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Holly Jacqueline Riddle

An Exploration into the Personal Impact that TV Documentaries which Feature Mental Health have on Viewers with Lived Experience of Mental Health Conditions

This paper adopts a phenomenological approach to researching the personal impact of mental health documentaries on people with lived experience of mental health issues. An underlying passion to challenge the societal stigma of mental health sufferers directed the researcher to explore mental health from the perspective of those whose voices do not currently influence how they are portrayed to the audience. Four global themes emerged from the interviews; sensationalisation of mental health in documentaries, a lack of understanding of mental health disorders differing from the participants own, a fear of societal judgement, and only showing the most severe cases of mental health rather than a spectrum of severity. To adhere to the restrictions associated with this paper, of the four significant themes, two were selected for a fuller exploration due to their close relationship and to allow mental health sufferers to voice their experiences and conquer their suppression.

Keywords: Mental health, lived experience, personal impact, media, TV, documentaries



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INTRODUCTION

This paper uses a phenomenological approach to explore the personal impact that mental health documentaries have on people that have suffered with mental health problems. As a researcher, I have a genuine interest in this area; a desire to explore mental health documentaries from the perspective of those who are often put at the centre of the programmes, yet do not seemingly have a voice as individuals about how they are portrayed to the audience. According to Diefenbach (1997), an increase in the number of documentaries that feature mental health should reduce stigma against sufferers in society; however despite an increase in broadcasts featuring mental health sufferers, mental illness is still said to receive the most stigma today (Albrechet et al

1982). Many studies have established a connection between negative representations of mental health sufferers in the media and a negative attitude from audiences towards people with mental health problems (Coverdale et al 2002; Cutcliffe and Hannigan 2001). These studies have researched the process by which audiences without lived experience of a sensitive issue such as mental health, understand and make sense of the message and experiences portrayed through the documentary (Casebier 1991). This has led researchers to argue that documentaries allow the audience to create meaning and sense of the issues through the documentary's portrayal, i.e. the audience are observers through television documentaries (Moyano 2011). However, most of these studies examine the audience as people without experience of mental health problems, rather than those who have suffered from mental illness. Furthermore, very little has been researched into the connection between the representation of mental health sufferers in documentaries and the personal and individual impact this has on people who have experienced mental health illness themselves.

The mass media is said to be the primary source for audiences to understand mental health, with television described as the leading medium for the education of mental health in society (Duaso and Cheung 2003). As the main source of information about mental health, television is argued to have a fundamental responsibility as a medium to correctly inform individuals about mental health problems (Novas and Nikolas 2000). Consequently, it is important for broadcasters to recognise the effects that documentary films featuring mental health issues, have on sufferers with lived experience of the themes they broadcast, with a view to increasing non-sufferers' understanding of mental health, and reducing stigma and rejection from society in the future. (Borinstein 1992).

LITERATURE REVIEW

What is a Documentary?

There are currently more documentaries aired on UK TV than ever before (Chris 2002). Documentaries are factual programmes, showing cultural events that are relevant to the public sphere of society (Jensen 2007). Furthermore, documentaries are said to be an important resource for society to investigate cultural and social activity (Hassard and Holliday 1998). Developing this, Nicholls (2010) argues that documentaries address a hunger from the audience for fresh perspectives and alternative visions. Additionally, it is argued that documentaries featuring sensitive issues aim to educate and engage the audience, contributing to the evolution of humanity (Moyano 2011). However, this definition is disputed by Murry (2004) who states that modern documentaries should no longer be defined as factual programmes, but should be described as the meeting of documentary and reality TV. Jersleve (2002) supports Murry and states that modern documentaries have many characteristics of reality TV programmes, and this categorises the issues raised in the documentaries; particularly delicate ones, as entertainment rather than factual information. Medical documentaries which feature mental health are argued to attempt to bridge the gap between a lack of knowledge about the subject between sufferers and the audience through provoking mainly emotional reactions (Backus 2006).

The Audience

It is stated that the audience makes sense of the world through mass media consumption (Gamson et al 1992). However, as more audiences are taking control of their media environment, it is debated that some audiences may be starting to recognise the possibility that "what one sees on television does not necessarily reflect reality"

(Wicks 2000 p.4). Audiences in the UK are exposed to mental health through television programmes, with broadcasters often choosing mental health disorders as frequent themes to report on (Diefenbach 1997). One reason for this is argued to be the use of TV as a leading medium to cost effectively educate the audience about mental health (Austin and Husted 1998). Historical portrayals of people with mental health issues through art and theatre show sufferers as mad, dishevelled and with staring eyes (Cross 2004). Although modern society has developed some understanding and empathy towards mental health, often these historical stereotypes are reinforced through the representation of mental health sufferers in modern mediums such as newspaper, TV and radio (Blackman and Walkerdine 2001).

As a source, the media is said to be a destination where the audience gathers the most information about mental health (Coverdale et al 2002). Johnson (1970) referred to television programmes as a place to access and learn information. Because of this, media representations of mental illness are argued to be so powerful that they can sometimes both inform and supersede the audiences' own thoughts and experiences in relation to how they perceive the mentally ill (Rose 1998). Despite audience empowerment in this context, the media remains to be a key 'framer' of audience understanding of topics.

The active and the passive audience

Passive audiences are said to accept what the media tell them as truth (MacDonald 1957). Documentary films are described as "the creative treatment of actuality" (Nichols 2010, p.6), therefore passive audience members would assume that the way in which documentaries show mental health sufferers is a true, representative and honest portrayal. An active audience is said to respond to media content according to their own experiences with the topic discussed (Nightingale 2011). For example, audience members who have had experience of an extramarital affair will empathise more with the content than audience members who have not, and will be more likely to respond to it according to their own personal experience of the matter. "The more active the audience, the more resilient and resistant it will be to persuasion, influence or manipulation" (McQuail 1997 p.22), and therefore less likely to accept false perceptions of the issue they have experienced. My study will explore whether people with lived experience of mental health issues are more likely to reject the media's manipulation of their experiences; therefore investigating whether people with lived experience are the 'active audience.'

In the case of documentary films, an active audience can be more favourable than a passive audience to reduce stigma around mental health sufferers, although an inaccurate portrayal of mental health could negatively inform the audience and create false perceptions of mental health sufferers. The literature so far would suggest that most active audiences that watch mental health documentaries will have direct experience of mental health, whether this is through suffering themselves, or indirectly through supporting sufferers (Anderson 2003). Notwithstanding this contention, there has been debate as to whether the passive and active audiences remain so unconnected. Block (1996 p.1) argues that the passive and active audiences are too contrasting, and the audiences' acceptance of mass media is based on "their interest in the content, their direct experience with the content, and the importance of the content to them." The direct experience and importance of the content could be interpreted as lived experience of a mental health issue, or through working or living with people with mental health conditions. Furthermore, Block (1966) suggests that people with

experience of a mental health problem are more likely to be part of an active audience, and therefore are less likely to accept negative stereotypes and are more likely to form an attitude about mental health sufferers through their own experiences.

Cultivation Theory

In the UK, people spend an average of 28 hours per week watching television (Guardian 2013). Cultivation Theory devised by George Gerbner (2002), explores the unique relationship between television and audiences' beliefs about the world (Hammermeister et al 2005). Gerbner et al (2002) state that audiences who watch a lot of television will "reiterate, confirm and nourish" values seen in television programmes and reproduce them in day-to-day life (Gerbner et al 2002, p.49). He also states that "those who spend more time 'living' in the world of television are more likely to see the 'real world' in terms of the images, values, portrayals and ideologies that emerge through the lens of television." (Gerbner et al 2002 p.47). Furthermore, Moyano (2011, p.62) argues that in documentaries, "repetition is one of the most important components to highlight important messages." However, if the messages portrayed to the audience are incorrect or sensationalised, this could create false perceptions of mental health sufferers leading them to feel socially eschewed.

An example of this is a common portrayal on television of mentally ill people as most likely to commit crimes, be violent and be victimised (Signorielli 1989). Furthermore, people with mental health problems are also often depicted as lacking any social identity (Wahl and Roth 1982). This suggests that people who spend a lot of time watching television will learn and imitate behaviour and attitudes that they have seen on programmes about mental health and apply them to the 'real world.' Although much of the mass media portrays mental health sufferers in a negative light, it is important to also consider the positive impact that documentaries featuring mental health have on the audience and those with lived experience of mental health problems. Channel 4 have previously worked with mental health charities such as Mind, Time to Change and Rethink Mental Illness to create series such as '4 goes mad' which aimed to challenge mental health stigma and discrimination (Channel 4 2012). It is argued that documentary series that feature sensitive issues aim to evoke an emotional reaction from the audience (Nichols 1991), which can change public opinion, and reverse stigma (Cahill and McGaugh 1995). Mental health documentaries can be used as a tool for change and can contribute to a better and more informed understanding of mental health, eventually reducing stigma towards sufferers (Stout et al 2004).

Previous research on Cultivation Theory has used ethnography to study fictional programmes about mental health such as soaps and TV dramas (Warwick and Pirkis 2001). This paper has used in-depth interviews to understand the personal impact of non-fiction mental health documentaries on mental health sufferers.

Social Learning Theory

Social Learning Theory (Bandura (1977), Supports the concept that audiences learn behaviours and ideologies from television. Social Learning Theory "explains how people learn by observing the behaviour of others" (Kretchmar 2014, p.1). Bandura (1991) argues that people who watch television acquire knowledge about social norms and conduct. According to Stout et al (2004 p.544) this theory can be applied when the audience watches mental health documentaries as "television teaches social conventions of how to treat individuals with mental illness." Combined, Cultivation Theory and Social Learning Theory are complimentary. Stout et al (2004 p.544) state that "cultivation analysis provides descriptions of the recurrent messages that are being vicariously

learned via observation" (Social Learning Theory). Therefore, the audience directly relies on the mass media's portrayal of people with mental illness to form their own opinions of mental health sufferers in the absence of real life, lived experience of the issue (Link and Cullen 1986). In the absence of personal experience, if the information shown through the mass media is exaggerated or incorrect, this could create and reinforce false beliefs and opinions in society.

The Spiral of Silence

The Spiral of Silence is a theory developed by Elizabeth Noelle-Neumann in 1984. The theory focus' on normative influence and states that people may be afraid to speak out against the majority view in society. Rather than risk being isolated for articulating a view which opposes the mainstream opinion, Noelle-Neumann states that people are more likely to match their opinion to the majority view for fear of exclusion. It is argued that individuals rely heavily on the mass media when aggregating collective opinion. A fear of isolation is said to encourage the audience to look to the mass media for an indication of the mainstream view of issues through their "Quasi-statistical sense." This is said to be a sixth sense that people have to collect information about society's thoughts and feelings (Shamir 1995).

Those in society who share the dominant opinion are more likely to speak out, resulting in one opinion becoming predominant over time (Schedfele et al. 2001). This suggests that the media's portrayal of mental health becomes the 'mainstream' way of thinking, by acting as a socialising agent which creates a standardised view of mental health sufferers which ultimately becomes the 'mainstream' opinion. It is discussed that different mediums portray sensitive issues in a homogenous manner, resulting in a monopolistic media environment which strengthens the impact that topics in the media have when shaping audience opinion (Salmon and Glynn 1996). This monopolistic media environment, which creates a majority view, then makes it difficult for audiences to share opinions which may differ from the mainstream opinion created by the media. This is because the media reduces the range of acceptable viewpoints that can be expressed by the audience without the fear of being socially shunned (Matera and Salwen 1992). A fear of speaking out in modern society could mean that mental health sufferers conceal their mental health from employers, friends and family. Furthermore, the media is argued to "operate in ways that promote apathy, cynicism, and quiescence, rather than active citizenship and participation" (Gamson et al 1992, p.3). In documentary films, this may encourage a 'Spiral of Silence' amongst the audience, as the media tends to represent mental health sufferers in a negative and aggressive way. This may create a powerful mainstream of opinion in society and could force the audience to conclude that this is a true representation of how mental health sufferers behave in the 'real world'. Audience members with lived experience of mental health problems will be less likely to speak out against the majority view, therefore the mainstream public opinion of mental health sufferers will be created by the mass media, rather than through the experience of sufferers themselves, ignoring the voices of mental health sufferers or worse, discouraging them to speak at all. (Wimmer and Dominik 2013).

Conclusion

Previous studies have looked at the impact of mental health in fictional programmes but nothing has yet been researched on the direct impact of mental health documentaries on people with lived experience of mental health issues. In the case of my research, lived experience refers to anyone who has been diagnosed with a mental health issue that can relate to the content in a documentary featuring mental health as part of 'self-definition.'

My study will seek an understanding of whether people with lived experience of mental health problems feel that documentaries portray a true representation of them and their experiences, and what the personal impact of broadcasting documentaries featuring mental health has had on their lives and their perception of themselves in society.

METHODS

Aim: To explore the personal impact of mental health documentaries on people with lived experience of mental health conditions. **Objectives:**

1. To investigate mental health sufferers' experience of watching mental health documentaries
2. To explore whether TV documentaries that feature mental health encourage sufferers to talk about their mental health wellbeing in society
3. To investigate whether people with mental health issues feel that documentaries featuring mental health present a real depiction of mental health to society according to their own lived experience. I took an interpretivist approach to allow me to explore and reveal explanations, rather than assume them from measurements (Gratton and Jones 2010). An existential phenomenological approach was used to interview people with mental health issues to understand the lived experience of each separate individual. This interview style looks to achieve a first-person description of the phenomenon as lived by the participant (Thompson et al 1989). This enabled me to explore and document the individual experiences of each participant, with a view to producing rich descriptions and accounts, from which a profound understanding of each person's experience could be gained (Thompson et al 1989; Creswell 2007). Furthermore, using a phenomenological approach allowed me to extensively study participants through prolonged engagement, which developed themes and relationships of meaning (Moustakas 1994). This method was appropriate to my study because it enabled me to have a conversation with participants about their personal experiences of a sensitive topic. The conversation style of interview enabled me to build a rapport with the participants which led to interviews resulting in rich, in-depth content.

To partake in the research, participants were required to have a diagnosed mental health issue and to have seen a documentary featuring mental health within the last 6-12 months. A pilot interview was conducted on a friend with OCD and anorexia, however other participants were recruited through two established mental health services; Bournemouth University's Additional Learning Support Service and Dorset Mind, inviting participants to a 'conversation' with me via email. This ensured that due to the sensitive nature of the topic, participants were at a low risk of vulnerability regarding their mental state. To ensure this, I needed to make sure that each participant was able to live safely and independently in society, this was also addressed in the ethics checklist carried out before the research took place, and in the consent form signed by each participant.

Furthermore, I chose to invite participants to a conversation to avoid the pressure of an 'interview', and this style also aligned with the method I adopted: "The interview is intended to yield a conversation, not a question and answer session." (Thompson et al 1989, p.138). All seven interviews were natural conversations with the participants, resulting in deep and meaningful content. Although initially anxious, I found that I was comfortable to initiate conversation without prompts or questions. Additionally, I made a conscious effort not to impose themes from earlier interviews on the conversations.

Six participants were recruited through the university, one through Dorset Mind and one other participant through a family friend. In total, there were five female participants and two male participants. As women are more likely to talk about their mental health and their feelings than men (Tousignant et al 1987), this could explain the small sample of male participants who volunteered to take part in the research. Participants were not required to have a specific type of mental health condition and these were not disclosed until the beginning of the interview. This resulted in the exploration of a broad range of conditions as listed in the table below. Furthermore, due to the diverse nature of mental health, as a researcher, I had to learn and adopt different approaches to my questions and responses according to the nature of the participants' mental health issue.

Table 1 Respondent Profiles

Name	Age	Gender	Mental health issue
Chris*	23	Male	Anorexia and OCD
Jenny*	54	Female	Manic Depression
Katie*	36	Female	OCD
Lucy*	20	Female	Anxiety and Depression
James*	28	Male	OCD and Depression
Moya*	21	Female	OCD and Seasonal Depression
Masie*	23	Female	Bipolar

Due to the sensitivity of the research topic, I used in-depth interviews to enable me to gain the trust of the participants; an important element of the research to ensure that detailed, authentic experiences were recalled (Powell et al 1996). In-depth interviews are described by Nykiel (2007) as one of the best qualitative methods to use to gain a thorough understanding of personal beliefs, values and opinions. A pilot interview was conducted to assess whether as a relatively inexperienced researcher, I was able to confidently initiate conversation without a guide. The pilot interview was extremely successful and produced strong content which has been included in the results. Although stimulus was used in the pilot interview, this discouraged a natural flow of conversation and did not ring true to the phenomenological style of interview I had chosen. Consequently, I did not use any stimulus in the interviews, creating an informal and relaxed atmosphere which encouraged natural, in-depth conversation about the

participant's lived experience. This allowed me to generate questions based on the participant's responses which meant that each interview followed a different conversational path, but produced global themes which are highlighted in the research findings.

To overcome the ethical issues related to the in-depth nature of a phenomenological style of interviewing, informed consent was attained. Participants were informed that the interview would be recorded, the purpose of the study explained, and anonymity and confidentiality assurance was provided throughout the interview and in the results of the research (Thompson et al 1989). Due to the changeable nature of mental health, interviews were carried out at Bournemouth University, to provide a safe and familiar environment for both myself and the participants. This made the interviews more valuable; participants felt relaxed and comfortable to talk to me in familiar surroundings, reducing pressure on the participant. The interviews proved extremely successful and as a researcher I tried to be as authentic as possible, avoiding using early themes from previous interviews to gather momentum in successive interviews.

The analysis of results was performed using hermeneutical circles and global themes. This involved studying each interview transcript individually, before relating the separate interviews to each other to discover common patterns (Thompson et al 1989). The common patterns were then identified as 'global themes' and are the findings of the research (Kvale 1983). I identified global themes by ascertaining where one participants' experience was similar to another; or in phenomenological terms, "where respondent intentionalities are the same" (Thompson et al 1989, p.142). To ensure that I identified these correctly, it was important to transcribe each interview and refer back to the transcripts to ensure that the themes were not removed from the individuals' experience.

A phenomenological approach "asks participants to search for the essence of their lived experience", with a view of understanding the participants' experience through the interviewer's point of view; or 'interpretation' of the participants experience (Seidman 2012, p.17). As a reader, it is important to remember that although I have interpreted themes from the participant's accounts of their own lived experiences, it is never possible to fully understand another person perfectly. To do so, I would have to have experienced what he or she has experienced and entered into their stream of consciousness, effectively becoming the individual (Schutz 1967). Consequently, the reader should identify that they are reading my interpretation of the lived experiences of the participants of the research. By avoiding the use of preconceptions and prior assumptions, my understanding of each individual grew throughout our conversations, enabling me to build trust and rapport with the participants, leading them to speak openly and honestly about their mental health experiences (Damon and Holloway 2011). As a researcher, this allowed me to interpret and present the findings in the most honest way possible, increasing the confirmability of the research (Bryman and Bell 2011). Consequently, in addition to helping to produce rich, in-depth content, this enabled me to understand each individual as a human being, and therefore has increased the credibility of the research through a deep understanding and personal connection with each individual. As well as connecting on a personal level, I also avoided influencing the interviews with early themes, and therefore evaded steering the conversation according to emerging themes or theories in the literature.

DISCUSSION

After individual analysis of each participant's transcripts, I was able to identify four important global themes that show the personal impact of viewing mental health documentaries on people who suffer from mental health issues. These were the sensationalisation of mental health, a lack of understanding of mental health disorders which differ to the participants own, a fear of how society judge's people with mental health based on documentary coverage, and focussing on the most severe cases of mental health, rather than a spectrum of severity. Although of equal importance to the research aim, this paper will provide an in-depth discussion on the severity of mental health conditions and a fear of societal judgement, due to the restriction of the size of the paper. It was also interesting to recognise that when investigating mental health sufferers' experience of watching mental health documentaries, the individual experiences discussed were recalled in a different manner according to the participants' mental health issue. For example, the participants with depression were particularly thoughtful about their responses and had a tendency to view their condition as 'boring' in comparison to other mental health disorders such as Bipolar and Schizophrenia.

Age was also something which affected participants' perceptions of their mental health. Three of the youngest participants, particularly Lucy, Masie and Chris did not see their current mental state as a condition that they would re-encounter throughout their lives. Participants with a longer experience of mental health such as Jenny, James and Katie were much more accepting of their mental health conditions and were able to talk about experiences of a longer mental health journey. This could be because they have had time to learn how to manage and understand their mental health issues. In contrast, younger participants were all diagnosed at the age of eighteen, an age where it is seen as important to fit in and conform to society's norms. This should remind the reader of the importance to remember that each participant is at a different stage of their mental health condition, and each experience is personal and individual according to the condition and the participants' environment.

Focusing on the most 'extreme' cases of mental health

Mental health is an individual, personal journey; therefore each participant has experienced a different degree of severity of their mental health condition, from very mild to very extreme. Of the seven participants, Jenny, Moya and Masie have been institutionalised as a result of their mental health condition, and although still suffering debilitating symptoms, Chris, Katie and Lucy have been able to manage their mental health with help from a doctor, but without intervention from a mental health institution. It was interesting to determine that although each individual had suffered from varying degrees of severity of mental health conditions, an important theme that emerged was that documentaries only appear to portray the most severe and therefore most debilitating cases of mental health to the audience.

Addressing objective one, Lucy (20), suffers from depression and anxiety but does not relate her experience directly to most cases of depression depicted in documentaries because sufferers are often shown to be suicidal. "They don't portray all extremes... sort of portraying those programmes they're showing people that are committing suicide, and that are you know, really really troubled... whereas there are people that are sort of in between. " Lucy finds people expressing suicidal thoughts on documentaries distressing; and although she has depression, she does not consider herself as someone who is suicidal; something that she feels is a common stereotype of depression in society. As the conversation developed, it was clear that whilst exhibiting

a range of extremities of depression, Lucy was also passionate about illustrating ranges of age, gender, and ethnicity within mental health documentaries.

“Well like I said, just showing sort of like a more diverse range, maybe ages, and stages of like the condition that they've got, whether its schizophrenia or depression or whatever, just to... I don't know, just it's a very, like it's just showing one extreme really, so if they showed a few different stories, different age groups, different ethnicities, like just get a broader range... It's all sort of like, in the schizophrenia and depression on that channel 4 one it was all sort of like middle age 40 30 that kind of thing... I think there was one young girl on it that was like 20 odd but it sort of just focused on like 21 plus, and there are you know, people that have dealt with it a lot longer, and a lot older too, like I know that my gran had depression at the age of like 89... which you just wouldn't think would you?”

Lucy suggests that using a spectrum within mental health documentaries of both the mental health problem featured and the people that suffer from it would offer a deeper understanding of depression for the audience, which in turn could reduce stigma towards sufferers. Katie is a 36 year old mother of two who has suffered from OCD since she was eight years old. Katie's OCD remained undiagnosed for over ten years; at one point in her early twenties the condition became so debilitating that she was unable to leave the house for three years. Katie shared two conflicting experiences of watching mental health documentaries that featured her condition. Positively, she relates watching documentaries that feature people with severe OCD as the encouragement she needed to seek a diagnosis in 2004.

“It was a television programme; it was genuinely a television programme... I don't remember much about it, but I can remember at the end um, there was, it did have one of those if you've been affected please look at this, and there was websites, and I, from there I looked on the web, cos everything that they were saying on this TV programme was like me, so I looked on the websites and the websites had a checklist and I marked nearly every one of the checklist, so I went to the doctors the next day and it was like... it was the first time I'd ever told anybody so of course, it was very tearful kind of thing, to actually say to the doctor 'I think I'm this' and they umm he was amazing my doctor, he's not good with illnesses, but he was very good with the mental health (laughs). Umm, no he was brilliant wrote me a letter to the psychiatrist person and then yeah, they took it from there, so it was genuinely a TV programme that did it.”

This supports Block (1996) who argues that the audiences' acceptance of mass media is based on their interest and experience in the content. Furthermore this addressed objective two, showing that Katie was encouraged to talk about the symptoms she identified with in the documentary resulting in her diagnosis. However, although initially a positive experience, Katie now finds watching documentaries that feature extreme cases of OCD frightening, as she identifies that the condition could overtake her life in a similar manner to the people featured in the programmes.

“You kind of worry, because I go up and down. At some points in my life I'm better, and I can see when it's starting to get worse again, umm, and I suppose... when I see it in somebody, when its much worse, then suddenly I think that could be me or, I could get to that stage or, cos obviously it's perfectly within my capability of going down that route I suppose.”

This demonstrates how Katie's engagement with documentaries has changed from pre to post diagnosis. Katie's determination to seek diagnosis was triggered as a direct result of seeing a documentary featuring OCD on television. Supporting Block (1996), she

continues to engage with, and interpret the information presented in documentaries according to her own experience of OCD. However, now diagnosed with OCD, the programmes which led to her diagnosis leave her frightened about the possibility that her condition could replicate that of the severe sufferers highlighted in the documentaries. Relating to objective one, this shows how her experience of watching documentaries has changed from positive to negative, pre-to- post diagnosis. Another participant that talked about the frequency of documentaries showing severe cases of her condition was Moya (21), who suffers from seasonal depression and anxiety. She indicated that TV companies use extreme cases of mental health to create entertaining television for the audience.

"The way they choose people with the most severe form of the disease because it makes good television – they won't depict people in everyday situations, they'll focus on people with very bad OCD... there is the balance it's not always down and it's not always up you kind of have up and down kind of things."

Moya believes that extreme cases of mental health need to be documented, however they need to be balanced with sufferers' day to day coping mechanisms, in addition to illustrating that mental health does not have to prevent sufferers from living a 'normal life.'

"We have had paramedics break down my door and like we have we have been, I have been there... but that's not the sum of my being, that is not my main mental health that's my very lowest point, and for them to pick that out as the main kind of signifier of mental health is... distinctly false because it's not... it's not the main thing I experience. The main thing I experience tends to be the day to day kind of down where I can't kind of read or think so it's more that kind of down time."

This addresses objective three, and illustrates that in Moya's case, although the documentaries that show extreme forms of depression including suicide cause her to empathise and relate to the sufferers, she feels that this is not an accurate portrayal of depression as these are not the only aspects of depression that should be shown to documentary audiences. Moya believes that depression is perceived as a 'boring' mental health issue, therefore TV programmes need to use extreme examples of the condition to make the content interesting. Moya states that to show the audience a true depiction of depression, in her experience, documentaries should show explain how mental health sufferers cope with the day-to-day management of their conditions. Furthermore, Moya talked in detail about the audience reaction to broadcasts of extreme mental health. Due to her studies of Media at University, Moya demonstrated a profound understanding about the reasoning behind documentary's excessive accounts of the symptoms of mental health conditions. It's probably a post filming agenda, I think they see what they've got and see how they can make it best fit the publics' interest, I think that's the nature of television. I don't think its overly ethical, especially when you're making a documentary to make it... it's more higher up the ladder, more executive producers really saying this needs to follow a certain... or they're given, not given, but follow a certain... you have to kind of make a storyline out of it, there has to be peaks and troughs, you have to show people at their lowest."

As a young person with depression, Moya's thoughts and opinions were similar to those of Lucy, in that TV documentaries only show people with depression as extreme and middle class.

"I watched one and then I wasn't inclined to watch it again, was umm the episode where he was very middle class and he kept trying to kill himself, and I think that's

probably the only, depiction, I think... There's always this depiction that every form of mental health problem is extremely debilitating, whereas from my experience most people living with mental health problems just get on with it, so this, this kind of... it kind of creates a negative image, a negative stereotype of people's mental health problems. Like, if you tell someone you have mental health problems they then assume that you're like the people they see on the telly... the kind of people that can't function, they're on mental wards, like they can't go outside because of dirt and stuff like that whereas in my experience that's not the case."

Referring to objective three, it came across powerfully that participants felt TV documentaries showing extreme cases of mental health conditions could give society a false perception of mental health sufferers, creating a negative stigma against people with mental health problems. Broadcasting extreme accounts of mental health sufferers supports Salmon and Glynn (1996) who state that showing sensitive issues in a homogenous manner results in a monopolistic media environment that in turn, strengthens the impact that sensitive topics have on shaping audience opinion. This research suggests that sufferers believe that only presenting extreme cases of mental health in a homogenous manner contributes to a negative and misunderstood audience perception of mental health sufferers. In relation to objective three, although the research shows that people who have experienced severe forms of their mental health condition can relate to the severe depictions of mental health in documentaries, it is clear that this is not the only characteristic of their condition that they have experienced. Therefore, to present a true portrayal of mental health according to sufferers' own experiences, TV documentaries also need to show how sufferers cope with and manage mental health on a day-to-day basis. Furthermore, this also supports Cultivation Theory (2002), which states that audiences, who spend more time watching television; particularly documentaries depicted as factual and unbiased, will apply the images and behaviours that they have seen to the real world. Showing extreme versions of mental health disorders could create and reinforce negative stereotypes of people who suffer from mental health, without explaining the condition to the audience. This research suggests that mental health sufferers believe that an audience without experience of a mental health condition will lack an understanding of it and therefore will be more inclined to learn from the extreme cases depicted in documentaries, and apply those learned stereotypes to people with mental health difficulties.

Fear of Societal Judgement

As discussed in section 3.1., exemplifying extreme cases of mental health on TV documentaries can sometimes lead sufferers to believe that audiences stereotype mental health sufferers according to the severe portrayals they see on television. The research undertaken found that this can then lead sufferers to fear the judgements that society makes against people with mental health issues, according to the stereotypes created by showing severe cases on TV.

Masie, (23), was diagnosed with bipolar disorder 18 months ago and as she has only suffered from one episode, does not see her condition as something which will reoccur in the future. Although she has an optimistic outlook on life and is positive about the state of her mental health, it was clear from our interview that she is fearful of how society would judge her if she were to tell people that she suffers from her condition.

"Like to be honest I haven't told very many people because it's only been couple of years, I've told like my close friends and obviously my uni friends and everything because they were there and they saw me and they called my mum and the doctors and stuff... but I don't often tell people, to be honest. I'm just worried about what they're gonna think. I don't know, I just don't tell people. I would love to be able to like, talk to people openly about it but I still think like, if I don't know someone that well I don't really know what they're like or really what their judgements are about it."

I asked Masie about her thoughts on the origins of peoples' judgement about bipolar. After a short pause, she revealed that she believes the judgement stems from representations of mental health on television, primarily documentaries, as they are purported to be factual and therefore believable to the viewers. The fact that Masie states that she would like to be able to talk openly about her mental health with people, confirms that she is not embarrassed or uncomfortable with her bipolar disorder. However, she is uncomfortable with the stereotype portrayed through documentaries; she fears that people will judge her condition based on what they have seen. This forces sufferers like Masie into a continuous cycle, and illustrates elements of Cultivation Theory, as Masie is concerned that the audience will apply the documentary generalisations to all sufferers of bipolar disorder. Due to a fear of social stigma, she is then forced into a Spiral of Silence for fear of being socially rejected. This addresses objective two and shows that rather than encouraging sufferers to talk about their condition, documentaries can discourage sufferers to talk openly about their mental health.

Another young female who is fearful of how society judges her based on her mental health condition is Lucy. Although at first she demonstrated light-heartedness in relation to disclosing her condition, beneath her calm exterior it was evident that she is frightened about peoples' perceptions of her if she reveals to them that she is from an affluent background and is well travelled, yet has depression.

"In society, like it's kind of like you do shy away if you've got something wrong. I think in like, our society, like it's sort of like there's that pressure to sort of be happy, like look happy, like you can't... if you're, or you appear to be sad, then people are going to look at you and think 'oh she's boring like or she's like so down all the time' or like, you've just gotta put on like a persona so that people don't think that of you."

Like Masie, this also demonstrates that as a mental health sufferer, Lucy has been forced into a Spiral of Silence. It can be understood that Lucy withholds her depression from society because of her 'Quasi-statistical' sense of society's pressure to be happy and carefree. Lucy exhibits a persona to conform to her perception of how she should conform to society's norms, which as a mental health sufferer, causes her to feel marginalised and isolated.

In contrast, James (28), a mature student who suffers from a form of OCD which culminates in obsessive thoughts, reveals that over the ten years of his diagnosis, he has become comfortable with his mental health condition and no longer worries about conforming to societies 'norms.' James describes his OCD as an important part of his personality, and argues that talking about his condition gives people the opportunity to try to understand it, rather than judging OCD based on someone that they have seen on TV. If there is one other thing that you might take away from this, is that everyone suffering... everyone's issue is going to be different. I am not going to be able to separate myself from the condition; it is part of me... It took me a long time to get to this point. I

used to be worried about what everyone thought of me. To a certain extent I still am, to a certain extent. Though it's not so bad now. I am not going to go home and worry why that person did not like me. If they don't like me - then fuck it, it's their loss.

This contradicts Tousignant et al (1987) whose theory states that women are more likely to talk about their mental health issues, than men. Lucy and Masie are distressed at the thought of sharing their mental health experiences in society, even to friends and family, for fear of being socially rejected and isolated. Contrastingly, James displays a belief that alongside helping the audience to understand mental health through factual content, talking to people about his OCD will break the Spiral of Silence, reducing the stigma associated with mental health sufferers. In relation to objective two however, James' willingness to talk about his OCD in society does not directly stem from watching TV documentaries. However, talking openly about mental health could help to integrate sufferers into society by raising the awareness and understanding of individuals without lived experience of mental health conditions.

CONCLUSION

In conclusion, the research suggests that mental health documentaries have a significant personal impact on people with lived experience of mental health issues. Although one participant recalled an initial positive experience leading to her diagnosis, primarily the research suggests that the way in which documentaries portray mental health sufferers has a profound impact on sufferers' views and attitudes about themselves, often leading to negative feelings and sentiments about how they are perceived in society. In a one to one situation, many of the participants presented a strong rejection of false depictions in documentaries which lead to social stereotypes. However, to me as a researcher, a powerful yet upsetting theme that emerged was that participants did not feel comfortable about revealing these rejections to society for fear of being rejected themselves. This suggests that although documentaries are said to be an important resource in the investigation of cultural and social activity (Hassard and Holliday 1998), they are, in the experience of those who suffer from mental health, creating further stigma and rejection through the portrayal of sufferers as erratic and extreme, rather than showing how they can cope with day to day societal norms. Depicting sufferers at their worst as violent, heavily medicated and institutionalised, reduces non-sufferers understanding of mental health conditions, and supports Kretchmar (2014), who asserts that this mode teaches the audience how to treat mental health suffers in society. From this, it can be understood that as a main medium of learning, documentaries ultimately contribute to a Spiral of Silence, inhibiting the understanding of mental health in society by alienating sufferers and leading them to withhold their condition from family and friends and adopt a quasi-statistical façade to avoid feeling eschewed.

Despite the differences in the participants' willingness to talk about their mental health within society, the research shows that as sufferers, each participant is very much part of an active audience when watching documentaries about their own diagnosed condition. It is evident that each participant can identify to some extent with the representation shown on TV documentaries, and although they would not necessarily voice this in society, they reject the representations shown, having developed a resilience to the broadcasted stereotypes according to their own experiences of the mental health issue. However, in support of Block (1996), a powerful leaning of the research showed that when watching a mental health documentary that featured a mental health condition that sufferers did not have experience of, participants

showed the elements of a passive audience, supporting the literature which states that the audiences acceptance of mass media is based on “their direct experience with the content and the importance of the content to them” (Block 1996, p.1). Although participants demonstrated powerful emotions in relation to their personal rejection of the stereotypes that documentaries reveal about their own mental health condition, it was clear that participants also contribute to a Spiral of Silence concerning mental health by accepting the portrayals of other mental health conditions shown on documentaries, and lack an understanding, or desire to understand, other conditions in the way that they implore the audience to understand theirs.

Although a large amount of research has been carried out on the effect of documentaries on the audience, very little research has been carried out on the impact of sensitive TV documentaries of the featured issues. This paper contributes to research on the audiences as viewers with experience of the topic, and also fills a gap in the literature about the direct personal impact of broadcasting sensitive issues in documentaries on audience members with lived experience of the issue featured. Further research could be carried out to explore the impact of documentaries on people with lived experience of other controversial topics such as prostitution, teenage pregnancy, crime and those living in poverty. There is scope for further research into mental health conditions and the impact of the additional two themes identified in the study; sensationalisation of mental health to create entertaining content, and a lack of understanding of mental health issues which differ from the participants own. Furthermore, the research could be repeated on a specific mental health disorder, to address the differences in participants’ responses in relation to the mental health issue they had experienced.

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