of healthy attachments between infants and their caregivers, with the aim of breaking negative family patterns and providing the foundation stone for the development of positive mental health," says Ms O'Donnell. As part of the infant mental health practice, the psychologists are offering families concrete assistance, emotional support, developmental guidance, early relationship assessment/support, advocacy and infant–parent psychotherapy, depending on the needs of the infant and his/her family. (Putting children first. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.20.)

IMH is described as having 'long been recognized' and 'necessary' in correcting a fault or deficiency in the mental health of infants and toddlers caused by a faulty family. This rhetoric establishes the legitimacy of IMH as an essential service, as taken for granted. Infants have 'care givers' rather than parents, positioning relationships in childhood in the pathological language of professionalism. Professional assistance is 'concrete' and provides a 'foundation stone' and 'healthy attachment' in contrast with the 'negative family patterns'. The article goes on to report on an initiative with primary school children bringing all of childhood into the visibility of professional services. These and other news items that focus on the mental health of specific groups, expand the range of sites for professional interest and the exercise of discipline on a wider range of individuals and aspects of individuals' lives.

New mechanisms for improving the recording of and access to information about people with mental health problems and improved access to assessment tools were reported on as positive developments providing new ways of making mental health problems visible. A description of a new computerized patient information system stated:

> Before now, it was difficult to ensure that we had the necessary pieces of relevant health information from all the different health professionals. It was a time-consuming process to check on this. Now that we have the new WISDOM system, our staff will be able to get a record from their computers throughout the county, whether they are working from Dungloe or Donegal Town, providing it's from a HSE secure line.
>
> If a person needs help at 4am, and has attended the service prior to this, information will be available immediately on that person and staff will get a better picture of the service user's mental health care pathway. (A little wisdom. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.6.)

Improving the efficiency of systems of surveillance is presented as positive innovation. The title of the system, 'WISDOM', suggests positive qualities of experience, knowledge, and good judgment. The information provided by the professionals is considered to be vitally important, whereas information from the person who is experiencing the problem is not considered worthy of mention. Development of more sophisticated tools for assessment was similarly reported on by the *HSE* as a sign of improvement in services. An article reporting on an educational development in a regional mental health service reports on the development of a portfolio of assessment tools.

> An education package has been made available to nurses in Longford, Westmeath, Laois and Offaly. The portfolio of assessment tools provides: mental health symptom screening tools; self-evaluation screening tools; medication-effect screening tools; alcohol/drug screening tools; living-skills screening tools; and a tool for making sense of the assessment data. The main aims of this initiative are to enable nurses to have the requisite skills to deliver comprehensive and holistic assessment to improve overall care for service users; to strengthen the care plan and interventions for service users; and to deliver a consistent standardised approach to patient care. (Building the skill base. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.16.)

The improvement of the means of assessment is presented here as an essential prerequisite to care and a positive development.

The exercise of disciplinary power involves the discipline of personal conduct as political action through mechanisms that allow self-regulation (Foucault 1977). Surveillance is an important technology in the exercise of disciplinary power. Visibility is essential for examination and normalizing judgement to become possible. If human behaviour cannot be seen it cannot be categorized. Foucault evoked the notion of the panoptican as a structure that was used to: "induce in the inmate a state of conscious and permanent visibility that ensures the authentic functioning of power" (Foucault 1977, p.201). The manner in which visibility was privileged can be understood as a disciplinary practice that acts on individuals to encourage openness and expression of distress and on others in society to be vigilant creating a panopticon in which the individual is required to be visible. The other means by which visibility was constructed in news items was the manner in which diagnosis was privileged as a means of giving linguistic expression to mental distress.

5.4.2 Diagnosis

News items referred to the diagnosis of mental health problems as the normative means of establishing visibility for mental distress, a desirable goal and a necessary precursor to treatment. They referred to the range of sites in which diagnosis could be achieved, considered the range of people who could be subjected to diagnosis, the range of behaviours that should be included as diagnostic criteria and the means of achieving diagnosis. Diagnosis was constituted as desirable and as previously mentioned sometimes as elusive and difficult to achieve. Reporting on OCD a news item stated:

> Regularly featured in film and TV programmes as neurotic and overtly quirky characters, people with obsessive compulsive disorders (OCD) can battle for years to be properly diagnosed. (Cycle of obsessive thoughts. Irish Times, Healthplus Supplement. 13 January, 2009, p.7.)

This item went on to quote research that suggested that people with OCD can see several doctors and wait as many as nine years for diagnosis and an average of 17 years for treatment or be misdiagnosed, constructing diagnosis as a desirable goal which people strive to achieve. The task of distinguishing between normal and abnormal was used in making the case for the difficulty in achieving a diagnosis for OCD, the article went on:

> Many of the symptoms of OCD are normal in other contexts-checking the iron is switched off or washing hands or keeping order. The main difference is that these behaviours do not cause the average person undue stress or worry. "Only when symptoms persist, make no sense, cause much distress or interfere with functioning should they be considered OCD," explains US doctor John S March in his book Talking Back to OCD. (Cycle of obsessive thoughts. Irish Times, Healthplus Supplement. 13 January, 2009, p. 7.)

Here criteria for diagnosis are described in detail with differentiation between 'normal' and 'pathological behaviour' being longevity, rationality, functioning and distress, constructing particular behaviours as symptoms. The importance of achieving diagnosis was emphasized in descriptions of it as a precursor to treatment. Of a man who has OCD it was reported:

> Once diagnosed, Quinn began taking medication and attending a psychiatrist on a regular basis. (Cycle of obsessive thoughts. Irish Times, Healthplus Supplement. 13 January, 2009, p.7.)

Treatment here is presented as following logically after diagnosis and can only happen once diagnosis is achieved. In another news items a woman presented diagnosis of a disorder as a positive occurrence and an event that initiated treatment.

> A miserable compulsive pattern engulfed me: my brain told me to do what I really did not want to do. I felt out of control. By now I recognised I had a problem. My GP was understanding; he diagnosed my condition as obsessive compulsive disorder (OCD). He talked me through the symptoms, recommending a mild antidepressant. My parish priest recommended I attend a group called Recovery. (Overcoming fear. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.5.)

Two traditional bastions of power, the Priest and the Doctor, are enlisted as experts in diagnosis and remedy, one following logically and inevitably from the other.

Diagnosis is not problematized; it is only questioned in so much as it is not sufficiently available or inclusive.

Improved access to services where diagnosis is provided was reported as a positive development and a precursor to gaining help. An article that reported on the opening of a new in-patient adolescent mental health facility stated:

> The community service will be a rapid access clinic run by a multidisciplinary team and its aim will be to catch and treat mental illness among 15-18 year-olds. (Major gaps still exist in psychiatric teen services. Irish Times Health Plus. 31 March, 2009, p.1.)

Achieving a diagnosis is made more accessible and timely. People were encouraged to diagnose themselves in a news item that reported on difficulties with diagnosis of OCD in which a psychologist suggested that people test themselves for OCD before going to a doctor and enquiring as to the doctor's experience in dealing with OCD.

> She (a psychologist) recommends that people who think they may have OCD to do their own research and even take an online self test (web address of organisation she works for given) before approaching a medical professional. "Unfortunately not all GPs are familiar with the disorder and misdiagnosis can be a big problem, she says." (Cycle of obsessive thoughts. Irish Times, Healthplus Supplement. 13 January, 2009, p.7.)

New people are enlisted in the pursuit and achievement of diagnosis, the GP, the person with the problem. On one hand checking the credentials of the person diagnosing, reinforces diagnosis as a technical, complex, legitimate process and on the other people can diagnose themselves. In Foucault's notion of subjectivity and power "subjects are active in producing themselves" (Kendall and Wickham 1999, p.53). Diagnosis is made more amenable by being brought into the realm of the non-professional. Problems with diagnosis are constructed as faulty practitioners or lack of availability, a difficulty with the execution of the process and not any fundamental difficulty with the nature of diagnosis itself. Diagnosis was only criticized for its technical application rather than for its underpinning ideology. In this extract a woman who has anorexia is calling for treatment to be provided based on a wider range of criteria.

> A huge problem in treating eating disorders is that patients are only
> considered for treatment when impossibly and dangerously thin, and not
> before. Yet many people I know have been turned away from treatment
> because they are "not thin enough". So there's a level? Yes: your BMI has to
> be below 17.5 to be diagnosed as anorexic. (Anorexia's open secrets. Irish
> Times Health Plus Supplement, 10 March, 2009, p.8.).

The writer is calling for the expansion of criteria for treatment of anorexia to
include higher BMI scores and thus including more subjects in the group, the only
problem with diagnosis is that it not sufficiently inclusive. Hindness (1996, p.115)
suggests that

> … the attempt to employ discipline in some specific context must suppose
> that the relevant forces-the human entities over which that discipline will be
> exercised-have been correctly identified. Discipline, in other words, is
> always predicated on a claim to knowledge concerning the character of the
> human subject. Given this claim, the effect of disciplinary failure is to
> suggest, not that the exercise of discipline itself is mistaken, but rather there
> is a need for more knowledge about the person or persons to be acted on.

The suggestion that mental health problems are unrecognized or hidden creates an
imperative for recognition and diagnosis, expanding access to diagnosis by making
diagnosis more readily available and amenable to more and more groups. Visibility
is privileged and constructing diagnosis as the normative mechanism to make
mental health problems visible establishes mental 'disorder' as a truth, as an
objective reality. The act of diagnosis is represented as the legitimate means of
'producing', or 'discovering' 'mental disorder' from an examination of the person.
More actors are included in the surveillance and diagnosis process. Surveillance of
self is encouraged in pursuing elusive diagnosis and treatment.

On the surface hiddenness is represented as problematic as it hinders achievement
of help and visibility is represented as desirable enlisting liberal discourses that
support openness and tolerance. However, examination of the strategies enlisted
in constructing mental health problems in relation to hiddenness and visibility
reveal discursive strategies which privilege particular meanings and thus reveal the
operation of power/knowledge. The notion that the appropriate response to the

'hiddenness' of mental health problems is increasing their visibility through surveillance and diagnosis contends with the notion that the possession of a diagnosis is also a reason for desiring 'hiddenness', as the possession of a mental health problem is constructed as something that people do not want to disclose and which society stigmatizes. This contention is evident in a news item on obsessive compulsive disorder (OCD) that suggested that the comic value associated with OCD in Hollywood films, even though it trivializes the condition, is beneficial in that it increases awareness of it (Cycle of obsessive thoughts. Irish Times, Healthplus Supplement. 13 January, 2009, p.7). Increased awareness is valued even when associated with negative connotations. One way of understanding this resistance between hiddenness and visibility is with reference to theories of how people make sense of the social world. People struggle to make sense of the world and categorization is one of the tools that society offers to assist with sense-making. A 'meta-rule' of intelligibility is suggested as one of the recurring elements that underlies the process of stigmatization. It requires that people are able to account intelligibly for their actions; while not being called to do so while they are behaving in a way that is considered consistent with social expectations, when 'rules' are transgressed an account is sought (Scott and Lyman 1968, cited in Rogers and Pilgrim 2010, p.29; Goffman 1955). Achievement of visibility, through processes of description, categorization and diagnosis can be understood as a sociological process involved in making sense of the behaviour of people. Anything that lies outside 'normal' understanding needs to be understood with recourse to one framework or another. "The diagnosis is a professional codification of the person's own view that they have transgressed a 'feeling rule', just as one of 'schizophrenia' reflects the lay judgment that others have acted unintelligibly" (Rogers and Pilgrim 2010, p.37). Achievement of a diagnosis fulfils an important step in the stigmatization cycle it that it gives linguistic expression to an abnormality, the marker, at which stereotypical beliefs, prejudicial attitudes and discriminating behaviour can be targeted (Sartorius and Schulze 2005; Corrigan and Watson 2002; Goffman 1955). De-institutionalization of mental health care has meant that the 'mentally ill' are not quite so identifiable now, dispersed as they are throughout the 'community' and not in hospitals as they once were. New and more

sophisticated mechanisms for making them visible are necessary if we are to be able to distinguish the 'normal' from the 'abnormal'. Repairing 'hiddenness' with awareness, surveillance and definition by diagnosis reinforces scientific, biomedical discourses that underpin a realist understanding of mental health problems as disorders that are stable entities that exist and are waiting to be discovered. Lupton (2013, p.27-28) suggests that "When notions of health, wellbeing and productivity are produced via data drawn from self-monitoring, the social determinants of these attributes are hidden". The way in which visibility is established as desirable creates a need for surveillance, making the person the site of interest, placing the focus on a faulty body, normalizing a biomedical understanding of mental distress and human existence, obscuring social determinants and making visible that which causes hiddenness.

5.5 Summary

This chapter has introduced the findings section and presented a description of some quantitative aspects of the data. Terms used to connote mental health problems tended to position them as illnesses. Health service providers were the main sources quoted and referred to in news items with relatively few articles written by or quoting people affected by mental health problems and both groups referred to mental health problems utilizing a biomedical understanding, with professionals being positioned as authoritative experts and people who have problems associated with mood and anxiety more frequently being represented.

Hiddenness was constituted as normative but problematic. It was taken for granted that having a mental health problem is a shameful secret felt by those who possess them and those associated with them. Hiddenness was also constructed as being a problem of definition, a difficulty in identifying mental health problems. Hiddenness was understood as not coming to the attention of 'the authorities' and used to legitimize a need for more services or more funding. Constructing mental health problems as 'hidden' paradoxically makes them visible, and the discursive

practices employed in constructing their hiddenness makes them visible in particular ways, they make a particular type of 'condition' visible. The reasons for hiddenness are important in establishing a particular type of visibility. At the most superficial level of understanding this perpetuates an understanding of mental health problems as worthy of shame. The way in which this aspect of hiddenness was referenced locates the 'problem' of stigma with the individual rather than referencing any societal attitudes or practices. Resistance between discourses produces new discursive practices (Irving *et al* 2006). The discourse of hiddenness is resisted by discursive practices that emphasize a need for greater awareness, visibility, surveillance and scrutiny making visible preferred mechanisms for establishing a particular way of understanding mental health problems. Awareness and surveillance were privileged over other responses. News items referred to the diagnosis of mental health problems as the normative means of establishing visibility for mental distress, a desirable goal and a necessary precursor to treatment. The construction of hiddenness in relation to difficulty of definition produces a particular meaning of mental health problems as being medically defined and diagnosed and confers on them visibility as illness providing legitimacy for the prevailing systems of classification and treatment and biomedical understandings of mental distress. It also legitimizes the services provided for mental health problems, as hiddenness is problematized as obviating recognition and treatment which were reported as desirable. If mental health problems are hidden and difficult to define then this provides support for the possibility of their existence, in great numbers, (possibly unlimited) even when not seen or encountered and thus in need of mental health services. Diagnosis was portrayed unproblematically as a positive, desirable goal by news items that presented it as a gateway to appropriate treatment, that presented as progressive, developments which expand the number of sites for diagnosis, in terms of locations, groups of people and behaviours and emotions that get to be included as symptoms, and improvements in diagnostic criteria that expand the means of scrutiny. Specific groups were targeted as requiring particular attention and as having mental health problems that are sometimes hidden or unrecognized, and thus is need of special surveillance. New mechanisms for obtaining information about people with mental

health problems and improved access to assessment tools were reported on as positive developments. This functions to widen the professional 'gaze'. Criticism of diagnosis was limited to its technical application, efficiency and practitioner competence. This reinforces a realist, bio-deterministic understanding of human existence and privileges individualistic explanations for human distress obscuring wider societal issues.

The next chapter presents the findings relating to the construction of crises, risk and danger and devastation.

Chapter 6 Constructing crises and risk and constructing devastation

6.1 Introduction

This chapter presents the findings in relation to the discursive categories of crises and risk and devastation.

6.2 Constructing crises and risk

Mental health problems were conflated in news items with crises, risk and danger. A discourse of risk was invoked in articles that represented mental health problems as being on the increase due to psychosocial and environmental factors that were increasingly adverse. Warnings of crises were made in connection with reports of increasing societal pressures as a result of the economic recession, changes in society that exert pressure on individuals, societal expectations, breakdown in community involvement and religious beliefs. The economic recession was the dominant environmental factor mentioned and other adverse events, circumstances that arise throughout the course of the person's life such as trauma, stress, financial pressure, lack of employment, relationship difficulties, childhood trauma, sexual abuse, sexual violence and bullying were also implicated. As well as the 'risk of developing' and the 'crises of an outbreak of mental health problems', a discourse of risk was evident in articles that reported on mental health problems as being associated with lethal harm to the person through suicide and associated with violence to others. The veracity of such associations is not what is of interest; it may well be the case that the experience of mental distress is increasing and is implicated in risk to those who experience it and others; what is interesting is the way in which these connotations were deployed, the discursive resources that were enlisted in producing them, and how were they used in making meaning of mental health problems as this provides insight into preferred understandings.

6.2.1 Suicide and economic recession

The year 2009 was a year in which Ireland was in the early stages of an economic recession. This was frequently mentioned as being associated with an increase or

exacerbation of mental health problems and in relation to an increase in rates of suicide, self-harm, anxiety and depression particularly among middle aged men and young people. Depression, anxiety and suicide were positioned as being the result of the economic crash with people being at increased risk of developing them. Related to this and somewhat paradoxically, a small number of other news items provided explanations that centered on a crisis of values in society related to a growth in materialism and a decline in religious beliefs. Particular stages in the life cycle were highlighted as problematic. Suicide rates were reported as rising and warnings were issued as to who is particularly at risk including teenagers, young adults and adult males affected by the economic recession. Generally the tone of articles that were concerned with suicide evoked urgency and unpredictability in constructing crises and risk. For example the *HSE* mental health supplement contained an item that stated, 'There is no single cause for suicide. It could happen to anyone' (Preventing suicide. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.8-9.) Reporting on a suicide prevention project, another item asserted:

> Suicide is now a major problem in practically every parish in the country. More people die through suicide in this country every year than are killed in road accidents and the Rooskey area on the Roscommon-Leitrim-Longford border is no different. (Suicide prevention project in Rooskey. Longford Leader, 27 March, 2009, p.30)

Risk of suicide was represented as widespread, pervasive and unpredictable.

Some news items speculated on the effects of the recession on adults, predicting dire consequences for people faced with loss of income, linking suicide with financial hardship and mental health problems. A number of articles reported on the deaths of particular men, suggesting that they died by suicide as a result of financial hardship caused by the economic recession. For example a news item carrying the headline: 'It's another financial'-suicide and the downturn', referring to a text a businessman had sent to a friend on hearing the news of the death of an acquaintance, reported on the impact that the financial downturn has had and the

143

effect financial institutions have had in relation to putting undue pressure on a number of men who have died by suicide.

DAYS before he died, John O'Dolan called his old friend, Fr. Peter Finnerty in uncharacteristically low form. The usually upbeat 51-year-old Galway developer told his friend he was under "fierce pressure" from one of the major banks to repay loans but gave no sign that he could no longer cope.

When we spoke on the telephone, he said, "Things are not going great, Peter' but despite him saying that there was no sign that he was in despair. John was always a very strong guy. If a deal didn't go right, he would say: 'OK, let's go on to the next one." He was ebullient.

Within a week, Mr. O'Dolan was dead. His body was discovered in a shed at his home in Salthill on a Friday morning in late February. The most successful property developer in the west of Ireland had succumbed to the unthinkable and taken his own life. He had spent €28m with a consortium buying the Ireland island in Dubai's massive World development. Last month, two of his businesses, Polska Properties and Kinlay House hotel, were in receivership.

"John was a very strong character. He was the last person I would have thought that this would happen to. He had rung me the week before and he did say he was under terrible pressure in relation to business matters," said Fr. Finnerty. "I would never put him down as a person who would go down that line of taking his own life. There is a sense of bewilderment but if there was unfair pressure put upon him by a financial institution which put him under terrible stress, the people concerned should be made answer for that."

Fr. Finnerty, is not alone in suggesting that banks be held accountable for the financial and psychological mess that is the legacy of years of wanton lending. Builders and businessmen are being ruthlessly pursued for their debts, according to business source.

Everyone from counselling groups to campaigners and Church leaders have warned of the alarming toll of the economic crises-the nation's mental health. The Samaritans have been warning since Christmas that the recession can lead to an increase in suicide, not only among those who become unemployed but also among tho'se who remain in employment but feel they may lose their jobs. ('It's another financial'-suicide and the downturn. Sunday Independent. 15 March 2009, p.26.)

This item rhetorically establishes a connection between suicide and the experience of financial hardship. The usually, 'upbeat', 'strong character', 'strong guy', 'ebullient' man described is catastrophically affected by the 'wanton' banks who exerted 'fierce pressure'. Financial concerns are the only explanation given for his suicide. There is no concrete evidence provided for 'unfair pressure' exerted by the banks but it is implied as an uncertain possibility through the use of 'if'. Particular groups, with expert status, 'church leaders', 'counselling groups' and 'campaigners' are enlisted to support claims for the risk of suicide and the link with mental health and the recession. Banks are implicated, being blamed for 'wanton lending', which could otherwise be described as 'wanton borrowing'.

The privileging of the economic crises in relation to causation is evident where even in the absence of evidence that the person concerned was experiencing financial difficulties; associations were made between their suicide and their financial situation. For example, in the same article the death by suicide of a well-known Dublin businessman was reported.

> The death of Patrick Rocca the gregarious tiling millionaire-turned-property developer, first focused public attention on the terrible toll of attrition the financial crisis is taking on the Irish business community. Mr. Rocca shot himself in the garden of his Castleknock home in Dublin in January. His death was reported across the world as symbolising the death of Ireland's Celtic Tiger, to the anger of his grieving widow, Michelle. She felt compelled to issue a statement to set the record straight: her husband was not in financial difficulties when he died. ('It's another financial'-suicide and the downturn. Sunday Independent. 15 March 2009, p.26.)

While this suicide is said to be focusing the public's attention on the impact of the economic crises on the business community, his wife is denying that he had financial difficulties. Her account is qualified by describing her as 'feeling compelled to issue a statement', placing its veracity in doubt. Anecdotal evidence is given of other suicides related to financial stresses.

..there is anecdotal evidence of other cases of business people taking their own lives in a time of financial turmoil. One senior garda said last week that he knew of three cases in one county since Christmas. They may not have been big players but the pressures they came under were no less devastating. "They were in the construction game and they were in financial difficulties. I would say you could take that figure and replicate it all over the country," he said. ('It's another financial'-suicide and the downturn. Sunday Independent. 15 March 2009, p.26.)

Conjecture is employed to inflate the crisis. Assertions in the article are qualified by statements that indicate a lack of tangible evidence of this pressure. Despite relating these suicides to financial pressures in some cases there is no evidence given that these men were in financial difficulties, instead it is suggested that they were in property development or had invested in the stock market.

No one can know for sure what caused these terrible tragedies or whether the sense of desperation that drove them to it was triggered by financial pressures. It is up to gardai to gather the facts surrounding the tragedies and to report back to the county and city coroners who will deliver a verdict on the cause of death at an inquest. However, the climate of fear and pressure within the business community is such that speculation can often run rife. Last week, for instance, a businessman texted a friend with news of the death of a mutual acquaintance. It finished with the words: "It's another financial." ('It's another financial'-suicide and the downturn. Sunday Independent. 15 March 2009, p.26.)

The writer makes the connection between financial pressure and suicide. Stating that it is not known whether it was financial pressure that caused them to suicide, creates the suggestion that it could have been financial pressure, when it could be denied that any number of factors may have been implicated, for example a history of depression, a biological condition, a long-term physical illness, poor coping strategies or relationship difficulties. This serves the purpose of reinforcing the veracity of the link and serves also to make the case for their main point which is that financial downturn has led to suicides with the banks being responsible. The use of conjecture and rhetorical strategies to link particular phenomena to cause and effect privileges particular social circumstances in the causation of mental health problems and in doing so obscures others. In an article reviewing a book on

146

the history of mental illness, the current economic decline was similarly evoked, calling for talking therapy:

> With the violence and chaos of the world view championed by the money men threatening to engulf us all, and our planet, perhaps it is time to start talking, and listening, again. (Time to start talking and listening again. Sunday Independent, Living Supplement. 22 March, 2009, p.12.)

Other articles similarly referred to businessmen who have died following financial troubles (Developer was 'singled out'. 2009, 4 March, Irish Times, p.2; Lifeline needed for those at risk of suicide. 15 March 2009, Sunday Independent, p.26.). An article written by a GP, commenting on a television programme about suicide, links suicide with the recession speculating on the psychological consequences of financial distress.

> Heading into the Celtic Collapse, two powerful emotions begin to appear that could trigger suicidal thoughts -- namely shame and hopelessness. Shame -- an unusual emotion to discuss -- has long been a potent stress trigger; in countries like Japan it led regularly to tragic consequences. In Ireland, a virtual revolution is occurring in homes, factories, businesses and professions, where all the certainties have been stripped bare.
>
> Many used to a certain quality of life but now struggling to cope with crippling losses and debts will feel ashamed of letting down their family or business. For some, the prolonged stress of coping with this sense of shame and failure may trigger depression and suicide. This will be confined not only to those losing their jobs but also many previously protected by money and power.
>
> Hopelessness is another state of mind that can lead to self-harm and suicide. We see no future for ourselves, those close to us or indeed the wider community. Ireland in 2009 is being portrayed in the media and by many experts as a place where 'all is lost', a land without hope. In practice, this view is, of course, just as false as the Tiger it replaces. But there are many susceptible people who could be affected by this view of life.
>
> In some cases depression may already be present and hopelessness finds a ready home; in others the stress they are feeling because of this could be the trigger that activates it. Depression and hopelessness are very deadly companions, particularly if people turn to alcohol because they feel it helps them cope. That can have disastrous results.
>
> Falling into hopelessness is easy when your job has gone. Your house and family are at risk, there is no prospective employment on the horizon and all

around is gloom. You once felt useful but now have no 'function'. It is also easy to see how shame and hopelessness can quickly combine to increase our sense of worthlessness.

(All is not lost even the darkest hour. Sunday Independent: Living Supplement, 8 March, 2009, p.8.)

The tone of the article is dramatic and pessimistic with a somewhat paradoxical message that there is hope, reflected in the headline 'All is not lost even the darkest hour. Mental health problems, suicide and self-harm are represented as an understandable response to financial hardship. Conjectured descriptions of people's responses to financial problems are provided, and associations between Ireland and Japan, a country where suicide is not stigmatized in the same way as it has been and to some extent still is in Ireland, are made. It refers to a particular group, people who were previously financially secure and who have lost jobs or who are in great debt. While it may be the case that the economic recession has exerted pressure on particular individuals and groups in society, this is not what is in question here. What is interesting is the rhetorical referencing used to privilege this over other possibilities and what is obscured in doing so. Some people may well respond in this way to sudden financial difficulties, that is not what is of interest in examining the 'truths' that are produced in such reports; what is of interest is the prominence of these concerns in news items in contrast to the relative absence of any corresponding coverage of mental health problems amongst other groups affected by poverty, for example people who live in poverty on a more permanent basis. Interesting also is the 'taken for grantedness' of depression, and suicide as a response to economic hardship.

An article written by a medical doctor made connections between economic crises in the past and the labelling and confinement of certain groups of people and the forms of madness that ensued. In it he compares people's current psychological responses to recession and adverse economic circumstances to events in the past. He refers to the 1980s recession in Ireland and suggested that the phenomenon of people reporting seeing religious statues moving in Ireland at that time might have

'been a manifestation of collective psychological distress'. He then goes on to cite

chronicles from medieval times which describe 'several outbreaks of 'compulsive

dancing' in France, Germany and the Low countries', described as mass hysteria by

a medical historian. One particular outbreak was described in Strasbourg in 1518, a

time of acute stress, when the harvest failed, high grain prices, syphilis was a new

illness, and leprosy and plague were prevalent. He makes the connection that while

the outbreaks of dancing are unlikely in current times

> …the extreme elements of a deep and prolonged economic recession could
> well produce some new expression of psychological distress.
>
> Symptoms of mental illness are not fixed but can be modified by changing
> cultural circumstances. What price an outbreak of "bankers brain" or "social
> partner paralysis" in the coming months? (All is not well in the psyche of the
> baby gloomers. Irish Times HealthPlus Supplement. 3 March, 2009, p.7.)

Mental illness is linked metaphorically with the recession through the linking of

words that connote disorders with terms used in business. The privileging of the

recession in evoking a crisis in relation to suicide and mental health was also

evidenced in the use of metaphors that associated the recession with disaster, for

example changes in a person's life and unexpected events like the *'economic*

tsunami' were spoken about as posing major challenges to a person's equilibrium

(Shock takes awesome toll on our psyche. Irish Times Healthplus Supplement, 10

March, 2009, p.8.). Simile was used to connect suicide and the recession by

referring to:

> It (suicide) is as real as our current banking crises, our economic downturn,
> and the litany of redundancies that we struggle to come to terms with on a
> daily basis. (Why? Irish Times HealthPlus Supplement. 3 March, 2009, p.4.).

Metaphors and other rhetorical strategies are resorted to as a means of making

meaning by establishing connections between different discourses, obscuring other

ways of talking about either phenomenon.

The economic crisis was also referred to in some news items that commented on a

loss of traditional value systems. Mental health problems were constructed in

some accounts as a result of existential concerns around finding meaning in life, connectedness and identifying clear ideals by which to live. One article that reported on a well-known singer's comments on alcohol consumption in Ireland, refers to the decline of religious beliefs:

> "Addiction to any substance is a disease of people who are ill at ease with themselves. The Irish are uncomfortable with their history and the Church has a lot to do with it."

> "People become separated emotionally and spiritually from themselves.

> "Young people have become completely at a loss for any sort of spiritual rudder. It's been computers, Bebo and alcohol." (Coughlan: Church to blame for Ireland's drinking. Sunday Mirror, 22 March2009, p.27.)

Similarly a GP, commenting on hopelessness and recession, writes:

> In the past, community and spirituality were bulwarks; now they have almost disappeared in the lives of many. We became a society immersed in a form of national rating -- we were our jobs and our possessions. We lived to work rather than working to live. When these are stripped away, many may struggle. (All is not lost even the darkest hour. Sunday Independent Living Supplement. 8 March, 2009, p.8.)

In this news item the recession is considered an opportunity to return to more 'traditional values' that were lost during the economic boom. Discourses of crises and risk are used in relation to mental health to evoke nostalgia for the past which is idealized. Public discourse on the recession refers to the 'Celtic Tiger', a period immediately prior to the recession in which Ireland experienced a period of economic growth. This is frequently spoken about as a time when there was a widespread focus on material matters to the detriment of 'values', nostalgically referred to a 'traditional'. This idealization is frequently invoked in public discourse on the recession in Ireland. Economic prosperity is associated with reference to greed and avarice, with the past idealized as a time when relative poverty was linked with good moral values. This places the focus at an individual level, by blaming greedy individuals, obscuring macro-level factors such as social and economic processes.

The link between mental ill health, recession and suicide was used to support various calls for action on societal issues such as the economy and provision and funding of particular services. Warnings of crises and risk were frequently made in association with complaints about lack of funding and calls for the development of services to address mental health needs. For example, an article that warned of dire consequences quoted a businessman who founded a charity to address the issue of suicide.

> Ireland is going to lose between 10 and 12 people a week to suicide, many of them among people hit by the recession, according to businessman Noel Smyth, who founded the charity Turning the Tide of Suicide.
>
> "What happens if it is 10 or 11 o'clock on a Friday night and you are feeling in the wrong place – who do you turn to?" he asked. "For those business people who have taken their own lives there was, in my opinion, nothing for them. There was no one to turn to for confidential advice and help."
>
> "Unless we take this issue seriously we are going to have these types of suicides arising because of the pressure that they [people who have been successful in business life but who have fallen upon lean times] are under and, more importantly, when they do come under pressure there is nothing out there for them. There is no place for them to go."
>
> "Because the banks are in such a bad place themselves you could end up where someone from the top is pushing someone in the middle of the bank and they are venting their spleen against clients. That could easily happen. And that kind of pressure can tell on people." (Lifeline needed for those at risk of suicide. Sunday Independent, 15 March, 2009, p.26.).

In a news item that reported on funding cuts to organizations involved in suicide prevention, the chairman of the *Action on Suicide Alliance* reported growing numbers of calls to helplines of various organizations and stated that they are barely able to cope with the demand and that people will be negatively affected if funding is cut by the *HSE*.

> "The NOSP (National Office for Suicide Prevention) couldn't have picked a worse time to cut funding to mental health groups. The dismal economic climate is having a massive effect on people who are turning to support groups for help now more than ever. Lives could be lost as a result", Alliance Chairman Paul Kelly said. (Funds for suicide prevention set to be cut by 12.5%. Irish Times 5 March, 2009, p.12.)

The risk of suicide is linked with the economic environment in making a claim for funding for services.

Constructing crises and risk by speaking about mental health problems as being related to the economic recession in this way, blaming banks and job losses and calling for increases in service provision, presents a simplistic view of suicide. Increases in suicide rates in some countries affected by economic recession are reported by empirical studies, for example in Greece (Economou *et al*. 2011) and Italy (De Vogli, Stuckler and Marmot 2012), with Ireland reporting a 9% increase between 2008 and 2009 (National Office of Suicide Prevention 2010). However, the relationship between mental health and economic hardship is complex and a wide variety of factors including social policy, social support, cultural factors, alcohol consumption and government responses to crisis and are implicated in explaining variations (Karanikolos *et al*. 2013), notwithstanding the considerable variation in reporting and recording practices. Implicating proximate factors in the causation of the financial crises obscures distal, macroeconomic factors such as ideologies and policies that rely on market self-regulation (De Vogli 2013) and factors such as income inequality which are suggested as impacting on health and welfare in general (Wilkenson and Pickett 2009) exonerating the social system of any responsibility.

While mental health, suicide and the recession were strongly referenced, crises risk and danger were also evoked in relation to other mental health problems which were constructed as dangerous to the physical integrity of the person in descriptions of people who have died by suicide and who were reported to have had a mental health problem. A woman who wrote a book about her husband's experience of post-traumatic stress disorder and subsequent suicide was quoted in a news item that stated:

> I hope too it helps people understand the dangers of post-traumatic stress. It's terribly dangerous and the more it's hidden, the longer it goes on, until

everyone around you is drawn in. I saw John go downhill as the demons from his Vietnam service ate away at him. Sunday Mirror, 22 March, 2009, p.26.)

The death by suicide of the son of Sylvia Plath and Ted Hughes was reported on as a result of long-term depression:

> In a statement issued late on Sunday evening, Frieda Hughes reported: "It is with profound sorrow that I must announce the death of my brother Nicolas Hughes, who died by his own hand on Monday 16th March, 2009, at his home in Alaska. He had been battling depression for sometime." (Son of poets Plath and Hughes takes his own life. Irish Times. 2009, 24 March p.10.)

The link between depression and suicide is established here in a causative relationship. Anorexia was the subject of an article that suggested the possibility of death in the absence of treatment. The writer argues for more awareness and more in-patient specialized treatment for people with anorexia.

> I am a 20 year-old sufferer of anorexia and have already twice been within days of death according to my doctors. I could yet die.
>
> On many occasions since being diagnosed with anorexia nervosa, I have been in need of a hospital bed, having become dangerously ill from lack of nutrition and fluids. I was just days from death due to dehydration and starvation, with my doctors having huge concern for my body's ability to keep going at such a low weight-at my most critical, my Body Mass Index was less than 13. I desperately needed one of those beds, immediately, and couldn't get it.

The writer goes on to describe how they got private hospital treatment in England and asks:

> What are those who do not have this luxury (finance for a private hospital) supposed to do? Die? (Anorexia's open secrets. Irish Times Health Plus Supplement. 10 March, 2009, p.8.)

Doctors are used here to legitimize the risk expressed by the person experiencing the mental health problem, and polarized responses (private treatment in hospital or death) are used rhetorically to support an argument for in-patient, medical treatment.

6.2.2 Risk for young people

A number of articles which focused on the mental health of children, teenagers and young adults invoked discourses of crises and risk in constructing adolescence as a particularly problematic time for the development of mental health problems. Reference was made to adolescence as a time of great risk, risk of suicide and risk of mental health problems and which was greater in the present day than at any other time in the past. These claims were frequently accompanied by complaints about lack of funding and service provision. For example an article reporting on the opening of a new service reported:

> Major gaps still exist in psychiatric services for teenagers even though adolescents are under a lot more pressure nowadays, a consultant child and adolescent psychiatrist has claimed. Dr. Sarah Buckley, who is leading up a range of new services for teenagers being opened by St. Patrick's Hospital, claimed there were waiting lists of up to two years to be seen in some clinics-even though research had shown clearly that early intervention was crucial. (Major gaps still exist in psychiatric teen services. Irish Times Health Plus Supplement 31 March, 2009, p.1.)

Increased pressure on adolescents leading to increased demand is used to make the case for a need for their new service. Urgency is invoked by research claims regarding the imperative for early intervention.

> Dr. Buckley said there were still major gaps in current psychiatric service provision for this group despite the fact that over three-quarters of mental illness actually started by the age of 16.
>
> The demand on existing services is growing, both because the services are in short supply and also because of the "increasing pressures in today's society" on young people. "We do think it is becoming harder for adolescents nowadays. There are a lot more pressures on them", she said. Many, she explained, had difficulties coping with everyday things such as school, peers and bullying. "Adolescence is a time of increased risk of poor mental health with anxiety, depression, psychosis, eating disorders and substance misuse becoming more prevalent as well as an increasing risk of deliberate self-harm and suicidal behaviour," she added. Dr. Buckley was speaking yesterday as the hospital announced plans for three new service-its first community-based adolescent services centre which will be based in Lucan, is due to open next month; a 14-bed in patient facility for teenagers will open later in the year with en-suite rooms and a gym and education centre; and a new support and information line for patients, health professionals and the public." (Major gaps still exist in psychiatric teen services. Irish Times Health Plus 2009, 31 March, p.1.).

Explanation is provided for the cause of poor mental health 'a lot more pressures' are mentioned but are acknowledged as 'everyday things' placing the responsibility for the difficulties with the 'non-coping' teenagers. The headline refers to gaps in services, and the increased demand is required to justify the new service. Another article reporting on the same service carried the headline 'One in five Irish teenagers has a mental illness' (Irish Daily Mirror, 31 March, 2009, p.25.)

A number of articles reported on or referred to a research on teenage mental health carried out by an organization calling itself the National Centre for Youth Mental Health (Headstrong) and which reported on statistics relating to the extent of problems that are reported by teenagers and the extent of support they perceive as being available to them.

> A total of just 64 per cent say they have an adult available to talk through problems regularly, while only 38 per cent report being able to cope with the problems they face. Almost half report having been bullied at some stage, while one in 10 say they have experienced serious mental health problems, but have not sought professional help. (Helping an anxious generation. The Irish Times Weekend Review. 28 March, 2009, p.3.)

Rhetorical work is done to present the existence of the problem in a particular manner. The adverbs' just', 'only' and 'almost 'make the case for the existence of a problem in relation to teenage mental health; if the sentence read '64 per cent say they have an adult available to talk through problems regularly and 38 per cent report being able to cope with the problems they face.' it would be left to the reader to decide whether this was an adequate percentage, qualifying it with 'just' suggests that this percentage is an inadequate number and concerning. Sixty-four per cent actually counts as small majority. The percentage of those having been bullied is not specified precisely but is less than 50% but rounded up by 'almost'. Commenting on the findings it goes on to state:

> Overall it paints a picture of a generation in which significant numbers are reporting high levels of psychological distress, resulting in disturbing behaviour such as eating disorders, self-harm, misuse of drink or drugs and suicide. What's more worrying is that many feel increasingly isolated and

155

> alienated and don't know where to turn for help. (Helping an anxious
> generation. The Irish Times Weekend Review. 28 March, 2009, p.3.)

The risk is applied to the whole generation and is used to support an argument for provision of 'help'. The link is made between suicide and mental health problems by quoting young people talking about their numerous friends who died by suicide and commenting on the statistics quoted:

> These figures set against a backdrop where Ireland has one of the highest
> youth suicide rates in Europe and where two income families have less time
> for children than ever before, make for alarming reading. (Helping an
> anxious generation. The Irish Times Weekend Review. 28 March, 2009, p.3.)

Risk is invoked by mentioning death by suicide and implicating the time people have to spend with their children. A link is made with suicide (consequence) and parenting (causation). Vagueness is used rhetorically to support the argument, ('one of the highest'), defending the account against refutation (Potter 1996). The article goes on:

> He (Director of centre for youth mental health) also points out that we
> shouldn't be surprised that young people go through stressful or anxious
> times. Establishing your independence, navigating your way through
> adulthood and making critical life decisions is no easy feat. Yet this
> generation faces additional stresses that previous ones haven't. "Today's
> young people are growing up in a period of rapid change, uncertainty over
> the future, the absence of a clear set of ideals that transcend material
> prosperity, and contradictory messages regarding what's expected of them.
> While this generation seems to have more in terms of education and career
> opportunities, it's finding it harder to experience a sense of meaning,
> belonging and purpose in life." (Helping an anxious generation. The Irish
> Times Weekend Review. 28 March, 2009, p.3.)

The argument for now being a particularly risky time for adolescent mental health is made here. Rapid change, uncertainty and absence of ideals are implicated in poor mental health and put forward as being a particular problem now more than at other times in the past. This obscures the existence of other societal conditions which might be implicated in exerting stress on young people and others, such as poverty, sexual oppression, war and famine, all of which have been prevalent in

Ireland's recent history. An editorial commenting on the same research states similarly the claim for adolescence as a particularly risky time:

> The old saying, "a problem shared is a problem halved" has particular relevance to the lives of young people who are struggling with the demons of adolescence. At this most vulnerable time, they need a trusted adult to talk to about their problems and their fears. Moral support and good advice and, if necessary professional help can make all the difference between a positive outcome and human tragedy. (The health of our youth. The Irish Times, 28 March 2009, p.15.)

A traditional adage is used, similarly evoking nostalgia for past 'traditional' values when 'moral support' and 'good advice' from 'trusted adults' was what was required to avert 'tragedy'. An editorial reporting on the research stated:

> A comprehensive survey conducted by the National Centre for Youth Mental Health has found that nearly two thirds of 12- to 18- year olds feel overwhelmed by their problems. One in 10 reported serious mental health problems for which they had not sought professional help. And less than 40 per cent said they were able to cope with the problems they faced. (The health of our youth. The Irish Times. 28 March, 2009, p.15.)

Again in constructing the argument in this way, the manner in which statistics are presented suggests that rhetorical work is being done to increase the plausibility of the argument being made in relation to teenage mental health. Talking to adults is privileged as the normative response to adolescent distress, obscuring other possible responses such as peer support, for example. The editorial relates the findings of the study to suicide rates:

> Ireland has the highest rate of suicide within the European Union. And young people are particularly at risk. In spite of that, the Government's response in devising a comprehensive range of services has been shamefully inadequate and a lack of funding has crippled professional help. (The health of our youth. The Irish Times. 28 March, 2009, p.15.)

Government provided services are presented unproblematically as the normative solution. Statistics were used in another article that reports a 'Huge increase in children treated for self-harm', reporting a 'shocking' 40% increase in children presenting to the A&E department of a children's hospital with deliberate self-harm and suggesting that concern about financial pressures on their parents was responsible:

The increase in self-harm admissions to the accident and emergency department among children and teenagers comes as a helpline reports more and more young people are deeply worried by the recession and its impact of job losses on their parents and families.

They are worried about what is happening in their own families and parents losing their jobs and issues like mortgage repayments. (The health of our youth. The Irish Times. 28 March, 2009, p.15.)

Katz (1996) refers to the social survey, "a key intellectual technology of population differentiation" that emerged in the 19th century, as deriving legitimacy from "alarmist demographic discourse on the woes of social life" (p.69). News items reporting on this research about the mental health of young people used research findings to support the argument for a crisis in Irish society, relating to on one hand economic hardship and on the other to ideological concerns. Research findings are presented in a way that establishes adolescence as a problematic time, and the present society as particularly challenging, privileging existential concerns and material matters. The suggestion is that the transition to adulthood is more difficult now than it was in the past due to particular contemporary contexts related to changing values. This obscures other possibilities. Even when those not affected were spoken about it is in a way that indicates they were coping with adversity, for example another article reporting on the study of adolescent mental health quoted:

Ms. Dooley (Director of research at Headstrong), who is also head of UCD's school of psychology, said it was important to point out that most young people navigate their way through the challenges of adolescence. (Two out of three teens feel unable to cope with problems. The Irish Times. 23 March, 2009, p.1.)

'Manage' and 'navigate' are used, implying some considerable effort is involved. A similar positioning of adolescence was evident in an article written by a psychologist working as a director of student counselling in a university, describing a mental health campaign, devised by students for students, and aiming to get students to discuss their difficulties with each other. It stated:

Students are talking to each other. All over Ireland they are talking to each other. They are talking to each other about what matters to them.

It continues with a long list of:

> …their deepest concerns: fears for the future, fears in this recession, that the degrees they are working so hard to achieve may not bring employment. Fears that the world had been spoilt for them and that their future has been compromised by those who should have protected it.

> They are talking to each other about stress, about the pressure of study, the tyranny of assignments, the anxiety of assessment, and the tension of exams: their fear of failure, of not achieving what they expect if themselves or what other people expect them to accomplish. (Simply talking can be the miracle pill. The Irish Times Healthplus Supplement, 3 March, 2009. p.11.)

Young people 'all over Ireland' are described globally as being angry, disappointed, stressed, self-loathing, having a sense of worthlessness, not being able to concentrate, focus, get out of bed for lectures, not being able to contain their rage, disappointment, emotions, anxiety and themselves, being able to care for each other, idealistic, enthusiastic, supportive of each other and as campaigning against unfairness, and as understanding the need and importance of being able to talk. The style of writing and use of anaphora[9] (all over Ireland students are….) rhetorically conveys urgency and pervasiveness. Students are characterized as bravely battling the immense adversity that they experience. The effect is to produce an understanding that every student is experiencing distress and to construct young adulthood as a dangerous, risky and problematic time. In addition to the risk to the self, a discourse of risk was evident in some news items in which people with mental health problems were written about as posing a risk to the physical integrity of others.

6.2.3 Risk of violence

Previous research on representation and depiction of people with mental health problems across media sources suggests that that they are frequently depicted as violent and unpredictable (Philo, Henderson and McCracken 2010, Billic and Georgaca 2007; Coverdale, Nairn and Claasen 2002; Nairn, Coverdale and Claasen

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[9] The repetition of a word or phrase at the beginning of successive clauses (Oxford English Dictionary 2014).

2001; Wilson *et al* 1999a; Allen and Nairn 1997; Crepaz-Kay 1996; Philo*,* McLaughlin and Henderson 1996; Signorielli 1989; Wahl and Roth 1982) despite research that suggests that people with mental health problems are more likely to be victims of violent incidents than perpetrators (Stuart 2003). Some news items described violent incidents that had been carried out and threats made by people who have mental health problems. A man who died by suicide having suffered from PTSD was reported to have threated to shoot himself many times and his widow described as having been afraid he might harm her, having once threatened to shoot police who were trying to stop him from shooting himself (An adventure in grief. Sunday Independent Living Supplement. 1 March 2009, p.3-4.). A news item that reported on an assault on a nurse in a general medical ward of a General Hospital, by a male patient who had a personality disorder described the incident as 'vicious', and 'unprovoked', and described as 'lashing out the patient kicked, punched and scraped'. It was reported that as the patient was 'classified' as having a personality disorder and not a psychiatric disorder, he was not deemed suitable for admission to the psychiatric unit. Union officials were quoted as calling for more security for staff. A local councilor was quoted:

> "…such an assault could re-occur and nurses should not be placed at risk of a repeat incident."

> "It would appear from the limited facts I have in relation to the case the man should be admitted to the psychiatric unit. This is best for his own safety and that of the nurses."

A union official was also quoted as saying:

> "…the employee was lucky not to suffer more serious injuries in the unprovoked assault." (Nurse saved as patient kicked and punched her. Irish Daily Mirror, 18 March, 2009, p.27.

Even though the man was stated not to have a psychiatric disorder, it is suggested that he be treated in a psychiatric unit, making the assumption that this unit is the appropriate place for someone who is violent. The suggestion is that there would be more possibilities for dealing with violence in a psychiatric hospital than in a general hospital, conflating mental health problems and violence. The man's violent actions are understood as products of mental health problems and assigned

thus. In addition to the reporting of the actual incident, predictions are made as to

the likelihood of this happening again and with much more serious consequences.

Homicide by people deemed to have a 'mental illness' was the focus of a book

review of a book on the history of madness that gave an account of the story of

Mary Lamb, sister of the poet Charles Lamb:

> Driven to distraction by a cold, unloving and invalid mother, a sick father, an
> adored brother just about to be betrothed and, adding insult to injury her
> having to support this entire circus by the sweat of her brow, (needlework),
> one evening Mary Lamb's nerves gave way, she stuck a knife in mum and
> killed her. (Time to start talking and listening again. Sunday Independent,
> Living Supplement. 22 March 2009, p.12.)

She is described as 'driven to distraction', leading to a sudden outburst, a loss of

control and calamitous, violent act which is inevitable. An article written by a

counsellor who warns that 'at the present time' it is easy to understand how people

might be brooding on 'frightening possibilities,' referring to the recession as a

contributing factor for depression, similarly evokes predictions of violent outbursts,

stating:

> This is demonstrated in acts of violence such as one neighbour killing
> another, perhaps in a boundary dispute that the killer has been ruminating
> over for years. The same is true of road rage. Very often the person who
> attacks another driver turns out to have been very angry and brooding
> before he got behind the wheel. (Thinking yourself out of depression. The
> Irish Times HealthPlus Supplement. 10 March, 2009, p.14.)

This makes a connection between mental health problems and violent,

uncontrolled outbursts. The danger of untreated mental health problems was the

orientation of an item that reported on a man who sexually assaulted a woman in a

hotel room.

> Eugene hit the headlines again late last year but this time he was up in court
> charged with sexually assaulting a woman in November 2006. The incident
> made bizarre reading, but given that Eugene was in the middle of a fit of
> psychosis it could only have been a crazy, unbelievable occurrence. Eugene
> had not taken his medication for two days when he knocked on the
> bedroom door of a woman. He later told gardai that when he entered the

woman's room he saw her crawling out the window. Eugene is clearly oblivious to the terrible incidents that happened in the intervening moments.

According to the evidence presented to the court, what actually happened was that he entered the room and after some ranting about the devil, he sexually assaulted the woman, who then escaped out the window. When the gardai arrived he then stood at the window taunting the gardai, showing them his "devil's penis" and asking to see theirs.

The appropriate way to deal with people like Eugene is to detain them in hospital as long as they are a risk to the public, to try to treat them for their mental illness, and to release them from hospital when they are mentally competent and no longer a risk to the public. (Eugene is not a sex criminal, he should not be locked up. Sunday independent. 2009, 15 March, p.33.)

This account presents a frightening picture of an attack by a man who is out of control unaware and dangerous, using satanic metaphors, stated as a result of not taking his medication for a short period of time resulting in a 'fit of psychosis'. The suggested response, 'for people like him' is to lock them up and treat their 'illness'. This portrayal suggests that this level of violent behaviour is typical of people with similar mental health problems and that that the mental hospital has a dual purpose of detention and treatment.

Mental health problems were discursively constructed by discourses of crises, risk and dangerousness in news items that represented mental health problems as being on the increase due to a crisis in society, as being associated with a risk of harm to self and violence towards others. Previous research has identified the dominance of crises imagery and alarmist demography in newspaper reporting of mental health problems particularly in relation to the debate relating to community versus institutional care (Rose 1998; Hazelton 1997). While there was no specific mention of policies of de-institutionalization in conjunction with conflation of risk in the news items examined, the discourses exist in a particular cultural context. In 2009, Ireland, having published a reforming Mental Health Act (2001) that brought Ireland in line with other EU countries with regard to upholding the rights of people with mental health problems with regard to detention and consent, and a new

mental health policy in 2006 (Government of Ireland 2006) that aimed to complete the de-institutionalization project that commenced in the 1980s, was at the same time experiencing an economic recession and cut backs in funding to health services. Discourses of crises and risk conflated recession with mental health problems producing an understanding of service provision as saving people from the 'risk' of danger from mental health problems and people who possess them.

The way in which the discourses were deployed implicates certain psychosocial factors in the causation of mental health problems. For example, implicating the economic recession in the creation of mental health problems ostensibly suggests psychosocial orientation but one which is selective. It focuses on proximal, episodic factors, and their effect on specific groups, those who were once prosperous and who have fallen on hard times. This obscures macroeconomic and ongoing factors such as poverty, deprivation and inequality which are suggested as being associated with poor mental health (Wilkenson and Pickett 2009) and which impact on a much wider group. Paradoxically, this discursive construction implicates societal stresses but tends to locate the individual as the focus of the solution, fixing on the person with mental health services rather than focusing on the adverse social circumstances. This, and the association with violence and harm, locates the locus of mental health problems with the individual on one hand and on the other produces an understanding of people with mental health problems as having little or no control over what happens to them and how they deal with adversity, rendering them inert, obscuring individual psychological processes. It creates an urgent imperative to action. The representation of people with mental health problems as having little control has been identified in previous research (Olstead 2002). This conflation with danger reinforces societal stigma making it less likely that people will be willing to be open about their mental distress. The way in which mental health problems were constructed as devastating to the person and others is discussed in the next section.

6.3 Constructing devastation

News items almost exclusively constructed mental health problems as devastating to the person and others through pessimistic depictions that emphasized abnormality and the negative, pervasive and ongoing impact they have on people's lives and the lives of those close to them. Pessimism dominated in articles that framed mental health problems as devastating to both the person in terms of loss of function, control and personal agency and in relation to the effect they have on others around them. Mental health problems were portrayed as being a negative experience or state, an abnormality, often having devastating consequences for people and impacting negatively on relationships, personal safety, occupational achievement and personal happiness, with pessimistic predictions for people who suffer. A pessimistic outlook was presented by news items that spoke about mental health problems having no cure. For example referring to obsessive compulsive disorder, one article stated:

> There is no cure for the disorder and treatment focusses on managing the symptoms of the disorder. Medication, in the form of selective serotonin reuptake inhibitors (SSRIs), can be effective in reducing the obsession to a manageable level. (Cycle of obsessive thoughts. The Irish Times, Healthplus Supplement. 13 January, 2009, p.7.)

The tone suggests resignation, with medication just offering alleviation but not complete relief and no hope for abolition of symptoms. The best that can be hoped for is reducing them to a level where they are 'manageable'. An article that reviewed a book on women and madness in history quoted Emil Kraepelin, who is described as: "one of the fathers of psychiatry" states:

> Insanity, even in its mildest forms, invokes the greatest suffering that physicians ever have to meet". Oh yes indeed, being mad is hell. (Time to start talking and listening again. Sunday Independent, Living Supplement. 22 March2009, p.12.)

6.3.1 Abnormality

Normalization is an important technique of disciplinary power which involves the distinction between normal and abnormal and provides the basis for the

organization and categorization of individuals in a disciplinary society (Foucault 1977). News items constructed the experience of mental distress as abnormal. The basis for establishing the existence of a mental health problem in an individual is comparison between 'normal' and 'abnormal' behavior, cognition and emotional experience. People with mental health problems were frequently portrayed as different from those who do not have a mental health problem, consistent with previous research that has identified polarized representations that support divisions between 'them' who have mental illness from 'us' that don't (Ostead 2002). An article about a woman who put her two children into care because she could not cope with them (one had ADHD and the other child had special needs) and her subsequent diagnosis of borderline personality disorder, comments on what 'most mothers' could or couldn't do, suggesting that it is considered abnormal for mother to dislike, or give away their children (How could any mother give her kids away? 2009, 11 March, Irish Daily Mirror, p.29). An article that reported on a new psycho-oncology service differentiated between 'normal' sadness and 'depression, anxiety and body-image problems'.

> Receiving a diagnosis of cancer and undergoing treatments are associated with significant psychological distress, ranging from 'normal' levels of sadness and fear to disabling symptoms such as depression, anxiety and body-image problems. (Support and cancer. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.12.)

Similarly in relation to OCD, the difference between what is normal with what is abnormal was debated:

> Many of the symptoms of OCD are normal in other contexts – checking the iron is switched off or washing hands or keeping order. The main difference is that these behaviours do not cause the average person undue stress or worry.

> Hand washing is a normal behaviour but washing your hands 15 times with three different types of soap and obsessing about how germs on your hands could cause the death of someone close to you is not normal. (Cycle of obsessive thoughts. The Irish Times. 13 January 2009, p.7)

News items represented people with mental health problems as being unable to function normally, as they usually would or according to social expectations. A man

who experienced depression following surgery for cancer was described as a 'broken man', who:

> …despite having many treatments for depression in the months following his cancer operation including medication and electroconvulsive therapy, he remained very shaken. Only leaving his home under protest, he no longer answered the phone. His many friends tried continuously to meet up with him, but he avoided all such contact. (Shock takes awesome toll on our psyche. The Irish Times Healthplus Supplement. 10 March, 2009, p.8).

A woman who experienced anxiety following a similar illness was described in the same item as being 'transfixed with anxiety', both accounts emphasizing bodily breakdown and impact on ability to function. An article written by an adult child of a woman who is described as having schizophrenia described her as a mother.

> ..her initial attempts at motherhood were thwarted by the fact that I simply refused to survive on the bottles of tea and sugar she blissfully fed me. My trip to the hospital as a six-week-old infant to be treated for starvation was followed by five years in the local Industrial School in Ballinasloe, to be reared by another wonderful "mother", Sr John Scully.

> Many times I'd come home from school as a child to find some homeless beggar ensconced by our fire, Mammy in her element serving up a heel of bread, jam and tea. They would sit there for hours chatting about God only knows what. The only interruption was either my whingeing for food, clambering up on to her lap to guard my territory, or sometimes the mewling of the 14-odd cats. Eau de cat fought with the thick smell of burning turf from the fire for supremacy. Both won. Other times were to witness her doing a ceili dance around the kitchen, humming the music happily to herself."

The same woman is portrayed as being unable to care for herself:

> My shame came from her flamboyance, her moth-eaten fur coat and hat thrown over torn and filthy clothes, her feet and neck black from never being washed. (I was always ashamed of my mother, but not now. Sunday Independent, 23 March, 2009, p.18.)

She is described as being incapable of fulfilling her role as a mother and to care for herself and this is because of her 'mental illness'. Description of her behaviour as abnormal is based on a comparison with expected social roles and conveyed as illness when what is described could be otherwise understood as a reaction to adversity.

Obsessive compulsive disorder was described as rendering a person unable to work:

> In extreme cases, sufferers are so consumed by the obsessive thoughts and compulsive rituals they are not able to work. (Cycle of obsessive thoughts. The Irish Times, 13 January, 2009, p.7.)

Normality is constructed, with particular levels and frequencies of behaviours, thoughts and feelings, being categorized and named as mental health problems. Other possibilities are denied, such as understanding them as human responses to life events and adverse circumstances. The basis for the establishment of a diagnosis of mental disorder involves a comparison between what is considered 'normal' feelings, thoughts and behaviour. This construction of particular emotional states or patterns of behaviour as pathological, as abnormal, puts the focus on a 'faulty' individual rather than other possibilities, a 'faulty' or 'unequal' society for example. It focuses attention on the individual's behaviours and emotions, judging them against what is considered 'normal', what is usual, what other people do or feel. Foucault described the process of 'normalizing judgement' a key element of disciplinary power involving as it does a judgment and sanctioning of the individual on the basis of a comparison with a 'norm' established by certain disciplines in society. Psychiatry is one such group, functioning to define what is considered normal behaviour, thoughts and feelings. The relationship is symbiotic, abnormality cannot be defined without the framework of psychiatry (or another similar discipline), but also psychiatry needs abnormality to justify its continued existence, for if there is no abnormal feelings, thoughts or behaviours, there is nothing to treat, no function for the discipline. Commenting on the rise in the incidence of people diagnosed with depression Rose (2003, p.56.) suggests that:

> The continual incitements to action, to choice, to self-realization and self-improvement act as a norm in relation to which individuals govern themselves and are governed by others, and against which these differences are judged as pathologies.

Media coverage of mental health problems that provides detail of 'normal' human states, implicates media as a site of disciplinary power, enabling the production of knowledge about what constitutes normality and thus abnormality.

6.3.2 Loss of personal agency

Some news items characterized people with mental health problems as lacking the capacity to act independently and to make their own free choices and mental health problems as damaging the very core of a person's being. A woman who had experienced obsessive compulsive disorder described her experience:

> A miserable compulsive pattern engulfed me: my brain told me to do what I really did not want to do. I felt out of control. (Overcoming fear. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.5.)

She describes OCD as 'engulfing her', her own body parts, her brain betraying her and taking her over. The tone is negative and the description suggests annihilation of the 'real' person and loss of control and helplessness. An item about people who have anorexia described the effect on the person:

> So they lose the ability to make decisions. Rational thinking is actually not an option: the person can't think straight, literally. (Anorexia's open secrets. The Irish Times Health Plus Supplement. 10 March, 2009, p.8.)

The core of being human, the ability to think, is described as being affected. A man writing to an advice column concerned about his girlfriend who he had discovered was stealing things that he thinks she didn't want or need, is told by the doctor that his girlfriend has kleptomania. She states that people with kleptomania know that their actions are harmful but that the urge to steal is so powerful they can't resist it (Girlfriend can't stop stealing. 2009, 16 March, Irish Daily Mirror.). The urge it states makes them anxious, tense or aroused and that they steal to soothe these feeling. She calls it:

> *...a real and serious mental health problem that can tear the person's life apart if not treated...* (Girlfriend can't stop stealing. Irish Daily Mirror. 16 March, 2009)

Lack of control is asserted and annihilation of the person's life is suggested as relating to the mental health problem.

One news item (previously referred to in relation to risk of violence) written by a journalist about a man (who she knew personally) who committed a sexual offence exemplifies the representation of mental health problems as depriving people of the capacity to self-govern and is considered here in detail as it rehearses in some detail the issue of capacity. Carrying the title 'Eugene is not a sex criminal, he should not be locked up', the central orientation of the article was a criticism of his treatment by the legal system, making the case for his treatment by psychiatry rather than punishment by the law. The article characterized him as not being conscious of carrying out the offence therefore not being responsible and culpable.

> A society can be judged by how we treat our most vulnerable. The jailing of Eugene O'Neill, a former titan of Irish business, for two years for sexual assault last week is a sad reflection on Irish justice. Why? Because Eugene, a former chief executive of Ryanair, and once the shining light of young business brains in Ireland, is now one of our more vulnerable citizens.
>
> He is afflicted with terrible mental illness that I first witnessed taking over his life 12 years ago. Over Christmas, I saw Eugene featured on the RTE programme Reeling Back the Years depicting the main news events of 1988. As Tony Ryan's then trusted chief executive of Ryanair, Eugene was determined to change the face of aviation in Ireland and do what Michael O'Leary later succeeded in doing – bring lower airfares to the Irish public and give all levels of society a chance to get off this claustrophobic island once in a while.
>
> The way Eugene was on television in 1988 is how I like to remember him, young, well dressed, handsome, articulate and ambitious. He was the perfect example of the kind of well-educated young Irish business talent that had previously emigrated, but who were now in a position, thanks to entrepreneurs like Tony Ryan, to stay in Ireland and achieve greatness on their home turf.

A comparison is made between the 'vulnerable Eugene' and the successful 'former titan of Irish business', evoking by comparison a pathetic, ineffectual figure which he had become. The 'perfect Eugene' is compared unfavourably with the 'afflicted', 'vulnerable' and 'imperfect' Eugene'.

The article went on to describe the incident.

> Eugene hit the headlines again late last year but this time he was up in court charged with sexually assaulting a woman in November 2006. The incident made bizarre reading, but given that Eugene was in the middle of a fit of psychosis it could only have been a crazy, unbelievable occurrence. Eugene

had not taken his medication for two days when he knocked on the bedroom door of a woman. He later told gardai that when he entered the woman's room he saw her crawling out the window. Eugene is clearly oblivious to the terrible incidents that happened in the intervening moments.

According to the evidence presented to the court, what actually happened was that he entered the room and after some ranting about the devil, he sexually assaulted the woman, who then escaped out the window. When the gardai arrived he then stood at the window taunting the gardai, showing them his "devil's penis" and asking to see theirs.

The jury found him guilty of sexual assault – which is understandable – there is no doubt that he did actually sexually assault the woman. However, it never crossed my mind that he would actually be imprisoned for this "crime", because he was clearly not responsible for his actions.

Eugene's victim must be commended for her kind, understanding and thoroughly decent attitude. The woman wrote in her victim impact statement that since the incident she is afraid to be alone and is frightened by middle-aged men. However, she accepted the incident arose from him not taking his medication and said she did not want Eugene O'Neill to go to jail.

So let's sum this up, the victim did not want him to go to prison, his crime was a result of him forgetting, or neglecting, to take his medication (a common occurrence among the mentally ill) and the incident happened 18 months ago, he has no previous convictions and the assault was completely out of character.

What purpose or justice does it serve to jail a mentally ill man for two years for something he did in the throws of psychosis, a symptom of his mental illness?

The real crime here is that 18 months ago he forgot to take his medicine, and now he is being punished for that omission with a two-year prison sentence.

If an epileptic forgot to take their medicine and had a fit while driving their car, causing injury to someone else, would we jail them? No, obviously not. So how are the actions of Eugene or others who suffer from his illness any different? Why is he being criminalised because his illness led him to do something admittedly awful but totally outside his control?

What's next, jailing toddlers every time they walk out of a shop with an unpaid for item clasped in their little hands?

Judge Patricia O'Neill in the Circuit Criminal Court, when handing down his sentence last week, ordered that Eugene is to receive appropriate medical treatment for his illness while in prison. However, this does not get over the issue that he is being punished for something he did not actually do – not in the real sense of being mentally responsible for his actions. I am no

bleeding-heart liberal but I am appalled at the notion of punishing someone for the crime of being ill. The appropriate place for Eugene O'Neill is a hospital, if his mental state requires it. It is also possible that 18 months after the event he is back on an even-keel mentally again, so a mandatory spell in hospital would not even have been a suitable "punishment". The appropriate way to deal with people like Eugene is to detain them in hospital as long as they are a risk to the public, to try to treat them for their mental illness, and to release them from hospital when they are mentally competent and no longer a risk to the public. (Eugene is not a sex criminal, he should not be locked up. Sunday independent, 15 March, 2009, p.33)

Eugene is portrayed as being out of control and reasons are provided for his loss of control. He is described as not being responsible for his actions because he was 'mentally ill', not 'mentally competent', his actions were 'outside his control' to the extent that the suggestion is made that he did not even commit the act 'in any real sense'. Only one explanation is offered for his actions, that he did not know what was happening, 'he is clearly oblivious to the terrible incidents that happened in the intervening moments.' This is stated as being a fact, without doubt or question. The victim is commended as being kind, understanding and decent for subscribing to the view that he should not be punished as he did not take his medication. His 'mental health problem' is likened to a physical disorder like epilepsy; the association suggested being a lack of personal control or choice over the 'illness'. Medication is established as the normative treatment, forgetting to take it is 'a crime' but not worthy of sanction. The terms used to suggest treatment in mental health services, 'detain' and 'release', are suggestive of criminality. A rhetorical question suggests that a person who has epilepsy and causes harm to someone else as a result of not taking medication would not be held culpable, when this may not be so. The link between a physical disease and its treatment is made, establishing physical causation for mental health problems. He is infantilized, likened to a child who steals sweets and who is incapable of taking responsibility for his own actions. He is considered vulnerable, in need of special regard. Comparisons are made between the intelligent, successful and prosperous man he was, with the incompetent, out of control person he has become due to mental illness. This infantalization is also evident in a report on the death by suicide of Nicholas

Hughes, son of Sylvia Plath and Ted Hughes who is reported as 'battling depression for some time'; quoting his sister's obituary of him:

> 'He was a loving brother, a loyal friend to those who knew him and despite the vagaries that life threw at him, he maintained an almost childlike innocence for the next project or plan.' (Son of poets Plath and Hughes takes his own life. The Irish Times, 24 March, 2009, p.10.)

The issue of capacity in relation to mental health was also the subject of an article that reported on a Supreme Court case in which a woman sought to have her marriage annulled on the grounds of her husband's lack of disclosure of his 'narcissistic personality disorder'. A psychiatrist diagnosed him as having a 'narcissistic personality disorder to such an extent as to make it impossible for him to consent to and sustain marriage with the woman,' and she sought to demonstrate that he 'lacked the necessary capacity to enter a valid contract of marriage' and that he 'lacked capacity to marry due to psychological immaturity and underdevelopment of character'. The news item reported that the court found that she did not have grounds for an annulment and distinguished between conduct and capacity. The judges described his behaviour as 'feckless, irresponsible and immature' and in commenting on him not being the man she thought she was marrying stated that 'the same could be said of many marriages'. They described his traits as selfish, egotistical, deceitful, dishonest, and badly behaved but stated that these did not constitute a personality disorder. They said his personality traits were 'not so outside the norm' as to constitute a personality disorder and that full information about a person's conduct or character did not constitute grounds for declaring a marriage void, but that in cases where information about a person's mental stability and inherent disposition was withheld, consent could not be considered informed. The courts did not accept the psychiatrist's diagnosis/expert opinion and made their own distinction between character, personality and behaviour and mental illness. They say that personality disorder exists, but that this is not it and that 'much stronger evidence (is required) to show the husband lacked the necessary capacity to enter a valid contract of marriage (Woman loses court action to get annulment. The Irish Times, 7 March, 2009, p.5.). The legal system

and the psychiatric system are the two sites where capacity is decided upon. The finding in this case deems the man to have capacity to engage in a contract of marriage, on the grounds that he does not have a personality disorder, which is distinguished from a faulty character. Regardless of the final judgment, the arguments rehearsed in the article are important as they emphasize the significance of a psychiatric diagnosis in judgments about a person's capacity and the contended nature of psychiatric diagnosis in 'normal' versus 'abnormal' debate about human characteristics and behaviour.

Constructing mental health problems as depriving people of capacity, exonerates them of responsibility for themselves, their mental health and their actions. This view was not only expressed by others but was sometimes held by people who have mental health problems themselves. In an article written by a woman who has anorexia and who was criticising the extent and nature of services available to her:

> Another time, in my worst ever condition, I spent several weeks on a general ward in a different hospital, simply under the guidance of a dietician. It was up to me to stick to the meal plan we devised together and put the weight on. If I had not done this, I would have been sectioned under the Mental Health Act and fed via a tube: naso-gastric feeding. It was entirely due to my own responsibility and autonomy that I avoided this: I had no professional help. (Anorexia's open secrets. The Irish Times Health Plus Supplement, 10 March, 2009, p.8.)

Having to take responsibility for active participation in a treatment strategy is described by way of complaint about lack of services. The implication is that the person should not have to take responsibility for their own behaviour. As well as implicating mental health problems in rendering the person abnormal and lacking in ability to self-govern, some news items represented mental health problems as damaged.

6.3.3 Damaged persons

Mental health problems were written about as diminishing and eroding the person and as taking away something from their personal identity, their selfhood, characterizing them as damaged. The ultimate annihilation of the person, death, was associated with mental health problems in numerous items that reported on the suicide or risk of suicide in relation people who experience trauma and mental health problems and this is discussed more extensively in relation to crises, risk and danger discourses in the previous chapter. However damage was also implied in articles that constructed mental health problems as damaging and diminishing the person's being. For example, an article reporting on the case of the man who assaulted the woman referred to in section 6.3.2, describes him thus: 'He had periods where he was absolutely perfect...' (Eugene is not a sex criminal, he should not be locked up. Sunday independent, 15 March, 2009, p.33). 'Perfect' referring to when he had no mental health problem as opposed to 'imperfect' when he was mentally unwell. An editorial that commented on spending in the *HSE* on suicide prevention states:

> It is bordering on the criminal that cash can be found to repair damaged linen when there is none available to mend broken lives. (It's the HSE that is beyond repair. Irish Daily Mirror, 28 March, 2009, p.10.)

The association of images of 'damaged linen' in conjunction with 'broken lives' evoking the notion of a life spoilt. In a book review of a novel concerning a psychiatrist and his patients, the work of the psychiatrist was described thus:

> Slowly, with Sturrock's intuitive (if self-doubting) intervention, these brave, damaged, trusting people step towards the light, blink....and see that they needn't fear the darkness so much any more.

And the book is described as giving providing insight:

> And the realisation that we are all flawed. And that all of us deserved to be forgiven. (Balm for troubled souls, but who will help the helper? Sunday Independent: Living Supplement, 8 March, 2009, p.14)

The patients are characterized as slightly pathetic, like small children trusting, unused to light, objects of pity who are 'brave', damaged', 'trusting' and 'flawed' and in need of forgiveness, even the psychiatrist is 'self-doubting', flawed by

association with mental illness. Bill Oddie (A television presenter), describing a recent episode of depression stated:'… my brain stopped working for the fourth time' (TV Bill in clinic for depression. Irish Daily Mirror. 12 March, 2009, p.3.). People with mental health problems were characterized as being weak. Describing a man who died by suicide after his businesses crashed one item commented:

> "John was a very strong character. He was the last person I would have thought that this would happen to. He had rung me the week before and he did say he was under terrible pressure in relation to business matters," said Fr Finnerty. "I would never put him down as a person who would go down that line of taking his own life." ('It's another financial'- suicide and the downturn. Sunday Independent. 15 March, 2009 p.26.)

It is stated as surprising that this strong man would succumb, suggesting that mental health problems are only the domain of the weak and ineffectual.

The dominant understanding of mental health problems was that they alter the person and diminish their lives. For example future prospects for the man Eugene, who committed the sexual offence, were pessimistic.

> It is difficult to accept that Eugene's illness has literally taken over his life now, and his chances of making a "come back" are unlikely to happen. His great achievements now seem to be in the distant past. I just hope that people can try to remember Eugene for the person that he was, and still is when he is not ill. The real Eugene (not Eugene in the middle of a fit of psychosis) had a lot of aspirations and ambition. (Eugene is not a sex criminal, he should not be locked up. 15 March, Sunday independent p.33.)

He is described as diminished, so much so that he is not 'himself', he is a different person when he is ill, he is removed from his 'real' self, he is depersonalized, he is so far gone he needs to 'comeback, but this is 'unlikely'. Suggesting 'who he is now', diminished, is different from 'who he was', 'the real Eugene' before he developed a mental health problem, he is changed and in a negative way. One article in particular described in great detail a daughter's understanding of the decline of her mother who had a 'serious mental illness'.

> Looking back at old sepia photographs of the beautiful woman in a flowery summer dress, pulled in stylishly at the waist by a thick black belt, and a

large brimmed sun hat rakishly framing her face, I feel a deep sadness for the woman she was to become, the woman who I knew as my mother.

The Forties and Fifties saw her working in London as a bus conductor, and then as a hairdresser in Galway city. My aunts tell me she was very outgoing, made friends easily, and enjoyed life to the full. Responsibilities were for "eejits" and life was sweet. Sweet, that is, until she started developing signs of the schizophrenia that was to take over her life, and eventually see her die when I was 19."

My shame came from her flamboyance, her moth-eaten fur coat and hat thrown over torn and filthy clothes, her feet and neck black from never being washed. My shame came from the fact that she still saw herself as the bountiful well-bred lady of the manor, when her poverty and the squalor of her surroundings were painfully obvious for all to see.

Mam hadn't a bad bone in her body, and she didn't let the fact that my clothes were usually worn out and filthy deter her from distributing them bountifully on other families in the village. To their credit, they never refused them, but accepted them thankfully -- and then threw them out.

My shame came from the times I'd witnessed her being dragged into a squad car by big burly gardai to be brought to the local psychiatric hospital. Some of the villagers loved to gather at a safe distance to watch the chaotic screaming scene and cheer as she walloped the hell out of whatever officer had the bad luck to let go of her arms.

From what I could see of her personality, she was a quiet, gentle woman, but when the voices in her head were getting too loud, or her own behaviour too erratic, the guards would come, and her personal shame became public property for various neighbours, some concerned and kind, others cruel and jeering.

It was difficult to know, when others laughed, whether they were laughing at her or with her…From what I could see of her personality, she was a quiet, gentle woman, but when the voices in her head were getting too loud, or her behaviour too erratic, the guards would come, and her personal shame became public property for various neighbours, some concerned and kind, others cruel and jeering. (I was always ashamed of my mother, but not now. Sunday Independent, 23 March, 2009, p.18.)

The pervasiveness of the 'illness' in 'taking over her life' changing from what she was, glamorous, happy, quiet, gentle, to what she became erratic, unkempt, a figure ridiculed by others. She is presented as pathetic and out of control by virtue of being 'mentally ill'. Her shame is made public by the scene acted out by her resistance against the police who come to take her to hospital. The onlookers'

motives are questioned by the writer, but the actions of the police are not censured or questioned.

6.3.4 Objectification and personification

The language used to describe the 'devastation' caused by mental health problems objectified and personified mental health problems positioning them as external forces. In the past those who were considered mad were viewed as possessed. Remnants of these discourses are visible in language which personified mental health problems, evoking a savage and pervasive quality for them. Language used was corporeal, evoking images of the body being eaten by something external to it, engulfed and consumed. The language used suggests that they (mental health problems) 'do' things, that they are intentional entities that exist outside the person and do something to the person. For example OCD was described thus:

> OCD is a neurophysiological disease which locks sufferers into a never-ending cycle of obsessive and distressing thoughts and meaningless rituals they feel compelled to perform to ward off those thoughts.

> OCD is often described as "hijacking" the brain centres, forcing the mind to get stuck on a particular thought or urge.

> OCD is like the classroom bully, according to Shoemaker (a psychologist) It promises it will go away if you do something for it, but it always comes back. (Cycle of obsessive thoughts. The Irish Times Healthplus Supplement. 13 January, 2009, p.7.)

The actions (of OCD) are described in vivid detail as the actions of an individual, using verbs, 'locks', 'hijacks', 'bullies', 'promises'. A woman who has experienced OCD described it as an external entity:

> A miserable compulsive pattern engulfed me: my brain told me to do what I really did not want to do. I felt out of control. (Overcoming fear. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.5.)

Depression was described in a number of news items as having to be "battled with" (TV Bill in clinic for depression. Irish Daily Mirror. 12 March, 2009, p.3.; Documentary I see a darkness. RTE1 9.30pm. The Irish Times Magazine. 23 March, 2009, p.44.; Memoir gives honest account about surviving the loss of a loved one to

suicide. The Irish Times. 31 March, 2009, p.11.) An article that reported on websites that promote anorexia and bulimia reports that anorexia and bulimia are personified in some of these websites by the use of terms like 'the Goddess Ana', and 'the Goddess Mia' (The weight game. Sunday Independent Life magazine. 29 March, 2009, p.12.). A man who suffered post-traumatic stress disorder is described by his wife thus:

> I had done my best to live with a man who was being eaten alive by his demons despite his great personal strength. (Memoir gives honest account about surviving the loss of a loved one to suicide. The Irish Times. 31 March, 2009, p.11.)

and:

> I think of the happy times, who he was before it began to eat away at him. (I saw John go downhill as the demons from his Vietnam service ate away at him. Sunday Mirror. 22 March, 2009, p.26).

Demonic metaphors were similarly invoked in relation to teenagers by an editorial commenting on research into the mental health problems of young people they were stated to be: 'struggling with the demons of adolescence' (The health of our youth. The Irish Times. 28 March, 2009, p.15.). Previous research into representation of attention deficit hyperactivity disorder suggests that media coverage exemplifies objectification in explaining biological determinants and suggests that this can be potentially beneficial to children in understanding and describing their condition (Schmitz, Filippone, and Edelman 2003). While such linguistic strategies may well assist in describing and understanding complex feelings and behaviours, they are not neutral in doing so. The particular selection of images and metaphors construct particular meanings that impact on the individual and societal understandings of mental health problems. The notion of having 'demons', being 'taken over', 'eaten away' or having a brain that stops working are powerful images that impact on personal and societal meanings of the nature of mental health problems and what it means to be considered to be affected by them. In addition to representing mental health problems as devastating to the individual experiencing them, some news items reported mental

health problems as having a negative impact on others, particularly those close to the person.

6.3.5 Affecting others

The negative impact on others surrounding the person with a mental health problem was the subject of some news items. In an article previously referred to, the writer's mother's bizarre behaviour caused her daughter much shame and embarrassment at the time and her memory of her behaviour towards her mother as a result was written about as a source of continued shame for her. Shame is mentioned 11 times in the article.

> My shame came from her flamboyance, her moth-eaten fur coat and hat thrown over torn and filthy clothes, her feet and neck black from never being washed. My shame came from the fact that she still saw herself as the bountiful well-bred lady of the manor, when her poverty and the squalor of her surroundings were painfully obvious for all to see.

> My shame came from the times I'd witnessed her being dragged into a squad car by big burly gardai to be brought to the local psychiatric hospital.

> As I got older her shame became mine.

> My shame of her has become my shame of myself…

> My shame of her has turned into my shame of myself, as I turned my back on this beautiful, intelligent and proud woman, her blame for the effect her illness had on my life, being no greater than her blame for the effect it had on her own. (I was always ashamed of my mother, but not now. Sunday Independent. 23 March, 2009, p.18.).

The social embarrassment and negativity associated with behaving bizarrely being transferred to the relative. The daughter here joins society in shunning the 'madness' of her mother, while at the same time feeling the shame of association and the shame of her own treatment and attitude towards her mother.

A number of news items reported on the impact of suicide on friends and family. Of the friends of a man who completed suicide it was stated: 'His family, girlfriend and a wide circle of close mates were left distraught and confused' (People need to

realise they are not alone. Irish Daily Mirror, 26 March, 2009, p.24.). A woman whose husband died by suicide following a long period of mental ill-health:

> ….tells how she has tried to pick up the pieces of her shattered life. The grief was horrendous. My body reacted violently. Every vein throbbed: at times it felt as if there were a hundred thousand boxing matches going on under my skin (An adventure in grief. Sunday independent, Living Supplement. 1 March, 2009, p.3-4.).

The same woman is described in another article:

> Catherine hit her lowest point two years after John died. She said: "For the first 18, 20 months there was a voice at the back of my head saying keep going, keep slogging away, but at the end of the 18 or 20 months I lost all interest. I didn't want to wake up in the morning, I was weary, tired all the time. I don't think I would have harmed myself, but the voice in the back of my head began to vanish and I didn't care." (I saw John go downhill as the demons from his Vietnam service ate away at him. Sunday Mirror. 22 March, 2009 p.26)

Talking about a book she has written about her experiences to help others affected by a relative's suicide and distress she states:

> I hope too it helps people understand the dangers of post-traumatic stress. It's terribly dangerous, and the more it's hidden the longer it goes on, until everyone around you is drawn in. (I saw John go downhill as the demons from his Vietnam service ate away at him. Sunday Mirror. 22 March, 2009 p.26).

The physical and psychological impact of the mental distress on a friend or relative is described graphically. This negative impact on others is reinforced by reports from professionals. An occupational therapist writing about her work states:

> Along with distressing symptoms, psychiatric illnesses can turn the lives of individuals and their families into disarray. (Fostering recovery. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.7.)

The mental health supplement in the *Sunday Independent* referred to families in a number of items. A report on a family support group suggests that people with mental health problems inevitably need carers:

> Established in 2008, the Bray Family Support Group supports family members as an integral part of the overall treatment of people with a schizophrenic or psychotic illness. It is recognised that few people become carers by making a rational decision about what they are going to do with

180

their lives. Rather the caring role creeps up on them, as it becomes clear that their relative is going to need help for much longer than anyone imagined. Having identified the need, the aim was to provide relatives with an outlet where they could safely discuss care issues, share experiences and develop better coping strategies. Living with a relative with enduring mental illness is not a burden easily explained or shared, so within the group process the emphasis was placed on "social support and mutual aid with members both providing and receiving help, while also serving as role models." (Support for families. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.17.)

Families are positioned as 'carers' and they are not only 'carers', but reluctant 'carers'. It is stated that they wouldn't make a rational decision to choose this 'role', it is a situation forced onto them, that they have no choice about, a burden and that it is an irrational choice. Help is required for longer than anticipated. The carer role is the subject of a news item about a booklet aimed at carers. It is described as:

An insightful guide for carers, the booklet looks at all aspects of the role of a carer when it comes to mental health. It defines a carer as "a person who gives up their own time, often without payment, recognition or thanks, to help another person who is disadvantaged due to physical or mental illness or disability." A summary of some of the most common mental illnesses and their treatments, such as schizophrenia, depression, obsessive compulsive disorder and eating disorders, is also provided, along with the contact details of organisations that can help. Very often, the jargon that comes with any health issue can be mind-boggling for both carers and service (sic), and to its credit 'The Journey Together' explains many terms in detail. These include 'psychosis', 'cognitive behavioural therapy' and 'holistic' to name a few.

Very useful is a checklist of questions, which experts say can help prepare you before you meet with any of the team involved in your relative's care and recovery. Sample questions about the diagnosis, assessment, care, treatment and recovery are provided in the booklet. (The journey together. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.18.)

Here people with mental health problems are constructed as needy and ungrateful (without thanks) and carers are characterized as being selfless. In an interesting omission the word 'user' is omitted from 'carers and service users'. 'The Journey Together' that the title refers to is really the 'carers' journey. The booklet is described and explains mental health problems in a biomedical frame. It provides

181

questions and a checklist that carers might use when speaking to the person's health care team indicating the areas they might focus on, taking for granted that they would be discussing the person, obscuring the person with the mental health problem from the dialogue.

Previous research has identified that media depictions of people with mental health problems have tended to portray them as lacking control and agency (Nairn, Coverdale and Claasen 2006; Rowe *et al* 2003), in a childlike manner (Wilson *et al*. 1999b), unproductive (Wilson *et al* 1999b) and in a pessimistic light (Nawavoka *et al* 2009; Billic and Georgaca 2007; Huang and Priebe 2003; Coverdale, Nairn and Claasen 2002; Wilson *et al* 2000; 1999b; Diefenbach 1997; Barnes 1993; Philo, Mc Laughlin and Henderson 1996; Signorelli 1989) and dangerous to others (Glick and Applbaum 2010). Constructing mental health problems as devastating to the person and those associated with them even at a manifest level conveys a pessimistic outlook that is likely to impact not only on those who might experience mental distress in terms of their self-esteem and likelihood to discuss their distress and to seek help but also impacts on societal attitudes towards mental health problems perpetuating prejudice and stigmatization (Sieff 2003). It constructs mental health problems as abnormal and devastating; the individual as fundamentally altered by having a mental health problem and potentially deprives people who experience them of agency in managing their own lives and taking responsibility for their recovery. This locates mental health problems outside the control of the person and in doing so conveys an understanding of the individual as having little responsibility for or control over their lives. This further reinforces societal stigma in relation to mental health problems and produces a need for the external government of mental health and the individual.

6.4 Summary

This chapter has presented the findings in relation to how the discursive categories of crises and risk and devastation were deployed in constructing mental health problems. Connotations of crises were evident in news items that conflated the

economic recession and societal changes with an increase in the incidence of mental health problems and suicide. Businessmen and young people were singled out as particularly at risk, with adolescence being represented as a particularly risky time in relation to the development of mental health problems. People with mental health problems were represented in some articles as dangerous to others. The effect of this conflation with risk, crises and danger is that a particular understanding of mental health problems is conveyed. Specific, relatively transient economic factors are foregrounded, obscuring macro-economic and enduring societal factors as impacting on mental health and well-being. Particular mental health problems depression, anxiety, self-harm, affecting particular groups are made visible, obscuring other problems and groups. This also has the effect of conveying an understanding of mental health problems as a problem located in a faulty individual and the association with dangerousness contributes to stigmatization of people affected by mental health problems. Connotations of crises, risk and danger were frequently used to make the case for more provision of services and more funding, resulting in a common sense understanding of health service provision, frequently mental health service provision, as the normative and only appropriate response.

The representation of mental health problems as negative, abnormal responses, causing a loss of agency, resulting in a damaged person and as external to the person produces understanding of the person as diminished and having little responsibility or control. This contends with the ideology of recovery that is enlisted in contemporary mental health policy, service and professional discourses that positions mental health problems as being possible to recover from and being within the control of the individual. It has the effect of conveying a pessimistic outlook that is likely to impact not only on those who might experience mental distress in terms of their self-esteem and likelihood to discuss their distress and to seek help but also impacts on societal attitudes towards mental health problems perpetuating prejudice and stigmatization. Perhaps more fundamentally it produces an understanding of 'not coping' with adversity as abnormal and

problematic and privileges particular patterns of behavior that fit with expected norms. This further reinforces societal stigma in relation to mental health problems and produces a need for external government of mental health. The next chapter presents the findings in relation to how illness and psychosocial causation discourses were enlisted in constructing mental health problems

Chapter 7 Constructing illness and constructing psychosocial causation

7.1 Introduction

The question of whether mental health problems are 'illnesses' has been central to the dialogue about how mental distress is understood. The issue of causation of mental health problems is contested and has been the subject of much debate and dispute. It has important implications both for how people experiencing mental distress are treated but also for those with vested interests such as government, mental health professionals and those involved in the pharmaceutical industry. Variability was evident in news coverage between discourses that emphasized adverse environmental events and those that referred to biological and illness discourses in relation to mental health problems. This chapter presents the findings in relation to how mental health problems were constructed as illnesses and the way in which they were constructed as being related to psychosocial factors.

7.2 Constructing illness

A biological discourse implicates physical factors such as brain chemistry, brain structure and genetic factors as causative in the development of mental health problems and forms the basis of an understanding of mental health problems as disease. The terms 'mental illness' and 'psychiatric illness' are commonly used in everyday language to refer to mental health problems. In professional parlance 'mental disorder' or 'psychiatric disorder' are used, similarly enlisting a biomedical discourse and reflecting the terminology and dominance of medical classification systems (American Psychiatric Association 2013; World Health Organization 2011). An illness discourse was enlisted in news items in two ways. Firstly in news items that reported on biological factors in the causation of mental health problems and which made comparisons between mental health problems and physical problems. Secondly news items frequently used the term 'illness' to refer to mental health problems and illness related language and associated terminology was used to refer to mental health problems and to describe feelings and behaviours.

7.2.1 Biological causes

The basis for an illness model of mental health problems lies with the assumption of mental health problems having a biological origin. Some news articles reported on biological factors implicated in the causation of particular mental health problems, such as anorexia, obsessive compulsive disorder (OCD), depression, addiction. For example, a report on neuropsychological research focusing on girls and women aged 12 to 25 who were being treated for anorexia, suggested that they suffered damage to neurotransmitters or had changes in brain structure or both.

> Thousands of girls are predisposed to develop anorexia because of the way their brains have developed in the womb a major study has revealed. The report's authors say school children could be screened at the age of eight to identify the signs that make them vulnerable to risk factors such as the size zero fad and the cult of the super-thin celebrity. Eating disorder charities said the findings could revolutionise the treatment of anorexia. "Our research shows that certain kids' brains are made in a way that makes them more vulnerable to the commonly-known risk factors for eating disorders such as the size-zero debate, media representations of very skinny women and bad parents, " said Ian Frampton, one of the authors, who is an honorary consultant in paediatric psychology at London's Great Ormond Street hospital. Dr. Frampton and his colleagues conducted in-depth neuropsychological testing on girls and young women aged between 12 and 25 who were being treated for anorexia. They found that around 70 per cent of the patients had suffered damage to their neurotransmitters, which help brain cells communicate with each other, had undergone subtle changes in the structure of their brains or both.
>
> One in every few hundred girls may be affected in this way, according to Dr. Frampton, who said the condition was random and not the result of poor maternal diet or environmental factors. (Anorexia linked to brain growth in the womb. 29 March. Sunday Independent, 2009, p.18.)

A vague description of the research is given and it is presented as having 'revealed' brain abnormalities, reinforcing their legitimacy by suggesting they were always there waiting to be 'revealed'. The impact of the 'in-depth' research on 'thousands of girls' that has the capacity to 'revolutionise' treatment of anorexia is presented with a certainty and optimism that is unwarranted by the level of detail provided. The research findings presented could be understood as a result or a cause of anorexia, but are represented unambiguously as causative. Biological factors are linked to social factors that are represented as 'commonly known risk factors',

increasing the plausibility of the argument by incorporating competing discourses. Biophysical abnormality is similarly implicated in the causation of OCD in another article.

> OCD is a neurophysiological disease which locks sufferers into a never-ending cycle of obsessive and distressing thoughts and meaningless rituals they feel compelled to perform to ward off those thoughts. The causes of OCD are still uncertain, but it is now widely accepted to be a neurobiological disorder that causes problems in information processing. Two particular parts of the brain which have been implicated in OCD are the caudate nucleus, which controls the stop signal for habitual behaviours, and the orbital-frontal cortex, which controls emotions such as worry about harming others, guilt and disgust, according to March. Insufficient levels of the chemical messenger serotonin have been pinpointed as a likely cause and it has been found that drugs that increase the brain concentration of serotonin can help improve OCD symptoms. (Cycle of obsessive thoughts. The Irish Times. 13 January, 2009, p. 7.)

This account similarly conveys more certainty and optimism about physical causation than is warranted by the detail provided. Even though doubt is expressed ('the causes are still uncertain'), the presence of biological explanations is acknowledged as being 'widely accepted'. Previous research has identified that print news portrayal of scientific research into genetic links to mental illness tended to be framed optimistically, even in the face of studies that disconfirmed such links (Conrad 2001).

7.2.2 Illness language

Many news items represented mental health problems as illnesses through the use of illness related terminology. An article about OCD reported:

> The condition is surprisingly common - it affects 2-3 per cent of the population and the World Health Organisation has named OCD among the top 10 most debilitating illnesses in terms of loss of income and quality of life, according to psychologist Leslie Shoemaker who is an adviser to OCD Ireland, which runs support groups in Dublin

> OCD is often described as "hijacking" the brain centres, forcing the mind to get stuck on a particular thought or urge. People with OCD sometimes describe the condition as having "mental hiccups that won't go away".

OCD is referred to as a 'condition', a 'debilitating illness', and is located in the brain. The 'hiccup' metaphor evokes the notion of physical condition by association with a commonly experienced, and importantly, involuntary physical phenomena, an event over which we have no control. The notion of an involuntary event is similarly evoked by an item, previously referred to, that describes a man as having 'a fit of psychosis' (Eugene is not a sex criminal, he should not be locked up. Sunday Independent. 15 March, 2009, p.33.). A well-known singer, who has been vocal about her alcoholism, described addiction in a news item as: 'Addiction to any substance is a disease of people who are ill at ease with themselves.' (Coughlan: Church to blame for Ireland's drinking. Sunday Mirror. 22 March, 2009, p.27) and a woman whose mother had a diagnosis of schizophrenia described her as: 'Having had a serious mental illness, she was known as the 'mad-woman of the village'' (I was always ashamed of my mother, but not now. Sunday Independent. 23 March, 2009, p.18.). Concern about weight among young women in a magazine supplement is described with reference to diagnostic terms such as 'high functioning anorexics', 'full blown eating disorder' (The fashionista. Sunday Independent Life Magazine. 29 March, 2009, p.19.) and 'body dysmorphia' (The reformed fad dieter. Sunday Independent Life. 29 March, 2009 p.20.).

Disease terminology was used across all newspapers in articles written and quoted by people who had mental health problems, relatives, journalists, politicians and professionals. The supplement sponsored by the *HSE* that focused on mental health in Ireland used the word 'illness' 41 times across 23 pages. In it and in other news items mental health problems were frequently likened to physical problems. An extract from the introduction to the supplement written by the National Director for Primary, Community and Continuing Care of the *HSE*, newspaper stated:

> We tend to find it easy to relate to physical illness, whether it is a broken leg, a cancer condition or diabetes. Our relationship with mental illness is less straightforward. In the past, mental illness was fraught with taboos and

stigmas. It often caused embarrassment and isolation for sufferers and those close to them. However, thanks to more awareness, openness, education and progressive treatments, things are changing. It is being increasingly recognised as an illness like any other that can be successfully treated, managed and overcome. It is being increasingly recognised as an illness like any other that can be successfully treated, managed and overcome. Also, we know that, with the right supports and lifestyle choices, such as controlling our stress and alcohol consumption, we can protect ourselves from some mental illnesses. (A Vision for Change. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.2.)

Mental health problems are 'an illness like any other'. Later in the same supplement, the prevalence of mental health problems is described with reference to asthma in order to legitimize them:

At any one time, one adult in four has experienced mental health problems. In other words, mental health problems are as common as asthma. (The road to recovery. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.4.)

Association with physical illness was used to legitimize the role of GPs in mental health care.

It is recognised that role of the GP is hugely important in identifying and treating the early stages of many illnesses, both physical and mental, and the same is true in the identification of people at risk of engaging in suicidal behaviour. (Preventing suicide. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.8-9.)

Advice given by an advice columnist that adopted a psychosocial approach but used comparison with physical illness to reassure the person with the problem. To legitimize her distress she likens feelings described by a young woman, feeling down and numb, to a physical illness:

You do not sound pathetic. You sound human, and like all of us, simply in need of a helping hand. I promise you, your distress at the moment is primarily caused by isolation. Break that isolation, and things will seem brighter. Nor should you beat yourself up for how you feel. If you had pain in a sprained wrist you wouldn't give out to yourself would you? Why, then, would you do yourself down because you have a sprained spirit? You're emotionally hurt. That's OK. (Dear Patricia I'm 17 and I feel numb and scared. Sunday Independent. 29 March, 2009, p.6.)

Previous research has identified the privileging of biological explanations (Clarke and Gawley 2009; Clarke 2011; Endelman 2003, Conrad 2001). Rowe *et al*. (2003, p.685) suggest that biomedical and psychosocial discourses dominated in newspaper depictions and that biological explanations were characterized by a rhetorical strategy, 'a studied use of vagueness' where explanations of causation were incomplete or inconsistent. Association with familiar physical illnesses using scientific terminology and explanations legitimizes the existence of 'mental illness' and positions it as a biological phenomenon. Association with physical illness is a commonly used strategy to legitimize mental health problems as being 'an illness like any other', the same as physical disease. The association is made to alleviate negative connotations, suggesting that mental health problems are not acceptable in their own right, they require association with physical illness to make them more acceptable and understandable, manageable and controllable. The association of a mental health problem with physical illness was written about in news items as positive, progressive, natural and unquestionable. This reification from metaphorical association where they are ' like' illness to 'being' an illness (Rowe *et al* 2003) not only provides a common sense understanding of mental health problems as illnesses that have a physical cause but the way in which they are positioned as 'a disease like any other' protects against possible contentions to the association that might imply blame. This strategy has been used widely in mental health campaigns that aim to alleviate stigma and raise awareness and normalizes mental health problems by anchoring them with a familiar frame of reference (Billic and Georgaca 2007). The association with physical disease has been widely accepted as a more positive understanding of mental health problems than historical notions of possession or wrong doing for example. It exonerates the individual of 'blame' for having a mental health problem, and is therefore less stigmatizing and encourages the individual to identify with the representation and act accordingly (Stark, Patterson and Devlin 2004). Any contention to this illness basis would mean they would once again be fraught with taboo and stigma.

The association of mental health problems with physical disease has its origins in medicine's association with madness, resulting in the creation of psychiatry as a discipline in the early Houses of Industry and asylums. Psychiatry emerged and flourished in the absence of scientific evidence linking biological factors with madness, based on observed responses to physical treatments. With the growth of neuro-biological research the association of mental health problems with biological causation has endured and perpetuated despite challenges from a wide variety of perspectives that question the legitimacy and validity of such claims. This occurs in the context of mental health policy that has resulted in the re-location of acute mental health services over the past 30 years into general hospitals which has been suggested was at least in part, was driven by a desire on behalf of psychiatrists for the status and gravitas enjoyed by their general medical colleagues (Rogers and Pilgrim 2010) rather than any real need for proximity to medical infrastructure. A desire for alleviation of stigma attached to mental health problems may not be limited to those who experience them but shared by those associated with its treatment. Positioning mental health problems as illnesses is not a neutral act. While the intention and the effect maybe to alleviate stigma and gain legitimacy for mental distress as a phenomenon, in foregrounding individual biological processes it obscures other possibilities such as psychological and social factors.

7.3 Constructing psychosocial causation

Contemporary professional discourses implicate a variety of factors, biological, psychological and social, in the causation of mental health problems, the extent of inter-relationship and dominance of one over the other varying depending on the nuanced perspective of the individual or professional group concerned. Psychiatry, while remaining principally located in biological determinism has expanded its perspective to incorporate psychological and social understandings. A psychosocial discourse emphasizes the interaction of the individual's psychological processes with environmental stressors in the maintenance of mental health and forms the basis of recent developments in mental health services and associated interventions. Factors which cause mental health problems were generally not the

central subject of articles, but causative factors were referred to or inferred in articles that reported on mental health problems. As well as biological causes, referred to in the previous section, adverse social environments and traumatic events, social stressors and individual psychological processes were represented as causing mental health problems.

7.3.1 Social and environmental stressors

The economic recession and associated financial and employment issues dominated but other circumstances that arise throughout the course of the person's life such as trauma, stress, relationship difficulties, childhood trauma, sexual abuse, sexual violence and bullying were also represented as causative. As discussed in chapter six (section 6.2) on constructing crises and risk, the period of data collection coincided with the beginning of an economic recession in Ireland following a long period of economic prosperity frequently referred to as the 'Celtic Tiger'. The associated economic hardship was frequently mentioned as being associated with an increase or exacerbation of mental health problems and in relation to an increase in rates of suicide and depression among middle aged men and self-harm among young people. Depression, anxiety and suicide were mentioned as being the result of the economic crash; businessmen, builders and their families among those mentioned as being affected (these are referred to in more detail in the section 6.2). Economic hardship was mentioned in relation to people becoming depressed as a result of becoming unemployed (Job loss ruins her big party. Irish Daily Mirror. 16 March, 2009), children and teenagers self-harming because they are worried about their parents' finances (Huge increase in children treated for self-harming. Sunday Independent. 29 March, 2009, p.8, One in five Irish teenagers has a mental illness. Irish Daily Mirror. 31 March, 2009, p.25.) and builders and developers dying by suicide due to extreme financial indebtedness ('It's another financial'- suicide and the downturn. Sunday Independent, 15 March, 2009, p.26.). Derivatives of the word depression were used as an adjective (depressing) indicating that the object being described by the adjective does something, or has an impact on people. Numerous articles referred to the economic recession as

'depressing', linguistically implicating it in causation. A sub headline dealing with research on tranquilizer usage stated: 'The latest research on tranquillizer usage make for depressing reading' (Are we a nation of junkies and depressives? The Irish Times Health Plus Supplement. 31 March, 2009, p.5.).

The experience of trauma was also represented as a causative factor for mental health problems. Events or circumstances that happen in the course of a person's life, bereavement, drug abuse, societal expectations, poor parental care, peer pressure, relationship problems, absence of friends and confiding relationships and bullying were all described as causing mental health problems in various different ways. Post-traumatic stress disorder by definition implicates traumatic events in the causation of a mental health problem and a number of articles focused on how a man who had a traumatic experience in the Vietnam war and was said to have post-traumatic stress disorder, experiencing nightmares, depression and severe emotional distress over a 15 year period, eventually dying by suicide (An adventure in grief. Sunday independent Living Supplement. 1 March, 2009 p.3-4., Memoir gives honest account about surviving the loss of a loved one to suicide. The Irish Times, 31 March, 2009, p.11.). His experiences were described in detail by his widow:

> Catherine said: "He didn't talk about the Vietnam war a lot, I think I learned after our first week together not to ask him about it. "He was stationed in Saigon, where there was a huge amount of death and destruction, and he would get very upset talking about how the Vietnamese people suffered. "He worked in the morgue, which was horrendous, he used to talk about it in his sleep. "That was how I learned about a lot of it, through listening to him talk in his sleep, but when I asked him about it the next day, he'd just say, 'How do you know about that?'. "The last 18 months was horrible, he was sobbing in his sleep at night, you could hear sobbing coming from way deep down. "When he killed himself it was a terrible shock, but it wasn't a surprise. A lot of people were surprised because he was still very good humoured, he was holding down a good job, it was only people who saw him in his home, and there weren't many of those, who knew how bad he was." (I saw John go downhill as the demons from his Vietnam service ate away at him. Sunday Mirror, 22 March, 2009, p.26.)

She directly relates his distress and subsequent death to his past experiences in Vietnam. Other traumatic events such as personal injury and death of loved ones are also mentioned as sources of trauma for example:

> Sometimes in life we are forced by events to walk an unexpected path. And if we heed the calls, we may end up in a much better place. That is true of Derval Dunford, 42, who, having endured two traumatic events, has bounced back to health, happiness and the creative life. When she was 17 and living in Castlebar, her father was killed and her mother badly injured in a head-on collision with a truck. Derval also suffered severe whiplash and a broken jaw; her brother was injured too. It took Derval two years to discover she was suffering from post-traumatic stress disorder (PTSD). In the meantime she continued with her arts degree in Galway, but she wasn't able to cope. "I didn't handle [the death] well. There wasn't much counselling in those days. I didn't know what to do." After moving to Dublin and giving birth to her son Stephen, Derval decided to do something about the emotional pain. For two years she took prescribed medication and with the help of a psychiatrist delved into her feelings about the accident. The therapy worked. "I got over it," she says succinctly. (How trauma brought Derval to tranquillity. Sunday independent Living Supplement. 15 March 2009, p.14.)

These two descriptions of post-traumatic stress disorder describe differing outcomes but both relate to ongoing distress caused to the person as a result of an external event, the nature of the distress being described as a mental health problem. In the second account while she reports recovering, two treatments are described but not differentiated in relation to the successful outcome.

Adverse environments and interpersonal difficulties were also implicated in the experience of trauma. A number of articles were concerned with the effect of bullying on teenagers and young people's mental health. An article by teenagers describing a project they undertook in transition year[10] on mental health among

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[10] Transition year is the 4th year of secondary school in Ireland and is a year in which students have the opportunity to study subjects outside the standard curriculum and engage in socially oriented project work.

their peer group makes the connection between the experience of trauma, bullying, and mental health problems.

> **"SIGN ur name if u h8 Laura Mc."** In our local town of Ennis, graffiti such as this is scrawled on doors, alleys and frankly any surface that will take permanent marker. But these mindless scribblings of teenagers are not mindless words to their victims. The issues of both bullying and mental health are very close to our classmates' hearts. While doing our Young Social Innovators project on bullying during transition year, we found that these two issues were very closely linked. As we dug deeper into the topic, we discovered that bullying was the cause of a huge number of mental illnesses. The availability of modern technology has resulted in great misuse. Advances that aim to make our lives easier have, in many cases, made them more complicated. In modern Ireland, there are many more mediums for a bully to torment his or her victim. The writer of the negative graffiti can now achieve the same message by creating an "I hate Laura Mc" Bebo or Facebook page. Within hours, the influx of insults can be read by the intended target. This type of non-confrontational bullying eats away at an adolescent's self-esteem. Criticism at any age can be devastating, but when the victim does not yet have the life skills to deal with it, the results are even more soul destroying. Negative self-image can lead to self destructive behaviour such as self-harm, eating disorders, substance abuse and, in extreme cases, suicide attempts. Isolating individuals simply because they are different or because they are perceived as a little strange is a common occurrence in Irish schools. (Bullying and Mental Health. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.10.)

Bullying is 'discovered' to be the cause of a variety of mental health problems and modern methods of communication are implicated in exacerbating the pervasiveness of bullying. Of a young man who died by suicide his mother is quoted as saying 'Mark had a fair few setbacks', including taking drugs, a conviction for shoplifting, death of a friend, having been assaulted and not having a father in his life (Bringing suicide out of the dark corners of Irish society. Sunday Independent Living Magazine, 15 March, 2009, p.2.). A woman writing to an advice column stated: 'Nothing traumatic has ever happened in my life.' Denying the connection, the writer invokes the trauma discourse. The advice columnist replies:

> I accept that nothing traumatic ever has ever happened to you. But sometimes a steady drip can do more damage, not least because it's so hard to detect. If you have low self-esteem and hate your body, then you have suffered real emotional damage, however it came about. (Dear Patricia I'm 17 and I feel numb and scared. Sunday Independent. 29 March, 2009, p.6.)

So even when the person denies any trauma, the answer is to find it somewhere, it's 'taken for grantedness' preferences it in causation.

Other news items linked a range of social stressors with mental health problems. Reporting on a survey of youth mental health, young people were described as needing to be equipped to deal with 'hardship'. Quoting the Director of *Headstrong*, the organization publishing the research report, the news item stated:

> But a young person's mental health can be influenced by a whole range of issues: school, friends, culture, consumerism, individualism, society becoming more disconnected… (Helping an anxious generation. The Irish Times: Weekend Review Supplement, 28 March, 2009, p.3.)

Evidence of 'increased pressures in today's society' on adolescents was discussed (Major gaps still exist in psychiatric teen services. The Irish Times Health Plus Supplement, 31 March, 2009, p.1.). An article that reported on the launch of a book based on a research study that investigated the impact friends have on teenagers' body image and which found a high prevalence of vomiting as a means of controlling body size, reported that friends and relatives have more of an influence on teenagers than media images (Friends influence body image. The Irish Times Health Supplement. 17 March, 2009, p.1.). In the same vein an article on anorexia and bulimia blamed 'harmful and unrealistic images' portrayed to young women of body size and shape. Pro anorexia and pro bulimia websites were blamed for encouraging 'girls' to lose weight and provide them with information on how best to do this together with images of very thin girls (The weight game. Sunday Independent Life Supplement. 29 March, 2009, p.12.). Abuse and trauma were implicated in self-harm:

> Research presented at a seminar in Trinity College Dublin yesterday indicated that many people who avail of services feel that the underlying causes of their self-injury, such as abuse or trauma are ignored. (Thousands treated for self-inflicted injuries feel that causes are ignored. The Irish Times, 3 March, 2009, p.11.)

A number of news items reported on specific events that were described as causing the person to develop a mental health problem. For example, a man who was distressed at his sister's memoir which claimed childhood abuse in their family is said to have depression and agoraphobia as a result (New hell over 'lies' in memoir. 2009, 11 March, Irish Daily Mirror, p.15.), and of the man described earlier who committed the sexual offence while allegedly psychotic , it was stated that :

> The genesis of Eugene's mental deterioration was certainly his fall out with the late Tony O'Reilly. (Eugene is not a sex criminal, he should not be locked up. Sunday independent. 15 March, 2009, p.33.)

A report on TV presenter Bill Oddie's depression stated that he had problems dealing with being famous when he first became famous, feeling 'hunted and claustrophobic', he did not like off screen attention and felt he was being hunted 'by a pack' and that doing the outdoors show improves his mood (TV Bill in clinic for depression. Irish Daily Mirror, 12 March, 2009, p.3.). An article that reported on the condition and treatment of Josef Fritzl (a man who had imprisoned and sexually abused his daughter for 24 years in a cellar) states that his mental health deteriorated since he received a guilty verdict that week previously and had heard his daughter's testimony which was reported to have affected him as he understood the full horror of his actions for the first time (Authorities are in red alert for Fritzl suicide. Sunday Independent, 22 March, 2009, p.21.).

While economic factors were implicated in the construction of causation, the focus tended to be on micro economics, a decrease in economic security for specific groups of individuals, people who once had financial security and who have lost it. Absent were some of the macro economic factors that impact on mental health such as enduring poverty, inequality and deprivation. There were however some exceptions for example, the subordinate status of women in society in the past is suggested as a cause of mental health problems was the subject of a book review of a book on the history of women and 'mind doctors'. This book chronicled the

stories of women who went 'mad' throughout history and up to recent times, 'women, driven demented by extraordinary pressures' including:

> The extraordinary story of Mary Lamb, sister of poet Charles. Driven to distraction by a cold, unloving and invalid mother, a sick father, an adored brother just about to be betrothed and, adding insult to injury, her having to support this entire circus by the sweat of her brow, (needlework), one evening Mary Lamb's nerves gave way, she stuck a knife in mum and killed her.

> Luckily for Mary, it happened just before madness became an institutionalized big business, and, thanks to her own shining intelligence, and her brother Charles's unflagging devotion, she spent only a short time in the "loony bin" before going on to lead a productive and happy life, her outbreak of madness not only forgiven, but also maybe more importantly, understood.

> "Madness" as she demonstrates over and over does not come out of the blue. Like physical illness, it's a process, and, amazingly, despite all the books, learning, drugs and doctors, the greatest possible hope of recovery still remains the loving support of one human being who believes in you, mad (and maddening) though you may be.

She comments on the status of women in society:

> Women were deemed inferior, weaker, stupider than men. Lower-class women were enslaved and upper-class women so hot-housed, champion of women's emancipation, John Stuart Mill, believed it was no wonder that those who didn't die of consumption, grew up with constitutions so weak they were "liable to derangement from slight causes.

> If women got the vote, argued the male Victorian worthies, it would lead to "madness and the decline of the species". Oh yes, even the lovely Charles Darwin, currently being (rightly) revered, gets a smart slapping about his whiskery chops. Women, he said, had smaller brains. QED they should spend the rest of eternity doing "the domestics". (Time to start talking and listening again. Sunday Independent Living Supplement. 22 March 2009, p.12.)

Here the impact of being marginalized in society is linked with having a mental health problem. A doctor writing about over use and over-prescription of anti-depressants and tranquillize asked:

> If we accept that 10 per cent of women and 5 per cent of men will be experiencing a bout of depression at any one time and that 300-400,000 people in Ireland are affected by this illness, and also add in the significant number with bipolar disorder and OCD, then figures of 6 and 4 per cent respectively seem reasonable. Women are twice as likely to develop

198

depression and since stress is the major trigger for this illness, it is no surprise that women in disadvantaged social situations are most at risk. Lack of self-esteem, poor nutrition, financial, educational and relationship difficulties, often in lone parent situations, combine to create a vulnerability to depression. (Are we a nation of junkies and depressives? The Irish Times Health Plus Supplement. 31 March, 2009 p.5.)

Contemporary society is similarly implicated in an item that reported on prescription drug misuse. The Chairman of the *National Advisory Committee on Drugs* was quoted reporting on the findings of a report that provided demographic information relating to the use of sedatives, tranquillizers and anti-depressants:

Respondents who are separated or divorced reported higher use of sedatives or tranquilizers and anti-depressants. Long-term state dependence, not being in paid work and lower levels of educational attainment are linked with higher prevalence rates. (1 in 5 pops a pill. Irish Daily Mirror. 27 March, 2009, p.25.)

This suggests that social and environmental factors are associated with use of psychotropic medication. However the suggested response to this issue was a Drug Trend Monitoring System, so although he reports on research that implies social determinants, the response is to ignore them in favour of a strategy of limiting access to the drugs. An article on youth mental health quoting the director of *Headstrong* (the *National Centre for Youth Mental Health*) while acknowledging the extent of the impact of societal issues, legitimizes the person as the focus of the response and obscuring society as a site for interest in terms of a response.

"The question for me is not how we can save the young people from this hardship, but how we can equip them to deal with these pressures and empower them." (Helping an anxious generation. The Irish Times Weekend Review., 28 March 2009, p.3.)

All of these factors, external events, trauma, bullying, abuse, bereavement, relationship difficulties, peer pressure, come together to construct mental health problems as emanating from the interaction of the individual with adverse events or conditions in their environment.

7.3.4 Individual psychology

While external environmental stressors dominated in most articles that either overtly discussed or inferred causation, only a few articles referred to individual psychological responses and the person's unique coping mechanisms in response to external stress. A GP (who is also a psychotherapist) wrote:

> A number of factors influence the effect of a bombshell on us: its size, the degree of impact on us, our relationships, our life, our perceptions of these, our previous track record regarding how effectively we have handled major change, shock, disappointment and challenge; and the perceived size of the challenge involved in integrating this new reality, overcoming the challenge, and reaching an acceptable integration and assimilation of the new reality. (Shock takes awesome toll on our psyche. The Irish Times Healthplus Supplement. 2009, 10 March, p.8.).

Individual factors were similarly acknowledged in another article that related to a person's ability to cope:

> In each of our lives there comes a time when the stresses we face seem to be more than we can handle. Some of us become deeply depressed, in such circumstances, some of us manage to cope. (Tackle your issues, don't let them fester. The Irish Times HealthPlus Supplement. 17 March, 2009, p.8.)

The 'effect', coping or not coping, is portrayed as contingent on factors that relate not only to the environmental stressor but to the person's own psychological make-up.

7.4 Summary

Previous research has identified that biological and psychosocial discourses are enlisted in media representations of mental health problems (Rowe *et al*. 2003) and that content related to causation tends to be relatively simplistic, focusing on single issues rather than considering the complex range of factors thought to be implicated (Pirkis *et al*. 2005). News items in this study enlisted both biological and psychosocial discourses in constructing causation but not through any sophisticated consideration of the relationship between or the relative contribution of the various factors. Factors implicated in causation tended to be definitively asserted not reflecting the contested nature of discourses on the causation of mental health

problems. An Illness discourse intermingled with psychosocial discourses to produce an understanding of the causation of mental health problems and while these discourses contest each other this inherent conflict was not alluded to or considered in any sophisticated manner, they were represented unproblematically.

News items represented mental health problems as illnesses through the use of 'illness' related language, by reporting on mental health problems as having biological origins and by making associations with physical illness as a means of legitimizing mental health problems and alleviating negative connotations. This is not surprising given the prevailing predominance of psychiatry in determining and treating mental health problems. Representing them in this way, as illnesses, reinforces a biological determinist understanding of human emotion and behaviour, obscuring or minimizing other factors such as psychological development and social influences. It emphasizes the importance of biology and the relative lack of control of the individual over their own mental health and locates the 'problem' with a 'faulty' individual. Psychosocial discourses constructed mental health problem as being caused by adverse social environments and traumatic events, social stressors and their interaction with individual psychological processes. The positioning of responses to life events as mental health problems pathologizes and medicalizes human states and emotional responses. Previous research has identified magazine portrayal of childhood depression as medicalizing childhood (Clarke 2011).

While illness and psychosocial discourses contest the basis of causation, they unite in constructing a realist understanding of mental health problems and place an emphasis on a faulty individual who is the recipient of the response obscuring other possibilities. Biological explanations might not be expected to lead to any questioning of the ontological foundations of mental health problems however implicating societal conditions and stressors might be expected to generate at least some doubt as to mental health problems as individually located states. However, the existence of mental health problems as illnesses of the individual was not

contested in any of the news items and while external factors were implicated in the generation of mental health problems, the focus of response and change tended to be on the person affected and not on any wider societal issues such as inequality, poverty and human rights; the response always focused on the individual. The next chapter presents the findings in relation to how discourses of recovery and professional treatment were deployed in constructing mental health problems.

Chapter 8 Constructing recovery and constructing professional treatment

8.1 Introduction

A key concern for government and people who experience mental health problems and their families is the provision of treatment and care. The concept of recovery has in recent times achieved a dominant place in the rhetoric of government mental health policy, service delivery and professional and service user discourses. This chapter presents the findings in relation to how discourses of recovery and professional treatment were enlisted in constructing mental health problems.

8.2 Constructing recovery

The notion of recovery as a concept in relation to mental health and mental health care, has emanated from the recovery movement and claims to offer a more optimistic understanding of mental health problems than previous understandings, emphasizing optimism about the possibility of recovery, person centeredness, social inclusion, self-determination, pluralistic perspectives and the importance of valuing personal experience (Mental Health Commission 2008). While the dominant presentation of mental health problems was negative a small number of news items in the main sections of the newspapers represented mental health problems as being a catalyst for growth. The mental health supplement repeatedly referenced recovery in its description of mental health services and the way in which the discourse of recovery was referenced constructs a particular understanding of mental health problems. Recovery was referenced in two ways, by articles that represented mental health problems as possible to recover from and as a concept incorporated into professional mental health services.

8.2.1 Possibility of recovery

A small number of news items portrayed mental health problems as possible to recover from. For example, a report on the celebrity Bill Oddies's recurrent depression, quoted his agent who states:

> "Bill gets these bouts every two or three years where he gets down and then recovers" (TV Bill in clinic for depression. Irish Daily Mirror. 12 March, 2009, p.3.).

A small number of news items depicted mental health problems as a catalyst for positive change in people's lives. The woman whose husband had PTSD and who died by suicide, while presenting a grim picture of her husband's life and describing the negative impact this had on her own life, wrote:

> With his death he pushed me to the limit once more, but this time into the complex emotional world of myself. The outcome has been surprisingly joyful and I find it easy just to be in the world and look forward to wherever it is taking me next. (An adventure in grief. Sunday Independent, Living Magazine. 1 March, 2009, p.3-4.)

Similar sentiments were expressed by a woman who experienced a series of traumas and adversity.

> Sometimes in life we are forced by events to walk an unexpected path. And if we heed the calls, we may end up in a much better place. That is true of Derval Dunford, 42, who, having endured two traumatic events, has bounced back to health, happiness and the creative life. "So what was a challenging time turned out to be a great opportunity for growth and learning," she says serenely. (How trauma brought Derval to tranquillity. Sunday independent Living Supplement. 15 March, 2009, p.14.).

Similarly a GP who is also a psychotherapist writing about shock and the impact it has on mental health wrote:

> Through this painful process, we often experience growth and find strength inside ourselves we never realised we possessed. (How to soar despite life's ruffled feathers. The Irish Times Health Plus Supplement. 24 March, 2009, p.6)

In contrast with discourses of devastation that represented mental health problems as exclusively negative experiences these few isolated reports portrayed mental health problems as being not only possible to recover from but as ultimately

positive due to learning, change and development on behalf of the individual. In the main sections of the newspapers this optimistic portrayal was isolated to a small number of news items.

8.2.2 Professionally defined recovery

The notion of recovery had a dominant position in the mental health supplement, sponsored as it was by the *HSE* and highlighting developments in mental health service provision in relation to mental health policy, which purports to have recovery as a central tenet. The news items in the supplement contained many references to recovery (the word recovery is mentioned 60 times across 23 pages), ostensibly adopting an optimistic tone and conveying a positive message. The way in which recovery was referenced in the professional discourse is interesting in that it provides insight into how it is deployed in relation to other discourses. A particular 'type' of recovery was represented. Mental health services were described with reference to 'recovery'. Recovery was constructed with reference to established biomedical psychiatric service provision by descriptions of recovery from mental health problems that emphasized the importance of engagement with established mental health services in achieving recovery. Describing the overall orientation of the mental health services and an initiative to develop mental health care in primary care, an item stated:

> Mental health issues range from more common conditions such as stress and depression to schizophrenia, which affects almost one person in 100. We need to create a greater understanding of mental health issues, informing the public that help is available and how modern successful treatments offer recovery and support. Today, 'A Vision for Change' is building on this progress by recommending that "service providers should work in partnership with service users and their families, and facilitate recovery and reintegration through the provision of accessible, comprehensive and community-based mental health services."

> A community mental health team will include occupational therapists, psychologists, social workers and nurses, along with consultant psychiatrists and other health professionals, to provide a range of skills to support people on their journey to recovery. (The road to recovery. Sunday Independent Your Health Your Life Supplement. 4 March, 2009, p 4.)

'Recovery' is contingent on accessing 'modern successful treatments' delivered by specified 'service providers' in 'comprehensive and community-based mental health services'. Similarly in relation to eating disorders, recovery is contingent on 'early identification' in this news item:

> "Though the physical effects of an eating disorder can be significant, it is important to remember that recovery is possible," says Jacinta Hastings, CEO of Bodywhys, the eating disorders association. Key to that recovery is early intervention, and the ability to access supports, both for the person experiencing an eating disorder and for their family and friends," she says. (Giving an insight. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.19.)

Early identification involves engaging with professionals who provide diagnosis, requiring the person to accept a particular understanding of their mental health issue. A Director of Nursing describing his role with reference to recovery wrote:

> While I have a clear management role to ensure we deliver the best standards of care, it's also vital to provide leadership, with a clear direction of care that gives hope and a true sense of recovery to the people with mental health issues in West Cork. (Making a difference. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.15.)

Care is presented as essential to 'true' recovery. The integration of recovery into the established care services is evident in a report on new professional roles that incorporate recovery in the title:

> Staff members include a rehabilitative training instructor, an outreach nurse, a recovery-support worker and a recovery-resource worker. (A new focus. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.17.)

Recovery moves from a being a concept to being an entity, a job, a commodity. Wellness Recovery Action Planning, (WRAP) is a formalized process used in mental health services to operationalize recovery and to orientate care planning towards recovery. It was described in one article:

> To achieve the objectives of a recovery-oriented mental health service, there is a growing recognition that we need to explore new and complementary approaches to facilitate individuals on their own unique recovery journey. Wellness Recovery Action Planning, or WRAP as it is more commonly referred to, is an internationally recognised approach developed

by Mary Ellen Copeland in 1989 (www.mentalhealthrecovery.com). It has been acknowledged by the Mental Health Commission and the Irish College of Psychiatrists as an integral part of an education and training programme for recovery-promoting services. WRAP has been designed by people with self-experience of mental health difficulties as a self-management approach, which facilitates individuals to look at what contributes to maintaining their wellness; what strategies are needed to stay well and, where possible, identify what might contribute to relapse. The plan also includes advance directives, indicating what the individual wishes to happen in the event of relapse. The core philosophy underpinning WRAP is the individual is empowered to control what happens in their lives and actively manages their wellness in collaboration with others, usually family, friends and mental health professionals. (Recovery Support. Wrap-Around Support. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.5.)

The recovery approach is presented as 'complementary' to other approaches. The WRAP programme is legitimized by being recognized by the *Mental Health Commission* and the *Irish College of Psychiatrists*, the regulator of state mental health services and the professional organization of psychiatrists, both groups heavily invested in the mental health services. Recovery is described as a 'self-management approach' that the individual is to engage in, contingent on support from the mental health services. Other formalized programmes to promote recovery also featured in the health supplement. An article reporting on a woman's experiences of obsessive compulsive disorder and reports how:

Julia Hennessy describes how she has learned to manage her obsessive compulsive disorder and fight her fears by joining Recovery (a group). (Overcoming fear. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.5.).

Recovery consists of 'managing' her 'disorder', implying that it does not go away. Writing about having a mental health problem over a long period of time a man writes:

My name is Rob and I was diagnosed with a mental health disorder in my 20s. Trying to understand my mind and learning to achieve a good quality of life is a continually challenging process for me. Suffering is a natural part of life for us all, and yet I often run from suffering, searching for escapes. Sleep and alcohol, TV, music and sex, living in the past or living in the future help me numb the pain and distract me from looking deeper at the problem. The hardest part is fully accepting my condition, asking for and getting the help that I need, taking the medicine and engaging with the long task of

recovery. (Growing together. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.5.)

Recovery involves acceptance of having 'a condition', 'getting help' and 'taking medication' and the tone implies great endurance and effort is required. A similar tone is adopted in an item written by *GROW* an international mental health organization made up of volunteers, professionals and people with mental health problems. It states:

> GROW in Ireland knows that people can and do recover from even the most serious and long-term mental health problems. For some people the recovery process can be long, slow and at times difficult but the reality is it can happen. We are the only national mental heath (sic) organisation working to promote mental health and wellbeing for all, to prevent mental ill-health for people who are "at risk" and to support people with mental health problems during their recovery. (GROW in Ireland. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.7.)

Here positivity about recovery is qualified by statements that indicate the difficulty and seriousness of the 'condition' and the length of time and effort involved in recovering.

The concept of recovery can be understood in two different ways. Firstly the conventional sense of the word means restoration of health and well-being, the second an understanding of achieving well-being as being able to live well with ongoing symptoms and disability (Davidson, Lawless and Leary 2006). Walker (2006, p.76) contends that the recovery model is, "saddled with the baggage of pathological and deficit-based vocabularies" and that hope, intrinsic to recovery is weighed down by psychiatric language that constructs life-long disease and treatment. The referencing of recovery in news items supports this view suggesting that recovery has been appropriated by psychiatry. Recovery was constituted with reference to the dominant biomedical system which expands to accommodate competing discourses. This privileges the professions involved in psychiatry, and expands their gaze creating more opportunities to define human distress in a biomedical way.

8.3 Constructing professional treatment

State provided psychiatric services have been dominant in the treatment of mental health problems in Ireland over the past 150 years. While the orientation of services has shifted from an institutional model to a community focus and policy emphasizes the importance of psychosocial approaches and the importance of client-centred services, legislation and service structure continues to support the dominance of professional and psychiatric discourses. Psychopharmacological and physical treatments prevail despite a questioning of research that has demonstrated efficacy and a growing awareness of the impact on people's lives of adverse effects (Read and Bentall 2010; Healy 2009; Moncrieff, Wessely and Hardy, R. 1998; Kirsch and Sapirstein 1998). The legitimacy of psychiatry as the dominant framework through which to understand and respond to mental health problems is contested. 'Modern' psychiatry has adapted to incorporate psychological and social discourses legitimized by a discourse of evidence based practice. This provides a façade of scientific rigour that is often unwarranted and uncritically accepted. Apart from the problems of reconciling these disparate approaches and a lack of definitive research into causation, none have proven unequivocal efficacy and all have been criticized for their iatrogenic effects (Rogers and Pilgrim 2010). News items represented professional mental health treatment as being unquestionably appropriate as a response, with the only problems identified being a lack of funding for more services. Treatment responses were bio medically mediated even when psychosocial in nature and every day activities were framed in professionalized language. Professional mental health care was represented as progressive by virtue of movement to new sites rather than by alteration in orientation or proven effectiveness.

8.3.1 Need for more services

News items that reported on therapeutic responses and services for people with mental health problems reported them unambiguously as an appropriate means of response. The provision of state provided, professionally delivered mental health services was the dominant normative response to mental health problems in

newspaper articles and they were characterized frequently as being under-funded and inadequate by virtue of lack of availability. An editorial stated:

> …the Government's response in devising a comprehensive range of services has been shamefully inadequate and a lack of funding has crippled professional help. (The health of our youth. The Irish Times. 28 March, 2009, p.15.)

Treatment approaches that were biological, psychological and social in orientation were reported on and frequently undifferentiated. Articles that called for a greater response to mental health problems or reported on deficits in services problemtatized only the lack of resources, not the nature or ideology of the services or the therapeutic approaches as a legitimate response to mental health problems. For example, several articles that reported on research into youth mental health discussed the problems young people faced and the mental health services provided (Mental health care too costly for young people. Irish Daily Mirror, 26 March 2009, p.24; Helping an anxious generation The Irish Times Weekend Review, 28 March 2009, p.3; Two out of three teens feel unable to cope with problems, The Irish Times, 23 March 2009, p.1; Services not geared towards needs of teens with mental health problems. The Irish Times, 26 March 2009, p.3.). A range of problems associated with services was reported on, being too costly, being inaccessible through long waiting times and inappropriate hours of service, being adult oriented, stigmatizing, too specialized and medically oriented. One article reported:

> Troubled young people are rejecting professional help because they cannot afford it, experts warned yesterday.

Later in the same article the director of the *Office for Disability and Mental Health* was quoted as saying:

> "efforts must be made to encourage young people to seek help" (Mental health care too costly for young people. Irish Daily Mirror, 26 March, p.24).

Reporting on a study into youth mental health, an editorial noted, that:

> "One in 10 reported serious mental problems for which they had not sought professional help."

concluding that:

It represents compelling evidence that a radical rethink is necessary in responding to the needs of young people at official level. (The health of our youth. The Irish Times. 28 March, 2009, p.15.).

The 'radical rethink' that is suggested is increased funding and more services. An article entitled 'One in five Irish teenagers has a mental illness' quoted:

St. Patrick's University Hospital boss [A private mental health service] Paul Gilligan added: "I think overall there is certainly a continuous demand for our service and we are seeing an increase. (One in five Irish teenagers has a mental illness. Irish Daily Mirror. 31 March, 2009, p.25.)

In relation to care for people with anorexia and eating disorders a writer who has anorexia wrote:

Firstly, we need beds dedicated to eating disorders. Our present three beds for 200,000 means endless waiting lists and months if not years of waiting. There is little a doctor can do: the facilities simply do not exist. (Anorexia's open secrets. The Irish Times Health Plus Supplement 2009, 10 March, p.8.)

The call is for more services but only hospital beds are mentioned, no specific other interventions are mentioned as being necessary. This legitimizes existing services and ideologies, problematizing only their accessibility and the lack of government funding, which are stated in another news item on youth mental health to be "shamefully inadequate" and "crippling professional help" (The health of our youth. The Irish Times, 28 March, 2009, p.15).

An article that reported on a newly established service for young people who have mental health problems and which is portrayed as new and innovative, reported:

And this is where Headstrong's big idea comes in. It has designed a simple model for young people to access mental health services which, it hopes, could be rolled out across the country. (Helping an anxious generation. The Irish Times Weekend Review Supplement. 28 March, 2009, p.3.)

The 'big idea' is to channel young people into existing services. Cuts to funding of services were criticized (Funds for suicide prevention set to be cut by 12.5%. The

Irish Times, 5 March, 2009, p.12.) with dire consequences predicted if resources were not reinstated.

> We know that many suicides can be prevented so there is an onus on the HSE to focus resources on this area. (€750K HSE suicide fund 'a disgrace'. Irish Daily Mirror, 28 March, 2009. p.9.)

An article reporting on the closure of a state psychiatric hospital reported concerns and protest among the local community as:

> ..the hospital is the only provider in the region of appropriate support and care for those suffering long term mental health difficulties in the Longford/Westmeath region. (Fears growing for future of St Loman's Hospital. Longford Leader, 13 March, 2009, p.5.)

As previously discussed in relation to crises, risk and danger, reports of increases in the number of people experiencing mental health problems were used to justify the need for a greater supply of services. Groups such as self-harming children and adults, teenagers with depression were among those singled out for attention (Huge increase in children treated for self-harming. Sunday Independent, 29 March 2009, p.8; Major gaps still exist in psychiatric teen services. The Irish Times Healthplus Supplement. 31 March, 2009, p.1.; Thousands treated for self-inflicted injuries feel that causes are ignored. The Irish Times, 3 March, 2009, p.11.). Statistics relating to prevalence and incidence of mental health problems were presented as evidence of need, frequently by professionals and others to support their argument for their services, which they were promoting and seeking funding for, establishing their legitimacy as an appropriate response. The linking of reports of increases in mental health problems with criticisms as to lack of funding and service provision increases the plausibility of the argument for the appropriateness of the particular services under discussion by constructing them as the normative response.

8.3.2 Bio medically oriented services

The mental health supplement that reported on mental health and services reported extensively on *HSE* mental health service provision (Sunday Independent Your Health Your Future Supplement, 2009, 22 March). It contained articles on specific mental health problems (suicide, anxiety, self-harm, dementia, alcohol abuse, eating disorders and depression), described the work of professionals in the services, reported on new initiatives in service provision and therapies introduced. As would be expected, given that it was a supplement sponsored by the main service provider of mental health services in the state, all articles were written in the context of state provided service provision, constituting this as the norm and portraying them as being of high quality and progressive. Developments in orientation to mental health care described in the supplement were located in the context of state service provision and were dominated by professional voices. This was evident in the way in which innovations were presented and service was positioned. Service developments that were psychosocial in nature were framed by reference to a biomedical care model and while discourses of consumer rights were present they tended to be referenced either by association with or by legitimization by service providers and mental health professionals, reinforcing a professional discourse.

The term 'service user' is used throughout the mental health supplement. Culturally available discourses construct people who experience mental health problems as 'service users'. Their involvement in mental health policy, service planning and service delivery is widely accepted as a positive development and an indication that services are modern and consumer oriented and this is required by policy and regulatory frameworks (Government of Ireland 2006; 2001). The term 'service user' is widely used throughout official documents and in practice to refer to people who have mental health problems but by implication it implies that all people who have mental health problems have used the services. The naming of people who have mental health problems as 'service users' positions them as patients (Stevenson, Grieves and Stein-Parbury 2004) limiting them by definition to

a particular role, defined by association with service, disallowing them other identities. It also denies visibility or voice to anyone who does not use or has not used services defining mental health problems and mental distress only with reference to a psychiatric discourse.

An article that reported on the establishment of the *National Service User Network* (NSUE), a newly established organization funded by the state to facilitate the inculcation of people with mental health problems into mental health care planning and development, described it:

> The National Service User Executive (NSUE) has been established to inform the health service and Mental Health Commission on issues relating to service user involvement and participation in planning, delivering and monitoring and evaluating services, including models of best practice and to develop and implement best-practice guidelines. (National Service User Executive. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.4.)

The creation of NSUE expands the number of organizations concerned with mental health problems and is defined by reference to established structures. The naming of this organization and the definition of its functions in the context of established state services limits other actions or functions in relation to mental health. NSUE was established by the state, its involvement mediated, defined and limited by the established organizations. The creation of a new post in a university with the title, 'Practice, Education, Research Expert by Experience' in mental health was described thus:

> The School of Nursing, Dublin City University, in partnership with the HSE, has developed a new post, 'practice, education, research expert by experience'. The post, when it was advertised, uniquely did not require academic qualifications, but, rather, sought an applicant who had experience as a user of mental health services in Ireland. This is the first time such a post has been offered in Europe. (A first for Europe. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.15.)

The criterion for the person was they would be a 'service user' rather than a person who had experienced a mental health problem. An initiative in the same university

214

designed to instigate mental health service development through a co-operative learning project involving service users, carers, families and service providers is described as an innovative model designed to encourage partnership in developing mental health services with shared participation among all parties. Of the four people named in the item, the people quoted in relation to the initiative were a mental health lecturer and a doctor. Both were given titles where as other participants named are not.

> The three West Cork participants were challenged by the course to overcome their differences and learn to work together. Dr Twamley says: "This initiative is incredibly exciting … it is opening the door to real cultural change within the mental health service, empowering service users and carers to work alongside service providers as active negotiators for change … and challenging service providers such as myself to learn to listen". (Partnering for progress. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.21.)

Describing service users' role in relation to the mental health services a Director of Nursing wrote:

> Service users and carers bring immense knowledge and expertise because they know what is required by their experience, and my job is to facilitate and create opportunities for their voice to be heard. It's also my role on a daily basis to see mental health as not just the provision of the statutory services. We have forged strong links with the NLN, Rehab Care, West Cork Community Partnership, Supported Housing and employment agencies to create a culture where mental health is everyone's business, including the community. This creates an environment for innovative projects that includes the Community Mental Health Forum, involving providers, service users and carers, to discuss through dialogue mental health issues, along with a Home Focus initiative, delivering a recovery-based support structure in people's homes to enhance their mental health and well-being. (Making a difference. Sunday Independent Your Health Your Life Supplement, 22 March, 2009, p.15.)

Service users' knowledge and expertise is spoken about as important but requiring facilitation in order to be heard. So service users are welcomed in but it is a conditional and mediated welcome. The mental health service is presented here as the focal point for all things mental health related.

The dominance of a biomedical discourse was evident in the way on which psychosocial and consumer responses were represented in the context of a biomedical frame of reference. In relation to treatment for mental health problems many articles provided accounts of medication for problems such as post-traumatic stress disorder (An adventure in grief. Sunday Independent Living Supplement. 1 March, 2009, p.3-4.), (How trauma brought Derval to tranquillity. Sunday independent Living Supplement 15 March, 2009, p.14.), 'severe' personality disorder (Authorities are on red alert for Fritzl suicide. 2009, 22 March Sunday Independent, p.21.), obsessive compulsive disorder (Cycle of obsessive thoughts. The Irish Times Healthplus Supplement, 13 January, 2009, p.70) (Overcoming fear. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.5.) and psychosis (Eugene is not a sex criminal, he should not be locked up. Sunday independent, 15 March, 2009, p.33.). This was presented unproblematically with no reference in any of the articles to the debates that exist in academic, clinical and consumer discourses concerning the appropriateness and efficacy of medication for the treatment of mental health problems and concerns about the serious and sometimes life threatening impact on the health of people from side effects of many of the psycho pharmaceutical agents.

Although mental health care remains dominated by a biomedical discourse it has expanded to include psychological and social understandings leading to a general consensus that 'best practice' involves a having a bio psychosocial orientation. A psychosocial orientation involves services and interventions that target the individual's psychological processes and social situation (Monaghan, Doyle and Keogh 2008). A range of psychosocial therapies were mentioned in articles, including, talking therapies, cognitive behaviour therapy, psychotherapy and social and family support (Tackle your issues, don't let them fester. The Irish Times HealthPlus Supplement, 17 March, 2009, p.8.). They were frequently mentioned alongside biomedical treatments with no differentiation regarding efficacy or mode of action, for example, an article describing a man who has obsessive compulsive disorder reported on his treatment:

Once diagnosed, Quinn began taking medication and attending a consultant psychiatrist on a regular basis. Later he did a course of cognitive behaviour therapy where, he says, he learned to take control and reassure himself that the obsessive thoughts were irrational.

There is no cure for the disorder and treatment focuses on managing the symptoms of the disorder. Medication, in the form of selective serotonin reuptake inhibitors (SSRIs), can be effective in reducing the obsession to a manageable level. Cognitive behavioural therapy (CBT) is also recommended. This involves getting sufferers to face their obsessions without having to use compulsions to reduce anxiety. (Cycle of obsessive thoughts. The Irish Times Healthplus Supplement. 13 January 2009, p.70)

In relation to eating disorders:

An outpatient programme provided by community mental health clinicians in Carlow and Kilkenny is helping to treat adults with eating disorders. The Community Integrated Eating Disorder Programme (CIEDP) consists of a number of strands, namely systemic family therapy, psychology, psychiatry, a family support and education meeting and GP medical reviews. (Giving an insight. Sunday Independent Your Health Your Life Supplement, 22 March, 2009, p.19.)

and in relation to depression a GP wrote:

I have always been in favour of the holistic approach to depression-a combination of lifestyle changes, drug therapy and talk therapies-with each person deciding on the road they wish to travel. (Are we a nation of junkies and depressives? The Irish Times Health Plus Supplement. 31 March, 2009, p.5.)

This presents an undifferentiated 'treatment', blurring the specificity of modalities, obscuring any possibility of scrutiny regarding effectiveness.

The dominance of a biomedical discourse was evident in some news items that used medical terminology to report psychological approaches. For example, an article on the mental health of third-level students, encouraging them to talk, bore the headline: "Simply talking can be the miracle pill" and reported "talking is the antidote to despair" (Simply talking can be the miracle pill. The Irish Times Healthplus Supplement. 3 March, 2009, p.11.). An article about suicide stated: "At the core of suicide is a feeling of hopelessness. The antidote for this is hope." (Why? The Irish Times HealthPlus Supplement. 3 March, 2009, p.4.), utilising

language associated with medicine to refer to what is essentially a personal feeling. Psychosocial approaches were recommended when integrated into 'treatment process'. A sub-headline of an article on anorexia stated:

> The availability of a support network is crucial, and for many the integration of family therapy into the treatment process can be very effective' (Giving an insight. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.19.).

Psychosocial approaches were legitimsed by psychiatric institutions and by association with science. An article describing a cognitive behaviour therapy service reported:

> However, CBT is generally not an overnight process. Even after those undergoing the therapy have learned to recognise when their thinking style is unhelpful, it can take months of effort to replace a dysfunctional cognitive or behavioural process or habit. Notwithstanding, the American Psychiatric Association practice guidelines have indicated that, among psychotherapeutic approaches, CBT is the best for treatment of major depressive disorder and anxiety (Think positive. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.21.)

A counsellor writing about meditation as a means of managing intrusive thoughts and feelings suggests a technique used in meditation, naming emotions as you feel them, that gives a detachment from what is going on in your head that has been shown by research to dampen down that emotion by activation another area of the brain. He comments:

> …so the centuries old meditation technique now has a bit of science behind it. (Thinking yourself out of depression. The Irish Times HealthPlus Supplement. 10 March, 2009, p.14.).

Science is used to legitimize meditation, indicating the foregrounding of science as the normative way of understanding mental distress.

A central tenet of mental health policy and evidence of a 'modern' mental health care system is the notion of a multidisciplinary team and its global availability in the mental health services (Government of Ireland 2006). The development of the multidisciplinary team is frequently presented as an indication of a move from a

biomedical approach incorporating psychological and social approaches. A wide range of groups who are involved in mental health care was reported on in news articles; in the main sections of newspapers, psychiatrists and psychologists dominated, in the mental health supplement, the list expanded to include general practitioners, speech therapists, psychotherapists, art therapists and non-professionals such as service users and advocacy workers. The way in which they were referenced, while referencing psychosocial discourses, at times however indicated the persistence of a biomedical discourse. For example, a speech and language therapist describes her newly established role in the mental health services:

> Speech and Language Therapy (SLT) for adults with mental health disorders is an exciting and much-needed new development in Ireland. In June 2006, I undertook the role of clinical specialist SLT in Adult Mental Health under the auspices of Tallaght Hospital and HSE Dublin South West. Over the past two years, I have been asked: 'Why SLT in psychiatry? Haven't we managed fine until now?' My answer has always been: 'Well, why not?' As speech and language therapists, we have a deep understanding of the various speech, language and communication disorders. We are also trained, in considerable depth in the areas of linguistics, neurology and psychology. The development of this service was influenced by a 2007 needs analysis study. This contributed to, firstly, an increased knowledge of the nature of the speech, communication, language and swallowing disorders associated with, or intrinsic to, many psychiatric presentations; and, secondly, an identified, marked prevalence of these disorders in this client group. (Giving a voice to mental illness. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.15.)

The role is located linguistically in 'psychiatry', she positions herself as a 'SLT in psychiatry' and with the use of terms such as 'mental illness', 'psychiatric presentations' and 'disorders'. New professionals involved are integrated into the established ideology. A number of articles report on a need for the inclusion of new groups, GPs, youth workers, teachers, Gardai, staff and volunteers in voluntary organizations in the recognition and response to depression and suicidality through community education programmes aimed at providing communities with a basic understanding of issues related to suicidal behaviour and prevention.

Reports of newly formed alliances also expanded the number of groups and institutions concerned with mental health, a *Mental Health Forum* established jointly by the *Irish College of General Practitioners* and the *Irish College of Psychiatrists* (The road to recovery. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.4.), the *National Office of Suicide Prevention* working in a campaign with other agencies, *Young Social Innovators, Dail na nOg, BeLong*, for example. The establishment of new groups and the inclusion of new individuals and organizations into the mental health arena is contingent on their fitting in to the framework of mental health services and a biomedical discourse. This allows the discourse to survive and flourish and disallows these groups from making other statements in relation to mental health.

8.3.3 Professionalizing everyday activities

The privileging of professional approaches was also evident in news items that described a range of activities that could be understood as part of normal living, and which were framed as therapy, organized and delivered by professionals. Activities such as meeting friends, reading books, shopping, leisure activities such as walking, sports, cookery were framed as therapeutic initiatives, state provided and initiated and led by mental health professionals. Describing a group that meets to partake of badminton, table tennis, 10-pin bowling, pool, walking and cookery a social worker was quoted:

> The group provides opportunities for people to tackle the adverse impact of mental health challenges in a socially supportive context. (Leisure with a difference. 2009, Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.19.)

A group set up to introduce people to each other was reported on:

> The aim of the group was to aid individuals with a psychiatric illness who were living in its community. The group is run on a weekly basis by volunteers from the Wicklow Mental Health Association, with support from the local community mental health nurse. Since its formation, Companions has gone from strength to strength, having 15 to 20 active members, all of whom have formed lasting friendships. (New companions. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.17.)

A similar initiative, a 'befriending service', took what is a part of everyday human life, forming friendships, and framed it as a service, reframing friendship as a commodity (A friendly face. Sunday Independent Your Health Your Life Supplement, 22 March, 2009, p.16.). Recommending that people read self-help books was framed as a 'therapy' and spoken about as a 'prescription'.

> Self help books have been used for therapeutic purposes — bibliotherapy— for many years, but now they are being prescribed by GPs as a means of providing psychological therapy.
>
> The effectiveness of bibliotherapy has been well established in clinical trials, and has been recommended by the National Institute for Clinical Excellence (NICE) UK as a useful start in treating mild and moderate depression, anxiety and panic and some other mental health problems.
>
> Most of the books included in the scheme are written by leading psychologists, and many present self-help versions of established treatment programmes. (The power of language to self-heal. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.23)

Reading books is reconstructed as a 'bibliotherapy' that is to be prescribed, as you would a drug. It is only legitimized for some groups and the books are written by a professional group and pertaining to established treatment programmes. The language referred to in the title of the as having 'power' is a professional language that has been 'approved' by professionally dominated institutions. This can be understood as a professional discourse that is expanded to encompass everyday social activities, appropriating them by repositioning them as 'therapy'. This protects the professional discourse from any challenges from counter or critical discourses that might de-professionalize responses to mental distress.

8.3.4 Moving sites

Contemporary discourses of de-institutionalization equate the development of progressive and modern mental health services with proximal location to the person's own community. This move in location of care has underpinned mental health policy and legislation in Ireland and elsewhere over the past 60 years and the re-orientation of services accordingly is widely accepted positive with criticism only emerging in relation to lack of adequate funding for appropriate infrastructure and

staffing. Care provision was mentioned with reference to the sites in which care is provided in a number of articles. The introduction to the mental health supplement by the National Director for Primary, Community and Continuing Care indicated the importance of location in representing mental health services:

> That's why the backbone of our approach is to move away from institutions towards providing more care, using modern approaches, locally within people's own communities. For example, as part of our programme to build local care teams for every 10,000 people across the country, we are establishing teams of experts that will concentrate on providing community-based mental health care. We are also establishing teams that will look after the mental health needs of children and adolescents. (A Vision for Change. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.2.)

This ostensibly implies a change in orientation of policy and approach. However, it functions to allow for the continuation of a biomedical approach, limiting criticism of past and current service provision to the location of care. The 'backbone' of the new approach is to provide care not in the 'institutions' (bad) but 'locally' (good) and to provide more of it. So criticism of care is dealt with by focusing not on ideological underpinnings, such as how mental health problems are understood, or the quality or orientation of treatment responses but by focus only on proximity to the person's usual residence.

In addition to the traditional sites for the provision of mental health care, psychiatric hospitals and clinics, other sites were mentioned in news items including, general hospitals (Alcohol liaison project-Cavan General Hospital. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.14.), prisons (Joined up services for prisoners with psychotic illnesses. Sunday Independent Your Health Your Life Supplement. 2 March, 2009, p.22.), GP practices (Preventing suicide. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.8-9.) and crises houses (Giving respite. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.16.). While this expansion of the number and range of sites where mental health care can be provided was reported on as a positive development, the manner in which it was referenced indicates that is does not

disturb the professional biomedical discourse. For example, a description of a Crises House where people can go as an alternative to acute in-patient psychiatric care reported:

> Greenbanks offers an alternative to in-patient care for people who would otherwise be admitted to the acute psychiatric unit, providing an effective response to specific requirements. It focuses on addressing the needs of people in a highly innovative way and may be used for crisis intervention or respite purposes. A crisis bed is offered to new or existing service users who are deemed to require a brief period to resolve some psychological or social crisis. The unit is accessible either through the day hospital at St Dympna's or by going through the community mental health teams or the Department of Psychiatry. The facility offers a collaborative approach from the multidisciplinary team. (Giving respite. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.16.)

Even though the new service is community based and an 'alternative', access is only through state provided mental health services.

People with what are termed 'severe', 'enduring' or 'long-term' mental health problems are frequently referred to by professionals as unwilling to engage with services and 'non-compliant'. The following news item reported on an initiative aimed addressing this 'problem'.

> Home Focus was setup to provide holistic, person-centred, recovery-based support to people with severe and enduring mental health difficulties who are isolated because of their inability or unwillingness to access traditional, centre based models of service delivery. The aim of the project is to deliver a service to this group of people in their own homes and communities in the west Cork areas of Skibbereen/Schull, Bantry/Castletownbere and Clonakilty/Dunmanway. Participants are enabled to enhance their mental health, well-being and quality of life, as well as improve their independent living skills and their ability to access training, education and employment opportunities. The project is delivered by a team combining service user and professional expertise. Staff members include a rehabilitative training instructor, an outreach nurse, a recovery-support worker and a recovery-resource worker. The project has led to a significant 47 percent reduction in hospital admissions over a period of 12 months for participants. (Supportive centre in Nenagh. Sunday Independent Your Health Your Life Supplement 22 March, 2009, p.17.)

The team will provide care in the person's home if they are unable or unwilling to attend the 'centre'. People's unwillingness to engage with services is dealt with by moving the services to their home. Another article which deals with the issue of mental health in primary care discussed the importance of GPs in recognizing and treating mental health problems.

> It is recognized that role of the GP is hugely important in identifying and treating the early stages of many illnesses, both physical and mental, and the same is true in the identification of people at risk of engaging in suicidal behaviour. (Preventing suicide. Sunday Independent Your Health Your Life Supplement. 22 March, 2009, p.8-9.)

The association being made here between physical illness and 'mental illness' suggests that in the move to a community setting, the orientation of the response is unchanged, it remains dominated by biomedical understandings.

Contemporary discourses of modernization in relation to mental health care privilege de-institutionalization, psychosocial approaches to care, advocacy and service user and carer involvement in mental health matters. Latour (1987 cited in Kendall and Wickham 1999) suggests that one of the tactics utilized in constructing knowledge about a subject is inventing a problem so that your solution becomes appealing. By inventing new goals and enrolling others to your view point, the discourse strengthens and perpetuates. The dominant biomedical discourse, previously the exclusive domain of psychiatrists and a limited number of others has changed in a number of ways to allow space for the incorporation of other discourses. The problematization of the institutional nature of care and the widespread reporting about and acceptance of de-institutionalization as an appropriate solution, defines the institution as the 'problem' and obscures biomedical psychiatry from criticism. The range of sites in which mental health care can be delivered has increased, the range of professionals and organizations legitimized to deliver or be involved in services be has increased and the range of interventions has expanded beyond traditional biomedical and custodial approaches. This move in orientation to community care, client centeredness and provision of psychologically and socially based interventions does not disturb the

dominant biomedical discourse as it has merely expanded to allow others in; people with mental health problems ('service users'), relatives and friends ('carers') and other health professionals (speech therapists , psychologists, occupational therapists, dieticians) are incorporated into the discourse. The gaze of treatment adjusts to adapt to discourses that might create resistance.

Discourses that construct 'authentic' response to mental health problems locate the responsibility for helping with statutory services (mostly located in health or mediated by health) or through the funding of voluntary bodies. It is taken for granted that state provided mental health services, structured according to a biomedical, professionally dominated model are the normative and most effective response to mental health problems. Criticism of services is confined to their availability rather than their nature. Innovations are presented in the context of expansion of therapeutic approaches, sites of care and groups involved all of who are inculcated into and described by reference to a biomedical system. This constructs mental health problems as the concern of a state controlled medical health system, limiting what can be said about mental health problems and limiting appropriate responses to that which can be legitimately be said to be the domain of healthcare. Rose (2003, p.58) referring to the capitalization of mental health, suggests that what gets to be described as pathological expands to match the expanding gaze of scientific treatment. He states:

> So the capitalisation of the power to treat intensifies the redefinition of that which is amenable to correction or modification. This is not simply blurring the borders between normality and pathology, or widening the net of pathology. We are seeing an enhancement in our capacities to adjust and readjust our somatic existence according to the exigencies of the life to which we aspire.

The expansion of sites, therapeutic approaches and groups involved in mental health care can be understood as providing more opportunities to define human distress and indeed human life in a biomedical way. Hazelton (1999) suggests that seemingly progressive mental health reforms offer only 'surface liberality' as they result in the emergence of new productive practices that govern the conduct of

people and are more far reaching and subtle because of their ostensibly liberal facade. The dominance of professionally delivered mental health services obscures other possible responses to mental health problems. Even though external issues such as trauma, economic hardship and stress were suggested in relation to causation, the focus of response is state mediated services that act on the individual, and not any broad consideration of factors in society. The individual is always the central focus of response.

8.4 Summary

This chapter has presented the findings in relation to how discourses of recovery and professional treatment in news items operate to privilege particular understandings of mental health problems. While the dominant construction of mental health problems was pessimistic with regard to the possibility of recovery a small number of articles portrayed mental health problems as 'recoverable' from and as potentially a catalyst for positive changes in a person's life. Recovery as a concept was also referenced in the context of mental health service provision and innovations and developments in care positioning it as contingent on compliance with established psychiatric oriented services. This appropriation of recovery, can be understood as a response of a dominant discourse, psychiatry, to deal with a competing discourse by accommodation. Biomedically based psychiatric treatment was represented as normative and discourses that question its efficacy and effects were not present in news items. Professional discourses were privileged, through the foregrounding of mental health treatments and services unproblematically as effective and the colonization of ostensible reforms and the professionalization of psychosocial care. Innovation and progress in mental health care provision was represented and tended to centre on the widening of sites for psychiatric care rather than any change or re-consideration of prevailing ideology which was represented uncritically as authentic.

8.5 Summary of findings

This chapter and the previous three chapters have presented the findings on the discursive strategies employed in the construction of mental health problems in Irish newspapers. Table 6 provides a summary of the discursive categories identified, their potential effects and consequences and the relative absences of particular discourses.

Discursive categories	Effects & Consequences	Absences
Constructing Hiddenness Secrecy, stigma and shame Deficient definition and identification Hidden from services	Normalizes and problemtatizes hiddenness. Reinforces the stigma associated with mental health problems. Makes the person the site of interest. Obscures society in the repair of stigma. Produces a need for visibility, definition and surveillance. Defines hiddenness with reference to being visible to the health services Produces a particular understanding of mental health problems as being defined by a psychiatric discourse. Encourages surveillance (self and others) producing more 'mental illness' which requires the services of professionals.	People who experience mental health problems/mental distress and who recover and find meaning in the experience. People who live with long-term mental health problems or psychosis were not quoted or represented.
Constructing Visibility Awareness, surveillance and identification Diagnosis	Establishes visibility as desirable. Makes the person the site of interest. Creates a need for surveillance. Privileges a particular way of making mental distress visible. Normalizes a biomedical understanding of mental distress and human existence. Makes visible that which causes hiddenness.	Discourses that implicate societal structures/inequality in the creation of mental health problems and mental distress.
Constructing crises and risk Suicide and the recession Risk for young people Risk of violence	Implicates certain psychosocial factors in causation-recession and social stressors but in a proximate limited way that focuses on a particular societal group, Obscures macroeconomic factors and their effect on wider society. Locates the problem with the individual. Produces an understanding of people with mental health problems as having little or no control. Implicates societal stresses but focuses the solution on the individual. Normalizes suicide as a response to mental distress. Reinforces societal stigma in relation to mental health problems.	Critical discourses that question societal understandings and conceptualizations of mental health problems/mental distress and the biological basis and the effectiveness of medication and physical treatments.
Constructing Devastation Abnormality Loss of personal agency Damaged persons Objectification and personification Affecting others	Produces an understanding of mental health problems as being devastating and negative to the individual and others. Constructs the individual as fundamentally altered by having a mental health problem. Renders the individual powerless, having no responsibility or control. Produces the need for the government of mental health. Locates mental health problems outside the person and thus outside their control. Reinforces societal stigma in relation to mental health problems.	

Constructing Illness	Reinforces a biological determinist understanding of human emotion, behavior and distress.	
Biological causes	Places focus on a faulty individual.	
Illness language	Obscures societal issues in the construction of mental distress.	
	Places control outside of the individual.	
	Produces a need for medical care.	
Constructing Psychosocial causation	Implicates proximal factors obscuring distal societal issues such as inequality.	
Social and environmental stressors	Locates the problem with individual.	
	Creates opportunities to define human distress in a biomedical way.	
Individual psychology	Reinforces a realist understanding of mental health problems.	
Constructing Recovery	Constitutes recovery with reference to the dominant biomedical system.	
Possibility of recovery	Expands the biomedical discourse to accommodate competing discourses.	
Professionally defined recovery	Privileges the professions, mainly medicine.	
	Expands the gaze of the professions.	
Constructing Professional Treatment	Unambiguously constructs psychiatrically oriented treatment and services as a legitimate response to mental health problems.	
Need for more services	Presents an undifferentiated 'treatment' blurring the specificity of modalities obscuring any possibility of scrutiny regarding effectiveness.	
Biomedically oriented services	Makes the individual the focus of the problem and solution.	
Professionalizing everyday activities	Medicalizes everyday human existence.	
Moving sites	Represent surface reforms as innovation obscuring dominant discourses from scrutiny.	

Table 6. Summary of findings

News items constructed mental health problems as being hidden due to secrecy, stigma and elusive definition and problematizes hiddenness, producing the need for visibility through awareness, surveillance and diagnosis. Increased awareness was reported on as the normative response to the problem of hiddenness. A number of ways of increasing the visibility of mental health problems were privileged. One such way is by raising awareness by providing more information about 'it' ('it' being situated in discourse), alerting others to watch out for it, and encouraging people who experience it to talk about it. This logic underpins mental health policy and mental health promotion campaigns that promote greater awareness and encourage people to be open and frank about their mental health problems with the aims of alleviating stigma and encouraging people to seek help. While this may well be helpful for people who experience mental distress, the mechanisms legitimized for producing such awareness are not neutral they are constructive.

The normative means of naming mental distress and the mechanisms for measuring it and bringing into public discourse construct it as 'mental illness', a health problem of the individual, the concern of psychiatry. The inevitability of visibility as a solution to this 'problem' of hiddenness is itself problematic as it makes visible the very 'thing' (diagnosis of a mental health problem) that people are keeping hidden, exposing them to society in a way that stigmatizes them. Another is by increasing the likelihood of it being defined by making diagnostic mechanisms more amenable and available and by suggesting that this is the route to treatment. By legitimizing diagnostic systems for identifying mental health problems in this way, a biomedical, psychiatric meaning of mental health problems is normalized and other ways of giving expression to mental distress are obscured or disallowed. This reinforces the existence of a particular type of mental distress, an entity called 'mental illness' or 'mental disorder'. Talking about it as hidden, creates an urgency to 'discover' more of 'it'.

Discourses of crises, risk and danger construct mental health problems as increasing and dangerous. News items implicated contemporary societal pressures, with the economic recession being unproblematically foregrounded. Constructing mental health problems in this way produces an understanding of people with mental health problems as having little or no control and is likely to engender fear, discomfort and stigma among the public towards people with mental health problems. It also focuses attention on proximate societal factors and particular groups of people affected by economic adversity (the middle classes), obscuring other distal and enduring economic factors such as inequality and poverty as important in the production of mental distress and other groups who are disadvantaged. It individualizes societal problems, constituting feelings such as sadness, dissatisfaction, disappointment, regret and unhappiness that are a result of difficulties encountered with the way the world is organized, as pathological states, 'mental health problems' or 'mental illness'. Understanding mental health problems as being related to crisis, risk and danger mental health problems means that hiddenness is problematic, because if 'they' are dangerous and risky and on

the increase then we need to know about them to save ourselves and others. The

risk of people harming themselves by self-harm or suicide or others by violent

outbreaks, was used to create an imperative for the provision of more mental

health services and more funding for existing services.

The discursive category of devastation produces an understanding of mental health

problems as having a devastating impact on the individual, in terms of their

functioning, agency and selfhood, and also impacting in a negative way on others.

This further diminishes the person with a mental health problem by portraying

them in a negative light and locates the imperative for action with outside agency.

This produces an 'inept' person incapable of taking responsibility and obscures

possibilities of recovery and potentially deprives people who experience them of

agency in managing their own lives and taking responsibility for their recovery. This

further reinforces societal stigma in relation to mental health problems and

produces a need for the external government of mental health and the individual.

Mental health problems were constructed as illnesses by news articles that referred

to biological causation and disease terminology. This was represented uncritically

and competing discourses that challenge the legitimacy of biological explanations

were absent. The association with physical illness was frequently used to legitimize

and de-stigmatize mental health problems. This reinforces a biological

understanding of human emotion and distress and places the focus on a faulty

individual, obscuring societal issues in causation and while it places focus on the

individual it locates control outside the individual. News items implicated

psychosocial factors like the economic environment and other social and

environmental stressors and the experience of trauma and in the causation of

mental health problems. However the focus was on limited proximal factors

obscuring macro structures that are implicated in the creation and perpetuation of

inequality and social deprivation and isolation.

A recovery discourse produces an understanding of mental health problems as being 'recoverable' from but the way in which recovery was referenced reinforces dominant professional discourses that emphasized adherence to treatment, medication and acceptance of biomedical diagnosis. The dominant normative response to mental health problems was constituted as government provided health services which were spoken about as being the 'taken for granted' best response to mental health problems. Discourses of reform represented the mental health services as having evolved to include contemporary developments such as community orientation, recovery based care and holistic psychosocial understandings of mental health care which were problemtatized only in so much as that there was not enough of them due to under-funding. However reforms that were represented involved expansion of sites, patient groups and therapies and approaches and did not disturb dominant biomedical discourses, which expanded to incorporate new concepts and to appropriate competing discourses, such as recovery and repackage everyday aspects of human life as therapeutic interventions.

These discourses converge to produce an understanding of mental health problems and mental distress as being an individual biomedically defined phenomenon, beyond the control of the individual, dangerous and devastating to the person, amenable to psychiatric treatment which was portrayed as the dominant normative response and was problemtatized only in so much as it was insufficiently funded and provided. These understandings were legitimized in news items by reference to the 'expert' opinion of mainly psychiatric professionals, but also of people who have mental health problems and their relatives who similarly invoke a biomedical discourse and whose voices were frequently endorsed by psychiatric professionals. These 'common sense' understandings of mental health problems, reinforce the superior status of psychiatric knowledge as the legitimate means of both making

mental distress visible and as a means of response. The next chapter provides a discussion of the findings.

Chapter 9 Discussion, implications and conclusion

9.1 Introduction

Foucault defined 'critical' work as not being a rejection or refutation of systems: "but a work of examination that consists of suspending as far as possible the system of values to which one refers when testing and assessing it" (Foucault 1988, p.107). This thesis has aimed to do this by providing a critical view of discursive practices enlisted in constructing mental health problems in Irish newspapers. The aim of this study was to gain a more sophisticated understanding of certain constructions of mental health problems through an examination of how mental health problems are constructed in Irish newspapers. The study objectives were to:

- Identify the discourses and points of resistance present in relation to mental health problems,
- Identify institutions or groups that are made visible or obscured by identified discourses,
- Reveal techniques employed in constructing mental health problems and the potential effects this has on the individual.

Potter and Wetherell (1987) suggest that validity in discourse analytic studies can judged on the basis of their fruitfulness to successfully generate novel explanations based on analysis and articulation of new discourses. This is the first study to consider newspaper representation of mental health problems from a discourse analytic perspective in Ireland. The findings offer important insights at a particular juncture in history as to the discourses that contribute to how mental health problems are understood in Irish society. The time at which the data were collected followed the introduction of mental health legislation in 2001 designed to bring Ireland into line with European Union policy on civil rights. On foot of this a new mental health policy document was published in 2006 which purported to be underpinned by a more optimistic 'recovery' focus and a commitment to make service users pivotal in the planning, delivery and evaluation of mental health services. These all emerged during a period of unprecedented economic prosperity in Ireland, followed by an economic recession which began in 2008 a time when efforts were being made to implement the new policy. This study illuminates

discourses present in news print reporting at this time and offers insight into privileged positions with regard to the production of knowledge and the power relations in operation in constructing dominant understandings.

This chapter will discuss the study findings with regard to constructions of mental health problems as illness, as risk and as individual concerns. The discussion will be integrated with empirical and theoretical literature. I will consider the discourses and points of resistance that emerged in representations of mental health problems. I will go on to explore the scope and limitations of the thesis and a brief response to these together with some personal reflections. This chapter will then address the implications of the study findings for media, health services, research, and education. Finally a conclusion to the thesis will be offered.

9.2. Mental health problems-visible as illness

The dominant understanding in newspaper representations of mental health problems was as 'illnesses'. This was achieved in a manifest way through the use of illness related language, reference to biological causation and by reference to psychiatric treatments. It was also achieved by the manner in which mental health problems were represented as hidden and in which visibility was represented as desirable to be accomplished by greater awareness, identification, surveillance and diagnosis as a response to the 'problem' of hiddenness. This imperative for visibility on the surface reflects common assumptions that having a mental health problem is perceived as attracting stigma, is understood as something to be ashamed of, a sign of weakness or a flaw in the person and is therefore something that people do not want to be admit to and a liberal stance that more 'openness' and 'acceptance' amongst sufferers and society is a good thing that will be ultimately beneficial for people who experience mental distress. Contemporary mental health policy and mental health promotion campaigns in media emphasize the importance of openness and increased visibility for people with mental health problems leading to greater acceptance and obtaining treatment. Critical consideration of the discursive practices in operation in constructing these

understandings suggests that while they are ostensibly represented as progressive and liberal they function to reinforce particular understandings of mental distress as illness and operate as disciplinary techniques in foregrounding one understanding over other possibilities and in encouraging surveillance of self and others (Holland 2012; Bracken and Thomas 2005) and are more pervasive due to their perceived liberal innocuousness (Johnson 2008). The findings of this study suggest that the association between mental health problems and physical illness, made as a means of ameliorating negativity, create common sense understandings of mental health problems as being illnesses and the manner in which the discourse was positioned, as a means of ameliorating stigma and achieving treatment, protects against any challenges.

9.2.1 The 'problem' of hiddenness

Emerging from the resistance between hiddenness and visibility was the means of making mental distress visible, diagnosis of a 'mental health problem' using biomedical classification systems and increased awareness and surveillance on the part of others and the individual to identify 'the individual who has a mental health problem'. Both converge to produce a particular 'visible individual'. Societal understandings of privacy and seclusion vary across cultures and time and have particular meanings in the context of what is considered 'normal' at a given time. For example, in ancient Greek culture, which did not value privacy or solitude, to hide oneself away was considered abnormal and an indication of a close relationship with the Gods. The Greek word 'idiotes', which referred to a 'private' person, is the origin of the word 'idiot' (Parker *et al*. 1995). This is reflected also in Irish language terms used to refer to people with a mental problems, for example 'duine le Dia' (person with God), or someone is referred to as being 'a bit touched' (in the Irish language, 'leag Dia lámh air' translated as 'God put his hand on him'), association with the 'Gods' being viewed with suspicion and a sign of abnormality.

Foucault maintained that disciplining the subject required the application of a normalising judgment, which was administered via a process, the examination, "the ceremony of this objectification" (Foucault 1977, p.187), which makes visible the individual as they become subject to the 'gaze'. Foucault (1977, p.187) maintained "The examination transformed the economy of visibility into the exercise of power". The examination is the process which makes it possible to qualify, classify and punish individuals; it is the administration of test for the 'good' of the individual. "It is the examination which, by combining hierarchical surveillance and normalizing judgment, assure the great disciplinary functions of distribution and classification" (Foucault 1977, p.192). News reporting that addressed issues of raising the visibility and identification of mental health problems frequently referred to what was considered 'normal' and 'abnormal' mood, behavior, feelings. Normalization, a key mechanism in the exercise of disciplinary power, is the construction of an idealized norm from a favoured paradigm, and the reward and punishment of individuals on the basis of deviation, in the interests of exerting efficient and pervasive social control. "The normalization process produces homogeneity through a process of comparison and differentiation" (Carabine 2001, p.278). Normalization exerts power by establishing 'truth', 'reality' and knowledge about a subject, by constituting what is normal as natural and 'taken for granted' and establishing rules for the government of conduct. Normalizing judgment refers to assessment through comparison with a norm derived from a favoured paradigm. Deviations are punished and corrective by nature, encouraging and forcing adherence to the norm. The norm represents what exists in the great institutions like medicine, military church and belonging to the norm is reinforced by sanctions for deviation. "It measures in quantitative terms and hierarchizes in terms of the abilities, the level, the 'nature' of individual" (Foucault 1977, p.183). In doing so it establishes the 'normal individual' and makes possible classification and categorization according to the norm possible. News reporting that privileged visibility, awareness and identification as a means of alleviating stigma, risk and achievement of treatment through achievement of a diagnosis, foregrounds medicalized constructions of norms of human behaviour.

'Madness' can be understood as a sociological construct that emerges when people behave in ways which threaten the 'normality' defined by society. 'Disorder', the term used in conjunction with 'mental', in psychiatric diagnostic systems can be variously described as: "the breakdown of peaceful and law-abiding public behaviour" and to "disrupt the systematic functioning or neat arrangement of" as well as referring to medical conditions (OED 2014). Pilgrim (2014b) suggests that:

> "An abiding social contract in all societies is that adults should, when required, render their conduct intelligible. This is required when people fail in their roles or transgress rules. Madness emerges then when role-rule failures or transgressions are observed by others and the offending party is unable or unwilling to render their transgressive conduct intelligible".

The 'mad', by engaging in behaviour that transgresses social norms have been a source of fear for others throughout history and as a result have been both segregated and a source of fascination. Moral treatment from the end of the eighteenth century in Europe in places like Tuke's Quaker Asylum "required the 'retreat', the secluded 'reflection' of the person on their individual distress" (Parker *et al.* 1995, p.9). The definition of 'madness' performs an important function in society, it allows us to define 'normality'. So 'hiddenness' is both problematic, in so much that it is viewed with suspicion, but also desirable as a response to deal with the abnormal. Hiddenness is problematic in establishing normality, if the individual cannot be seen, and seen in a particular way then they cannot be examined and judged normal or abnormal with associated judgments about productivity. The move to de-institutionalize mental health care in Ireland (and elsewhere) could be understood as having revived the 'problem' of hiddenness. As there is now no one unique physical structure (the asylum, the mental hospital) in which to identify where the 'mad' people are, privacy and secrecy is problematic. How are we to know who is 'mad' or 'abnormal;' and thus by association 'normal,' if they are hidden? In constructing ourselves and others as normal in society, identifying the 'abnormal' is essential, differentiating 'reason from 'unreason'. To be able to govern one needs to be able to make visible and identifiable. The absence of the physical structures that made hierarchical observation possible mean that

surveillance, identification and diagnosis are relied upon and that 'awareness' is necessary to increase visibility so that these acts can be possible. This gives visibility a centrality, a vital importance, as identification is not possible without visibility. Visibility can thus be considered as a necessary condition for the exercise of disciplinary power, and as such a disciplinary practice. The mechanism for establishing visibility, the naming of mental health problems as psychiatric illness through diagnosis obscures and silences the person's experiences and their distress by reducing it to the level of 'disorder'.

9.2.2 Visibility-a necessary condition for disciplinary power

Considering visibility as a necessary condition involves an understanding of the centrality of surveillance in Foucault's notion of disciplinary power. As discussed in chapter four, the context of how we currently treat people who have mental health problems has its origins in the institutional structures created to deal with vagrants and lunatics those considered 'mad' beginning during the Great Confinement in the 17th and 18th centuries. The Great Confinement in Europe occurred in the context of wider political movements. The 17th century was a time when due to economic decline and harvest failure, states needed to exert more control over the people and labour when there was an increase in the floating population and a rise in industrialization and capitalism, resulting in a need for changing ways of supervision and manipulation and a growth in the apparatus of production (Foucault 1977, p.218). The insane and poor were associated with lack of endeavor and so madness appeared in a space created by a society that placed a high ethical value on work (Foucault 1965). The imperative to work was necessary for survival and those who could not be usefully employed were a nuisance and a burden for society. Economic development was supported by an ethical theory that argued for the moral value of work, placing those who were unable to work as morally deficient and bad (Foucault 1965). In *Discipline and Punish* Foucault charted the move at the end of the eighteenth century from a focus on the highly individualized sovereign authority, which was becoming less efficient as a means of regulating the European

populations, to the development of new techniques of social control (O'Farrell 2005). Disciplinary power aims to surveil, train and control and to:

> obtain the exercise of power at the lowest possible (economic and political) cost, …to bring the effects of this social power to their maximum intensity and to extend them as far a possible …to link this 'economic' growth of power with the output of the apparatuses (educational, military, industrial or medicine) within which it is exercised (Foucault 1977, p.10).

Foucault viewed education, penology, the military, psychiatry and psychology as discursive formations through which disciplinary power was exercised replacing the previous punitive mechanisms of discipline,

> … there is a shame in punishing…..This sense of shame is constantly growing: the psychologists and the minor civil servants of moral orthopaedics proliferate on the wound it leaves (Foucault 1977, p.10).

Visibility is a crucial condition for surveillance, a technique of disciplinary power. The visibility of the 'insane' was critical in the exercise of disciplinary power, in order for one's behaviour to be considered deviant it had first to be visible.

One of the techniques which facilitated the operation of disciplinary power, the organization of space and activity (O'Farrell 2005), was made possible by the confinement of 'the mad' and others in institutions. The asylum became a physical location for the exercise of disciplinary practice by enabling the organization of space and activity. The population of the leprosarium, the Houses of Industry and later the psychiatric hospitals, great physical institutions, while hiding the 'mad' away from the rest of society, paradoxically made madness visible as 'madness'. The fear associated with the hidden nature of 'madness' was alleviated as privacy was less problematic when people could be corralled and observed in groups and contained in physical structures that facilitated hierarchical observation (Foucault 1977). Disciplinary power makes the individual visible through and in discourse that itself is invisible.

> Disciplinary power…is exercised through its invisibility; at the same time it imposes on those whom it subjects a principle of compulsory visibility. In discipline, it is the subject who has to be seen. Their visibility assures the

hold of power that is exercised over them, It is the fact of being constantly seen, of being always to be seen, that maintains the disciplined individual in his subjection (Foucault 1977, p.187).

Visibility is essential for the exercise of disciplinary power but it has the effect of rendering subjects at the same time 'invisible' by constructing them with recourse to particular knowledges. Foucault (1963) used the term 'the gaze' which referred to the mechanism through which clinical medicine organized knowledge around visible structures such as physical symptoms.

'The gaze' at the end of the eighteenth century was aimed at revealing what had hitherto remained hidden and unseen not only in the physical body but also in the social and political body. Visibility could dissipate both disease and political and social tyranny" (O'Farrell 2005, p.39).

Foucault considered that language and the gaze rendered what was previously invisible and unsayable visible, not because this was always there or self-evident or real, but because it was produced in discourse. "At the beginning of the nineteenth century, doctors described what for centuries had remained below the threshold of the visible and the expressible, but this did not mean that, after over-indulging in speculation, they had begun to perceive once again, or that they listened to reason rather than to imagination; it meant that the relation between the visible and invisible—which is necessary to all concrete knowledge—changed its structure, revealing through gaze and language what had previously been below and beyond their domain" (Foucault 1973, p.xiii).

The way in which mental health problems were constructed in newspapers functions to establish visibility as desirable and normative and the mechanisms suggested for doing so, identification of 'symptoms', achievement of a diagnosis, getting 'treatment', constitute particular knowledge about mental health problems. Visibility can be considered a disciplinary practice in that how something is made visible defines it with recourse to the knowledge/power of the discipline. News items emphasized a need for awareness and identification of mental health problems by problematizing their invisibility, conflating this with crisis, risk, danger and stigma. The mechanism for establishing visibility was surveillance,

watchfulness of individuals themselves, their relatives and community and the establishment of a psychiatric diagnosis was privileged as desirable and a gateway to 'getting help'. This was normalized, 'taken for granted'. Discursive practices according to Foucault are: "characterised by the demarcation of a field of objects, by the definition of a legitimate perspective for a subject of knowledge, by the setting of norms for elaborating concepts and theories" (Foucault 1971, cited in O'Farrell 2005, p.11). Discourse by making something visible in a particular way, renders other possibilities, other knowledges about it invisible.

> Each discursive practice deals with a field of objects, which are things presented to thought and on which thoughts is exercised.

> …the objects of psychiatry are certain morbid mental states. These objects do not exist independently of knowledge, they are not 'discovered' but are constructed in relation to a whole set of physical, social and cultural occurrences (O'Farrell 2005, p.79).

Foucault described the juncture in history that in the move from sovereign to state the examination made visible the individual rather than the sovereign. As such the individual became the object of discipline through the combination of hierarchical observation and normalizing judgment. Disciplinary power is exercised by the use of technologies of surveillance, panopticism, normalization and the examination which subject the individual to scrutiny rendering them at once visible by virtue of the discursive practices deployed and invisible in that other possibilities are silenced.

News items portrayed part of the hiddenness of mental health problems as a difficulty of definition. Mental health problems were referred to in news items as difficult to define due to a lack of expertise on behalf of practitioners, a lack of services to carry out assessment and diagnosis and elusiveness related to the nature of mental distress. When something is unnamed we cannot talk about it, language is a necessary condition for existence. By giving it a name it is brought into existence. However the manner in which it is brought into existence in language functions as a discursive practice that is underpinned by on one hand a

need for knowledge about and scrutiny of the individual and on the other assumptions about the nature and character of the individual. The findings of this study suggest that the normative means of making mental distress visible (and gaining help) is through achievement of a diagnosis of a mental health problem. This is predicated on a particular understanding of mental distress as an illness, a disorder and a problem of individual failure, that of psychiatric diagnosis. The naming of a phenomenon has a paradoxical effect, as once the name is created we have to look for more and more examples of it to promote its existence. Once something is named, it is brought into existence and then it is always there. When the name fails, as it always will, we break it down into more and more minute categories to attempt to repair the failure. Hindness (1996) argues that the effect of disciplinary failure is to suggest that it is not the exercise of discipline that has failed but that the failure is in relation to the amount of knowledge about the person. In the news reporting of mental health problems the legitimacy of the knowledge system used to define and name mental health problems (psychiatric diagnosis) was not was called into question, the problem was always stated as insufficient openness or visibility of the person or elusiveness of definition of the problem.

9.2.3 Diagnosis as a disciplinary practice

In news items the establishment of a diagnosis was privileged as an important part of recovering from mental health problems and important in reducing risk. News items that privileged diagnosis of 'conditions' emphasized the distinction between 'normal' and 'abnormal' coping, behaviour and feelings. Diagnosis as a practice, the "systematic government of the psychological domain", manages subjectivity "according to norms claiming the status of science" (Rose 1990, p.106). Diagnosis as a practice that constitutes mental distress as 'mental health problems' is contested. Psychiatric classification systems enable the judgment to be made between normal and abnormal by clustering emotional states and behaviours and giving them names, which are then classified. Criticisms of the use of diagnostic classification systems, such as DSM and ICD have centred on questioning the

objectivity that they imply, the equivalence they suggest with physical disorders and their tautological nature (Moncrieff 2010). Thomas Szasz and R.D. Laing have outlined the crucial differences between physical illness and what are called mental disorders, while acknowledging the existence of human distress. Szasz (1974, p.x-xi) emphasized the metaphorical use of the term illness when used in relation to mental distress.

> …I maintain that mental illness is a metaphorical disease: that bodily illness stands in the same relation to mental illness as a defective television set stands to a bad television program. Of course the word "sick" is often used metaphorically. We call jokes "sick", economies "sick", sometimes even the whole world "sick"; but only when we call minds "sick" do we systematically mistake and strategically misinterpret metaphor for fact-and send for the doctor to "cure" the "illness". It is as if a television viewer were to send for a television repairman because he dislikes the program he sees on the screen.

He argued against diagnosis and in favour of understanding and awareness of human suffering as the vicissitudes of living as opposed to an illness. Diagnosis stands in the way of understanding, as it limits distress to a specific set of criteria that are either flawed or so broad that anyone can be fitted in. Once a diagnosis is put in place it dominates everything that will happen and in some way reduces the opportunity to understand the person, what Foucault referred to as: "experience reduced to silence by positivism" (1965, p.198). Psychiatric classification systems (DSM and ICD) individualize distress, rhetorically obscuring and ruling out, issues such a race and gender for example as considerations (Parker *et al*, 1995). The findings of this study indicate that when social factors were mentioned they were confined to proximal issues such as economic hardship, the experience of trauma and proximal social stressors and broader social factors such as inequality were absent.

Latour (1986), referring to science, suggests that one of the epistemological strategies in which goals are pursued and knowledge and truth are constructed is that complex concepts are 'black-boxed'. When a concept is 'black-boxed' its detailed, technical workings are not described, explained or examined; it is considered inviolable (Kendall and Wickham 1999). Diagnosis in relation to mental

health problems can be understood as being 'black boxed'. Its legitimacy is derived from an understanding of the act of diagnosis as a scientific process, one that measures and defines a concrete, objective, stable reality that exists as in the case of physical health. The act of diagnosis in psychiatry involves the comparison of reported and observed behaviours, thoughts and feelings with a set of criteria agreed upon through consensus by a group of psychiatrists, this is different to the many physical measurements and tests that go towards making a diagnosis of a physical condition. Moncrieff (2010, p.372) suggests that: "The use of the concept of diagnosis in psychiatry implies equivalence between psychiatric classification and the process of medical diagnosis with the implication that psychiatric problems are caused by a bodily dysfunction". She argues that by suggesting the existence of an objective biological state or disease, psychiatric diagnosis functions to re-designate social problems as medical problems and the social responses to them as medical treatments, affording them a legitimacy and optimism that is associated with physical illnesses and the related medical treatments. News items in this study tended to report on causation and treatment in a way that positioned mental health problems as caused by psychosocial factors impacting on a biological brain, but treatments tended to be represented as targeted at fixing the person rather than the social environment. This represents a dichotomy or mismatch between cause and treatment which emphasizes the ambivalence we have about the locus of mental health problems.

Diagnosis is legitimized by the medical profession and the status of the medic in society and this is then converted into a scientific discourse, the DSM, which history has shown via its frequent revisions that it lacks rigour and constancy (Verhaghe 2008). Diagnosis also in turn legitimizes the medical specialty of psychiatry. Pilgrim (2014b) suggests that adopting a biological reductionist understanding of mental health problems is 'anti rational' and 'anti-scientific' which is an anathema to the very claims of neuroscience. The fact that the psychiatric diagnostic categories change with each edition of the diagnostic manuals alerts us to their shifting, unstable and unreliable nature as statements of 'stable reality'. The objectivity

implied by the use of the word 'statistical' is suggestive of the existence of symptoms that are quantifiable and are capable of being objectively measured, independent of the observer (Vergharge 2008). Thomas Szasz questioned the validity of any 'illness' that derived its existence from a process 'voting', noting that that the condition diabetes was not established by voting and some argue that the DSM is more appropriately understood as only a classification system, rather than a diagnostic system which by definition implies definitive statements regarding causation.

Diagnostic systems perform important functions in the exercise of disciplinary power. They classify disorders and so enable research and the establishment and prescription of treatments. People have to be diagnosed in order for treatments to be prescribed and psychiatric diagnosis makes particular treatment options possible. Diagnosis is the gateway to treatment and a necessary precursor to medication, therapy, social welfare payments, entitlement to sick leave, as they are reliant on the achievement of a diagnosis. The suggestion that mental health problems are unrecognized and could be more readily diagnosed has been used to promote particular treatment modalities. For example a book entitled '*Recognizing the Depressed Patient*' by the U.S. psychiatrist, Frank Ayd, which suggested that much of depression is unrecognized and that a psychiatrist was not needed for diagnosis but that it could be diagnosed on general medical wards and in primary care offices, was distributed widely by Merck who filed the first patent for use of amitriptyline as an anti-depressant (Rose 2003, p.57). Diagnosis is a means of getting more of the problem recognized and so more of the treatment sold. Rose (2003) argues that developments in pharmaceutical agents and the capitalization of treatment modalities influences the definition of what is amenable to treatment and thus what is mental disorder and as such influences our notions of what is normal and abnormal. The findings of this study suggest that newspaper reporting of mental health problems performs an important function in the exercise of disciplinary power by foregrounding professional, medial discourses that privilege the definition of mental health problems as illnesses of the body.

9.3 Mental health problems-visible as risk

In this study mental health problems were conflated with the economic crisis, societal values, dangerousness and devastation to the person and others, producing connotations of risk. Discourses of crises, risk, danger and devastation produced an understanding of mental health problems as being on the increase, dangerous to the person and others, and causing an annihilation of the individual rendering them out of control and unable to take responsibility for themselves. Previous research has identified connotations of crises, risk and danger in media coverage of mental health problems (Glick and Applbaum 2010; Bilic and Georgaca 2007; Nairn, Coverdale and Claasen 2006; Nairn and Coverdale 2005; Cross 2004; Osltead 2002; Nairn, Coverdale and Claasen 2001; Wilson *et al.* 2000; Wilson *et al* 1999; Rose 1998; Allen and Nairn 1997; Diefenbach 1997; Hazelton 1997; Philo, McLaughlin and Henderson 1996) in studies that have identified people with mental health problems are portrayed as potentially dangerous to themselves and others, this being sometimes used to argue for more coercive treatment and surveillance.

9.3.1 The function of risk

Various theorists have considered the concept of risk in modern society. Van Loon (2000, p.166) suggests that "risks imply a specific form of knowledge of causal relationships between particular conditions, specific actions (decisions) and possible consequences". Ulrich Beck, who coined the term ' risk society', considers risk a response to the increase in globalization, urbanization and industrialization of Western society and the resultant increase in dangers and hazards, making identification and calculation of risk a political and personal concern, a "synthesis of knowledge and unawareness" (Beck 2000, p.215). From this perspective in late modern society, where risk is generated by human action rather than by natural disaster as in the past, scientific knowledge from experts is relied upon on one hand by people to identify and deal with risk, and viewed suspiciously on the other as the same expert groups are implicated in its causation, making risk a highly political

concept (Lupton 2006, Beck 2000). Beck suggests that one of the sources of the

particular nature of political dynamics that allows statements of risk to be made is

related to the:

> ..the attribution of dangers to the producers of the social order (business,
> politics, law, science), that is to the suspicion that those who endanger the
> public well-being and those charged with its protection may well be
> identical. ……. Established risk definitions are thus a magic wand with which
> a stagnant society can terrify itself and thereby activate its political centres
> and become politicized from within (Beck 2000, p.215).

News items conflated risk with mental health problems in a number of ways.

Discourses of crises and risk were deployed in linking the economic recession with

suicide and mental health problems in relation to a perceived increase in and risk of

mental health problems and suicide. Somewhat paradoxically other articles linked

the rise in and development of mental health to a moral crisis related to the

previous upsurge in prosperity, the *'celtic tiger'* and an associated loss of moral

values. Crises and risk were also constructed in news items that portrayed people

with mental health problems as dangerous, out of control and diminished by being

mentally unwell. News items constructing risk suggested self-monitoring activities,

seeking assessment and diagnosis, surveillance of the behaviour of others and

compliance with medical treatment as a means of managing the risk of either

developing mental health problems or ameliorating the risk of potential danger

from people who are mentally unwell.

A Foucaldian consideration of risk draws on an understanding of the construction of

risk in discourse and the 'problem of government' in neo liberal society.

Government, in a Foucauldian sense, is concerned with 'conduct of conduct', the

regulation of individual behaviour in the interests of productivity. Risk beliefs and

practices are a means of "maintaining social cohesion, stability and order and

dealing with deviance" (Lupton 2006, p.13.). While Foucault's early notions of

disciplinary power centred on the exercise of political sovereignty (O'Farrell 2005),

he later described the concept of 'governmentality' to describe how societies are organized in ways that produce self-regulation and compliance (Lupton 2006). Rose (2003) referring to the construction of the self as a 'neurochemical being', observes the function of flexibility in accommodating preferred and prevailing discourses. Discussing the rise in the use of psychopharmaceutical agents he states:

> In the field of health, the active and responsible citizen must engage in constant monitoring of health, a constant work of modulation, adjustment, improvement in response to the changing requirements of the practices of his or her mode of everyday life. These new self-technologies do no seek to retune a pathological or problematic individual to a fixed norm of civilized conduct through a once-off programme of normalization. Rather, they oblige the individual to engage in constant risk management, and to act on him or herself to minimize risks by reshaping diet, lifestyle, and now by means of pharmaceuticals, the body itself, (Rose 2003, p. 62).

Governmentality represents a liberal form of rule which operates through free individuals (Dean 2010). Lupton (2006, p.14) considers: "from the governmentality perspective, (risk) is a major apparatus through which individuals in a society are encouraged to engage in self-regulation". The belief that mental health problems are on the increase and are escalating is endorsed by organizations such as the World Health Organization who predict huge growth in the numbers of people who experience depression and the likely impact this would have on morbidity in populations. Rabinow and Rose (2006) suggest that such predictions are influenced by many factors including a belief in the suffering caused by under diagnosis of a medical condition, confidence in the safety and efficacy of drug treatments, governmental concern as to lost revenue through absenteeism, the relative importance of suicide rates in international health comparisons and strategies adopted by pharmaceutical companies such as marketing and awareness campaigns aimed at creating a need for their products. Liberalism, a political ideology "concerned with the maximization of individual liberty and, in particular, with the defence of natural liberty against encroachments of the state" (Hindness 1996, p.124), presents a particular problem for the state in the government of individuals in capitalist societies and the associated demands for productivity. Discourses of risk require citizens to engage in self-monitoring and adjust their behaviour to avoid risk. News items in this study which referred to risk (of suicide,

248

self-harm, danger) conflated this with an imperative for self-awareness and awareness of the mental health of others. Aside from the ostensibly individualistic nature of this 'monitoring' and 'awareness', the 'tools' available against which the self is judged are designed to assess and judge the individual rather than their social milieu. This positions mental distress as an individual phenomenon obscuring social determinants (Lupton 2013). Risk can be understood as operating as a technology of biopower in that it satisfies the needs of modern government to control populations by generating concerns about health and providing authoritative guidance on risk aversion and encouraging self-monitoring and surveillance. The voice of the state was dominant in the sample of newspapers, in the form of the supplement on mental health sponsored by the *HSE*. This can be understood as an uncritical advertisement for state mental health policy and services. A representation of state consideration of how mental distress should be understood and dealt with, as an individual illness rather than a wider issue which might bring into question other socio-political processes, is resonant of what Henderson and Kitzinger (2007, p.80), referring to the media coverage of the announcement of the Human Genome Project, term "a valuable case study in which the worlds of science, media and policy came together in a common goal".

A social constructionist understanding of risk while accepting the existence of potential hazards, is not concerned with the reality of the risk, it considers the socio-cultural context in which risk is produced by considering the way in which risk is constructed and the foregrounding of some behaviours as risky over others. The suggestion that the economic crisis is associated with a rise in mental health problems can be considered in the context of tension between neoliberal ideologies of individual freedom and the needs of government. Dean (2010) suggests that the global financial crash in the years 2008 and 2009 were seen as heralding the death of neo-liberalism, implicating policies of de-regulation and free markets in collapse of banks. Psychiatry functions as a rationality of government to provide the basis for the control of conduct through the individual. Lupton considers that "expert knowledges are central to neo-liberal government, providing the guidelines

whereby citizens are assessed, compared against norms and rendered productive."
p.213. This positioning of risk news in relation to mental health problems functions to locate the problem with the individual, obscuring global and distal sociological phenomena, such as liberal government and capitalism. The conflation of risk with the recession and mental health problems, locates the focus with the individual, embodying the 'problem' in a governable entity. It reinforces a biomedical approach to understanding mental health problems by representing psychiatry in way that that is natural, normal and unquestioned, as the means of naming the problem, the cure and the salvation for the risk. It also functions to represent individual isolated incidents as typical (Blood and Holland 2004), for example, in the data, the death of one developer from suicide is presented as evidence of a risk for all individuals in financial difficulty, or the violent crime committed by one person is represented as the risk when someone does not take medication. This functions to reinforce psychiatry and biomedical knowledge as authentic.

9.3.2 Panopticism, synopticism and omniopticism

The problematization of 'hiddenness' and the privileging of 'visibility' through awareness and the construction of mental health problems as devastating, dangerous, on the increase and hidden creates an imperative for surveillance, and psychiatry offers a mechanism for differentiation between normal and abnormal and thus identification. Foucault's notion of panopticism was based on an architectural structure with a central observation point around which cells are arranged, facilitating observation of those in the cells, without those in the cells knowing whether they are being watched or not, having the effect of constant surveillance and them regulating their own behaviour. Its aim was to: "induce in the inmate a state of conscious and permanent visibility that ensures the automatic functioning of power" (Foucault 1977, p.201). The panopticon meant that many could be observed by the invisible few, the invisibility of the surveillance inducing the individual to self-discipline. Panoptic surveillance, where the few observe the many, by virtue of the invisibility of the viewer, governs through self-surveillance. Articles that urged people to take 'online tests' to self-diagnose, encouraged

parents to 'watch their children for signs of mental disorder' and news items in which people experiencing mental distress described themselves as 'mentally ill' emphasize the disciplinary function of the media in constructing the 'mentally ill individual'.

Considering growth of the celebrity and the ubiquity of media, Mathieson coined the term 'syntopticism' to refer to:

> an opposite process of great significance (parallel and opposite to 'panopticism') which has occurred simultaneously and at an equally accelerated rate: the mass media, and especially television, which today bring the many — literally hundreds of millions of people at the same time — with great force to see and admire the few. In contrast to Foucault's panoptical process, the latter process is referred to as synoptical (1997, p.215).

Mathieson argues that at the same time that the birth of the modern prison was happening, forming the basis for Foucault's notion of the importance of the panopticon as a disciplinary device, the mass press was born (Mathieson 1997). Film, radio and television were to follow. He suggests that the control and discipline of the 'soul', by the creation of human beings who control themselves through self-control and fit into a 'democratic' capitalist society, is fulfilled by the modern synopticon, which is facilitated by media, and now social media. News media, in making the mental health problems of the 'few' visible to the 'many', can be considered 'synoptical'. Institutions can be both panoptical and synoptical, an example being the Catholic Church which functions panoptically, whereby the priests observe the flock and synoptically, whereby the flock come to observe and listen to the spectacle of the sermon, (Mathieson 1997). The combination of both producing the "viewer society" (Mathieson 1997, p.215).

In the digital world today it is a necessary condition to prove your existence by making yourself visible and this appears to make hiddenness even more problematic. We are all subject to CCTV and encouraged and sometimes required

to engage with social media in work, leisure, and domestic aspects of our lives. We have found new ways to be suspect of hiddenness and new ways to subject ourselves to power by making ourselves visible for scrutiny to an infinite and invisible audience. Joyce (2003 cited in Rose-Redwood 2006) suggests the 'omniopticon', where the many watch the many, is perhaps a more adequate term to conceptualize liberal governmentality. The effects of increased digitalization and developments in social media create an omnioptic effect where psychiatry and media coincide in providing both an imperative and a means and for omnioptic surveillance. The 'many' who read are provided with an imperative (crises, risk, danger and devastation) and a means (signs, symptoms, diagnosis) to watch the increasing 'many' who suffer with the associated inculcation of self-monitoring as a practice.

9.3.3 Recovery as resistance

While many news items tended to portray a largely pessimistic understanding of mental health problems, a discourse of recovery resists this understanding, producing knowledge that at least on the surface suggests optimism about mental health problems. Discourses of recovery and treatment represented mental health problems as 'recoverable from' and 'liveable with'. The findings of this study suggest that 'recovery' is appropriated by biomedical discourses that make it contingent on acceptance of and compliance with treatment by psychiatric and health services, these services expanding to incorporate discourses that resist without disturbing their underlying ideology. This is evidenced in the suggestion of the regulatory authority for mental health services in Ireland, the *Mental Health Commission,* that the juxtaposition and polarization of the recovery with the medical model is: "likely to prove ultimately unhelpful and an integrated perspective, respecting the contribution of each is likely to provide a way forward for the development of effective services" (Mental Health Commission, 2005, p.14). Walker (2006, p.74) suggests that:

> …the recovery model is a state of partial transformation: it is truly client-centred; however it is contextually "weighed down" by the vestigial and

> anachronistic use of the medical and psychological vocabularies. These
> vocabularies invisibly and insidiously support the old paternalistic roles.

The findings of this study that indicate recovery was constituted with reference to the dominant biomedical system support this assertion, however as a consequence the extent to which recovery can be understood as 'truly client-centred' is brought into question.

Professional biomedical discourse has expanded its gaze to incorporate challenges to its legitimacy without disturbing its underlying ideology. Modern psychiatry has proliferated to various sites in relation to geography, classification, techniques of normalization, treatments, markets and professional powers (Rose 1996). Psychiatry has expanded its gaze through the development of new locations of practice, description of new disorders, adoption of new assessment procedures and the incorporation of more and more groups. This is redolent of the observations of Baruch and Treacher (1978, cited in Pilgrim and Rogers 2010, p.221) in referring to the work of some reforming psychiatrists in the 1970s, such as Anthony Claire who wrote about social factors in the causation of mental health problems, as representing "a form of inclusive compromise", "a portmanteau model" that lies between the biomedical model and radical social critiques of society. The 'service user' or 'survivor' movement has emerged in resistance to the unilateral patriarchy of the psychiatric care system. The movement functions to advocate for personal and collective rights of those who have experienced mental health difficulties or have been diagnosed with mental health problems in the context of discrimination within the mental health system (Walcraft and Bryant 2003). The legitimacy of the service user movement and the centrality of their involvement in all parts of service planning, delivery and evaluation was formally acknowledged in Ireland in mental health policy for the first time in *A Vision for Change* (Government of Ireland 2006). Previous research suggests that even when people with mental health problems contribute or author a media item, their view is supportive of expertise and is likely to be qualified by a health professional (Rowe *et al* 2003). The findings of this study suggest that the resistance that emanates from the service user movement is

represented in news items by reference to a professional discourse, which has expanded to incorporate its challenges without disturbing its underlying ideology.

9.4 Mental health problems–making the individual visible

News items variously portrayed the causes of mental health problems as being either biologically or psychosocially derived, both implicating a 'faulty' individual and as being related to environmental or societal events (recession, poverty, unemployment, trauma) with proximal environmental factors obscuring more distal, global environmental issues.

9.4.1 The individual and society

Psychosocial causation constructs mental health problems as emanating from the interaction between environmental stressors and individual psychological processes and a discourse of illness characterizes them as physical disorders, a fault of the individual. While these discourses resist each other, the effect of both is to individualize mental health problems, obscuring wider societal issues. Societal factors such as economic crises, and associated pressure, social isolation, unemployment were frequently mentioned as being associated with mental health problems obscuring other factors such as such as inequality, poverty and deprivation. Rose (2003) suggests that older sociological explanations for mental health problems, such as the neurasthenia generated by urban living and the isolation and inequality generated by capitalism, have been replaced by a focus on proximal life stresses of social factors which are considered to have their effects through impact on the neurochemical brain. Thus mental illness is understood as physical disease. News coverage regardless of attribution of causation tended to focus on the individual, who was described with reference to their diagnosis, or behaviour, or loss of function, control, treatment, feelings and symptoms. So, while the origins or causes of mental health problems may be sometimes positioned as externally located, the focus of manifestation and response is on the individual who is required to change so they can cope with, manage, deal with the adverse

254

environment, it is the person with the mental health problem who is focused on in media. The juxtaposition of psychosocial issues with reference to causation, and the focus on the individual as the site for manifestation and treatment reveals a preference for the individual as the site of interest. This perpetuates an understanding of mental health problems as being a problem of the individual, outside of their control and perpetuates biomedical understandings of mental distress by maintaining the superior status of psychiatric knowledge as the legitimate means of both making mental distress visible and as a means of response.

As aforementioned at the time of data collection Ireland was entering an unstable economic period of recession which was contributed to by a property boom, light regulation of lending by financial institutions in tandem with poor adherence to good practice, leading to bank crashes by many of the major banks, coinciding with a global recession. This resulted in many job losses, business insolvencies and personal bankruptcies, which were cited as causes of mental health problems, stress and suicide in a variety of groups such as teenagers, property developers and businessmen. As discussed in chapter four historically, understandings of 'madness' and treatment of the insane have been influenced by socio economic factors in society. Foucault commenting on the origins of the Great Confinement in Europe states that in France: "When the effects of the economic renaissance disappeared with the Thirty Years' War, the problems of mendicancy and idleness reappeared; until the middle of the century, the regular increase of taxes hindered manufactures and augmented unemployment" (Foucault 1984a, p.129). The purpose of the *Hopital General*, the first institution of the Confinement in France established in 1656, was to prevent "mendicancy and idleness as the source of all disorders" (Foucault 1965, p.29). The birth of the medical clinic in Europe in the eighteenth century and the state's preoccupation with controlling bodies and the maintenance and surveillance of the health of individuals had to do with "...the preservation, upkeep and conservation of the "labor force"" (Foucault 1984b, p.278). During the enlightenment, the Age of Reason, Descartian notions of mind-

body dualism emphasized the ability to think and doubt as a central tenet of being human. Foucault suggested that the 'mad', who were considered to have lost this ability, thus required policing (Parker *et al.* 1995). Parker *et al* (1995, p.61) suggest that: "It is easy to forget that this dualism has only been with us since the time of Descartes but it became politically useful at the birth of the modern state when the individual became a unit of governmental concern".

The socio-political positioning of illness between the individual and as a collective concern fulfilled, according to Foucault, a state need for the control of populations through the introduction of collective control measures. He argued a new discourse emerged at this time: "which problematized disease as an economic and political problem for societies, not just an individual concern, which therefore required some degree of collective control measures" (Lupton 2003, p.34.). Confinement coincided with periods of great poverty and madness came to be inextricably, causatively linked with a lack of endeavour. Changes in ideology that followed the great confinement, emphasizing moral treatment and ostensibly more benevolent treatment of people, continued to associate endeavour with mental and physical health. Parker *et al* (1995, p.7) suggest that:

> Foucault's case is that the humanization of treatments of the insane encouraged the internalization of the difficulties they exhibited. The mad then had to take responsibility for cure, and the kind treatment which replaced the rods and whips would work its way inwards. The conscience of the mentally ill would act as a self-discipline all the more efficient than the social discipline of the general hospital.

The focus is on the body as a site that displays the consequences of the economic recession. Foucault considered the body as the site for disciplinary control by the state through state apparatuses such as medicine, the law, the education system and psychiatry. He argues that they "define the limits of behaviour and record activities, punishing those bodies which violate the established boundaries, and thus rendering bodies productive and politically and economically useful," (Lupton, 2003, p.25). Read and Sanders (2010, p.25) suggest that at various historical periods those groups deemed mad are "typically that which best symbolises the

nature of a society's collective anxiety". The referencing of the economic recession and the previous 'celtic tiger' boom in relation to individual mental health problems, found in this study, demonstrates the way in which what gets to be understood as 'mental health problems' is influenced by collective societal concerns. Blaming the banks for increases in mental health problems can be understood as a group response from society. Bion (1990) suggests that one of the tasks of a group is to identify a common enemy who can be held responsible for a problem. The recession has become the 'common enemy' that we must all fight against and 'madness' is used to support this fight. Once the enemy is in place the group that is society do not have to do anything more than keeping the enemy in place by attributing blame to him. There are many societal examples of groups being ostracized and blamed for societal woes, for example gays were the enemy for spreading aids and the Jews were the cause of the economic recession in post war Germany. It does not need to be realistic or even believable. News items in this study attributed blame to the economic environment for the suicide, depression and self-harm of various individuals. The individual may have had multiple reasons or a single one to kill or harm themselves or be depressed, however by linking it to the common enemy of society, the recession, we can ignore the potential and possibly more valid reasons or ignore the possibility that we may never really know why.

9.4.2 Obscuring socio-economic structures and processes

The work of Emile Durkheim (1951) on suicide and social connectedness and others has contributed to social causation theory which while accepting psychiatric constructs of mental distress emphasizes the relationship between social disadvantage and mental health problems (Pilgrim and Rogers 2010). While the growth of the family therapy movement and the development of models such as the 'stress vulnerability model' might been seen as an attempt to privilege the social over the individual (Parker 1995), they focus on proximal social factors, such as family and local community rather than distal social processes such as economic systems, political movements and cultural issues. The notion of problems being

located in an individual removes any responsibility from society, although there is a need for a concept of the social (the 'normal population') to compare the 'abnormal' with. The referencing of mental health problems in the context of recession and in relation to causation individualizes the 'problem' and rules out discussion about wider societal issues such as the nature of capitalism (of which economic ups and downs are an integral part) as a political system. Hallam (1994) suggests that the mental health problem anxiety, for example, plays an important role in social control, as it emphasizes a need to 'cope' with life events rather than seek political change. Allwood (1995 cited in Parker *et al.* 1995, p.47) suggests that constructing 'depression' individualizes the experience of distress, encouraging self-regulation and emphasizing personal responsibility obscuring a need for social change. Understanding and positioning mental distress in this way provides a simple 'fixable' solution, obscuring the need for greater scrutiny and the possibility of more pervasive change that might disturb the socio economic system.

A variety of factors have been implicated in impacting on mental well-being in society, including factors such as poverty, ethnicity, trauma and stress. Research across the world has consistently identified that people who are poor and disadvantaged are more likely to be diagnosed with mental health problems. Numerous studies have identified a relationship between poverty, social deprivation and schizophrenia (Read 2010; Fortney *et al*. 2007; Read 2004; Harrison *et al*. 2001; Kohn 1976; Hollingshead and Redlich 1954), depression (Brown and Harris 1978;) and a range of other mental health problems. More recent work suggests a correlation between poor mental health and relative income, identifying high levels of mental health problems in countries where the degree of income disparity is higher (Wilkinson and Pickett 2009). The impact of trauma on mental health, which was recognized by psychiatry in the shell-shocked veterans of the first world and Vietnam wars is more recently implicated in the development of psychosis (Molnar, Bukka and Kessler 2001; Greenfield *et al.* 1994) with research indicating that at least 70% of people who hear voices have experienced a traumatic incident that they can relate to the voices (Romme and Escher 1989).

The tendency to privilege proximal factors is suggested by Smail (2005) as emanating from their relative visibility and perceived pervasiveness in contrast to the arguably more pervasive invisible distal forces of social movements. He argues that more distal social institutions are more powerful, in terms of their ability to affect the individual's well-being, than those that are more proximal, but that the more proximal are perceived by the individual as more powerful due to their relative visibility. If the examination in the 17th century obscured the sovereign, the examination in the 21st century obscures the state by virtue of its pervasive function in constructing individualist understandings of 'madness'.

9.4.3 Bio-power and anatamo-politics

Contemporary rhetoric suggests changes in the ideological approach to mental health issues from a biomedical approach to a psychosocial understanding of mental health. Current Irish health policy makes claims for reform towards a consumer orientation, with new care models developed, new treatments and additional professionals, policies of de-institutionalization and the inclusion of service users and carers into aspects of policy making and delivery of services, put forward as evidence of progress. The discursive practices enlisted in representing mental health problems in news items made visible psychiatric discourses that position mental distress as illness and principally a biomedical problem of the individual. This obscures other ways of understanding and expressing mental distress, for example a response to adverse circumstances or an existential problem. The main group whose voices were heard were professionals who were positioned as 'experts' and whose views were represented as authoritative and factual. When service users and relatives were included their understandings tended to converge with professionals and were limited to their experiences rather than any sophisticated consideration of causes or responses. Diagnostic and illness related language was used to describe emotionally distressed states, biological explanations were used to refer to causation and treatment approaches and mental

health problems were generally referred to as illnesses. Diagnostic systems were represented as being unquestionably accurate, obscuring the many arguments against their use. Psychiatric diagnosis has been described as being in crisis evidenced in the refusal of the *National Institute of Mental Health*'s decision to use DSM-5 and the conceptual, empirical and methodological limitation of neuroscience in attempting to understand human experience (Thomas 2014). Critical discourses, emanating from professionals, academics and service users, that reject the legitimacy of psychiatry as a way of understanding and responding to mental distress were not present in news items. Psychiatric discourse has its origins in the European Enlightenment and the movement's concern with reason and the individual subject (Bracken and Thomas 2001). A modernist trend of thought, that emphasizes the importance of scientific knowledge, technology and experimentation to understand phenomena, produces an understanding of mental distress as disorder, derived from biological causes, psychological causes, social interaction or a combination of these and being amenable to measurement. The consequences of this modernist focus has meant that emotional distress has been defined in terms of the disordered individual rather than the context in which they exist, that technical explanations have prevailed as the way mental distress is conceptualized and that the power of coercion has been vested in the profession who controls the definition, namely psychiatry (Bracken and Thomas 2001). The bio-medical discourse has continued to dominate investigation and inquiry into mental health problems to this day, funded as it is by the pharmaceutical industry, supported by and supporting the 'industry' of psychiatry.

Foucault considered bio-power to be the recruitment of new sciences to regulate populations and individuals to confront the challenges of urbanization and the needs of industrial capitalism through the growth of knowledge and practices related to public health, hygiene, sexuality and reproduction which operated to make the individual an object of power and knowledge under the gaze of the disciplines. Biopower operates in two key ways; the regulation of bodies en masse, the 'bio-politic', through the collection of data about populations, and 'anatamo-

260

politics', the regulation of the individual body by the internalization of rules and ideas of modern science (Hyde, Lohan and McDonnell 2004). Rabinow and Rose (2006, p.197) suggest that the operation of biopower requires three elements: "authorities that are considered competent to speak truth discourses about the 'vital' nature of living human beings, suggested strategies for intervention targeted at collective existence in the interest of life and health and modes of subjectification that enable individuals to work on themselves with regard to forms of authority and truth discourse". Rose (1998, p.11) argues that the growth of the 'psy' disciplines (psychology, psychiatry, psychotherapy, psychoanalysis) is linked with changes in the exercise of political power in the latter part of the nineteenth century. This discontinuity he argues has transformed individual conceptions of personhood, who and what we are and how we should act. Rather than being scientific disciplines that can legitimately make claim to objective knowledge, existing independently of the person, they emerged in relation to particular social economic and political circumstances and as "intellectual technologies" that "make up" the person (Rose 1998, p.11). The findings of this study support the notion that scientific disciplines were privileged in providing explanations as to the nature of the individual. The authorities considered competent to speak in news items emanate from professional disciplines and represent biomedical understandings that have expanded to incorporate other scientific disciplines. In news reporting, while external environmental stressors and biological factors dominated in relation to causation, some articles referred to individual psychological responses and the person's unique coping mechanisms in response to external stress. A psychological discourse emphasizes the importance of an individual's internal mental processes and their interaction with the social environment as an explanation for mental distress. So rather than a fault in their biological make-up, the fault lies in their psychological structure. The emergence in the early part of the late 19th and early twentieth century of work by psychiatrists and psychologists such as Sigmund Freud, John Bowlby, J.B. Watson, B.F. Skinner, Ivan Pavlov, Albert Bandura, Aaron Beck and Abraham Maslow and others generated theories that influenced the development of a psychological discourse (Read and Saunders 2010). Psychoanalytic, attachment, learning, cognitive and humanistic theory all

emphasize the importance of personality in the human experience, offering differing explanations about the way in which humans develop their patterns of thinking, feeling and behaving. These theories offered opportunities to understand mental health problems in new ways and to develop new treatment strategies to help people. Psychoanalysis, counselling, behaviour and cognitive behaviour therapy all emerged in the professional domain and became to a greater or lesser extent integrated into the work of psychiatrists, nurses, psychologists and others. While the development of psychological understandings of mental distress and their integration into treatment in the early to mid- twentieth century were seen as progressive, less coercive, restrictive and more humane for the individual, they remove from social processes responsibility for their effects on individual citizen (Parker, 1995). Foucault (1965) considered that while psychoanalysis is considered the basis for psychological therapy, its importance lay in opening up space for dialogue about the nature of reason and unreason. He considered that Freud returned madness, "an experience reduced to silence by positivism", back to level of language and opened up "the possibility of a dialogue with unreason". He suggested that the possibilities opened up by psychoanalysis, which substituted the "silent magic" of the asylum with the "endless monologue of the person watched—thus preserving the old asylum structure of non-reciprocal observation but balancing it, in a nonsymmetrical reciprocity, by the new structure of language without response" (Foucault 1965, p.250-251) continued to reinforce the interiority of mental health problems. These understandings had potential to disturb the dominant biomedical discourse, offering as they do an alternative understanding of the basis for mental distress. Prior (1993) argues that instead they operated to widen the scope of psychiatry to focus on the social and behavioural aspects of the person and not just their biology.

Bracken and Thomas (2001, p.725) contend that:

> Psychiatry continues to separate mental phenomena from background contexts. Psychosis and emotional distress are defined in terms of disordered individual experience. Social and cultural factors are, at best, secondary and may or may not be taken into account.

They attribute this to the individual focus of service structure and of the conceptual basis of therapeutic models. Cromby, Harper and Reavey (2007) argue that the idea that unhappiness is an individually based pathological condition, predicated on assumptions of unhappiness as a product of faulty individual perception and a valid scientific basis for psychology and psychotherapy, is a myth. They suggest that what is required is essentially a political task of placing distress in a social and material context. Psychological approaches emphasize the interiority of human distress and the notion of personal agency diverts attention from the operation of social power (Smail 1995).

Aspects of philosophy which emphasize concern with interpretation of human experience, for example phenomenology, are influencing psychiatry through the increasing description and interpretation of service users experiences and the development of services around a more sociological perspective (Thomas, Bracken and Leudar 2004). 'Post-modern psychiatry' describes a way of thinking about psychiatry that reflects the postmodern movement in society which is characterized by the notion that there is no such thing as objective facts (relativism) and that reality may have many meanings (Bracken and Thomas 2001; Muir Gray 1999). Post-modern psychiatry puts forward a way of thinking about mental distress that emphasizes the importance of considering social, political and cultural contexts when providing services and help for those experiencing mental distress, emphasizes the importance of an ethical, value based approach to mental health which considers the meaning attached to mental distress and questions the power of psychiatry to coerce an detain people (Bracken and Thomas 2001).

The findings of this study suggest that news media representations of mental health problems privilege psychiatric understandings of mental health problems, positioning them as normative. News items which made claims as to the existence of the risk and danger of 'unrecognized', 'hidden' and 'increasing' mental health problems frequently accompanied this with complaints about lack of funding and inadequate provision of services. The validity of mental health service provision

263

and the treatments offered was not considered or questioned. Critical discourses from both within the disciplines and outside were not represented. The 'psy-disciplines' are integral to the operation of governmentality in how they bring the individual body into visibility as a site of discipline and the perpetuation of such understandings is essential for the continued existence of the psy-disciplines. Belief in the power of human agency is an essential tenet for the successful existence of psychology (Smail 1995). Rose (2003) and others, argue that what gets to be understood as a 'mental health problem', and how they are understood, is shaped by the commercial decisions of pharmaceutical companies who have the capital to expend on testing new psychiatric drugs. Cross (2010, p.96) commenting on the popularization of psychiatry in media sources contends that the psychiatric profession "which secured its legitimacy as the preliminary mediators of madness in the segregated world of the public asylum, is now involved in shoring its legitimacy in the open arenas of the public sphere".

9.6 Strengths and limitations of the study

While this study offers important insights into discursive constructions of mental health problems at a particular time in Ireland, it is necessarily limited to that which pertains to the one data source selected, newspaper reporting. A variety of media sources might have yielded more data and arguably a wider range of discourses. However the strength of this study lies in its in-depth focus on print news which I consider important in its own right due to its public prominence and because of the authority which it is afforded in society. This makes it suitable as a site which both reveals and constitutes discourses that is widely engaged with by the general public and therefore important in contributing to public discourses of mental health.

With regard to the specific period of data collection, the findings are necessarily restricted to one particular juncture. Sternod (2011, p.274) suggests that: "The advantage of viewing history as a series of ruptures and breaks is that it better allows for possibilities of change", and the illumination of discourse at a particular

moment provides information relating to the operation of discourse, power and knowledge (Carabine 2001) that is a necessary precursor to those possibilities.

One of the factors that has been identified in previous research relating to the reporting and depiction of mental health problems in media is that 'mental health problems' tend to be considered as homogenous and in an undifferentiated manner, ignoring the complexity and uniqueness of the vast array of states of mental distress experienced by individuals. In this study I have included articles that referred to particular types of mental health problems alongside those that referred to undifferentiated 'mental health problems'. Generally news reporting did not offer any sophisticated consideration of the uniqueness of one type of mental health problem over another. In my analysis I considered if there were particular differences in reporting when problems were differentiated. However, in general, I have considered the specific mental health problems alongside generic 'mental health problems' in making statements about discursive practices. In doing so, I acknowledge that I am contributing to homogenization. However this is justified, in my view, by the aim of the study which was to consider the issue of mental health problems and fact that they tend to be undifferentiated in public discourse on policy and service provision.

This study examined a limited archive. As there was little research done on news reporting in Ireland I made the decision to collect the data by personal scrutiny of newspapers rather than by digital searching, using key words. This decision was driven by a desire to get a feel for the full 'presence' of mental health problems in Irish newspapers. This proved time consuming but fruitful in that I was satisfied that I obtained a complete sample. However, I subsequently conducted a digital search using key words and this brought up the same sample. While this is reassuring in terms of the completeness of my sample, it indicates that for future research digital sampling would be appropriate, would result in the achievement of larger data sets, allow more focused searching and be more efficient.

9.7 Implications

Anyone attempting to write from a Foucauldian perspective proceeds with extreme caution in asserting implications. Foucault said "I don't write a book so that it will be the final word; I write a book so that other books are possible, not necessarily written by me," (1971, p.162 cited in O' Farrell). Discourses analysts have tended to avoid making recommendations rather viewing the deconstruction of discourses and the potential of this for opening up spaces for alternative knowledges and practices as the goal of their research (Georgaca 2014). However this has been criticized as ineffective in leading to a change in interventions (Harper 2006). The following therefore should be considered as merely a few of many possible implications that could be elicited from the findings of this study. The way in which mental distress is understood in society has important implications for those who experience it, those around them and those involved in providing services and arguably for everyone in society concerned with human experience. This study has important political implications in relation to the visibility of particular perspectives in defining and responding to mental health issues. It also has implications for media reporting, for education and for research.

9.7.1 Political implications

To position mental distress as an individual problem, a systems problem or a societal problem is a political act. Locating the cause and solutions to mental health problems with individuals has implications about for example where we focus resources, what particular therapies will be made available and who will provide them. To foreground some responses means to privilege them and to obscure or ignore others. This study was undertaken at a particular juncture in Ireland, a time of economic recession that impacted on the socio-economic conditions of the population. The findings indicate that the way in which mental health problems were constructed was strongly associated with particular prevailing, transient, proximate socio-economic factors, while other more distal and arguably more enduring were absent and ignored. Such meaning has the potential to impact not

266

only on public understandings but also on the formation of public policy and the associated allocation of resources. This means that more profound and enduring socio-economic factors such as poverty and disadvantage may not be addressed as political priorities in relation to the mental health and welfare of the population, particularly important at a time of constraints in public funding of services. This also highlights the influence of sociopolitical factors in the definition of mental distress.

The findings of this study suggest that some understandings achieve dominance in news reporting and in the orientation of services as reported on in public information material. While critical discourses are visible in professional, academic fields, online and in social media these perspectives do not appear to have a presence in mainstream news print media. The dominance of biomedical understandings of mental health problems and an almost complete absence in newspapers of any critical perspective despite the presence in society of many groups critical of the psychiatric perspective, particularly in relation to individual human rights and the efficacy and risks associated with psychopharmaceuticals has important implications for how mental distress is understood in society. For groups representing such perspectives this s is an important consideration in how they position themselves, their strategies for awareness raising and their place in the creating meaning about mental health problems. A richer mix of understandings being aired in public would contribute to wider diversity in discourse about the nature of human existence and distress opening up the 'dialogue' that Foucault considered was closed down by the 'science of mental disease' that developed in the asylum (Foucault 1965, p.250).

The findings of the study suggest that strategies aimed at alleviating stigma, raising awareness and encouraging openness about mental health problems preference one form of knowledge about human distress obscuring other possibilities. Public

health strategies aimed alleviating stigma and promoting openness need to be considered critically so that discourses can be illuminated.

9.7.2 Implications for media reporting

Professional voices were prominent in news coverage. Lewison *et al* (2012) suggest that the ready availability of 'commentators', persons willing to act as sources of information or commentate, contributes to the presence or absence of particular topics or orientation of news items. Particular professional groups tend to have structures in place which allow for easy access to spokespersons, such as representative organizations and these appeal to news media which operates with a speed and immediacy which requires instant access to opinion. The resources available to large organizations with the financial wherewithal to employ public relations staff who prepare and package targeted messages by 'experts' means that the ready availability of their 'shaped' coverage can make the work of journalists easier (Henderson and Kitzinger 2007). It requires more effort and a different kind of work to investigate and find the voices of individuals who experience mental health problems. They remain hidden; we have set up a system that is both easy and that contributes to hiddenness. The relative absence of service users and critical views represented in the news items suggests that increased efforts need to be made by media professionals and by representative and other groups to proactively target news media sources with content related to their understandings of mental health problems.

This study, and the review of literature that informed it suggests that existing guidelines for media on best practice in reporting frequently reinforce particular understandings of mental health problems, for example as illnesses. Special interest groups are generally consulted in the creation of such guidelines. While it is acknowledged that the replacement of one discourse with another forms part of discursive practice, efforts should be made to widen the groups approached to provide in-put into such consultations to include a variety of understandings.

9.7.3 Implications for education

Smail (1995, p.355) suggests that: "By making social power the explicit focus of our deliberations, we would throw a great deal of light on broadly 'psychological' concerns and processes which tend at present to be obscured by ideology, wishful thinking and mistaken assumptions". While discourse can be elicited and examined in many surfaces, the findings of this study indicate that the study of news media representation is a valid means of doing this. The insights offered by this study as to the way in which mental health problems are discursively constructed suggest that there is merit in inclusion in curriculum related to mental health issues content on discourse and the social construction of mental health problems to promote an understanding of the manner in which meaning about mental health problems is created. This has relevance for a wide range of curricula including those for mental health professionals, health professionals, media professionals and people engaged in advocacy and public relations.

9.7.4 Implications for further research

The insights achieved in this study indicate that Foucauldian discourse analysis continues to be a useful means through which to consider how knowledge meaning and power are produced in society in relation to mental health problems. Given the diverse nature of mental health problems it would be interesting and fruitful to focus on particular mental health problems for example, depression or schizophrenia to provide more specific understandings of particular constructions. As the recession is now perceived to be over in Ireland further research on news reporting would be interesting in considering how mental health problems are constructed in this context. Given the absence of counter discourses critical of psychiatry in news print reporting identified in this study, consideration of social and digital media would be interesting given their frequently unedited nature and the relative immediacy and ease with which they can be accessed.

Another issue that has emerged for me as a result of doing this study is a consideration of the various terms used and categories into which society places those who are 'disaffected'. Some of them get to be called 'people with mental health problems' but others come under the category of 'prisoner' or 'homeless person', groups impacted or created by socio-political forces. The diminution of mental health services from large scale institutional care into the community has impacted on where people interface with the state and state services. Research indicates high levels of mental health problems among these groups. People experiencing mental distress may not always get to be categorized as such. A consideration of media coverage of such groups would provide valuable insights into the operation of power/knowledge in relation to the discourses present in constructing normality and deviance in society and the experience of mental distress.

9.8 Personal reflection

In my journey from the development of the idea for the study through to its completion, I have needed to challenge my own assumptions about the nature of the world and knowledge. One particular challenge concerned my understanding of 'mental health problems'. Parker (1992, p.6) suggests that "once an object has been elaborated in a discourse it is difficult not to refer to it as if it were real". Having worked and been immersed in various aspects of mental health for all of my career, I have struggled to reappraise a realist understanding of mental health problems and to adopt the necessary 'disbelief' required to question established social constructions, to which I contribute, whilst at the same time finding a language that acknowledges the 'real' nature of mental distress. Having trained as a psychiatric nurse in a traditional 'mental hospital' in the 1980s where a biological understanding of 'mental illness' was taken for granted and largely unquestioned, I now, alongside my academic career, work as a facilitator with the *Hearing Voices Network Ireland*. This organization, founded in 2012 in Ireland, emanates from the work of Marius Romme and Sandra Escher in Holland, is part of an international movement (*Intervoice*) and adopts an understanding of the experience of voice

hearing as a variation in human experience rather than a pathological process and aims to assist people to cope with the distress associated with the experience and to develop an understanding of the experience in the context of their own unique lives. As well as challenging biomedical understandings, this approach, alongside other survivor movements and organizations critical of conventional psychiatry, challenges the primacy of professionals and presumptions of superior understandings afforded them and aims to reposition those who experience mental health problem as 'experts' by virtue of their lived experience. Doing this work, working alongside voice hearers and relatives, in a collaborative manner and approaching 'psychosis' from an alternative perspective has influenced my thinking on the nature of mental health and mental health problems and has been helpful in distinguishing meanings and context while analyzing news coverage.

Another personal challenge concerned notions of power. I came to the study heavily influenced by traditional notions of power and while I understood power as being productive I struggled with understanding the notion of power being dispersed and relational. The selection of Foucault's work as a methodological guide has helped me grapple with and reconcile to the complex nature of not only mental health its positioning in society. I acknowledge that this study and the decisions I have made throughout which have been shaped by my perspective itself forms part of discourse.

9.9 Conclusion

This chapter has presented a discussion of the findings of the study and identified the strengths, limitations of the study and implications of the study. I opened this thesis with a quote from Foucault: "People know what they do; they frequently know why they do what they do; what they don't know is what they do does" (Foucault 1983 p.187). This one consideration of discourse in news media representation of mental health problems at a particular juncture in Ireland

contributes to an understanding of what we do and say about mental health problems does in making meaning about mental distress.

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Appendix A. Newspaper articles included in the study

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