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“Dangerous and Disordered”:
The Discursive Construction of "Mental Illness" in Public Texts

Section A: Examining discursive constructions of mental illness in public mental health-related texts: A review of discourse analytic studies

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Section B: Constructing “mental disorder” and its related practices: A discourse analysis of the House of Commons’ debates regarding the 2007 Mental Health Act

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I would like to use this opportunity to remember my sister, Rebecca.

This portfolio investigates the constructions of “mental illness” in public texts.

Section A reviewed discourse analytic research in order to examine discourses and discursive strategies that have been used in public mental health-related texts (e.g., newspapers) to construct specific versions of mental illness. This section also provided a critique of issues in discourse analytic theory and method relevant to the studies. It was suggested that discourses relating to mental illness appeared predominantly unfavourable to people diagnosed with mental illness, for example, its association with dangerousness. There was broad agreement between studies about how mental illness was constructed, suggesting that at least in Western Countries there is a shared understanding of the term.

Section B examined how “mental disorder” was discursively constructed and how different institutional interventions and practices were justified and legitimised in the House of Commons’ debates regarding the Mental Health Act 2007. Verbatim transcripts from these debates (conducted between 24th April and 15th May 2007) were studied through a discourse analysis. It was suggested that mental disorder was represented in selective and systemic ways that can help justify and legitimise different interventions and practices, for example, enforced medication, making government legislation and psychiatric practices seem necessary.

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Section A

Examining Discursive Constructions of Mental Illness in Public Mental Health-Related
Texts: A Review of Discourse Analytic Studies

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Abstract

Background: Representations of mental illness in public texts, for example newspapers, are often negative. This can be problematic for people diagnosed with mental illness. Discourse analytic research has provided critical insights into these textual representations of mental illness. *Objective:* This narrative review draws on discourse analytic research to examine ways in which versions of mental illness have been discursively constructed within public mental health-related texts. *Method:* Fifteen electronic databases were searched for relevant studies. Sixteen studies were identified and their findings critically analysed. *Results:* The studies identified six broad discourses, namely: violence, risk, dangerousness and criminality; medical discourse; an “us versus them” discourse; an administrative and managerial discourse; the “social context”; and “religion.” *Conclusion:* Discourses relating to mental illness appeared predominantly unfavourable to people diagnosed with mental illness, for example, its association with dangerousness. There was broad agreement between studies about how mental illness is constructed, suggesting that at least in Western Countries there is a shared understanding of the term. The possible significance and implications of these findings are discussed.

Keywords: mental illness, discourse analysis, representations, dangerous, text

Examining Discursive Constructions of Mental Illness in Public Mental Health-Related Texts: A Review of Discourse Analytic Studies

For the purpose of this review “public text” is defined as published written material that can be accessed and viewed by a variety of populations from lay people to professionals. Texts include newspapers, autobiographies, professional practice manuals, government papers and policies, academic journals, service user literature, and accessible case notes.

Discursive construction and discourse are defined as a group of statements that produce social meaning and practices (Laclau, 1980; Parker, 1992). For the purpose of this review, “discursive strategy” is defined as the way that language is used in order to convey a certain meaning to the reader. The emphasis is on the effects of the language used, rather than the intentions of the speaker. It is not assumed that speakers are necessarily using certain constructions consciously in order to support particular positions.

The Media and Representations of Mental Illness

Wahl (2004) has suggested that public information about mental illness¹ is primarily conveyed through the media. Previous reviews focusing on media portrayals of mental illness have concluded that they are predominantly negative and unfavourable (Nairn, 2007; Stuart, 2006; Wahl, 1992). Stuart (2006) concluded that studies showed that the media provided distorted and dramatised images of mental illness by emphasising dangerousness, criminality, and unpredictability. Nairn (2007) argued that such representations are problematic for individuals seeking recovery, particularly when negative representations are underpinned by a lay understanding of “madness.”

¹ The terms mental illness, patient, mentally ill, and service user are used interchangeably as they reflect the terms used in the different studies that have been cited and reviewed. These terms are not in quotation marks for reasons of presentation, but it is acknowledged that these terms are highly contested.

Recent Depictions of Mental Illness in the Media

Negative and biological representations of mental illness are still embedded in media reporting. In 2013 a British newspaper, *The Sun*, ran a front-page headline entitled ‘1200 killed by mental patients’ (Parry & Moyes, 2013). Mental health campaigners were angered due to the stigma that can result from such a portrayal, pointing out that 95 per cent of people who commit homicides have not been diagnosed with a mental illness (Morse, 2013).

Media often has a tendency to promote biological understandings of mental distress. For example, Holttum (2014) argued that a recent Radio 4 programme overemphasised biological explanations of mental distress signalling a “cause and effect” approach to depictions of mental illness. The programme had reported a study that found a correlation between cortisol and mild depression in teenage boys. Holttum pointed to the extensive research evidence that indicated that life events contribute to the onset of depression, for example, Hammen, Brennan and Le Brocque (2011).

Discourse Analytic Theory and Mental Illness

Discourse analytic theory stresses the importance of language in representations of mental illness. Wood and Kroger (2000) outlined three theoretical assumptions about discourse. Firstly, “language is action,” which means that language “does” things. For example, to insult someone is not just an act of speech, it can also hurt the hearer’s feelings. Secondly, “language is function.” It functions to achieve things—to evaluate, to persuade, etc.. And thirdly, “language has variability”—it creates different versions of the world.

These theoretical assumptions (Wood & Kroger, 2000) have several important implications for the reporting of mental illness:

- Media and texts may not only represent mental illness, but from a discourse analytic perspective they actively construct it, creating different “versions” of mental illness, for

example, a version where people diagnosed are considered potentially dangerous.

Foucault (1965) has argued that the way in which people use language has implications for the way in which they and others are treated. (“Language is action.”)

- Reporting mental illness in certain ways can be seen to have a function. For example, characterising people diagnosed with mental illness as dangerous could persuade the reader to think about detention as an acceptable solution. (“Language is function.”)
- Mental illness could be viewed in other ways. For example, Szasz (1973) interpreted mental illness as “problems in living” rather than as a biological disease. The assumption in this review is that there are other possible versions of mental illness. (“Language has variability.”)

Discourse Analytic Method, Research and Mental Illness

A discourse analytic framework provides a method (discourse analysis) by which researchers can analyse how mental illness is constructed through language. There are several reasons why discourse analysis is a particularly apt method of analysing the representation of mental illness in the media and in texts. Hall, Critcher, Jefferson, Clarke and Roberts (1978) argued that in news reporting, the media is involved in the formation of social norms and values and does not necessarily report in neutral or context-specific ways. Nairn (2007) pointed out that journalists and other writers produce interpretations of experiences for large audiences. Therefore, discourse analysis can offer critical and contextual insights into the reported versions or interpretations of mental illness.

Nairn (2007) reviewed discourse analytic research as part of a broader review of social constructionist research on media representations of mental illness, concluding that depictions of people with mental illnesses draw on archetypes of a mad man or woman. Georgaca (2012), within a review of discourse analytic research on mental distress, identified

research on a category that was described as “mental health-related public texts.” This research analysed texts such as newspapers and policies. Georgaca (2012) argued that “danger” and “medical” discourses were used in constructing mental distress in these texts. Furthermore, the review pointed out that the media is not the only source where mental illness is depicted. Government literature in the form of policies, white papers and guidelines also offers depictions of mental illness.

Types of discourse analysis

Willig (2008) distinguished between two major versions of discourse analysis—discursive psychology and Foucauldian discourse analysis. Discursive psychology is concerned with the role of language in social action, particularly everyday interaction, and how people linguistically build accounts of events (Burr, 2003). Foucauldian discourse analysis grew out of the work of Michel Foucault and other post-structuralist writers and is concerned with the role of language in structuring social and psychological life, particularly in relation to power (Willig, 2008). This review will include studies that employ either of these different types of discourse analysis.

Rationale

In the context of the continued negative reporting of mental illness, this paper will consider how discourse analytic theory, methods and research can offer critical insights and contribute to emerging research in the area of mental health-related public texts. This narrative review will pose the following question:

According to discourse analytic research, what discourses and discursive strategies have been used in public texts to construct specific versions of mental illness?

This review seeks to build on Georgaca’s (2012) descriptive overview of mental health-related public text, providing a more extensive in depth analysis on a wider range of

texts. By focusing on texts other than the media (the main focus of previous reviews) , it highlights other types of text that are influential in constructing mental illness, such as government policies, professional manuals and academic papers. This paper will then provide a critique of issues in discourse analytic theory and method relevant to the studies.

Methodology

Fifteen electronic databases were searched in order to locate relevant studies: EBSCO's Psychology and Behavioral Sciences Collection, Google Scholar, Taylor & Francis Online, ScienceDirect, ERIC, Arts & Sciences (JSTOR), Project MUSE, SAGE Journals, MEDLINE, Wiley Online Library, Dialnet, Directory of Open Access Journals, Pubmed Central, BioMed Central, and PsychSource. No date parameters were used in the search in order to ensure that all relevant studies were identified.

Various search terms including and relating to discourse analysis were used in combination with a variety of terms related to mental illness or health related texts. (See Appendix A for further information regarding search procedures, terms and combinations.)

Studies were included in the review if they met all the following criteria: (a) primarily related to mental illness; (b) used a discourse or discursive analytic method; (c) primarily analysed public text (as defined in the introduction) and (d) drew on guidelines or literature to control quality. Studies excluded contained material that primarily used other sources such as interviews.

Sixteen relevant studies were identified which met these criteria.

The quality of the studies

Qualitative research arguably “represents a distinctive paradigm and as such it cannot and should not be judged by conventional measures of validity, generalisability and reliability” (Mays & Pope, 2000, p. 50). It has been debated whether qualitative research should be subjected to quality criteria and if so, which criteria are appropriate. Mays and Pope (2000) suggested that it would be imprudent to contemplate a single set of guidelines as definitive. In addition, there is no one definitive method of conducting a discourse analysis (Crowe, 2000; Morgan, 2010). Despite these reservations, the current review references Mays and Pope’s (2000) quality criteria as a guide with respect to clear exposition of methods of data collection, analysis, and relevance.

Results

This section provides an overview of the 16 studies identified. Table 1 summarises the main features of the 16 studies, providing the author, year, country, genre of text, number of texts analysed, and a brief description of the analysed text.

See Appendix B for a complete list of analysis guidelines and types of discourse analysis used in these studies.

The following six broad discourses were identified from the studies: violence, risk, dangerousness and criminality; medical discourse; an “us versus them” discourse; an administrative and managerial discourse; the “social context”; and “religion.” Within each discourse examples of discursive strategies are given.

Table 1. *Main features of the 16 studies reviewed*

Authors	Year	Country	Genre (no. of texts)	Brief description of text analysed
Allen & Nairn	1997	New Zealand	Newspaper (12)	“Non-sensationalist” and “educative in intent” articles on mental illness.
Andersen, Hasund, & Larsen	2013	Norway	Autobiography (6)	Use of religious terms in Norwegian autobiographies by people who had been patients in mental health services.
Bilic & Georgaca	2007	Germany & Greece	Newspaper (165)	Serbian daily newspapers referencing mental illness.
Coverdale, Nairn, & Claasen	2002	New Zealand	Newspaper (600)	“Cuttings” of items depicting a person or persons with mental illness.
Crowe	2000	New Zealand	Professional practice manual (1)	Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
Harper	2004	United Kingdom	Government paper (1)	White Paper on reforming the Mental Health Act.
Hazelton	1997	Australia	Newspaper (490)	Mental health-related news items in two newspapers.
Hui & Stickley	2007	United Kingdom	Government paper (5) Service user literature (16)	Service user involvement.
Johnstone & Frith	2005	United Kingdom	Academic journal (2)	Electroconvulsive therapy and patient experiences.
Moon	2000	United Kingdom	Government paper (2)	Modernising mental health services and local services for service users.
Nairn	1999	New Zealand	Newspaper (7)	“Special Report on Mental Health”
Nairn & Coverdale	2005	New Zealand	Newspaper (5)	“Cuttings” of items that offered readers access to thoughts, explanations and depictions provided by people living with a diagnosed mental disorder.
Nairn, Coverdale, & Claasen	2001	New Zealand	Newspaper (53) Patient’s case notes (1)	Items related to the Privacy Commissioner’s opinion of disclosure of a patient’s information and their case notes.
Olstead	2002	Canada	Newspaper (195)	Articles including editorials and letters referencing mental illness.
Rowe, Tilbury, Rapley, & O’Ferrall	2003	Australia	Newspaper (49)	Articles that had the keyword “depression.”
Teghtsoonian	2009	Canada	Government paper (2)	Depression strategy and development for mental health literacy.

Violence, risk, dangerousness, and criminality (the characters and actions of the “Mentally Ill”)

Eight studies analysed newspaper accounts and found that people with mental illness were discursively constructed as being violent, risky, dangerous, and/or criminal (Allen & Nairn, 1997; Bilic & Georgaca, 2007; Coverdale et al., 2002; Hazelton, 1997; Nairn, 1999; Nairn & Coverdale, 2005; Nairn et al., 2001; Olstead, 2002). All of the studies drew attention to how the reporting of violence perpetrated by people with mental health problems were seen as newsworthy and appealed to sensationalism. The authors of two studies that analysed government papers also identified how the text drew on discourses of dangerousness and risk. The authors suggested that these functioned to make a case for change in mental health law and service provision (Harper, 2004; Moon, 2000).

Coverdale et al. (2001) reported in their analysis of newspaper items that negative depictions of mental illness predominated, with danger to others (61.3%) and criminality (47.3%) being the most common among the cluster of coherent words, images and storylines. The words chosen and the headlines written in the texts provided the basic resources for these constructions, such as “unpredictable and threatening,” “more disturbed” (Allen & Nairn, 1997, p. 378) or “two mentally ill people are shot as they lunged at officers with knives” (Hazelton, 1997, p. 86).

Bilic and Georgaca (2007) and Olstead (2002) both identified in the text the conflation of the mentally ill with other stigmatised and “deviant” groups, such as drug addicts and HIV-positive patients. Furthermore, Bilic and Georgaca (2007) conceived the portrayal of people with mental illness as devoid of individual and social characteristics, which the authors see as a unified and less humanising category that can also have stigmatising implications.

The authors of five studies emphasised how the newspaper articles they analysed rely on the reader to draw on their own lay and common sense understandings of mental illness as unpredictable and dangerous (Allen & Nairn, 1997; Coverdale et al., 2002; Nairn, 1999; Nairn & Coverdale, 2005). Nairn et al. (2001) underlined how the news stories did not differentiate depictions of mental illness and how references to elements such as “secure unit” or “state of mind,” prompted readers to draw on their own common sense understanding of mental illness as being dangerous.

Hazelton (1997) remarked on how the media construct agendas for public debates. An example in the author’s study was the 1994 reporting of a fatal police shooting of “seriously mentally ill persons” in Victoria (Australia), which was used to articulate concerns about the degree that deinstitutionalisation might be a fundamentally risky policy. Discursively, the writers of the report framed the meaning for the readers.

Harper (2004) and Moon (2000) , in analysing government papers, noted the reporting of high-profile murder cases that involved people diagnosed with mental health problems. According to Harper (2004), risk in mental illness is constructed by referring to extreme cases that result in suicides and homicides. This has been termed ‘extreme case formulation’ (Edwards & Potter, 1992). Bilic and Georgaca (2007) point to an unusual construction of dangerousness in the text, whereby mental illness is portrayed as a dangerous and potentially contagious virus.

Medical discourse (mental illness as a medical condition)

Bilic and Georgaca (2007) proposed that the medical discourse classified mental illness as a medical disorder, with psychiatrists as experts in its interpretation and management. It could be argued that all the studies drew on the medical discourse since mental illness is identified in the texts through the use of medical terminology. The authors of

11 studies referred to mental illness as a medical construction. Bilic and Georgaca (2007), Hazelton (1997) and Rowe et al. (2003) identified a medical discourse, whereas eight studies examined the use of medical terminology in their respective texts; psychiatric patient and disorder (Nairn et al., 2001), patient and psychopath (Olstead, 2002), evidence-based treatment (Teghtsoonian, 2009), mental disorder and abnormality (Crowe, 2000), patient (Johnstone & Frith, 2005), psychiatrists (Nairn, 1999), service user and patient (Hui & Stickley, 2007), and disorder and treatment (Nairn and Coverdale, 2005).

Various discursive strategies identified by the authors serve to construct mental illness as a medical matter. Rowe et al. (2003) noted that depression is compared with physical diseases like diabetes and was mentioned in the same sentences. Physical health associations acted rhetorically as an explanation rather than only as a description. Rowe et al. (2003) noted a lack of precision when scientific and medical terminology was used—a rhetorical device called “studied use of vagueness” (Edwards & Potter, 1992). Bilic and Georgaca (2007) also highlighted the use of vagueness in the application of scientific terminology, such as “ions” and “cells,” which can make it unclear to the reader the exact detail underpinning a biological explanation for mental illness. The authors argued that this serves to deepen the difference between the psychiatrist and the reader, constructing the former as an authority and an expert. Hazelton (1997) argued, in identifying a discourse of “medical-scientific marvel,” that there is a tendency for media practices to glorify medical progress and that a “magic bullet” is waiting to be found for mental illness. For example, Hazelton (1997) noted how one article stated that new drugs offer hope and that medical science would find a cure for schizophrenia.

Psychiatrists have featured in many of the texts, giving their professional opinions in matters of mental illness. Johnstone and Frith (2005), Nairn (1999), and Bilic and Georgaca (2007) all noted the use of category entitlement (Edward & Potter, 1992) of doctors who are

expected to have certain kinds of knowledge due to their position. Bilic and Georgaca (2007) noticed that in the reports from Serbian newspapers, psychiatrists had their professional titles reported and institutional position stated, whereas service users were less precisely described and quotations from them were used to support the psychiatrists' opinion. Nairn (1999) also noted that reporters acknowledged the psychiatrists' titles and that the psychiatrists' opinions were more likely to appear in their own words in the newspapers.

Individualism (mental illness as located in individuals)

Crowe (2000) and Teghtsoonian (2009) have identified the construction of "the individual" in their respective texts. Teghtsoonian's (2009) study analysed two policies and suggested that discussions in the text constructed mental health challenges as being located within individuals. The author emphasised the discourse of "responsibilisation," whereby the individual is seen as responsible for and is expected to shape their behaviour through informed choices. Teghtsoonian (2009) argued the increasing rates of depression were explained (in the policy) as individuals having gaps in their knowledge and information. She suggested that individuals were presented as unable to identify depression and as being incapable of making appropriate treatment choices. She pointed out that systemic inequalities associated with depression, such as poverty, were not considered in these documents and that the policy constructs individuals as needing information in order to make better decisions. Teghtsoonian (2009) goes further in suggesting that mental distress is a vehicle for political ideology in that it is used to further privatisation. She suggested that individualism is driven by neoliberal policies in which people are expected to become their own resource. Although patients are encouraged to make their own decisions, the relevant decisions are seen as those that concern cost-effectiveness and are evidence based. Teghtsoonian (2009) noted that the government policy on depression constructed gender-neutral strategies. The author argued

that these policies did not account for higher rates of depression in women and their social roles in society, where they often have family responsibilities as an additional pressure.

Crowe (2000), in analysing the DSM-IV, suggested that it constructs mental illness not only as an individual problem but also specifically as the failure of the individual to conform to societal norms. For example, when an individual fails to demonstrate the productivity valued by society this can be seen as a symptom of mental disorder. Crowe (2000) argues that the language in the DSM-IV constructs a “normal” individual who does not violate certain assumptions of normality concerning sleep, speech, and goal-orientated behaviour etc.. Crowe (2000) claimed that the DSM-IV constructs the individual as “unitary”: well-defined and stable with boundaries.

The Patient, the Mentally Ill and the Service User

All the studies contained quotations from the texts where the distressed subject was referred to as either a patient, as mentally ill or as a service user. Some texts even used diagnostic categories such as “schizophrenic,” (Nairn et al., 2001). Johnstone and Frith (2005), in analysing an academic paper written by two psychiatrists on patients’ experiences and attitudes of Electroconvulsive Therapy (ECT), emphasised the different characteristics attributed to patients and argued that the participants’ accounts of ECT were undermined by the unfavourable construction of the patient. The patient, it was argued, was constructed (within the context of ECT) as being passive, irrational, ignorant and/or hostile. A striking example of the construction of the patient as passive and compliant was the paper’s reference to two patients who misunderstood the request to participate in the psychiatrist’s study and who came expecting to commence ECT despite being well. Olstead (2002) also suggested that newspaper articles construct patients as passive, implying that this is how they should behave, attempting to be “normal.”

Johnstone and Frith (2005) proposed that patients were constructed in the paper as “hysterical,” noting that figures were quoted in an attempt to reinforce this point. For example, the paper stated that 50% of “subjects” felt that going to the dentist was a more frightening experience than ECT. Discursively, the authors felt that this established the normalisation of ECT and undermined reasonable anxiety about such procedures.

Hui and Stickley (2007) and Olstead (2002) also drew attention to how service users or patients have been presented as having varying perspectives. Hui and Stickley (2007), in analysing service user literature, claimed that there is no unified service user perspective. Service users had different perceptions about the improvements needed, for example, patient choice or greater involvement in policy making. Hui and Stickley (2007) suggested that these arguments are presented discursively through the perspective of service users’ experiences of oppressive organisational power and discrepancies between policies and practice. The authors argued that service users have individual differences but they need collective action for change. Olstead (2002) noted the different portrayals of class in the reporting of mental illness of service users. If the people diagnosed with mental illness were middle class, then prestigious occupations, influential families or socio-economic privilege were referred to. There was a greater emphasis on what they felt, whereas depictions of poor people focused on what they did.

The mentally ill are reported as being both rational and irrational (Olstead, 2002; Philo, 1996), depending on the framing of the event. Nairn et al. (2001) argued that the mentally ill patient (“Ryder”) in the texts analysed is constructed as being vulnerable and barely able to manage day-to-day tasks. However, when he assaulted a boy, his agency was foregrounded and the vulnerability construction was obscured. In terms of discourse, Nairn et al. (2001) noted how the text changed to an active grammatical voice to demonstrate the patient’s agency.

An “Us Versus Them” discourse

The authors of five studies (Crowe, 2000; Harper, 2004; Hazelton, 1997; Nairn, 1999; Olstead, 2002) emphasised that texts tended to position people as either side of a “divide” between mental illness and normality: in Olstead’s (2002) words, the “us (the world) versus them (the mentally ill)” divide. The studies identified depictions of the abnormal “other” (mentally ill) where accounts of incidents involving people with mental illness often present no explanation or context for their behaviour. Allen and Nairn (1997) analysed an article describing a community that felt that the “mentally ill” neighbours were being disruptive. The authors presented the text as giving no explanations for the actions of the disruptive residents and as constructing the behaviours as unexplained and unpredictable. Harper (2004) suggested that the idea of “motiveless and mad crimes” is invoked to function as an apparent explanation for bizarre and frightening behaviour, implying the impossibility of explaining actions through “normal” psychological processes.

Olstead (2002) noted the conflation of mental illness with criminality through the language used (e.g., the lexical association of the “mentally ill psychopath” with “predator”), which helped to polarise the “us versus them” division. The strategy of opposing the negative actions of a person or group with the good action of others accentuated the negative characteristics of the mentally ill. Crowe’s (2000) analysis of the DSM inferred that “mental illness” is built upon the “us versus them” differentiation alongside the constructing of normality. It could be argued that the concepts of normality and abnormality are dependent on one another.

Hazelton (1997) argued that newspaper depictions accentuate bizarre and curious incidents associated with mental illness and that these constructions are newsworthy and appeal to voyeurism. Hazelton (1997) cited the sexual practices of a sadomasochistic doctor

or a taped murder-suicide as the types of incidents that are reported (these stories were considered to be related to mental illness). This can heighten the construction of the abnormal “other.”

Administrative and managerial discourse

Four studies focused on how administrative and managerial discourses are drawn upon in the texts as a way of constructing mental illness (Hui & Stickley, 2007; Moon, 2000; Rowe et al., 2003; Teghtsoonian, 2009). Teghtsoonian (2009), in analysing British Columbia’s Provincial Depression Strategy (Goldner, 2002), suggested that the policy constructs practices of standardisation and audit as key in determining practitioners’ treatment decisions in mental health. Rowe et al. (2003) noted how a third of articles they analysed referred to the need for improved management, recognition, and administration in services for depression, for example, articles refer to the financial cost of depression and the inadequacy of current service provision.

Hui and Stickley (2007) emphasised the legal requirement for service users’ involvement in mental health services. However, the authors suggested that the government documents do not state what this involvement actually entails. Moon (2000) argued that the policies construct the failure of community care as a result of ineffective surveillance measures and suggests that the absence of care provision is used as a justification for a return to confinement. Moon (2000) also noted that mental illness is differentiated with the focus on targeted problem groups (such as those with schizophrenia and personality disorders) as being failed by services.

“Social context” (mental illness as a product of social circumstances)

Bilic and Georgaca (2007) and Rowe et al. (2003) identified social explanations and considered how context is included in the construction of mental illness in the texts. Rowe et

al. (2003) identified a psychosocial discourse relating to depression where human misery is depicted as a result of life circumstances and social, cultural, and political conditions.

However, Rowe et al. (2003) noted that the definition of depression as a biological mental illness is not questioned despite the emphasis on social causes. Bilic and Georgaca (2007) identified a discourse of “socio-political transition”—mental illness was considered in the context of Serbia experiencing political and social instability and being involved in wars.

These authors, who examined Serbian newspaper articles, offered two constructions within the discourse of “socio-political transition.” One is an attempt to normalise Serbia as a nation by describing it as “healthy” and attributing the increased cases of mental illness to social problems—wars, diseases and economics. The other construction is through the normalisation of abnormality—“a nation saturated by abnormality” (Bilic & Georgaca, 2007, p.180).

“Religion” (religious terms as a metaphor for mental illness)

Andersen et al. (2013) analysed six autobiographies by people who had used mental health services. They identified the rhetorical use of religious terms to characterise mental health problems. Andersen et al. (2013) are the only authors to suggest that religious discourse is drawn upon in the construction of mental illness. This is probably due to religious terms being an *a priori* category in the analysis, however it could also be a consequence of the personal perspective in autobiographical accounts. Interestingly, the authors noted that the use of religious terms has not decreased over time despite the emergence of a dominant medical discourse. They described how people who were diagnosed with mental illness explained their experience in relation to religion, for example, in feeling like an evil spirit, seeing asylums as representing hell, or believing that praying to God would help. Rhetorically, experiences of mental illness were conveyed through metaphors.

Discussion

The aim of this review was to examine discourses and discursive strategies that have been used in public mental health-related texts to construct specific versions of mental illness according to discourse analytic research. In reviewing the research, this paper suggested that the construction of mental illness could be grouped into the following broad discourses: violence, risk, dangerousness and criminality; medical; “us versus them”; administrative and managerial; the “social context”; and “religion.” The most dominant discursive constructions of mental illness appeared to be violence, risk, dangerousness and criminality, medical discourses and the discourse of “us versus them,” and seem unfavourable to people diagnosed with mental illness. This is consistent with previous reviews of media depictions of mental illness (Nairn, 2007; Stuart, 2006; Wahl, 1992). The authors have suggested many strategies that have been used to persuade the reader to view mental illness in particular ways. This review has provided many examples of this, such as the association of mental illness with deviant groups (Bilic & Georgaca, 2007; Olstead, 2002) or the use of category entitlement to claim knowledge of mental illness (e.g., Johnstone & Frith (2005)).

In summary, many authors suggested that the texts present a version of mental illness that is biologically-based, with treatment primarily the province of medical doctors and that people diagnosed with mental illness are seen as potentially dangerous and as a risk to the public. Even within these constructions, the discursive strategies used in texts can shift the function, social meaning, and possible practical effects. For example, Nairn et al. (2001) noted in their analysis of newspapers that subtle changes in language could intensify the perceived threat to public safety (e.g., the difference between *potentially* dangerous patients and *particularly* dangerous patients). The likelihood of the patients’ dangerousness is altered and can inform how fearfully the public might react. Harper (2007) suggested, citing statistics from the Department of Health, that only 18% of people who committed homicide have had

contact with mental health services. Therefore, these constructions of the dangers associated with mental illness are not necessarily representative of mental illness. Many authors (e.g., Allen & Nairn, 1997; Olstead, 2002) have also argued that the text creates a dichotomy whereby people diagnosed with mental illness are constructed as an abnormal ‘other’ and where accounts for their behaviour are given no explanation or context.

Unlike the previous reviews, including the work of Georgaca (2012), this review identified other discursive constructions that are not overtly negative—the “social context,” administrative and managerial discourses, and religion. Social context discourses, in particular, could be seen as offering an alternative and a less pathological version of mental illness to biomedical discourses. The discourse of “mental illness as socio-political transition” (Bilic & Georgaca, 2007) was particularly interesting as, unlike other discourses, it presented mental illness as something that is affected by the social context and the conditions of the time. Bilic and Georgaca (2007) related mental illness to the context of contemporary Serbia and specifically to Serbia as a nation. As with other discourses, the extent to which administrative and managerial discourses of mental illness are seen as beneficial is dependent on the reader’s values and worldview. Some readers may be supportive of neoliberal ideology with its view that people should be responsible for themselves. Teghtsoonian (2009) suggested that this was the ideology underlying the then government’s policy. The discourse of religion, as considered by Andersen et al. (2013), appeared to be a medium in which people diagnosed with mental illness could express their experiences of mental distress.

This paper has provided an in depth synthesis and summary of discourse analytic research in order to answer the question posed. A critique of issues in discourse analytic theory and method in relation to the studies will now be provided.

Discourse analytic methodology and the studies

It can be argued that the discourse analytic method is quite idiosyncratic. However, this is due to the deliberate lack of prescription in methodology, because theoretically there is considered to be no singular reality and therefore no definitive and objective “results” available. Furthermore, methodological rigidity may close down the possibility of other interpretations of the texts (Wood & Kroger, 2000). However, Antaki, Billig, Edwards, and Potter (2003) dismissed claims that in discourse analysis “anything goes” and identified ways in which an analysis can fall short. For example, Coverdale et al.’s (2002) results represents an under-analysed text as it only identified frequency of words assuming that the text speaks for itself and is summative. Another example is Allen and Nairn’s (1997) study. This study analysed “non-sensationalist material,” arguing that the results were inconsistent with the “sensation sells” explanation for negative depictions of mental illness, which appears a circular approach to “discover” discourses.

Certain authors of the studies used combinations of two or more guidelines in producing their results, even combining different types of discourse analysis guidelines (see Appendix B). However, Wetherell (1998) has argued that the traditions of discursive psychology are not incompatible with those of Foucauldian discourse analysis. Teghtsoonian’s study (2009) was the only one that did not specify any guidelines that it used, merely stating that it drew on Foucauldian literature on governmentality. It should be noted that the Coverdale et al. (2002) study, despite using discourse analytic guidelines, could also be seen as a content analysis in that it referred to the frequency with which certain categories of statements appeared in the text. Finally, the Coverdale et al. (2002) study had an *a priori* category of positive representations of mental illness, which arguably pre-empts the analysis.

The “representativeness” of constructions of mental illness

The authors of the studies selected the texts and quotations, thus leaving open the question of whether the text chosen were representative. It could be argued that in selecting the texts, the authors were searching for certain discourses around mental illness. Also, the number and length of text analysed in the studies ranged from one to 600 texts and from full documents to “cuttings.” In fact, two of the studies used the same cuttings (Coverdale et al., 2002; Nairn & Coverdale, 2005). The sampling of text can be potentially problematic, as noted by Coverdale et al. (2002). The sample of text that they had analysed included coverage of two unusual events that had received significant media attention and may have skewed the results. Andersen et al.’s (2013) analysed autobiographies, written by service users, focused on a very different discursive construction to the other texts, namely religion. In this genre of text, people have the opportunity to portray directly their own depictions of mental illness. Interestingly, it was a text where patients could attempt to resist the category of mental illness. Andersen et al. (2013) described how two patients, despite being diagnosed with mental illness, did not agree that they had a mental illness and therefore did not pray for help, unlike the other people in the autobiographies, since they believed that they had no reason to.

It is important to note that the five studies conducted by Nairn all focused on the construction of the danger associated with mental illness. It is possible that the author’s results reflect his own bias towards these constructs. Also, it should be considered that the majority of the research had been conducted in the same countries. For example, there were six studies conducted in New Zealand and four studies in the UK (see Table 1). It is possible that the constructions in these texts are specific to these countries. However, it is worth noting that there appeared to be agreement relating to certain constructions of mental illness. Constructions of violence, risk, dangerousness, and criminality were found in texts from

Serbia (Bilic & Georgaca, 2007), England (Harper, 2004) and Canada (Olstead, 2000). In addition, throughout ten years of research, from Hazelton (1997) through to Bilic and Georgaca (2007), a similar understanding of mental illness as being dangerous has been upheld. Although there may be issues of “bias” in interpretative frames and selection of texts, the authors have come to comparable conclusions.

It may not be appropriate to critique the texts used in these studies in terms of their “representativeness.” Ryan, Coughlan, and Cronin (2007) argued that qualitative research does not aim to generalise findings. Wood and Kroger (2000) suggested that discourse analysis is about identifying some of the ways in which language is used. It is not essentially interested in comprehensiveness and exhaustive categories. Therefore, whether these constructions are representative or not, they are some of the different accounts that exist in the portrayal of mental illness.

“Taking sides,” researchers’ stances, and reflexivity

There is debate about whether the researcher (in conducting a discourse analysis) should take a position in relation to the material analysed. For example, Antaki et al. (2003) warned against “taking sides” in analysing text whereas Jager and Maier, (2009) argued, “the analyst can—and has to—take a stand” (p. 36). The relativistic stance of discourse analysis poses a problem—if all views are equally valid how could one take a moral, political or factual position (Edwards, Ashmore, & Potter, 1995)? Jager and Maier (2009) stated that the researcher could invoke values, norms, etc. as long as it is in the knowledge that these too have been discursively constructed, that the critique is not situated outside discourse. Harper (2007) argued that all researchers have a stake in their research and interpret their results through certain ways. One way of helping the reader to evaluate the merits of the author’s work is by the author being reflexive in the study. Some studies demonstrated better

reflexivity by stating their biases in relation to the topic. For example, Johnstone acknowledged that she has previously argued against the use of ECT and Harper that he is influenced by critical psychology and concerned by the mental health reforms. However, some studies have been less reflexive, the studies authored by Nairn did not provide a statement of the author's position on the issues concerned.

Situated texts and constructions

There is a dilemma in discourse analytic work about how far the researcher should go beyond the text they analyse to arrive at an interpretation of what is happening (Burman & Parker, 1993). Teghtsoonian (2009) situated the text analysed within political ideology and located it firmly in British Columbia. Bilic and Georgaca (2007) situated their text within the socio-political situation in post-socialist Serbia. This can help the reader to understand the context and circumstances to their suggested constructions and evaluate their claims. However, the research is based on a selected context by the author and may guide the reader to particular conclusions. Since interpretations of the text are specifically situated it becomes inappropriate to generalise results.

The complexity of discourse

The term "negative" has been used in the conclusion of many studies, e.g., Allen and Nairn (1997). Many of the discourses identified can be seen as negative for people diagnosed with mental illness. However, labelling depictions as negative or positive in a polarised fashion (e.g., Coverdale et al., 2002) negates the idea that discourse can be productive in different ways. Who is it negative for and in what circumstances? It is possible for the same discourse to be used by the same speaker to justify different accounts (see Edwards & Potter, 1992)? Rowe et al. (2003) have argued that discourses are not isolated but intersect. An example the authors gave is the suggestion that both therapy and medication are needed in a

particular case, which combines a medical discourse with a psychosocial one. They claimed that this can give the biological argument credibility by not appearing partisan and providing an explanation where medical treatments have failed. Furthermore, Rapley and Ridway (as cited in Rowe et al., 2003) argued that discourses are not necessarily competing and that both medical and psychosocial discourses are included within an overarching administrative and managerial discourse. Therefore, the identification of single discourses in the construction of mental illness may not capture the complex way that discourses are used.

Theoretical issues

The studies reviewed are populated by groups of people (e.g., the “mentally ill,” mental health professionals, neighbours, and families). There is an assumption in discourse analytic theory that people are embedded in discourses, that “discourses contain subjects” (Parker, 1992, p. 9). There has been criticism that an exclusive focus on discourse can lead to the “lack of a person” (Langridge, 2004, p. 345) and lack of a concept of “self” with internal subjective states. Discourse analysis does not address the subjective world of the speaker nor their possible motivation for adopting a certain discourse, for example, what might motivate journalists or politicians to represent mental illness in negative ways (Willig, 2008).

Discourse analytic theory and methods rely on the motivations of persons to take up positions or adopt discourses yet these motivations are not theorized (Willig, 2008); for example, Rowe et al. (2002) in analysing newspapers, identified discourses that work together to normalise depression. However, this does not explain why journalists would want to produce discourses that normalise depression. The discourse analytic framework perhaps lacks explanatory power beyond naming these discourses or discursive constructions and what they “do” publically.

There are alternative theories that may help to account for the dominant negativity of these representations. Journalists, psychiatrists and governmental figures appear, from the texts, to choose to construct mental illness in problematic ways. However, they could be simply seen as figureheads for societal attitudes and views about mental illness. Moral panic theory suggests that “a group of persons emerge to become defined as a threat to societal values and interest” (Cohen, 1973, p. 9). The bizarre behaviour of people with mental illness that is reported in the Harper (2004) and Hazelton (1997) studies can be seen as a threat to social order. Psychoanalytic theory could also provide an explanation of such representations. Individuals project the unfavourable aspects of themselves onto others (Lemma, 2004). Olstead’s (2002) study (which identified the polarisation of “normal people” and the “mentally ill”) is suggestive of this theory; we can be good if others are bad. Many of the authors suggested that unfavourable depictions of people with mental illness are due to a need for sensationalism, for example, Hazelton (1997), which may demonstrate an editorial bias rather than a theory.

With regard to government literature, it is perhaps easier to interpret what it is attempting to do in practice—for example in Teghtsoonian’s (2009) study it is suggested that individuals are persuaded to be responsible for themselves (in line with neoliberal ideology) and therefore reduce costs on services. The emphasis is on the importance of social order, which again is in line with moral panic theory.

This review raises another theoretical question; does the reader passively accept these constructions of mental illness or are they negotiated or resisted? The following theories give different answers to this question. There is the “hypodermic needle theory” of communication (Croteau & Hoynes, 1997), where a passive audience directly receives the intended message and wholly accepts it. Alternatively, there is the “reception theory” (Hall, 1980), where accepting the meaning of a specific text tends to occur when the readers share a

cultural background and thus interpret the text in similar ways. This is what Nairn seemed to be suggesting in his work—that the reader draws on shared common sense or a lay understanding of mental illness as dangerous. All the studies were conducted in westernised countries and people in these countries would be likely to share a certain cultural understanding.

Implications for Practice and Research

This review demonstrates that there is a growing body of discourse analytic research on mental health-related public texts which provides critical insights into the construction of mental illness by questioning knowledge that is usually taken for granted. There are possible implications for future practice and research.

Implications for practice

The studies in this review point to ways in which the reporting of mental illness could be improved to reduce “negative” constructions of mental illness. Here are some suggestions:

- If newspapers are the main source of lay knowledge about mental illness, as Hazelton (1997) suggested, then newspapers could take a more informed role in education and in directly reporting service user accounts and quotations.
- People with mental illness could, where appropriate, be offered the opportunity to provide motivations and explanations for their actions in media reporting.
- Relevant counter evidence could be supplied in the reporting. For example, in the reporting of a homicide perpetrated by a person with a mental illness, counter evidence could be provided, such as statistics showing that only a fraction of people with mental illness pose a danger.

- It can be unhelpful for mental illness to be portrayed as a unified category and for people diagnosed with mental illness to be associated with other perceived “deviant” groups.

This review is relevant to the practice of psychologists. It demonstrates the important role that language plays in constructing mental illness. Psychologists have a responsibility to produce written texts, for example, reports, academic research, and statements on behalf of organisations and thus they construct versions of mental illness. Furthermore, psychologists should be aware of the stigma that written texts (such as those found in newspapers) can cause and the effect that this can have on their clients. They could develop their role in contributing to the media’s understanding of mental illness, possibly by training journalists on the reporting of mental illness and thus further contributing to public discourse.

Future research

There is much scope for future research using discourse analysis in this area. Certainly, research would benefit from drawing on different interpretative frames to diversify possible interpretations of the texts. Much of the review has focused on research based on newspaper texts. However, governmental literature is more neglected in discourse analytic research with only three studies reviewed. Further exploration of this genre is warranted considering the influence that such literature has on policy and practice. This is of particular importance considering the wider function of government in determining the constructions of mental illness, for example by creating legislation that detains people diagnosed with a mental illness. Publicly available texts, such as transcripts from parliament and white papers on law reform, could prove to be interesting sources for exploring how mental illness is discursively constructed and how practices are justified.

Service user accounts are another area that could be of interest when questioning what alternative constructions of mental illness might be possible. Andersen et al. (2013) and Hui and Stickley (2007) both analysed text written by people who have used mental health services. These studies identified different discourses from those identified in newspapers and policies. How do service users construct themselves and the systems that they find themselves in? What are their concerns?

There are questions left that are worth exploring surrounding the extent to which people are influenced by reading different accounts of mental illness. Do readers incorporate these new accounts into their understanding of mental illness?

Conclusion

This review has demonstrated that discourse analytic research on mental health related public texts produced a number of different discourses. The most predominant discourses position mental illness in an unfavourable light, depicting those suffering from a mental illness as dangerous and unpredictable. Few studies drew on discourses that positioned mental illness as a product of social circumstance. However, in summary, since there can be no “right” interpretation in a discourse analysis of texts and with the assumption (within the discourse analytic paradigm) that all knowledge is contestable and provisional (Burr, 2003) —it ultimately becomes difficult to have definitive conclusions. Burman and Parker (1993) noted that there are no fixed answers to the dilemmas in discourse analysis. Nevertheless, it should be noted that despite the dilemmas and debates, the results were surprising in their agreement regarding the discourses and discursive strategies that constructed mental illness, which suggests that there is a shared public understanding of mental illness (at least in the West). Ultimately, if language is to be believed as constructive of experience and, according to Parker’s (1992) position that there is a reality existing outside discourse, then discourse has

“real effects” and all these studies could be said to be relevant by their claims of the (problematic) effects of these constructions on people diagnosed with mental illness.

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Section B

Constructing “Mental Disorder” and its Related Practices: A Discourse Analysis of
the House of Commons’ Debates regarding the 2007 Mental Health Act

Word Count 7987

Abstract

Background The Mental Health Act 1983 was amended in 2007. This legislation appears based on the assumption that an undisputed entity of “mental disorder” exists, that people who are designated mentally disordered should be treated, and if necessary, detained by doctors. *Aims* To examine how mental disorder was discursively constructed and how different institutional interventions and practices were justified and legitimised in the House of Commons’ debates regarding the Mental Health Act 2007. *Method* Verbatim transcripts from House of Commons debates on the Mental Health Act (conducted between 24th April and 15th May 2007) were studied through a discourse analysis. *Results* Seven primary discursive constructions were identified: “The Trusted and Medically Objective Expert,” “The Emergency,” “A Fair Process,” “Supporting Subjects,” “The Decision-Making Impaired and Vulnerably Ill Patient,” “The Lawyer’s Field Day,” and “Societal (Dis)Order.” *Conclusion* Mental disorder was represented in selective and systemic ways that can help justify and legitimise different interventions and practices, for example, enforced medication, making government legislation and psychiatric practices seem necessary. Consideration was given to how psychiatric practices could be problematic for some service users and how legislation could be based on political and public concerns about social disorder.

Keywords: Mental disorder, mental illness, discourse analysis, Mental Health Act, social and political issues

Constructing “Mental Disorder” and its Related Practices: A Discourse Analysis of
the House of Commons’ Debates regarding the 2007 Mental Health Act

Introduction

“(The Honourable Lady) seems to be suggesting that, because we are changing the definition of mental disorder, ... (we) would suddenly fall under the Act and therefore everyone might be up for detention.” (Chris Bryant, lines 485–87)

The Mental Health Act 1983 is arguably the most powerful piece of legislation in England and Wales, as it uniquely allows detention without trial and the administration of powerful drugs without patient consent. This Act was amended in 2007, but the amendments have been described as “draconian” (Rose, 2008) and the government’s emphasis on public safety, rather than service quality and human rights, has been criticised (Pilgrim, 2007). The original legislation and amendments seem to be based on the assumption that an undisputed entity called “mental disorder”¹ exists, that people who are designated as having mental disorder² are diseased and disordered, and that they should therefore be detained and treated by doctors. They are labelled with certain characteristics, such as being a danger to others (Harper, 2008). However, these assumptions have been contested in academic literature through historical and scientific critiques and social commentaries (e.g., Boyle, 2002; Foucault, 1965; Vassilev & Pilgrim, 2007).

¹ The terms “mental disorder” and “patient” are not in quotation marks in the main body of this text for reasons of presentation, but it is acknowledged that these notions are contested.

² “People designated with mental disorder,” “patient,” “mentally disordered,” “mentally ill,” and “service user” are terms used interchangeably in this paper to illustrate common labelling employed.

Mental distress has not always been described as a disorder or illness. It has been constructed differently throughout the ages, being regarded variously as a visitation or punishment from the gods, demonic possession, “madness,” or “lunacy,” or requiring rational inquiry (Porter, 2002). It was only in 1774 that British legislation on mental disorder first mentioned doctors, when the Madhouse Act allowed doctors to visit asylums (Cromby, Harper, & Reavey, 2013). In his analysis of madness through time, Foucault (1965) argued that mental illness is a social construction rather than a natural fact. He suggested that the modern notion of mental illness is maintained through psychiatric practices—that “mad” persons/subjects are created by discursive practices centred on notions of “madness” and “reason.” Hacking (1986) suggested that, historically, both these categorisations and different diagnoses have been created in relation to the different power-knowledge configurations that have emerged, for example, he claimed that the clinical phenomenon of the multiple personality was invented in 1875. Similarly, Davidson (as cited in Hacking, 1986), expanding on Foucault’s (1978) argument regarding sexuality, proposed that the concept of a “pervert” did not exist before the nineteenth century, but that the ideas of perversion as a disease and the pervert as a diseased person were created from a new functional understanding of disease. Hence, rather than being an unchanging ahistorical fact, it may be more appropriate to understand mental disorder as a social construction that is a product of language and historical, cultural and social circumstances.

The scientific basis of the ways in which mental disorders are categorised has also been challenged. Bentall (2004) has questioned the reliability and validity of the diagnosis of schizophrenia (see also Boyle, 2002), and Moncrieff (2008) has argued that drugs used in the treatment of different disorders exert general psychoactive actions rather than disease-specific actions. Some authors have examined how the notion of mental disorder has been maintained in research and professional environments, for example, Boyle (2002) suggested

that the idea of schizophrenia as a brain disorder has been perpetuated by casual, uncritical assertions in texts, promoting the assumption of causal associations between schizophrenia diagnoses and biological processes and the privileging of biology in examinations of its multiple causes. Similarly, a discourse analysis by Harper (1999) suggested that clinicians explain away the lack of success of neuroleptic medication (considered a treatment for mental disorder) by suggesting that the patient is on too low or too high a dose, that the patient's problems are chronic, or that they are on the wrong drug, rather than by questioning the usefulness of the medication in treating the supposed disorder.

Some social commentaries on and critiques of the Mental Health Act (e.g., Pilgrim, 2007) have suggested that that the legislative amendments of 2007 were primarily added for social control. These authors suggested that the Act is not about protecting patients from themselves or others—it is about the government wanting to minimise the perceived risks of mental disorder (Vassilev & Pilgrim, 2007). Harper (2008) undertook a scholarly analysis of proposals to reform the mental health legislation and identified the constructions of risk and danger. Similarly, Moon (2000) explored the mental health policy of the time and stressed the significance of discourses of protection, safety, risk, and dangerousness in the positioning of confinement as a respectable and strategic response.

Rationale

Parliamentary debate transcripts have been used in other research areas to examine assumptions and discursive strategies in discussions about law reform, for example homosexuality (Baker, 2004) and human fertilization (Kettell, 2010). Therefore parliamentary debates could be considered ripe for analysis in the area of mental health, particularly law reform.

In the context of the problematized concept of mental disorder and its practices, it would be of value to critically examine the House of Commons debates with respect to the

Mental Health Act 2007. This examination would explore the ways in which mental disorder is constructed and the possible practical effects of that construction.

Research questions

How was mental disorder discursively constructed in the House of Commons' debates regarding the Mental Health Act 2007?

How did the discourses adopted justify and legitimise different institutional interventions and practices?

Context and text

In 1998, the Labour government announced its intention to review the 1983 Mental Health Act. Several consultative papers and draft bills were presented before the amendments were introduced into the House of Lords on November 2006. The bill then transferred to the House of Commons (Department of Health, 2010), and the House of Commons Public Bill Committee debated the proposed Mental Health Act in twelve sittings from 24th April to 15th May 2007. The total time devoted to the debate was 27 hours and 16 minutes. The House of Commons debates, in particular, have been selected for analysis because of its legislative supremacy over the House of Lords, as asserted by the 1911 Parliament Act. The current research utilised electronic verbatim reports of the debates, which are freely accessible to the general public online from the Parliament UK website (Parliament UK, 2007).

The issues debated included:

- Change to a single definition of mental disorder, abolishing references to different categories of mental disorder.

- Abolishing the “treatability test³” and replacing it with an “appropriate test,” the aim of which is to ensure that the treatment is appropriate to the mental disorder.
- The introduction of Supervised Treatment Orders (also referred to as community treatment orders [CTO]). These subject patients to certain conditions while living in the community in order to ensure that they continue with treatment.
- Broadening the group of practitioners who can take on the role of Responsible Medical Officer (retitled Responsible Clinician).
- Ensuring age appropriate treatment, for example the requirement that medical practitioners treating children under the age of 18 have particular expertise in child mental health.
- The possible introduction of an “impaired decision-making” test, ensuring that no one may be detained under the provisions of the Act unless their ability to make decisions about their treatment is significantly impaired by their mental disorder.
- Safeguards for electroconvulsive therapy treatment (ECT) with respect to capacity and consent.
- Availability of independent mental health advocacy.

(Department of Health, 2009)

Theory and Method

These parliamentary transcripts were interpreted using the method of discourse analysis. This was chosen as it allows the researcher to critically engage with (Burr, 2003) and explore the macro-structure of the discourses used to construct both mental disorder and the psychiatric

³ "Treatability test" means that the treatment for a service user must be likely to alleviate the condition or prevent it from worsening (Mental Health Law Online, 2008).

and psychological practices related to it. This paper does not separate method from theory, and recognises that discourse analysis (the method used) is a theory in itself – as Potter (2004) has previously argued. The basic theoretical principles, which drive discourse analysis suggest that discourse is; action orientated (i.e., the primary medium for action), situated (i.e., organised sequentially, embedded in practice and rhetorically orientated to counter relevant alternatives), constructed (i.e., composed from different elements (e.g. words, categories)) and constructive (i.e., versions of the world are assembled and stabilized in talk) (Potter, 2003).

Epistemological position

Discourse analysis is broadly situated in a social constructionist epistemology. This does not necessarily deny the existence of a material reality outside discourse, but suggests that we can only experience this reality through discourse. “The world does not come ready-made in categories of events or type of objects, but that order is imposed on the world through our linguistic description of it” (Burr, 2003, p. 89).

Data analysis

The analysis in this paper is based on guidelines presented by Parker (1992). He guides the researcher to consider ten criteria for distinguishing discourses in a text. A discourse: (1) is realised in text; (2) about objects; (3) contains subjects; (4) is a coherent system of meanings; (5) refers to other discourses; (6) reflects on its own way of speaking; (7) is historically located; (8) supports institutions; (9) reproduce power relations; (10) have ideological effects (see Appendix C for further information regarding each criterion). Parker (1992) stated that these criteria do not have to be followed sequentially and that, depending on the text, some may be of more interest than others. It should be emphasised that rigid adherence to a particular guide would be inconsistent with a discourse analytic approach.

Initial reading and coding

The text (a 215,500 word transcript of the Public Bill Committee debates) was carefully read, re-read, and annotations or “codings” were made on the text, based on the above guidelines. One thousand and twenty six annotations were generated from the text that identified dominant and interesting constructions of mental disorder and how practices were justified. These annotations were then used to inform the analysis (Wood & Kroger, 2000).

Ethical considerations

Ethical approval for this research project was obtained from Canterbury Christ Church University (Appendix D). The results were fed back to the Research Governance Manager (Appendix E).

Quality of the analysis

The results represent only one interpretation of the text, which may be influenced by the author’s own position; alternative interpretations are possible. The author has worked as a social therapist and trainee psychologist in acute inpatient wards and seen some service users’ distress increase during their detention and treatment. He questions the benefit of psychiatric and psychological practices based on the understanding of mental distress as a medical condition.

The procedures suggested by Mays & Pope (2000) were followed to ensure the “quality” of the results: data coding was periodically reviewed by an academic supervisor with experience in discourse analysis, a reflexive diary was written (Appendix F), and an audit trail was compiled (Appendix G). Extensive quotations from the debates are provided in the text of this analysis in order to enable the reader to decide for themselves the merit of the conclusions drawn. Graham (2011) has argued that, despite the focus in discourse analysis on the author’s interpretation, the meaning of a text is inherently unstable and it is the reader who has the ultimate authority over its interpretation.

Results

Seven discourses were identified in the analysis. Each discourse is presented in turn with some illustrative quotations. The reading focused on how mental disorder is discursively constructed within the debates and how these discourses provided a framework that justified the different interventions and practices for treatment and detention of those deemed mentally disordered. In accordance with other discourse analytic research (e.g., Hui & Stickley, 2007; Stevens & Harper, 2007), the results are discussed in relation to their position within the wider literature in this area.

The trusted and objective medical expert

An overarching discourse of “expert” was identified in the debates. A number of different objects formed part of this discourse; knowledge, training, specialism, trust, and claims of reality. The “expert” discourse could be seen as a power-knowledge configuration where doctors have a privileged knowledge and status that legitimise the treatment and detention of people designated with mental disorder. This privileged knowledge and status appears supported by the legal framework that relies primarily on psychiatric opinion. “Mental illness” is considered the same in the legal sense as in its psychiatric definitions and psychiatric opinion has been positioned as the expert view (Davies & Bhugra, 2004): “After all, as lay people we are, in this Bill, relying on psychiatrists to make that decision as to whether judgment is impaired. Making that decision is what they do” (Angela Browning, lines 2243–2244). This implies “expertise and knowledge.”

Expertise and knowledge. Ussher (1991) suggested that madness could be seen as a social category that is generated by a process of expert definition. The expert position is often associated with psychiatrists who are seen as possessing sufficient knowledge about mental disorder to assess and interpret the law. It must be left to their discretion—it is “what they do” (Angela Browning, line 2244). The position of an expert is further underlined in contrast

to lay people and others, including prison staff, the police, MPs and the Secretary of State, who are presented as lacking expertise: “I do not claim to be an expert” (Angela Browning, line 9850); “I am not an expert on that” (Rosie Winterson, line 8740);

It would remove the discretion to judge whether that individual has a problem, because the Secretary of State for Justice is not medically qualified, competent or expected to judge somebody’s medical condition. That is why we have experts to do so. That is what the legislation is all about. (Tim Loughton, lines 10250–10252)

The idea of “an expert” suggested exclusivity, implying that others may not have equivalent knowledge or the right to make decisions in this area. This construction could be seen to suggest that the psychiatrist’s knowledge on mental disorder is authoritative and final, denying this right to others in positions of power. The selection of the “expert” discourse, in relation to knowledge and the psychiatrist, could obscure other types of expertise such as patients’ own expertise by experience—“experts by experience” (McLaughlin, 2009, p. 1111). There does not appear to be an acknowledgement of other ways of “knowing things.” Knowledge appears to be established through training.

Expert training. There was an assumption that the person who has undergone the longest training (in this case, the psychiatrist) is the most apt professional to diagnose and treat mental disorder:

For a full-blown consultant psychiatrist, however, we are talking about 13 years, which means that considerable training, expertise and experience go into the specific job that psychiatrists are put in place to do. It is different from what a psychologist and consultant nurse will do. (Tim Loughton, lines 4769–4771)

However, it was acknowledged that expertise was not confined to the psychiatrist; prison staff also can learn relevant skills:

In Committee, we were told by the Department of Health that there are plans to implement a mental health first aid training package to provide corrections staff with the skills to recognise symptoms and provide initial assistance and referrals, and that higher-level training is being considered for key staff, as there are few specialist mental health staff in the prison system. (Tim Loughton, lines 10135–10141)

The politician appeared to construct the problem as relating to identifying mental disorder rather than acknowledging that the concept of mental disorder itself might be problematic. He suggested that the solution is further training for staff to enable them to recognise symptoms; arguably, identification is the first step to legitimise detention and treatment. Although prison members of staff are not psychiatrists, this up-skilling strategy can be seen to support the emphasis on expertise by “identifying” and directing newly constructed patients into the psychiatric system. Also, this seems to suggest that training is hierarchical as it is necessary to be a specialist (i.e., doctor) in order to detain and treat.

The notion of the specialist. Politicians in the debates discussed specialisms that could further reinforce this notion of expertise. For instance, they made demands regarding the need for expertise in offering age-appropriate services: “Children’s services require appropriate settings, assessments by people who are clinically approved and who have an appropriate qualification in treating children, and clinical supervision in all cases. By definition, such services require specialism” (Angela Browning, lines 6610-6612). The presence of this specialist knowledge could be seen to legitimise action, here specifically relating to treating children. In addition, by constructing “child specialist” as a subcategory, this could reinforce the notion of mental disorder: logically, for a subcategory to exist, one needs a valid category in the first place. Specialisms can hierarchise individuals and this hierarchy can be used to control professionals as well as patients.

It could be argued that knowledge, training, and specialism does not empower the expert in themselves, but they create the notion of trust in which lay people can accept the expert's authority to make decisions on their behalf.

Trusted expert. Giddens (1990) has suggested that lay people trust in expert systems and assume their expert trustworthiness and competence. The following quotation is built on the assumption that the clinician is a moral person with good ethics: "As always, the clinician makes the decision on what is right for the patient" (Rosie Winterton, line 8992). Members of the public invest faith in practitioners to do the right thing and make the right decisions during detention and treatment. In selecting the construction of trust in relation to the "expert" it could seem unnecessary to question psychiatric practices.

Interestingly, the psychiatrist is also presented as the safeguard in an unquestioning position of trust: "The SOAD (Second Opinion Appointed Doctor) is a safeguard. That is its purpose" (Angela Browning, lines 9977–9978). This implies that a second opinion increases the validity, reliability, and safety of a decision, even though it is a medical opinion in addition to another medical opinion. Drawing on the subject of the trusted expert as a safeguard appears to justify the decision that no external safeguards are needed; instead, the experts themselves are allowed to become the safeguards, trusted to make the right decisions through the expert knowledge and their suggested natural morality.

Expertise based on claims of reality. The use of realist language constructed mental disorder as something that it is possible to know and be an expert about: "...the *fact* [emphasis added] of a mental disorder" (Chris Bryant, line 1893); "...except *genuine* [emphasis added] mental disorder" (Rosie Winterton, lines 1456–1457); "...there must be *reliable evidence of a true* [emphasis added] mental disorder" (Sandra Gidley, line 1874). The apparent tangibility and reality of a disorder are then seen to legitimise certain practices by a psychiatrist, including detention and medication.

The following discourses could be seen as enabling discourses that support different interventions and practices that make it possible for the “expert” to treat and detain a person designated with mental disorder.

“The emergency”

In the debates, the word “emergency” was used to describe situations outside of the “normal” in an attempt to justify certain actions since it is seen as an exception. The legislation appears to give the psychiatrist implicit permission to deviate from the law; its application could also benefit the government as it would excuse them from having to provide the resources and provision that is enshrined in law. This was the justification provided for giving the psychiatrist freedom to deviate from procedure:

If it was right to place someone in accommodation because it was deemed in an emergency situation that they might otherwise have taken their own life... A clinician in such a situation might deem a move more dangerous than meeting the requirements of a clause in a Bill. (Chris Bryant, line 6579-6583)

In the debates, it was suggested that the use of force to give treatment would also be justified in the case of an emergency: “I conclude by saying again that force may be used to administer treatment in an emergency—for example, to save a patient’s life” (Rosie Winterton, line 10016). This emergency status could also potentially be used to justify a psychiatrist’s power to use a particular treatment, for example, ECT, however hazardous or irreversible this treatment may be. The rhetoric of the emergency can be seen as powerful when death is presented as the alternative. The implied inhumanity of not acting in such situations means that this emergency status becomes difficult to question: “We are not looking to take away the powers of a clinician to administer such treatment (ECT) in an emergency. If a decision had to be made in life-threatening circumstances...” (Tim Loughton, lines 7755–7756). Stevens and Harper (2007) also identified the use of this

rhetoric of “life-saving” and emergency to justify ECT.

“A fair process”

In the text of these debates, the statutory and professional responses to mental disorder appeared to be presented as a fair process. The process created a structure in which mental disorder and its related practices could be normalised through a series of actions, for example, the process by which doctors diagnose and detain a person: “First, though, two doctors have to agree that a mental disorder is present. If that is disputed—if the patient believes that they have no mental disorder—they can take it to a mental health tribunal to challenge it” (Rosie Winterton, lines 450–451). It was not seen as possible for a mental disorder to be self-evident: two doctors are needed to decide upon its presence in order for a person to be detained.

Process in the debates, as demonstrated through the language of regulation and documentation, implied the normality and objective reality of mental disorder.

Process as regulation. Arrangements for checking, regulating, inspecting, and documenting discussed in the debates all helped to construct a process that appears fair. However, these bureaucratic functions could be interpreted as extending control through observation using an administrative framework. Foucault (1977) used the term “hierarchical observation” to describe situations where the very act of observation controls what people do: “Responsible medical officers know that their treatment decisions can be subject to a second opinion. The SOAD provides a check on the RMOs’ practice” (Tim Loughton, lines 8414–8415); “...the extent to which we can encourage regulators and inspectors to examine local protocols and see whether they are working effectively” (Rosie Winterton, lines 11629–11630). There is an implication that bureaucratic procedures are needed to manage mental disorder.

Process supported by documentation. Documentation is cited many times in the debates and may be used in attempts to apparently legitimise specific actions:

Does the Minister agree that it would be wise in such circumstances, both in terms of clinical governance and any possible legal challenge, for the clinicians to make a careful note of the circumstances that led up to the situation and informed his or her clinical decision? (Tim Boswell, lines 8038–8039)

Documentation can also be used in an attempt to justify the use of treatment e.g., ECT. The presentation of information to the patient could be seen as a form of persuasion:

“Full and appropriate information about ECT should be given, including information about its potential risks and benefits, both general and specific, to the individual” (Quoting NICE guidelines). NICE recommends that information leaflets should be available, too. That is an important part of the process. (Ian Gibson, lines 7844–7846)

Here, documentation could be interpreted as legitimising an action, overriding an advance decision. As long as documentation is used in this way, it remains possible for patients’ wishes to be discarded: “I would like to strengthen the measure in chapter 16A of the code of practice, which states that a decision to override an advance decision should be recorded in a person’s notes” (Rosie Winterton, 8531–8532).

Arguably, documentation is used as a convincing rhetorical device through the assumption that that mental disorder exists in objective reality (see Edwards, Ashmore & Potter, 1995). Documentation provides a “physical” solidarity.

“Supporting subjects”

Within the discourses certain subjects were created that supported the construction of mental disorder and its practices. Some politicians in the debates argued for the use of an independent mental health advocate and an advance directive regarding the patient’s choice of their nearest relative. These suggested amendments would seem to involve a progressive

dispersal of power to the patient—however, they can still be seen as supporting the construction of the idea of the “mentally disordered” person.

The advocate. The existence of an advocate role could be seen as positioning the patients as unable to speak for themselves and create a subject that needs additional help, thus further legitimising the need for state care in the form of detention. One politician suggested that patients could be inarticulate; here, the presence of an advocate to speak for them could be interpreted as silencing the patients’ own voices: “However, it is clear that there is a need for somebody to stand up for a large population of distressed, disempowered, perhaps not very articulate and very troubled people” (Tim Boswell, lines 7607–7608).

“Carers” of people designated with mental disorder. In debating the supervised community treatment orders, the politicians emphasised the importance of the carers’ cooperation in the practicalities of the CTO. The carers’ involvement could be seen, by implication, to accept their relative’s identity as “mentally ill” and acquiesce in psychiatric practices: “Without the co-operation of the parents, SCT (supervised community treatment) will not work” (Rosie Winterton, lines 8699–8700). It appears to frame people designated with mental disorder as unable to manage themselves, making it necessary for a system to support them in coercive practices.

In the supervised community treatment order, the carer is seen as the law-enforcer, as they will be responsible for the restrictions that are placed on the patient:

A duty to consult will help to ensure that the needs of all those providing care for the patient are taken into account when making a supervised CTO. For example, it will ensure that the limitations and conditions placed on a CTO, such as curfew orders or a ban on going to the pub, which we will be questioning later during discussions on other amendments to the clause, are proportionate and have the support of those who are responsible for enforcing them—the carers. (Tim Loughton, lines 8778–8781)

There were concerns regarding the potential legal obligation in a community treatment order if the carer failed to comply with the order, as the carer (who could be seen as the discipliner) could become subject to discipline:-

Is he at all worried that carers, for example, or others involved in the delivery of this supervised compulsory treatment order, may be subject to some legal obligation and may be at some legal risk if they are unable to comply with terms set in relation to the individual? (Tim Boswell, lines 8791–8793)

The supervised community treatment order and supporting subjects demonstrate power in the Foucauldian sense, not necessarily as oppressive but as forming a set of relations in which the carer allows him/herself to be acted upon (Foucault, 1988).

“The decision-making impaired patient”

The patient was presented as being decision-making impaired which questioned their agency. The debates contained assumptions about a person’s actions and decisions, particularly in relation to suicidal and parasuicidal behaviour. Marsh (2010) has identified assumptions in research and practice that suicide is pathological and the action of an unwell individual. The politicians in the debates appear to select this understanding of certain behaviours, such as suicide, as “disordered” and related to notions of reason, thus obscuring other understandings of these behaviours. The decision impaired construction of mental disorder positions the need for doctors to make decisions on their behalf. The following quotations illustrate this: “Clearly, in a clinician’s professional judgment, if somebody was going to self-harm that would automatically raise the question of impaired judgment” (Angela Browning, lines 2240–2242); “If a person is in crisis and wishes to commit suicide, at that point their decision-making is clearly impaired and they would be subject to coercion under the provisions” (Tim Loughton, lines 2368–2369).

The Law Society's brief stated: "We are clear that this amendment (impaired decision-making) would not exclude a mentally disordered person who was a danger to themselves or other people from compulsory detention and treatment under the 1983 Act—since their decision making ability would by definition be impaired." (Tim Loughton, lines 2918–2920)

The Law Society considers those who are mentally disordered and a risk to themselves or others, by definition, to have an impaired decision-making ability. However, the discourse of law was used to provide more than statements within the debates.

"The Lawyer's field day"

"Legal" discourse in the debates constructed the notion of mental disorder through its attempt to qualify who is deemed to be mentally ill. A term that is repeated throughout the debates that appeared to justify the fashioning of the clause—the "lawyer's field day"—referred to challenges that lawyers may make on behalf of their clients.

Legal discourse was drawn upon to support the need for medically objective expertise (i.e., that of psychiatrists) and to prevent the group of practitioners who are able to take on the role of "Responsible Medical Officer" (which was re-titled "Responsible Clinician") from broadening. In the following quotation, the politician cited the Strasbourg Court case (a European judgement on mental health law) and positioned lawyers as opportunistic and able to challenge detention if the legislation is changed:

"In *Varbanov versus Bulgaria*, the Strasbourg Court gave every indication... that objective medical expertise involved reports from psychiatrists who are doctors. The Court made it clear that the opinion of a medical expert who is a psychiatrist is necessary for a lawful detention on grounds of unsoundness of mind... This indicates that the opinion justifying detention should come from a medically qualified expert... who has recognised skills in psychiatric diagnosis and treatment." My point is that, if

the Government get their way, there is every chance that there will be a serious legal challenge of the basis of the legislation. The Minister has warned on a number of occasions against having a field day for lawyers. This is a field day for international lawyers. (Tim Loughton, lines 4739–4745)

Also, by adding more exclusions (such as drug abuse) to the definition of mental disorder, it was suggested that the decision-making process would be further complicated for psychiatrists and that the possibility of legal challenges through litigation would be increased. However, without these exclusions, psychiatrists are arguably allowed to make decisions regarding mental disorder with few limitations. The case for not increasing the exclusions was presented by emphasising the economic repercussions of such challenges:

The hon. Member for Romsey said that we lived in a litigious climate, and that is absolutely true. That is why I have made the point that, if we open up the Bill to more exclusions, we will increase the opportunity for litigation. (Rosie Winterton, lines 2066–2067)

Societal (dis)order

The concept of mental disorder in these debates frequently appeared to be constructed as involving everyone and posing a threat to wider society. The equating of social disorder with mental disorder could be seen as providing a framework for needing increased powers of compulsion. Order is presented as an imperative.

Historical context. Risk and threat were historically located in order to provide a rationale for why the amendments had to be introduced into the Bill. The agenda of public order and the government reforms of the Act (Jackson, 2006) may have been connected to the historical and social context of the case of Michael Stone, who was convicted for double murder and diagnosed with a severe anti-social personality disorder and multiple drug and alcohol abuse (Prins, 2007). Highly selected, high profile but unusual historical events are

presented as evidence that mental disorder is associated with risk and threat. At the time, not only was the treatability test problematic for the “untreatable personality disorder” but there was also difficulty in finding professionals who could detain potential offenders:

I remind the Minister that around the time of the Michael Stone case, when there was great public discussion on how we should deal with people like him, there was an exchange of letters in the national press between the then president of the Royal College of Psychiatrists and the then Home Secretary, who is now the Leader of the House of Commons... I recall that those three letters went along these lines: the psychiatrists expressed their reservations about what an Act such as this would require them to do, in terms of detention, and the then Home Secretary put it into the public domain that, if psychiatrists did not want to deal with detentions, the Government would seek other ways of dealing with them and would find others who would. And here we have the solution in clause 6. The clause is not about creating equal opportunities for nurses, occupational therapists, and psychologists: it is about finding a way around the difficulty that the Labour Government met when they bravely told the world out there that they were going to find a solution to the problem of locking up people like Michael Stone. (Angela Browning, lines 4903–4911)

In addition, references were also made to the Virginia Tech Massacre, dissolving geographical circumstances by suggesting that an event in America could be predictive of a future event in England. The devastating potential of risk was also evoked to help legitimise the recommendations that were made to this Bill: “I am particularly alarmed by comments by Labour members on the recent tragic shootings at Virginia Tech. One right hon. Member who spoke on the Second Reading drew a close parallel between what happened in Virginia and what could happen here...” (Tim Loughton, lines 119–120).

Constructions of risk and threat were repeatedly drawn upon in the debates to help provide convincing rhetoric for the restrictions of liberties for those deemed to be “mentally disordered.”

Risk and threat. The debates suggested that mental disorder is a threat to society in moral (“greater good”) and social ways. Foucault (1965) argued that doctors have authority not because of their medical knowledge but because they are representing the moral demands of society. The impaired decision-making test, as suggested in the debates, constructed the psychiatrist as a fortune-teller and jailer for potential crimes—policing potential harm to others by detaining the mentally disordered:

That is why we have to consider, in terms of mental disorder, that there may be circumstances in which the psychiatrist thinks that there is a wider risk to society—not that the person has done something already, because this does not apply to mentally disordered offenders... We must accept that in some exceptional circumstances, there are actions that we, as a society, decide to take for the greater good. (Rosie Winterton, lines 2420–2426)

“We are always trying in legislation to prevent offending” (Rosie Winterton, line 2459). There appeared to be a conflation of “madness” and “badness” in mental disorder. The idea of a mentally disordered offender presenting a risk to others was also used as a justification for abolishing the treatability test and replacing it with an appropriate treatment test:

The treatability test is also a perverse incentive for people not to comply with treatment. Tony Maden, a forensic psychiatrist, has spoken to me about the fact that in Broadmoor, for example, lawyers have advised their patients not to engage with treatment because if it can be proved that they are not treatable they have to be released. (Rosie Winterton, lines 3293–3295)

Interestingly, the “mentally disordered” do appear to be constructed as having agency, even a “perverse incentive”—note the language of deviance here—when they are positioned as perpetrators and offenders. The successful replacement of the treatability test allows any intervention to be treatment and to be at a low level. As one politician remarked: “Everyone should deserve support, so everybody should be treated” (James Duddridge, line 3440)—seeming to legitimise the detention and treatment of more people. There no longer seems to be a requirement that a treatment should be effective, or that the person should actively engage with it.

There were also calls for the construction of mental disorder to be redefined to include “sexual deviancy,” by the abolition for the exclusion of sexual deviancy, making it a medical rather than criminal phenomenon. Prison sentences are usually time-limited, whereas one can be continually readmitted under section, giving greater freedom for the Act to be used as part of the imposition of moral order: “As I said, we remain convinced that the exclusion for sexual deviancy should go. Paedophilia and various other paraphilias can constitute mental disorders and there may well be treatment that can be offered” (Rosie Winterton, lines 1241–1242).

Medication and non-compliance. Medication and particularly non-compliance with medication formed the cornerstone of justifications that were presented for detention and CTOs. The assumption appeared to be that a patient needed to comply with taking medication in order to stay well. If the patient would not comply, then enforcement is suggested. There were also emotive suggestions that, if people with mental disorders did not comply with medication, it could result in suicide or homicide: “The last confidential inquiry into suicide featured 56 people who had stopped taking their medication during that time” (Rosie Winterton, line 2266); “The Zito Trust has reported that, according to 35 independent

homicide reports, non-compliance with medication was a contributory factor in 57 per cent of cases of breakdown of care that led to homicide” (Madeleine Moon, lines 5215–5217).

This implies that a patient being medication-compliant will prevent such tragedies. In addition, constructing people with mental disorder as non-compliant makes surveillance appear necessary.

Again, it was proposed that a CTO be used to ensure that the individual receives and takes medication as prescribed. The focus here is on the necessity of medication compliance, and emphasising the need for further controls:

Very often, the issue is not that the treatment is not available, but that the individual does not turn up for a depot injection, for example. That very often happens, and it is the sort of issue that we are trying to overcome. (Rosie Winterton, lines 9031–9033)

The politicians asserted that, if a patient deteriorates, it would often be the result of their failure to take medication or have contact with professionals:

Unfortunately, parents, carers and others would often have to stand by and watch as the patient deteriorated to such an extent that they had to go back in hospital for another detention. That could happen time after time. It often happened because people had failed to take medication and to stay in touch with health care professionals. (Rosie Winterton, lines 8881–8883)

The contributors to the debate suggested that compliance with a CTO could ensure that a patient is less likely to be detained in hospital. The need for continued observation was presented through the terminology of medication non-compliance and its consequences (potential suicide and homicide).

Discussion

This paper has presented a reading of the debates suggesting that mental disorder is constructed in selective and partial ways that justify and legitimise different interventions and

practices. Within a discourse analytic framework, since language is considered to be action oriented (to achieve certain effects in the world), the construction of mental disorder and the construction of its practices are not separate constructions—they are interdependent. Each discourse works to construct mental disorder and achieve different actions in the united objective of treatment and detention of people designated with that mental disorder. The reading of these debates has emphasised how mental disorder is constructed as a system, where it involved, for example, experts, bureaucratic processes, and societal disorder. The selection of the systemic elements suggests an important rationale for why the public must act and make it seem necessary for immediate legislative action. Specific justifications and actions can be drawn from these discursive constructions of mental disorder: Authority is ascribed to doctors based on an assumption of an objective and knowable reality of mental disorder in order to diagnose, detain and treat (“The Trusted and Medically Objective Expert,”); “experts” are allowed to deviate from the law and administer certain treatments, for example, ECT (“The Emergency,”); a structure is created that normalises mental disorder and its practices through a series of bureaucratic actions (“A Fair Process,”); “lay people” are involved in the treatment and detention of the mentally disordered to support psychiatric practices for example, CTO (“Supporting Subjects”); doctors are positioned to be able to make decisions on patients’ behalf (“The Decision-Making Impaired Patient”); the possibility of legal challenges are evoked to maintain the original legislation (“The Lawyer’s Field Day,”); and the restrictions of liberties for those deemed to be mentally ill, are justified by the notion of social disorder, for example, through the use of the detention and CTOs (“Societal Order,”). The results shared a commonality with previous literature; the emphases on risk and danger mirror the results of previous studies on mental health reforms (Harper, 2008) and policy (Moon, 2000). The arguments also echoed the ideas of control and discipline through observation that were claimed by Foucault (1977), the rhetoric of treatment as life-saving, for

example, ECT (Stevens & Harper, 2007) and the assumption that suicide is pathological (Marsh 2010). However, the discourses in the debates could have implications for those deemed “mentally disordered” as they provided a framework, not only for the construction of mental disorder but also how that “disorder” should be treated. The effects of these discourses are both general and specific in that this parliamentary debate not only forms part of a wider body of public texts that construct mental disorder in particular ways requiring particular responses, but it also led directly to the passing of legislation which codifies those responses, for example, CTOs. The following section will address the way in which these responses could be seen as problematic for a number of service users.

Problematic experiences of psychiatric practices

The constructions, in the debates, suggested that doctors are trusted and will make the right treatment decisions on the behalf of the patient. However, whilst many service users are grateful for medical intervention, other survivor accounts have described how treatment that was supposed to help exacerbated their suffering (see Lee, 2013). For example, Dillon (2011) described her psychiatric admission as an experience that “nearly drove me over the edge” (p. 145) and provided an unsafe environment. She was told by a psychiatrist that her memories of sexual abuse were delusions, part of her illness. Longden (2009) described her admission as a “savage and terrifying experience” (p. 143), and stated that the impact served to make the voices that she heard stronger and more aggressive.

The debates framed enforced treatment as necessary for those deemed “mentally disordered,” with the rationale that being treatment compliant would help the patient stay well. However, many professional and service user accounts suggest that this is far from always being the case: for example, Goldsmith & Moncrieff (2011) suggested antidepressants have been associated with increased suicidal thought and action, impaired cognition, increased anxiety, and aggression, among other effects. It appears that for some service users

medication might actually increase “mental disorder symptomology.” The debates did consider the issue of safeguards against the inappropriate or excessive use of ECT, but the practice has not been stopped, despite studies that show minimal support for its effectiveness with either depression or “schizophrenia,” and the strong evidence appears to be of its potential to cause persistent brain dysfunction (Read & Bentall, 2010). In addition to those associated with psychiatric treatments, a second potential problem that has been highlighted is the potential of this discourse to lead to excessive use of social control under the guise of “treatment.”

An alternative interpretation of the discourses as social control

A dominant assumption in the debates is that the practices are in the interest of all people designated with mental disorder. However, an alternative interpretation is that psychiatric practices within the legislation could be one of social control. The discourses could be argued to reflect the “political preoccupation of risk and the ‘politics of anxiety’ pervading the public imagination” (Vassilev & Pilgrim, 2007, p. 354) and the necessity to “control” the patient. This could be illustrated not only by the potential detention of the “mentally disordered” person but also by the CTO, which is framed as helping the patient stay well and suggesting it would be better than hospital detention. However, the CTO could simply represent a different form of restriction and it could be seen as a “metaphysical hospital”—the same disciplinary action within different physical spaces. Within this model, the patients would have the continual gaze of the professional upon them, judging their illness status and medication intake. Arguably, the CTO and its threat of possible observation could also exert more control over the patients through a sense of unknown omnipresence.

Limitations

As has been acknowledged, this paper represents only one interpretation of a particular group of texts and there could be different interpretations. In addition, this reading

of text cannot be situated outside discourse and the author could be accused of using rhetorical devices in order to privilege a certain interpretation (Jager & Maier, 2013). This study, in using a discourse analytic theory and method, has been unable to account for the personal motivations of politicians for adopting certain discourses (Willig, 2008).

Implications

Foucault (1981) resisted the pressure of practical “real world” recommendations, stating: “Critique doesn’t have to be the premise of deduction, which concludes: this is what needs to be done” (p. 84). Such practices and conclusions make subjects conform to a prescriptive, prophetic discourse (Foucault, 1981). Similarly, Judith Butler (interviewed by Bell, 1999) refused to conclude her work with “what is to be done,” as it pre-empts the problem of context and contingency. Is it ethical to recommend action without a certain knowledge of the future context? Therefore these implications represent only a broad guide to future research and practice.

Research. These findings relate to and are from a particular text at a particular time and further research analysing the language used in other political contexts (e.g., politicians’ public speeches on mental illness) would be of interest in determining whether these constructions used in the debates are dominant within political discourse. Discourse analytic theory and method can be used to continue to provide critical engagement with the presentation of mental disorder and practices related to it.

Clinicians. The amendments to the Mental Health Act in 2007 were directly relevant to psychologists as, under the new law, they can now exercise powers of compulsion as responsible clinicians. This study demonstrates how the use of language in the debates has shaped psychologists’ responsibilities as clinicians. In choosing whether or not to opt for such a role, it is important to recognise how the new powers given to psychologists are

predicated on particular constructions of mental disorder and the practices legitimised by those constructions.

Conclusion

This study has suggested ways in which mental disorder is constructed through particular, selective discourses, for example, “social (dis)order,” that help justify and legitimise different interventions and practices, for example, restrictions in the community. In framing mental disorder as a system (involving everyone), it can make psychiatric practices and government legislation seem necessary. However, at least for some patients, these treatments could be problematic and these amendments and psychiatric practices could be based on political and public concerns about social disorder.

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Section C: Appendix of Supporting Material

APPENDIX A

FURTHER INFORMATION REGARDING SEARCH PROCEDURES AND TERMS

The studies identified from the following two searches were immediately scanned for their appropriateness and 20 studies were initially selected for further investigation. These studies were examined against the inclusion and exclusion criteria that had been developed. The references of the relevant studies were manually searched for any missed studies that fell within the criteria and these were included in the review.

First Search

“Discourse analysis”

“Discourse”

“Discursive “

“Construction”

“Analysis”

AND

“mental illness”, or “mental health” or
“policy” or “newspaper(s)”, or
“government policy” or “policy” or
“text” or “articles”

Second Search (these terms were developed from scanning the studies in first search)

“Discourse analysis”

“Discourse”

“Discursive”

“Construction”

“Analysis”

AND

“autobiography” or “patients notes”
“biography” or “mental health” and
“journal” or “mental health” and
“manual” or “service user” and “mental
health”

APPENDIX B

Authors	Year	Analysis Guidelines Used¹	Type of discourse analysis²
Allen & Nairn	1997	Potter & Wetherell (1987)	Discursive Psychology
Andersen, Hasund & Larsen	2013	Fairclough (1992)	Foucauldian/Post Structuralist
Bilic & Georgaca	2007	Wetherell et al. (2001) Willig (2004)	Discursive Psychology & Foucauldian/Post Structuralist
Coverdale, Nairn & Claasen	2002	Wetherell (1998) Potter & Wetherell (1987)	Discursive Psychology
Crowe	2000	Fairclough (1992)	Foucauldian/Post Structuralist
Harper	2004	Edwards & Potter (1992)	Discursive Psychology
Hazelton	1997	Potter & Wetherall (1987) Lupton (1992)	Discursive Psychology
Hui & Stickley	2007	Parker (1992) Foucault (2001)	Foucauldian/Post Structuralist
Johnstone & Frith	2005	Potter & Wetherall (1987) Willig (2001)	Discursive Psychology & Foucauldian/Post Structuralist
Moon	2000	Castel (1988; 1991) Beck (1992; 1994)	Foucauldian/Post Structuralist
Nairn	1999	Ericson (1987) Van Dijk (1991)	Foucauldian/Post Structuralist
Nairn & Coverdale	2005	Wetherell (1998)	Discursive Psychology
Nairn, Coverdale & Claasen	2001	Wetherell (1998) Fairclough (1993) Potter & Wetherell (1987)	Discursive Psychology & Foucauldian/Post Structuralist
Olstead	2002	Foucault (1972) Van Dijk (1998)	Foucauldian/Post Structuralist
Rowe, Tilbury, Rapley & O'Ferrall	2003	Edwards & Potter (1996) Sacks (1992)	Discursive Psychology
Teghtsoonian	2009	Foucauldian Literature on Governmentality	Foucauldian/Post Structuralist

¹ Full references to the guidelines can be found in authors' original studies.

² Please note the types of discourse analysis given are not definite categories provided by the studies but are there to provide a guide to readers unfamiliar with discourse analysis.

APPENDIX C

Parker's (1992) Criteria for Discourse Analysis

Criteria	Analytic focus
A discourse is realised in text	Identify text to be studied and consider the meanings and connotations in the text.
A discourse is about objects	Objectify the text. Treating the text as if it were an object, a discourse and describe them.
A discourse contains subjects	Identify types of person who talk about the discourse. Speculate what can be said in the discourse and what rights they have to speak.
A discourse is a coherent system of meanings	Considering attempts at employing coherence and stable set meanings in the text.
A discourse refers to other discourses	Understanding how multiple discourses interact.
A discourse reflects on its own way of speaking	Understanding speakers' own awareness of their discursive incoherence and inconsistency and how this is managed.
A discourse is historically located	Discourses are located in time. Consider how discourse emerged and have changed.
Discourses support institutions	Identifying institutions that are reinforced when a discourse is used.
Discourses reproduce power relations	Categories of person that gain or lose from the employment of discourse. Who would want to promote or dissolve certain discourse?
Discourse have ideological effects	Discourses that connect with other discourses to sanction oppression.

APPENDIX D

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APPENDIX E

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