

# THE INFLUENCE OF MEDIA REPRESENTATIONS ON MENTAL HEALTH PRACTITIONERS

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A thesis submitted in partial fulfilment of the requirements of the Manchester Metropolitan University for the degree of Doctor of Philosophy. Faculty of Health, Psychology and Social Care.

2015

## **Abstract**

The debates related to the representation of the mentally ill in the media have been wide ranging over the last 20 years. Emergent representations have often been stigmatizing, claiming that the mentally ill are violent and dangerous. This study used an emergent methodological design to explore what the current representations of the mentally ill were and identify a case study from the available representations. It then examined the influence that the case study had on the thoughts and practice of experienced mental health practitioners. The study involved 8 practitioners and identified thoughts influenced by reading the case study and an academic article. Practitioner's thoughts were captured over 3 separate interviews and by practitioners providing written reflections. At the last interview, practitioners were asked to provide comments as to what the experience of taking part in the study had meant to them. Generic themes related to risk, blame and professionalism all emerged. The study also found that practitioners were able to reflect on the influence that the material had on them, finding that only after discussing the reflections in the interviews that they became aware of some of their defensive thoughts and actions. The outcome of the study is that the media continue to present a negative representation of the mentally ill and mental health care, and that practitioner's thoughts and actions are influenced by the media representation.

# **Acknowledgement**

Sincere thanks are due to my supervisors Dr Christopher Wibberley and Dr Francis Fatoye as they made the stressful journey of completing a PhD enjoyable.

Thanks are also however due to my wife (who's strength in the face of adversity has kept me on track) and children for their love and support and forgiveness for missed time together.

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## **Preface**

### **Reflections on the development of academic identity during the completion of this thesis**

A PhD is often considered to be a journey, a journey that builds new knowledge and extends existing knowledge by use of original approaches and ways of writing (Wellington 2010 p 87). Within this thesis, such a journey is taken, original thoughts are refined and implications for practitioners, others and myself are identified.

This study has been a catalyst for personal and professional development. It has made me focus on my identity as a nurse and an educator and led to me developing an understanding of the personal, relational and contextual factors that have been involved in creating my current academic identity (see Loeff *et al.* 2012).

I have reflected on my awareness of the emergence of my developing academic identity and have pinpointed this present understanding to starting this thesis. Snyder (1997) inferred that such development is probably a career long journey, and this may be true, but I see this experience as the tipping point to my current level of awareness. My level of self-confidence, related to my role and ability, at the start of this thesis was high and I thought that my thinking was clear as to what I needed to do and how I was going to achieve this. I was enthusiastic about what I felt to be a challenge, but a challenge I was capable of handling. What I was not fully aware of was



the breadth and depth of understanding that I was going to develop and the level of hard work that gaining such an understanding entailed. I hadn't realised perhaps how much I knew about a few specific areas of healthcare and life, and how confident that made me feel. I can now see that I was aware of how, as an academic at this stage of my life I had come 'to be' (academic ontology, Quigley 2011) but had a faulty awareness of how as an academic I would come to know (academic epistemology, Quigley 2011). As Watson and Thompson (2006) had suggested, knowledge is seen as a product of a technical process rather than intellectual work (p124), and up to this point in my career, I had immersed myself in the technical aspects of health and care. Reflecting on these practices and technical aspects with a fresh insight started the development of an understanding of my identity (see Wenger 1998).

It is clear that from the outset of this thesis that initial supervision provided gentle prompts to read texts that I would not have naturally read or referred to. Through supervision some of my fixed thoughts were questioned and I was encouraged to look for alternatives. This had what felt like a detrimental effect on my self-confidence. The certainty I arrived at, at the start of the study was challenged with alternative views to some of my default coping strategies and allegiances to technical processes of care. This in some ways challenged my thoughts of professionalism.

Functionally I felt I remained relatively autonomous in clinical practice and had a fairly high level of specific as well as general knowledge related to

health and society. This was probably due to my clinical practice being in a narrow, yet specialised field. In the university my role was broader, but one where I became increasingly aware of how I was being manipulated to pigeon hole my traits in order to cast myself as either a teacher or a researcher. There seemed no place for a practitioner researcher; something I thought I was. Yet I am aware that I started to increasingly refer to myself as a practitioner researcher rather than a nurse. I am unsure why I did this but Lieff *et al.* (2011) identified that in the development of an academic identity, professionals amended language that described what they did, as they aligned themselves with and to a new role. It is understandable to me why I, as an academic, maintained ownership of professional allegiances and the title of practitioner, as this provided personal credibility and membership of a professional body. I feel this was a safety net for the emerging anxiety of developing a new identity as a lecturer and a PhD student.

Instead of fixing my allegiances to teaching, research or clinical practice, I decided I would continue in all three. This left me in a situation created by my personal beliefs where I had to manage multiple roles and avoid fixing my identity fully in any one camp. This caused anxiety and the need to sacrifice time in one of the areas because of demands in one of the others. However, this enhanced my image with colleagues and managers as being adaptable and capable, but realistically only reaffirming the traits that they wanted to see. This, on further reflection, led to the identification of a sense of belonging and yet differentness to the academic community, one

where I was part of the system but offering something slightly different to others in that community.

This approach can leave an academic, as I was, seeming to accommodate participation but experiencing a sense of exclusion (Hodges 1998). Wenger (1998) argues that academics can undergo such an experience when engaging in academic communities, and that the development of an identity can be both positively and negatively influenced by the practices of the community. Full membership of a community is identified by joint enterprise and engagement (Lave and Wenger 1991), but on reflection this was something that I was neither able to nor ready to do.

I can see the area that I chose to investigate for my thesis was something I felt at first was a safe topic for me to address, and one in which I felt others (colleagues and managers) would support. However, I was aware of personal experiences related to the area of inquiry and uneasy with some of the associated emotions I had experienced in the past. I did have baggage related to the theme of risk and media, yet felt a need to explore something related to it. I was aware of other academics that had explored media and risk, and although my initial thoughts were to join their academic community, I lacked the confidence to do so. This was probably a fear related to being compared to others, which I felt may inhibit my sense of self-confidence and only further identify traits that others felt were important instead of myself.

I must have realised in the second year of the study that my identity was changing. I felt that I had to understand some of my 'biographical baggage' (Collinson 2004), and brought this into the thesis and decided to face this head on (see Chapter 3). I broadened my academic profile by joining Research Gate, and uploaded past academic articles to my University SEEK and USIR accounts (staff profile and university repository websites). I must have realised that an academic identity is not a fixed thing, but something that needs to grow. This growth of identity may involve networking, disclosing personal beliefs and creating a presence in the academic community. The problem with creating a presence in the academic community was that I felt I would be pigeon-holed again and seen as the sum of my research, not the person I am. The fears that I had, in some ways came true, as I was asked to teach more about risk (as much of my past research has been in this area) but not accepted into the research community as my area of interest did not fit with the university's main focus.

This was a sobering experience and the developing awareness of my academic identity came with the realisation that I was quite isolated in relation to support for my research. I had my supervisors, but felt the university I worked at should be involved. I attempted to engage with the research department. Perhaps I should have done this earlier, but I found my approaches were rebuffed. I can recall asking for help with equipment for some digital audio recording and received a curt response that they (the research team) had no remit to help me as I was not doing my PhD at this university. My naivety as a researcher and my anxieties about engaging in

the research community in the university were part of the problem. I already had my ideas and had not involved others at the university. Although feeling hurt by the curt response, I had to acknowledge that part of this situation I found myself in was of my own making. I had become wrapped up in my study and not thought of others and how I could help them and they me. A lesson learned from this passage of time was that I needed to engage in the research community of the university, but such engagement may have to wait.

At this time I was unaware of any real changes in my opinion of research, just that I had completed some studies and had a few ideas about how I wanted this thesis to develop. I returned to the SEEK and USIR profile, and I reviewed the work I had published. Prior to reviewing the papers I had felt proud of my work and felt it was of a good academic standard; after all it had been peer reviewed and published. With my developing and wider understanding of research approaches and academic writing I critically reviewed my previous work and came to a different conclusion of the quality. I realised that the journals had not edited mistakes and grammatical and referencing errors in some of my published work. I could only accept that this was partially my fault, and this acceptance led to me becoming more critical of the depth and quality of my work.

I began to identify gaps in the evidence that I was using for my teaching and research. I realised that pedagogically, I was focusing on narrow sources of evidence and that the sources of evidence I engaged with were

all similar and reinforced rather than questioned my viewpoint. With a sense of increasing confidence in my own viewpoint I took a risk and started to look further afield for data. This included looking at online feedback from newspapers (see appendix 4.2). The online feedback presented a contrasting opinion to that of the practitioners interviewed and my own opinion. The feedback comments were less sympathetic and more blaming. This experience in many ways highlighted the sheltered view I was collecting from practitioners, and the general public's view on the story being read.

Over the duration of this study I have become clearer in my thinking about utilising 'real' stories and events to explore the influence they have on people's thinking. Rather than creating a story that depicts a specific theme or behaviour for others to discuss, I feel that 'real-life' events exist that can do this better. I reflected on the Nordt *et al.* (2006) study and found myself asking why they had to create vignettes to explore attitudes to mental illness, when real-life stories already existed (see also Wright, Heathcoate and Wibberley 2014). Whilst the findings of Nordt *et al.* (2006) were exciting in that they identified both the general public and mental health professionals may hold stigmatising views of the mentally ill, they were identified from a manufactured vignette. In this thesis I wanted to use real stories (admittedly reported in a sensationalised way), that practitioners were exposed to so that they could use their knowledge of health care and illness to arrive at an opinion.

On reflection, this pragmatic approach prior to starting this thesis had become fixed in a narrow path of reusing tried and tested methods that I felt comfortable with. With the experiences encountered during this study, I have broadened my view and challenged what I thought was evidence. The self-reflective and autoethnographic stage of this study (see Chapter 3) made me remove self imposed 'blinkers' and focus on myself in order to widen my view. Such self questioning of personal philosophy enabled me to see the identity I was developing as an academic instead of trying to manufacture one. I could see the changes in my writing, thinking and teaching. I look back at the first paper that emerged from this study (*The Changing Face of Newspaper Representation of the Mentally ill*, published in the *Journal of Mental Health* 2013), and can see how it was adhering to an approach I had used before (*An Investigation into how Community Mental Health Nurses Assess the Risk of Violence from their Clients*, published in the *Journal of Psychiatric and Mental Health Nursing* 2004). Both papers, on reflection, I would now have the confidence to write in a different way.

My writing in a different way and engaging in other perspectives has developed throughout the time of constructing this thesis. The confidence to change my usual approach to writing and use other perspectives was probably helped by feedback after publishing a fairly poorly constructed but honest reflective paper in the *Mental Health Nursing Journal* and the development of a more creative and engaging conference paper (Wibberley and Murphy 2012) presented at the Qualitative Research Conference (QRMH4), Nottingham.

As well as my approach to thinking and writing changing, so did the audience I wanted to reach. I understand the need to publish articles in journals with high impact factors, but I also want more people to read and comment on them. Therefore, the paper that was developed following the conference presentation was offered to an open journal and one where the freedom of access and comment is evident. I realised, as in the online feedback on newspaper articles that a great number of people (both professional and non-professional) read and comment on published work. Not all of their comments are useful, and I suppose it has to be accepted that some people will comment in a derogatory way, but others in the academic field may be too polite to criticise. Throughout the time dedicated to this thesis, both my supervisors and myself have had to use our network to access what appears to be interesting and useful texts. Each of our establishments only hold a specific range of journal articles, and this highlighted that I would only be making my work available to those who subscribed to a particular journal if it was not made open access. If I wanted wide ranging comments, then the article needed to be open to everyone.

As I started to become more confident with using evidence from a wider field and re-evaluated what I was doing in my research, I identified that there was a cross over from the research to my teaching. The range of areas I was willing to teach and supervise was becoming wider and my arguments for ways to face academic dilemmas more inclusive of work I had not considered a couple of years previously. I started to discuss the work I did in my research. Colleagues at the university and the trust became interested in



my initial findings and felt that I could offer something to modules and training programmes I had not been involved in before. I became involved in working with the Advanced Practitioners and started to work with students who were not from a mental health nursing background. There were people from audiology, midwifery, others from all aspects of adult nursing. It was then that I began to realise how I had changed and how people were looking at me. Perhaps on reflection, as Lave and Wenger (1991) had argued, my academic identity was becoming identified with membership of an academic community. I was seen to have special knowledge and an alternative view to others, and was gaining membership by default. I can now see that when I first started as a lecturer I was developing in a way that suited the university rather than myself (Abbas 2003). This was probably due to a lack of confidence in myself in this new area and an unconscious need to fit into the academic community.

My identity attached to risk has changed over time and I have realised that I was being encouraged and approached for advice on research related themes. This was probably because I had come to understand that I needed to share what I knew instead of keeping it to myself. Joining Research Gate, LinkedIn, etc, was something I would never have engaged with in the past. Joining in on online chats about research and developing discussion boards for modules made my view more accessible.

Throughout the last five years (2010-2015) I had become immersed in media representations and the way that they had appeared to stigmatise the

mentally ill and scapegoat practitioners. Publicising the knowledge I had developed about representations (instead of holding it close to myself and using it like a power thing that others didn't know as much about as me) made me realise that I was not the mental health practitioner that I had been before I started this thesis. I could see that my prior practice was a reflection of the culture I was working in and that I now had a different identity to that which was emerging.

Over time I came to the understanding that representations of the mentally ill had a use in my academic work. I realised that stories are a representation of what certain parts of society wanted to read about; that the stories were used not only to sell papers, but also to convey a message that could shape views in society. I began to understand the way that the stories were framed and the use they had in arousing thoughts in me and potentially others were useable in healthcare education.

The media stories started to be drawn into my teaching, initially in relation to risk, but also in relation to human rights and practice development. I started to take them into clinical supervision sessions with colleagues in the trust to get them to look at the things (other than the more overt things like policies and academic literature) that influenced the way they think and then practice. I started to develop an understanding that the media were influencing the general public, and colleagues and myself were members of this general public and media production. The academic side of me was probably now more questioning than accepting. I identified that I was

uncomfortable with the image and representations of mental illness and the realisation that the way practitioners were practicing may be influenced by what they had read in newspapers.

Having developed a wider interest through engaging with practitioners from outside of mental health, I realised that the influence of the media extended beyond just stigmatising the mentally ill as violent and feckless. Media representations were influencing others to believe that things like obesity and heart disease were caused by the person experiencing them. I considered that repeated news stories seemed to 'energise' politicians and later down the road led to policy changes and amendment to clinical practice for practitioners. Having read Cohen's *Moral Panics* (2002) with an open mind, I reread some of the work and identified similarities to the way representations may have guided public opinion in a way I felt I was being guided now.

I feel that these experiences, stimulated by developing this thesis, have probably started to put the past into some context. The experiences I had prior to starting this thesis, such as the killing of my old tutor, the person I was living with being on the same 'hit list' as the tutor, and the lack of media attention of such facts, were hidden contributors to my interest in media representations. The fascination with media and the repression of thoughts about the events that unfolded, all should have worried me. I needed to deal with them then, but I didn't. The stress of completing this thesis and the exposure to some of the traumatic autoethnographic stories struck a chord

with me. Although my principle supervisor was possibly unaware that he had done so, he had made me relook at personal difficulties whilst attempting to challenge professional difficulties (Chan and Schwind 2006). I can recognise a coping strategy that I use; looking for positives in anything in order to avoid having to look at the negatives. Throwing myself into tangible and seemingly limited areas of things like risk seemed quite safe. But looking at risk and representations 'through a different lens', opened Pandora's box to some of my past baggage. Regardless, the experience of completing this thesis has widened my view of who I was becoming and the identity of the person behind this front.

Interestingly when I relook at the media there appears to be the repeating of one message in various ways. The media consistently tells people that the mentally ill are dangerous. If this is continually repeated, the mentally ill, as well as the readers, will start to believe that they are violent and dangerous. Similarly if the media continues to tell practitioners that they are not good at their jobs, at some time this is going to influence them to believe this. Finally if I continued to only talk about risk, then that is what I would become recognised for.

My knowledge of my academic identity has struggled to emerge, probably due to the university where I work making frequent changes and reforms to practice and research that has led to a more structured environment. Such reflections echo the arguments of Henkel (2000) and start to address why I have found it difficult to pinpoint an event other than starting this thesis for

an understanding of the development of an academic identity. I have moved from being a practitioner with an interest in the way practitioners assess and manage risk to a lecturer that still happens to practice with an understanding of the way that media influences practice. I have been on an uncomfortable journey which others have been on, and like them, probably doubted my own ability to finish what I started. My identity seems to have been moved from an academic that would automatically think within a narrow path, to an academic who stopped this automatic thought process to explore the wider ramifications for the area of discussion.

I have developed new knowledge, skills and ways of practicing, leading to a new identity; from understanding about the use of a mixture of methods for research to truly mixing methods of research. Ultimately my identity has shifted from a practitioner in risk training, to a researcher who can construct a study that explores media and the development of practice. I feel I have an identity that shows that I am a researcher and a relatively widely read, free thinker that can produce research that contributes new knowledge and use such knowledge to make informed decisions that may influence both health care staff and the general public. I have also been given the opportunity to become excited about moving onto my next study and having a much wider perspective on how to construct and manage it.

The realisation of the changes in me has led to my confidence improving and a willingness to try new things. I recently joined an editorial board. Before this stage of my academic identity I had peer reviewed articles, but shied

away from making organisational decisions. I had been happy being a member of various modules, but now lead a programme and have moved into a new school. I had relied on technical aspects of care and teaching, but now felt confident to broaden my teaching style, practice and those I teach to. I also feel confident to offer my written work to a wider audience that may not be too polite, and want to stimulate discussion and learn from others that are not necessarily just in the health care or my academic field.

# **Volume 1.**

## **1. Introduction**

### **1.1 Setting the scene**

The aim of this thesis is to explore the influence that newspaper representations of mental illness have, on mental health practitioners. The aim of this thesis came about as a result of me feeling that there may be potential changes in media reporting and that some recent reporting seemed to be at odds with my past experiences. I also wondered whether representations influenced my thinking and actions and therefore potentially other practitioners. It explores initially the way that mental health/ mental illness has been represented in UK newspapers in the recent past, before then exploring the influences on myself and then other experienced mental health practitioners that such coverage may have.

Throughout the thesis a pragmatic approach to inquiry is adopted which acknowledges Dewey's and latterly Rorty's naturalistic pragmatic approach, that comes about from the changes that a person makes in their lives to cope with their environment. In this thesis such changes relate to that which came about in practitioner thinking and actions, after reading a newspaper story about a mentally ill person, his care and treatment. An emergent design (Hesse-Biber and Leavy 2008) is used throughout the thesis and is discussed in detail in section 1.5.

Before exploring the influence of representations on mental health practitioners, a review of media representations of the mentally ill in newspapers was needed in order to establish what the representations were. An initial search found that much of the literature relating to newspaper representations of the mentally ill was in need of updating. This is discussed in chapter 2 in relation to the pattern of representations and common words used in mental health related newspaper stories. A content analysis approach was used to aid understanding of the data collected, and comparison (where possible) is made with past research. Having completed this review a range of stories were identified that could be used as potential case studies (case studies is used in the thesis as a newspaper story that is used for practitioners to read and reflect on) was identified from the overall coverage; with the Peter Bryan story being used for the subsequent two stages of the study.

Whilst conducting the media review it became clear that my thinking and potentially the way I was acting was being influenced by what I was reading (this is debated further in chapter 3). Building on the findings of this chapter, a self-reflective stage was completed to identify any potential changes that had occurred in my thinking and actions after reading a specific story (the case study). The self-discourse in which I engaged, potentially influenced the way I interacted with others and in some ways influenced how I was practicing at that time. Reflecting on the self-discourse also led to a personal decision to explore the way others may reflect on the newspaper stories and



to explore if they (people with a similar level of experience) identified any such influence on their thoughts and potentially, their practice.

The investigation with other practitioners, detailed in chapter 4, used interviews and reflections as data. The chapter builds on the findings of chapter 3 and explores how the reflections of experienced mental health practitioners developed in relation to their engagement with the newspaper story of Peter Bryan (the case study) over a three week period of time. Peter Bryan had been tried and convicted for killing three people. He had a history of mental illness and his care and treatment had been presented in the newspaper story.

Having reflected on the impact that the newspapers had on me, (and recognising that my thoughts and actions were potentially influenced) I used a similar process with the practitioners who were to be the sample for this thesis. A pilot stage was used to test out adaptations from the process used on myself before use with practitioners. The pilot identified the need to formalise the intuitive questions I asked myself to enable the recording of the practitioners verbal and written reflections.

The practitioners were all mental health professionals from a range of clinical areas; all were experienced and held senior roles. The study population was selected as it was, to a large extent, from a comparable background to myself. Using such a group of practitioners enabled me to identify if my thinking was similar to others who had a comparable level of experience and training (Ellis 2011).

The findings present accounts of the experiences of practitioners at the time of reading the story and identify reflections on practice and on self-awareness. These findings highlight the way that some practitioners creatively manage risk whilst working within the present structure of mental health care.

The final chapter presents a synopsis of the previous chapters, drawing together the pertinent points before exploring the implications for the participant practitioners, clinical practice, education and research, as well as for the mentally ill.

## **1.2 Personal approach to research**

I have found that a combination of academic supervision, reflection and the use of textbooks important in the identification and development of my understanding related to research philosophy and methodological approaches. I have come to the conclusion that the way in which I research is influenced by the questions that I felt needed to be answered (see Creswell 2003; Grix 2004; Hesse-Biber and Leavy 2008; Mason 2002; Tashakkori and Teddlie 2003).

Over the years I have realised that there are many different ways of viewing how and why things happen, that there are equally many ways to investigate how and why things occur. Identifying concrete scientific facts is one way of exploring the world, but I contest that this approach is strengthened by narrative explanation. Over my career, I contend that the utility of both

objective and subjective information has helped me to develop a questioning approach to why things happen. Being able to both understand and use different methods of investigation could be described as a pragmatic approach (Creswell 2003). I came to understand more about the approach and the philosophy, I found myself becoming more comfortable with alternative approaches (such as using a mixture of methods in one study). This eventually influenced the design of my early research activity.

It was not until completing my MSc (Practice Development- research route) that I explored personal philosophy in relation to research and came to see the way I defaulted to specific approaches to research. It was at this point that I identified that much of my research thinking was probably related to a pragmatic philosophy.

From a personal point of view I contend that a pragmatic approach is instrumental in leading change in practice, as a pragmatic approach can create knowledge that is useful for practice. This can be done by being either inside or outside of the research field (or both). However, the researcher must be engaged with practice.

A pragmatic philosophy involves understanding how knowledge is developed and emphasises the role of the researcher in this development. "The researcher is participating in practice in order to explore - through own actions or close observations of others' actions - the effects and success of different tactics" (Goldkuhl 2012, p141). Goles and Hirschheim (2000) argued that pragmatic research was often pluralistic in nature, using the

method (or methods) that work in relation to the purpose of the research. The main themes (of pragmatic research) being that thoughts and practices should be considered in relation to the usefulness and practicality of the research, and that this would highlight the level of value to the individual practitioner, patient or researcher (Goldkuhl 2012).

Grix (2004) argued that a researcher's intentions, goals and philosophical viewpoint are linked to the sort of research they carry out. As highlighted in the methodology section later, my ontological and epistemological position influenced the design and thus the methods that I used. I believe that the adoption of such a philosophy enabled me, as it had others, to "understand, explain and demystify social reality" (Cohen *et al.* 2007, p19).

The questions that I identified as being in need of answering were interpretive in nature (and were a way to address the aim of the thesis; identify the influence that newspaper representations of mental illness have on mental health practitioners). Identifying research questions early on is important (from a pragmatic perspective), as they influence the design rather than letting the design influence the question(s) (Tashakkori and Teedlie 1998). A pragmatic approach requires me to address each question in the way that I feel answers the question, which in turn moves toward addressing the aim.

I see myself as a pragmatist, not in order to excuse the use of various methods in one thesis and avoid ontological and epistemological questions, but because this reflects the way that I view real world and practice

research. This is probably why before becoming aware of this, I was comfortable with a mixed method approach, yet found it difficult to articulate accurately why I felt comfortable. When starting this PhD thesis, I defaulted to identifying questions that needed the use of a mixture of methods in order to satisfy what I thought was needed. But it was not until I realised that I was not integrating the findings from the various stages of addressing the questions I had, that I realised that I was not using a mixed methods approach.

I came to the understanding that research does not need the “sole consideration of knowledge and knows... knowings and meanings” (Tashakkori and Teedlie 1998 p52), and that knowledge is not necessarily universal, it is something possessed at an individual level. Hesse-Biber and Leavy (2006) in many ways support such an understanding as they argue that:

*Research methods are not fixed entities. They are fluid, can bend and be combined to create tools for newly emerging issues and to unearth previously subjugated knowledge. Emergent methods are often driven by new epistemologies on knowledge production, which in turn create new research questions (methodologies) that often require an innovation in methods. (pxxx)*

The questions identified (p9) to address the aim (p8) of this study, were probably identified because of my comfort at using a range of designs and developing more detailed and complex questions in an attempt to answer them. Addressing and valuing objective and subjective knowledge through the use of various approaches is underpinned by the notion of using ‘what

works' (Cherryholmes 1992). However, Hesse-Biber and Leavy (2006) accept the use of 'what works' but argue that some researchers are 'suppressed' by their alignment with their disciplines, and consequently this limits the scope and type of research that they undertake. After all, if researchers have only seen something done one way, and have never looked at alternatives, then they may think that there is the only way to do research. In health care such a narrow view of research can be fostered and endorsed by funding agencies and research departments aspiring to a narrow 'gold standard' of positivistic research founded on statistical proof. While this has its place in health care research, it is not sufficient to be the beginning and the end of a research study. I have come to an understanding that research questions drive the design (and these questions do not necessarily need to be all closed and concrete). My research questions and research approach may not be aligned to my discipline, but this was probably due to being involved with innovative researchers in my education who themselves neither fully embraced nor taught traditional research designs or methodologies.

### **1.3 Aim of the study**

To identify the influence of newspaper representations of mental illness on mental health practitioners.

## 1.4 Questions

- What is known about newspaper reporting on mental illness?
- What case studies are there of media representations of mental illness?
- Could such representations of mental illness influence an experienced practitioner like myself?
- Could such representations impact on the decision making of experienced practitioners (myself and others) who work in the mental health field?
- Could such representations subsequently influence the practitioner's practice?

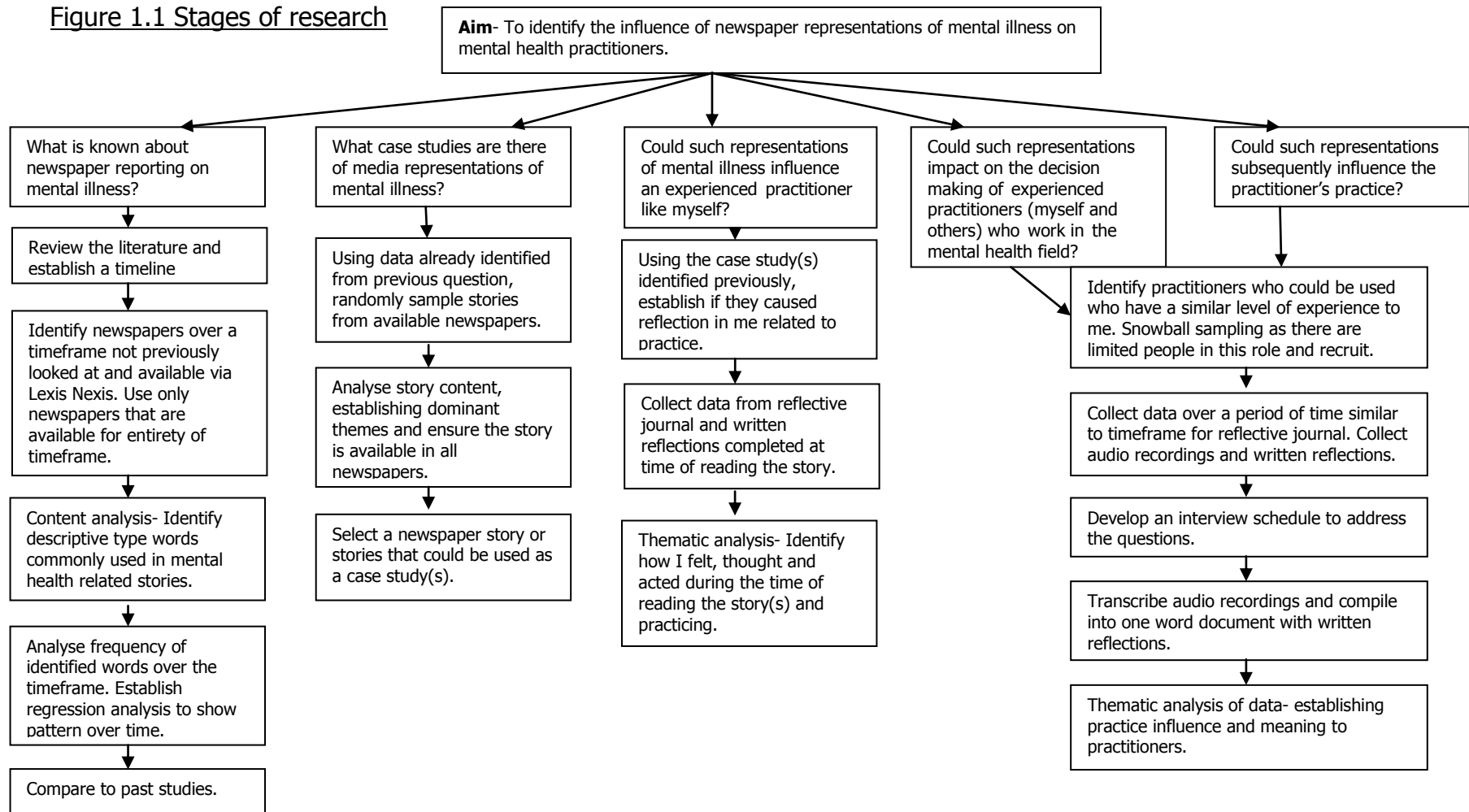
Different methods of inquiry are required to answer these different questions. This resulted in a staged study to ensure all questions were answered appropriately. The stages are represented in Figure 1.1. which outlines the final template for the study. Although it may appear that the methods were pre-determined at the outset of the study, this was not the case. Many of the methods that were used to address the questions were decided upon during the study, i.e. the study adopted an emergent research design (see Overarching methodology section 1.5).

The terms 'case study' and 'media representation' are used interchangeably throughout the thesis. Within this thesis, the term 'case study' is used for a newspaper story involving a mental health theme that participants are to

read and reflect on. The term, case studies, when employed in this way, is commonly used as a part of health care training to identify a practice related issue for further discussion. This presents the opportunity for participants in training to explore the nature of a story and reflect on and identify ways to address emergent problems. 'Media representation' is the term used in the thesis to highlight the way that the media portrays someone or some group of people with health problems.



Figure 1.1 Stages of research



It is important to know and articulate how these stages represent a 'study' *per se* with a research methodology. The emergent design, rather than an *a priori* design will become evident in this thesis.

## **1.5 Overarching Methodology**

As noted earlier, over many years of academic study I have come to understand that my personal view related to research is pragmatic in nature. Guba (1990) argued that this relates to the nature of reality (ontology), the relationship between the researcher and what is known (epistemology) and importantly in this methodology, how I and others gain an understanding about the world in which we live. Balanced with this is the notion of the 'shifting nature' of knowledge (Kuhn as cited in Wendel 2008) and the ever changing environment in which knowledge is developed.

It became clear to me that my understanding about mental health practice and education was based on the answers I derived from the questions I asked about them. It was also evident that when reviewing my approach to previous research studies that I had used the research questions to drive the research study.

I believe that the methodology for this study needed to:

- identify questions related to a practice type dilemma

- address the questions using whatever method was most appropriate and to not be restricted by a rigid paradigm or interpretive process (Denzin and Lincoln 2013)
- be open to adopting a fresh approach to a research study that would be driven by the questions that emerged.

This was not an attempt to abandon the traditional research approaches; rather, I wanted to modify them within an emergent design (see Hesse-Biber and Leavy 2008).

Hesse-Biber and Leavy (2008) argue that methodology aims to bridge the gap between what was known (epistemology) and the ways in which the study explored (method) the research problem. Taking such an approach allowed me to “illuminate something about the social world” (Hesse-Biber and Leavy 2008, p1) that I felt was important.

Addressing the research questions (see page 9) would require a methodology that bridged the knowledge relating to the present reporting on mental health in newspapers and the identification of a case study to represent this. It would also need to establish ways of exploring if the representation influenced an experienced practitioner (me), before exploring the influence on a wider group of experienced practitioners. Finally, finding answers to the research questions would need to use methods of inquiry that addressed the individual questions at all stages of the research process, but not be restricted to one method that solely addressed the aim. The methodology needed to illicit ‘multiple meanings and establish various viewpoints’, as argued by Hesse-Biber and Leavy (2008).

Each of the following chapters (chapters 2, 3 and 4) adopt an independent method that aimed to address specific research question(s). These methods were both qualitative and quantitative. Each element of the inquiry builds on others in order to address the aim of the study, inferring a mixed methods approach. Although the discussion related to mixed methods is taken up again later in this section (see p15), it seems appropriate at this time to briefly discuss this point. The study uses an emergent method approach which mixes methods as required. The study is not a mixed methods approach, since mixed methods requires the explicit integration of the approaches used (Creswell and Tashakkori 2008 p 115). The chapters are presented with key points, a summary and reference to appendices. The appendices are provided as a separate volume to allow the reader to access this material 'alongside' the main text if required or at a later point if this is preferred.

The emergent design initially explores representations of the mentally ill in newspapers, and if they have changed over time. Using the findings from this element a case study was identified and exploration of the experiences of practitioners in mental health identified. This set a research path that was dependent upon what was found, balanced against how best to explore this further. It also enabled me to understand that individuals working in the same environment, and appearing to adhere to similar values and practices can hold complicated and contradictory beliefs about practice and 'things' that influence practice.

Throughout the study, I have remained active as a clinical practitioner, and a university lecturer. This privileged position allowed me to see factors that were influencing practitioners from both an inside (as a practitioner) and outside (as a university lecturer) perspective. Adopting the insider role in exploring something that may influence my work and the work of my colleagues in the clinical area is definitive of practitioner research; "research carried out by practitioners for the purpose of advancing their own practice" (McLeod 1999, p8). Although engaging in practitioner research, I am aware that other academics are less enthusiastic about its scope and influence. Hammersley (1993) has argued that practitioner research often adopts too narrow a focus as it was believed, optimistically, that such research would ultimately influence policy change. Although this may be true for some research studies, awareness of such criticism enabled me to ensure that a fresh approach was adopted to designing a research study that allowed detailed investigation and a presentation from different positions.

An assumption on which this work is founded is that practitioners would evaluate their experiences in practice by identifying thoughts and actions after reading the case study. It is argued that much of a practitioner's practice related knowledge and actions are developed through clinical experience (Titchen and Higgs 2001), and these experiences can shape practice (McNiff 1998). Exploring the thoughts related to practice (stimulated by reading the case study) may enable practitioners to start to make sense of their experiences, and explore the influence on their practice related actions. I have

been unable to find any past research studies involving such experienced mental health practitioners.

Using experienced practitioners as participants enabled an exploration of those with what Fish (1999) describes as a 'discerning eye' (p 195), and the ability for critical inquiry (Macpherson *et al.* 2004; McTaggart 1989). It is anticipated that their level of experience will enable the practitioners to make sense of the story, it's possible influence on their thinking and practice, and that they would be able to articulate this (Fasoli and Ford 2001).

The overall research strategy was inductive in nature; discovering what the influence of newspapers is, rather than testing out any hypothesis. However, participants in the study may have offered (on occasions) deductive comments. This is not uncommon as Brannen (2005) suggested that some qualitative studies may involve inductive and deductive logic and may lead to testing ideas as well as generating them.

This study utilised methods to examine themes in a sequential way. This involved a mixture of methods related to the questions being addressed. At first glance, the methodology may appear to be what Bryman (2001) argued was a 'Multi Method Research' or a 'Mixed Methods' approach. However, the particular staged approach (I wanted in this study) does not fit a standard design for mixed methods (see e.g. Creswell 2003; Tashakkori and Teddlie 2003), as there was going to be a limited amount of integration of the data from the quantitative and qualitative stages. One of the main arguments accepted for categorising a methodology as mixed methods lies in the integration of data:

*Data needs to be integrated into a coherent whole or separate set of coherent wholes (quantitative and qualitative). Data integration leads to an initial data interpretation...* (Onwuegbuzie and Teddlie 2003 pp377-378).

Such interpretation can be in the discussion section in concurrent studies or between the stages of sequential studies. Unfortunately this level of integration is not supported in many studies that are labelled as mixed method (Greene *et al.* 1989). Bryman (2007) found in reviewing the use of mixed methods that many studies (labelled mixed methods) tended not to integrate data in every case, and Teddlie and Tashakkori (2006) inferred that integration was not always completed. To quantify the lack of integration, Bryman (2006) conducted a content analysis of 232 studies that were labelled mixed methods and reported that only 18% integrating their findings. A conclusion derived by Bryman was that the integration was not necessarily planned or intended, however, the main problem with not integrating the information is that the researcher(s) may not be making the best and most use of the data collected, therefore questioning the need to use a non-standardised mixed methods design in the first place.

My conclusion is that researchers may at the outset intend to integrate data and utilise a mixed methods design, but due to the data collected may find that one phase becomes very interesting and the other adds little to the discussion. Others may believe that they are mixed methods researchers, but be uncomfortable analysing and representing disparate data results. They therefore favour one set of data over the other. They may believe that they are mixed methodologists but have an overriding positivistic or constructivist

standpoint. This is not an unusual position for researchers to find themselves in. Researchers often arrive at a difficult position when they find, that to address the research question(s) they feel are important, traditional methods for exploring them do not meet the need (Hesse-Biber and Leavy 2006). Commonly they will use a mixture of quantitative and qualitative measures, but find that the combinations do not fit any recognised design for research. This was the position I found myself in, using emergent methods to address the research questions, and developing a 'hybrid' design that borrowed and adapted existing methods to address the questions (Hesse-Biber and Leavy 2008).

I was comfortable with using a mixture of methods in this research study, and have used mixed methods in the investigation of the way that community mental health nurses assess risk (Murphy 2004) and the continued use of Family Interventions following a training programme (Murphy and Withnell 2013). The difference between the present study and the past ones is that in the past studies there was a level of integration across stages, where the findings of one stage influenced the development of the next. In this study each stage is logical, systematic and understandable. This approach over the course of the stages of research addresses the overarching aim but there is a lack of true integration.

Adopting an emergent or multiple method approach presented me with the opportunity to look at the representations and not be restricted by only one method. Adopting this approach presented me with the opportunity to collect the data in the way that best fitted or 'worked' to address the question(s) and



ultimately the research aim.

In many ways (epistemologically) I reconstructed and analysed the participant's comments in the interviews which will hopefully lead to what Lincoln and Guba (1989) would refer to as a meaningful view of the data. This would give a deeper understanding of their social world by exploring the concepts that emerge in the interviews (Snape and Spencer 2003). This will present the opportunity to identify how different participants understand and derive meaning from the same data, but not, as Crotty (1998) argues, in the same way.

I made a decision to present this thesis with a comprehensive appendix. This means that the thesis will be presented in two volumes. This decision was made to ease the reader through the different parts of the study and not get bogged down with detail that would upset the flow of the unfolding journey. It allows the reader the option of reading the thesis in the way they feel suits them.

A concern I have is that colleagues, reviewers and prospective funders of research will only see the individual elements of this research, treating them as discrete individual studies instead of one whole study. This in my view would downplay the creative use of methodology that this study was utilising. I contest that such beliefs are fostered by funding agencies and academics that prescribe one method and the mastery of such within one study or thesis. It is clear from my own research department and from organisations offering funding that a focus on a specific (often narrow) methodology is often demanded.

# Chapter 2

## 2.1 Introduction

This chapter will explore the way the mentally ill are represented in UK National newspapers and identify the extent and nature of such representations. It uses literature (data) collected from UK National newspapers between Dec 1998 and Nov 2008, aiming to provide a baseline of the representations of mental illness in newspapers that may inform attitudes of readers towards the mentally ill.

Comparing these findings to the existing literature\* is an important element in establishing:

- any changes in the frequency of newspaper reporting related to the mentally ill over the time period of the data collection
- any change in the way newspapers represented the mentally ill, and if so, whether there were any trends within these changes
- any changes and trends discovered in the data, that would enable comparison (including contrast) with previous studies that were concerned with the representations of mental illness in the media.

This stage is needed to justify further investigation and to identify potential case studies that could be used to identify any influences of opinion and practice on mental health practitioners.

\* The data presented in Table 2.1 provides a global overview of media coverage, however, for the purpose of this thesis analysis of newspaper text will focus only on UK examples.

## **2.2 Representations of illness**

It is argued by Pirkis and Francis (2012) that mass media are important in shaping people's knowledge, attitude and behaviour. One example relating to this was reported in a survey of politicians by Rethink (2007) where they found that many politicians reported that they gained much of their knowledge about mental illness from the press.

It is identified in this thesis that the way the media both informs and potentially misinforms people are important factors in constructing understanding. It also becomes clear that the representations of illness and mental illness are not always that positive. The mass media as a term infers a range of differing forms of media, each presenting information and opinions on the world and those that live in it, and this information acting as a representation of the world. With this in mind it was felt prudent to narrow the exploration down to one source of media. This chapter predominantly focuses on newspaper media, but does on occasion refer to other forms of media to exemplify other influences.

Representations commonly involve language and are considered by Hall (2003) to be central to the development of meaning and understanding of society and the culture we live and work in. He suggests that in our society we see representations used in many ways by different agencies to present their view on specific issues for individuals and society to interpret. This can be from people speaking, paintings, posters, books, cinema to social media. I, like many other people, use these representations to generate a view on things of interest or things that I feel may be important to me. A great deal of the stories that

the media produce I accept are not seen by myself. This is probably because I either have no interest in the story or it has no potential impact on my life. Themes that have become of interest, are health related because of family illness, my profession and my experiences.

The way the media depicts things in our social life leads to individuals making decisions about what it all means to them. Although my interest is in representations of mental health, I am aware of studies that explore representations that have been made about a range of social and cultural themes, a sample of these include:

- Gender; gender (Gill 2007), breast cancer (Blanchard *et al.* 2002)
- Health related; change in health behaviour (Wakefield *et al.* 2010) smoking (Smith- Clegg *et al.* 2008)
- Practitioner practice; obesity (Hilton *et al.* 2012)
- Other; police (Cummins, Foley and King 2014; Dowler 2003), politics (Gibson 2009).

It is clear from the literature read that the media, including newspapers, are argued to influence the way we think, feel and behave (Anderson *et al.* 2010, Wartella *et al.* 1998), however, what is important is what it is making us feel and think about. Commonly the theme is related to our behaviour and habits and the unhealthy side of them.

An example of this is obesity and body image involving our health and relationship with food. Hilton *et al.* (2012) explored the forms of representations of obesity in newspapers. They found that the newspapers

linked ill health with obesity and that change was needed in society's approach to it. Interestingly the media differentiated between people who over ate and those that under ate. People who became obese were blamed for their ill health, yet people with anorexia or bulimia were represented as victims (Saguy and Gruys 2010). Over time the frequency of reporting increased and the focus shifted from stigmatising labels to arguing for regulatory change (De Brun *et al* 2012). The key theme was the increasing cost to the health service of the care of those with obesity.

Another example of the study of media representations relates to the theme of teenage smoking. Smith-Clegg *et al.* (2008) highlighted how newspapers kept the negative image of smoking in the public arena. They found that the newspapers indicated the health problems caused and the cost to the individual and society if this did not change. They went on to argue that this approach was an important tool in tackling youth smoking.

Both the examples used demonstrate general themes that we all have either experienced in our own lives or the lives of those we live and work with. Both examples tended to blame the individual, the organisations involved and the culture of acceptance of the products.

Historically, the process of drawing conclusions from media representations, and exploring the influence it has on the reader has been made difficult in many ways.

On investigation it became clear that trying to investigate any links between media messages and decision making of third parties can be challenging and

confusing as one of the main problems with the media "is that it presents us with multiple and contradictory points of view on nearly everything" (Karp 1996, p186). It has to be accepted that the media is only a part of the complicated series of factors that create the perceptions related to mental illness (Pilgrim and Rogers, 1999). However, such perceptions, at the time of starting this study are argued to be affected by the representations that the newspaper presents for the reader to interpret.

The representation of the mentally ill in the media has historically been sensational and selective in the content used. Over fifty years ago Nunnally (1961) in *Popular Conceptions of Mental Health* highlighted how the mentally ill were commonly presented as bad; thus questioning the level of trust that could be placed in them. He went on to argue that the treatment of mental illness was generally seen in a simplistic manner and any presentation of mental illness with exaggerated symptoms. He suggested that '*mental illness usually appears in a context of horror, sin and violence*' (p.233). He identified that where a person was regarded as 'insane' that selected words were used to describe the person and their behaviour (e.g. dangerous; dirty; bad and cold). These words presented a negative image of mental illness and are something that will be explored further in this thesis.

Media representations often present the mentally ill as criminal (Cutcliffe and Hannigan 2001), and as such they are potentially identified as different and less trustworthy than others in society. The development of an association between groups of people who are often seen as outside of society's norms and

criminality is not unusual. Other than the mentally ill, youths (Rendell 1997), indigenous groups and refugees (Simmons and LeCouteur, 2009; Collins *et al.* 2000), are often represented in the media as criminal. The theme of crime has been represented in the media in many studies and most argue that our knowledge of crime is developed from representations made on TV and what is read in the newspapers (Nguyen *et al.*, 2005).

Studies exploring whether crime alone in a representation caused fear in the reader identified varying outcomes. Examples include; the argument that there is no link between the reporting of crime in newspapers and fear created in the reader (Chandee and Ditton 2005), yet others such as Schlesinger, *et al.* (1991) and Williams and Dickinson (1993), argue for a link. This variance may be due to the differing sample of participants, different decades when the studies were completed and the type of crime being reported, but a consistent message is not made about the actual influence of media on fear.

The mentally ill have been seen to be consistently presented as violent (Coverdale *et al.* 2002), and the criminal inference is exemplified by the suggested increased level of personal violence that the mentally ill pose (Phelan and Link 1998). These representations are argued by Thornton and Wahl (1996) to be inherently important in the creation of a negative attitude to the mentally ill person in society and yet they are also viewed as no more criminal or dangerous than the general public (Brennan *et al.*, 2000; Cutcliffe and Hannigan, 2001).

The maintenance of a negative attitude toward the mentally ill may only be temporary. Appleby and Wessley (1988) found that for a period of time following a violent crime involving a suspected mentally ill person that was reported in the press, that the general public became less trusting of the mentally ill. The level of mistrust was found to reduce with an increase in time, and within 6 months the level of mistrust had returned to a level found prior to the violent incident.

Representations of mental illness are presented to us in many different ways; television (Rose 1998), film (Schneider 2003), books and the print media (Philo *et al.* 1996, Wahl 1996). Each form using language to convey meaning. My personal interest is in newspaper media and its representations of mental illness. I have over the many years of practice seen newspapers report on mental health related stories that have involved people I know and with whom I have worked with. Sometimes the stories have been short and what I would call factual. Other times they have been blaming and sensational. Anecdotally, I felt that the most recent stories have been more sensational and blaming, each having limited input from mental health practitioners.

I am proposing that in this thesis the focus should be on mental health representation and the impact this has on practitioners and their decision making. Practitioners are members of the general public and consequently exposed to the same representations as everyone else. A major difference is that the practitioners are not only exposed to the representations but also represented in the stories.



## **2.3 Representations in Newspapers**

A review of newspaper representation of mental health and mental illness was conducted using the SOLAR search engine at the outset of this thesis in 2008. This enabled the search of databases (e.g. AHMED; CINAHL; Medline; ProQuest; SwetsWise) and national library catalogues. The search terms were limited to; newspaper, social representation, mental ill\*, mental health, and the findings are presented in the table below. The aim of this search was to generate an overview of the available research and establish the main findings. A chronological timeline of published studies is presented.

This search looked at data collected between December 1998 and November 2008. Therefore only published studies up to December 2008 are included in this table. The rationale for this is detailed in section 2.6 of the main body of the thesis. The table presents the studies completed up to the time of starting this thesis. The review will act as a timeline of prior studies. Articles published after these dates are presented as Appendix 2.1.

Table 2.1 To show the newspaper portrayal of the mentally ill (key studies)

Authors	Title	Type of Study	Place	Findings
Bengs <i>et al.</i> (2008)	Gendered portraits of depression in Swedish newspapers	Descriptive using qualitative analysis	Sweden	Focused on the way that depression was reported in Swedish daily newspapers. 26 articles were selected and articles involving women were argued to have an emotional presentation whereas with men the presentations were dramatic.
Clement & Foster (2008)	Newspaper reporting on schizophrenia: A content analysis of five national newspapers at two time points	Descriptive using Content Analysis	UK	This study assessed the change in the quality of reporting of schizophrenia in UK national daily newspapers. It compared two specific years; 1996 with 2005.  It looked at five newspapers using the PROQUEST database for articles published in 1996 or 2005. The main search theme was the term 'schizo...' and there were 1196 articles identified. It argued that there was " <i>no significant change in the use of stigmatising descriptors; the non-inclusion of information putting risk of violence into perspective</i> ".

Bilic & Georgaca (2007)	Representations of "mental illness" in Serbian newspapers:  A critical discourse analysis	Discourse analysis to identify framing	Serbia	Identified 165 articles and found that there were generally 3 portrayals of mental illness; 1. People with a mental illness are dangerous, 2. Expert opinion of doctors and health care workers was used for evidence, 3. That many of the mental health problems were related to the socio-political problems in Serbia at the time of the study.
Boke <i>et al.</i> (2007)	Schizophrenia in Turkish newspapers:  Retrospective scanning study	Descriptive, identifying metaphors for mental illness	Turkey	Between January 2001 and May 2006 Boke <i>et al.</i> identified 878 articles using the term schizophrenia (or variants) in 12 Turkish newspapers. One reference to mental illness was found every 2.2 days. The majority of references were negative with about 46% of references using the term schizophrenia metaphorically.
Chopra & Doody (2007a)	Crime rates and local newspaper coverage of schizophrenia	Compared reporting of mental illness in 2 areas; one where there was a high crime rate the	UK	Identified 98 newspaper articles in local newspapers in Nottingham (high crime rate) and Dorset (low crime rate). Looking specifically at the reporting of schizophrenia they found no difference in the portrayal. 36% of the stories had a negative portrayal of schizophrenia, 57% neutral and only 7% positive. From the data collected there were only around 6% of articles that had contributions from people that either had the illness or had experience of caring for someone with schizophrenia.

		other a low crime rate		
Chopra & Doody (2007b)	Schizophrenia, an illness and a Metaphor: analysis of the use of the term 'schizophrenia' in the UK national newspapers	Compared the reporting of schizophrenia and cancer in 6 UK newspapers	UK	Using the Lexis Nexis database they identified the most recent 600 articles that contained the term schizophreni* and 600 articles containing the word cancer. Data was collected between August 2004 and November 2005. Around 11% of articles about schizophrenia used it as a metaphor that described something as split or discordant. There were only around 0.02% use of metaphors for cancer.
Paterson (2007)	A discourse analysis of the construction of mental illness in two UK newspapers from 1985-2000	Discourse analysis to identify frames developed for the mentally ill	UK	Identified 10 frames used to represent the mentally ill in just over 3000 stories in 2 national newspapers. The findings identified that moral judgements were commonly paternalistic towards the mentally ill. They inferred that the mentally ill were people that had been failed by the services offered and that they were victims of such a service.
Whitley & Hickling	Open papers, open minds? Media representations of	Descriptive	Jamaica	Using one national broadsheet for data Whitley & Hickling collected articles from January 2003 to March 2005 related to the closure of mental health units in the country. There were only 21 articles and the

(2007)	psychiatric de-institutionalization in Jamaica			findings were all positive about the changes. They found the stories argued that the closures would benefit the public and the mentally ill alike. The stories on the whole acknowledged that there were concerns about the closures and development of community care and used expert opinion to present supportive arguments for the moves that were happening.
Stuart (2006)	Media Portrayal of Mental Illness and its Treatments: What Effect Does it Have on People with Mental Illness?	Descriptive	UK	Entertainment and news media exaggerate the link between mental illness and dangerousness. This link is argued to affect the chances of recovery and to increase stigma. The research did however identify that the same media may be an important ally in creating debates and challenging stereotypes in the public arena. It argued for a move away from cataloguing the media content and focusing on ways to use the media in a more positive way.
Paterson (2006)	'Newspaper representations of mental illness and the impact of the reporting of 'events'	Descriptive using Discourse Analysis	UK	The exploration of the resultant reporting related to two individuals that were killed by different mentally ill people. The study in part used the Lexis Nexis Database and examines the relationship between the (reporting of the) deaths and changes to the English social policy agenda. It presents a challenge to researchers interested in social

	on social policy: the 'framing' of Isabel Schwarz and Jonathan Zito'			policy and media representations to examine the link with agency. He went onto argue that there may be a causal link between changes in policy and the media representations.
Foster (2006)	'Media presentation of the mental health bill and representations of mental health problems'	Descriptive using Focus Groups	UK	Utilising a social constructivist approach the study initially utilised the Lexis Nexis database to identify articles related to the new Mental Health Act. This was followed by focus groups that identified that social groups constructed meanings from what they were presented with. It is suggested that the media may be presenting a milder view of mental illness, especially in the broadsheets. There does remain however a link between mental illness and violence but also that the mentally ill person who is passive is in need of help from capable others.
Dietrich <i>et al.</i> (2006)	Influence of newspaper reporting on adolescents: attitudes towards people with mental	Experimental	Germany	The focus of the Dietrich <i>et al.</i> study was on the impact that the newspaper reporting had on attitudes to mental illness. The study explored the notion that violent crimes are committed by people that have a mental illness. The findings linked negative media portrayal and the generation of negative attitudes towards the mentally ill. It found that students who read the negative portrayals were more likely

	illness.			to have a negative attitude to mental illness than students that read positive stories. The descriptions elicited for the mentally ill implicated the mentally ill as violent or dangerous.
Corrigan <i>et al.</i> (2005)	Newspaper stories as measures of structural stigma.	Descriptive	USA	Corrigan <i>et al.</i> categorised over 3000 articles published in 70 major US newspapers. Thematically coded data into four groups; 1. Dangerousness, 2. Blame, 3. Treatment and 4. Recovery. All data was collected in a 6 week period in 2002.  39% of articles detailed an account of dangerousness or violence involving mental illness. A positive outcome was that around 20% of all articles argued for more resources for mental health services.
Farrow & O'Brien (2005)	Discourse analysis of newspaper coverage of the 2001/2002 Canterbury, New Zealand mental health nurses' strike	Discourse analysis related to a nurse's strike	New Zealand	There were 3 main emergent themes in the newspaper reporting. The main one was that the mentally ill are dangerous and that the actions of the nurses to go on strike were putting the public at risk. Other themes related to the mentally ill being victims who suffered because of the strike and that the nurses were avaricious and lazy. Few comments were reported from nurses on the strike.
Harper (2005)	'Media, madness and misrepresentation:	Descriptive review of	UK	The exploration of anti stigma discourse was used to generate focus for future research into stigma and mental illness. The author argues

	critical reflections on anti-stigma discourse'	literature		that content analysis of media coverage needs to be properly controlled and needs to look at the real world evidence. He suggests that there is a need to seek out the narrative, generic and formal complexities of the problem. The problem with verisimilitude as a representation of acceptability is identified. He goes onto argue that the medias representation remains problematic but the general public's acceptance of specific headlines are not necessarily an endorsement of the newspaper view.
Crisp <i>et al.</i> (2004)	'The College's Anti-stigma campaign 1998-2003: A shortened version of the concluding report'	Descriptive	UK	The Royal College of Psychiatry had identified in 1998 that the level of stigma attached to mental illness was in need of addressing. It set up an advertising campaign that used leaflets, short films and a variety of information mediums such as tube cards. The targets of the information were doctors, children, the general public, the media and the workplace. Crisp <i>et al.</i> established that a survey should be conducted every five years to establish movement to reduce stigma. In the initial five years (1998-2003) they found little movement on their criteria and acknowledge that change would be slow.
Stark <i>et al.</i> (2004)	'Newspaper coverage of a violent assault	Experimental	UK	Following an assault by a mentally ill man in the remote Highlands of Scotland the investigators looked at how the story was represented in



	by a mentally ill person'			<p>the local, regional and national press and telephone interviewed some of the journalists involved.</p> <p>The coverage was related to the assault and the subsequent court case. Although an inquiry had been heard only '3 out of 10' of the recommendations related to the case were reported on. The authors argue that the media coverage may have an effect on people's perception of mental illness. Further that the NHS should be more active in providing information related to such cases.</p>
Stout <i>et al.</i> (2004)	Images of Mental Illness in the Media: Identifying the Gaps in the Research	Descriptive-Longitudinal	USA	<p>This article was a summary of a decade of research aimed at exploring the role that the media had in 'fostering or reducing mental illness stigma'. Stout <i>et al</i>/found a gap in the relationship between media images and mental illness stigma. Stout <i>et al</i>/also found that content analysis identified that mental illness is consistently misrepresented through exaggerations and misinformation. It was concluded that the link between media images and individuals perceptions is still theoretical. More research is needed to identify media exposure and impact. Exactness in the terminology defining mental illness is needed.</p>
Francis <i>et al.</i>	The Portrayal of Mental Health and	Descriptive using quality	Australia	<p>This study aimed to depict how mental illness was portrayed in Australian non-fiction media. Part of the study collected 4351</p>

(2004)	Illness in Australian Non-fiction Media.	rating on a random sample		<p>newspaper items. They found that in contrast to a lot of other research that the media depiction of mental illness was good and didn't overly focus on crime, accounting for only 8.3% of the articles. The highest proportion of articles related to policy/ programme initiatives (34.2%). They did accept that Australian coverage of mental illness was probably higher than in other countries. They did advise that more research was needed in relation to the quality of the reporting and if this mediated the impact of perception on mental illness.</p>
Huang & Priebe (2003).	Media Coverage of Mental Health Care in UK, USA and Australia	Descriptive-Comparative Analysis	UK, Australia and USA	<p>Focused on the content and the tone of UK print media articles published in the UK and then compared this to randomly selected articles from the USA and Australia. The newspapers used were broadsheets and the study was completed via the internet by randomly selecting articles in a 4 month period in one specific year. They identified 118 articles about mental health care.</p> <p>The results were that the UK articles were more negative than the others, but where positive articles did exist they were generally related to reports about things such as research findings. A factor that should not be overlooked was that all 3 countries reporting on mental health</p>

				issues were predominantly negative.
Rowe <i>et al.</i> (2003)	'About a year before the breakdown I was having symptoms': Sadness, pathology and the Australian newspaper media	Discourse analysis, descriptive	Australia	Rowe <i>et al.</i> identified 49 articles that discussed depression in a range of local and state newspapers in Western Australia during 2000. It identified a move from linking violence and caution, which had been identified in past studies, to arguing for protection for the sufferer of depression. The discourse was argued to normalise the illness due to it being out of the control of the sufferer and being a biomedical complaint.
Stuart (2003)	Stigma and the daily news: Evaluation of a newspaper intervention	Descriptive	Canada	The focus of the study identified the way the media reported stories, in one Canadian newspaper, related to mental illness, more specifically schizophrenia before and after an anti-stigma campaign related to mental illness was published. Both before and after the campaign it identified that there were more positive than negative stories related to mental illness and schizophrenia, positive stories increased by 33%. However, negative stories related to mental illness also increased by 25% and in the case of schizophrenia by 46%.
Coverdale <i>et al.</i> (2002)	Depictions of Mental Health in Print Media: A Prospective	Descriptive using Content	New Zealand	Coverdale <i>et al.</i> evaluated the reporting in national newspapers in a single month of stories that had mental illness or mental health aspects. They found 600 stories, the majority (n=562) were editorials.

	National Sample.	Analysis		The stories were examined for positive or negative depiction. Coverdale <i>et al</i> /found negative focuses or relationship to dangerousness and the mentally ill in (n=368) nearly 61% of the stories. It was also found that criminality (n=284, 47%) was clearly linked and that the focus on positive depiction only featured in (n=168) about 27% of the articles. Coverdale <i>et al</i> /concluded that negative depictions of mental health in the press were predominating and that this was stigmatizing.
Olstead (2002)	Contesting the text: Canadian media depictions of the conflation of mental illness and criminality	Discourse analysis using textual strategies	Canada	Using 2 major Canadian newspapers the study examined 195 articles in order to identify how popular images of mental illness were created. The study identified 3 main depictions, the most common being a criminal, where a level of differentiation between the mentally ill person and the public was used. The second most common depiction was a class based illness and finally a passive patient. A hierarchy of mental illnesses was discussed in relation to how far from 'normal' the mentally ill are.
Angermeyer & Schulze (2001)	The Stereotype of Schizophrenia and Its Impact on Discrimination Against People With	Descriptive-grouped articles into	Germany	Used only BILD-Zeitung tabloid newspaper. Collected articles in a 9 month time period. Mental illness articles accounted for less than 1% of all articles published. The most common article including a

	Schizophrenia: Results From a Representative Survey in Germany	themes.		reference to mental illness involved crime (about 50% of the sample).
Foster (2001)	Unification and differentiation: a study of the social representation of mental illness.	Descriptive using Focus Groups and Content Analysis	UK	Two methods of data collection were used in this study; focus groups (using lay people) and content analysis using an FTProfile search of media in two newspapers (Daily Mirror and The Daily Telegraph) over a time period of January 1996 to January 1998. Although some representation was found that the mentally ill were seen as unpredictable and possibly violent, differentiation was found in relation to the level of mental illness. This was possibly maintained as an attempt to justify that the 'self' was mentally normal and identifying the mentally ill (other) as unpredictable and different to the healthy self.
Ward (1997)	Making Headlines: mental Health and the National Press	Descriptive using Content Analysis	UK	The author was provided with press cuttings from national UK newspapers for the whole of 1996. Each article was assessed and given a rating from +10 to -10 for favourability to mental illness. The study looked at four key messages and generated value judgements about how the press addressed the messages. What was found was that stories related to criminality and violence were given more newspaper attention than other positive mental illness stories. There

				were stigmatising reports but the newspapers did present mental illness a part of life and the broadsheets suggested that mentally ill people led meaningful lives.
Allen & Nairn (1997)	Media depiction of mental illness: an analysis of the use of Dangerousness	Descriptive using discourse analysis	New Zealand	Focusing on dangerousness and using one New Zealand newspaper Allen & Nairn analysed 12 stories and identified that the mentally ill were negatively portrayed. Allen & Nairn also identified that stories inferred a danger and this may pose a level of threat to the community.
Hazelton (1997)	Reporting mental health: a discourse analysis of mental health-related news in two Australian newspapers	Discourse analysis, descriptive	Australia	Using 2 newspapers (one national and one local) in 1994, a manual search identified 490 articles related to mental illness. The most common feature in the articles was related to problems with the mentally ill (a negative theme of risk, disorder and crisis). Less common were articles related to treatment and human rights.
Thornton & Wahl (1996)	Impact of a newspaper article on attitudes toward mental illness	Prospective	USA	3 groups of participants were given a stigmatising article related to mental illness, with or without explanatory information. A control group was given what were regarded as neutral stories. The findings (following the use of the CAMI- Community Attitude toward the Mentally Ill) identified that participants given the stigmatised story

				were less accepting of the mentally ill in their community. They also perceived them as dangerous.
Wahl (1996)	Schizophrenia in the News	Descriptive using Qualitative Analysis	USA	Wahl looked at the use of the diagnosis 'schizophrenia' in newspapers. He used 101 stories from three newspapers in a five year time frame from different areas of the country. All articles had high circulation numbers. Wahl found that one particular newspaper (New York Times) had about 62% of all the articles identified. The highest amount of content was not uniform and focused on drug treatment and prevalence. Wahl found that only 14% of the articles focused on violence and crime. These findings were something the author found 'unexpected'.
Grierson & Scott (1995)	Comparison of attitudes of editors and public towards mental illness	Survey exploring attitudes of people towards the mentally ill	USA	Surveyed 590 people from Alabama and compared the results from similar work conducted with 60 newspaper editors. Found that editors reported less stigmatising language about the mentally ill and were not as likely to view the mentally ill as unpredictable and dangerous than the general public. However, when it came to the question of employing the mentally ill, the editors were less likely to consider offering work.

Meagher <i>et al.</i> (1995)	The coverage of psychiatry in the Irish print media	Descriptive	Ireland	Meagher <i>et al.</i> identified 380 articles discussing psychiatry published in a 6 month period in Irish newspapers. This averaged around one story per newspaper per day. The most common theme reported in relation to mental health discussed violence and dangerousness, towards self or others. Tabloid coverage was more likely to be sensational in its claims than broad sheets, and less likely to provide a mental health professional opinion.
Williams & Taylor (1995)	Mental illness: Media perpetuation of stigma	Content analysis	USA	Identified 83 articles in major newspapers in the USA between February 1991 and January 1993. Established 2 main themes that were discussed; the closure of mental health hospitals and the representation of the mentally ill as dangerous and violent.
Lupton (1993)	Back to Bedlam? Chelmsford and the press	Discourse analysis, descriptive	Australia	Identified 79 articles retrieved from December 1990 to January 1991, published in metropolitan newspapers concerning a specific treatment (deep sleep therapy) for mental illness offered at a private hospital. The mentally ill were presented as vulnerable and weak and the facilities as archaic with oppressive treatment. The newspapers challenged the medical professions treatment and promoted the human rights of the mentally ill.



Day & Page (1986)	Portrayal of Mental Illness in Canadian Newspapers.	Descriptive using Content Analysis	Canada	Day & Page randomly select 103 newspaper articles to identify the way the story was presented. Day & Page coded the articles as, positive, negative or neutral. The content of the articles were viewed from the perspective of tone and ideology. The results found that only about 18% of the articles tone was positive. Day & Page identified that about 74% of the articles adopted a non-traditional ideology to mental health. There were a large number of negative comments attached to front page stories and generally the editorials were where positive comments were found.
Matas <i>et al.</i> (1986)	Mental illness and the media: part II. Content analysis of press coverage of mental health topics	Descriptive using Content Analysis	Canada	Matas <i>et al</i> /adopted a retrospective view of newspaper reporting over a 20 year period. The study aimed to identify if the way that mental health was reported had changed. Matas <i>et al</i> /used 90 articles that were randomly selected from 2 newspapers and utilized a rating tool that focused on; articles attitude, quality of journalism, scientific accuracy and tone. Matas <i>et al</i> /concluded that the quality of journalism had improved but overall little change had actually occurred in reference to mental illness. Importantly Matas <i>et al</i> / felt that there was accuracy around crime reporting.
Morrison &	The effect of	Cross	USA	This article detailed 3 surveys exploring the awareness of a mental

Libow (1977)	newspaper publicity on a mental health center's community visibility	sectional survey		health care centre in New York. The 3 surveys were carried out just before, just after and 6 weeks after a publicity campaign in local newspapers that aimed to publicise the centre and its work with the mentally ill. It found that awareness increased following the newspaper campaign and remained consistent after 6 weeks.
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Much of the literature in Table 2.1 utilised data that had been collected many years before being published. Other literature adopted differing ways and time frames of collecting data which made comparison difficult.

Much of the literature described the mentally ill in a negative way and this led to the linking of mental illness with negative images (Coverdale 2002; Day and Page 1986; Hazelton 1997). The impact of the language and negative images used was discussed in some of the literature and was related to the potential influence on the general public (see Stout *et al.* 2004; Thornton and Wahl 1996).

A great deal of the literature focussed on the way the media influences the way that the general public view mental illness (Francis *et al.* 2004; Harper 2005; Stuart 2003) and there is evidence of negative media representation related to mental illness and its treatment influencing public beliefs (Farrow and O'Brien 2005; Lupton 1993; Olstead 2002). Cutcliffe and Hannigan (2001) suggested that there is rarely a week in the year where mental illness is not mentioned in the media. In fact, the frequency of mental health stories appearing in the media is reported to be much greater than this. It was argued that a mental health related story appeared in newspapers between one story every 2.2 days (Boke *et al.* 2007), and every day in every newspaper (Meagher *et al.* 1995). These representations often relate mental illness to violence and criminality (Bilic and Georgaca 2007; Corrigan *et al.* 2005; Dietrich *et al.* 2006; Meagher *et al.* 1995; Philo *et al.* 1996; Wahl, 1997; Ward, 1997; Williams and Taylor 1995).

Social stigma was seen as a consequence of negative media representations. Foster (2001) suggested that the social stigma and the creation of 'differentness' may well be a way that the general public reinforce their own normality. By distancing themselves from the actions of some mentally ill people, they suggest that certain crimes could only be committed by a mentally ill person. The media provides the information for the public to make their understandings (Francis *et al.* 2004) and the Government provide the laws to reinforce the 'differentness' (Patterson 1996; Rethink 2007). It is therefore understandable that incidents of violence committed by the mentally ill person and reported in the newspapers can lead to changes in attitude to the mentally ill. This includes an increase in social distance given to the mentally ill (Angermeyer and Matschinger 1996) and fear (Thornton and Wahl 1996) created by accepting that the mentally ill are living in the community (Link *et al.* 1999).

The newspaper media has, over time, presented representations that reinforced the image that the mentally ill are dangerous (Bilic and Georganca 2002; Corrigan *et al.* 2005; Dietrich *et al.* 2006; Grierson and Scott 1995; Meagher *et al.* 1995; Allen and Nairn 1997; Williams and Taylor 1995) and criminal (Angermeyer and Schulze 2001). Newspapers have also inferred that the care provided for this group is often poor and archaic (Lupton 1993) and that changes to the way the mentally ill are cared for and monitored under specific laws (Cutcliffe and Hannigan 2001; Paterson 2006).

Representations in newspapers occasionally explored the way mental illness affects different people (gender differences, Bengs *et al.* 2008) and what could potentially cause the illness (Bilic and Georganca 2002). An increase in public awareness developed by anti-stigma campaigns had a limited impact on public perceptions of mental illness (Crisp *et al.* 2004), but increased publicity led to an awareness of services and what they did (Morrison and Libow 1977). The main problem was that the newspaper media maintained a fairly consistent negative representation towards mental health related stories (Clement and Foster 2008).

Public misperception of mental illness created by the media was reported in the work of Corrigan and Watson (2002), who argued that it created prejudice and discrimination. A similar influence has been reported on politicians (Francis *et al.* 2004; Rethink 2007; see brief discussion \* at the foot of the page) and professionals (Wahl 1997) that read the stories.

\* A level of influence was contextualised in a survey of politicians by Rethink (2007) where they found that many politicians reported that they gained much of their knowledge about mental illness from the press. The consequence of a politician becoming mentally ill and this being reported in the press was explored by the Royal College of Psychiatrists (2008). The Royal College of Psychiatrists found that politicians believed that if such an event was publicised then their parliamentary career would be finished. Legislation does exist that if a politician was sectioned for 6 months under the Mental Health Act (Department of Health 1983) then under Section 141 of the Mental Health Act (Department of Health 1983) they should be removed from Parliament. Such a law is one that is now being amended but few of the people spoken to in the Rethink study, felt it would improve their career chances.

The UK Press Complaints Committee (PCC) issued two series of guidance notes to editors on the reporting of stories related to the mentally ill (1997, 2006).

The committee stated:

*The new Note reminds Editors of the importance of terminology in reporting, pointing out that people are detained under the Mental Health Act 1983 in "hospitals" not "prisons", and are "patients" not "prisoners". Furthermore, the terms "jail", "cell" and "cage" are inaccurate under the terms of the Act when referring to the accommodation of patients (PCC 2006).*

*Editors are also reminded that epithets such as "nutter" and "schizo" may raise a breach of Clause 12 (Discrimination) of the Code of Practice in discriminating against individuals who are mentally ill, or Clause 1 (Accuracy), and points out such language can result in both distress to patients as well as contributing to a climate of public fear or rejection (PCC 2006).*

It was argued the level of stigma (related to mental illness) may be reducing in the content of press reports (Foster 2006), but the fear of the consequence of being identified as mentally ill remained high (Rethink 2007). The emergent attitude of the reader was affected by what they read in the media (Dietrich *et al.* 2004) and that attempts to reduce the stigma and impact on the reader, was having limited positive influence (Crisp *et al.* 2004). This lack of a positive impact was identified by Stuart (2006) in that people with mental illness could be potentially affected by the content of media reports. She went on to suggest that the reporting had a potentially negative influence on their recovery.

Mental illness is reported in the media in all countries of the world, and there were some differences identified. Huange and Priebe (2003) found that the UK press was more negative than the Australian and the USA press, but argued that they

were all still too negative. The frequency of mental health related stories being published was found to be less in Australia and New Zealand than the UK. The less frequent reporting was argued to be possibly due to the development of research committees and media monitoring organisations in these countries (Pirkis *et al.* 2001). Such organisations do exist in the UK (Glasgow Media Group and Royal College of Psychiatry) but for unknown reasons they seem to have less of an influence on the media. What was clear was that the frequency of stories reduced slightly in Australia and New Zealand as did the negative content (Francis *et al.* 2004). This was further argued to be have been influenced by a lower homicide rate by mentally ill people in these countries (Simpson *et al.* 2004).

The data presented explored the representations of mental illness in the newspapers up to the end of the data collection period. Since then there have been several new studies published, including my own, on representations of mental illness in newspaper media. For an overview of these studies and a brief discussion see Appendix 2.1 and 2.2. However, at the time of this current study there was a gap in such literature.

## **2.4 Summary of representations**

The reporting of stories involving people with mental illness in the media appears to be growing in frequency despite the relatively static presentation of mental illness in the general population. The media represent everyday events and social life to the public and a story involving people with mental illness is one of the

many social realities the media portrays. For people who would like to understand what mental illness is, definitions are readily available: *any of various disorders (whatever they may be) in which a person's thoughts, emotions, or behaviour are so abnormal as to cause suffering to himself, herself, or other people* (Collins 2003). Here the definition avoids the technical detail related to the disorder and emphasis is placed upon the abnormality having a causal relationship to suffering for somebody. Therefore the inference is that mental illness is not a good thing to have.

The outcome of this abnormality is commonly discussed in the literature as causing separation from society and 'otherness' (see Jodelet 1992). The mentally ill person is portrayed as 'different' (Foster 2001) and somehow outside of the societal norms therefore inferring that their thoughts, emotions and behaviours are also different to everyone else's.

Representations in the media seem to maintain this view. These representations are important as they are often seen as a source of health information and knowledge for the general public and health care providers (Hofstetter *et al.* 1992). The power of the media over health related themes is endorsed by Johnson and Meischke (1994) and Philo (1999), who argue that the media set the agenda of health related discussion in relation to society.

Having so far found that whilst there is a tradition of exploring media representations of mental health and mental illness, at the time the study was



conceived, there was a need for a current review of the extent and nature of the coverage of mental health/ mental illness in the press. More detailed questions developed to explore the nature and coverage of mental health/ mental illness in the press further. These questions were:

- a) Whether there is (still) a significant (in the lay sense) coverage of mental health/illness issues in the press?
- b) If so, whether this coverage is in nature and extent (still) negative in its tone?

Additionally:

- c) The identification of an appropriate case to use, in a case study of the influence of media representations on mental health practitioners, could be achieved by such a review.

If these steps of exploration were not undertaken, then the necessity for embarking on a study of the influence of media representations on mental health practitioners would be questionable and the means for undertaking the study uncertain.

## 2.5 Methods

The questions will be explored in the following way:

- a) Whether there is (still) a significant (in the lay sense) coverage of mental health /illness issues in the press?

This will be explored in the content analysis section (2.6) and will identify the frequency of newspaper reporting on mental illness and mental health for a range of newspapers. It will also identify keywords used in the range of newspaper stories (linked with the mental health theme of the story) and quantitatively report, on the way the words were used across each newspaper. This exploration will use content analysis to systematically detail the evolving representations.

- b) If so, whether this coverage is in nature and extent (still) negative in its tone?

This nature of coverage will be explored in the identification of themes (section 2.9), will identify a sample of stories from the available newspapers and examine the emergent themes and the single most prominent theme. Content analysis will be used to systematically detail the emergent representations and thematic analysis of the data to generate a series of qualitative themes recurring in the data.

Having addressed these questions it would then seem reasonable to identify specific examples (stories) from the press for further investigation in terms of their potential impact on mental health practice. This would present the opportunity to:

- c) Identify an appropriate case to use in a case study of the influence of media representations on mental health practitioners.

This final aspect will be addressed in the next chapter and will result in the identification of a potential case study and explore its utility in identifying any influence the case study has on mental health practitioners. It will utilise thematic analysis and present self-reflection on the identified case study. Justification for the selection of a potential case will also be presented.

## **2.6 Content Analysis**

In order to quantitatively measure the media representations a method commonly adopted in researching media representations, namely content analysis (see; Clement and Foster 2008; Coverdale *et al.* 2002; Day and Page 1986 and Ward 1997) was used. Adopting such a method presented the opportunity to compare the emergent findings with previous literature.

Content analysis has a specific tradition in academia dating back to the 1950s. It has been described as a technique for making inferences through objective and systematic analysis of the specifics of any message (Holsti, 1969, p. 14), and to be "*one of the most important research techniques in the social sciences ... understanding data not as a collection of physical events but as symbolic phenomena*" (Krippendorff, 1980, p. 7). These symbolic phenomena can be words, statements, actions, etc, that can be viewed as having a relationship, commonly,

to an event (Berelson 1952). This relationship infers that there is an outcome created by the assumed meaning to the words used and that these can be interpreted. Interpretation can take various forms but the form adopted in this thesis was aligned with Berelson's (1952) definition; "*content analysis is a research technique for the objective, systematic, and quantitative description of the manifest content of communication*"(p18).

Although content analysis is widely used for representation studies, there are some major criticisms of it; for example Rugg and Petre (2007) argue that content analysis "*is often a laborious way of gathering evidence to support what you expected to find in the first place*"Rugg and Petre (2007 p161). This criticism is seen as an historical one and something challenged by Krippendorff (1980). Krippendorff (1980) acknowledged that many had this view, and that it was equated to reading a newspaper in more depth, but he refuted this. He argued that content analysis had developed its own methodology that was rigorous and valid. Ultimately, Krippendorff (1980) argued that there had been a shift from content analysis being understood as the meaning of what was said, to a process that enables analysis of the symbolic relationship to what was said. Weber (1990) argued that this process needed to exclusively identify 'meanings' and 'connotations' of what was said, and be reliable across individuals coding the data. This coding would lead to some categorisation that in the future would need to be tightened up to maintain the exclusivity.

Krippendorff (1980) argued that any content analysis needed to have a clear set of data to be analysed, defined from a specific population. The context that the data are drawn from and the boundaries for analysis need to be established, culminating in a conclusive outcome. In this thesis, the data was drawn from the Lexis Nexis (Butterworth) database that stores a vast range of newspaper data.

I was aware of previous reviews of media and newspaper representations of mental illness that had been conducted in the UK. A study that focused on representations of mental illness that used data from a range of UK newspapers was that of Ward (1997). Since this study, other research has been completed in the UK around representations of mental illness, but most have had a limited focus on:

- Crime (Chopra and Doody 2007a)
- Schizophrenia (Chopra and Doody 2007b; Clement and Foster 2008)
- Mental Health Act (Foster 2006)
- Policy (Paterson 2006; Stark *et al.* 2004)
- Stigma (Crisp *et al.* 2004; Harper 2005; Stuart 2003)

For this study there was a need to explore all available newspaper stories over a long period of time. Therefore, acknowledging that the last such study in the UK using these criteria was the Ward (1997) study, I felt it prudent to commence data collection after that time. This presented the opportunity to compare findings and identify current representations and recent case studies published in the

newspapers since the last review. It was anticipated that due to the lengthy time period and the range of newspapers available, a narrowing of the search would be needed; thus the search was limited to UK national newspapers. Whilst limiting the data collection by narrowing the breadth of data in my research, it was felt that the results would still provide sufficient information for analysis (Sandelowski and Barroso, 2003) and would add coherence to the sample. This is also in line with Krippendorff's (1980) and Berelson's (1952) suggestions regarding content analysis. Both argued that potentially available materials should be reduced so that what is left remains large enough to contain enough information but small enough for sufficiently in-depth analysis. It was also intended to avoid utilising only a small sample of media items, a limitation (according to Francis *et al.* 2001) of previous studies exploring representations of mental illness in the news media.

To adhere to Krippendorff's (1980) guidance for a clear set of data to be analysed, all UK national newspapers were included in the initial search since the completion of the Ward (1997) study. However, full access to articles was only freely available for four of these papers over this time period; The Times, The Guardian, The Mail and The Telegraph. The main focus on freely available articles was to keep the research costs low and to also utilise articles that could still be accessed by any person wishing to do so without having to pay or join a membership scheme.

The relevant newspaper articles were identified by searching for a reference to mental illness or mental health in the text and which were catalogued. Articles that were included were feature articles, personal commentaries in the form of life

stories and letters to the newspaper. Articles excluded were a) repeat/edited articles on the same day, or b) reviews of film, books or TV documentaries. The catalogued articles were then examined by the author using a “scanning approach”, involving a process of searching, collecting and evaluating information as advocated by Etzioni (1986). This process was subject to scrutiny by two members of my PhD supervising team.

The articles were collected from the four newspapers that represented a range of political views, although it excluded The Sun whose circulation at the time was the highest in the UK. This exclusion was based on a pragmatic decision, as comprehensive material for The Sun was not available for the total time frame of the study. It was felt, however, that the four papers selected provided a good range of available popular newspapers, and so it was decided that their use as the sampling frame was appropriate.

The duration and dates for data inclusion (10 years) were arrived at:

- To focus on a period of time that had not previously been examined through this form of investigation;
- To use data up to the commencement of the study; and
- To utilise an arbitrary but nevertheless sufficiently lengthy period of time to establish any trends in the way those with mental illness were represented in newspapers.

Given the above information, the 10-year time frame decided upon was from

December 1998 to November 2008. This time period also coincided with a time when, in the UK, newspapers had access to press guidance on terms and terminology appropriate to coverage of those with a mental illness (see p 46). Coincidentally, the time at which the study was undertaken was found to be timely as shortly after the initial data collection the Telegraph's owners withdrew (temporarily) data for 1988–2000, along with unspecified stories by some freelance authors up to the end of the data collection period. This latter factor would make the replication of this study difficult, if it were to include data for The Telegraph.

## **2.7 Content analysis data analysis**

The four newspapers were initially analysed using descriptive data analysis with data being inputted into Microsoft Excel. The analysis allowed the comparison of the number of articles related to mental health each newspaper published and the percentage of such publication across the sample. Regression analysis was also carried out to determine if there was a significant linear trend in the reporting of mental illness in these newspapers. This presented the opportunity to see if there was any increase or decrease in the number of stories related to mental illness and also to establish if this may be a pro rata relationship with comparative increases and decreases in the number of stories presented in each newspaper.

The sample of stories further presented the opportunity to identify the terms of reference made about the mentally ill people in the stories sampled. Such references were explored by identifying the frequency of descriptive words used in



reference to the mentally ill in the stories and a comparison of the frequencies of such words used in each newspaper.

## **2.8 Frequency and trends of reporting in four UK national newspapers**

Initially, as noted previously, this part of the thesis aimed to address the question; is there (still) a significant (in the lay sense) coverage of mental health /mental illness issues in the press?

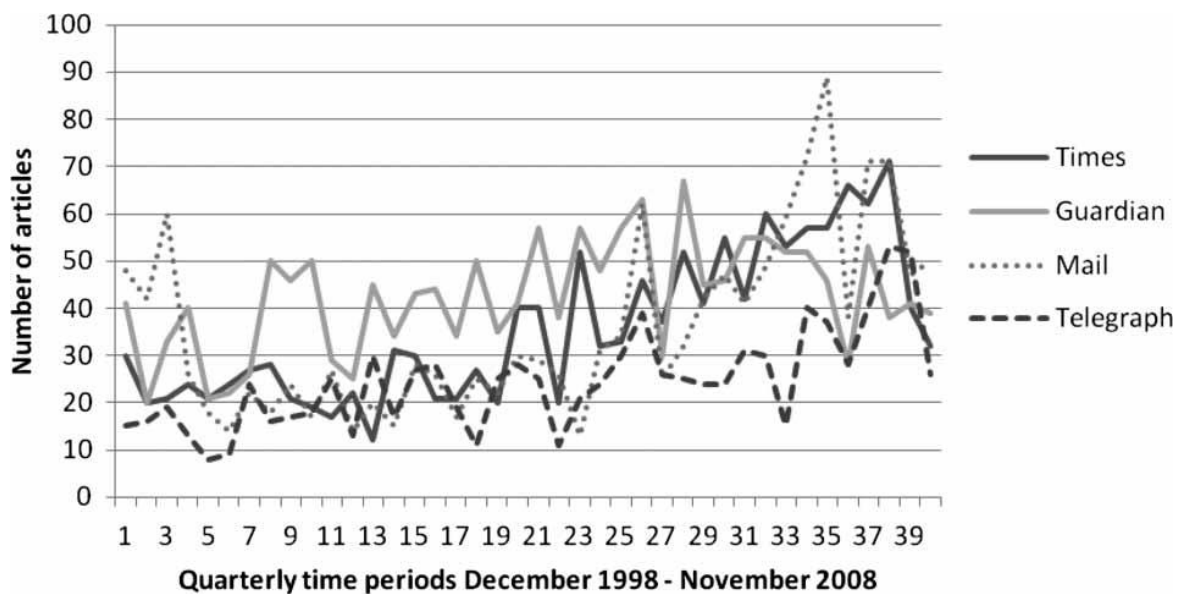
As highlighted in the content analysis section, there were problems in accessing comprehensive information for the time period for all UK national newspapers, therefore there was a decision made to limit this to the four papers where consistent and full data was available at the time. The use of the four newspapers was still felt to offer a fair representation of the available UK newspapers.

The number of articles (n = 5537) published across the four UK national newspapers, which included the phrase “mental illness” and or “mental health” from December 1998 to November 2008, is presented in Table 2.2. The distribution of stories over the same period is shown in Figure 2.1.

Table 2.2 The number of articles published by four UK national newspapers which included the phrase 'mental illness' and or 'mental health' from December 1998 to November 2008.

Newspaper	Times	Guardian	Mail	Telegraph	All papers
Number of articles	1421	1713	1425	978	5537
% of coverage across the 4 newspapers	25.7	30.9	25.7	17.7	100

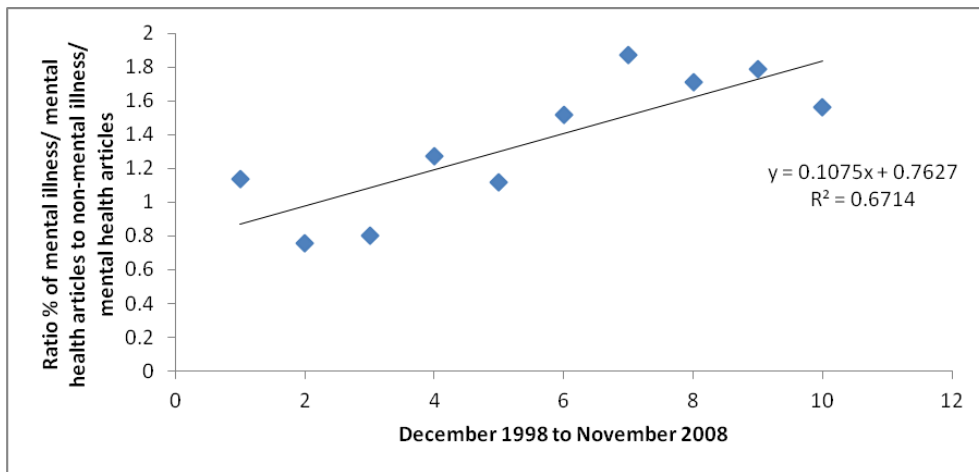
Figure 2.1 To show the frequency of reporting by each newspaper on the terms of "mental illness" and or "mental health" from December 1998 to November 2008.



From Figure 2.1, it can be seen that there was a gradual increase in reports related to mental illness, across all four newspapers over 10 years. All the newspapers are seen to present similar starting points and finishing points in relation to each other; thus the relative frequency of reporting was similar across

time and across the newspapers. A comparison of the data trends, trend lines and  $R^2$  values for each newspaper, along with a discussion why an  $R^2$  value for each newspaper was calculated, is presented as Appendix 2.3. The  $R^2$  values for each newspaper show a range of scores, from which it can be deduced that any increase in the number of stories identified over time could be due to chance. The level of chance for an increase in the number of stories in each newspaper was; The Guardian- 80.6%; The Times- 61.3%; The Telegraph- 48.3%; The Mail- 33.4%.

Figure 2.2 Ratio of all newspapers' reporting of all articles December 1998 – November 2008.



Using the data collected for Figure 2.2, it was further calculated that proportionally the number of mental health and or mental illness articles increased from 0.88% of the total articles at the start of the data collection to 1.84% at the end. This equates to a doubling of the number of articles relating to mental health and or

mental illness from the start of the data collection period (1998), to the end of the data collection period (2008). The number of articles that each newspaper published that included the term mental health and or mental illness varied. The Guardian published the greatest number of articles, with 30.9% (n = 1713) of the coverage of the total sample, followed by The Mail and The Times (both with 25.7% of total coverage, n = 1425 and 1421, respectively) with The Telegraph publishing the least, proportionally, with 17.7% of coverage (n = 978).

To address the identification of keywords and their use across the newspapers, further quantitative analysis was necessary. A sample of mental health/ mental illness related articles were identified in the Lexis Nexis database and these were read to identify commonly used words to describe the mentally ill in the story. These words were then searched for in the Lexis Nexis database for all four newspapers in the time frame of the study. The most frequently used terms are presented in Table 2.3.

Table 2.3 The frequency of terms of reference made about the mentally ill in the four newspapers.

Newspaper	All	The Times (Ti)		The Guardian (G)		The Mail (M)		The Telegraph (Te)	
Number of articles	5537	1421		1713		1425		978	
Terms identified		Number (use per article %)	use across all papers (%)	Number (use per article %)	use across all papers (%)	Number (use per article %)	use across all papers (%)	Number (use per article %)	use across all papers (%)
Drugs	1752	416 (29.3)	23.7	563 (32.8)	32.1	570 (39.7)	32.5	203 (33.6)	11.6
Violence/ Violent	1,147	324 (22.8)	28.2	343 (20.0)	29.9	356 (24.8)	31.0	124 (20.5)	10.8
Protection	333	108 (7.6)	32.4	107 (6.2)	32.1	85 (5.9)	25.5	33 (5.5)	10.0
Schizophrenic	284	99 (7.0)	34.9	109 (6.3)	38.3	192 (13.4)	67.6	57 (9.4)	20.0
Aggressive	200	53 (3.7)	26.5	56 (3.3)	28.0	70 (4.8)	35	21 (3.5)	10.5
Addict	179	39 (2.8)	21.8	48 (2.8)	26.8	72 (5.0)	40.2	20 (3.3)	11.2
Psycho	63	16 (1.1)	25.4	32 (1.9)	50.8	12 (0.8)	19.0	3 (0.5)	4.8
Deranged	59	12 (0.8)	20.3	13 (0.8)	22.0	29 (2.0)	49.2	5 (0.8)	8.5
Schizo	22	0 (0.0)	0	15 (0.9)	68.2	2 (0.1)	9.1	5 (0.8)	22.7

The most frequently used terms in the stories were drugs (reliant on, and or, in need of prescribed medication, or use of illicit drugs), violence (commonly either past violence or perceived threat), protection (in relation the general public) and schizophrenic (as a diagnostic label). To demonstrate the range of the use of terms across newspapers, using the example of drugs: the term drugs was used in

no fewer than 29.3% of all the sampled articles in The Times; this figure rose to 32.8% of such articles in The Guardian, 33.6% in The Telegraph and 39.7% in The Mail. The number of derogatory or pejorative terms were evident in the sampled stories; the terms schizo, psycho or deranged were used, although in less than 2% of the entire sample.

When the data for each newspaper was compared to the rest of the data collected for all the newspapers, no statistical difference, using  $p=0.05$  as a guide for significance (Field 2013), was found across the time of the study or across each of the newspapers. The Fisher Exact Test was used in each test and a score of  $p<0.2$  was found.

## **2.9 Qualitative identification of themes**

So far, the frequency and use of some words (commonly used) in newspaper reporting generally on mental health/ mental illness have been quantitatively presented. To explore the nature of the reporting in greater depth, qualitative analysis of fewer reports was necessary. It was therefore decided to randomly sample the available newspapers and sample three articles from each (randomisation of data is briefly discussed\* at the foot of next page). These were then read and read again to unearth the themes of each of the stories (Bazeley 2013). The themes were then sorted and coded.

To explore the nature of the representations used in the media it was decided to look at how specific stories had been themed. This provided the opportunity to establish the way practitioners may potentially understand what the story means to them (which is important for the next stage of the thesis) and also further identify the way in which the most frequently used terms of reference found earlier were used.

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\* The stories for each newspaper were numbered as they were generated by the Lexis Nexis database. This presented a range of numbered stories for each newspaper. A random number generator was used to identify random numbers for each of the ranges of numbered stories for each newspaper. This meant that each newspaper would be represented in the sample, and stories identified would be randomly identified. The random number generator used was Numberator (2012).

Thematic analysis was used by Clement and Foster (2008) on the UK newspaper reporting of schizophrenia and in newspapers in the USA by Corrigan *et al* (2005) whilst exploring the theme of structural stigma.

Themes are used in this study to identify the recurrent use of language in the story. Thematic categories were identified in each story and the most dominant theme presented. The main difficulty in identifying a dominant theme in a story may lie with the opinion of the person reading the stories. To manage this, as each story may present a variety of themes for the reader to identify, the dominant theme will be identified as the one that is discussed in most detail. This may include reference to it in the headline and other emergent themes being cited as a consequence of the dominant theme (Thomas 2006). The identification of themes are used to establish the meaning of the story to the practitioners and later for them to identify any influence it may play on their practice.

## **2.10 Sampled stories**

A sample of stories was looked at for each newspaper used in the content analysis section. This was done to present a narrative account of the way the stories were presented and to identify the developing themes and then the dominant theme that the writer was presenting in the story. This approach was adopted to allow brief excerpts from the newspapers to be used to highlight emerging themes and to then indicate how the language ultimately was used to get the message of the story over. Details of the sampled stories are presented as Appendix 2.4.



The synopsis of the newspaper stories identified the emergence of dominant themes related to the mentally ill being dangerous, and the mental health services being unable to protect the public. Recurrent themes were also identified, threaded into the stories leading to the development of the dominant theme. Recurrent themes that were identified included; the use of an emotive or stigmatising headline, the lack of trust the public should place on the mentally ill because they are dangerous, that mental health services are unable to protect the public from the mentally ill, that the mental health services are not to be trusted, and that having a mental illness only has a negative outcome.

Hazelton (1997) presented an approach to analysis of newspapers that focused on the identification of the dominant argument that the story was making. When applied to newspaper stories about the mentally ill, it was found that the newspaper used predictable narratives in the story writing that differentiated the mentally ill from others in society. The representations were often emphasising the risky nature of the mentally ill and crisis related and bizarre themes. In the sampled stories I identified, risk was seen in the use of an emotive or stigmatising headline. Examples from the sample are; "*crazed killer*"(G1), "*random attacks to emulate horror film character*"(G2), "*Paranoid killer was released*"(Ti2) and "*Nutters, axe-wielding, schizophrenic, dangerous mental patient*"(Te1).

The sensational headlines catch the eye of the reader, potentially tempting the curiosity of the reader to continue reading. Themes further present the argument

that the mentally ill are dangerous. The importance of the theme is developed by drawing attention to the person in the story being mentally ill, in hospital and being unsupervised. For example; one article stated that a "...*patient who disappeared while on day release was yesterday being questioned over the fatal stabbing*" (Ti3). The patient's level of dangerousness is presented with "*compelling statistics*" (Ti1) and linked with negative terms when making reference to the mentally ill. Examples include; *suffering* (G2), *excluded* (G1), *another attack* (Ti3), *serious risk* (Te2). Further emphasis is given to the suggestion that mental illness never goes away, inferring a hidden risk and the need "*to protect the public from another such episode*" (G3).

The level of danger that the mentally ill posed was frequently presented; even in stories where danger was not a theme. The theme of medication was linked with a reduced level of dangerousness from the mentally ill, "*those on medication... seem very pleasant and not at all threatening*" (Te1), but as a result of taking medication the mentally ill were presented as being "*vulnerable*" (Te3).

Although described as vulnerable, a level of differentness was used in the story (Te3) to present the mentally ill as being secretive with an unknown potential. Emphasis of normality of the victim is exemplified by; describing the person killed as, working and married with two children, "*going about ... everyday activities*" (M1).

Inference is made that the lack of supervision may play a part in the outcome of violent incidents involving the mentally ill. This lack of supervision is developed in

the theme related to the mental health services being to blame for the threat that the mentally ill pose, due to staff practice. The services are presented as relying more *“on agency carers, less trained and inexperienced”* (G1) than experienced qualified staff to provide supervision and support. The service is also presented in the Times (Ti2) as protecting the mental health service user’s human rights above any other persons, and this included the general public.

The practice of mental health care is presented as secretive (Ti2), utilising poor practice (Te2) and hiding behind mental health law (Te3 and Ti2). An example of this is presented in a story that explored the way that services attempted to protect the public through the use of legal powers rather than health care in order to *“protect the public from another such episode...[the mentally ill man]...was sectioned under the Mental Health Act”* (G3). In this case the person ‘being sectioned’ was allowed to become so ill that he had to be forcibly taken into care. The newspapers present a picture of the mental health services having no strategy for treatment other than imposing legal powers.

A further point is that mental health care staff may know of dangers posed by the mentally ill, but do nothing about it. For example, one article wrote that *“it is understood she originally made the ‘confession’ two years ago while seeing a psychiatrist as an outpatient”* (M3). When discharging someone from the service, the mentally ill person *“was given no care plan, no risk assessment or systematic monitoring of his medication and no out-patient follow-up”* (Te2). In this case the person left hospital and killed a stranger.

A belief that mental health practitioners have of a 'lack of interest' in patients emerged in the stories, and this 'lack of interest' was directly linked with mental health services being less inquisitive and organised. This 'lack of interest' was also argued to directly affect the mental health services ability to protect the public from the mentally ill. The Times reported that the services did not know (or get to know) their patients well enough and that these people were potentially violent. The Times also suggested that the staff "*failed time and again. Sometimes they go against the wishes of the medical officers and frequently take no heed of what patient's families say*" (Ti2). The culmination of both themes led to the suggestion that mental health services could not "*protect individual patients and the public if a person poses a serious risk to themselves or to others*" (Te3).

The final theme that emerged was related to people that developed a mental illness and the inevitable negative outcome. The newspapers highlighted the outcome for patients who were getting care under the present system as negative, stating that mental illness "*destroys lives*" (Te1). The Mail suggests that mental illness causes the "*loss of family, career and normal relationships*" (M2) and the place in 'normal' society'. The themes identified led to patients and families having trouble accessing help, for example, the "*family... tried to get him psychiatric help*" (G2), and the belief that the mental health service was not interested in caring for the mentally ill, employing an unskilled workforce, and providing a service that used fractured policies and procedures.

## **2.11 Understanding gained from reading the stories in each newspaper**

All readers will read and interpret what is written in their own way. This interpretation is influenced by their knowledge and experiences. As a mental health practitioner I have read the stories with a knowledge and level of experience of mental health services and the laws used in mental health care. Understanding that the stories sampled were negatively orientated by use of negative themes is saddening to me, but I initially felt in no way influenced my opinion of the content.

On reflection, after taking time to consider the reading of the stories, I identified thoughts related to my experiences in mental health care. Although not discussed in this section, I am aware that the stories have put me in a position where I am reflecting on my own practice and actions, and may continue to in the future. This realisation led to the development of an interest in more reflective, autoethnographic type approach to analysis.

## **2.12 Discussion related to newspaper representations**

This stage of the thesis highlighted the predominantly negative representations made by the newspapers towards the mentally ill. Whilst reading the stories I did feel somewhat angered by the tone and content, and also identified that sometime after reading these representations I became aware that my thoughts and feelings

were potentially being influenced in some way. At this point in time I was unaware of the exact nature of the influence, merely that I had found myself thinking more about the stories than I expected and had occasional thoughts related to practice at such times.

At the time of writing this thesis I identified no literature that had explored the influence of representations on mental health practitioners practice, but was aware that Thornton and Wahl (1996) had argued that newspaper representations influenced the public's attitude to mental illness, and Wahl (1997) inferred a potential influence on 'professionals' attitude. There were many criticisms of the media representations (see Clement and Foster 2008; Harper 2005; Stuart 2006), each arguing the negativity of the representation.

The criticisms had been acknowledged by the Press Complaints Committee (PCC) and they issued guidelines for editors when reporting mental health related stories (PCC 1997; PCC 2006). It is unclear from my findings what the influence may have been on the nature and extent of any changes in relation to newspapers representing the mentally ill. It was found that stigmatising terms (schizo, psycho and deranged) were infrequently used over the time period of the data collection in most of the newspapers, and that these were terms that the PCC had asked not to be used when describing the mentally ill. It can only be concluded that the newspapers have not fully adhered to the guidance provided by the PCC and that the media's own self-regulation remains faulty. Such faults continue to be highlighted in campaigns by mental health charities ('Attitudes to Mental Illness'

2012; 'Time to Change', MIND and Rethink Mental Illness 2013), arguing that the language used in newspapers remains stigmatising to the mentally ill.

At the time of starting this thesis, there were no published studies that explored the frequency of mental health related stories that had been published in newspapers over a long period of time. However, Goulden *et al* (2011) have since published a review of media representations in UK newspapers 1992-2008.

Goulden *et al*'s (2011) study was both detailed and echoed many of the findings that were developing in my own study; reporting that stigmatising language was evident in the newspaper stories, and the stories discussing schizophrenia were often negative.

Goulden *et al* (2011) sampled data from 3 time frames between 1992 and 2008 (whilst in this thesis all available stories included were used across the 10 years), and then compared the data from the 3 time frames. They identified that data collected later was less stigmatising than earlier data collected. Goulden *et al* (2011) argued that a limitation in their study was the lack of qualitative type exploration and comparison of stories, which this thesis aimed to conduct with the exploration of themes of newspaper reporting related to mental illness and later on the reporting of a single case study- that of Peter Bryan.

Other studies have tended to look at the frequency of mental health related themes, such as care, treatment, work, etc, and the description of the language used in newspapers (see Pirkis *et al*. 2001; Pirkis and Francis 2012). Some

compared the frequency of specific key words and terms in a sample of articles where a theme of mental illness was found (see Ward 1997; Coverdale *et al.* 2002). The findings of this thesis indicated that the frequency of reporting of mental illness related stories had increased over time, with the identification of a relatively strong relationship between the number of stories being published and time ( $R^2= 0.6714$ ). The frequency of reporting of mental health related stories compared to all other stories in the newspapers had increased from 0.88% to 1.84% over the ten year period. It also identified the trends for reporting and some of the key words and terms used to describe the mentally ill in these newspapers. A relatively strong linear relationship was demonstrated between the increase of the number of stories being published across all newspapers and time. The increase in the number and frequency of newspaper stories related to mental illness may, in part, be due to the development of the Department of Health legislation occurring during the time of the study's data collection, such as the development and implementation of a National Service Framework for Mental Health (Department of Health 1999) and the controversial amendments to the Mental Health Act (Department of Health 2007). These two specific pieces of legislation brought mental illness into the public eye, firstly by emphasising that a reduction in 'risk' is a standard that needs to be achieved by mental health services, and secondly by making the reporting of deaths involving a mentally ill person an annual reportable event. This included the development of an inquiry team and reporting as the 'The National Confidential Inquiry into Suicide and



Homicide by People with Mental Illness', which was first published in 1999. The inquiry team had aims to provide annual figures on suicide and homicide involving someone known to have a mental illness, and to update services about the risk factors related to the mentally ill who were accessing their service (Healthcare Quality Improvement Partnership 2013). Prior to the publishing of this information there was little awareness within the public domain of the rates of suicide and homicide committed by the mentally ill. Even following the killing of Jonathon Zito by Christopher Clunis in 1992 risks associated with the mentally ill had been seen to be caused by poor judgement on the part of psychiatric services (Morgan 2007) yet it was also seen as an isolated and rare incident. The publication of detailed data related to the number of deaths occurring, I contend, started a trend of reporting that only lead to a heightening fear of the dangerousness of the mentally ill regardless of the actual number of deaths.

The amendments to the Mental Health Act (Department of Health 2007) followed a long and drawn out process where, for the first time, mental illness legislation was debated in the public eye. Themes of risk and changes to established human rights (both for the mentally ill and the general public) underpinned much of the reporting but kept the focus of mental illness in the press for several years. A compromised version of the Act was eventually passed by Parliament in 2007. However, during the process of getting the Act to Parliament, there was a continued increased awareness of mental health related information, much of which was used in the linking of mental illness and homicide in newspapers.

When looking at the trends that emerged in the newspaper representations, the findings infer that some terms such as 'violence' and 'drugs' were regularly used in the reporting of mental illness within the time period. Such reporting in some way highlighted that the mentally ill were potentially different to the general public. The negative representations added to the existing differentiation discussed by Foster (2001), with further emphasis as to differentness through the use of diagnostic terms, such as 'schizophrenic', as descriptors for people who commit violent crime and a need for 'protection' from people with a mental illness. Foster (2001) went on to describe how her analysis of the findings suggested that there was an attempt to identify 'self' as normal (in the reader) and attribute something to the mentally ill so as to make them different to them. In this thesis the use of a story that uses differentiating terms could be used to further qualitatively explore the influence on a reader's opinion of mental illness and the mentally ill, and establish if it had any influence on their actions.

Many of the representations infer a high level of risk to the general public from the mentally ill. The risk is detailed by Taylor and Gunn (1999), who argued that the odds of someone being killed by a mentally ill person would be similar to the odds of someone winning the national lottery. The level of risk was contextualised in that there were 61 cases of reported homicides carried out by a mentally ill patient on a stranger out of a total of 5189 reported homicides in the UK between 1997–2005 (National Patient Safety Agency, 2009). This is not to say that the mentally ill

do not pose any risks, as Silver (2006) notes in a comprehensive narrative review of the literature

*"Although most people with major mental disorder do not engage in violence, the likelihood of committing violence is greater for people with a major mental disorder than for those without"*(Silver, 2006, p. 685).

The argument that the mentally ill are dangerous is further confused by the presence of potentially co-morbid conditions (Douglas *et al.* 2009) that confound attempts to come to some simple linking of mental illness and violence.

The reporting of violence in the same story as mental illness was clearly a focus of past studies and something that emerged in this one. Reference to violence involving the mentally ill was identified in around half the limited sample of stories used by Ward (1997) and about four times more frequently than any other term in a study by Philo *et al.* (1996). In this thesis it was established that 'violence' was used in around 21% of stories involving a mental health reference. Compared to the other studies cited here, this appears to be a reduction in the frequency of the use of the term violence in mental health related stories. The stories were however, still considered to be stigmatising.

Each of the terms used in Table 2.3 is a potentially stigmatising term, and in this stage of the thesis each has been identified and has been quantitatively analysed. The linking of the terms identified and causal reactions is not explored, however, it

is evident in some earlier studies (see Angermeyer and Matschinger 1996; Appleby and Wessley 1988) there was following the publication of stories involving mental illness and violence, an increased social distance caused and a less inclusive public attitude toward the mentally ill. These studies however, made no attempt to explore influence on actions and only identified what people potentially felt toward the mentally ill. There was no study that used available data to examine the potential causal relationship between a term and an action. This thesis aims to utilise the understanding that stigmatising newspaper stories evoke feelings in people, and in later chapters it will explore the feelings that a case study related to mental illness creates in practitioners. These feelings will be explored in more depth than in the studies highlighted (Angermeyer and Matschinger 1996; Appleby and Wessley 1988), and any possible practice influences after reading the story will be examined.

My analysis of the newspapers sampled in this time frame identified that the terms presented in Table 2.3 not only highlight the 'differentness' of the mentally ill but also potentially incite fear, stigma and stereotyping through the use of derogatory language. The prevalence of mental illness in the general public is around one in four, 23% (Health and Social Care Information Centre, HSCIC 2009), with only a small percentage of those people presenting any danger to themselves or others (Appleby *et al.* 2012). The findings in this thesis and past studies (see Pirkis *et al.* 2012) has suggested that newspapers present mental illness as rare, but partly that those experiencing it are dangerous. The suggestion of dangerousness by use

of certain terms in a story is something that this thesis will explore further when identifying a case study for practitioner reflection.

A term identified in the findings of this thesis frequently linked to mental illness (drugs) had not been identified in other studies related to newspapers and mental illness and this warrants further discussion. Drugs are often referred to in the sampled newspapers as being illicit, misused or not taken. Newspapers commonly linked prescribed drugs with illicit drugs in the same story. Although this is not explored in any depth in this thesis, there is a suggestion in the stories sampled that if the mentally ill took their drugs correctly or avoided illegal drugs then their illness would not be problematic. None of the stories sampled presented any scientific or expert evidence to support their inferences, yet evidence does exist in relation to relapse, caused by misuse of drugs (Mitchell and Selmes 2007), and that many mentally ill people are becoming more violent due to taking illicit drugs (Hodgin *et al.* 2007; Swartz *et al.* 1998; Volavka and Citrome 2008).

There is an argument presented that if the mentally ill were unwilling to take their drugs, then they should be made to do so (Kemshall 2001; Stanley and Manthorpe 2004). This argument simplifies a complex question related to human rights and self-determination. Compulsion by mental health staff can only occur if the person has a lack of capacity or is detained under specific sections of the Mental Health Act (Department of Health 2005, Department of Health 2007).

The way that the mentally ill are represented in newspapers is dependent on the editors of newspapers. The editors ultimately determine the type of story they want to publish and the choice of words used. The editors that make such decisions would argue that they are driven by news values and by what they feel will appeal to their readers. The findings suggest that the editors are continuing to give a great deal of negative attention to the mentally ill, possibly in search of a sensational story. Such an approach has led to the British press being regarded as one of the "most unprincipled press in the world because they don't let the truth get in the way of the story" (Lacey 2009, p43).

Generally mental illness, along with some other illnesses (e.g. obesity), represented in the media, is presented as being under the control of the person experiencing the illness. This level of control is presented as the person making a choice to be ill. Stories and representations using the theme of choice in illness are increasingly being used in newspapers (De Brun *et al.* 2012). This choice however, is presented alongside criticisms of the options that health services offer. HIV/AIDS and its spread in society (Martin *et al.* 2013), and representations of teenage girls as weak and vulnerable (Mazzarella and Pecora 2007) have been publicised in the press, with blame being pointed at health failings by the service providers as well as failings by the individuals experiencing the problems. It has been argued that such negative press coverage is influencing societal views and policy makers (Martin *et al.* 2013; Paterson 2006). Negative media reports appear to be inferring that the person in the story is different to others in society, and that their

behaviour is in need of control. Each person whose behaviour is suggested to be in need of control is represented as a burden to the community in which they live.

The media's use of derogatory language suggests that people with a mental illness are a burden and are probably unable to positively contribute to society (Wahl 2001). Occasionally the media does provide a positive representation of mental illness that aims to shape knowledge (Batchelor *et al.* 2004). However, these positive representations are often harmful as they contain inaccuracies that hinder education and understanding (Edney 2004).

The findings in this chapter identify that the use of specific terms, such as violence, and schizophrenia, could be viewed as stigmatising and have historically influenced opinion on the mentally ill (Clement and Foster 2008; Philo *et al* 1996; Wahl 1996). The findings of this stage of the study have also identified a new stigmatising term (drugs) and found that it may well be used more frequently in stories related to mental illness than other terms. The term protection is also a relatively new stigmatising word used in the stories related to mental illness, and this is a term that singularly identifies the threat from the mentally ill to the general public. Although there is limited evidence from past studies as to influence on action caused by stigmatising terms, I did find that my thoughts were influenced, and acknowledge that if my thoughts are influenced then so may my actions. A concern that I identified on developing this understanding relates to the risks associated with such potential thinking, on practice. The risks may be related to clinical decisions but also the way I manage junior colleagues and the advice I

may offer. Reviewing previous studies, none have taken this focus of the study forward or explored the influence that newspaper stories about the mentally ill may have on actions of the people that care for them.

### **2.13 Key Points**

- There is an increase in the number and frequency of newspaper stories related to mental illness published in the time frame of the study, 1998-2008.
- There were specific terms often used to represent the mentally ill in all UK national newspapers that could be viewed as stigmatising.
- Mental illness and some other specific illnesses (where it may be thought that the person had control over the illness) are frequently represented negatively in newspaper stories.
- The use of the term 'drugs' in mental health related stories was the most common term linked to mental illness in the sampled stories.
- The terms identified, had been found to influence general public opinion in past studies, and the same terms continue to be used (in similar frequencies) in this sample of stories.
- When read, the stories left me with recurrent thoughts about the stories and concern as to the influence they may have on my actions and those of other practitioners.



# Chapter 3

## 3.1 Introduction

This chapter builds on the findings from chapter 2 which can be summarised by the headings:

- little overall change occurred over time to the negativity of articles in relation to the representations of mental illness.
- the style used in newspaper stories to describe the mentally ill was sensational, 'eye catching', and caused some uncomfortable personal reflections.
- reading the representations lead to me think about the way I felt and the influence the representations may have on me and others.

Within this chapter an investigation into my initial personal thoughts and feelings caused by reading a case study will be explored. The investigation will use an autoethnographic type approach which will "seek to describe and systematically analyse personal experience in order to understand cultural experience" (Ellis 2011, p1). Using reflection critically will develop a deeper understanding of practice and the practitioner (Fook *et al.* 2011), and involve self-analysis of lived experiences (Zaner 2004), initially from myself and later in the thesis from a group of practitioners. The outcome of this analysis will help to establish the impact of the case study and if it has potential for further investigation with other practitioners.

### **3.2 Identification of potential newspaper stories**

It was asked (p53), that there was a need to c) Identify an appropriate case to use in a case study of the influence of media representations on mental health practitioners. To address this point, it was decided that any case study should have been reported in all the available newspapers including those in the media review. This decision was made to allow practitioners (in the next stage of the thesis) the opportunity to read the case study, in the newspaper that they would commonly read, as each may have a different preference. This would reduce any potential bias that a practitioner may have towards a particular newspaper and allow for a more 'naturalistic' approach.

Getting the practitioners to focus on reading a particular newspaper story and establishing the understanding and knowledge created from their own values and reasoning is quite naturalistic in nature. This is not an attempt to identify 'truths' or 'causal relationships', rather it is an attempt to understand their personal perspective on the story and the influence they feel it may have.

I was aware that reading newspaper stories had created some feelings and thoughts in me, but I was unclear regarding the reflections generated of their influence. I decided to test out a story on myself and establish the thoughts and personal understandings related to practice.

It seemed prudent to select a story from those already read (Appendix 2.4). The Lexis Nexis database was used to search all newspapers. Unfortunately, not all the stories were published in all the newspapers. At this stage it seemed reasonable to

re-look at this data collected and establish any patterns of reporting which had not been identified in the previous chapter. However, I identified that the individual stories which involved a named mentally ill person that had committed a violent crime were more likely to be reported in all four newspapers.

The Lexis Nexis database was searched again, using the original dates established in chapter 2. The search terms; mental health, mental illness, violence, crime were used to limit the results. The resultant list was then scanned for a named person. Only stories with a named person were included. An alphabetical list is presented as Appendix 3.1. Each of these stories was checked to ensure that it had been reported in each newspaper. Of these, seven were represented in all the available newspapers; each featured at various times but most commonly at the time of any court case and the publication of a tribunal report. A brief synopsis of each of the seven stories is presented below in alphabetical order:

- Michael Abram- in 1999 attacked George Harrison in his home. Tribunal October 2001.
- John Barrett- Stabbed and killed a stranger Denis Finnegan in 2004. Tribunal November 2006.
- Peter Bryan- Referred to as a 'Cannibal', killed and ate part of Brian Cherry in 2004. Then whilst under the care of mental health inpatient forensic services, killed Richard Loudwell. Tribunal one June 2009 and joint inquiry with Richard Loudwell September 2009.
- Barry George – alleged to have killed Jill Dando 1999. No tribunal. Acquitted

2008.

- Daniel Gonzalez- Convicted of murdering Marie Harding, Kevin Molloy, Derek Robinson and Jean Robinson, and for the attempted murders of Peter King and Koumis Constantinou in 2004. Tribunal January 2009. Committed suicide August 2007.
- Anthony Hardy- Nicknamed the 'Camden Ripper' by newspapers in 2003. The murders (n=3) were found to be unrelated to his ongoing mental illness. Tribunal September 2005.
- Stephen Soans-Wade- Pushed Christophe Duclos under a train in 2003. Tribunal September 2006.

Each of these stories was identified as possible case studies. As only one case study was needed, a decision to select the most recently reported story to have a court case and tribunal seemed a reasonable way to select from those identified. At this stage, a potential case study was identified but it was necessary to establish if the case study had potential for causing the reader to reflect. This was conducted by the use of myself in the study by completing a series of reflections and accessing my personal reflective journal.

### **3.3 Methods for self-reflection**

The method for this self-reflective stage of the thesis, as alluded to in the introduction, was autoethnographic, yet pragmatic in nature. An autoethnographic

approach is “a personalised account that draws upon the experience of the author/researcher for the purposes of extending sociological understanding” (Sparkes 2000, p21). In this stage of the thesis the aim was to identify thoughts, feelings and actions following the reading of the case study. By using newspapers and a reflective journal for data, I attempted to arrive at an awareness of the experience of personal practice influenced by reading the case study (extended discussions exploring personal decision making are attached as Appendices 3.2, 3.3 and 3.4).

Using a newspaper story to stimulate reflection on clinical practice in mental health care has, to my knowledge, had no previous research conducted relating to its influence on experienced mental health practitioners. Ortlipp (2008) used a reflective journal in her self-reflections related to the use of such journals in research studies. She found that the use of a reflective journal made her question personal assumptions and identify evidence that supported the justification for the research method used to address the research questions. Ortlipp (2008) also argued that the journal helped to identify personal developments linked to her identity as a researcher.

As in any study a need for ethics approval is necessary and this was gained following the approval of the study by Manchester Metropolitan University (see Appendix 3.5). Care, was needed in anonymising others in any contribution from my reflective journal. The debate regarding self anonymisation (Wall 2008) was considered, however, I decided that this was not warranted and I accepted that

the comments made were accurate depictions of my thoughts and experiences. The identification of personal thoughts might cause some anxiety in some writers as “personal stories indulge our culture’s perverse curiosity about the private, peeking in on damaged selves” (Ellis and Bochner, 2000, p. 749), but I am comfortable with this. Most importantly the reflections will help in the telling of a story stimulated by a newspaper story and attempt to let the reader understand and feel part of the story (Ellis 1999). The reflection may include honest expressions of emotion, whilst identifying meaning from my experiences.

The methodological approach draws on both reflective research approaches as advocated by Ortlipp (2008) and Sparkes (2000) and on autoethnographic approaches as advocated by Ellis (1999), Ellis and Bochner (2000) and Wall (2008). Such a methodological choice was made for the pragmatic reasons of identifying practical solutions to contemporary problems (James 1907) experienced by practitioners in their clinical work.

### **3.4 Case study**

The Peter Bryan story in all available newspapers was printed out. The print outs included newspapers that were not used for the analysis in chapter 2 (questions a and b). The newspapers used were; The Guardian, The Telegraph, The Mail, The Times, The Sun, The Mirror, The Independent and The Express. The Peter Bryan story was published in each newspaper on 16<sup>th</sup> March 2006.

The newspaper stories were all to be read and reflections were to be written on initial feelings and thoughts that came to mind. A review of my reflective journal over the time of starting to read about Peter Bryan was also to be read at the end of an arbitrary time frame of one month. Excerpts from the reflective journal were to be retrieved and added to the reflective comments written after reading the Peter Bryan newspaper stories. The data was then pooled and presented as a text document for thematic analysis. An approach whereby initial thoughts and reflections were recorded, then from the reflective journal, more considered thoughts and reflections were identified. The information identified was chronologically ordered into a text document as it was thought to present an opportunity to identify potential influences (in thinking, feelings and actions) that may have happened.

### **3.5 Themes emergent from the reflective journal and Peter Bryan stories**

The chronologically ordered text document, as described in section 3.4 was constructed following reading the transcripts of the reflective journal and written reflections I had made on each of the stories reporting the Peter Bryan case. I then used Miles and Huberman's (1994) guidance to organise and start the identification of themes by coding and inserting memos.

Passages of text were read and each had notes and memos added that started to identify thoughts and understanding established from the reading of the text. Once the text had been read and notes added, a code was made for that passage of text that reflected my understanding of what the text was about. This approach was used for all the text and once it had all been coded, similar coded text was grouped. This collection of coded text was then reread and reinterpreted. The reinterpreted text was then relabelled with a theme that I felt best described the content and context of the coded text.

These themes were reviewed with my PhD supervisory team and the process and establishment of codes and themes examined. After this review, the series of themes that had been agreed upon were developed further by adding passages of text and my understanding around that text.

The themes that emerged from the text; defensiveness, personal practice, blame and the influence of what has been written are now discussed in more depth:

### **3.5.1 Defensiveness**

One of the first things I noticed was a numbing sensation from reading such a story, swiftly followed by outrage. This outrage formed of a defensive reaction that focused on all the negative things I had read. There appeared little structure to my reflections, as the initial thoughts were impulsive, and what was understood



altered in an attempt to make sense of the reports and the various emotions that were emerging.

*Do they really think we would just allow someone who was dangerous to walk around without supervision? This really hurts! The fact that he was able to fool us is one thing but then to be criticized for doing what we thought was right is another thing completely. We attempt to provide the least restrictive environment for someone who is ill, having made a fair assessment of that individual's mental state. It is a really difficult job to assess someone who masks symptoms. It makes you wonder if they think we read people's minds, or have some magic diagnostic machine.*

I noted a comment that I had inserted sometime after this reflection that remarked on the process of reading such stories.

*I found it deeply upsetting but I had to read on. It felt like one of those books you pick up and cannot put down but feel uncomfortable with, but can dismiss it as fantasy as it is a novel. This was not. This was like a story I read a short time before looking at the Peter Bryan reporting. The William Styron book, *Darkness Visible*, he catalogues his slip into depression and the futility of effort to enact some change in his life. The fact that he saw friends killing themselves as a waste, yet found himself reflecting on his own life and then identifying the similarities in his thoughts to those he criticised. The Peter Bryan story took me on a path that initially allowed me to see the events and feel like a spectator watching the tale unfold, only at some unmarked point to realise that I could have been a part of what I was witnessing.*

Shortly after I found myself becoming aware of how uncomfortable I was with this story

*It's morbid to have an interest in such things. The more I read the more I get drawn deeper and deeper into the inferences being made. I feel drawn to the detail, and then start to see me in this.*

### 3.5.2 Personal practice

Initial doubts over my own practice and decision making were evident. This was linked with the scenario potentially happening in practice.

*The story is something of a rollercoaster horror tale that made me question some of the basic work that I do, maybe unconsciously. This might be because I like others am embroiled in the everyday work of trying to complete a day's work with increasing red tape and a mire of administration. Like the Mirror reported, a person from the organisation Sane (mental health charity), suggesting that "Mental Health Trusts are under such pressure that they are forced to take unacceptable risks". These risks however are only seen as risks once they have gone horribly wrong. I personally do not believe I have taken or take unacceptable risks, but I am not one of the staff involved in this case. I am however, a member of staff who has faced similar decisions in a similar position.*

I later noted that my confidence may have been affected. I recorded that I had checked my work and, somewhat secretively, hadn't wanted to let others know that I was doing this.

*It certainly made me look back at my notes. Anxiously looking back over cases and then asking colleagues about people I have worked with. Candidly, circumspectly asking vague questions that try not to show interest or arouse concern. I found myself checking over paperwork to ensure it was completed and accurate. Not that I could do anything anyway. Reinforcing the impotence yet driven to seek out any potential cases and validate my self-fuelling drive to quell my angst. I did think around this time 'what are you doing? What would you advise your clients to do?' A line from the Times did little to help "The defendant is the victim of a terrible illness and regrettably, we must submit, he is also a victim of a state unable to control it."*

I did notice that some client's names and cases came into my mind at the time of reading the stories. My work became risk orientated and I was unaware that I was, perhaps, more irritable.

*I have made a couple of contacts with clients and supervised several members of staff. A focal point in all contacts was risk, in particular, how much was posed and double checking policy for adherence. I was unaware I was doing this, yet aware of the angst as indicated before and my self protective examination of my past practice.*

I identified self-doubt, something I was unaware of until a colleague I supervised (Emma, a pseudonym) challenged me in a clinical supervision session. I can now see that I manipulated the session to focus on her risk management approach. I recorded on the personal supervision log that each member of staff maintains;

*Emma needs to consider the various ways that risk presents itself. Needs to think about the way she identifies risk and the management within the guidelines. Care is needed to make sure all risks are carefully documented and shared. Asked to think about the varying ways that risk presents itself; not only as a risk of self harm or violence.*

For my own personal records I maintain a portfolio, as guided by the Nursing and Midwifery Council (2008a), and a research reflective journal. Whilst making an entry I thought about the reporting and the supervision session I had facilitated.

*Now what is the crux of what happened? Having undergone the anxiety and self-doubt caused by the reporting I can start to see the behavioural components that I adopted unconsciously. Following reading all the stories, I feel I have become too defensive and averse to risk taking. I must thank Emma for this candid observation. The fact is that it can only be the stuff I have been reading. I can recall no other new changes. Emma continues to work with the same client group as for the last couple of sessions.*

I returned to my initial reactions to the story and the comments I gave to my supervisor as a reaction to reading the reports for the first time. In little time my

view had moved from irritation at the suggestion of more restriction of practice, to unconsciously looking at my own and others practice in regard to risk.

*We already operate a locked ward system and impose a restrictive environment upon patients; shall we abandon all pretense of care and for the safety of the public lock all 'the mad' away and throw away the key. We have to make decisions on balance; that balance cannot always be maintained, it potentially tips one way or the other.*

In some ways I felt that both my colleagues and myself were implementing a risk averse approach and that there was no blanket approach to risk. Each decision needed to be taken on an individual basis. Policies from the Department of Health argued that not all risks could be avoided.

*"Decisions about risk management involve improving the service user's quality of life and plans for recovery, while remaining aware of the safety of the service users, their carers and the public ..... Over-defensive practice is bad practice. Avoiding all possible risks is not good for the service user or society in the long term ..."*(Department of Health and National Risk Management Programme 2007, p8).

But awareness of policies and my initial thoughts in relation to the story caused doubt in my understanding of how I was actually practicing. What I thought I was doing and what I was actually doing may not be in harmony.

### **3.5.3 Blame**

I identified in my notes an account of the different ways newspapers had presented the story. The general theme of blame that was aimed at all.

*Comparing the way that the story was painted does vary. The tabloids tend to go for the grittier in your face approach. Casting aspersions aimed at everyone. The broadsheets provide a technical and detailed account of the events with questions being raised as to approach and reasons behind the event such as government policy.*

My reflective notes became more detailed with quotes from the newspapers. I am unsure why I started making more detailed notes, but it made the staff involved appear uncaring.

*I felt anger towards the newspaper, yet understood that they are quite uninformed and only interested in the message their headlines produce. The anger was short lived but the impact of further reading was not. The consequences of the staff actions were soon to be seen. The Mail led with "within hours he had murdered and dismembered his friend before eating the flesh and brains". The Express wrote that "he cooked and ate a man's brains with a knob of butter", and the Mirror and Guardian painted the grimmest picture, "he rained 24 hammer blows on his head before sawing off his arms and left leg with a Stanley knife and kitchen knives". Why was this not seen?*

The word 'butter' jumped out at me. I can recall feeling frustrated that the journalist didn't seem to know that 'Clover' was not butter! This seemed to signify to me the ignorance of the journalist and the lack of the attention to detail that the story contained. But reading on, I found that I was identifying similarities (maybe in the words used) with personal clinical cases. I can also recall that at the time I thought that my attention, to the detail and words used, was potentially a defensive reaction to distract myself from what I was trying not to recollect. One particular case was written about as part of a scenario to be discussed in clinical supervision with a colleague. I feel I was unconsciously asking 'who was to blame?'

*A client I worked with was unwell and living in a community setting. He was on the face of things in an in between state of wellness and illness. He created no anxiety in me and I had worked with him for some time. I had little concern as the risk assessments indicated low risk and like my colleagues, I thought we knew him well. Having left him one weekend I returned to work to find that he had on a whim committed arson with intent to kill.*

I felt to blame for this client's actions. I looked at my role in clinical work and considered other colleagues who I thought had a similar role. The questions generated were clear in my reflections.

*Why didn't they just assess him? Record it and plan something? Why with such a history would you not act? All the training and common sense says he is dangerous.*

I considered the Department of Health National Risk Management Programme's (2007) argument that over-defensive practice was potentially bad practice. After reading the story I became aware that I was being overly defensive; I felt both defensive of my thinking and actions. This defensiveness led to checking records to address how I had started to feel, as though I was at fault for having such thoughts.

#### **3.5.4 The influence of what has been written**

The feelings of blame moved on to how such stories could influence what I did and how I could help others in clinical practice. The reflections focused on the newspapers reporting of common language in patient records. I have personally

used such statements in patient records, commonly using "appeared to be settled" and "no psychotic features were observed".

*Having read what the staff working with Peter Bryan were reported to have written in his records; The Mirror suggested that the "doctors said he was harmless", and that "Ward staff said they had no concerns about his mental state". The Guardian selected that "he appeared to be settled" and "no psychotic features were observed". The Sun said he was "calm and jovial". These statements certainly applied to the man that I had worked with that committed arson. There were no concerns, but this only heightens anxiety. What about all those other clients that I feel this about. I acknowledge that not all of them have a history of violence, but as the Guardian identified about Peter Bryan, "he repeatedly fooled doctors because of his ability to remain calm and appear normal". This could apply to many of the people I have worked with.*

Initially, I anxiously examined my own practice and looked for personal examples that separated my thinking and practice from that of the clinicians in the story.

Uncomfortably, I found that odd words and scenarios increased my anxiety and led to a level of frustration and anger.

*Reading this certainly made me feel quite impotent. I question the purpose of what I am doing...is it just to stop another killing? Well it was certainly painted that way by the press. That errors in judgement by staff cannot be ignored but I felt it depressing that an "Old Bailey judge called for an inquiry into the 'kid glove' treatment by medical staff and social workers" (Mail), almost insinuating that they were scared of him. They cannot have been scared of him, just scared of making a decision that could be judged by others as restrictive or removing his rights.*

It is quite chastening to think your practice can be criticised when you believed you were doing a good job. The reflective analysis suggested to me that mental health services would become restrictive and 'batten down the hatches'. I can see that the management will feel confident in their assertions that they know best.

*The mental health tribunal gives clients the right to appeal against what they may feel is unjustified detention or treatment. Having attended many tribunals I can see that poorly justified care packages that involved restrictions on clients, were often challenged by tribunals. In some, the decisions seemed overly favourable to the clients, yet I did feel a level of impartiality. The Mail argued "mental health review tribunals ignored home office advice at a secret meeting". It is inferred that tribunals protect the rights of the patient and the Home Secretary the rights of the public. This was in reference to the then Home Secretary David Blunkett not sanctioning a move of care for Peter Bryan. This theme seemed to undermine the policy and rights booklet of care challenging the only course of impartiality available to the client.*

The reflection did appear to clarify what the story had meant to me.

*The system is broken and the gaps are getting bigger. This story really shows how what we think works, really doesn't. That we are caught in thinking we are doing innovative stuff, but really being guided. The level of work and the stress must be clouding my judgement and that of others. I am only now beginning to see what a mess things are and how we attempt to paper over the cracks.*

The level of personal self-confidence to make a difference in the care of the mentally ill is affected by the representation.

*The argument consistently posed was that the services "manifestly failed to protect the general public". In this case it has to be accepted as accurate, but there are thousands of other cases that are not reported that get it right. The fact that the mentally ill are more at risk from the general public than the general public from the mentally ill has been made so many times. It feels like your work is under constant scrutiny not only from overzealous systems-orientated managers, but also from the press.*

The influence of the representation was felt to affect not only my work, but others.

*It is clear who the victims are from these lines, but not in our minds. No one asks about how the people who were with him feel, the staff that worked with him. Not*



*knowing his level of dangerousness nor the potential, the fact that they may have disclosed something about themselves or family; be worried and horrified themselves about him coming for them or their family. Also other people with mental health problems may fear they will be viewed in the same way, as inherently dangerous, just waiting for that fuse to be lit ... some may even believe this.*

The story is stigmatising to the mentally ill. It is critical of the mental health practitioners. But as a result of reflecting on this story I realised that others may be as culpable as the staff in the stories and it hurts that you may have made similar errors. Three weeks on from reading the story I met with Emma again. I noted in my personal supervision log;

*My own drive for potential hidden skeletons had driven me to try to unearth them in others. Emma said that I was suggesting limited positive risk taking in her work and an intolerance of minor sloppiness. Those who know me would say that I am a tolerant man and one not to become irritated at things that could be overcome with gentle exploration of intent and inference to adherence to tidiness in practice so there is some determinable trail.*

Reading and reflecting on the stories left me ebbing and flowing between anger, embarrassment and self-indulgence. I felt a level of sadness but a thought that someone was at fault. There was anger towards the staff involved yet I understood why they made the decisions in their practice. I felt embarrassment at times because of the practice detailed in the case study, but also that I am associated with such practice having been in the caring profession for 30+ years. Blame emerged as I had thoughts that this sort of practice should not go on, and that the staff had shown a lack of professionalism and care. This sort of story I

believed could affect the care the profession gives and lead to reduced autonomy of practice and stigma for the patients, for whom we care. In an excerpt from the article I was writing, I see that the blame felt is presented quite passionately.

*Such statements negate all the time and effort that has gone in to educating the general population, to try to normalize mental illness. The image of straight jackets and a leather mask and the obvious .... The licking of lips and eating body parts with a nice Chianti. Why bother! Maybe we should even go back to the Victorian days and Bedlam; why not go the whole hog, introduce some new treatments...cold showers and public viewings of the mentally ill, a penny admittance two if you want a stick to poke them with.*

My conclusion in the reflective log was:

*What is the story? Peter Bryan is clearly a dangerous man who has killed 3 people and has a mental health problem. That may be so, but the way the story unfolds creates an initial emotion of sadness. This might seem a little trite considering the fact that Peter Bryan killed and ate parts of one of his friends! But it became apparent that he and everyone else had been let down by the workers, the service protocols, policies and by Peter himself.*

The reflection was quite sobering in that I was 'sort of aware' of the emotions and feelings I was experiencing, yet not aware of the change in behaviour that I was adopting. A couple of questions spring to mind related to this; how long had I been behaving in this way and how long would it have gone on for? Somehow my reflections had put me in tune with the themes of the article.

The changes in practice and potentially in my thinking were subtle enough to go unnoticed by me until now. The realisation of my changes did provide a shock to me that I could be influenced in some way. I, perhaps, like others, felt that I was

immune to suggestion. The realisation led to further questions, particularly if other practitioners had such thoughts and feeling. It also made me consider if others practice may be influenced?

### **3.6 Discussion/ reflection on this stage of the thesis**

In this chapter I have attempted both to identify my own thoughts and actions related to the time when I read the newspaper story of Peter Bryan. A reflective journal facilitated reflexivity and as Ahern (cited in Russell and Kelly, 2002) argued, it enabled me to identify "personal assumptions and goals" and clarify "individual belief" (p2). Experiencing this reflexive action made it clear to me that the story was causing me to reflect and then identify that those reflections (albeit sometimes unconsciously) were influencing my practice (explanation to reflective approach is attached at the foot of the next page\*).

The understanding that the reflections were influencing my practice was felt to be justification to explore whether other's reflections were influenced by reading such a story.

The reflections that emerged highlighted the overarching theme of 'risk', causing a sense of defensiveness and blame towards myself. As a result of these thoughts I conducted a review of the recent literature related to risk and violence and mental illness. I had already carried out a similar review as part of a paper published in

2004, (Murphy 2004), so focused the literature from this time on to the present day. The findings are arranged as Appendix 3.6.

Having identified the theme of risk caused by reading the story, I felt that this needed more investigation with other practitioners. Such a focus could be explored by using an academic article that explored the concept of risk for practitioners as well as the newspaper story. I felt that the use of such an academic article may generate deeper and more focused thoughts related to those caused by the story, unearthing more detailed reflections.

\* Over years of practice and engagement in Cognitive Behavioural Training (CBT) I developed a non-traditional approach to reflection that utilised reflective writing (as advocated by Moon 2004), in conjunction with a formulaic CBT structure that mirrored the approach used in my clinical practice. As with any reflection, there involved an exploration of how an event (or trigger) was perceived and then how this influenced the way I felt and acted. A cognitive behavioural intervention advocates for the development of a formulation to drive therapy (Westbrook, Kennerley and Kirk 2011). Such a formulation enables both the practitioner and client to understand the influence of the trigger and identify the associated influences on; thoughts, emotions, feelings, and behaviours, that occur as a consequence of such a trigger (Wills 2008).

I can see that threaded across my reflective writing is a sort of structure that addresses each of these influences. Clearly I am unconsciously superimposing my clinical formulation approach used with clients within my reflective writing, which in turn is aiding me to develop understanding and challenge practice (Dewey 1933). This approach is not a recognised reflective model, however, it has various elements that could be seen in reflective models (e.g. Gibbs 1988, suggests that the person reflecting has something to reflect about and that they identify how the experience made them feel and the consequences of such feelings on their behaviour and thinking).

I can see that a reflective journal completed throughout the time period of reading the newspaper story captured personal thoughts and assumptions. The journal also identified other details that were unrelated to the story and linked to confidential clinical practice. It became clear that asking practitioners to maintain a reflective journal for the duration of any interview stage may cause confidentiality problems with their practice and identify unrelated information that may influence any future analysis. Although I felt that this approach had utility in identifying initial reflections, that analysis of multiple journals may present many unrelated themes that were not influenced by the story. I therefore felt that the practitioners should offer some verbal reflections and asking the practitioners to add one written reflection to the data collected from them, might provide detailed data related to the overarching research question. Getting the practitioners to offer verbal and written reflections should provide sufficient data to establish thoughts and feelings of practitioners generated by the story and article, but also to understand the rationale for the research.

I can see from reflecting on the time I spent reading the story about Peter Bryan, that it was helping me to understand more about the research methods that I was employing. Such an understanding helped in the justification for the way I collected data, generated questions and then designed the subsequent research activities (in this thesis, a study with many parts). Having focussed on one aspect of the reflective journal I now felt that buried within it there were probably entries that show some further influences on my thinking and decisions made in relation

to the research design and questions generated about the research. The emergent design of the study presented me with the opportunity to evaluate my experiences, and to identify modifications to the design that were needed due to the new insights caused by the completion of this stage of the research. Adopting this design meant that I would not be restricted to one method of exploration and would be able to address the research questions in the way that I felt was most appropriate.

The experience of reflecting on a specific text and scrutinising my reflective journal made me consider all the past events I had encountered and what I could have potentially altered in my practice. The experience highlighted my decision making and things that influenced the choices I made. It has become clear that with an awareness of my reflections, I may have made different practice decisions. The identified practice, both in the story and my reflective journal, seemed to be at odds with common sense (Brookfield 2007). I can see that a level of emotional intelligence (Goleman 1995) developed, and continued to develop as I now began to make sense of what had happened.

Reflecting on the same story over and over challenged initial impressions and questioned tacit knowledge. This repeated action developed a more critical reflective approach (Bright 1996) which unearthed some automatic assumptions related to care of the mentally ill. The identification of such assumptions in turn, led to an evaluation of how I viewed the working environment and colleagues (Gunasekara 2013).

This process was anxiety provoking as it challenged the identity that I had established in my clinical work prior to starting this study. This position is common in education with Lindsay (2006) arguing that such incidents enabled enlightenment in work and aided the bridging of personal and professional identity. At this time I felt isolated and in conflict with my safety net (Pickering 2006) of more concrete medical research that I had in the past thought was the only form of empirical evidence. I was now seeing the utility of personal insight and reflection in research studies, but more importantly the need to accept the emergent nature of some studies.

The use of self-reflection led to an understanding of how the Peter Bryan story had influenced my practice. Identifying this understanding however caused further questions. As discussed I identified modification to the way that I managed my self-reflections and the need to follow the theme of risk that was emerging. The use of the reflective journal and written reflections aided the analysis and the coding of the data for themes. Therefore there will be a need to generate written text from the practitioner interviews to enable a similar analysis process in the next chapter.

### **3.7 Key points**

- Newspapers have the utility to be used for generating reflection in practitioners.
- The use of an autoethnographic type approach based on a critical reflective

tradition to research enabled a deeper analysis of data which led to a richer understanding of the influence of a newspaper story on the way I viewed my work and society.

- Generating a text document from written reflections and reflective journal entries presented the opportunity to chronologically order the data and identify emergent themes from the data.
- The utilisation of a reflective journal enabled the clarification of thoughts and practice at the time of reading the story of Peter Bryan.
- The story of Peter Bryan caused reflection in me and the self analysis led to identifying behaviours that I was unaware I was using as coping strategies.
- Reflection on the story and the journal identified the lack of practitioner awareness to the risks clients and practitioners may cause in practice.
- Although identifying risk in supervision sessions of other colleagues, the risks were never explored in any depth in my own reflections or journal entries.



# Chapter 4.

## 4.1 Introduction

This chapter builds on the findings from chapter 3 which were that;

- reading the story of Peter Bryan led to learning and new knowledge about myself
- the use of writing a reflective journal and recording reflective thoughts enabled the clarification of potential influences on thinking and practice at the time of reading the story of Peter Bryan
- using an autoethnographic approach and a critical reflective approach to research, developed a deeper understanding of the influence of a newspaper story on the coping strategies I used in clinical practice
- reflection led to questions related to the influence such an approach could have on other practitioners who were experienced mental health practitioners like me.

Having worked with experienced mental health practitioners for over 30 years, in various roles, I have developed an interest in what influences their practice. I contend that being a practitioner myself and having completed practice related research studies places me in a privileged position, which, as Ellis (2005) reflected, is a very different position to researchers who have never practiced. Both working and researching in the practice area provides an insider type view. This view

presents the opportunity to look at the cultures and relational practices, common values and beliefs, and shared experiences for the purpose of helping to understand the culture of practice (Maso 2001).

After completing the previous stage of the study (presented in chapter 3) and having reflected on my own reactions to a newspaper story, I felt justified in following the guidance of Ellis (2011) and explored whether my experiences and thinking were similar to others.

Having already identified a way of exploring questions related to experiences and thoughts, I felt that the use of a similar method should be employed in the exploration with experienced practitioners. The use of such a method will in some ways address a personal reliability question; are these thoughts and actions solely down to something in me rather than being present in others? The collection of such information will produce what Geertz (1973) referred to as 'thick descriptions' that can then be further analysed and compared with even more practitioner's experiences.

I feel that practitioners need to be able to reflect on their practice and identify things that they do well, as well as things not done so well. Practitioners need to identify some of the things that have influenced their practice and reflect on how they are going to manage them. I identified that my thinking and actions were influenced in a particular way and because of this, further investigation is warranted. Using one's own experiences and thoughts for evidence is not a new

approach to research but one that is probably viewed with less credibility (Ellis 2005). The use of such evidence was potentially a way of identifying latent thoughts and actions and to highlighting information that may be commonly dismissed as an independent artefact, and excluded as evidence from some studies. Individual studies that present one perspective are in my view a practical way to identify research topics in practice. Most importantly it is the way the study is critically analysed that is intrinsic in its value (Cutcliffe and Ward 2003), not the size of the sample.

## **4.2 Methodology**

The practitioners that agreed to take part in this study were asked to meet me on three scheduled occasions over a three week time period. During the study they were asked to read a newspaper story (the case study) and an academic article. The practitioners were encouraged to provide initial reflective feedback after reading the story, and in the latter meetings offer some more considered reflections. Furthermore, the practitioners were asked to think about the material they had read and, following the first interview, write some reflections (no guidance was presented to the practitioners to aide them in structuring their reflections, and this point is discussed further as Appendix 4.1).

A similar approach had been used to collect data in the self-reflective approach used in chapter 3 that involved reading the case study, writing reflections and

reviewing a reflective journal (that involved clinical and academic reflections) over an arbitrary time frame of one month (see section 3.3 and 3.4). The practitioners were, however, asked questions from an interview schedule (see section 4.5) at each meeting and encouraged to sum up what they felt the experience of the interviews meant to them at the final meeting.

An alternative method of collecting the data could have used blogs or electronic forums (see Appendix 4.2). These are more frequently used for sharing information, but more recently for canvassing for opinions on specific stories (see Appendix 4.3, on-line comments from Mail readers on the Peter Bryan story). Such an approach however may not have captured practitioner initial thoughts, as they would have had the opportunity to think and possibly reflect a little about how they were going to comment whilst typing.

The research approach taken here is qualitative in nature, being interpretive and focusing on the participants giving meaning to the influence of reading the case study and an academic article. The focus in this chapter is to develop a deeper understanding of participant thoughts and action in the social world by exploring the concepts that emerge in the research interviews (Snape and Spencer 2003). Fisher and Freshwater (2014) argue that narrative exercises such as these do not develop "*a fixed identity*" but themes that can be explored further (p202). Emergent themes are built on following the findings of the previous chapter. The approach to this study is pragmatic in nature, however, there is a social constructivist leaning, and this is understandable as the story being used is

constructed by the media for influence on the reader and presents a view of the construction of society created by the media (this construction is part of the data but not wholly part of the overarching methodology).

A novel approach taken here is the selection of experienced mental health professionals which none of the studies discussed in this thesis or the review of the literature have used. An understanding of thoughts, feelings and actions in relation to the case study and the academic article is arrived at by the use of individual interviews (the structure is detailed in the interview schedule below). The use of interviews places the focus on the individual practitioner and their personal view. Such an approach will, as Ellis (2004) argued, add layers and context to the reflections about the practitioner's experiences. The practitioners will be able to use the story as a catalyst to stimulate thoughts related to emergent reflections to practice and raise consciousness to potential changes in practice that may have gone unnoticed by them. Reflections related to the justification for this approach and the uses of newspaper stories for the study are presented as Appendix 4.4 and Appendix 4.5.

### **4.3 Interviews**

The interviews adopted a semi structured approach with some questions and prompts added as necessary (Olsen 2012). Interviews of this sort are commonly used to collect data for qualitative type studies (Streubert and Carpenter 2007)

and can gain a narrative nature that can help participants access the meaning they attribute to the social world under question (Silverman p133 2011) and the social world that the practitioners worked within (Miller and Glassner 2004). This was felt to be an important approach as the interviews were designed to engage the participants in a reflective type process to self-examine how something they have read can impact on their understanding and actions in practice.

Bowling (1997) argued that semi-structured interviews aimed to move beyond superficial understanding, trying to identify the participants meaning to these experiences. Although the interviews used were fairly formal in nature (the interviewees had appointment times, recordings, schedules and homework) the aim was to generate the practitioner's views and not the researcher's view.

Around one hour was set aside for the interviews. This length of time had been identified from a pilot that had been completed to test out the questions with some colleagues who had also worked as practitioners in mental health. The outcome of this pilot is attached as Appendix 4.6.

#### **4.4 Sample**

The sample of participants for this study was experienced mental health professionals. They were expected to be experienced and it was assumed that they would possess 'practical wisdom', i.e. to be able to understand and interpret influences on actions through their exposure to practice (Begley *et al.* 2010). This

was seen as a necessary constituent for being able to articulate how a piece of media can impact on the person's decision-making. In addition to this, a second level of 'theoretical wisdom' was also looked for in participants, i.e. where they had undergone instruction and were probably able to demonstrate theoretical understanding (Begley *et al.* 2010) of concepts involved in practice. In addition, the practitioner would need to be able to act on any conclusions derived, so a level of autonomy (usually held by senior staff) was also sought. Ethics approval for this aspect of the study was gained through research governance at Manchester Metropolitan University (see Appendix 3.5).

There was anticipation that the number of participants that would fit the inclusion criteria would probably be limited. To access such limited groups Van Meter (1990) argued that an ascending methodology should be used. Such a methodology often uses snowball sampling as a way of identifying and accessing individuals. The use of snowball sampling is endorsed by Hendricks and Blanken (1992) and Korf (1997) when the focus of the study is on a limited population and the use of a sensitive theme (in this case, reflections related to practice).

Faugier and Sargeant (1997) argued that if snowball sampling was to be used, then the researcher must actively develop and control the sample's initiation, progress and conclusion; having a target sample in mind that could meet the appropriate criteria. There was an anticipation that each person in the sample would probably know someone else who was from a similar background and field

of work that could also meet the inclusion criteria. This in some ways places the participants as active assistants in recruiting other participants.

Initially three potential people were identified from discussion within the research supervision team. From these three people other potential people were then identified in a chaining process where each participant became a referral assistant (Korf 1997). Although getting people to suggest potential participants generates a list of people to approach for the study, it is not a guarantee of the potential person either joining or becoming involved in the research. It is however, a process where new participants can have a frame of reference from the person suggesting their name. Over a two month time period, eight participants consented to participate in the study. Each read the information and signed the consent forms before engaging in any interview. Each participant was aware that they could withdraw from the study at any time and that they would not be challenged for making such a decision. Each gave implicit consent for the data collected to be used for this research and any associated publications.

The sample size originally scheduled in the ethics application for interview was between 6 and 9 participants (who from here on shall be referred to as practitioners). This figure was felt by myself to be sufficient to gain a range of interpretations in the time available. The sample size was also arrived at with recognition of the limited number of people that would fit the sampling criteria. The sample size is a difficult estimation with Baker and Edwards (2012) having no definitive answer after canvassing opinions of 14 writers on qualitative methods.



Their conclusion was that the sample size 'depends', but in each case on different factors. Jennifer Mason, who was one that contributed to Baker and Edwards's discussion, added that

*it is better to have a smaller number of interviews, creatively and interpretively analysed, than a larger number where the researcher runs out of time to do them justice analytically. It is better to aim to offer sound qualitative insights, than try to mimic a quantitative 'representative' logic.* (Mason 2010, p30).

Although eight practitioners were recruited, one person did not complete all the interviews in accordance with the research outline, so that practitioner's data was withdrawn. Therefore seven practitioners were used and the demographic details of these people are presented as Appendix 4.7.

#### **4.5 The interview schedule**

Each of the practitioners that took part in the study negotiated places and times for interviews which were suitable for them, over a three week time frame. The outline of the interview process is attached as Appendix 4.8.

Interview 1 involved practitioners reading the case study (a newspaper story about Peter Bryan) and then offering reflections. All newspaper stories used were from the newspaper of choice of the participant and covered the same story on the same date of printing. A choice of paper was given to mirror real life exposure i.e. they would be reading their usual choice of newspaper. The story used was a

report of the trial and the sentencing of Peter Bryan for the murder of Brian Cherry and Richard Loudwell (March 2005)

At the interview the main questions were

*How did reading this make you feel?*

*How might this affect your practice?*

*How might this affect your practice in the future?*

The interview was digitally recorded and the recording stored safely once the interview was completed. The interviews were transcribed after all recordings had been completed. At the end of the first interview the practitioners were asked to look at the case study again before meeting for a second interview in about one week. The practitioners were also asked to undertake some reflective writing about the story for the next interview. No guidance about an expected style was given, so each could adopt a style of their preference.

Interview 2 adopted the same process as the first interview with the focus on the case study that each practitioner had. The same main questions were used again and the interview was once again recorded and information handled in the same way as previously in interview 1.

At the end of the interview, practitioners were given a chapter from Godin's book (Risk and Nursing Practice, 2006), the chapter 'Managing risk in community practice: nursing, risk and decision- making' by Alaszewski (see discussion as

Appendix 4.9). The practitioners were asked to read this in preparation for the final interview in the following week. All the data collected was stored under one code for each practitioner.

Interview 3 used a similar framework to the earlier two but the focus this time was on the chapter they had just read as well as the case study. The same main questions were used, but this time a final extra question was introduced

*What has all this meant to you?*

At the end of the interviews the practitioner was asked if they were aware of any other person who they thought may fit the inclusion criteria and be willing to engage in the study.

## **4.6 Data collection, analysis and management**

All the interview data was digitally recorded and later transcribed once all interviews had been completed. The transcriptions were verbatim transcripts of the whole interview (a brief discussion related to transcription process is presented as Appendix 4.10) with notes and memos added referring to observations made during the interview.

The written reflections were collected at the start of interview 2. Both interview and written data were merged into one chronologically ordered 'Word' document

for each practitioner. The development of the 'Word' documents did not start until all interviews had been completed.

Analysis, on completion of collecting all data, involved a similar process to that used in the last chapter: codes and themes being identified through a constant comparative method. Such an approach allowed for further analysis and the opportunity to further order and group similar data. Detailed discussions related to the data analysis and management are presented as Appendix 4.11.

#### **4.7 Findings- Practitioner interviews**

The amount of data generated was initially exciting, as I thought that I had so much rich and interesting information that analysing it would be easy. I found that much of the data showed common themes and insights into the practitioner's feelings and practice related to the case study and the chapter. The initial excitement was replaced by anxiety and frustration as the process of listening to the interviews again and again generated more themes and interesting anecdotes. This led to me becoming a little overwhelmed by the amount of information and confused as to the best way to present the data. The use of QDA Minor (a computer programme designed to aid qualitative and quantitative data analysis), to manage the data electronically was initially used, but was abandoned due to adding further layers of complexity. A decision to return to ways that I have used in the past to analyse qualitative data was taken. Therefore a process of printing,

memoing and coding of hard copies of the data took place using a constant comparison approach.

Many themes from the narrative accounts were identified with some overlapping in the initial themes I had generated. On relooking at where the overlaps occurred I began to see generalisations that joined together recurrent themes. These generalisations were analysed further and grouped together under general statements which were finally labelled with a descriptive term that summed up the focus of the information. This led to the identification of three descriptive terms that are described below:

### **1. Coming to an understanding about the influence on role**

Reading the case study unearthed the thoughts that influence the practice of practitioners. Practitioners reflecting on their clinical role balance, their level of experience and their impotence to control the outcome of a client's decisions.

### **2. Modifications created on reflection**

Repeated reflection on the case study enabled practitioners to challenge initial beliefs created by reading the case study and chapter. Initial thoughts related to blame were challenged and new considered and modified practices were developed.

### **3. Reappraisal of representational influences**

Reading the representations led to an identification of the various ways the case study and chapter could affect the practitioner's work. These influences led to a reappraisal of the representational influence on the mentally ill and the service providers. This generated thoughts in the practitioners that challenges were needed from them to address the stigmatising view of the mentally ill and the misrepresentations identified.

The presentation of the findings achieves a confirmatory depiction of how the practitioners felt that their reading such a case study and chapter may influence their thoughts and then practice. The use of the practitioner's personal thoughts on the influence on practice led to discussions related to specific practice in their place of work. Care was needed in the write up to avoid identifying both practitioner and practice area meaning some data had to be omitted from the findings section so as to avoid breaching confidentiality.

#### **4.7.1 Coming to an understanding about the influence on role**

The practitioner's initial thoughts were of shock about the severity of the incident but also sadness for all involved. There was a concern that the incident may have some impact on practice and may cause some stigma for clients. Some practitioners felt that such incidents involving mentally ill people could influence the general public's view about the dangerousness that the mentally ill posed.

Some practitioners felt that their standing in society may be affected with people being more critical of their role and ability.

On a more individual level there was discussion around acknowledging the way the incident came about, but that the practitioners didn't believe it could happen to them. Although some practitioners commented in later interviews on having gone back to their offices and checked on paperwork involving risky clients. None felt that their ability to work with the mentally ill would be affected, but felt that there may be negative practice consequences from such an incident. A level of empathy developed throughout the interviews for Peter Bryan and the common thought was that he had been let down by the people caring for him.

*It makes health professionals seem wrong... unskilled because ...to whoever reads the article, the general public, if this article is the only thing they are going to read about mental health they are going to read about a lot of failure...we don't even know when people are safe to come out of special hospitals?*

For some practitioners the case study caused no reported anxiety, but for those practitioners that said they went back to check records, levels of anxiety related to perceived criticism remained high. The case study appeared to make the practitioners more sensitive to the possibility of critical comment. A level of professional pride was evident from all practitioners and a sense of defensiveness related to personal practice emerged. Some degree of personal sensitivity to other potential negative publicity regarding mental health care was evident.

*There was something on the telly yesterday, as I was walking through the house... there was something that happened, I think it was 2 years ago? A girl had once again left a psychiatric unit, and killed somebody... and I do try to avoid these kinds of things as much as possible, but once again somebody from a charity, I think it was Mind or Rethink was saying that it was absolutely disgusting and the reflection was on the staff at the hospital and how could they let such a dangerous person leave? There is something not right with the way these services are run. Erm! ... I don't think you cannot help but feel, and I am sure that not everybody feels this way, but it does feel quite personal, you feel like a kinda personal responsibility for... I suppose towards your profession. I think?... and then reading about Peter Bryan and that coming up you think that this is becoming a bit of a regular occurrence. I feel it doesn't give people much faith in you and at that time I was feeling a little bit defensive at home about it really.*

Defensive thoughts were evident in the practitioners that were linked to the complex nature of mental health work and the level of responsibility they felt they had to accept. Although many spoke about the confidence they had in their work role, each made anxiety related inferences about the risks associated with the job. One such inference was related to the responsibility for their decisions around risk and the prediction of violence or self-harm. Many felt that reading such case studies created anxiety and worrying thoughts related to the responsibility of making clinical decisions.

*There's a potential to activate a defensive part of my thinking, because these kinds of stories always have lots of layers about how systems and people have failed, how mental health workers haven't done stuff... and how tricky a business predicting risk is, and if you get it wrong you're worried about feeling responsible, or the worry about being responsible, and I think it activates those thoughts.*



The case study and chapter stimulated discussion about the process of assessment dictated by the mental health care system and how practitioners individually managed the risks they identified. Thoughts emerged related to the management of risks and the client's part in such management. Many argued that clients needed to take some responsibility for their own and others safety. In the later interviews some practitioners revisited clinical decisions that they had made and discussed their approach to risk management.

*But you take what is, which is in here about the culture, we have a culture of what questions to ask, I use them, so when I assess for risk I don't use tools I ask questions. That negotiated thing is definitely the case because when you are working with a lot of people that have a lot of self-harming thoughts, and are suddenly very low in mood, you have to make the decision about how to manage the risk. It's not just about assessing... and for me that's where the negotiation comes in. A lot of people now don't want to go into hospital. Some are banging on your door, demanding to go in every week, but I have quite a few on my caseload that don't want to go in, and I have had one or two that I felt were very risky but didn't want to go in. So my next questions in terms of risk is... what a lot see as managing the risk by admitting them but would it make the risk lower or would it make the risk higher? And I have to make the decision, the choice once or twice that the risk will be higher by admitting them because it would be such a disaster for them...but I have had to be explicit and say that I'm trusting you...and trust is mentioned in here and it's a very good point 'cause that really chimed with me because I have to say to people more than once that I'm concerned, what assurances can you give me that we are going to meet in one day, two days time, that you will still be here.*

Frustration emerged that practitioner decision making may be removed and replaced by a blanket response to all risk decisions. Practitioners felt that the case study may cause the mental health service to impose restrictions (without

sufficient information) on risky clients. A fear created by the case study was that autonomy in relation to clinical decision making may be removed.

*I feel frustrated as I feel as if I'm being encouraged to believe that that's true without all of the right information. I also feel frustrated as there's an underlying message that because there was an issue ten years before...there's a kind of an underlying message that since you've been identified as someone with severe mental health problems that's it, the mental health system's obligation to you and the public is to keep you inside... I feel frustrated by that.*

Emerging thoughts were discussed in relation to the influence of such a case study on practitioners. Practitioners felt that responsibility for decisions had to stay with practitioners, but less experienced practitioners may not have the ability to recognise alternative ways of dealing with such people that had complex presentations. Many of the less experienced practitioners were felt to be working in hospital settings where restrictive practice could be used. This was felt to have been a contributory factor in the case study. Community practitioners were felt to be more experienced and more likely to share responsibility for decision making. Paradoxically each felt that if risks such as those in the case study occurred in their work that they would try to get them into hospital where they felt the person and the public would be safe.

*As you become more experienced and longer qualified, etc, etc, you realise that other people's opinions are important but you realise that other people's opinions in that team are theirs, but you still have to do your mental health assessment and it's about your decision and on what you believe to be right. And if you recognise*

*signs that somebody was becoming unwell you would have to do something about it rather than leaving it ...in a hospital it just feels safer at times*

#### **4.7.2 Modifications created on reflection**

There was a feeling that the work practitioners undertook was under constant scrutiny. The series of interviews exposed some thoughts, emerging from reading the case study, that all the problems presented by the mentally ill are predictable and manageable. A level of anxiety was inferred about making risky decisions and that on each occasion a decision is made, somebody is responsible for the outcome. Acknowledging this responsibility engaged the practitioners in considering clinical presentations and later debating experiences of risk taking, by them.

Thoughts related to professionalism and decision making started to emerge in later interviews. There was a feeling that practitioners were only included in stories when the decisions made had a negative outcome. Each of the practitioners could not see reports of services getting it right.

*There is always a kind of hindsight thing of how mental health services got it wrong, everything is preventable and somebody's always at fault when a mistake happens*

There was a feeling that the profession 'got it wrong' in the decisions made about Peter Bryan. Practitioners drew on their experience of what should have happened if they were the practitioner involved in the case study. As each interview

progressed, there was a feeling that the practitioners became more involved and spoke about what should happen, rather than what did happen. There was concern that such case studies gave a negative view of the profession, but also a realisation that poor decision making had occurred. Each practitioner suggested they were learning from the case study as they re-evaluated the case study again and again, comparing and contrasting what happened and what they would do.

A realisation that the practices of mental health services may be misunderstood emerged. What practitioners believed to be common practice by people who worked in the field of mental health care, may appear strange or uncaring to journalists. The practitioners initially found that they were viewing the case study almost as a report by another professional. With time they started to see how naively the case study was written, and that the nature of mental health service work (in an attempt to protect clients) led to a lack of transparency in practice that could be misrepresented and misunderstood. It became understandable how the case study was written, but, nonetheless anxiety provoking.

*The part about it that probably plays on my mind is the part where Peter Bryan had been an in-patient and been on day release and there was some reflection from the media about how that could happen. The reflection was probably about how dangerous that person was and how they had just allowed him to go out.*

The case study caused concern related to the level of autonomy practitioners possessed over the work they did. The practitioners felt that such negative case

studies could lead to a reduction in their autonomy and freedom in their clinical decision making. In one account where clinical decision making had to be balanced against moral judgement, a discussion related to clients (who were regarded as unwell) being admitted to hospital; or not. This account was compared in relation to the case study and chapter. The practitioner reflected on their practice, and considered modifications to practice, swiftly moving their thoughts to the implications for patient care.

*I obtained a warrant from the local magistrates... mental disorder grounds. So going back I get a call that we don't have any beds locally in the hospitals. We had legal advice from the local authority that even if you do not have a bed that you should still continue with the mental health act assessment. Regardless if you have a bed as this is the correct legal thing to do. I thought about this. This 50-60 year old woman I am going to rip out of her own home, execute a warrant and take her to a section 136 suite, where she will wait for up to 72 hours, where she will then be moved from that suite to possibly a hospital the other side of the city, may be further afield where she will be in with young lads of 20's and 30's with a range of disorders. And then after a day or two, we will move her back to another hospital, and I felt about the health professional's registration that one must act in the best interests of the clients and I didn't do it, and the bombardment of e-mails and phone calls that I got for not acting on that... But I felt I was acting in the best interests of the patient and I spoke to the patient's relative as well, and she said of course that is the right thing to do*

With each practitioner more personal and practice related themes started to emerge as the interviews progressed. Challenges and dilemmas faced were raised in relation to the case study and they reflected on similar clinical experiences. Between interviews, practitioners continued to reflect on the case study and felt

that the content hadn't necessarily upset them, but the causal response in their practice made them re-examine risk related clinical incidents.

*I found it coming into my mind a few times, much more than I might have expected. In particular, I found myself thinking about it in relation to when I'm making appraisals of people's risk or levels of improvement.*

Some practitioners identified that the case study made them think more about clinical decisions that had to be made. Reading and reflecting on the case study didn't necessarily lead to a mistrust of client accounts, but led to more detailed questioning and a focus of attention on the care needed. Initial anxiety was raised that such case studies would lead to defensive practice and a lack of risk taking. In later interviews practitioners spoke of a need to appraise the mental health of clients better and to establish clear risk factors in order to make a decision about discharge or leave. Emphasis was placed upon demonstrating a clear decision making trail for actions. Each felt that the interviews allowed them the time and space to come to these conclusions.

*What's the best way of putting this? ... You have to bear in mind that some people won't be open and honest with us... Which doesn't mean your automatic default position that you either trust them or distrust them? You need to weigh up all the possibilities. But it means when you work with them you don't just take their assurances at face value. You don't call them lying, you don't say this to them because that could break down the therapeutic relationship. You have to be very careful how you do it. But even with their reassurances that...hey I don't do things like that! You would still leave in place a comprehensive package of care... given*

*this case... that sometimes people don't always tell what they are thinking or feeling...or strange thoughts they are having.*

A practitioner identified initial similarities in one of the cases they were working with and the case study of Peter Bryan. Whilst discussing their reactions, they were able to identify their immediate thoughts and link them with their actions. The practitioner then started to emphasise the importance of identifying past behaviour and described what I thought was an approach to care demanded by their service provider. I felt the practitioner went on to detail a service approach to such a client rather than an approach they would have used.

*If I got a chap like that and he presented on my doorstep... .. then I asked him where've you come from? And he said I've just come out of Rampton, or I've just come out of Ashworth, Erm!... or we got say a referral from say Ashworth saying he killed this young woman in a shop and we think he's got schizophrenia and antisocial personality disorder traits, however, we have now assessed him and he is reasonably safe and well and so we let him out in the community... well we'd be jumping all over that. We really would! And there are cases, almost opposite cases of that, like a young chap I am dealing with at the moment. He has got that co morbidity but his level of offenses hasn't been as serious as this guy but we've jumped all over it in terms of getting the forensic services to come and do assessments on him and he's now back in Strangeways (a prison in Manchester) because he has assaulted somebody*

Reflection on personal practice was combined with the practice of others. As indicated earlier, the level of experience of the practitioner was felt to play a part in the way stories and client accounts influence practice. One practitioner could see that a junior colleague was not seeing the clinical picture of a client the same

way they were. Although they acknowledged that the client was not as risky as Peter Bryan, awareness of support for other practitioners to make correct decisions is explored. Here the practitioner initially discussed levels of care, elaborating on how others that are not as experienced or detailed in their assessment procedures can make mistakes. Emphasis is placed on the problems of having less experienced practitioners working in an unsupervised way.

*We work with very complex people... some of them are. I am working with some standard cases and some of them think they are not as ill as they think they are. I work with a lot of people who are very unhappy but not clinically depressed. They think they are riskier than they are and there are cases that I discharge from services that think that they should stay under services. So my own experiences, clinically at the moment, is that they don't get the mental health services, the specialist services, for the severe and enduring mentally ill in secondary care. But also we work with people with personality difficulties... ... we had a case recently of a young woman who convinced the CPN that she couldn't walk. I was certain she could walk and I hadn't even met her. But just on the clinical picture I was presented with. The CPN had a default position of anything my patient says to me I must believe, I must trust them. It is my job to work for the patient. Which is almost like erm...professional naivety? As a policy of clinical naivety and I am a clinical supervisor, I had that discussion with her and it was proved that I was proved right*

The examination of the case study and chapter led the practitioners to re-appraise their actions related to leave and risk plans. Rather than leaving the work to junior members of staff, involvement of them by supervision was felt to be important. Defensive thoughts about decision making emerged. Discussion about supervision and ensuring risk plans were completed, were brought into the discussion. The



discussion of risk plans were linked to protection of the general public and the development of good practice for practitioners.

*I guess for me it's...testing people out in the community. For rather than just letting people through the system, it's more they are tested out in the community more. I mean that access to community leave... access to the general public is more risk managed or has stringent risk management plans in place to manage the potential risks... erm...that they may pose... erm! and I guess for me it's making sure that if it changes anything it's making sure that the risk management plans are... .. very detailed and understandable by others. So there's no potential for misunderstanding of them. Yes, I think I would, as reading anything like this sort of highlights to professionals that they need to improve their own practice*

Each of the practitioners was angered by the statements reported to have been made by the Social Worker in the case study (that being aware of Peter Bryan's history and reported relapse, that he had no concerns). Each could not see themselves making such a statement in any situation. Reflecting on the case study again the practitioners re-examined their knowledge of risky behaviour and what it constituted. Past violence was seen as a marker for understanding the potential of clients. Discussion of past clients, released from prison was debated with each practitioner concluding that if someone has committed murder, then they had the potential to do so again. This needed to be factored into any care in the community.

*It's easy for me to say that they (the staff) got it wrong. Even in a specialist hospital. That should be the starting point as they are the gatekeepers. When you have someone that has committed a murder, they are the people that make the*

*biggest decisions... They got it wrong, but there isn't much about that and that is interesting. And then the social worker to come out with a statement that...you know...that there was no, necessarily any major risk present. That is the one statement that jumps out at me. So anybody that has done what he did (Peter Bryan) from hitting the young woman in the shop, obviously still carries that major risk. He (the social worker) comes across as defensive and very very wrong.*

#### **4.7.3 Reappraisal of representational influences**

The representation made in the case study was argued to stigmatise the mentally ill and infer that they remained dangerous when discharged from hospital. The diagnosis of a mental illness was felt (in the case study) to be an attempt to deny responsibility and excuse the crime that had been committed. Practitioners saw their clients to be different from the one in the case study but felt that clients like him were in other caseloads. The practitioners could see that the people they cared for were often difficult to assess but not as dangerous as the media image that was being presented. Each struggled to see how someone with a mental illness that they had cared for could have potentially committed the crimes reported. Even though the practitioners did not work with Peter Bryan, there was 'empathy' for him as the feeling was that he was let down as were other mental health service users.

Reflecting on the images created by the media representations, practitioners saw that poor assessments and not correctly identifying the risks potentially led to the crimes reported in the case study. This, the practitioners felt, was presented as a common event that happened in mental health services but they could only recall one or two such instances to their knowledge.

Each practitioner was unsettled that the case study may lead to policy and practice change. A fear was that the representation may lead to having to lock people up as a consequence of such case studies. The case study however, engaged the practitioners in identifying what they believed were positive approaches that they had adopted in collaboration with clients. Frustration was evident that the time the practitioners had spent in trying to shape services to meet the needs of the service users could be detrimentally affected by such representations. Each practitioner acknowledged the potentially powerful impact the reporting had on the lay person and how the services had been overprotective of its practices. Equally, each practitioner identified the immediate shock of the language used and the thoughts that this could not have been carried out by someone that was thought to be 'well'. The practitioners concluded that a member of staff, in the case study, had made a great mistake in letting Peter Bryan leave their care.

*Everyone with mental health problems... are all dangerous so we must have a locked door policy or we sit on the door to find out who goes and who doesn't. It's kind of those practical things they look down on rather than addressing things like how services work better between one another.*

In agreement with Grierson and Scott (1995) (see Table 2.1 p 40), practitioners believed that the representations simplified a complex problem by 'broad brushing' and framing mental illness as predictable. The mental health services, and in particular individual ward staff, should have predicted Peter Bryan's behaviour.

Practitioners although acknowledging the difficulty of predicting behaviours were able to detail the tools that should have been used to identify the risks he posed. However, these tools were argued to be only valuable at the time the assessment was conducted, and no suggestion of use was seen in the case study.

The limited evidence in the case study emphasised the lack of care given and challenged the level of professionalism and trustworthiness of the staff. Such evidence reinforced the image that the staff did not know what they were doing in regard to treating Peter Bryan or protecting the public from such people.

The practitioners believed that the media was trying to exert some social control over the mentally ill's freedom and the actions of those who cared for them. Such control was felt to challenge the practice of offering the least restrictive care for people and eradicate the need to predict health changes. Predictions about risk have been explored using various generations of risk tools, each fraught with poor accuracy. Yet each practitioner felt that a lack of understanding and misrepresentation existed about the unpredictable nature of people's behaviour.

*But there is also that bit that we are expected to predict people's behaviour at all times and sometimes we can't always predict what people are going to do. We can do our best based on risk assessments and past clinical history but if someone is presenting as well and improved over time does that mean they should still stay locked up the rest of their lives?*

A repeated discussion point was that the representation and the practitioners lived experience of working with the mentally ill did not match. The representation engaged the practitioner's in reflecting upon their own practice and re-evaluating what they did when caring for someone who they believed to be a risk.

Even though the practitioners could not see the event represented, as happening to them, each justified how it could be avoided. Such a view was supported by the cyclical exploration of their experiences and repeated references to the clients they had worked with. Each practitioner referred to their cases that were potentially dangerous but that had been managed, yet elaborated on other cases that this case study had made them think of where colleagues had been involved.

*I don't think I've ever heard of anyone eating anyone's brains with paranoid schizophrenia. It's rare people hurting anyone and I think we have had one or two incidents across the whole division but nothing to that sort of degree. I kind of wonder whether it was paranoid schizophrenia that led him to that? Or was it other elements of his make-up that led him to do these things.*

Many of the practitioners had worked in mental health care for many years. The representations used in the case study were felt to have been specific of a particular period of time in the past. Many of the demands that the case study made went against what practitioners felt were the client's human rights.

Each practitioner could reflect on the changing workforce and how they had individually adapted to changes over time. The practitioners could equally identify

past colleagues that had entered the profession a long time ago, and would have found it difficult to cope in the present system. The reflection highlighted skills they had at being adaptable and implementing repeated policy change, each unaware until reflecting on the representation about such personal skills.

The reflection highlighted how past practice had been weighted toward the practitioner being the most important person (as opposed to the client now) in the decision making process. Such a weighting was something that each practitioner initially refuted, but could now see that the changes that occurred happened so insidiously, that they had not noticed until now. Practitioners believed that the case study demanded a return to practitioner responsibility, as the clients could not be trusted. Each practitioner was happy that the client now had more involvement in decision making. In the discussion at this time, practitioners had come to the understanding that the risks of violence and self-harm had increased, but then on further reflection the skills of the practitioners had improved and the actual frequency of violence and self-harm was felt to be at similar or at even a lower level.

*The job has changed and I think that years ago people that are out working in the community would have been able to find a nice safe rehab ward in an institution as a staff nurse. I could...I've seen people come through after me into nursing, struggle with it and leave. One or two people I work with now would have enjoyed their career more if they had just been able to stay on the wards. But that's all gone. There are people out in the community that I think when they came into nursing and what it would entail, the reality is very different. And the risks that we have to carry and share are higher than they wanted to do.*

Practitioners used the representation to further reflect on their experiences with the media and the courts. One practitioner acknowledged that reading the case study had made them recall an experience in court. It caused the practitioner to relook at the passage of recalled events and identify that the reporting on their experience may be similar to the case study being read.

*I guess it makes me think about a story quite recently in my practice as I've not long since given evidence in an inquest and there was a local news story that sought to use some of the material from my inquest report in a very selective way to represent the story. It reminds me of that and makes me feel anxious.*

The representation in the case study initially made the practitioner relook at how they had reacted to the court case, and how the case study made them feel. Although initially anxious about errors being identified and publicised, this passage of thinking made the practitioner explore the changes made in practice and the process of learning. The practitioner accepted that past practice was influenced by the system of care offered at that time. The practitioner initially worried about unearthing past practice but with time identified that there were factors influencing their practice and thinking outside of their control. Thoughts emerged where the practitioner believed at the time of the coroner's court case they had followed policy unerringly. Reflecting again, it was felt that the staff in the case study potentially followed policy.

The practitioner explained that events sometimes just happened and that there was no deliberate attempt to do things wrong. A belief that experience and confidence to stop and think about the consequences of the decisions being made was probably not practiced. The case study however, triggered anxious thoughts related to potential blame for the outcome.

Practitioners attributed their understanding to obligations and broad goals for the service. Each looked at the personal impact that the case study had on them. Each practitioner self-examined their role and what they had done or could do.

The representations were seen in a negative way. A belief in all practitioners was that the only publicity that occurred in mental health was negative. This did not stop each practitioner feeling that part of their role was to educate colleagues and the general public to the realities of mental illness. Practitioners did feel that case studies, such as this one, were useful for them to reflect on and analyse their potential actions, but that they worried about the influence they had on the public and their reaction to the mentally ill.

None of the practitioners felt that media stories should be ignored, as often they were an account of the things that had gone wrong. The practitioners felt that such media stories could be a learning tool for practice development. Each practitioner found that reading the case study and chapter enabled them to articulate their role and clarify some of their thinking in relation to risk.



*I feel like these are the only stories where we are discussed in the media, and it makes me think about what my obligation is as a mental health practitioner ... to try and broaden public awareness and whether I do that enough and what is my true contribution to that.*

The representation of Peter Bryan caused each practitioner to identify clients and risks in the care they were involved in. Reading the representations caused reflections about care and management of dangerous people. Practitioners were able to identify what they would have done and the changes to practice that they would do.

*If this person was in my caseload it would affect my practice. I'd be gonna make sure that we have regular reviews that there are going to be multiagency panels involved because we have to manage the risk. We're going to share the knowledge of him with certain agencies because he carries a high risk because of his unpredictability.*

#### **4.7.4 What the interview process meant to the practitioners.**

The practitioners had both thought about the case study and reflected on practice during the timeframe of the interview schedule. During this time the practitioners had developed some understanding and identified meaning for them on the influence the case study may have had on them. Historically, Heidegger (1927) argued that the development of understanding often involves attaching it to something already known. As seen in the practitioner narratives used in this findings section, they used clinical examples that came to mind whilst reflecting on the case study and chapter. The practitioners also inferred anxiety related to

changes in practice and the potential loss of autonomy. The unearthing of personal understanding about what the interviews and the study meant to them highlighted a potential lack of confidence in continuing to practice how they felt they should. Revisiting the same thing or folding thoughts on thoughts (Webster 2008) engaged the practitioners in reflexively developing understanding in relation to the case study, the chapter and practice.

Each practitioner admitted that the interviews had given them time to look at their thinking and practice in a different way to normal. Although identifying the interviews as a challenge, they felt that the content of the interview and the process had made them re-examine their part in local practice and scrutinise their part in relation to risk. Practitioners suggested that an initial reaction would be to take no risks, leading to a defensive form of practice. Although thinking this, each practitioner felt that this approach would be unworkable for them.

For some, the experience had reaffirmed their level of experience and that sometimes policy and guidelines needed a moral underpinning. Some felt that risk policies and guidelines were cold and non-therapeutic. However, each practitioner recalled instances where policies had been followed and that they were a useful guide for practice. The experience for some highlighted the need for intuition and adaptability in the clinical area. Having reflected further the practitioners went on to argue that clinical risk taking was in need of further clarification in practice.

*Making sure nothing bad occurs to that person or to other people. But sometimes risk is about taking positive steps and allowing people to just have that little bit of freedom so they can develop. That they can flourish...in the same way you do with children and teenagers. You wouldn't keep them contained all the time as you don't develop the skills and knowledge you need to become independent in life without taking some risks and sometimes they may not always go according to plan. But you learn from that experience and move on... and think a bit more about your own practice. It makes you think what part intuition plays in my practice?*

There was a need for an objective view of risk in light of the failings highlighted in the case study, and some review of staff knowledge and training on risk.

*It was to do with just not acknowledging the seriousness of the crime. The crimes that he committed and ... that people around him were sucked into behaving in a certain way and minimising the problem. I don't think that was about intuition it was about looking at past history and how he was presenting and the reasons why he was there in the first place. And that was disregarded... and the thing of one person making the decision.*

An understanding of the role of practitioners and the media had in regard to the generation of an opinion, which then led to a reaction in clinical practice was discussed.

*The article was very narrow in focus and I don't think was effective in enlightening the public ...quite the reverse actually that it could be seen as promulgating the stereotypical fears within the public....I think for me it's around, does pressure of the media influence services and influence therefore how I work and therefore how my colleagues work? ... with clients ... and are we ...do we embrace risk as an opportunity to learn through experience*

An understanding that the work of the mental health practitioner carried a level of responsibility to protect the public was discussed. The practitioners acknowledged that they often worked with difficult clients, but felt that a level of autonomy was still needed. In essence it was acceptable that not all the risks could be eradicated.

*We have an opportunity as practitioners to help clients safely work with those risks, in a managed safe way, with an emphasis on safety, but you can't guarantee safety. The emphasis on managing safety and holding somebody through that ...so I fear my capacity to do that will be less, if the institutional framework prescribes action to try to eradicate those risks...*

There was an understanding that the use of case studies and chapters made the practitioners relook at their personal knowledge of risk and the implications for practice. Such an understanding enabled them to articulate their role and clarify things that potentially influenced their actions. Further, the action of relooking at practice highlighted the need to revisit themes such as risk and openly evaluate practitioner understanding and action.

*It has meant that I have reflected and thought about risk. And how do I assess and manage risk. Erm! ... But this has been useful to me to understand what I do with risk. It has helped make sense of what I already do. In some respects, because if you had sat me down, I wouldn't have been able to describe or frame it... and this has helped me to frame it. I enjoyed the process because it's good to think about things in different ways. I am a bit wary of where it finishes as it says we deliver a service that is not needs based, it's risk management based. I never really thought of it like that. Which is quite sad really as I thought we did both.*

The practitioners conceptualised the interviews as a mental exercise that pushed them to relook at their role as a mental health practitioner and their reactions to potential contradictions to their understanding of practice. It also made them consider practitioner vulnerability of working with people who do not tell you what they think, and the consequences as described in the case study.

*I've really enjoyed thinking about things that are absolutely to do with my everyday work and practice but in a particular context that is relevant but apart... risk and recovery, safeguarding, vulnerability, all of those kinds of things are absolutely my everyday business. It's been really nice to have some formalised space to think about those things in a more abstract way, but there's something important about context free reflection. It's sharpened in my mind. It reaffirmed what it means to be a mental health nurse and what I think it means to be a mental health nurse, which is to sit alongside people and to make sense and understand all kinds of distress outside of the bounds of social convention and how different that can be to the perceived societal role of mental health nursing keeping the public safe and predicting when someone is going to be violent. It made me think about failure to identify dangerousness. There are always hindsight appraisals, and what they're saying is that you've failed to guess what is in somebody else's mind.*

The experience made the practitioners consider responsibility, not only of the practitioner and the service, but also the clients. The practitioners identified that a change in practice in relation to risk related work was needed.

*It makes me sit back and think of more of the patient's experience of mental health services and how people fall through the gaps and that kind of interests me... and something I got from reading it was how he (Peter Bryan) seemed to slip through the net and bounce around in forensic services and non-forensic services. I think changes for myself is looking at risk management plans that are*

*going to identify work with the contributing factors not just about identifying the nature of someone's risk but actually what works at managing that risk with them.....something's gone wrong!*

A final understanding emerged in that practitioners spoke about the way that, as a practitioner, they often view the same information in different ways. An explanation as to why this may occur focused on latent pressure of responsibility and blame.

*Each time I have thought about the same thing I have had a completely different perspective on it... I mentioned at the beginning that I cannot believe when I first read it how I felt about it and that it provoked these feelings in me where I felt almost sick. I did feel sick and sorry for the people that were involved...and the things that they are going through. And it is not pleasant, and although they say that the NHS is not a blame culture, ultimately they want somebody to be responsible for that...and have lessons been learned? I am not sure. Ah! but it makes you reflect on those situations and things have to go wrong for change to happen. I would hope they don't have to, but that's what happens as a result. They look at the way it is managed... but I think I have found this very interesting how mental health nurses, me as well, seem to accept responsibility and blame very quickly.*

## **4.8 Discussion**

The influence of a newspaper representation of mental illness on mental health practitioners has clearly been explored. This study has identified a variety of areas where the media influenced the thoughts and actions of practitioners. The media representations led to:

- a) Practitioners focusing on the negative outcomes and the lack of control they may have over the decisions made in service, evoking fears related to personal autonomy and a sense of inevitability of something going wrong.
- b) Development of an understanding related to coping strategies and an appreciation of revisiting the same case study for another appraisal.
- c) Practitioners identifying the utility of reflection and ways to use it in both the clinical environment and education.

Each of these points is discussed further:

#### **4.8.1 Discussion of:**

The practitioners focusing on the negative outcomes and the lack of control they may have over the decisions made in service, evoking fears related to personal autonomy and a sense of inevitability of something going wrong.

The practitioners identified a concern related to changes in their working practice. The concern was not necessarily related to changes they imposed on their own practice but changes caused as a reaction to other's interpretation of the case study. There were worries that the practitioner's ability to deal with the outcome of such case studies would be ignored and management would introduce reforms. Practitioners believed that such reforms may potentially reduce their autonomy in care provision and challenge the practitioner's clinical experience. Although this fear was raised in the findings, little theoretical evidence is available about the

relationship of immediate change to practice caused by such case studies by management, although changes to practice by practitioners are evident.

Anecdotally, I can recall from years of practice, service directives, but these changes usually take the form of guidance, and eventually are absorbed into some service delivery review months later. But these fears were evident and possibly reinforced by micro management of all aspects of health care that practitioners now have to report on.

Where a story indicates that mental health services may be partly responsible for the death of a patient, it would seem logical that some change to practice would occur. The speed of change however, may not be as quick or as sweeping as initial practitioner fears may believe. Commonly, a return to familiarisation with existing policies is encouraged, and an increased adherence to such policies is argued for by management. Often, as in the case study, the problem is not in the policies, but in their application in practice. Such faults are used in the newspaper stories to exemplify dangers and to produce a sensational story that may sell more newspapers.

In truth, everybody would be pleased with a quick response to amend service failure, but if such a response was available quickly, then questions would be raised as to why it hadn't been introduced already. Health care systems are part of a large bureaucracy and changes in policy often take time and are incrementally applied (Deeming 2004; John and Beavan 2012; Miles *et al.* 1978; Walsh and



Ungson 1991, Wildavsky 1964). Therefore changes may occur but not necessarily in the short-term (Fixsen *et al.* 2005).

A fear of change is understandable having read the case study. There is an inference that the staff did not do all they could have done to protect the public and treat the illness that Peter Bryan had. Publication of the case study highlighted the lack of quality of care and protection provided by mental health staff and indicated the potential dangerousness of the mentally ill. The work of Cohen (2002), who explored the creation of 'moral panic' where something (in this case the mentally ill person epitomised by Peter Bryan) becomes a threat to societal values, can lead to a change in opinion related to a section of the population. In his book "Folk Devils and Moral Panics" Cohen details the reactions to the 'Teds' and 'Rockers' and the fear generated by the way they were portrayed.

Practitioners are exposed to stylised reports of the failure of the system of care they work in and the clients they work with, none more so than in the case study. The highlighting of such failures could increase personal anxiety, influence feelings and lead to a change in opinion related to the mentally ill and how the practitioner would work with them (Alaszewski 2003; Boyle *et al* 2009; Paterson and Stark 2001). The feelings created (in this case anxiety) have been argued to influence professional practice in mental health workers (Boyle *et al* 2009) in a prejudicial but often unconscious way (Prins 2002).

Feelings of relative powerlessness experienced by professionals, and practitioners in this study, could be argued to potentially lead to the development of a range of 'professional defences'. When used by practitioners, such defences may lead to (rare, but) catastrophic outcomes (Rumgay and Munro 2001). Defensive practice can take many forms; from not taking any risk decisions to taking risks but abdicating responsibility on to others. A problem is that when staff became defensive in this way they often used clinical judgement, and based decisions on emotions and feelings. Each of these factors is difficult to articulate and care packages become vague and poorly focused. Evidence of this is seen in the initial responses of the practitioners in this study.

*It reminds me that you only know what you know of the people at the time that you work with them... there's a potential to activate a defensive part of my thinking, because these kinds of stories always have lots of layers about how systems and people have failed, how mental health workers haven't done stuff and how tricky business predicting risk is, and if you get it wrong you're worried about feeling responsible, or the worry about being responsible, and I think it activates those thoughts.*

Such vague thinking and concerns about the complexity of cases and the responsibility of the practitioner have been described in independent reviews of care of mentally ill people who have killed. Verita (2005) detailed

*....staff clearly had concerns about Mr Hardy's past and current behaviour, but their reasons for being concerned remained only vaguely formulated and to a large extent implicit in the expressed feelings of staff, rather than explicitly described and monitored. The translation of implicit to explicit knowledge is essential in developing adequate care plans in general and in risk management in particular (11.5.8).*

In clinical practice, the practitioners work within a system of care that is risk averse, and policies are developed to balance the risks and ease the level of criticism that can be made on policy makers (Wolff 2002). There was a realisation in the practitioners that when decisions go wrong, that the practitioner will become the focus of criticism, not the policy makers. Hence, it is understandable that experienced practitioners, who have an understanding of the ways that policy and health care systems operate, feel a level of unease on reading such a case study (Prins 2002; 2005).

Birkland (1997) discussed the influence of events that arise suddenly and without any warning. To many the engagement in reading the case study for the first time mirrors this. Birkland (1997) also suggests that events arising suddenly can have an influence on the community in which the events occur and create a focus where attention is diverted to identifying the faults in the present system. Experienced practitioners work within and help to develop the systems of care. This is something that many of the practitioners discussed in their interviews it may, therefore be understandable for them to feel anxious that the blame for any events that the case study may highlight, may lead to criticism of their work.

Such themes of blame and criticism emerged in the interviews, and when reading the newspapers one would feel that mistakes are never acceptable, yet practitioners are human and do, on occasion, make errors of judgement (newspaper highlighting practice errors of letting people leave hospital, personal

errors in judgement and practitioners acting naively). However, Peter Bryan was able to fool the staff that allowed him to leave the unit, after all the only reason he was in medium secure accommodation at this time was to protect him from others. Therefore, it seemed understandable that the staff allowed him to leave if they felt that the problems threatening him had reduced. Whether the staff in the case study properly assessed the risk related to Peter Bryan is unclear, but it was clear from the experienced practitioners in this study that having read the case study and seen the outcomes they initially felt that the staff made the wrong decision allowing Peter Bryan to leave. With more time to reflect between interviews, the practitioners started to identify understandable reasons for the decision to let him leave the hospital. However, the practitioners were concerned about the potential lack of adherence to policies in the case study and the lack of collaboration from Peter Bryan. The practitioners did suggest that there seemed a sense of inevitability if staff acted outside of what they thought was safe practice. Furthermore, the practitioners felt that the staff in the case study probably didn't realise that they were acting in a dangerous way and could not have foreseen the outcome.

#### **4.8.2 Discussion of:**

The development of an understanding related to coping strategies and an appreciation of revisiting the same case study for another appraisal.

Practitioner's initial interviews acted as a catalyst for discussion for the next two interviews. With one week between interviews, the practitioners had time to consider the case study, the questions asked, and were able to revise their opinions of the case study. The time between interviews potentially led to a more carefully constructed series of responses in the next two interviews. A more considered view may have been helped by the practitioners being asked to complete a reflective journal for the experience. However, the deeper thoughts garnered from the case study tended to focus on what the practitioners would have done in the situation and the identification of structural inaccuracies with the reporting. Many introduced their approach and management that dealt with blame and misrepresentation. Each practitioner identified learning that was happening for them. Such learning was in the form of being given the opportunity to return to the 'same scenario and review without the fear of criticism'. The fact that they felt they had to offer this comment is potentially related to their appraisal of what was going on and their understanding of the aims of the interviews.

In the second interview, practitioners referred to their past comments, exploring initial impressions and tacit knowledge. Such an exploration started the process of a more critical reflective approach (Bright 1996) which led to them unearthing more detailed assumptions that the practitioners made on themselves, colleagues and the work they engaged in. The importance of this level of personal experience is seen in that it can influence the way we interpret our work and working

environment (Gunasekara 2013; McMillan-Coddington 2013; Smith *et al.* 2014; Somerville and Keeling 2004).

Some practitioners identified that the case study had come into their heads at unexpected times, recalling incidents at home that had made them think about the case study. One had actively avoided stories about mental illness in the media, but due to engaging in this study had developed a different approach. The practitioner recalled a past incident where they had given evidence in an inquiry and their statement was quoted in a way that did not represent their view. Like any other person who felt that they had been misrepresented the practitioner was angry. The experience of feeling misrepresented had left a distrust of the media and led to an avoidance of mental health related stories in the media as a coping strategy to avoid becoming angry. The practitioner acknowledged that when colleagues and clients talked to them about things that were currently happening in the news related to mental illness, they were unable and unwilling to offer an opinion. Although unhappy at this as they felt that others may think that they were not interested in the care of the mentally ill, the potential stress avoided outweighed the potential image that others may develop of them. The adoption of such an approach to dealing with media reports led to the practitioner practicing more on their own and not fully engaging in social discourse in the office and *ad hoc* peer supervision.

Other practitioners did not avoid media reports. Whether this was because these practitioners had not been misrepresented was never explored in the study. Many

of the practitioners identified that reading the case study and then rereading the same information helped them to identify how their thoughts may have changed. Such an approach enabled the practitioners to utilise broad reflective processes to question practice and then focus on specific themes they felt were in need of debate. Clearly practiced in the art of exploring dialogue and analysing emergent themes the practitioners mediated their emotional speech identified in the first interview and produced a more considered and less blaming analysis in the second interview. By the third interview a level of confidence was seen in the practitioners approach to management of themselves and others.

All practitioners involved in the study utilised past experiences to explain their actions and justified personal coping strategies at this time. Each practitioner saw utility of the interview material in their clinical practice as it enabled them to revisit themes they personally identified and review coping strategies used at that time (also see Themes emergent from the reflective journal and Peter Bryan stories in chapter 3). Clinical practice includes both time with clients and time away from clients discussing their care, often in multi-disciplinary team meetings and clinical supervision. Time away from clients is often seen by practitioners as a personal and professional developmental opportunity. The identification of 'ring fenced' time for such time away from clients for reflection and clinical supervision is a well-documented theme (British Association of Social Workers 2011; Cope 2010; Care Quality Commission [CQC] 2013; Nursing and Midwifery Council 2008b), but clinical supervision is also viewed with suspicion (Cole 2002). The quality of the

experience is dependent on the skills of both the supervisee and supervisor to make meaningful connections to practice (Bond and Holland 2011), but too many demands made by either party on the other could lead to resistance and a reduction in self-worth (Winnicott 1971). Extracts (see findings in chapters 3 and 4) from practitioner interviews allude to clinical supervision sessions with colleagues and the need to challenge practice.

The involvement in the interviews engaged the practitioners in something similar to a supervision type experience. Such an experience in itself identified that the experienced practitioner had a high level of self-awareness but still learned something new about their practice. This emancipatory experience is debated by Heath and Freshwater (2000) and was evident from the accounts of practitioners in respect to what the process had meant to them. The development of a level of personal meaning, in many ways identified that the experienced practitioners were self-evaluating and considering the effectiveness of their practice in the context of the case study. Furthermore, it also suggested that the practitioner had a level of understanding related to the working culture that went beyond the organisational level of understanding and found itself in the more interpersonal relationships developed outside of supervision and management. These seemingly 'high level' practices only emerged in the reflections due to self-awareness and repeated reflection on the case study with a level of academic challenge. This, almost paradoxical approach; looking back to move forward, that reflection caused in this



study, potentially only happened because of the structure of the interview process returning to the same theme but with new and fresh viewpoints over time.

Practitioners identified changes in emotions, from anxious and shock at the start to a more considered and confident at the conclusion. At times practitioners, during the identification of this change, noted that the level of confidence in practice was buoyed by the use of neat structures such as risk assessment and risk tool application. Worries emerged with the realisation that the practicalities of clinical practice did not always conform to the same level of neatness. Case studies such as Peter Bryan, and the outcome of the case study reinforced anxiety related to colleagues who may not possess their level of knowledge and confidence in selectively applying risk assessment tools.

The interviews and reflections made the practitioner's reappraise both their practice and that of others. Some saw it as an opportunity to talk about work in a way that the present supervisory structures did not permit. Others felt it enabled an understanding of the complicated nature of the work engaged in and the complex presentations that clients experienced. The approach of reading case studies and reflecting over time was felt to involve the use of clinical reasoning to make sense of the thoughts that emerged. Such a level of reasoning made the practitioners consider a wider range of influential factors than usually thought about.

Each practitioner identified varying influences of intuitive thinking that led to them considering changing clinical practice. The understanding gained from the experience in some way allowed them to articulate what they did as practitioners. The practitioners gained an understanding that their experience and level of knowledge gave purpose to who they were and what they did (Brookfield 2007).

The interview process was found to enable practitioners to appraise interpretations of the case study at different times and address their assumptions of the case study and the practice of others. This appraisal was potentially similar to the influence experienced when reading multiple versions of the same case study (see chapter 3). The practitioners acknowledged the opportunity to have space to review the case study and address their assumptions, comparing them to models of care and other's clinical practice.

The development of further understanding by reflection identified risk related thoughts about personal coping strategies. The practitioners were aware from reading the case study and chapter that when decisions 'go wrong' that an increase in criticism and feeling of blame (also see Themes emergent from the reflective journal and Peter Bryan stories in chapter 3) may be experienced by practitioners. A common coping strategy discussed in research was one of acceptance. The acceptance of things going wrong and people dying was suggested by Appleby *et al.* (2006) as something that was evident in the attitude of some staff, such as nurses and doctors. Appleby *et al.* (2006) argued that on occasion the staff were wrong to accept that there was an inevitability of deaths

occurring involving the mentally ill. The argument was clarified by Hussain (2006), who suggested that staff had become 'desensitised' to the violence and suicidality of some of their patients. I would challenge this view, arguing that the approach to risk management (using locally devised risk assessment tools) by the mental health services and the lack of in-patient beds has created a dangerous environment to practice in. Often risk assessment involves the use of a risk assessment tool, however, locally devised tools have questionable utility (see Carroll 2007), yet are often used in clinical practice. In all previous newspaper stories (see chapter 2), the use of such risk assessment tools are not referred to. In each occasion a risk assessment is debated and the outcome of the assessment is argued to guide staff in their understanding of the level of risk the person poses. The use of such tools in some ways differs from previous research carried out (Murphy 2004) where 'gut reaction' and 'experience' guided risk practice. Having assessments and tools that suggested risk but having no way to address the risk identified (by admitting to hospital) makes practitioners sceptical about the utility of the procedure. This was epitomised in some of the discussions (see findings in chapter 4) of the practitioners when discussing the outcome of risk assessments in practice. In one instance the practitioner looked at the consequences for the person who needed admission and decided against it. Although the risks were high, no harm came to the client. The trust in the assessment and tools were therefore questioned and modifications to personal practice involving assessing risk happened.

In clinical practice the use of risk assessment and risk tools are often used interchangeably and are a service policy that has to be followed. It became clear (see findings in chapter 4) that the practitioners accepted the use of the tools as everyday routine. However, the practitioner has no choice in the use of the risk tool or in the assessment process. The practitioners have to follow the policy of the Trust and utilise the assessment provided. This practice in many ways presents the practitioner with a lack of autonomy and control over what they may feel is the best assessment or tool to use. The practice may also lead to the action of assessing risk being seen by practitioners as another task rather than an important element in the assessment of the safety of an individual. Risk tools are often presented as a 'safety net' for practitioners, but in essence they have had a limited role in reducing homicides in the UK (Munro and Ramgay 2000). There is an argument that the lack of consistent routine care rather than the lack of the risk tool (Nielsen *et al.* 2011) is a factor in maintaining the homicide rate (The discussion related to risk assessment and tools is further developed in section 4.8.3 within this discussion).

#### **4.8.3 Discussion of:**

The practitioners identifying the utility of reflection and ways to use it in both the clinical environment and education.

The process of reading and then commenting on a case study from their practice and discussing a journal type article or chapter was not a new experience for the practitioners. All were experienced practitioners that had engaged in clinical supervision as supervisors and supervisees. Each practitioner had examined stories related to either their practice or others practice and unpacked them in supervision sessions. The main difference to what they had experienced in the past was in the content of discussion. None of the practitioners had used a newspaper story before for discussion in relation to their practice and to reflect on. Furthermore, they had not returned to the same story for a reappraisal, and then explored the impact of a chapter related to one specific theme of the case study.

Practitioners are encouraged to engage in reflection and clinical/ professional supervision (CQC 2013). Much of the everyday actions related to reflection are unmanaged and not recorded. Many reflective moments occur after contact with clients or after incidents which required some writing of reports or attending meetings. Other reflections occur in response to feedback (this could be from a colleague, client or something written, e.g. an article or story in print) which is something I have experienced (see chapter 1 and chapter 3) and felt was a contributory factor to starting this thesis.

The aim of the interview stage was to get the practitioners to give their thoughts about how the case study may affect their practice. The initial interview placed some practitioners in an uncomfortable position. Such a position was created by the interview schedule and a need to comment about initial impressions, but at the

initial interview they were not given time to consider the impact the case study may have in a wider sense. Such an approach placed them in a 'here and now' situation.

Supervision sessions commonly lead to reflections on practice and within this the practitioners have the opportunity to uncap feelings and values related to the practice they are engaging in. How the practitioners make sense of their reflections probably develops with experience. Earlier in their careers the practitioners probably had a limited sense of the work that a qualified practitioner would do and had the opportunity to look to others such as tutors for guidance and support (Warne and McAndrew 2009). As experienced practitioners the practitioners are reliant in large part on themselves for their development and on others such as supervisors that they use to 'bounce ideas off'. From starting as a student to coming to the point the practitioners find themselves in now, they have had to develop their own values and understanding of what is happening to them in practice by talking to others, reading and reflecting (Meyers and Jones 1993). The practitioners however, needed a level of creativity to make sense of the clinical experiences (Warne and McAndrew 2009). Case studies such as Peter Bryan's embrace that opportunity of using creativity and instead of focusing on students who are starting on a career in mental health work (Warne and McAndrew 2009) I have focused on experienced practitioners who have had little research conducted on them. Developing an understanding of the values that led to the interpretation

of how to practice in a given situation adds to the sense of self-meaning (Yalom 1980).

As students and junior members of a team, the practitioners were given time to think and reflect with tutors and mentors who attempted to help them to try to understand the emotional values of the experiences. This aim was to develop a level of emotional intelligence such as self-awareness, self-regulation, motivation, empathy, and social skill (Goleman 1995) that could help them to make sense of what was going on. As experienced practitioners it was hoped that an awareness of the emotional experiences they were encountering on a regular basis would be prompting thoughts that would lead to a level of learning and introspection.

Introducing a novel piece of information such as an article from a newspaper (with its themed account) may introduce some new knowledge that the practitioner may find emotionally troublesome to deal with (Meyer and Land 2005). This level of difficulty prompted reflection to seek out experiences that enabled practitioners to understand and make sense of what they have read.

Many, as reported in the previous sections of this discussion, were shocked at the content but angry with the portrayal. A negative portrayal of mental health care is commonly presented in the media (see chapter 2), but practitioners seemed a little unready for the experience and caught in a situation where they could only say what they felt at that time and influenced by the experiences they had with past media representations. Working in the 'here and now' with all the associated problems caused by negative images is important as clinical practice involves

dealing with complicated and often stressful scenarios influenced by clients, colleagues and the media as they occur.

Much of this experience is not a new thing for experienced practitioners, as they have (all the practitioners involved in this study) engaged in academic courses that demanded the linking of theory and practice. The outcome of linking theory and practice led them to achieve academic recognition but also to understand the technical aspects of care that can be repeated and demonstrated to others. Moving into clinical practice, practitioners are exposed to a newer form of learning that is generally self-directed and influenced by the here and now experiences. Instead of having to demonstrate the technical aspects of care to others that are watching the practitioners, the practitioners need to apply the technical skills to situations they interpret as needing them. Instead of going back to university to discuss with personal tutors, qualified staff often engage in less frequent and less formal supervision type encounters with colleagues.

There was anticipation that an experienced practitioner would possess the technical and academic skills to understand the learning that happens following the completion of health care education programmes. Understanding what influenced their understanding and decision making is part of this study. Awareness of application of technical skills such as using risk assessments is presented in the case study to focus on something the practitioners regularly do in practice and has a theoretical and procedural component which is inherent in practice. Using this approach was felt to potentially place the practitioner in a situation where they



would reframe their understanding and practice. Such reframing would enable the practitioner to start to make sense of the wider influences other than those based solely in the clinical arena.

However, there are influences and tasks in practice that each practitioner has to work with. One such task, risk assessment /risk tools, has been a consistent theme throughout this study and is evident in each chapter. The guidance on the use of risk assessment tools has not critically questioned their utility (Monaghan and Steadman 1996; Szmukler 2000). Doubts related to guidance emerged in the literature to the present day with a range of articles exploring their use in assessing suicide (Simon and Hales 2006), the perception of risk (Slovic 2000), and the way that professional mental health care workers communicate the risk of violence (Heilbrun *et al.* 2004). The practitioners, after reflecting further, understood the way that they modified their approach to risk assessment and risk tools used in clinical work. Having read the chapter (from the Godin book presented at the end of interview 2), the practitioners were able to candidly suggest the 'tricky business' of risk assessment and the anxiety that reflection on case studies like that of Peter Bryan caused them.

They acknowledged that risk assessment explores many uncertainties, that only experience and further education can start to answer. A level of understanding emerged from the reflections that authors such as Webster *et al.* (2013) were probably aware of the limitations of present risk assessments and were attempting to address the uncertainties with further development of an 'all singing and

dancing' risk tool. Webster *et al.* (2013) embed the risk assessment tools into a more robust approach that addresses the concerns of Monaghan and Steadman (1996), developing a structured professional judgement approach. Such judgement is seen in the narratives of some of the practitioners when reflecting on clinical care, especially ones that suggest that they do not use a risk assessment tool. In each case the approach used by the practitioner attempted to identify causal factors related to risk and improve risk identification and potential management.

Although Webster *et al.* (2013) feel that the development of structured judgement may address the concerns of authors such as Petch (2001), who endorses the arguments of Monaghan and Steadman (1996) and Szmukler (2000). They fail to address Petch's (2001) argument that they (risk assessments) do not make a significant impact on public safety and are reliant on the correct choice of tool, use and interpretation by practitioners. The more considered reflections of practitioners went further in detailing the influence of some risk assessment tools on clients, arguing that the use may in some cases make things worse for the client (see findings in chapter 4). The present day situation is summed up by Appelbaum and the Federal Judicial Center (2011) where they feel that all the work on risk assessments has led to general statements of probability of particular outcomes, with an acknowledgment of the uncertainties involved. Therefore, arguing that research on risk tool usage leaves the question of safety of the public in a similar uncertain position as it was when Monaghan and Steadman (1996) suggested potential problems with their usage.

## **4.9 Conclusion**

The case study did create some changes in the thinking and actions of the practitioners. The implications are debated later, but there was a clear process of reacting to the reading of the case study to conceptualising what was needed to address personal interpretations. Such a process in some ways mirrors some of the formulaic models identified in managing 'bad news' (bereavement- Kübler-Ross 1969). Although there were different triggers, there does seem to be a similar process to that of managing bad news followed by the practitioners that needs further investigation.

The implications for both practice and education are clear and the availability of such a wealth of usable stories for all fields of health care and allied services is an untapped resource.

## **4.10 Key points**

- The case study enabled all the practitioners to engage in a reflective series of interviews and establish initial and later more considered reflections.
- The use of a reflexive approach with each of the practitioners allowed them to frame their reflections in their personal perspective of how the case study used, influenced their thinking and actions.

- Generic themes related to risk, blame and professionalism emerged in the reflections.
- Practitioners were able to reflect on the influence that the case study had on them and found that only after discussing the reflections in the interviews that they became aware of some of their defensive type thoughts and actions.
- After reading the case study and chapter, the practitioners were able to understand the influence their role had on service delivery and identified the influence they had on other practitioners and the general public.
- The practitioners were able to utilise the interviews to discuss their immediate thoughts and revisit and modify views in later interviews with a focus on changing practice.
- Each practitioner identified personal coping strategies and was able to re-evaluate their effectiveness in context of risk management and assessment.
- All the practitioners saw utility of the interviews and the case study for clinical and educational use in developing and challenging practice related decisions.
- Each practitioner during the three interviews changed their view of the care offered and presented a view as to what should have happened if they were working with the case study.

# Chapter 5

## 5.1 Commentary

The aim of the study was: To identify the influence of newspaper representations of mental illness on mental health practitioners. This was achieved by the use of an emergent design that used various methods, addressing the questions that arose throughout the study. The methods employed included the use of content analysis, self-reflection and the analysis of interviews involving experienced mental health practitioners.

Using an emergent design, this thesis has:

- explored the way the mentally ill are represented in UK National newspapers and identified the extent and nature of such representations
- identified the way which a case study, representative of the portrayal of the mentally ill in newspapers, influenced my thoughts relating to the care of the mentally ill
- identified the ways that a case study impacted on the decision making and practice of experienced practitioners who work in the mental health field.

Each of these aspects has been discussed individually and in detail in chapter 2, 3 and 4 respectively. This chapter aims to draw the findings together and identify potential implications of these findings to my practice as a mental health practitioner, a mental health lecturer and a researcher, and practice in general.

This study should act as a reminder of how the mentally ill have been portrayed in the past, but also more importantly how they are portrayed in the present and the influence this has on people. Such portrayals have been explored in relation to personal and collective reflections and have been linked to the ways they may influence practitioners' actions. The reflections are important in identifying values for care and collectively enlightening what we and others should care about and potentially how changes in our practice can occur.

The initial stage of this study, although not necessarily aiming to develop new knowledge, can be considered to be at the forefront of exploring the representation of mental illness in newspapers, as such studies, whilst being carried out in the past, have not been conducted for some time. I have to accept that during the time of the study Goulden *et al.* (2011) published a paper that explored the representations of mental illness in newspapers. However, as discussed in chapter 2 the outcomes for Goulden *et al.* (2011) were slightly different than mine.

My study led to the identification of terms of reference used in the media for the mentally ill and the development of a new set of baselines for such terms. The rhetoric of the media seemed largely unaffected since past studies (Philo 1996; Ward 1997; Wahl 1996) and by the Press Complaints Committee guidance (PCC 1997 and 2006). Generally the language used by the newspapers continued to reference violence and danger within stories relating to a mental health matter.

The study also identified the new term 'drugs' was commonly used in mental health stories, both prescribed and non-prescribed.

The collective reflections on the portrayal of mental illness, and in particular a case study, led to new knowledge and the identification of shared norms of a group of practitioners. This was achieved by the practitioners exploring initial and unmodified reflections that suggested blame and frustration. The data collection design of the study provided the time and thinking space to offer more considered reflections that shifted the focus away from the individual and on to the organisation. The practitioners embedded themselves in the story, offering personal values and practice exemplifiers of how they would have handled the presenting story. Such reflections created a situation where the practitioners identified personal fears for practice but collective challenges for the future.

The design of the study was at the forefront of practice related research. The emergent nature of the study allowed for a more naturalistic investigation that gathered information in relation to the questions identified. The design was allowed to follow a path that was central to practice development and identify insider and outsider views on things that were felt important to mental health care. Many insights relating to the treatment and care of the mentally ill were identified. These insights were from a personal perspective (chapter 3), and from the perspectives of a group of experienced mental health practitioners (chapter 4). Each practitioner unpacked the information in a singular fashion, yet when looked

at as a whole similarities were apparent in the values expressed and the identification of potential influences on care.

The reflections presented many practical visions for care and new insights that allowed the practitioners to begin to make sense of how a newspaper story could make an experienced practitioner feel, and potentially affect their practice. The reflections enlightened the practitioners to see the influence not only on them but also on colleagues and the decisions made in the care of the mentally ill that such a story had. The approach engaged the practitioners and enabled them to look back on their practice and to consider changes that may happen in the future. I am sure that this was not an easy experience for the practitioners, leading some to potentially identify a crisis in self-confidence leading to them rechecking clinical information that they were previously confident about, a process similar to the one I had gone through in exploring this material. Such a journey led to the identification of potential conflicts with practice and changes in thinking and in practice that the practitioners were initially unaware of. Identifying this enhanced the awareness of autonomy in the experienced practitioner and the value of this was exemplified by the fear of the loss of such autonomy because of the case study and actions of those involved in the case study, i.e. that practice would be driven by reaction to media representations as opposed to personal professional values.

An awareness of the bureaucracy of the mental health care system and the seemingly immovable pieces of legislation (Mental Health Act, Department of



Health 1983) were not viewed as limitations on the practice of each of the practitioners. Modifications to practice that allowed autonomy were made, and risk taking was made in a compassionate and sensitive way. Each practitioner took risks even though they knew the potential consequences for the client, for the service and for themselves may be negative. Each practitioner, although separating their risk taking from that taken in the story, could see that safeguards had clearly not been undertaken (evidence of a risk assessment) within the case study used. All the practitioners saw the utility of reflecting on academic literature to enable them to identify alternative ways of risk management and to articulate their role in relation to risk taking.

The study enabled a reconstruction of the reading of a risk related practice incident that had relevance to practice. The study also allowed the practitioners to review and evaluate practice related policies, exploring their utility in their clinical contacts. Each practitioner identified what appeared to be new practical understandings of what went on in the story, and offered equally practical ways to manage such understandings. What did become clear was that the practitioners understood the complexities of health care in the NHS, and that quick fixes were not necessarily available.

To my knowledge no comparable study, at present exists in the literature to the one undertaken. Therefore, much of the information identified presents a new level of knowledge about the influence a newspaper story may have on a reader.

The study also embraced a novel design that ultimately addressed the aim of the study.

The study allowed practitioners to unpack a real story and embed themselves in the complexities of the particular case, presenting them with an unfolding story that used a rhetoric that was stigmatising in several ways. Firstly, the language used in the newspapers. Secondly, the language used in clinical practice. The newspapers were found to present stories that emphasise the danger that the mentally ill present. The clinicians in the study seemed uneasy with this yet admitted to continuing to practice in an environment where risk assessments and risk language was used for all people using the mental health services to establish the danger they posed. The fact that must not be ignored from the case study was that Peter Bryan (who was extremely dangerous) was in hospital because of the threat to him, not because of the threat he posed. With hindsight, it would be easy to argue that the staff should have completed a risk assessment, knowing how the story unfolded, but no question was addressed as to why they hadn't.

Whilst listening to the practitioners, it became clear that each was passionate about the care they provided for the mentally ill. The practitioners were, however, frustrated by the systems that influenced the care they provided and although senior in the profession, felt impotent to influence change. This frustration, however, did not stop them from practicing in a creative way and, occasionally, outside of what they thought were practice guidelines.

I have come to the conclusion that individual cases like that of Peter Bryan have a great deal of utility in getting practitioners to look at their values and practice. Reading and reflecting on such a case enabled both the practitioners, and myself, to identify new knowledge and to see the gradual changes that had happened in practice, but also to see changes that needed to happen in themselves and their colleagues. The emergence of such information has implications for; practitioners, clinical practice, education, research and people with a mental illness. Each of these implications is addressed in the next section.

## **5.2 Implications for practitioners**

The influences identified in this thesis of reading the newspaper story caused defensive type thoughts related to practice and in some cases led to reported changes in practice. Embedding myself in the study enabled me to relook at the influence that the representations had on practitioners of such a study. This insider view led me to conclude that there was a sense of some social control being used to guide my opinion of the mentally ill and their care (Adshead 2009). Although this realisation (in both me and the practitioners) led to fears for practice and autonomy to make decisions, it generated an understanding of latent factors that influence practitioner's thoughts and action.

The use of a method of data collection that repeatedly returned to thoughts related to one story enabled the practitioners to compare intuitive thoughts and

more considered thoughts. Such an approach is similar to those used in clinical supervision type sessions (Campbell 2006), however, clinical supervision tends to return to themes and actions rather than a whole story.

Key implications:

- for practitioners to broaden their view of factors that may influence their thinking and practice
- to engage in clinical supervision and return to cases more frequently and explore further potential ways to provide care.

### **5.3 Implications for clinical practice**

Having reviewed the case of Peter Bryan and listened to the comments of practitioners in this study, I feel that clinical practice needs to make some changes in the way that care is envisaged and provided. I feel that many of the changes can be achieved by the use of Continuing Professional Development (CPD), and the release of staff for training. At present the clinical arena is considered to have lost its focus on care and become a service that is directed by the number of contacts commissioners and purchasers want the service to provide (NHS 2014). The outcome and improvement of the people that receive care from the service is poorly identified and practitioners are advised on minimum numbers of contacts and schedules to achieve this. Autonomy has thus been reduced on the type of care provided and on the duration of care offered. Mental health service users

receive a standardised formulaic package of care that is measured by a variety of narrow markers for change. Such a problem was highlighted by Castel (1991), and led to the point where he argued that modern health care had become reliant on multiple systems that rendered individual interviews between practitioners and clients almost dispensable.

During the time of conducting this study, I have felt the need to both make changes in my practice and offer alternative advice to clinical practice areas. One such piece of advice related to the identification of how practitioners were practicing and the use of such information in clinical supervision sessions. To enable practitioners to identify how they were practicing I started to use Routine Outcome Measurement Scales (ROMS) and Routine Experiential Measurement Scales (REMS). These scales were developed in my practice area and completed by clients of the practitioners. The scales, I believe, have use in clinical supervision sessions, but also have utility for a wider service review related to care. Each of the scales provided feedback on the care provided and with an opportunity for the practitioner to identify in each case the way they performed. The development of such a position of understanding enabled the practitioner to initially have the feedback and then consider the actions needed to address what they made of it. Hence replicating part of the approach used in the data collection with practitioners.

Although not discussed in the body of this thesis, I feel the use of such scales to be part of a future publication. I believe that changes to practice need to be

shared and publication is one way to do this. Other ways of sharing information could be by the use of electronic forums (as used by newspapers).

Key implications:

- that staff are encouraged to focus on their own thoughts and practice in a systematic way via clinical supervision time
- staff need to be encouraged (by having support locally) to publish clinical stories, both to the public and other professionals, and utilise journals that have a wide and, potentially, free availability.

## **5.4 Implications for education**

This study has identified that there is a wealth of material that represents how society's and professional's attitudes may be being guided about the mentally ill and their care. This material at present is an untapped source of learning in many health care institutions due to narrow curricula, an increase in technical demands for practitioners by professional bodies (Nursing and Midwifery Council 2008b) and a drive from institutions to utilise evidence based care. The latter point is an important one as there was a limited evidence base related to the influence of newspaper stories on care.

Many educational institutions embed 'values based practice' (Woodbridge and Fulford 2004) in curricula, and engage practitioners to reflect on factors that influence care. Yet "*clinicians are not always aware of how their values*

*influence their decisions and communications*” (Adshead 2009 p 470). The implications from this study enhance the understanding of the lack of awareness that our present educational approach is having on practitioners. It proposes that a broader view of material that could be utilised in education should be made, but also that returning to material at a later date may enable practitioners to understand changes that have been made in their thinking and practice.

The educational implications apply for all aspects of health care education, including nursing and allied health care workers. Such information can be offered via professional training courses and also CPD days. The information should also be embedded in supervision training and Trust policies.

Key implications:

- broaden curricula to ensure a wider understanding of the influential factors affecting practitioner attitude and practice
- embrace ‘values based practice’ but broaden it to explore factors involved in the development of an attitude
- provide educational opportunities for staff using real-life stories that challenge how they think about themselves and their practice.

## **5.5 Implications for research**

A great deal of past literature related to representations has focused on identifying and quantifying what was being said (e.g. see Pirkis and Francis 2012). This study is at the forefront of research in this area as it has moved the exploration on to a new level of exploring what impact these representations have on practitioners in mental health. This study also identified novel information related to clinical practice and understanding how practitioners react to a newspaper story that has reference to the mentally ill and mental health care.

The emergent nature of this study has allowed me to follow paths of inquiry that addressed the research questions. It however made me make a decision at times, where more than one line of inquiry emerged and a choice had to be made as to how to proceed. Being aware of this is important, as further research can be conducted to explore these other lines of inquiry and this would further enhance the knowledge related to the representations of mental illness.

An implication of this study is that the inclusion criteria for practitioners were potentially too limited. For future research, a study should include a broadening of practitioner inclusion to ensure that a range of experience and practitioners from different areas of the UK were involved. Such a research study is realistic as the University where I work has a focus of generating an impact on the community and on the public sector. Much of the focus for the coming years is going to be on developing research that goes beyond academia and has utility in the community



where we live and work and with public sector involvement (University of Salford 2013).

The structure of the study has been found to be useful in identifying how newspaper representations are currently presented and for identifying practitioner understanding and practitioner actions following the reading of such a representation. This study has developed a template for future research that focuses on exploring the influence of media stories on people.

Key implications:

- engage in further research related to a wider sample of practitioners (users and carers) from differing disciplines and varying experience
- encourage researchers and teachers to start to embrace the use of hybrid approaches to research design and highlight their utility in real world research
- examine the modifications to supervision type models for clinical practice and establish outcomes.

## **5.6 Implications for the mentally ill**

The mentally ill continue to be represented in a stigmatising way by the language used to describe them in newspapers (Murphy *et al.* 2013). Such stigmatising language has been identified to negatively influence the time taken to recover from an episode of mental illness (Stuart 2006). The implications for the mentally

ill of this stigmatisation is a potentially negative influence on the acceptance of mental illness in society by the general public (Dietrich *et al.* 2006; Thornton and Wahl 1996; Philo *et al.* 1997), by employers (Biggs *et al.* 2010; Danson and Gilmore 2009; Henderson *et al.* 2013) and potentially mental health practitioners (Bevan *et al.* 2013; Marwaha *et al.* 2009).

As practitioner's thoughts and actions were influenced by the media, so, potentially, are the thoughts and actions of the mentally ill. An implication could be that the mentally ill's experience and engagement in treatment is affected and they are asked more risk related questions. The emphasis on asking more risk related questions could cause the mentally ill and others close to them, to negatively question their own understanding of health and recovery.

Key implications:

- to continue to explore the influence that media representations have on the mentally ill, establishing how such media representations continue to influence recovery and engagement in treatment
- to engage in further research to explore the influence media representations have on family members and carers of the mentally ill.

## **5.7 Summary**

The thesis is built on data collected from three stages of inquiry. The design of these stages was not predetermined and was developed to address questions that

emerged as the inquiry moved on (see Figure 5.1 for review of research stages and index of evidence). The overall design of the inquiry would be termed an 'emergent design'.

The findings from the inquiry highlighted the lack of change that has happened to the way the mentally ill and mental health practice is represented in a sample of UK newspapers over a ten year period of time. This is in spite of campaigns by the Royal College of Psychiatry (Crisp *et al.* 2004) and the comments made by the Press Complaints Committee (1997; 2006) to present less negative and stigmatising representations of mental illness.

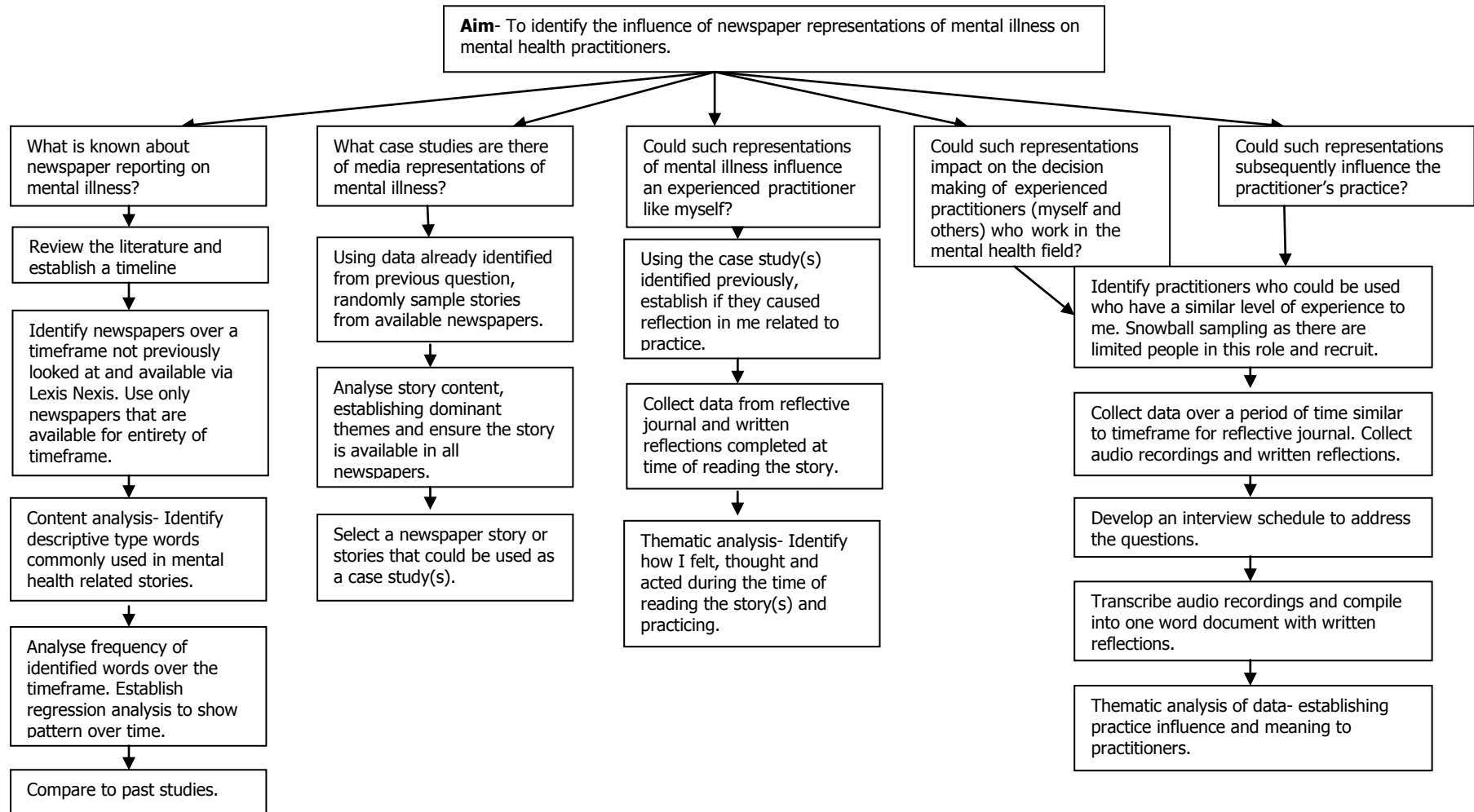
The reading of a newspaper story that presents a negatively orientated representation caused reflections in experienced practitioners. The practitioners were initially unaware of any influence on their thoughts or actions, but with further reflections they started to see subtle changes in their thinking and practice. Thoughts emerged related to risk, blame and professionalism. Such thoughts when discussed in interviews highlight a level of defensiveness related to practice and the influence such thoughts had on their role and service delivery.

The use of reflection in the interviews presented the practitioners with the opportunity to revisit and modify initial impressions of the case study and identify personal coping strategies that had use in clinical and educational settings. The reflections aided the practitioners in identifying and challenging thoughts and actions potentially linked to their initial impressions of reading the case study. Each

of the practitioners modified their view of the case study (from their initial impression) and identified similarities in cases that they had encountered in their clinical practice. All practitioners saw the utility of using case studies (a newspaper story involving a mental health theme) for clinical and educational purposes.

The concept of reflective practice, particularly in mental health nursing is well documented however; the approach used within this thesis appears more powerful than is often used in practice. One of the key issues appears to be the ability of practitioners to access supervision (and the use of reflective practice within this) within their day to day work.

**Figure 5.1 Stages of research (review-index of evidence and key points)**



Process of the study

**Key Points**

- Stigmatising language was used to represent mental illness and the mentally ill in the timeframe of the study (see section 2.2; Table 2.1, section 2.4, Appendix 2.1)
- The analysis completed, identified frequently used terms; e.g. drugs and violence, in mental health related stories (see Table 2.3; Appendix 2.3).
- There was an increase in frequency of mental health related newspaper stories over the time of the study (see section 2.8; Appendix 2.3)
- The identification of the term 'drugs' in mental health stories had not been discussed in previous studies, but the linking of violence was a common trend (see section 2.9; section 2.12, Appendix 2.4)

**Key Points**

- The dominant themes established a negative image of both the mentally ill and the care they received (see section 2.10; Appendix 2.4).
- Emphasis was made on the need for protection for the general public (from the mentally ill) and the lack of trust that should be accepted for the established services that both care for the mentally ill and manage the provision of care (see section 2.12).
- A story involving a named person who had committed a violent act was more often found in all newspapers and contained detailed accounts of the incident and background to the incident (see section 3.2; Appendix 3.1).

**Key Points**

- The story of Peter Bryan was used as the 'case study' and the newspaper story was found to cause me to reflect on practice (see section 3.4; section 3.5).
- Using concurrent data collection methods allowed for a linking of reflections on the story and the identification of specific practice in the clinical area (see section 3.5; section 3.6).
- The story caused me to feel defensive and focused my attention on risk related practice (see section 3.5; section 3.6).

**Key Points**

- The identification of practitioners with a similar level of experience was difficult as there were a limited number of practitioners with such experience (see section 4.4).
- The use of an interview with themed questions and the collection of written reflections generated data that was similar across all practitioners see section 4.5; section 4.6; section 4.7; Appendix 4.3).
- Practitioners were able to reflect on the Peter Bryan story and found they focused on risk and how risks could become an issue in clinical practice following the reading of the story (see section 4.7).
- The influence identified by practitioners was that each saw initial thoughts about the story change with time, and that they modified what their actions would be over the series of interviews (see section 4.8).

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## **Volume 2.**

### **Introduction to volume 2**

This volume is presented for the reader to use as a reference point for further information. It is envisaged that the volume will be read side by side with volume 1. Such an approach will present the reader with a choice of how they want to read the thesis and identify a time when supplementary reading is needed.

Initially the thesis was going to be bound as one document, but it was found that any flow that was generated was regularly interrupted by passages of important text that adopted a different style of writing. Following discussion with the supervision team it was agreed that an alternate approach would be to remove most of the text that upset the flow and develop a second volume.

The development of this volume has enhanced the flow of volume 1 and presents a volume that adds detail and clarification for use at the reader's discretion.



## Appendices.

### Appendix 2.1 Updated published newspaper representation literature 2008-2013.

Authors	Title	Type of Study	Place	Findings
Thornicroft <i>et al.</i> (2013)	Newspaper coverage of mental illness in England 2008-2011.	Content analysis	UK	The study focused on newspaper reporting following the 'Time to Change' anti-stigma campaign from the Royal College of Psychiatry. Using 2 randomly sampled days in the period 2008-2011, 27 local and national newspapers were searched for articles related to mental illness. They identified a significant increase in the number of anti-stigma articles from 2008 to 2011, but no reduction in the stigmatising articles. The authors present the findings as a guide for newspaper editors and journalists that report on mental illness stories.
Murphy <i>et al.</i> (2013)	The changing face of newspaper representations of mental illness	Content analysis	UK	Using the Lexis Nexis database, the study looked at articles with a reference to mental illness in the time period of December 1998 and November 2008. The study identified a trend of an increasing number of mental health related stories being published in 4 UK national newspapers compared to all other stories. The study also identified the

				frequent use of negative terms such as violence in around 21% of all mental health related articles. The term drugs emerged as frequently associated term in around 35% of the sampled stories and stigmatising diagnostic terms (schizophrenic) were identified but in only 2% of the sampled mental health articles.
Chen <i>et al.</i> (2012)	Media Representation of Gender Patterns of Suicide in Taiwan	Comparative analysis	Taiwan	The study compared the reporting of suicide in 4 major Taiwanese newspapers in 2009. Gender differences in relation to contributing factors and methods were analysed. The study found that where an unusual method of suicide was used in males, there was a tendency to over report. In women, over reporting was identified in extended suicides. Reasons for suicide in men were work related issues after legal problems and in women due to mental illness or relationship problems. An under-reporting of mental illness as a factor in the suicide of men was identified.
Dubugras <i>et al.</i> (2011)	Portrayal of schizophrenia in a prestigious newspaper in Brazil	Descriptive	Brazil	The study explored reporting in Brazil's largest national newspaper, <i>Folha de Sao Paulo</i> , between 2007 and 2008. Out of a total of 219 articles published with a reference to schizophrenia, 60 of these stories developed negative accounts of the illness and only 14 gave a positive account. Importantly 144 stories presented the illness out of context

				with the medical definition and used metaphors and slang language to describe the illness.
Goulden <i>et al.</i> (2011)	Newspaper coverage of mental illness in the UK, 1992-2008	Content analysis	UK	Identified 1361 article published in 3 specific years (1992, 2000 and 2008) in a range of UK newspapers. Stories were categorised into categories such as; bad news or danger to others; danger to self; victimisation and strange. Good news was categorised as understanding of mental illness and advocacy. The number of stories in each category was then compared to each of the years the data was collected for. Goulden <i>et al</i> /found a decrease in the frequency of bad news stories with time and an increase in good news stories. Stories where schizophrenia was discussed remained in the bad news stories and there was no great change in the frequency. Most bad news stories appeared in tabloids.
Holman (2011)	Building Bias: Media portrayal of postpartum disorders and mental illness stereotypes	Descriptive, comparative analysis	USA	The study used a purposive sample of stories involving post-partum depression and post-partum psychosis in newspapers and magazines between 1998 and 2008. The study looked at how articles about women with post-partum disorders were more frequently presented where violence against children occurred than where violence was not present. The portrayals attributed exaggerated symptoms and

				behaviour. With time, the study found that the exaggerations and claims about symptoms became less dramatic.
Kalucy <i>et al.</i> (2011)	Comparison of British national newspaper coverage of homicide committed by perpetrators with and without mental illness	Descriptive and regression analysis	UK	The study explored whether homicides committed by the mentally ill were more likely to be reported in newspapers than homicides committed by non-mentally ill people. Between April 2000 and March 2001, there were 577 homicides in the UK. They found that homicides by people with a mental illness and people without the illness were equally likely to be reported.
Magliano <i>et al.</i> (2011)	Metaphoric and non-metaphoric use of the term "schizophrenia" in Italian newspapers	Descriptive	Italy	The study looked at how the term schizophreni* was reported in 22 Italian newspapers during 2008. The study identified 1087 articles, 74% of these used the term metaphorically. Where the term was used in this way, the majority discussed incoherence (85%), oddness (11%) and dangerousness in only 4%. In articles where schizophreni* was not used as a metaphor, reference to homicides and assaults (49% and 43% respectively) frequently occurred.
Shepherd & Seale (2011)	Eating disorders in the media: The changing nature of	Descriptive and comparative	UK	Using Lexis Nexis database, Shepherd & Seale looked at the representation of eating disorders in 7 UK newspapers. Data was collected between October 2004 and October 2005. Direct comparisons

	UK newspaper reports	analysis		were made with the O'Hara and Smith (2007) study. Further searches involving other dates were conducted in order to establish trends and patterns of reporting. They argued that the UK reporting of eating disorders was more accurate than the USA and suggested that the disorder was most prevalent in young white females. There was difference in the newspaper reporting with tabloids focussing more on complications and the broadsheets on research.
Wilde <i>et al.</i> (2011)	Portrayal of psychiatric genetics in Australian print news media, 1996-2009	Content and frame analysis	Australia	The study looked at the representation of the genetic arguments for mental illness. The study involved the searching of 14 Australian newspapers (1996-2009). The study identified that the majority of stories related to the cause of mental illness and the role that genes played in the development of a mental illness. More often the evidence was used to present a positive picture of therapy for the mentally ill in the future rather than a negative one.
Saguy & Gruys (2010)	News media constructions of overweight and eating disorders	Descriptive	USA	Using data collected from the New York Times and Newsweek, the study focused on the representation of obesity, anorexia and bulimia between 1995 and 2005. There were 174 articles on obesity and 64 on anorexia or bulimia. The representations suggested that people who were obese were to blame for their problems and people with anorexia

				or bulimic were victims.
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## **Appendix 2.2 'Discussion on recent research in relation to representations in newspapers of mental illness'.**

Little change has been found in the content of newspaper reporting related to mental illness and mental health care. Stigmatising and negative representations continue to be used and this is at a similar level to that found previously (Dubugras *et al.* 2011; Magliano *et al.* 2011; Murphy *et al.* 2013; Thornicroft *et al.* 2013). However, there have been explorations of newer themes and potential factors contributing to mental illness, and these have been reported to present a more positive representation of the illness (Wilde *et al.* 2011).

More detailed studies have explored the way the newspapers discuss suicide and mental health as a contributory factor. Chen *et al.* (2012) argued that the newspapers often present the cause for mental illness and suicide to be socio-economic in nature (similar to Bilic and Geoganca 2007) however, they also reported gender differences. Men tended to commit suicide due to work and legal problems, women due to relationship difficulties. It would seem reasonable to believe that men experiencing problems such work and legal problems and being in a relationship may experience emotional and relationship difficulties as well. Such an association was never explored in any depth in this study.

Other recent studies have looked at newspaper representations of eating disorders (Saguy and Gruys 2010; Shepherd and Seale 2011) and established that people with obesity problems were blamed for their illness

and those with anorexia or bulimia were not (Saguy and Gruys 2010). In past studies it was found that newspapers differentiated forms of mental illness in a similar way. People with depressive type problems are represented more ambiguously and normal than people with psychosis who are often presented as violent (Ray and Hinnant 2009; Rowe *et al.* 2003).



**Appendix 2.3 Tables and Figures demonstrating the statistical results from the data collected from Lexis Nexis – December 1998- November 2008.**

Table A2.4 to show R<sup>2</sup> values for each newspapers trend line.

Newspaper	Trendline Equation	R <sup>2</sup>
The Times	$y = 1.0505x + 14.065$	R <sup>2</sup> = 0.6132
The Guardian	$y = 0.4424x + 33.331$	R <sup>2</sup> = 0.194
The Mail	$y = 0.9421x + 16.712$	R <sup>2</sup> = 0.3354
The Telegraph	$y = 0.6241x + 11.681$	R <sup>2</sup> = 0.4837

Discussion about the use of R<sup>2</sup>.

R<sup>2</sup> is sometimes referred to as the coefficient of determination. It is often defined by least squares method, and can be calculated by dividing the residual of the sum of the squares (the sum of variation from the line of best fit or regression line squared) by the total of the sum of squares (the sum of the variation from the mean squared). R<sup>2</sup> provides an indication of the fit of the data to the regression line where a value of one is a perfect fit and zero represents no correlation between the data set and the regression line.

The R<sup>2</sup> calculation aided the evaluation of the linear relationship between the number of stories published and time. The greater the R<sup>2</sup> value, the greater the linear relationship; the R<sup>2</sup> for all the newspapers used = 0.620, 62% of the variation in the number of articles can be explained as an

increase related to time. For each of the newspapers; in The Guardian ( $R^2 = 0.194$ ), 19.4% of the variation in the number of articles can be explained as an increase related to time, whereas in the Mail (33.4%), the Telegraph (48.3%) and the Times (61.3%).

Thus for all the newspapers reporting, 38% of the variation from the linear relationship, in reporting over time could be due to chance (80.6% for The Guardian, 66.6% for the Mail, 51.7% for the Telegraph and 38.7% for the Times) – see Figures A2.4.1-A2.4.4. The pattern for all newspapers' articles (combined) over the time of the study is shown in Figure A2.4.5.

Figure 2.2 (in main text) identifies a relatively strong positive relationship between the number of stories published and time. The  $R^2$  calculated for this dataset is higher than for any of the individual values for the newspapers. This is due to the creation of a new data set by amalgamating all the data found for each newspaper. The new data set although not independent of the individual data, has its own statistical identity. The new data set has a larger sample size and has a different regression line. The combination of these factors results in an  $R^2$  value that is now independent of the original data sets. Such an effect is generated due the averaging effect of a larger data set and a reduction in the impact of anomalous values on the concluding  $R^2$  value. As  $R^2$  is calculated using the function of the regression line, any change in this value will also affect  $R^2$ .

Figure A2.3.1 showing regression analysis for the Times newspapers reporting of articles relating to mental health December 1998 –November 2008.

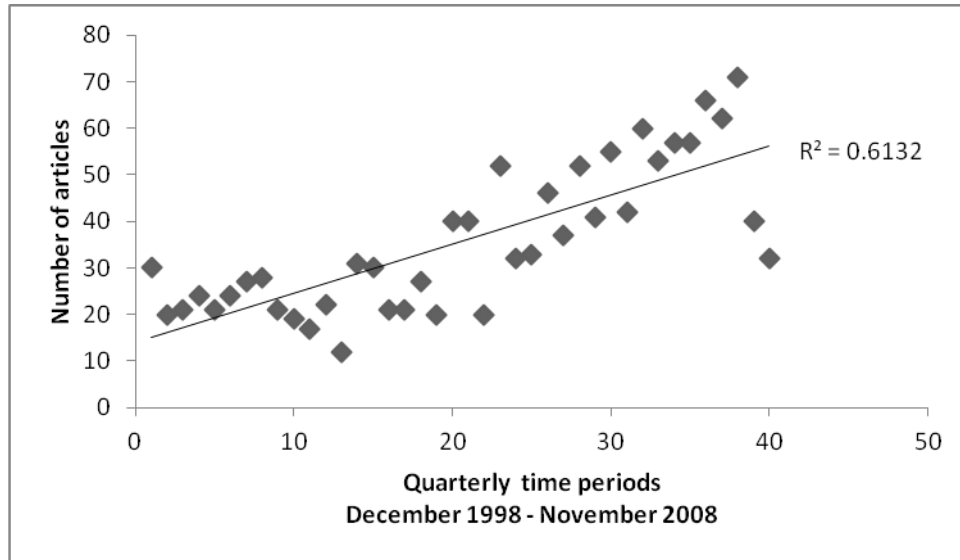


Figure A2.3.2 showing regression analysis for the Guardian newspapers reporting of articles relating to mental health December 1998 –November 2008.

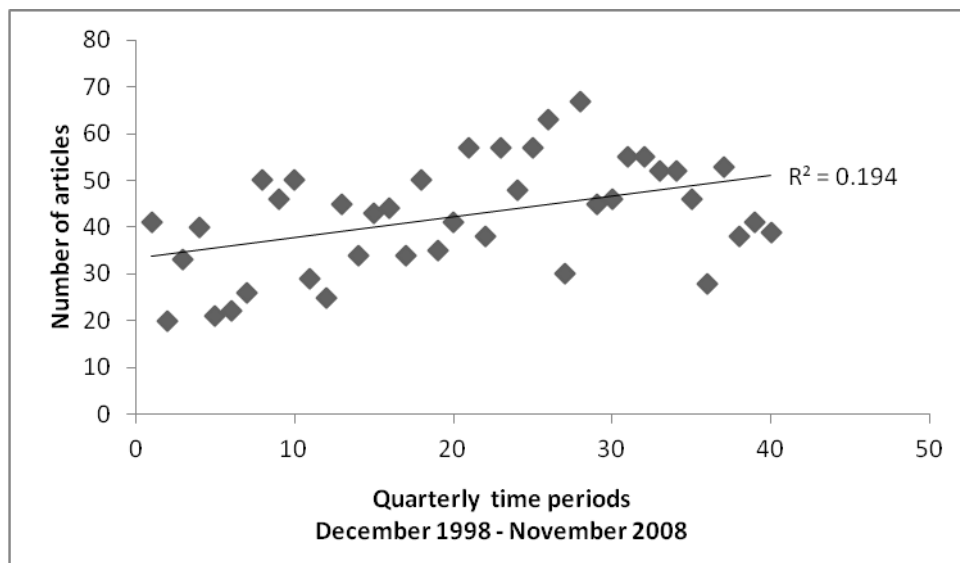


Figure A2.3.3 showing regression analysis for the Mail newspapers reporting of articles relating to mental health December 1998 –November 2008.

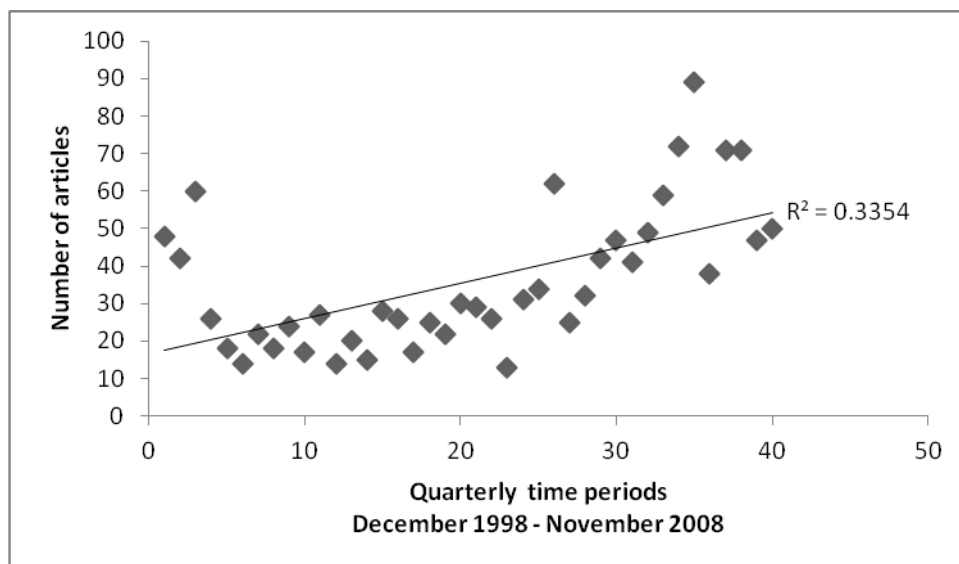
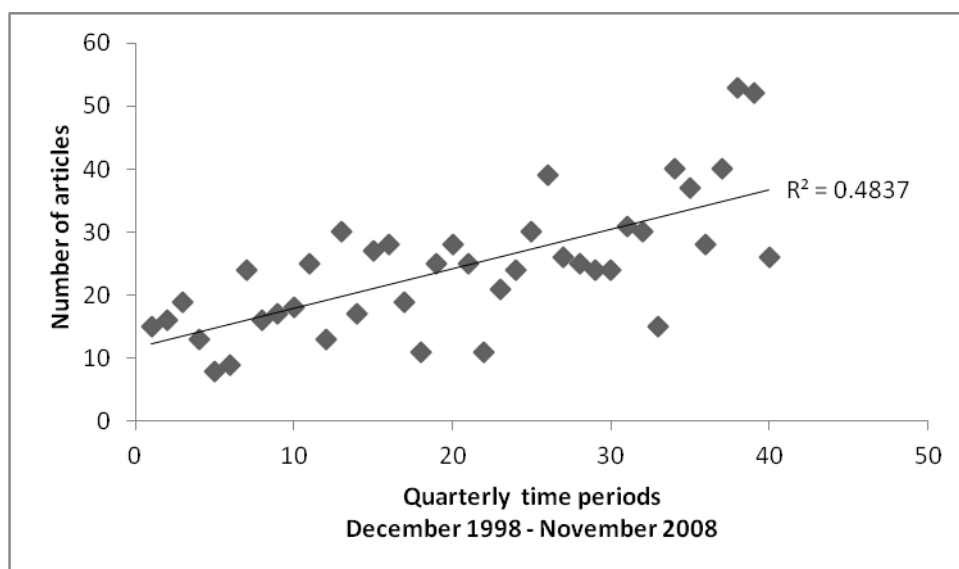
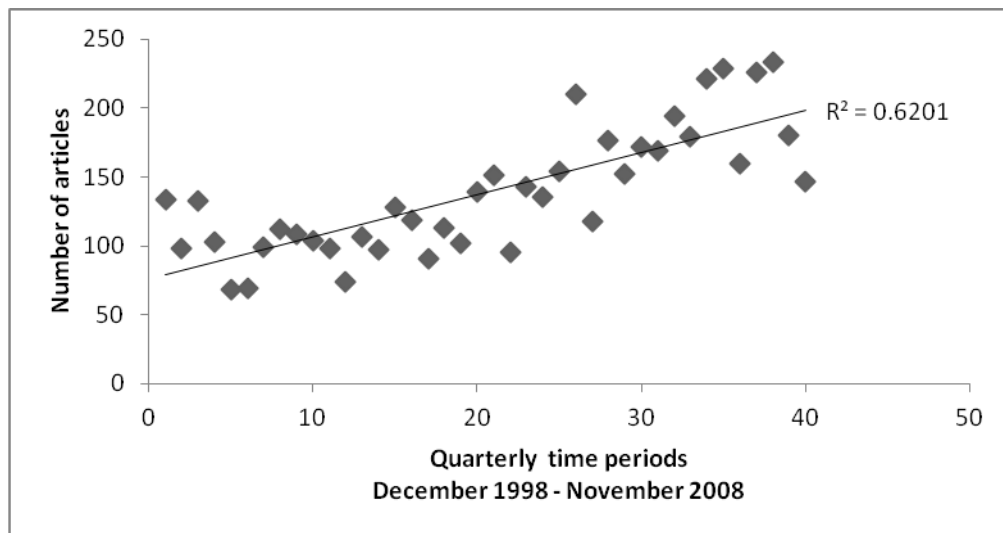


Figure A2.3.4 showing regression analysis for the Telegraph newspapers reporting of articles relating to mental health December 1998 –November 2008.



Consideration was given to the fact that the newspapers were publishing more stories in total; in which case whilst there may be an overall increase in the number of mental illness stories, such an increase might not necessarily represent an increase in the ratio of mental illness related stories to all stories. This ratio was calculated following identification of the average number of articles published for all the newspapers used over the time period. This is shown in Figure A2.4.5.

Figure A2..5 showing regression analysis for all newspapers reporting of articles relating to mental health December 1998 –November 2008.



**Appendix 2.4 Table to show sampled stories from each newspaper and presenting the headline, theme and conclusion used.**

<b>Newspaper</b>	<b>Date</b>	<b>Headline</b>	<b>Theme (interpretation of the dominant message made by researcher on reading the story)</b>	<b>Conclusion (direct quote from story)</b>
<b>Guardian</b> <b>G1</b>	March 10 1998	<i>Crazed Killers and Crazier Policies</i>	<i>A lack of protection due to a lack of skilled care.</i>	<i>They are now dependent on agency carers, less trained and inexperienced; or family care, excluded from the professional caring loop.</i>
<b>G2</b>	March 17 2006	<i>Killer made random attacks to emulate horror film character</i>	<i>A lack of protection as services do not listen.</i>	<i>He brought unknown suffering to his family who tried to get him psychiatric help.</i>
<b>G3</b>	August 14 2002	<i>Adam Ant pleads guilty to affray</i>	<i>Mentally ill people need locking up to protect the public.</i>	<i>Doctors agreed that Goddard had been in a "hyper-manic state" and Judge Roberts said he had to protect the public from another such episode. The singer has struggled with severe depression for years and was sectioned under the Mental Health Act shortly after the incident on January 12.</i>
<b>Times</b>	November	<i>Statistics with a</i>	<i>The mentally ill are</i>	<i>Is there a material link between mental illness and</i>

<b>Ti1</b>	20 2006	<i>deadly Message</i>	<i>violent.</i>	<i>violence? Here are some compelling statistics.</i>
<b>Ti2</b>	May 20 2005	<i>Paranoid killer was released by Mental Health tribunal</i>	<i>A lack of protection and the systems put in place do not work (for anybody).</i>	<i>Mrs Wallace said, "the tribunal system has failed time and again. Sometimes they go against the wishes of the medical officers and frequently take no heed of what patient's families say".</i>
<b>Ti3</b>	March 9 1999	<i>Psychiatric patient questioned on killing</i>	<i>A lack of protection and not knowing their patients.</i>	<i>A PSYCHIATRIC patient who disappeared while on day release was yesterday being questioned over the fatal stabbing of a 50-year-old man and another attack on a woman.</i>
<b>Telegraph Te1</b>	March 6 2006	<i>'Nutters' aren't all axe-wielding maniacs - they are far more scared of you TRUST ME I'M A JUNIOR DOCTOR</i>	<i>The mentally ill should be pitied.</i>	<i>After a day on the ward, my prevailing feeling is of sadness at how mental illness can destroy lives. The patients are on medication and seem very pleasant and not at all threatening. One has even made a card to welcome me.</i>
<b>Te2</b>	February 27 2005	<i>Hospital that let out killer has history of fatal errors Schizophrenic stabbed cyclist</i>	<i>Services are putting the general public and patients at risk due to poor practice.</i>	<i>When Joseph was discharged from Springfield Hospital, he was given no care plan, no risk assessment or systematic monitoring of his medication and no out-patient follow up.</i>

<b>Te3</b>	December 21 2000	<p><i>after being given leave despite violent record and earlier management failures that led to four deaths at the hand of patients</i></p> <p><i>Dangerous mental patients may be detained indefinitely</i></p>	<p><i>Services cannot be trusted. Less violent patients have to be kept locked up because the service do not know who is dangerous and who is not.</i></p>	<p><i>"The vast majority of people with mental illness represent no threat to anyone," said the White Paper. "Many mentally ill people are among the most vulnerable members of society. But the Government has a duty to protect individual patients and the public if a person poses a serious risk to themselves or to others".</i></p>
<b>Mail M1</b>	April 20 2004	<p><i>Freed patient is held over knifing of his neighbour</i></p>	<p><i>A lack of protection for people going about their everyday activities.</i></p>	<p><i>Mr Breed, a keen violinist, was stabbed from behind as he returned from orchestra practice to the home he shared with his wife Diane and two grown up sons.</i></p>
<b>M2</b>	September 24 2003	<p><i>Sad Frank has never needed his wife more</i></p>	<p><i>If you are mentally ill, regardless of who you are, you cannot sustain relationships.</i></p>	<p><i>He seemed to have it all. Today he lost his wife Laura, his two daughters and son, and tragically his sanity.</i></p>
<b>M3</b>	March 7	<p><i>I KILLED</i></p>	<p><i>Services cannot be trusted</i></p>	<p><i>It is understood she originally made the 'confession' two</i></p>



	2003	<i>SEVEN OF MY BABIES; Suicide bid by mother aftershock confession sparks murder probe</i>	<i>as they cover up errors.</i>	<i>years ago while seeing a psychiatrist as an outpatient. She is thought to have been suffering from the rare mental illness Munchausen's Syndrome by Proxy - the condition that drove nurse Beverly Allitt to kill four children in her care.</i>
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**Appendix 3.1 Table to show the frequency of named mentally ill people identified in Lexis Nexis search of the database where violence was reported in the story (December 1998- November 2008).**

Name	The Telegraph (number of times appears in newspaper)	The Daily Mail (number of times appears in newspaper)	The Times (number of times appears in newspaper)	The Guardian (number of times appears in newspaper)
Abram, Michael	9	24	13	12
Bala, Mehmet	0	3	0	0
Barrett, John	9	13	17	9
Bryan, Peter	5	7	13	6
Butler, Glaister Earl	1	0	2	1
Corner, Mark	1	2	0	6
Dixon, Ronald	1	2	1	0
Dogan, Ismail	2	3	6	0
Frankum, Benjamin	2	0	1	0
George, Barry	12	19	15	7
Gonzalez, Daniel	2	12	10	6
Hardy, Anthony	1	6	6	6
Harrington, Mark	1	0	0	0
Hill, Peter	0	3	1	0
Holiday, Benjamin	1	0	0	1
Khan, Paul	3	4	2	0

Lilburn, David	1	7	2	0
MacKay, Roy	0	5	0	0
McLeish, Darrell	0	0	1	0
Moffatt, Christopher	0	2	2	1
Newland, Matthew	0	0	1	1
O'Dwyer, Patrick	0	1	2	1
Pick, Dale	2	0	0	1
Smith, James	0	6	3	2
Smith, Paul	1	2	1	0
Soans-Wade, Stephen	3	2	7	2
Strang, Eden	0	9	9	7
Theophilou, Theophilos	0	2	0	0
Walker, Stewart	0	2	0	0
Wayne, Philip	1	0	1	1

### **Appendix 3.2 Reflective journal as a data source.**

Throughout the time I have spent on this research process I have maintained contemporaneous notes of my thoughts and actions related to the research process and clinical activities. This included personal notes of supervision sessions conducted by my clinical and research supervisors and by myself on colleagues. These notes took the form of jottings and logs that could be used for reference and guidance at a later date. Such information is commonly maintained in health care practice and is often added to portfolios in order to aid reflection. These notes have become invaluable to me in ensuring that I look at things and then relook at things again in order to consider alternatives to my own automatic view. The notes were especially important in the next section of analysis as this involved my personal reflections.

In the early stages of this thesis I read what seemed to be countless articles and stories about mentally ill people being violent and different. I know that all the stories are not negative, but it felt like that. Not all the negatively framed stories were as negative as perhaps suggested, but some negative phrases used seemed to linger in my mind. As to the reason for some phrases lingering longer in my mind, I am unsure. Perhaps it is due to my past experiences, present role in work or something else. What is clear is that in my research supervision sessions, my supervisor picked up on my potential negative attitude to the press and my criticism of the way I thought they were representing the mentally ill.

Some of the associated thinking is captured in my reflective type journal of thoughts caused by the information I have read. This log has become a running commentary of the stages of investigation I am working on at the time, and often includes thoughts on methods of inquiry. Some of these thoughts have moved into action. Early on in the search for cases, I came across the name of Peter Bryan among others. My supervisor asked me to read the stories and write a reflective account. These reflective accounts were completed and stored in my encrypted PhD files on an old computer. The content of these files were later found to be of use for an article that my supervisor and I started to develop, "The Influence of the media on practice in mental health- a bricolage of a single case study" (Wibberley and Murphy, unpublished). In this article I was able to use the reflections to identify ways in which newspapers could influence my thinking. Within the article we moved on from my initial reflections, revisiting the article and making more considered reflections. This was developed further and offered for publication to the Journal of Health, Risk & Society (January 2015).

These initial reflections are an important piece of information for this thesis as they are personal reflections on a story that (at the time of writing) had not been presented to any other practitioner. The reflections were therefore not influenced by discussion or consideration for practice other than at the time of writing. I had also recorded some reflections from practice that coincided with the writing of the reflections and can see that there may have been some influence on my practice.

The reflections were about the story of Peter Bryan as published in the UK newspapers at the time of his trial. I read all available accounts including newspapers that were not included in the data set for Chapter 2. Certain newspapers (including The Sun, The Mirror, The Independent and The Express) were not fully available for the inclusion criteria of that stage of the research.

The reflective accounts are not included in their entirety, nor are the notes made from practice. Excerpts are used to show the influence on my thinking and practice.

### **Appendix 3.3 Reflective process related to justification for approach.**

Using some of my own personal reflections as data in the research paradoxically felt wrong (probably because of the continued positivistic leanings of some senior colleagues, and because I had never done this before in a research study), and right. The decision that my reflections should be included as data was related to my personal belief that our thinking influences the way we act, and I had a variety of thoughts in my head that were making me think more about the story and its outcome and could possibly be influencing my actions. I commonly reflect and problem-solve clinical and personal dilemmas by mulling over the potential actions. However, I am not always allowed much time to think in this way and in some instances I have become emotional and potentially acted on the spur of the moment. I am a practical person that when faced with a dilemma will think about it and come to the conclusion that whatever is in front of me, has probably been faced by me before. As a result I feel comfortable in using what has worked before to resolve the problem or thoughts. This approach can be seen throughout this thesis and is probably related to my pragmatic approach to practice and research. In this instance (using personal reflections as data) I could see that there was some useful information that bridged the space between the stimulus and the resultant action or thought. This information, if not used, would leave a gap that would remain unanswered if the reflections were not included.

Reflecting on the decision to include self-reflection, I identified supervision notes with my supervisor where we discussed the utility of such an approach. This led onto me exploring heuristic approaches and identifying the aim of such.

*"Awaken and inspire researchers to make contact with and respect their own questions and problems, to suggest a process that affirms imagination, intuition, self-reflection, and the tacit dimension as valid ways in the search for knowledge and understanding"* (Douglass and Moustakas, 1985, p40).

This self-discovery through reflecting seemed not only sensible, but also now validated. The self-reflecting/ self-discovery type approach also linked with the beliefs that underpinned one of my first drafts of the proposal for this study.

*"Human beings act toward things on the basis of the meanings that the things have for them..."*

*The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows...*

*These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters"* (Blumer 1969 p2).

In many ways I had some unconscious measures that were influencing the way I read media reports, but until this exercise, I had never really explored what they were or what they may mean for my practice. Although worrying that I was acting like a driver 'under the influence' I could also see that if I did not reflect on the story, then I would be asking someone else to do this and then potentially using my biased and unchecked viewpoint to analyse the data.



The reflective journal acted as a sort of story board for the research activities, and a running commentary on things that have influenced my thinking and actions. Accessing this at the time of reading the Peter Bryan story presented a sort of litmus test on how, over a passage of time, my thinking and actions may be causally influenced by the media.

I was aware the data may contain personal and professional privileged information, therefore confidentiality, in regards to access of the data, was applied, and like any other research data, it was filed in encrypted electronic logs and in locked cabinets. This information became part of the raw data used for this study and handled in the same way as all other data.

### **Appendix 3.4 Reflection on use of self-reflection in research studies.**

I contend, utilising self-reflection and embedding it into a study added to what my PhD handbook alluded to as an aim of any study of this level; to complete a study that was original and developed a substantial contribution to knowledge. I feel if I had not used the information I had collected I may be disposing of a considerable amount of information related to how I came to understand about the representations, the way that I may have changed practice, my personal coping strategies and the research process. I felt that the data being recorded in my personal journal had information that would contribute to the development of an understanding of the influence of reading newspaper stories and the influence of time on reflections. I saw that other writers had completed studies that expressed the influence of the media but had not reported any of the influences on their thinking and actions (see, for example, Ward 1997 and Philo *et al.* 1996). At the time of writing this thesis I could not identify any writers that discussed their reflections of the influence media stories on their thinking and actions.

The use of a journal throughout the study helped in maintaining my pragmatic values. The journal entries enabled me to see the way I was thinking and then acting in relation to events, and helping to identify similar coping strategies used across a range of dilemmas. As a consequence of reviewing my journal I understand how I have been able to identify what I believed to be the best method to address the emergent questions and have not felt limited by

philosophical leanings. In many ways the journal enabled me to be reflexive and explore many emergent assumptions and plan 'best fit' strategies (Russell and Kelly 2002). I feel it may have added to the transparency of the research choices and delivery. In many ways the journal enabled me to unearth some of the subconscious thoughts discussed early on in the study and provide me with a motivation to look further into the influence of such thoughts.

I feel that the journal started what Tobin (1993) refers to as the development of a social construction towards meaning. This development of meaning clarified some of the confusing thoughts that I was having about how I was to write up this thesis. I feel the understanding guided me to consider the interpretations and constructions involving the data, and positioned me in a way that Denzin and Lincoln (2013) referred to as "*the writer as the interpreter*" (p30).

I have come to terms with being reflexive in this way, as it is different to being reflective. Chriseri-Strater (1996) distinguished the difference arguing that to be reflexive there was a need for self-scrutiny and something or someone to be reflexive about, whereas to be reflective does not need any 'other'.

Self-reflection, I felt, was needed for several reasons in this study. Primarily, there was a need to explore my own personal feelings on the story of Peter Bryan and identify how these feelings affected my practice. At this point I was unaware of how the story had made me feel or practice and unsure if I had encountered or was encountering something similar. As Fook (2011) argued, that a level of critical reflection aided in the development of an understanding

of the practitioner and practice. Therefore, reflecting on the way the story made me feel and continuing to reflect on practice for a short time could potentially identify the ways that I understood and acted as a consequence to reading the story.

If I found that the story became a trigger for reflection, then such a trigger could be used with other practitioners to establish if the thoughts and actions that happened to me could potentially happen to others. Therefore, once it was established that the story caused reflection and I could identify influences on my thinking and actions, then further exploration may be warranted.

Reflection in this way may lead to personal assumptions being identified and this may be something that is unconsciously suppressed. Care is needed in the handling of such sensitive information and utilising myself in the first instance enabled the identification of potential problems with using reflections on such stories with others. As I think about this theme and write this passage I am finding that I am coming to the conclusion that I have seen such stories in the past and have coped with them, but am unsure as to the influence they had on me and my practice. Similarly, I feel other colleagues have gone through the same experience and they are in a similar position to myself.

## **Appendix 3.5 Ethics approval**

Attached to original paperwork in hard copy.

## **Appendix 3.6 An overview of recent literature on risk and violence.**

### **Aim and method**

The aim and scope of this brief report is to:

identify and review empirical studies of mental illness and violence, and explore advice presented to mental health practitioners.

The review of the literature was broad and involved the collection of data from the Medline database, CIHNAL, Psyc Info, SOLAR and Science Direct (available on line from the University of Salford Staff Search Engine). Relevant articles were also found in reference lists and by a search by hand including books. Articles and other material were included where it was felt salient. The search was limited to English language articles from 2004 to present day and focused on an adult population (as my previous studies explored literature to that date and limits).

I was aware, as Booth *et al.* (2012) commented that even when a systematic approach to a review is adopted and grey literature and the like is explored, some relevant literature may still be missed. Therefore, I am aware that other literature may exist, but may not have come to my attention using the search terms or search engines used.

The terms searched for were; risk, risk assessment, violence, mental health/ill\*, practitioner. The search yielded 14 papers that I felt, presented a broad overview of the recent risk related publications.

## **Introduction**

The assessment of risk related to the mentally ill has, over the last 25 years, become a major concern for all, especially as there appears to be no reduction in the level and severity of violence reported in mental health care (Health Care Commission 2007). Much of the information related to risk started to surface in the 1990s, when academics, the public and Members of Parliament saw cuts in hospital in-patient bed numbers and the introduction of new mental health legislation (*Care Programme Approach*, Department of Health 1990). Since then the care of the mentally ill has moved mainly from hospital to a community setting. Along with this change in setting has been the change in representations identified in this thesis and the gradual shift in risk assessment and violence assessment by staff. The fact that violence in mental health care has always been a problem (Fisher 1994) has been a regular theme from the literature and that reviews on patient violence indicated that the literature caused problems for the patients, the staff and the care environment (Needham *et al.* 2004). There was an argument that violence was endemic in mental health care (United Kingdom Central Council 2001) and that mental health nurses were historically the workforce most at risk of being a victim of violence (Gallagher 1999).

Murphy (2004) investigated the way that community mental health nurses assessed the risk of violence posed by their clients. On reviewing the available evidence he established that risk assessment was probably seen as part of the role of the mental health nurse. He identified that the nurses were aware that

historical evidence of violence could be used as a benchmark for the potential of future violence. He went on to present, from the sample of practitioners used, that they relied on clinical experience and personal impressions of the evidence, rather than utilising a standardised risk assessment tool. Although having standardised tools available, they stored more credibility in the assessment of the risk of violence in clinical judgement. It is from this point in time that the review of the literature in this study commences.

The following sections will review the available studies that focus on the relationship that exists between mental health/ mental illness and violence. It will also examine advice provided to practitioners working with such violence.

### **Mental Illness and violence**

Violence is a frequently reviewed and explored term in mental health care. Past reviews have moved from finding a limited link between mental illness and violence (Monahan and Steadman 1994) to more recent reviews identifying a specific link (Fazel *et al.* 2009). However, specific link is often for those diagnosed with a schizophrenic or personality disordered state.

Pedersen *et al.* (2010) examined the available data related to the influence that 'stage of illnesses' had on violence of schizophrenic men. 83 men in Denmark (46 were of non-Danish origin) who were discharged over a two year time period (2001-2002) were involved in the study and had all their medical records examined for potential signs of anti-social behaviour patterns. All the



participants had been convicted of at least one violent crime and the average number of violent crimes was 8.5.

Pedersen *et al.* (2010) identified that early onset anti-social behaviour was associated with a sub-group of people diagnosed with schizophrenia (such findings concurred with the outcome of the Hodgins and Muller-Isberner 2004 study). Pedersen *et al.* (2010) argued that awareness of this information could be a useful factor in preventing future violence and admission to forensic services. Pedersen *et al.* (2010) also found that the early onset anti-social behaviour schizophrenic group spent more time in prison than later onset and had a poor educational achievement. The early onset group of people were argued to have developed more deep rooted problems with violence.

A major problem was that the study had limited access to information pre 18 years of age. Information related to early childhood could have been factored into the understanding and identification of patterns of early development and coping strategies.

Fazel *et al.* (2009) conducted a systematic review and meta-analysis related to schizophrenia and violence. Data was sourced from various databases between January 1990 and February 2009. Grey literature and hand searches were also carried out for data. The review only included case controlled and cohort studies and excluding studies with a lack of focus on violence and schizophrenia. Twenty studies were used and they found that the risk of violence was increased in people with schizophrenia or a psychotic illness when compared to the general public. Fazel *et al.* (2009) also found that the risk of

violence in a schizophrenia and psychosis group of people with a co-morbid substance misuse was at a similar level of frequency to that of people with only a co-morbid substance misuse problem.

Fazel *et al.* (2009) had used the Wallace *et al.* (2004) study within the review, but only made limited emphasis to one of the main factors to emerge from this study. Wallace *et al.* (2004) had reviewed criminal convictions of people with schizophrenia over a 25 year period. Within the Wallace *et al.* (2004) study it was found that the convictions of people with schizophrenia for violent offenses had increased, and that there was an increase in convictions of people with schizophrenia who also had a co-morbid substance misuse problem. However, the rate of offending by such a group of people was influenced by a 'dramatic escalation in the frequency of substance misuse problems with people with schizophrenia' (p716). Wallace *et al.* (2004) went on to suggest that linking schizophrenia and violence was probably not down to one single factor (e.g. substance misuse), but related to many things that were going on before, during and potentially after an episode of illness behaviour.

### **Predictors of violence**

Sands *et al.* (2012) conducted a systematic review of the available literature relating to patient initiated violence. They identified 6847 articles published in a two year period (2008-2009), and after applying inclusion criteria reviewed 49 studies. Sands *et al.* (2012) found that in nine studies, hostility and anger were common precursor for violence in in-patient units. Six studies identified the

presence of thought disorder as an indicator of future violence in a sample of in-patient and community care patients. Sands *et al.* (2012) also found that eight studies argued that positive symptoms of psychosis (Hallucinations and delusions were used as descriptors of positive symptoms), having a diagnosis of antisocial personality disorder and cognitive impairment were linked to violent incidents. Other symptoms linked to violence included; suspiciousness, reduced social functioning, irritability and poor self-care. Previous history of violence was explored in eight papers. The presence of a past history of violence was linked in differing ways as some studies explored the incidence of violence pre-symptoms of illness, whilst others explored violence related to specific symptoms after.

Sands *et al.* (2012) concluded that many of the risk factors were identifiable in a patient's general behaviour before the violent incident occurred. Such an argument concurred with the earlier work of McNiel (2003), who argued that clinical risk factors (such as specific behaviours displayed before any violence) were accurate in the prediction of violence. Sands *et al.* (2012) went on to argue that clinicians need to acknowledge that some patients with specific symptoms pose a risk of being violent and that the use of a standardised risk assessment tool was useful in identifying predictive behaviours of violence, but it was unclear whether this would work across all mental health settings.

Ullrich and Coid (2011) explored evidence for protective factors (argued to reduce violent offending) in a sample of 800 UK ex-prisoners. Ullrich and Coid (2011) argued that the identification of risk factors only goes part way to

managing the risk somebody poses. Within the data collected for the study, it was found that only a few risk assessment tools identified protective factors (in particular was the START, devised by Webster *et al.* 2004, see Doyle and Logan 2012 below).

Ullrich and Coid (2011) used a two phase approach to locate and engage participants before and after release from prison. These phases included an interview and the use of an assessment on release. One of the main problems experienced by the research team in the Ullrich and Coid (2011) study seemed to be the difficulty in engaging participants. Some of the identified participants refused to take part where as others died or were deported before the opportunity to engage them happened. 1933 people were eligible for the study with only 1396 people being initially interviewed in the first phase.

Ullrich and Coid (2011) identified that 5 of a potential 15 protective factors had a significant influence on reducing violent behaviour after release from prison. These protective factors included social support, emotional support, spare time spent with family, involvement in religious acts and closeness to others. Such factors are argued to be important knowledge for clinicians, workers following up ex-prisoners, and a way of reducing potential future factors that may lead to reoffending.

A problem with this study was that a large number of violent people were not included in the study and were allowed day release and community engagement. It was not clear what assessments had taken place with these prisoners, and whether the ex-prisoners in the study had engaged in such pre-

release experiences. More research is probably warranted with this group of people.

As seen in the Pederson *et al.* (2010) study (see above) an early onset theme was felt to be an important factor in the prediction of violence in the mentally ill. Spidel *et al.* (2010) also explored the linking of violence and mental illness but focused on the identification of predictors of violence in people with an early onset of psychosis. In a short but focused paper, Spidel *et al.* (2010) detailed the contribution of childhood abuse, psychopathy and substance misuse in the development of violent behaviour. Using a sample of 118 people who were diagnosed with early onset psychosis in Canada, each completed a self-report questionnaire related to childhood abuse, psychopathy and substance misuse and past violent/ aggressive behaviour.

The results identified that around 43% had a history of violence and 62% a history of verbal aggression. A large number experienced some form of childhood abuse and that a similar number had substance misuse problems. Spidel *et al.* (2010) concluded that violent behaviour was evident in those presenting with an early onset psychosis. 70% of participants admitted to committing a violent act during the 12 months of the study. An important factor identified was the association between violence and past childhood abuse. Spidel *et al.*'s (2010) unclear explanation for the link between childhood abuse and violence was that violence may be related to the development of the feeling of vulnerability, but similar presentations are related to the development of psychotic type problems as well.

Amore *et al.* (2008) reviewed the cases of 374 people admitted to a locked ward in Northern Italy. Of the people admitted to the ward, the study found a variety of unifying themes that existed in the demographic information collected. Sands *et al.* (2012) referred to the Amore *et al.* (2008) study, and included some of the predictors of violence Amore *et al.* identified. However, Sands *et al.* (2012) failed to discuss the escalation of violence predicted by the BPRS used in the Amore *et al.* (2008) study. Sands *et al.* (2012) made limited reference to Amore *et al.*'s (2008) belief that an increase in the BPRS scores were related to an increase in suspiciousness, thought disturbance and hostility. Such information probably adds credibility to the use of risk assessment documentation to identify an increase in potential risky behaviour in people with a mental health problem. Amore *et al.* (2008) argued for staff to complete comprehensive evaluations of the past history of people in psychiatric settings as they believed this sole factor had an implication in the prediction of future violence. This would, however, lead to an increase time spent collecting information and costs to the service.

Warren *et al.* (2008) examined data collected from an ongoing study and identified a sub-group of mentally ill offenders that had threatened to kill in the years 1993 and 1994 in Victoria, Australia. Warren *et al.* (2008) found that 613 people had been convicted with such a history and examined their records with mental health services. A follow up of this group was then conducted after ten years with included access to the police criminal database.

Warren *et al.* (2008) found that 44% of the sample had been convicted of further violent offences and that 3% had committed homicide, with 2.6% killing themselves. The highest rates for reoffending were young substance mis-users. People who went on to commit homicide were more frequently diagnosed with schizophrenia.

The Warren *et al.* (2008) study identified that people who make threats to kill are often violent and some commit homicide. People with a mentally disordered offender's history were found to be represented more than other groups in these categories. Warren *et al.* (2008) went onto argue that people who make threats to kill should trigger clinical concerns and not be contained by solely legal actions. They argued that the threats needed to be taken seriously and an increased therapeutic set of interventions instigated.

Laajasalo and Hakkanen (2006) reviewed the case records of offenders convicted of homicide with a diagnosis of schizophrenia in Finland. The cases of 125 people were reviewed and from the review it was found that around one third involved what Laajasalo and Hakkanen (2006) felt was excessive violence (mutilation, sadism, sexual inference or repeated stabbing). Such excessive violence was found to be more frequently seen in people who had committed homicide before, but not those with current positive symptoms of their illness. Laajasalo and Hakkanen (2006) did however identify that in the people who committed non-excessive homicide that 88% of the people were experiencing delusions and 42% hallucinations.

Laajasalo and Hakkanen (2006) argued that although positive symptoms were not associated with excessive violent homicide, they were prevalent in the homicides by people with a mental illness. Laajasalo and Hakkanen (2006) did however identify that the Finnish legal system was unusual to other European countries as each person who committed homicide regularly went through forensic mental health assessments.

### **Risk assessment tools**

Szmukler and Rose (2013) debated the cost to mental health services of adhering to risk assessment procedures and the apparent trade off in care and attitude developed by following such a procedure. Szmukler and Rose (2013) discussed not only the obvious costs of finance and time spent conducting assessments, but also the costs of exclusion on the patients, the negative influence on staff practice and the moral cost of responding to pressure groups for more coercive care. Within Szmukler and Rose's (2013) debate, they questioned the utility of risk assessment as the rate of homicide by someone with a psychotic illness was argued to be only 1 in 10,000 per year.

Furthermore, Szmukler and Rose (2013) went on to argue that the process of attempting to calculate risks merely added confusion to any objectivity that was being developed. Such attempts to calculate risk was argued to erode clinical skills and influence the judgement of the clinician to a more risk averse attitude. The use of risk assessment was also argued to potentially negatively influence the development and maintenance of trust between clinician and



patient. From the patient's view, it could become the focus of clinical work, raising the question of the aim of the care (for the patient's interests or the communities). The continued use of a risk assessment procedure was also felt by Szmukler and Rose (2013) to place patients in a situation where full disclosure of thoughts and beliefs may lead to a reduction in liberty and restrictive actions by the clinician.

Doyle and Logan (2012) discussed the evidence for the use of a standardised risk assessment tool, suggesting that there was good evidence for the use of such tools in all areas of mental health care. After exploring the various ways that risk assessments were conducted Doyle and Logan (2012) presented an argument for the use of the START; a guide to the dynamic assessment of risks, strengths and treatability, developed by Webster *et al.* (2004). Doyle and Logan (2012) argued that the tool had many strengths as it considered current mental state, behaviour and functioning and it also allowed the clinician to evaluate scores over various time periods, from weeks to months. The resultant scores are argued to indicate the most serious risks the person poses. Such information was felt to aid clinical care in a range of clinical settings. The scores alert clinicians to a person's present level of risk and care packages can therefore be implemented in a timely fashion.

An important factor associated with such tools is the use of a formulation (narrative description that identifies the underlying mechanisms in the presentation of the risk). Such formulations aide understanding of the risks presented in differing settings for both clinician and patient. Doyle and Logan

(2012) outlined a simple approach to modify practice to enable such formulations to be conducted and built into care packages. Such advice was not clearly presented in the original Webster *et al.* (2004) manual.

Green *et al.* (2010) also looked at the use of risk assessment tools, particularly structured risk assessment. The use of a structured risk assessment is a similar theme debated by Doyle and Logan (2012). However, Green *et al.* (2010) focused on the use of the HCR-20 (Webster *et al.* 1997), a tool widely used to assess the risk of violence. The study focused on community forensic services in Australia with ten teams agreeing to take part. Questionnaires were distributed to the teams with the advice that on average the process would take up to 14 hours to complete and may often involve multiple interviews with up to two members of staff. Some areas provided training to staff (n=9) for the use of a structure risk approach. Training was argued by Green *et al.* (2010) to be an important factor in establishing risks in a reliable fashion. Green *et al.* (2010) also argued that the structured approach enabled clinicians to identify imminent risks and was a useful tool for monitoring risk over time. A major concern that emerged from the study was the financial cost of utilising such a time resource hungry approach.

Time completing risk assessments was a major concern for Hawley *et al.* (2010). 300 mental health professionals were surveyed in a mental health trust in England, and there was the identification that each group of professionals dedicated varying amounts of time to completing risk related paperwork. The results of the survey also found that there was a median of 18 minutes for

completing risk tools but this did not include time preparing, searching for evidence or implementing any management. The survey found that psychiatrists spent less time than nurses completing risk related documentation and the range of time completing tools varied from 1-240 minutes. Such findings brought in to question the value each member of staff placed in the process of completing risk tools. 76% of the psychiatrist that responded commented that risk assessment was involved in less than half of their clinical judgements. A proportion of the psychiatrists reported that risk tools had 'close to none' influence on their clinical judgement.

Carroll (2007) also discussed the use of risk assessment tools. He acknowledged the inconsistent use and application of tools and identified that such practice may make reviewing difficult. Carroll (2007) engaged in a debate related to structured clinical tool use and clinical decision making, arguing that the default of some risk assessment tools was to use a tick box approach. Such an approach was felt to be 'no better than useless'. Carroll (2007) identified the utility of the use of risk assessments to practitioners in identifying both static and dynamic risk factors. Although Carroll (2007) did not endorse all forms of risk assessment procedures and tools, he rejected arguments, especially those forwarded later by Szmukler and Rose (2013), that the risk assessment process can stigmatise the mentally ill. However, Carroll (2007) added that utility was only achieved if the tool was applied appropriately. Carroll (2007) also argued that locally devised risk assessment tools were unlikely to be any better than standard care.

## **Summary and conclusions**

The purpose of the exercise was to identify studies and papers that explored the relationship between mental illness and violence. Furthermore, to identify any advice presented for practitioners in these papers.

The review consisted of 14 papers that addressed a range of themes related to risk; mental illness and violence, predictors of violence and risk assessment tools. The style and scope of the papers varied from systematic, meta-analytical papers to discussion and commentary papers. Each of the papers contributed to the development of an understanding related to mental illness and violence.

The mental illness and violence literature identified that an early onset of illness was indicated as a link to violence, particularly in people diagnosed with schizophrenia or psychosis. However, violence was probably not caused by one single factor but related to a variety of factors in early development. Evidence from early development was often not included in all the evidence data by researchers.

Co-morbid substance misuse was linked to violence, however, this was found to be at a similar level to that of co-morbid substance misuse clients. Importantly the frequency of violence by people with schizophrenia was found to be increasing over the course of the review and to be higher than that of the general public.

The prediction of violence in mental illness literature identified that there was a range of indicators linked to the act of violence, such as suspiciousness,

hostility, anger, positive symptoms, anti-social personality disorder.

Importantly, previous violence was clearly linked to both future and excessive violence. People who threatened to kill, and were mentally ill, were found to commit violent acts more frequently.

The use of risk assessment tools identified the use of various tools for practice. However, the cost of using such tools was suggested to outweigh the utility of the use in many services. The use of a locally devised tool was felt to be only as good as standard care and therefore not advised.

Overall the studies demonstrated that violence and mental illness are linked and that there are a series of factors that indicate the risk of violence, particularly with people diagnosed with schizophrenia or psychosis. The compilation of such indicators into a risk tool, however, is not regarded as necessary and although indicating risk in trials, is not felt to help in the decision making made in the clinical area.

**Table1. Summary of risk articles**

Year, Author(s) & Title	Study Population	Aims of Study	Methodology	Outcome	Important Results
Szmukler, G., & Rose, N. (2013) Risk assessment in mental health care: Values and cost	Adult psychiatric population	Cost in risk assessment and the trade off in mental health care	Review	Risk assessment and management have become new professional responsibilities	Mental health professionals are placed in an impossible position where they are asked to predict and prevent violence. Their practice is being reshaped by risk assessment procedures.
Sands, Elsom, Gerdtz & Khaw (2012) Mental health-related risk factors for violence: using the evidence to guide mental health triage decision making	Focus on in-patient mental health staff	Explored: <i>'What are the risk factors for patient-initiated violence in acute healthcare settings?'</i>	Systematic Review	Using 49 papers in the review which enabled the grading of potential risk factors for violence.	Identified that dynamic clinical factors, seen in a patient's appearance, behaviour and speech were indicators of immediate risk. Examples included thought disorder, hostility and schizophrenia.
Doyle, M. & Logan, C. (2012) Operationalizing the Assessment and Management of Violence Risk in the Short-term	For use in mental health clinical practice (community, in-patient and forensic)	Explores the use of a Short-term assessment of risk and treatability (START) tool and its use in developing a Structured Risk Assessment and	Review	The tool focuses on short-term risks and could be used in conjunction with a Structured Risk Assessment approach.	It was argued that only the START tool 'encapsulates potential triggers, the characteristics that switch risk on at any given time in a client's daily life on a hospital ward or unit' (p 417).

		management approach in clinical practice.			
Ullrich & Coid (2011) Protective factors for violence among released prisoners- Effects over time and interactions with static risk.	Prisoners (n=800) sentenced to 2 or more years for sexual or violent offenses in England and Wales.	The study aimed to investigate the protective influence of factors felt to be effective in reducing reoffending after release from prison.	Survey	Protective factors can reduce the risk of violent behaviour in the sample of prisoners released from prison.	Factors found to be protective included support and having social networks. Protective factors for violent behaviour included social contacts, emotional and family support, involvement in religious activities and closeness to others.
Green, B., Carroll, A. & Brett, A. (2010) Structured risk assessment in community forensic mental health practice	10 Community Mental Health Teams	Investigating the application of Structured Professional Judgment risk assessment tools in clinical practice	Survey	The Structured Professional Judgement approach was found to make sure that clinically important evidence was taken into account when make risk related decisions.	The need for staff to be trained and have their work looked at using 'quality assurance processes'.
Hawley, C. J., Gale, T. M., Sivakumaran, T., & Littlechild, B. (2010). Risk assessment in mental health:	Mental health professionals	To establish how much time was dedicated to completing risk assessment paperwork	Survey	300 members of staff were surveyed. The amount of time spent completing paperwork varied from 1-240 minutes	The authors argued that the paperwork accounted for a great deal of clinical time. Differences existed between professions, as to how much time was spent, attitude and belief towards the use of risk assessment

Staff attitudes and an estimate of time cost				with a mean of 18 minutes.	paperwork. Future developments of tools needed to consider such findings.
Pedersen, L., Rasmussen, K., & Elsass, P. (2010). Risk assessment: The value of structured professional judgement	Mentally ill people who were in-patients in a specialist secure unit in Denmark	Identify whether early onset offending was linked to future types of offending	Retrospective case study of 83 men with schizophrenia	Violence was linked to hospital admission and conviction. The group of people had a significantly high number of criminal convictions prior to admission.	A specific group of people with schizophrenia were found to be identified by their offender type behaviour. This information could be used for more individual management plans.
Spidel, A., Lecomte, T., Greaves, C., Sahlstrom, K. & Yuille, J.C (2010) Early psychosis and aggression: predictors and prevalence of violent behaviour amongst individuals with early onset psychosis	118 people diagnosed with a severe mental illness but regarded as 'early onset'.	To identify 'predictors' of violent behaviour with a group of people with an early onset psychotic illness.	Cross-sections review of cases sampled from an early intervention programme in Canada.	Violence was found to have been perpetrated by people with early onset psychosis. One in 14 displayed violence that led to injure to another person.	The majority of people in this study were male. Many had experienced sexual abuse in the severe to extreme range. A strong link was found between abuse and violence. Substance misuse was evident in 61% of the sample.
Fazel, S., Gulati, G., Linsell, L., Geddes, J.R. & Grann, M. (2009)	People diagnosed with schizophrenia	Identify factors associated with homicide after discharge from	Systematic review that included information from five studies that	The rate of homicide in people with schizophrenia was 0.3% and the	The authors acknowledged that although the rate of homicide committed by people with schizophrenia was low there was



Schizophrenia and violence: systematic review and meta-analysis		mental health units	compare the risk of homicide committed by a person with psychosis and the general population	general population 0.2%.	still a strong association between homicide and schizophrenia.
Amore, M., Menchetti, M., Tonti, C., Scarlatti, F., Lundgren, E., Esposito, W. & Berardi, D. (2008) Predictors of violent behavior among acute psychiatric patients: clinical study.	In-patient mental health patients	Identify violence risk factors in in-patient mental health units.	Clinical study-review	Over one year 374 patients were reviewed and the identification of violent behaviour recorded.	A past history of violence was a significant indicator of future violence.
Warren, L.J., Mullen, P.E., Thomas, S.D.M., Ogloff, J.R.P. & Burgess, P.M. (2008) Threats to kill: a follow-up study	All adults (n=668) in the Victoria region of Australia who had been convicted of making threats to kill between 1993 and 1994.	To establish data related to people who make threats to kill as there was found to be limited evidence available to mental health clinicians.	Retrospective case reviews (data linkage).	Threats were found to not be predictive of subsequent violence, but within 10 years 44% of people that threatened to kill had been convicted of a violent offence.	People with a mental health diagnosis had a higher prevalence of making threats to kill. Linked with this were high rates of violence and homicide. High rates of violence were evident before conviction, but not as common (as in the whole sample) in the mentally ill sub group. From the sample, people who threatened

					were found to be at risk of suicide.
Carroll, A. (2007) Are violence risk assessment tools clinically useful?	Aimed at practitioners	Discuss the reasons behind the belief that risk assessments have had a limited impact on mental health practice	Review of available evidence	Locally developed risk tools provide no improvement over standard clinical care	The belief that standardised risk assessment tools can stigmatise the mentally ill are no longer warranted, if they are applied in an appropriate way. The choice of tool should be governed by the needs of the specific area of care.
Laajasalo, T. & Häkkänen, H. (2006) Excessive violence and psychotic symptomatology among homicide offenders with schizophrenia	Mentally ill offenders	Identify the factors involved in the use of violence by homicide offender diagnosed with schizophrenia.	Cases notes and criminal index files were examined of 125 offenders in Finland.	A range of demographic factors were identified to the characteristics of a homicide offender.	Nearly all homicide offenders are assessed by a psychiatrist in Finland. Over 50% of the sample had a criminal conviction prior to the current one. Nearly 93% experienced either delusions or hallucinations at the time of the offence.
Wallace, C., Mullen, P.E. & Burgess, P. (2004) Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization	People with a diagnosis of schizophrenia	To establish if the socio-environmental influences on the presentation of violence	Review of secondary data (case registers and data on convictions)	People with a diagnosis of schizophrenia were matched to a control person (by age, gender, residence from the community) and comparisons of behaviour were made over time. Each of the people	People diagnosed with schizophrenia were up to five times more likely to be convicted of violent offenses than people without the diagnosis.

				included had a conviction for assault, causing serious injury or homicide.	
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## **Appendix 4.1 Rationale for non-prescription to a 'Reflective Model'.**

Reflection is used throughout the thesis, however, little guidance is presented as to how practitioners were to construct their reflections or frame their understanding derived from the case study, media representation or experiences in practice. It was assumed that practitioners who were to be involved in the research should possess reflective skills and therefore, be thoughtful and analytical about their practice (Boud and Walker 1998).

I was concerned about presenting experienced practitioners with a model to frame their reflections and understandings that was either a model that they did not use or was one that they would reject due to a lack of faith in its use. This approach was not aimed to ignore the utility of reflective models, but to allow the practitioners to frame their reflections in their way.

Reflective models are used in healthcare education and are embedded in healthcare practice. Commonly at the start of a course, healthcare practice students are introduced to one of the many models used (see Driscoll 1994; Gibbs 1988; Johns 1995) in the courses they enrol on. I contend that the aim of this use of models is to engage students in looking at the events that happen around them and explore the influence it may have on their thinking and actions. I feel that these student healthcare practitioners initially need such a model to organise and structure experiences in order to help them understand the importance of reflection. With more experience and further understanding of the underpinning philosophy of, for example Dewey (1933), where reflection was argued to enable people to problem solve by

the use of some controlled thinking and the work of Schon (1983) who focused the experiences to reflecting 'in-practice' and 'on-practice, healthcare practitioners start to identify the potential limitations of overly structured models of reflection and engage in more reflexive and broader thinking. I experienced such a journey and with many years of experience and trying various models I eventually settled with the use of a reflective type writing approach as advocated by Moon (2004), but also influenced by a cognitive behavioural leaning (see page 100). Such a journey I contend is undertaken by other practitioners, especially practitioners who continue to engage in higher education and are challenged to justify the complex activities engaged in within practice.

## **Appendix 4.2 Blogging.**

The practitioners were to be presented with a story and an academic article which they were to discuss and write a short reflective summary on.

Thoughts emergent at the interviews related to the story being read were to be captured using a digital recorder and transcribed in order to develop a set of data that could be analysed.

I am aware that an alternative method of collecting such data could have been an on-line forum or personal blog, an example of such is Microsoft Wordpress. Blogs have been used in data collection for research. Efimova (2009) and Davies and Merchant (2007) used blogs for their research in an auto-biographical way. Efimova (2009) was able to identify personal meaning to events and analyse them as a 'new sort of text', providing simple access and organisation. The identity of personal meaning to reading a story is one of the elements of my study and the simplification of access to data, a goal I feel all researchers would like.

Reflecting on the use of such an approach, I can see that the use of a blog probably would have been of benefit for my own personal reflections and note taking. However, when I rethink the data collection for others, such as participants in this study, I am less confident in getting them to take part. I feel that they would be asked to generate all the written data, and be asking them to resist modifying comments they were posting. The use of a blog would allow me the luxury of not having to transcribe the interviews, but I may not gain true initial thoughts that would hopefully come out of an

interview recording. This lack of spontaneity was found to have been lost in a study using such an approach by Luzón (2009) in research on academic blogging. Such thoughts are important in this study as they will hopefully identify initial thoughts. More considered thoughts are to be captured later in other interviews.

Returning to this section on writing up the results, I have had the opportunity to see the written reflections of participants. The reflective pieces are brief, almost bullet point in nature. The reflective pieces do identify reflection and feeling, but lack the detail of the recording. I feel that the blogs may have mirrored this presentation and left me with limited rich data.

### **Appendix 4.3 On-line comments from Mail readers on the Peter Bryan story.**

Researching the comments made about the Peter Bryan story in newspapers unearthed a frequently used online forum page. These pages are managed by the newspapers and allow anyone to comment on specific stories contained in the newspaper. The forums often present a topical story, but commonly pose a question to the reader as to how to deal with the events highlighted in the story (in the Peter Bryan story a mentally ill person killing someone) and what the story meant to them. The reader has the freedom to comment in their own words.

Where a killing does occur and the mentally ill person is found guilty, the newspaper's online forum adds a new dimension that allows the public to comment. The story of Peter Bryan used in this thesis, can be used as an example for the sort of comments made that often demand the death penalty, but demonstrate the fear generated by the reporting.

Excerpts from the 145 comments posted on the Mail Online (2009):

*After all the money we freaking give to the community with taxes that I pay with my hard work, one has to be worried that a crazy man might eat one's brain or attack my 17 years old daughter!?!*

*I bet he's out again in less than 10 years!!! Good Old British Justice!!!!!!!!!!!!*

*The common denominator always seems to be negligence in the local health boards*



*Once a cold blooded killer, always a cold blooded killer. If only the Governments would learn what we already know.*

The comments posted are not necessarily a representative sample of the general public, but the comments used here contain accuracies suggesting they have read the story; 10 years was the time since the last killing, that Peter Bryan has killed before and that the focus of his in-patient stay involved a teenage girl. Such information in itself is interesting as newspapers are argued to construct stories so that the reader can get the gist of the story in the first paragraph, and move on to another story if they do not find it interesting (Lacey 2009). Here the comments infer that the people posting comments had found the story interesting, and engaged them enough to cause them to read the whole story.

This interactive format was not included in this thesis, but these comments do raise some interesting questions related to the reporting of the mentally ill and the general public's perception of such cases. Thorson (2006) discussed the influence that the media had on readers, this included the reading of crime reports, which tended to influence the reader to favour punitive measures rather than preventative measure in dealing with incident. Such an outcome is clearly seen in the reader's views published in the Daily Mail Online (2009).

Just as the public is influenced by media stories so, potentially, are health care professionals (Entwistle 1995; Wahl 1997), although one would expect a health care professional to have a more considered and less punitive

reaction. The reaction identified in one of the practitioners was for her to avoid media stories.

## **Appendix 4.4 Reflective process related to justification for approach.**

Having previously analysed personal reflective data in the last chapter, and the identification of the story causing reflective and reflexive moments, a justification for use in this study with practitioners was thought to have been made. I felt that the approach used, linked with my pragmatic values, was the best method to address the emergent questions.

I was aware that I was encouraging the practitioners to reflect on their thoughts and action related to practice. Although the use of self-reflection is a commonly used tool by qualitative researchers (Hanrahan 1999), the use of the findings in a research study are less acknowledged. Even less acknowledged was that I was using myself as part of the overarching research study, and then interviewing practitioners who were to reflect on the same story I had. I needed to be aware of the difficulties alluded to by Denzin (1994) of the 'imperative crisis'. Such a crisis refers to the potential bias of researcher influence in interviews, after all, I had developed my own thoughts around the same story. Scheurich (1997) suggested that you need to make the 'baggage' you bring to the interview open. To manage this 'baggage' I planned to tell the participants that I had read and reflected on versions of the story they were to read, and that I would not offer any comments as to my personal feelings that the story created in me. The use of an interview schedule with specific questions that presented a semi structured approach would limit the influence any researcher could have on

the course of the interview. Audio recordings remain to scrutinise interview management.

Self-reflection, I felt, was needed for several reasons in this study. Primarily, there was a need to explore my own personal feelings to the story of Peter Bryan and identify how it made me feel. This self-reflection would present the opportunity to establish if the story created thoughts in my mind that potentially influenced my practice. If I identified such thoughts and potentially actions, then exploring if it influenced other practitioners would seem reasonable. Having completed this approach with myself and found that the story caused reflections, it seemed reasonable to get the sample of practitioners to also use self-reflection.

## **Appendix 4.5 The use of newspapers for the study.**

The use of newspaper articles present a story-tellers' interpretation of an event and what they feel is important information for any reader to have. Fiske (2010) argued that the interpretation was a way that the journalist and editor connected to society and kept the public aware of important views. In healthcare, many of the events that practitioners encounter are influenced by societal values and actions that are thought to be outside of the healthcare system. These values are potentially influenced by the media (Fiske 2010). Using a story that presents a challenge to societal values and has a level of relevance to practitioners practice may place them in a situation where they are able to explore their own views of events and identify practical reasoning to understand the influence such events may have on them.

The constant variable in media reporting is the media item itself. Practitioners in this study were expected to read and develop opinions of their own based on the story. The practitioners would potentially construct a reality based on this media, therefore constructing their own reality on others 'social construction of reality' (Croteau and Hoynes 2002 p7).

From a personal perspective the media is an important factor in our social lives, and in our understanding of the world. I am concerned as Fiske (1990) argues that the media can "underestimate the ability of readers to make sense of the text in ways that relate it directly to their social situation" (p157), and instead of adopting the expected viewpoint, misinterpret the aim

of the communication. I am aware that not all readers will read the entire article as the dense type face can be off putting. It is also understandable that the reader will probably, at first, read the headline and then the first paragraph, and if still interested, potentially the rest. To engage the reader, the newspaper author utilises a process similar to therapy in mental health. The author will try to conceptualise the whole story in a snapshot first paragraph. The article used employed this approach. Journalists use the 5 'w's; who, what, where, when and why, to frame the story (Lacey 2009). In using the 5 'w's, journalists try to provide sufficient information to start an opinion of who is involved, what is going on, where it happened, when and then their opinion of (if necessary) why. To establish if a story is 'newsworthy' Galtung and Ruge (1965) highlighted what process is needed. Galtung and Ruge (1965) go on to argue that the article will need to have an element of personalisation (about mental health practice) and negativity (infers blame). This will need to have some threshold (scale of event), unexpectedness (man eats friends brains) and continuity (can be covered for many days).

The interest in reading newspaper stories is argued to be generated by 'human interest', these can be best served by "previously unknown individuals" (Fine and White 2002, p59). If an opportunity is developed by the author to get the reader to identify with the people and become emotionally involved (Wirth and Schramm, 2005) in the story then the impact may be increased. It was anticipated that the story used would have some relevance to the practitioners practice and challenge practical and

theoretical wisdom of those involved at the time. The practitioners involved in the study should have been able to engage with the story and reflect (with the help of questions from the interview) on their personal appraisal and feelings related to the story. I had already reflected on the story and had (with the use of research supervision) arrived at a series of brief open ended questions aimed to engage the practitioner in talking about the influence of reading the story.

One of the themes embedded in the story relates to risk and how the practitioner not only managed this but how they identify risks related to practice. The difficulty is that each practitioner may interpret the risks differently and take different actions. Littlejohn (1999) suggested that the audience (the practitioners in this case) make active decisions as what to do with the media they have just faced, inferring choice and a conscious level decision. The outcome of the interviews aimed to place the practitioner in the situation of making meaning of the media by the use of reflection, then returning to it and reconfiguring thoughts and experiences (Polkinghorne 1988).

## **Appendix 4.6 Pilot interviews.**

The pilot interviews involved two colleagues from different universities that had been mental health practitioners and were currently researching projects of their own. They were interviewed on three occasions over a three week period of time. The interviewees were asked questions that later became the questions used in the interview schedule (see section 4.5). The outcome of this was pilot was relatively uneventful as the literature generated interest and conversation. The questions were understood and the structure and timing of the interviews appeared to generate some flow in the proceedings and engagement in the homework. The main feedback I elicited was that the story of Peter Bryan was very interesting and caused reflection on practice.

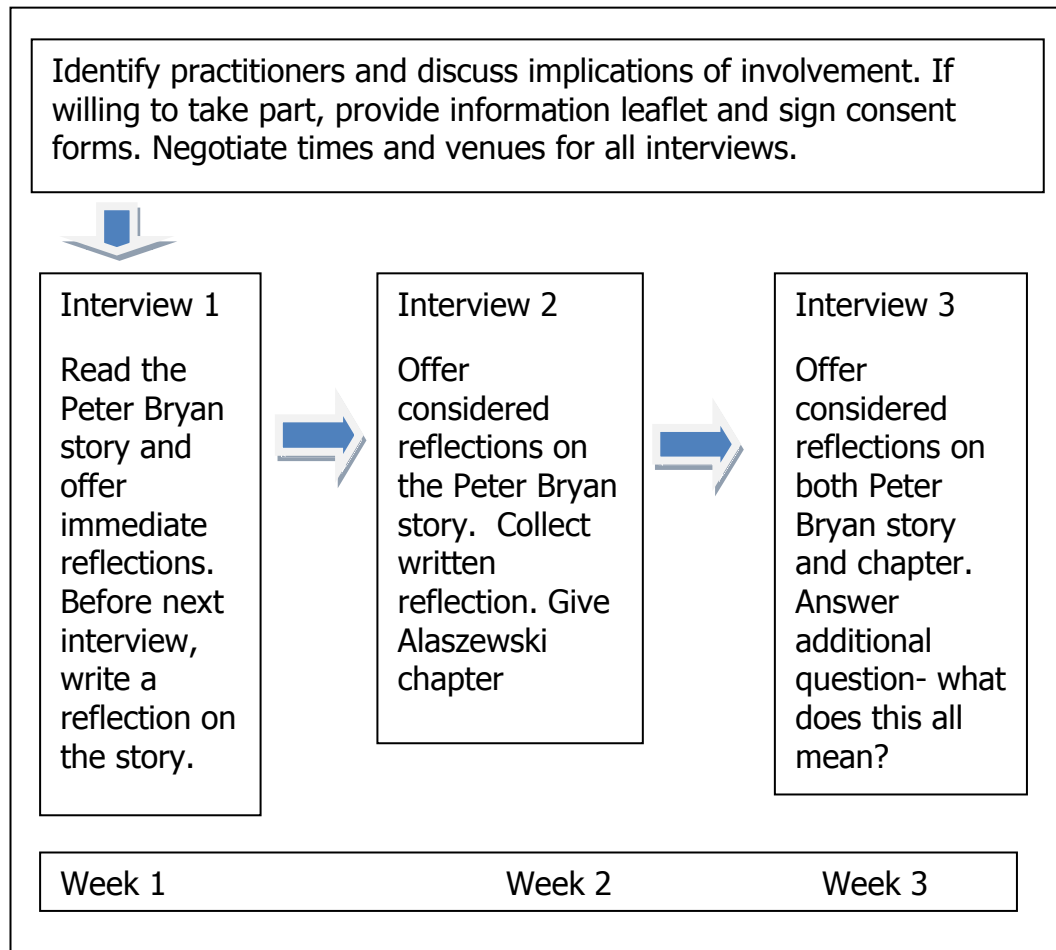
As a researcher I was aware in the pilot interviews that I needed to be consistent and avoid offering too many comments or prompts. The pilot interviewees did ask questions during the interviews, but these were more for clarification, enquiring if this was the sort of information needed. I understood that these comments were aimed at being helpful as they wanted the information to be what I had expected. From the results of the pilot, I decided to improve the opening statement to participants explaining that the information they gave was their interpretation, and that no preconceived plan for what participants should do or say had been made.



## Appendix 4.7 Demographic of the practitioner sample.

<b>Practitioners</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>Age (Band)</b>	30-40	40-50	30-40	40-50	40-50	40-50	30-40
<b>Sex(M=Male, F=Female)</b>	F	M	F	F	M	M	M
<b>Experience (years)</b>	+15	+15	+10	+20	+20	+15	+10
<b>Description of work</b>	Adolescent Community	Adult Community	Adult Community	Adult Community	Adult Community	Adult Community	In patient Forensic
<b>Organisation</b>	NHS	NHS	Independent	NHS	NHS	NHS	Independent
<b>Role</b>	Clinician	Clinician	Manager	Clinician	Clinician	Clinician	Manager
<b>Supervisor</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Clinically active</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Highest Award</b>	MSc	Masters Module BSc	Masters Module BSc	MSc	PhD	MSc	MSc

## Appendix 4.8 To show outline of interview process.



**Appendix 4.9 Discussion related to the choice of 'Managing risk in community practice: nursing, risk and decision- making' by Alaszewski as the academic article.**

Having researched and taught the subject of risk at both University and in the Trusts, I felt I had an awareness of a wide range of risk related literature. I was also aware; by reviewing risk related literature, the commonly used references and standard texts used in guidelines and policies. Such guidelines and policies are available to mental health staff, and are commonly used on reading lists for University courses where practice and risk are a component.

An assumption I made was that if I had read the guidelines and policies, then so may the practitioners I was approaching to take part in the study. In supervision I discussed my thoughts related to the choice of an academic article to use in the research. We debated the nature of literature that I was drawn to and that it was predominantly mainstream mental health literature. I was encouraged to look at wider literature, and in doing this came across the Alaszewski chapter.

Having read the chapter I was surprised that I had never come across this text before. It was clear to me that such a text should be included in reading lists and was different to other texts I had read related to risk. I feel that presenting an alternate view to risk (such as this chapter) may enable practitioners to relook at their present understanding of risk and evaluate what influenced their decision making. This would include the reading of the case study.

The Alaszewski chapter in Godin's (2006) book, although much longer than most of the other potential texts, presented an alternate view of risk in practice to all other texts. The chapter compared practitioners from different fields of nursing, different areas of care giving and their interpretation of risk. It presented a picture of how the interpretation of risk may influence decision making and that risk is an important factor to be considered when offering support to patients. The chapter highlights that hazards are present in risk related decision making, but risk decisions still needed to be taken. There was a discussion that explored how risk taking often adopted a restrictive approach and highlighted the need to identify hazards in any assessment. A central point of the chapter related to the assumption that the way nurses assess and manage risk is related to how they define what risk is. The chapter also emphasised that there may be a difference between what nurses said about their risk related practice and how they actually practiced.

## **Appendix 4.10 Transcription.**

The data collection adopted a standard qualitative type approach of digitally recording the interview and adding supplementary handwritten notes throughout (Olsen 2012). The recordings were transcribed verbatim by myself. The decision to self-transcribe was reached as transcriptions by private companies can be expensive and would still need proof reading and amending. Self-transcription of the 21 final interviews, although seen as a way of engaging with the data, was understood to be time consuming. This aside, verbatim transcription was conducted by myself, as it was felt to be the only opportunity to unpack the interviews and address completely everything spoken about by the practitioner.

The debate about the utility of verbatim accounts of interviews is explored by Halcomb and Davidson (2006). Such exploration found that the use of verbatim accounts had become integral in nursing research, and although an important approach, one that is fraught with pitfalls. Halcomb and Davidson (2006) felt that the data was in danger of the meaning becoming lost in the interpretation of the transcribers. Often the written word does not reflect the emphasis made in the spoken word. Although arguing that verbatim transcription is important, Halcomb and Davidson (2006) concluded that there was no definitive way of transcribing in a verbatim way, and this was not helped by published research failing to explain any guidance on transcription and tending to refer to the data as having been transcribed.

In my study, transcription refers to listening to the data and typing it out verbatim. This included marking the script with pauses where the practitioner stopped talking and was clearly either thinking about what to say or had lost the thread of their thinking. Sighs were entered, and a phonetic style adopted (e.g. when saying kind of, the participants often said 'kinda'). Common words used to join sentences and start ones such as 'erm', 'ah', etc, were also entered. All interruptions and questions were highlighted and any non-verbal communication such as smiling, frowning, etc, were also added at transcription (these were linked via recorded written notes taken during the interview).

The production of transcripts for each interview and individual were anonymised and a code book for linking interviews and any other data collected for practitioner was developed and stored according to University policy.

## **Appendix 4.11 Discussion related to data analysis.**

Once all the data had been ordered into a word document it became apparent that there was an overwhelming amount of data that looked overwhelming. Miles and Huberman (1994) advised that analysis needed to be systematic and that researchers should be careful not to rush into coding. Bazeley (2013) suggested reading the transcripts again and again to get a feel for all the work. Bazeley (2013) also advised that primary urges to code should be put on hold, but that whilst reading, potential codes should be noted and joined up into themes. The approach of simple memoing and writing about what the practitioners were saying was used. This led to what Dey (1993) suggested was the outcome of analysis, grouping all the categories together and finding relationships between them. The identification of initial categories, then further categories, led to the development of larger groupings and potential generalising terms emerging.

A decision to use QDA Minor (mixed methods software) was initially made so that a single programme could be used to manage and explore the transcriptions. Using QDA Minor required the uploading of the 'Word' document and populating the coding section of the programme. The opportunity to generate codes and modify them initially seemed exciting, but with continued use it was found that the QDA coding struggled when multiple documents were developed and reading became distracting with colours, codes and 'pop ups'. A decision to revert to hard copy analysis was made due to the distraction caused. The transcripts were printed, and then the process of cutting them up and arranging quotes under themes and

unifying descriptive statements was carried out. This presented the opportunity to move things around in full view of all the other data which enabled me to see how unifying themes were represented.

Whilst analysing the data, consideration was given to influences on selecting codes. Professional background, experience and training were considered. In nursing we are constantly pushed for evidence to either back up or challenge practice. Such a push for evidence became distracting and at one point it became apparent that the qualitative data was unconsciously being quantified in an attempt to identify causal relationships; one of the problems with QDA Minor, as it continually attempted to quantify the qualitative data. As stated by Bazeley (2013), jumping to conclusions and making general assumptions at an early stage is a common problem encountered by researchers. Reading once more and gradually categorising the themes allowed for the development of many themes and then the opportunity to identify unifying descriptive statements. The use of memos and references to observations enabled the joining together of what initially appeared slightly different themes.

The conclusion of the analysis led to a merging of data from all interviews that presented a journey for the practitioner and identified emergent thoughts and actions raised by the reading of the story and the academic article. The outcome of this analysis is presented in a narrative fashion in the findings section.



In this research study a decision regarding the presentation of the analysis of data was needed as presenting seven verbatim accounts would have been confusing and repetitive. The individual interviews all took place over a three week period and were consecutive in nature. Each was framed with specific main questions and supplementary ones dependant on the conversation produced. The supplementary questions were used to gain further details and encourage adherence to the main question.

A decision to pool and synthesise the data was made as it was felt that this would allow the opportunity to thread emergent themes from different interviews together and to not be restricted by interview number. It was found when reading and re-reading the transcripts that similar themes emerged in each interview as different practitioners moved on to reflect in different ways and at different speeds. It was only when all three interviews were read in entirety that the pattern of understanding could be seen. The approach of pooling all data had been used prior to this study for data covering different dates of collection (Harris and McElrath 2012) and was felt to aid the presentation of a comprehensive account of the practitioner's information.

The interviews took place from September 2012 to March 2013. Initially it was felt that the interviews would be completed by January 2013 but two practitioners could not offer the commitment for the consecutive interviews until March 2013.

## **Supplementary paperwork.**

Attached are copies of papers, as submitted to journals (final Word documents).

Each is described briefly:

*The changing face of newspaper representations of the mentally ill-* published in The Journal of Mental Health (2013).

This paper is written in a similar fashion to that presented in the relevant section of the thesis and presents the findings for the early stage of the research related to newspaper representations. On reflection, I feel that the presentation used in the main body of this thesis is easier to follow and less distracting than the paper.

*The Influence of the media on practice in mental health- a bricolage of a single case study-* submitted to Health, Risk & Society (under review).

This paper was developed after presenting the autoethnographic findings at the Qualitative Research Conference (QRMH4) in Nottingham. In this paper I attempt to present findings in different way to the changing face of newspaper representations of the mentally ill. The development of this paper presented me with the confidence to write in a more narrative way and embrace wider qualitative methods for use in this thesis.

# **The changing face of newspaper representations of the mentally ill**

**Authors** Murphy, Fatoye and Wibberley

## **Abstract**

### **Background**

Negative stereotypes presented in the media may contribute to the stigma associated with mental illness. People's attitudes toward the mentally ill are initially influenced and subsequently maintained in part by the frequent media presentation of negative stereotypes of mental illness. This could result in social rejection of individuals with mental illnesses.

### **Aim**

To explore how four main UK national newspapers reported on mental health/mental illness stories over a ten year period.

### **Method**

This study utilised content analysis to identify words, themes and trends of representation related to the mentally ill in articles from the four newspapers.

### **Results**

The findings indicated that there was an increase in the number of articles related to mental health/ illness over the time of the study. The rate of increase was far greater than that for the increase in the total number of articles carried in the press over this time period.

It was also identified that pejorative terms were used, in a number of the articles, to describe the mentally ill person.

### **Conclusion**

Many of the newspaper reports highlighted the need for protection of the general public from the mentally ill; and that the mentally ill were in some way different to the general public. In particular, both the words violence and drugs were linked to mental health/mental illness in these articles.

### **Key Words**

Content analysis, representation, mentally ill, reporting trends.

### **Introduction**

The mass media present us with multiple and contradictory points of view on nearly everything; and human beings often make their moral choices unreflectively, as they are simply guided by abstract principles (Karp and Watts-Roy 1999). People create their understanding from information reported from the mass media and share this with the world/society that they live in. The fact that

society is ever changing and that technology is constantly being updated is important, as our view of the world is constantly shaped and re-shaped through various types of media.

Within this paper the medium being focused on is newspapers and the reporting that the newspapers produce will concern the mentally ill. We accept that the media is only a part of the complicated series of factors that create the perceptions related to mental illness (Pilgrim and Rogers 1999). However such perceptions, it will be argued, are affected by the representations that the newspaper presents for the reader to interpret.

Historically there seems fairly unequivocal evidence that newspaper reporting has portrayed a negative image towards the mentally ill. Three frequently cited studies (Philo et al. 1996; Wahl 1997; Ward 1997) would suggest that mental illness is portrayed negatively and that in particular that this portrayal often links mental illness to violence and/or criminality (see Francis et al. 2001 for a review of these and other studies). Francis et al. (2001) also suggest that much of the information derived about mental illness, for lay persons, politicians and professionals comes from the media. There appears to be a link between the story being told and the emergent attitude of the reader towards mental illness (Appleby and Wessley 1988; Dietrich et al. 2004) and this it has been argued leads to a generalised fear and increase in social distance given to the mentally ill (Angermeyer and

Matschinger 1997). Thus previous studies, when taken together, can be seen to conclude that the media influences public perceptions of those with mental illness in a negative way, leading to social stigma for this group.

This negative media portrayal may have heightened the belief that the mentally ill are different and consequently need laws and policies to control them (Paterson 2006). This may influence the media's message and suggest that they pose a significant risk of interpersonal violence (Phelan and Link 1998) and possess a level of dangerousness and criminality above that of the general public. This image has been created without regard for the evidence that, on the whole, they are no more criminal or dangerous than the general public (Cutcliffe and Hannigan 2001; Brennan et al. 2000). When reading the literature it would appear that this negative portrayal has been consistent over many years and that the representation is reflected in the conceptualisation of the mentally ill being dangerous.

Over a decade on from when much of the literature cited above was written, it seems appropriate to revisit the question of the way that the literature represents those with mental illness. This is especially true as since this literature has been produced, a guidance note has been published (and subsequently reissued) in the UK by the Press Complaints Commission (PCC 1997/2006). The press release accompanying the reissued guidance note stated that

“The new Note reminds Editors of the importance of terminology in

reporting, pointing out that people are detained under the Mental Health Act 1983 in 'hospitals' not 'prisons', and are 'patients' not 'prisoners'.

Furthermore, the terms 'jail', 'cell' and 'cage' are inaccurate under the terms of the Act when referring to the accommodation of patients.

Editors are also reminded that epithets such as 'nutter' and 'schizo' may raise a breach of Clause 12 (Discrimination) of the Code of Practice in discriminating against individuals who are mentally ill, or Clause 1 (Accuracy), and points out such language can result in both distress to patients as well as contributing to a climate of public fear or rejection".

To address these issues, the aims for this paper were established:

- To detail newspaper reporting on the mentally ill, exploring whether there were any changes in the frequency of newspaper reporting related to the mentally ill over a 10 year period (1998 - 2008).
- To explore whether there was any change in the way newspapers represented the mentally ill; and if so, whether there were any trends within these changes.
- To compare and contrast any changes and trends discovered in this study, with previous studies that were concerned with the representations of mental illness in the media.

## **Methods**

To achieve the aims identified and to provide the opportunity to compare the findings with previous literature, content analysis was used. Content analysis has been described as a technique for making inferences through objective and systematic analysis of the specifics of any message (Holsti 1969, p.14), and to be *"one of the most important research techniques in the social sciences...understanding data not as a collection of physical events but as symbolic phenomena"* (Krippendorff 1980, p.7).

Krippendorff (1980) argued that any content analysis needed to have a clear set of data to be analysed, defined from a specific population. The context that the data is drawn from and the boundaries for analysis need to be established, culminating in a conclusive outcome.

This involved the exploration of the Lexis Nexis Butterworth database that stores a vast range of newspaper data.

Initially the identification of relevant articles was carried out; this involved cataloguing any article that had reference to mental illness or mental health in the text. Articles included were feature articles, personal commentaries in the form of life stories and letters to the newspaper. They did not include repeat/ edited articles on the same day nor reviews of film, books or tv documentaries. These catalogued articles were then examined by one author using a 'scanning



approach', involving a process of searching, collecting and evaluating information as advocated by Etzioni (1986). The inclusive and potentially mechanistic approach of using all available articles that had the terms mental illness or mental health and addressed the criteria above reduced the chance of preconception influencing the data collection.

It was anticipated that due to the lengthy time period and the range of newspapers available, a narrowing of the search would be needed; thus the search was limited to UK national newspapers. It was felt that whilst limiting the data collection in this way, would have a certain effect on the breadth of data available, it would still provide sufficient information for analysis (Sandelowski and Borroso 2003) and additionally add coherence to the sample. This is also in line with Krippendorff's (1980) and Berelson's (1952) suggestions regarding content analysis. They argued that potentially available materials should be reduced so that what is left remains large enough to contain enough information but small enough for sufficiently in depth analysis. It was also intended to avoid utilising only a small sample of media items, a limitation (according to Francis et al. 2001) of previous studies exploring representations of mental illness in the news media.

To adhere to Krippendorff's (1980) guidance, for a clear set of data to be analysed, all UK national newspapers were included in the initial search over the time period. However, full access to articles was only freely available for four of these papers over this time period: the Times, the Guardian, the Mail and the Telegraph. This availability did not include any of the 'red top' newspapers, and we

must acknowledge that The Sun sold most copies in the UK at the time of data collection. It was felt that these papers still provided a good range of available popular newspapers, and so it was decided that their use as the sampling frame was appropriate.

The duration and dates for data inclusion (10 years) was arrived at:

- To focus on a period of time that had not previously been examined through this form of investigation;
- to use data up to the commencement of the study; and
- to utilise an arbitrary but nevertheless sufficiently lengthy period of time to establish any trends in the way those with mental illness were represented in newspapers.

Given the above information, the ten-year time frame decided upon was from December 1998 to November 2008. This time period also coincided with a time when, in the UK, newspapers had access to guidance on terms and terminology appropriate to coverage of those with a mental illness. Coincidentally, the time at which the study was undertaken was found to be timely as shortly after the initial data collection the Telegraph's owners withdrew (temporarily) data for 1988 - 2000, along with unspecified stories by some freelance authors up to the end of the data collection period. This latter factor would make the replication of this study very difficult currently, if it were to include data for the Telegraph.

Ethical approval for the study was obtained from the Academic Ethics Committee, Manchester Metropolitan University (Faculty of Health, Psychology & Social Care).

### **Data Analysis**

The four newspapers were initially analysed using descriptive data analysis, to determine the total number of articles. This allowed the comparison of the number of articles related to mental health each newspaper published; and the percentage of such publication across the sample. Regression analysis was also carried out to determine if there was a significant linear trend in the reporting of mental illness in these newspapers.

### **Results**

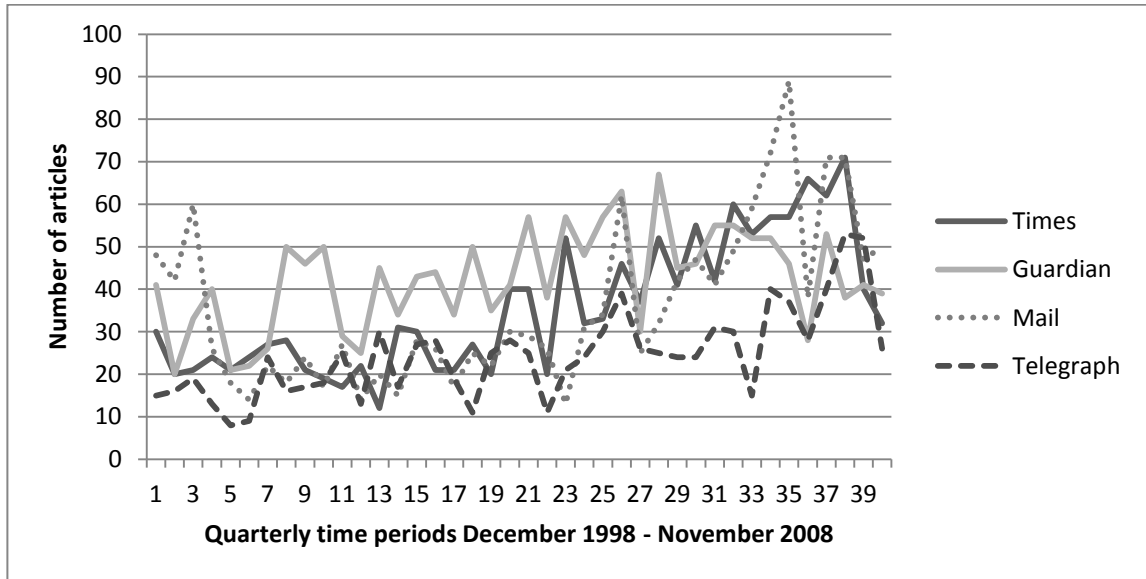
The number of articles ( $n = 5537$ ) published across four UK national newspapers, which included the phrase 'mental illness' and or 'mental health' from December 1998 to November 2008 is presented in Table 1. Figure 1 depicts how the newspapers have reported information on mental illness over the ten year period when compared to each other.

**Table 1: The number of articles published by 4 UK national newspapers which included the phrase 'mental illness' and or 'mental health' from December 1998 to November 2008.**

Newspaper	Times	Guardian	Mail	Telegraph	All papers
Number of articles	1421	1713	1425	978	5537
% of all coverage across the 4 newspapers	25.7	30.9	25.7	17.7	100

From this sample an exploration of the phrases associated with mental health/mental illness coverage was undertaken. Terms used to describe the mentally ill person included drug user, schizophrenic, and as someone being deranged. A comprehensive list and results of these phrases are provided in Table 3. From Figure 1 it can be seen that there was a gradual increase in reports related to mental illness, across all four newspapers over the ten years. All the newspapers are seen to present similar starting points and finishing points in relation to each other; thus the relative frequency of reporting was similar across time across the newspapers. In order to compare the data trends, trendlines and an R<sup>2</sup> value for each line were calculated, shown in Table 2 and Figures 2-7.

**Figure 1: To show the frequency of reporting by each newspaper on the terms of 'mental illness' and or 'mental health' for the time period November 2008- December 1998.**



**Table 2: Table to show the frequency of terms of reference made to the mentally ill for the 4 newspapers**

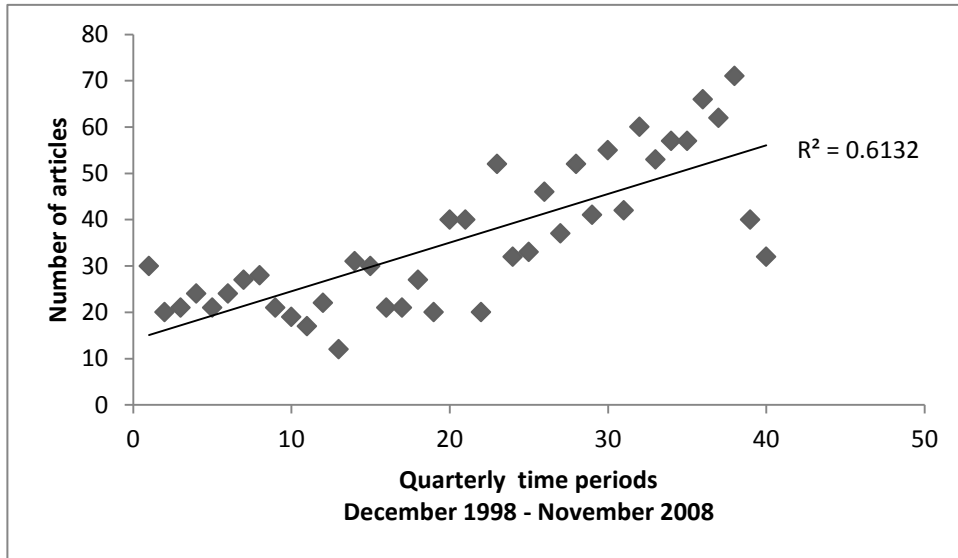
Newspaper	All	The Times		The Guardian		The Mail		The Telegraph	
	5537	1421		1713		1425		978	
Number of articles		Number (use per article %)	use across all papers (%)	Number (use per article %)	use across all papers (%)	Number (use per article %)	use across all papers (%)	Number (use per article %)	use across all papers (%)
Terms identified									
Drugs	1752	416 (29.3)	23.7	563 (32.8)	32.1	570 (39.7)	32.5	203 (33.6)	11.6
Violence/ Violent	1,147	324 (22.8)	28.2	343 (20.0)	29.9	356 (24.8)	31.0	124 (20.5)	10.8
Protection	333	108 (7.6)	32.4	107 (6.2)	32.1	85 (5.9)	25.5	33 (5.5)	10.0
Schizophrenic	284	99 (7.0)	34.9	109 (6.3)	38.3	192 (13.4)	67.6	57 (9.4)	20.0
Aggressive	200	53 (3.7)	26.5	56 (3.3)	28.0	70 (4.8)	35	21 (3.5)	10.5
Addict	179	39 (2.8)	21.8	48 (2.8)	26.8	72 (5.0)	40.2	20 (3.3)	11.2
Psycho	63	16 (1.1)	25.4	32 (1.9)	50.8	12 (0.8)	19.0	3 (0.5)	4.8
Deranged	59	12 (0.8)	20.3	13 (0.8)	22.0	29 (2.0)	49.2	5 (0.8)	8.5
Schizo	22	0 (0.0)	0	15 (0.9)	68.2	2 (0.1)	9.1	5 (0.8)	22.7

**Table 3: R<sup>2</sup> values for each newspapers trend line**

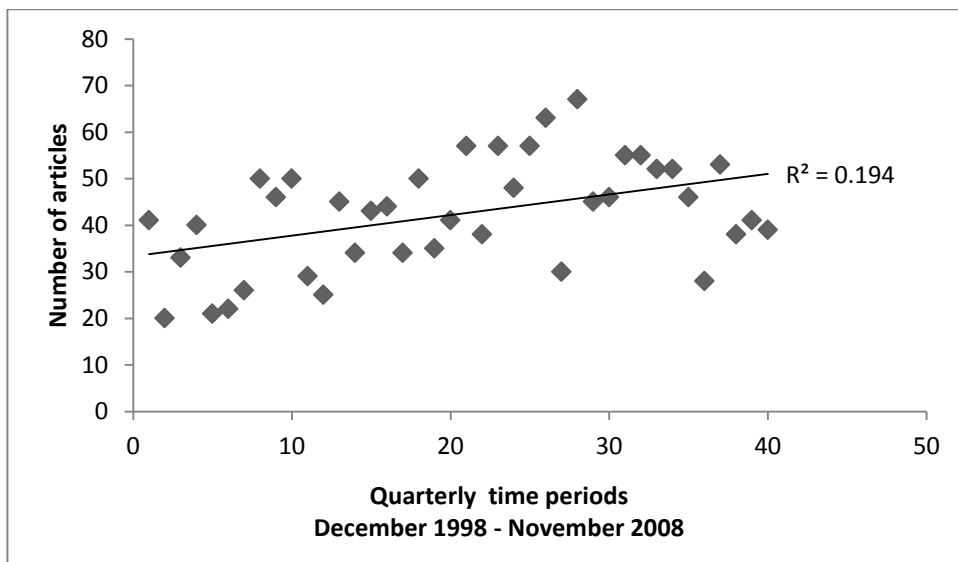
Newspaper	R <sup>2</sup> Equation	R <sup>2</sup>
The Times	$y = 1.0505x + 14.065$	$R^2 = 0.6132$
The Guardian	$y = 0.4424x + 33.331$	$R^2 = 0.194$
The Mail	$y = 0.9421x + 16.712$	$R^2 = 0.3354$
The Telegraph	$y = 0.6241x + 11.681$	$R^2 = 0.4837$

The R<sup>2</sup> calculation aided the evaluation of the linear relationship between the number of stories published and time. The greater the R<sup>2</sup> value the greater the linear relationship is; for example in The Times ( $R^2 = 0.613$ ) 61.3% of the variation in the number of articles can be explained as an increase related to time; whereas only 19.4 % of the variation in the number of articles can be explained as an increase related to time for the Guardian. Thus for the Times reporting 38.7% of the variation, from the linear relationship, in reporting over time could be due to chance (80.6% for the Guardian) - see Figures 2-5. The pattern for all newspapers' articles (combined) over the time of the study is shown in Figure 6.

**Figure 2: The Times newspapers reporting of articles relating to mental health December 1998 –November 2008.**

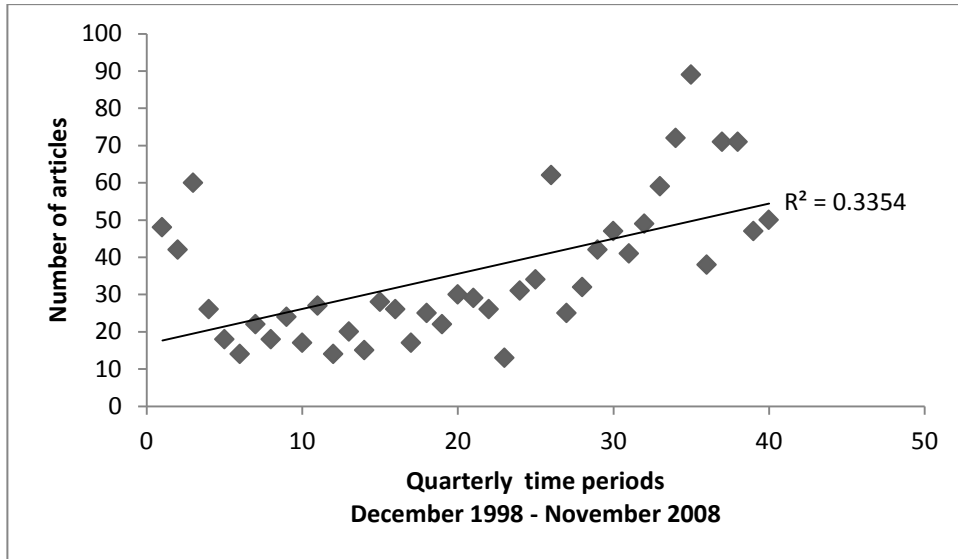


**Figure 3: The Guardian newspapers reporting of articles relating to mental health December 1998 –November 2008.**

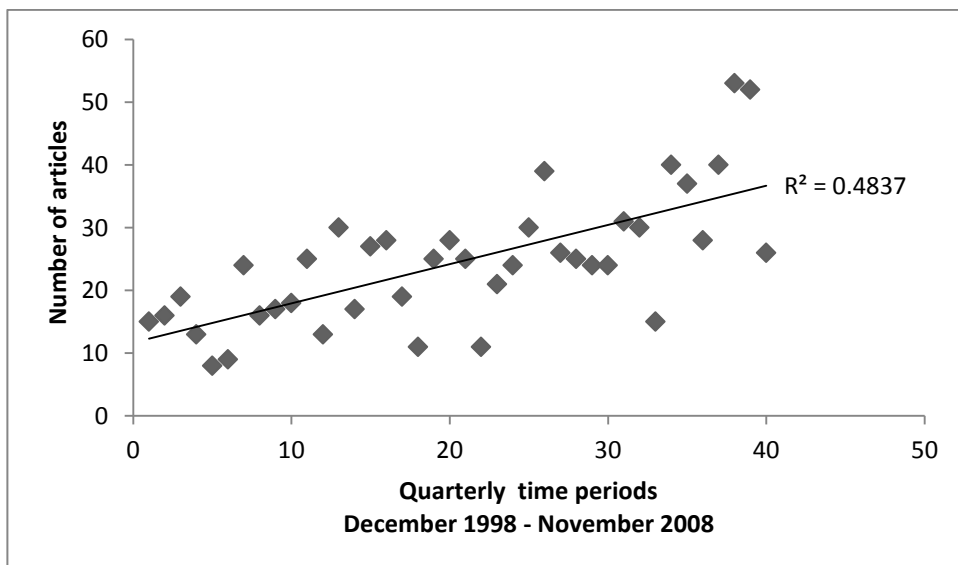




**Figure 4: The Mail newspapers reporting of articles relating to mental health December 1998 –November 2008.**



**Figure 5: The Telegraph newspapers reporting of articles relating to mental health December 1998 –November 2008.**



**Figure 6: All newspapers reporting of articles relating to mental health December 1998 –November 2008.**

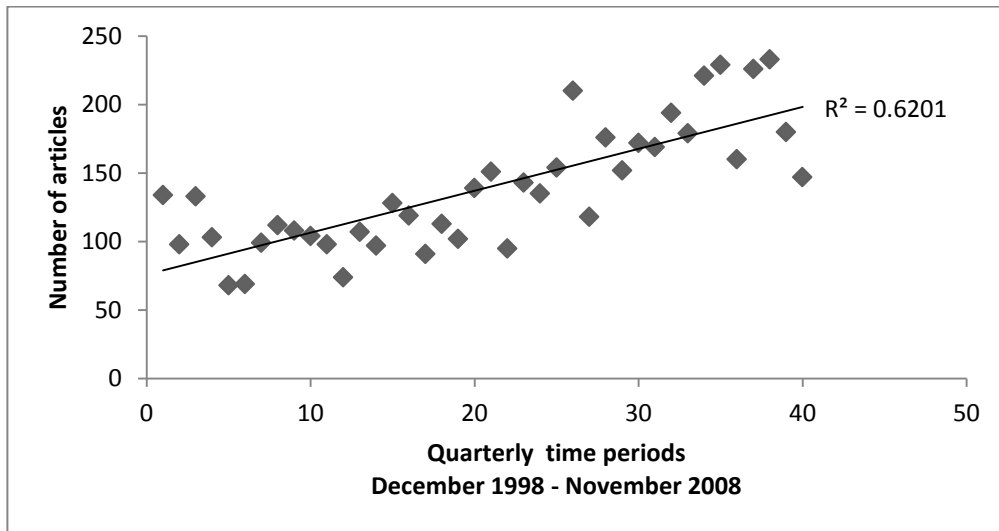
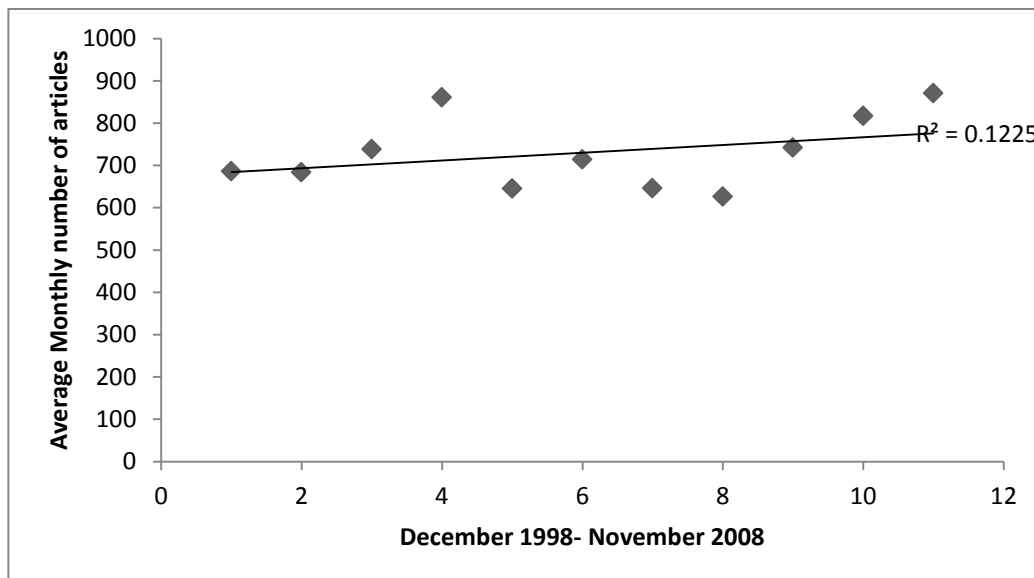


Figure 6 identifies a relatively strong positive relationship between the number of stories published and time. Consideration was given to the fact that the newspapers were publishing more stories in total; in which case whilst there may be an overall increase in the number of mental illness stories, such an increase might not necessarily represent an increase in the ratio of mental illness related stories to all stories. This ratio was calculated following identification of the average number of articles published for all the newspapers used over the time period. This is shown in Figure 7.

This suggests that proportionally the number of mental health/mental illness articles is increasing from 0.88% of the total articles at the start of the data collection to 1.84% at the end. Thus as a proportion of all articles, there has been a doubling of articles relating to mental health / mental illness over the period

1998 – 2008. The number of articles that each newspaper published that included the term mental health or mental illness varied. The Guardian published the greatest number of articles, with 30.9% (n = 1713) of the coverage of the total sample; followed by The Mail and The Times (both with 25.7% of total coverage, n = 1425 and 1421 respectively); with The Telegraph publishing the least, proportionally, with 17.7% of coverage (n = 978).

**Figure 7: All newspapers reporting of all articles December 1998 – November 2008.**



A range of terms were used, across articles, to either describe or to infer a relationship with those who are mentally ill. The most frequently used terms are presented in Table 3; the most used terms in the articles as a whole were drugs

(reliant/ in need of prescribed medication or illicit drugs), violence (commonly either past violence or perceived threat), protection (that the general public needed protection) and schizophrenic (as a diagnostic label). To take the example of the use of the term drugs within articles about the mentally ill: drugs was used in no fewer than 29.3% of all the sampled articles in the Times; this figure rose to 32.8% of such articles in The Guardian, 33.6% in The Telegraph and 39.7% in the Mail. In addition, a number of derogatory or pejorative terms were evident in the sampled stories; the terms schizo, psycho or deranged were used, although in less than 2% of the entire sample.

## **Discussion**

Over a decade on from the much of the literature cited in the introduction, we have produced a new series of baselines relating to the representations of mental health/mental illness in four UK national newspapers. The aims of the study were

- To detail newspaper reporting on the mentally ill, exploring whether there were any changes in the frequency of newspaper reporting related to the mentally ill over a ten year period (1998 - 2008).
- To explore whether there was any change in the way newspapers represented the mentally ill; and if so, whether there were any trends within these changes.

- To compare and contrast any changes and trends discovered in this study, with previous studies that were concerned with the representations of mental illness in the media.

The findings presented clearly show an increase of reporting on issues related to mental health/ mental illness over the ten year period of time and the uncovering of various trends related to descriptive words frequently used. Additionally a relatively strong linear relationship was demonstrated between the increase in the number of stories being published in many of the newspapers and increasing time from 1998 - 2008. The reason for the increase is not clear as there have been no major increases in either the homicide rate or suicide by the mentally ill during the time frame of the study (National Patient Safety Agency 2009). Service related policies toward risk assessment and management may have altered throughout the period, and regular publication of reports on homicide and suicide rates by the mentally ill have been published. These changes in policy and routine reports would not necessarily account for an increase in the reporting as they are relatively regular in nature.

A factor that may have been influential could have been an increase in health promotion for mental health problems and may have had a positive angle in the representation. This may well be a factor in the increase in the number of articles and the consequential lower ratio of derogatory terms found in the sample. To have coded the articles as positive or negative could have potentially addressed

this situation, however there are many articles that had a range of positive and negative representations within the same story. The coding of such articles would have reduced the objectivity of the data collection and introduce potential bias to inclusion and exclusion of articles.

When looking at the trends that emerged, the findings appear to imply that some terms such as violence and drugs were regularly used in the reporting on mental illness within the time period 1998 - 2008. This may serve to heighten the notion of differentiation (Foster 2001), in the reporting of the mentally ill as different to the general public. This apparent level of differentness was further reinforced by the trend for stories to use diagnostic terms as descriptors for people who commit violent crime. The term schizophrenic was found to be used, and although limited in our data, was clearly stigmatising to people with such an illness. Clement and Foster (2008) had identified the use of the term in media as a stigmatising descriptor consistently in such representations. When looking at our findings, the stigmatising use of the term schizophrenic was found to be the fourth ranked of the terms commonly used. Crisp et al. (2004) and Harper (2005) identified the need for further in depth investigation into the use of stigmatising language. They suggested that such stigmatising terms were used in films, television and books, and possibly led to the creation of myths linking the terms to mental illness/mental health.

One particular myth was found in the inference of risk posed by the mentally ill. This was evidenced with the emergence of the term 'protection' and the relation of

protection of the public from either a person or persons with mental illness/mental health problems. It would be acceptable to interpret that if you needed protecting from somebody, then they must be dangerous. This could raise fears of harm even the chance of being killed. Taylor and Gunn (1999) argued that the odds of someone being killed by a mentally ill person would be similar to the odds of someone winning the lottery. To contextualise this there were 61 cases reported of homicides carried out by a mentally ill patient on a stranger out of a total of 5189 reported homicides in the UK over a time period of 1997 - 2005 (National Patient Safety Agency 2009).

To say that the mentally ill do not pose any risks would be naïve. Douglas, Guy and Hart (2009) in debating if people with psychosis were violent found; "compared with individuals with no mental disorders, people with psychosis seem to be at a substantially elevated risk for violence. Compared with individual's with externalizing psychopathology, psychosis does not appear to further elevate the risk for violence" (p696). They did go on to add that the presence of substance misuse that the level of violence was higher. However, in further contextualisation, the National Patient Safety Agency (2009) argued that the risk is only higher when not under the care of mental health services.

When considering these results in relation to previous studies, there are quite possibly a large number of similarities (ie there has been little change in the overall nature of reporting of mental illness in the news media). Francis et al. (2001) in

their review of the literature on mental illness and the media concluded that "mental illness is portrayed negatively in the mass media...and there is a strong link between mental illness and violence (Francis et al. 2001 p.5-6). If we look in particular at two previous UK studies published in the mid-1990s (Philo et al 1996 and Ward 1997) then we can conclude that much is the same, although coverage is perhaps getting slightly 'better'. Philo et al suggested that "there are many more items which relate violence to the mentally ill than those which present a more positive image" (Philo et al. 1996, p.47). These findings related not only to newspaper coverage (tabloids only) but also other non-fiction and fiction media coverage. Ward (1997) whose study was closer to ours, in that it looked at UK tabloid and broadsheet coverage, concluded that

"Almost half of all coverage, in broadsheets and tabloids, was about the subjects of crime, harm to others and self-harm. Stories linking violence and individuals with a mental illness diagnosis were common, and generally given more prominence than more positive pieces. Editors will say that they are driven by news values, by what will appeal to their readers. Yet to give so much attention to these issues seems odd, especially since those with mental health problems are no more likely than anyone else to harm others and because there has been no increase in killings by people with mental illness".



(Ward 1997 p16)

In Philo et al's (1996) study the term 'violence' outweighed other terms (in relation to mental illness) by about four to one and the Ward (1997) study identified that mental illness was linked to crime and violence in about half of the sampled articles. In our study this was much less as there were such links in 1147 articles out of a total of 5537, around 21% of the total sample; thus, it could be argued that there has been an improvement in newspaper coverage of mental illness. However, we would suggest that overall coverage is still too negative.

## **Conclusion**

Whichever way the results of this study are viewed they present a negative image of reporting related to mental illness. This image is differentiating, stigmatising and potentially inaccurate. This however is no different to past findings from the majority of studies on the representation of mental illness in the media. The derogatory way in which reporters commented on mental illness has been criticised (Stark et al. 2004; Anderson 2003), and reporters were challenged to be more positive in their reports. Whist guidelines have been produced - perhaps as a result of similar earlier criticism (PPC 1997/2006) - neither the criticism nor the guidelines seem to have filtered through to the writers of such reports or their editors, as yet. Thus society, as reflected by the media, seem no more 'forgiving' of those with mental health problems in the time period 1998 - 2008, than it has in the past.

This social context has possible, if not probable, implications for those with mental health problems and for those caring for such people (whether in a formal or informal capacity). Further study of the effect that media coverage of those with mental illness has on: those with mental health problems; the public; policy makers; and on those caring for such people is still warranted. In particular study of the influence of the media on mental health practice by formal carers is advocated, as this an area of neglect relative to the study of such influence on the other actors identified.

### **Declaration of Interests**

The authors report no conflict of interest. The authors are responsible for the content and writing of the paper.

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# **The Influence of the media on practice in mental health- a bricolage of a single case study**

**Authors** Wibberley and Murphy

## **Abstract**

This paper has its genesis in the convergence of two individuals' interests - one with a long standing general interest in mental health and the media, one with an emergent interest in the use of bricolage as a research approach. These interests converged around the ways in which mental health care practitioners might react to and subsequently reflect on images of mental health that they may come across in the media. A bricolage was developed relating to newspaper coverage of a homicide carried out by someone with a mental health problem. The bricolage presented draws on the assumption that practitioners will have immediate reactions to material they come across; will then, hopefully, take a more considered overview of this material; and finally may then attempt to contextualize this reflection in terms of appropriate evidence provided by the literature. The bricolage as presented mirrors this process for an experienced practitioner.

**Key Words:** bricolage, mental health, reflective practice, media, risk assessment.

## **Introduction**

The genesis of this paper lies in the convergence of two individuals' interests. One had a long standing general interest in mental health and the media - with a desire to look more at the impact of the media (and particularly newspaper reporting) on mental health practitioners. One had an emergent interest in the use of bricolage, as a research approach to practice-focused inquiry in health and social care. These interests converged around the ways in which mental health care practitioners might react to and subsequently reflect on images of mental health that they may come across in the media, and in particular newspaper reporting. Initial reflection and discussion between the two individuals suggested that the most memorable reporting related to homicides carried out by those with mental health problems.

The vast majority of people only ever gain experience of violent death through vicarious experience. In the times we live in, this may well be through television or film providing fictional accounts of such events. These vicarious experiences we know are fictional; that we perceive them as entertainment reinforces this. More fact-based accounts may well be accessed through news reports, whether on television, the web or in newspapers (web or hard copy). Whilst both fictional and fact-based accounts may well impinge on our view of violent death, fact-based accounts may well be given greater credence in the way we conjure up such a

view. The mental health care practitioner will not differ greatly from the lay person in his or her vicarious experience of violent death itself; however, especially if working in the forensic sector, they may come into contact with those who have carried out violent acts, including killing. The question, therefore, arises as to what impact vicarious media experiences have on such practitioners and their subsequent behaviour in caring for those with mental health problems.

Previous studies relating to the media and mental health have explored the nature of such coverage in terms of its stigmatizing nature, suggesting on the whole that the mentally ill are represented, *inter alia*, as different, unpredictable, unable to care for themselves, violent and criminal, in particular criminally violent (see Cutcliffe & Hannigan, 2003; Rasmussen & Hoijer, 2005; Sieff, 2003; Stout, Villegas & Jennings, 2004). That such coverage acts to reinforce stigmatization is suggested by Sieff (2003) and Taylor & Gunn (1999), amongst others.

A number of studies over a number of years have explored the effect of media coverage of those with mental health problems and public perceptions of mental health (see for example Appleby & Wessley, 1988; Crisp, Gelder, Rix, Meltzer & Rowlands, 2000; Philo, McLaughlin & Henderson, 1996; Stuart, 2006) The findings of such studies suggest that mental health service users felt that their self-definition, self-esteem and recovery were impaired by the content of such

coverage. Public opinion was influenced by how recent coverage was, by the perceived severity of reporting, and also by the attitude attributed to a particular diagnosis (how someone with a particular diagnosis is perceived and categorized).

Similarly studies have explored the impact of such media coverage on policy making (see for example Hallam, 2002; Paterson, 2006). These studies suggest that policies have become more coercive and constraining on the mentally ill, potentially as a result of media coverage.

What has been little explored in the past, is the impact of media coverage of those with mental health problems on the practitioners who are charged with caring for them (Murphy, Fatoye & Wibberley, 2013); thus, it is this that the present paper will focus on. Such a study is appropriate in particular, given as Warner notes

Homicides by people with mental health problems are presented in the media as an outcome of the failure of community care policies to contain 'dangerous people' (or, more specifically, in the cultural sense the 'dangerous Other'), and of individual professional incompetence.

(Warner, 2006 p226)



A small number of homicides carried out by people with mental health problems have been reported extensively in UK national newspapers since the turn of the century (the country in which the study was based). At the time the study was planned, Peter Bryan was the last of these cases for which an Independent Inquiry had been published. Thus it was decided to adopt the trial for this particular homicide as a case study. Newspaper coverage of the final day of the court case was selected for analysis (i.e. after reporting restrictions would have been lifted).

## **Methodology**

Bricolage is a relatively little used approach to research. Therefore, researchers utilizing bricolage as a research design have fewer exemplary texts and so less of an established tradition to draw on in coming to their own understanding of this approach to research (Wibberley, 2012). However, drawing on a selection of potential exemplars of bricolage (Denzin, 2008; Haw, 2005; Lather & Smithies, 1997; Markham, 2005; Mol, 2002; Rambo Ronai, 1995); bricolage can be considered to be a research approach which involves bringing together, in some form, different sources of data (usually a relatively diverse range of data, to include multiple perspectives). Decisions are made so that the bricolage is the result of a deliberate process of placement/positioning, that follows on from 'made decisions'; with this positioning, potentially influencing the way in which meaning is constructed by the reader. Some of these decisions imply an ordering of the text

that the reader should follow (e.g. Haw, 2005; Markham, 2005; Rambo Ronai, 1995); whilst others infer that such a decision should be made by the reader, with text juxtaposed against other text (e.g. Lather & Smithies, 1997; Mol, 2002).

Decisions on how to order the material in the present study drew in particular on Lather & Smithies (1997); Markham (2005); Mol (2002); Rambo Ronai (1995); all of whom utilize a layering of data; with reflexive / reflective comment being used alongside other material - this reflection forming a commentary of sorts on the other material. We decided to order the text in line with how, as practitioners, we might reflect on reading media reports.

As practitioners we will have immediate reactions / initial impressions of material we come across; we then, hopefully, will take a more considered overview of this material based on more detailed reading of the material itself and reflection on how this material relates to our experience and tacit knowledge; finally we may then attempt to contextualize this reflection in terms of appropriate evidence as provided by the literature (admittedly quite possibly drawn from a limited, favoured, source). The bricolage as presented, attempts to mirror this process in a recursive manner; layering the return to consideration of the events depicted in the newspapers by one or both of the two authors. Thus there is an implicit sequence which any reader would, by default, follow.

Thus the bricolage draws on the following three elements:

- newspaper coverage from the final day of the trial of Peter Bryan in March 2005 (at which time reporting restrictions would have been lifted) along with the report of the Independent Inquiry into the care and treatment of Peter Bryan (Mischon, Exworthy, Wix, & Lindsay, 2009);
- practitioner reflection on the coverage of the trial and the report of the Independent Inquiry;
- selective academic and quasi-governmental literature.

As presented the bricolage is an interplay of these first two elements (in primary and secondary reflections) with the third element being introduced only within the tertiary reflections (see below). These tertiary reflections differ from the other reflections, in that extracts from academic text is layered into / after the reflection as opposed to reflection being triggered by and thus layered after the text.

Newspaper coverage was taken from all national UK newspapers available in online editions, accessed through the LexisNexis Butterworth database.

## **Results**

### ***Results: Initial Practitioner Reflections #1 (Primary Reflections)***

We had immersed ourselves, as the textbooks say, in newspaper reports on the trial of Peter Bryan. This left one of us angry, and the other somewhat sad. We re-read the opening lines of the newspaper coverage and then reacted to some of them as indicated below; these reactions (primary reflections) being recorded as joint commentaries. The opening lines seemed to relate to four different 'themes': mistakes and manipulation; attempting to make a balanced decision; perceived effects on others; and reinforcing the stereotypes. Opening lines followed by reaction to them are presented below under the four themes identified.

*Mistakes and manipulation.*

Despite the chilling menace posed by 35-year-old Bryan – a known killer supposedly under the care of Britain's mental health system – he was allowed to roam free. He walked out of a hospital hours before he butchered pal Brian Cherry with a claw hammer and screwdriver. (Hepburn, 2005 p8).

A mental patient who got a "thrill and feeling of power" from killing and eating his victims was free to carry out his crime thanks to a "manifest failure" in his treatment, the Old Bailey heard yesterday ..... The court heard he fooled his doctors by masking his illness under a "veneer of near

normality" and that he killed his second victim hours after his social worker and a panel of experts deemed him safe.

(Davies, 2005 p4).

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Practitioner reflection on this coverage - Do they really think we would just allow someone who was dangerous to walk around without supervision? This really hurts! The fact that he was able to fool us is one thing but then to be criticized for doing what we thought was right is another thing completely. We attempt to provide the least restrictive environment for someone who is ill, having made a fair assessment of that individual's mental state. It is a really difficult job to assess someone who masks symptoms. It makes you wonder if they think we read people's minds, or have some magic diagnostic machine.

*Attempting to make a balanced decision.*

The court heard how an array of mental health experts decided Bryan could be returned to community-based treatment less than 10 years after he was sent to a secure hospital in 1994.

(Barkham, 2005 p5).

Mental patient Peter Bryan ... chopped up Bryan Cherry hours after being let out of hospital by doctors who said he was HARMLESS, a court heard yesterday.

(Brough, 2005 p1) [emphasis in original].

Described by a psychiatrist as probably the most dangerous man he had ever assessed, Peter Bryan was let out of high-security detention to fulfil the violent fantasies that swirled in his mind.

(Frean & Peek, 2005 p8).

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Practitioner reflection on this coverage - This is desperate. One of us feels like all the work, education and risks he had taken in the name of care are just being ignored. We already operate a locked ward system and impose a restrictive environment upon patients; shall we abandon all pretence of care and for the safety of the public lock all 'the mad' away and throw away the key. We have to make decisions on balance; that balance cannot always be maintained, it potentially tips one way or the other. We remind ourselves of best practice "Decisions about risk management involve improving the service user's quality of life and plans for recovery, while remaining aware of the safety of the service user, their carer and the public ..... Over-defensive practice is bad practice. Avoiding all

possible risks is not good for the service user or society in the long term ...”  
(Department of Health & National Risk Management Programme., 2007 p8).

*Perceived effects on others.*

Horror turned to anger for the families of the victim and another man that Bryan went on to kill while waiting for his trial, when it was discovered that the cannibal had been released from a high security hospital where he was sentenced for battering a woman to death.

(Bennetto, 2005 p16).

Police officers were horrified to discover Peter Bryan calmly frying human brains on a stove with the dismembered body of his victim at his feet.

(Frean & Peek, 2005 p8).

\*\*\*

Practitioner reflection on this coverage - It is clear who the victims are from these lines, but not in our minds. No one asks about how the people who were with him feel, the staff that worked with him. Not knowing his level of dangerousness nor the potential, the fact that they may have disclosed something about themselves

or family; be worried and horrified themselves about him coming for them or their family. Other opening lines paint these staff as the villains. Additionally other people with mental health problems may fear they will be viewed in the same way, as inherently dangerous, just waiting for that fuse to be lit ... some may even believe this.

*Reinforcing the stereotypes.*

A British Hannibal Lecterstyle killer ate a victim's brain after frying it in butter, a jury heard yesterday. Peter Bryan – dubbed the Cannibal by police – was freed to kill despite being detained “indefinitely” after a previous murder.

(Anonymous, 2005 p1).

A cannibal killer fried and ate the brain of one of his three victims and said: “I enjoyed it. It was really nice.” ..... The paranoid schizophrenic, described by a psychiatrist as the most dangerous man he had ever seen, told horrified police: I ate his brain with butter. I'd have done someone else if you hadn't come along. I wanted their souls.

(Brough, 2005 p1).

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Practitioner reflection on this coverage - Such statements negate all the time and effort that has gone in to educating the general population, to try to normalize mental illness. The image of straight jackets and a leather mask and the obvious ..... the licking of lips and eating body parts with a nice Chianti. Why bother! Maybe we should even go back to the Victorian days and Bethlem; why not go the whole hog, introduce some new treatments...cold showers and public viewings of the mentally ill, a penny admittance two if you want a stick to poke them with.

***Results: Initial Practitioner Reflections #2 (Secondary Reflections)***

We read and then re-read a number of times each form of coverage of the Peter Bryan case: the tabloid (the popular newspapers) coverage of the final day of the court case; the broadsheet (the 'serious' newspapers) coverage of the final day of the court case; and the report of the Independent Inquiry. Each form of coverage was considered 'in isolation' and a summary of the coverage produced by one of the authors (Author 1); the other author (Author 2), an experienced practitioner from the field of mental health then reflected on each individual summary provided (secondary reflections). Whilst the reflector was not naive to the original materials, it was some time since he had previously immersed himself in the coverage. A summary of each form of coverage of the Peter Bryan case is presented below, with reflection on that coverage recorded underneath the summary. Where quotes

are used in this section without attribution, these quotes were used by a number of the papers – reporting on what was said in the trial.

*PB an overview of tabloid coverage.*

Peter Bryan was an extremely dangerous man, who should never have been free to carry out the crimes that he was allowed to carry out. His mental health condition was mismanaged a number of times, so that more than once he was able to carry out horrific attacks on people – that is, the danger that he posed to himself and others was underestimated or missed completely on more than one occasion.

Different elements of the mental health system all made mistakes, tribunals releasing him from a secure unit; assessments made which enabled him to move down the system into less and less secure settings. These decisions were even made hours before some of his attacks on people. He was clearly mad, in the lay sense of the term, openly talking about eating or wanting to eat his victims and potential victims – suggesting that this would give him the powers of his victims. He also stated that it was normal to eat his prey – talking about attacking the weakest people, considering them to be lowest in the food chain. Again and again it is reported that the system 'had manifestly failed to protect the public'.

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Practitioner reflection on this coverage - this left me with a feeling of 'we've failed'. The staff not me! How could they not have known he was ill or address the fact that they were exposing vulnerable people to someone so 'dangerous'? It really angers me that the catalogue of mistakes had no 'quality control'. If I was working with him I feel that I would have fought 'tooth and nail' to keep him in hospital and ensure treatment packages were designed and followed through. I suppose I am elevating myself and my practice above that presented, and hope I would have seen the signs. I think I would! Staff like this create problems for everyone. They will create work for me; generate layers of bureaucracy that get in the way of care.

It leaves me asking 'who was responsible and what has happened to them?' I cannot personally understand why he was let out. I know colleagues who are 'chancers' and they are often good team members, but they could be taking chances like this. I am sure they are not as bad as this, but I don't really know! This in some ways poses a dilemma for me. What to do next or just put up with it. But I would be culpable for any mistakes if I had consciously avoided the issue. It makes me feel like I need to watch others practice as well as my own.

I am left with a trust dilemma. I know people I work with, like and relate to socially, but they could affect my work. I suppose I feel a little tarnished as a professional and not so proud, but I also feel that there is no smoke without fire. None of this could have happened without anyone not knowing.

*PB an overview of broadsheet coverage.*

Peter Bryan was a man whose mental health status was misjudged, allowing him the freedom to kill even though still under the care of health and social services. The question is whether he was failed by 'the system' or fooled 'the system'; or whether his behaviour was just too unpredictable to allow for an accurate assessment of his likelihood to be a danger to the public.

It is clear that insufficient caution was shown by those responsible for his care, and he was given the freedom to carry out acts of horrific violence (including mutilation and cannibalism). It would also seem clear that he was able to appear calm and settled, even hours before an attack: the phrase a 'veneer of near normality' appearing in one report. However, a comment that is repeated across nearly all, if not all, reports is that one doctor considered Bryan to be (probably) the most dangerous man he had assessed; indicating the paradox of this case – ultimately as the prosecuting barrister's summing up stated "the role of experts in the determination of whether this man would no longer present a danger to the

public has demonstrably failed". It is clear that this was not a single failure though – an 'array of mental health experts' having been involved. Relatives of Bryan and of his victims are reported as blaming the mental health care system; and pressure groups reported as being increasingly worried about the threat that those with mental health conditions pose to the public. Thus, Peter Bryan is seen as just one example of the failure of treatment of violent offenders with mental health care problems, although it is also reported that the mental health care trust described the case as highly unusual.

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Practitioner reflection on this coverage - reading this summary of material I was already familiar with, was quite chastening. To me it reflects the difficulty of the job of assessing someone but also that we got it wrong. The problem is when you get it wrong this can happen. This in some way heightens personal anxiety about the people you both work alongside and with. It reaffirms the unpredictability of people and if you are not careful you start, as I have, 'looking over your shoulder' at the people you meet. This indirectly raises questions about my decision-making and that of others.

I am unsure if the fact that he could 'fool' a system that was working *well* could effectively happen. Yet with all the demands and stresses that working within

targets places us under, we could all make mistakes. It does irk though, that non-professionals can criticize in respect to this case and cast doubt over our abilities in a seemingly un-informed way. So I find myself being defensive towards my peers, though without any real evidence on which to do so.

Even though I feel defensive towards criticism and in some way internalize this, as though I am as much to blame (the lack of directness and a named culprit, to me, suggests blame on everyone) I still feel deeply angry that this was allowed to happen. I feel that the family was right in 'blaming the mental health care' system in this case, given what happened. At the same time, maybe because of this blame my own practice will be more closely scrutinized; and if it is anything like in the past I will end up doing more and more extra paperwork. Paperwork that keeps me away from face to face contact, consequently reducing my chance to assess people in more detail. Thus I feel a certain resentment at this display of blame, and that the diffusion of this blame - resulting from the practice of these 'professionals' working within this system - will make things 'worse' for myself and other practitioners like me.

A really irritating thing is that the so-called pressure groups, who seem to only criticize, are quoted and yet no professionals or professional bodies are given the 'right' to comment. It does feel like our opinions are worthless. Nothing positive seems to be said about what we do, only bad things.

*PB an overview of coverage by the 'official report'.*

Peter Bryan is clearly a dangerous man – this is evident from the murders he has committed; one of which was described in the report of an independent inquiry to be “particularly horrific and bizarre” (Mischon et al., 2009 p9).

It is the relatively hidden nature of this dangerousness, however, that poses the real problem – his ability to “appear relatively normal whilst remaining capable of extreme and unpredictable violence” (Mischon et al., 2009 p10). He also appears to have developed the ability to control situations, when in secure care, through deception or manipulation. Whether his behaviour was purposefully controlled or not, numerous witnesses that saw him in the hours immediately before and after the ‘horrific and bizarre’ murder, reported that: he appeared normal; displaying no signs of mental disorder; calm and no different to other times. Thus it would appear (and it is reported) that Peter Bryan was a very difficult patient to assess and to manage appropriately – in part because of the atypical and complicated nature of his mental disorder, which consequently presented in an unusual way. To be successfully managed he required specialized highly structured environments which resulted in a high degree of certainty. Unfortunately the success (or apparent success) of such measures, in the past, resulted in his release to less appropriate environments. Once released to less secure environments he was

nonetheless able to mask deterioration and manipulate staff – particularly those with less experience of dealing with such complex clients; especially if they had little knowledge of him and his history. With hindsight much of this became apparent; without this hindsight, he and others became victims of his dangerousness.

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Practitioner reflection on this coverage - this worries me, as this is an area that I have worked in. I could have easily ended up working with this man who appeared 'normal' yet went on to 'kill'. I am finding myself fumbling around for something tangible to hold on to, to give me comfort but can only see the 'runaway train'. In a caring role I feel quite impotent, as the staff were unwittingly controlled, I also found this disturbing. This is reinforced by my belief that whatever happened would have happened anyway, as he called all the shots. Maybe I think of this as a measure of self-protection and I am trying to convince myself that what I do is good.

Anxiety is raised in me that less experienced (vulnerable) staff, were left to deal with him, especially given his 'manipulative' past. As a clinical supervisor of such staff, it left me questioning where all the supervision was and who would allocate someone like this to an inexperienced member of staff? It seems to smack of



money saving, employing junior staff to replace senior ones and treating them as though they are the same; staffing levels being maintained, but only in a numerical sense.

It leaves uneasiness about the amount of control I have over what I do and how I will practice. Ultimately I question what could have been done and could I have acted any differently. I can see that I am more edgy in respect to risk and whilst reading the narrative I experienced odd yet related thoughts to risk assessment questions and tactics that may have been or may not have been used. It did leave me feeling that the outcome was inevitable with this person in this situation when he was inappropriately managed; but that I would have managed it differently (although this could be me, trying to convince myself that it couldn't happen to me). It also highlighted fears in me that say you can only be measured on what you do wrong, never by what was exceptional work. Therefore you are always one step away from getting your 15 minutes of fame for the wrong reason.

***Results: Final Practitioner Reflections #3 (Tertiary Reflections)***

As noted above, these final reflections differ from previous ones, in that the text used (selective academic and quasi-governmental literature) is mostly layered after reflection.

Re-reading our previous reflections we were struck by how defensive, of mental health practitioners, the reactions to the opening lines of the newspaper reports are (primary reflections). The reflections stress the difficulties in dealing with clients such as Peter Bryan; and relate to the threat to progress in caring for those with mental health problems, that such coverage poses, by potentially promoting defensive practice.

In contrast the secondary reflections are not so clear. In responding to tabloid coverage defensiveness towards practitioners turns to an attempt to apportion blame, such attempts being driven by an element of professional pride; and the potential implications that media coverage of this case has for practice in general and the personal professional practice of the second author. Reflections on broadsheet coverage are more ambiguous, there is still a strong sense of blame that something was wrong in the way this case was managed, but tinged with a sense of the difficulties in dealing with such a case. The implications for personal practice still emerge as a concern. This ambiguity is continued when reflection turns to the Independent Inquiry Report. The sense of blame is now muted, but concern remains: for the way inexperienced practitioners were left to manage this case; and for the implications of the case for others practice.

The main question that these reflections pose is: 'Would an experienced team of workers, working to best practice have dealt with Peter Bryan in a more appropriate way, with better outcomes for all concerned'? At the time that the newspaper reports reviewed were produced, a raft of related documents was available that would indicate that evidence-based practice, operating within a framework of values-based practice, both could and would improve outcomes (Morgan, 2000; National Institute for Mental Health in England, Sainsbury Centre For Mental Health; National Health Service University, 2004; The Sainsbury Centre for Mental Health, 2001; Woodbridge & Fulford, 2004). What is being suggested, in such documents, is that the capability of mental health care practitioners is developed as core knowledge and skills are: firstly applied in practice; and secondly reflected upon. Such knowledge and skills include the implementation of evidence-based interventions such as the use of appropriate assessment tools. Reviews of such tools and their use in practice (see Doyle & Dolan, 2002; Kettles, 2004; Towl, 2005) identify that there has been a movement away from the use of clinical judgment in assessing risk, initially towards the use of an actuarial approach (reliant on the predictive power of assessment tools to calculate levels of risk) and finally on to an approach of structured clinical judgment that "bridges the gap between empirical science and clinical practice" (Kettles, 2004 p488; see also Webster, Hague & Hucker, 2013).

Thus, there is the suggestion, in such literature, that an experienced practitioner is

able to utilize and articulate the role of clinical experience and expertise in applying the evidence base relating to risk assessment; it is this ability to undertake such mediation that separates the experienced practitioner from the informed novice. Thus, this capability alongside others (in particular effective communication within a multi-disciplinary team) could well be considered to mean that an experienced team of workers, working to best practice, would have dealt with Peter Bryan in a more appropriate way, with better outcomes for all concerned.

A word of caution should be added here though, as Szmukler argues that

Risk factors for violence by mentally ill persons are common, but homicide is extremely rare. If all persons with risk factors were treated as potential perpetrators of homicides we would deprive many thousands of their liberty to (possibly) avoid one death.

(Szmukler, 2000 p7).

Suggesting therefore that such events are by their very nature unpredictable.

Additionally though, the question arises as to whether adverse media coverage such as that of the Peter Bryan trial, may result in a mental health practitioner

altering their practice, in a risk aversive manner, resulting in them acting in a way that might reduce the quality of care provided.

The reactions and reflections (primary and secondary reflections) presented above suggest that in the case of one experienced practitioner this may well be the case. But these reactions were immediate reactions / initial impressions of material that we come across; followed by a more considered overview of the material based on more detailed reading of the material itself, and reflection on how this material related to our own experience and tacit knowledge. Thus there was still a need to attempt to contextualize this reflection in terms of appropriate evidence as provided by the literature (admittedly quite possibly drawn from a limited, favoured, source).

The literature we had to hand dealt with debates about the use of risk assessment tools (Doyle & Dolan, 2002; Kettles, 2004; Towl, 2005); but we searched further and came across other material – moving from literature which could be considered to be from mainstream psychiatric and mental health journals to literature relating to risk and mental health more generally. One of the early papers we considered from this latter literature was Godin (2004); this led us to a book edited by Godin (2006a) and so to chapters written in the same book by Alaszewski (2006) and Godin (2006b). It also led

us to a book chapter by Castel (1991) and an article by Rose (1998). Added in to this mix were a number of reports and guidelines (Department of Health & National Risk Management Programme, 2007; Morgan, 2000; National Institute for Mental Health in England, Sainsbury Centre for Mental Health, National Health Service University, 2004; The Sainsbury Centre for Mental Health, 2001; Woodbridge & Fulford, 2004)

Turning to one of the chapters written in Godin's book, by Alaszewski (2006); this text accepted the following two premises, thus providing some verification of our own practitioner reflection:

... a series of high profile inquiries in mental health services have highlighted public concerns and the need to identify and manage dangerous individuals ... .. Contemporary health and welfare agencies ..... need to identify risk so that they can avoid investigation and blame.

(Alaszewski, 2006, p.30-31).

Although Godin had suggested something similar in an earlier work (Godin 2004), in a chapter in the same book as Alaszewski (2006), he stated that although media coverage of high profile cases of homicides and suicides involving mental patients in the community may be a relevant factor in the development of risk thinking; this development had its roots in a broader

move towards greater governmentality. In so doing Godin drew strongly on Castel (1991) who argued that modern medicine in general had drifted:

... towards the point where the multiplication of systems of health checks makes the individualized interview between practitioner and client almost dispensable.

(Castel, 1991, p.281).

continuing that this had resulted in the development of:

... a new mode of surveillance: that of systematic predetection. This is a form of surveillance, in the sense that the intended objective is that of anticipating and preventing the emergence of some undesirable event: illness, abnormality, deviant behavior, etc.

(Castel, 1991, p.288).

If we take these statements at face value, then perhaps media coverage of mental health is not as influential as our own reflections had suggested; although Godin also noted that, amongst other things:

- Risk assessment is tacitly and conveniently assumed to encompass what a client needs, whilst medical diagnosis and treatment have become just one part of the greater process of risk assessment and

risk management. (Godin, 2006b, p.74);

- ... would any mental health care nurses disagree that their caring function is at times, perhaps frequently, compromised by the imperatives of risk thinking? (Godin, 2006b, p.74);
- Though the data are, in part, supposed to measure good patient care, the collection of data (rather than the patients) becomes an end in itself ... (Godin, 2006b, p.75);
- Mental health care workers are also frustrated with a system that requires them to regard their clients as objects of risk, crowding out the care for the well-being of individuals. They become frustrated with feeding data into the system and its disapproval of therapeutic risk taking. (Godin, 2006b, p.77).

Thus, whatever the reason for the rise of formalized risk assessment, some of the issues for the mental health practitioner stay the same; and we found ourselves in general agreement with Godin's statement that

... mental health care workers are allowed discretion in how, amongst other things, they assess and manage risk. They could use this discretion to broaden the concept of risk to incorporate what might be seen as patients' needs and wants, to redefine them as the risks that would, as such, merit attention ..... In doing so, mental health care



workers might be able to change risk thinking into a discourse that includes the things that service users are concerned about. Through such redirection of risk thinking nurses might be able to reassert their professional mission of caring.

(Godin, 2006b, p.78).

Before entering into our own final reflections Alaszewski (2006) – a text which drew on two studies he had carried out previously into the perception of risk by nurses from a range of specialist practice including mental health - can be considered to provide us with a sting in the tail. He noted that of the range of nurses studied, those from a mental health background were the most likely to use formal structured processes in making their decisions.

### **Final Reflections Or Summing Up**

As in criminal trials, such as that of Peter Bryan, bricolage often presents evidence and lets the jury come to their own conclusions or as Wibberley (2012 p.2) stated in a number of examples of bricolage “ultimately the account is left to speak for itself, so that the reader can make of it what they will”.

However we feel in this case, that as in trials, some summing up is warranted.

The worry that we initially had, was that all this reflection had left us no further forward in our thinking about: a) the media's impact on practitioners - in terms of them perhaps adopting more risk averse practice than perhaps was in the best interests of their clients; and b) how this may be avoided, if appropriate, through reflective practice. But then we considered what normally happened after independent inquiries into incidents such as the one we were reflecting on – that a spokesperson for the 'responsible' organization would be sent out to the press with a statement that suggested that the report would be read carefully and any lessons that needed to be learnt by the organization, would be learnt and changes implemented. The question is though, how might others learn from such incidents.

We stated earlier that an experienced practitioner is able to utilize and articulate the role of clinical experience and expertise in applying the evidence base relating to risk assessment; it is this ability to undertake such mediation that separates the experienced practitioner from the informed novice. The experienced practitioner in our team (Author 2) despite our initial worries, did feel that reflection on the Peter Bryan case had helped him to consolidate his position in relation to the assessment of risk posed by those with a mental health problem. Thus it would also not seem unreasonable to suggest that a relatively novice practitioner could benefit from reflection on this and other cases – learning, at least partially, 'the lessons' from vicarious experience. In practice, those that have more experience may learn more from such reflection (being able to reflect on their own experiences when reflecting

on the case); but both experienced and novice practitioners would hopefully become more informed practitioners from their reflections. This does seem a pertinent way to think of the use of such an incident, as occurred with Peter Bryan, as in this case it was the relative inexperience of the practitioners that led, at least in part, to inappropriate practice being followed. Thus we would recommend the use of reflection on such cases both in clinical supervision and formal education; so that such learning can be embedded in the practice of mental health practitioners.

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