VOLUME I: RESEARCH COMPONENT

THE IMPACT OF MEDIA ON MENTAL HEALTH

by

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A THESIS SUBMITTED TO THE UNIVERSITY OF BIRMINGHAM FOR THE DEGREE OF DOCTOR OF CLINICAL PSYCHOLOGY

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THESIS OVERVIEW

This thesis is submitted to the University of Birmingham in partial fulfilment of the requirements for the degree of Doctorate of Clinical Psychology. The thesis comprises of two volumes.

Volume I reports a systematic review and an empirical research paper. The systematic review examines the efficacy of media interventions in changing attitudes and intentions towards help-seeking for mental health difficulties. A systematic search of relevant databases identified sixteen studies suitable for the review. The included studies encompassed a range of media approaches, including web and internet-based interventions, audio-visual interventions and print interventions. Findings were inconsistent suggesting there was a small-to-moderate effect of interventions on help-seeking attitudes and intentions. Studies were limited by methodological and reporting issues meaning that currently it is not possible to determine the utility of media interventions in targeting help-seeking for mental health difficulties.

The empirical paper reports a qualitative study investigating the impact of the media on recovery of men in forensic settings. Interviews were conducted with male service users residing in Medium Secure Units (MSU) and were analysed using Interpretative Phenomenological Analysis (IPA). Five superordinate themes, and a further nine sub-ordinate themes were identified. A *Double-Edged Sword* identified participants' views that the media often gave positive or negative experiences. *Blind to my Experience* and *No Escape from an Unwell Me* gave experiential accounts of the media omitting important aspects of their lives and preventing them from moving on beyond stigmatising labels and sociological stereotypes. These experiences could hinder recovery for some participants. *Hope and Growth* identified positive experiences arising from the media that encouraged

hope and growth in recovery. However, participants' recoveries were not always affected by media experiences and were dependent of the *Transformative Nature of the Experience*. This was based on participants' psychological flexibility, social circumstances and coping skills. The discussion focuses on theories around narratives and stigma, and reports clinical implications, future directions for research and the limitations of the study. Volume I also contains a public domain briefing paper, which provides an overview of the systematic review and empirical study.

Volume II documents the clinical component and contains five Clinical Practice Reports (CPR) completed over the course of training. The reports represent clinical and empirical work carried out during placements in an adult mental health forensic service, an older adult hospital service, a community learning disabilities service and a specialist eating disorders service. CPR 1 presents a cognitive-behavioural and psychodynamic formulation of an adult male experiencing psychosis. CPR 2 presents a single-case experimental design evaluating the effectiveness of a cognitive-behavioural and staff intervention for an adult male demonstrating challenging sexual behaviour. CPR 3 presents a service evaluation examining the role of consultancy in a community learning disabilities service. CPR 4 presents a formulation and intervention with an older-adult experiencing medically unexplained symptoms. CPR5 is an abstract of a presentation on the use of compassion-focused therapy with a woman experiencing an eating disorder.

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Introduction

Context of the Review

It is estimated around 38.2 per cent of the European population experiences some form of mental health difficulty in any one year (Wittchen et al., 2011). Evidence suggests that despite this prevalence, around 52 to 89 per cent of people will not seek formal treatment (Alonso et al., 2004; Thornicroft, Rose, & Kassam, 2007; Wang et al., 2005; Wittchen & Jacobi, 2005). In Europe, only around 26 per cent of people with mental health difficulties sought formal help over a 12-month period, with an even smaller percentage of people accessing services from specialist mental health professionals (Mojtabai et al., 2011).

Although some individuals will recover without formal healthcare, evidence suggests that an absence of formal professional involvement can have significant consequences (Dell'Osso, Glick, Baldwin, & Altamura, 2013). The literature highlights that longer durations of untreated psychosis lead to significantly poorer outcomes for individuals, including increased risk of harm to self or others, slower remission of positive symptoms and poorer social functioning (Álvarez-Jiménez et al., 2012; Boonstra et al., 2012; Crumlish et al., 2009; Harris et al., 2005). Delayed treatment for mood disorders and generalised anxiety also leads to symptoms that are more severe and less responsive to treatment (de Diego-Adeliño et Al, 2010; Altamura et al, 2008).

Low healthcare utilisation can be attributed to a range of structural, personal, and societal barriers. Studies have differentiated between structural and personal/individual determinants of help-seeking (Barker, Olukoya, & Aggleton, 2005; Gulliver, Griffiths, & Christensen, 2012). Individual factors include personal beliefs, internalised norms, personal coping skills, self-efficacy, and perceived stigma. These are thought to interact with structural factors like social support, inconvenience, availability, accessibility, and

affordability of a health system. Mojtabai et al (2011) proposed that attitudinal and evaluative factors are more important than structural barriers both to the initiating and to the continuing of treatment for mental health difficulties.

Considering the importance of personal attitudinal and belief factors, researchers have explored how they are influenced; one such influence is the media and its content. Research has suggested that media consumption can promote better knowledge and literacy of mental illness, which are associated with higher help-seeking intentions (Burns & Rapee, 2006; Jorm, 2000; ten Have, Ormel, Vilagut, Kovess, & Alonso, 2010). In contrast, it can also generate mental health related stigma, which can affect how a person seeks help for a mental health difficulty (Clement et al., 2015). Reducing the negative effect of various types of stigma on help-seeking is a common area for media campaigns (Clement et al., 2013).

This review will consider how the media interventions use this understanding of help-seeking to change attitudes, intentions and behaviour for mental health difficulties. In order to conduct the review, definitions and a theoretical understanding are required for both media and help-seeking. This will provide both the rationale and the criteria to conduct the review.

Mass media

A significant body of research has attempted to define the term "mass media". Potter (2009) examined numerous definitions and proposed that mass media can be described as:

> *"organizations that use technological channels to distribute messages for the purpose of attracting an increasingly large audience and conditioning those audiences for repeated exposures so as to increase one's resources such that the enterprise is at least self-supporting".*

Potter (2011) also argues that focus should not be on the specific channels used to communicate, but more on the sender and their intentions.

In contrast, the idea of media channels has been proposed (Sullivan, Dutton, & Rayner, 2003). It is argued that seven channels of media exist, as outlined in Table 1, and all media can be placed into one of these categories. Criticisms of this idea are that in the modern world, media channels are no longer as easily distinguished (Crosbie, 2002). In addition, mass media may be an encompassing term for channels of communication intended to reach a large number of people without person-to-person contact (Brinn, Carson, Esterman, Chang, & Smith, 2010; Clement et al., 2013). These factors have been used when creating a definition and inclusion exclusion criteria for this review.

Table 1: The Seven Mass Media Concepts Included in the Review

Channel	Example sources
Print	Books, Newspapers, Pamphlets, Magazines
Recordings	Gramophones, Tapes, Cassettes, CDs, DVDs
Cinema	Cinema
Radio	Radio broadcast
Television	Television series, documentaries, factual, historical
Internet	Websites, forums, social media plus all of the above
Mobile Phones	All of the above

In summary, the media is difficult to clearly conceptualise. For the purposes of the review a combination of the ideas outlined above has been used to generate a definition of media as follows:

> *The use of technological channels of communication used by organisations to distribute their message, with the intent of exposing a large number of people to the message being communicated without interpersonal contact. The aim of which is to affect a cognitive, attitudinal, belief, affective, physiological or behavioural change in an individual or social entity.*

Help-seeking

Help-seeking is a general term that describes a range of behaviours related to actively seeking help from other people. This process involves individuals communicating their needs, problems, or distress with others in order to gain help in the form of information, guidance, understanding, or treatment. This can be from a range of sources; from professionals with distinct and professionally trained roles, to informal help that includes friends and family. This lends to the idea that help-seeking is coping that is based in social relationships. However, more recently help-seeking may also involve non-direct contact with others in a pseudo relationship, such as the internet or mobile phones.

Numerous models are available to explain help-seeking or behaviour change, however this is beyond the scope of this review. A brief inspection of the literature indicates that there is little consensus on a universal framework for help-seeking. Studies frequently provide heterogeneous definitions and methodological discrepancies across studies are highlighted within the literature. Subsequently, there seems limited agreement on all the components.

Despite this lack of a universal framework, Gulliver, Griffiths, Christensen, and Brewer (2012) conclude that research into help-seeking has provided three core areas of help-seeking: attitudes towards help-seeking including beliefs or willingness to seek help, help-seeking intentions, and actual help-seeking behaviour, and that attitudes and intentions can predict help-seeking behaviour. These aspects of help-seeking are present at all stages of this process, encompassing initiation of, and engagement with, professional formal services related to healthcare (Kovandžić et al., 2011). This review will identify the attitudes, intentions and behaviours as outlined by Gulliver, Griffiths, Christensen and Brewer (2012).

How interventions might work

Edney (2004) and Smith (2015) both describe the media as one of the most significant influences on individuals and society, impacting upon our beliefs, attitudes, and behaviours. Media interventions therefore have the ability to change help-seeking attitudes, intentions, and behaviour, although this is not always their explicit aim, known as the mass media effect. Potter (2011) summarises that the mass media effect can be measured in six domains: cognitions, attitudes, beliefs, affect, physiology, and behaviours taking place across a range of social levels. These are defined as: the individual level, where the person is used as a measure of change and outcome; group level, where measures would be concepts like group cohesion, interpersonal interactions and group opinion; and organisation level, whereby measures may be stigma, openness, or rigidity. In summary, the six domains the media is conceptualised to effect can take place across these three levels, which is an important concept for studies to examine in regards to the review question. Therefore, media interventions attempting to improve help-seeking would address the factors from help-seeking models and work across these societal levels.

Objectives of the Review

For the purpose of the review, help-seeking refers to attitudes, intentions and behaviours toward utilising formal help from a mental health professional. The primary aims of the current systematic review are to assess the effectiveness of media interventions at changing help-seeking attitudes, intentions, and behaviour related to mental health. Two main questions will be asked of the literature:

1. What is the effectiveness of media interventions in changing mental health help-seeking attitudes, intentions and behaviours when compared to either a control or comparison group?
2. Which channels of media are most effective at improving help-seeking attitudes, intentions and behaviours for mental health?

Secondary objectives will use criteria devised by Noar (2006), who argued that media interventions for behavioural change need to be evaluated against the theory used to guide the intervention, how it is targeted, the intensity, nature and content of the intervention and the channel of media that is used for the campaign.

Methodology

Review strategy & Search terms

This review includes all studies that refer to the use of media interventions used in promoting help-seeking attitudes, intentions or behaviour in regards to mental illness. This includes non-published articles and "grey" literature. Articles were identified by conducting individual search strategies of electronic databases. The databases used to conduct the review were PsychINFO (1967 to November week 4 2015), Embase (1974 to 2015 November 27), and Ovid MEDLINE (R) (1946 to Week 4 November 2015). In addition to the main search strategy, a review of the identified articles' references was conducted and also the use of Google's cross-citing and "cited by" functions.

Search terms were developed by the researcher to describe the concepts of media and help-seeking. The key concepts, subject headings and additional keywords used for each database are Table 2.

Table 2: Subject Headings, Keyword and Free Search Terms used in the Search

Key Concepts including truncations					
	Mass Media		**Help-Seeking**		**Mental Health**
Variations for each construct and search term based on database	**PsychINFO** Exp. Mass Media Exp. Media Exposure Exp. Internet Exp. Communications Media	**And**	**PsychINFO** Exp. Help-seeking Behavior Exp. Health Care Seeking Behavior	**And**	**PsychINFO** Exp. Mental Disorders Exp. Mental Health
	MEDLINE Exp. Mass Media Exp. Communications Media Exp. Internet		**MEDLINE** Exp. Health Knowledge, Attitudes, Practice		**MEDLINE** Exp. Mental Disorders Exp. Mental Health
	EMBASE Exp. Mass Communication Exp. Internet Exp. Mass Medium		**EMBASE** Exp. Help-seeking Behavior		**EMBASE** Exp. Mental Disease Exp. Mental Health
Key words and free search terms for all databases					
	Mass Media		**Help-Seeking**		**Mental Health**
	Mass medi* $media Online* Internet* Web*	**And**	Help Seek* $care seek* Support seek* Assistance seek*	**And**	Mental health Mental* ill* Mental* dis* Major mental illness*

The search terms were entered separately into each electronic database. In addition, the list generated from the search of relevant review/analysis, theoretical, conceptual, and empirical papers were examined for other relevant papers.

Inclusion and exclusion criteria

The Cochrane Handbook for Systematic Reviews of Interventions (Higgins et al., 2011) recommends that the review should specify the types of population (participants), types of interventions (and comparisons), and the types of outcomes that are of interest. This has been used along with a review of theoretical, empirical and conceptual papers, to generate the inclusion and exclusion criteria. The review specifies the following inclusion and exclusion criteria in Table 3.

Table 3: Inclusion and Exclusion Criteria for Studies

Inclusion	Exclusion
☑ Intervention studies with media as the main method of intervention and an explicit description of the media used	☒ Studies with poorly defined media or where media use is unclear or media not conducted by an organisation/ reseacher (e.g. social media between users)
☑ Explicit description of the intention of the media intervention	☒ Studies not aimed at help-seeking attitudes, intentions or behaviour for mental health
☑ Studies aimed at mental health help-seeking	☒ Non-intervention study, conceptual/theoretical, or review article.
☑ A channel of communication intended to reach large numbers and people which is not dependent on person-to-person contact	☒ Studies which include face to face interventions
☑ Randomised Controlled Trial (RCT) or Controlled Trial	☒ Cross-sectional, Cohort or Case-Control Studies

Results

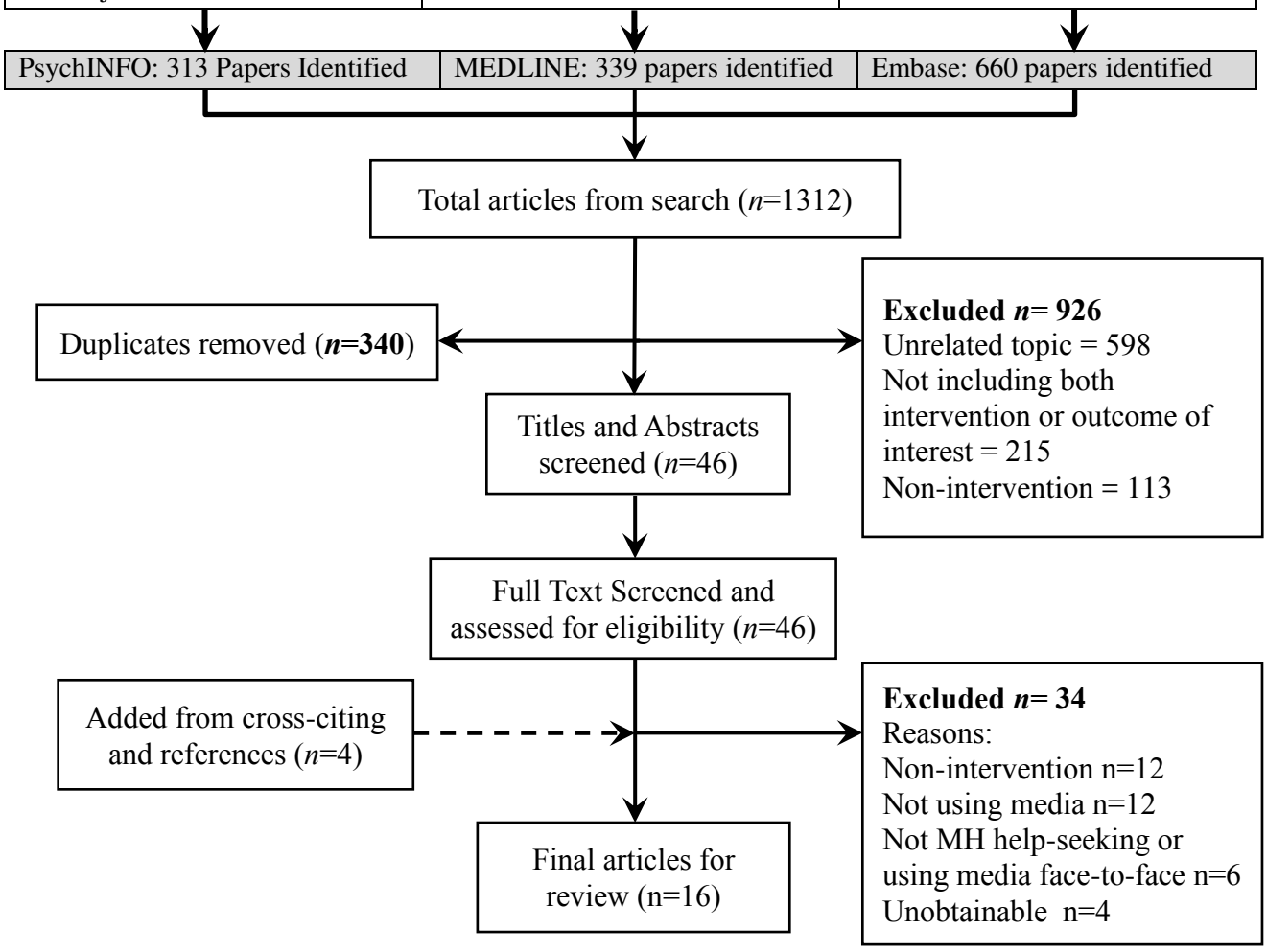
Search Results

The database search identified 1312 articles (including duplicates). Duplicates were removed, leaving 926 articles. Abstracts were then screened using the inclusion and exclusion criteria, removing 598 articles on unrelated topics, 215 that did not include the population of interest, a media intervention, or an exploration of the outcome of interest (help-seeking), and 113 that did not describe an intervention, or were a review or theoretical paper.

This yielded a remaining 46 articles, which then underwent full-text review. Following full-text review, 34 papers were removed for the following reasons: 12 were not an intervention study, 12 were not using media as defined by this review, and 6 were not focused on mental health help-seeking or used media in face-to-face contact. A further 4 papers were unobtainable (Buckley & Malouff, 2005; Dias-Vieira, 2005; LaLonde, 2014; Owusu, 2002) since either no details for contact were available or despite contacting the authors no response was received. Finally, 4 papers were added to the review through cross-citing. The final total of review papers was 16 (Christensen, Leach, Barney, Mackinnon, & Griffiths, 2006; Corrigan, Powell, & Al-Khouja, 2015; Costin et al., 2009; Demyan & Anderson, 2012; Gulliver, Griffiths, Christensen, Mackinnon, et al., 2012; Hammer & Vogel, 2010; Han, Chen, Hwang, & Wei, 2006; Hernandez & Organista, 2013; Hui, Wong, & Fu, 2015; A. F. Jorm et al., 2003; Kaplan, 2010; Lienemann, Siegel, & Crano, 2013; Lindsley, 2014; Siegel, Lienemann, & Tan, 2015; Taylor-Rodgers & Batterham, 2014; Wong & Chan, 2015). Figure 1 provides an illustration of the process.

Figure 1: The Search Strategy used to Identify the Articles for Review

PsychINFO	MEDLINE	Embase
Exp. Mass Media OR Exp. Media Exposure OR Exp. Internet OR Exp. Communications Media OR Exp. Websites OR Mass medi* OR $media Online* OR Internet* OR Web* **AND** Exp. Help-seeking Behavior OR Exp. Health Care Seeking Behavior OR Help Seek* OR healthcare seek* OR Health seek* OR Support seek* OR Assistance seek* **AND** Exp. Mental Disorders OR Exp. Mental Health OR Mental health OR Mental* ill* OR Mental* dis* OR Major mental ill*	Exp. Mass Media OR Exp. Communications Media OR Exp. Internet OR Mass medi* OR $media OR Online* OR Internet* OR Web* **AND** Exp. Health Knowledge, Attitudes, Practice OR Help Seek* OR $care seek* Support seek* OR Assistance seek* **AND** Exp. Mental Disorders OR Exp. Mental Health OR Mental Health OR Mental* ill* OR Mental* Dis* OR Major Mental Ill*	Exp. Mass Medium OR Exp. Mass Communication OR Exp. Internet OR Mass medi* OR Online* Internet* OR Web* **AND** Exp. Help-seeking Behavior OR Help Seek* OR $care seek* OR Support seek* OR Assistance seek* **AND** Exp. Mental Disease OR Exp. Mental Health OR Mental* ill* OR Mental* Dis* Or Major Mental Ill*



Overview of included studies

The studies included in the review measured a range of outcomes related to help-seeking intentions, cognitions, and attitudes, but none on help-seeking behaviour. These variables were targeted by a wide range of media interventions that consisted of different intensity, message, and channel. The articles included in the review are summarised in Table 4. Types of study included for the review were RCTs and controlled trials only. The decision to include experimental studies only was based on the principle that experimental findings can be used to plan mass media campaigns. The ecological validity of studies will be discussed in the findings.

The final review includes fourteen RCTs and two controlled trials. Media channels used include: Five internet/ web-based, five video/film, three using print media, and three using multimedia (audio, video, print and internet in one intervention). The studies varied in terms of the exposure to the intervention, from single exposures to multiple exposures of media.

Table 4: Summary Table of the Included Studies in the Review			
Author	**Design**	**Participants and measures**	**Results**
Christensen, Leach, Barney, Mackinnon, & Griffiths (2006)	**Study design** RCT - Two intervention groups and one control group **Primary hypothesis/aim:** BluePages intervention will increase help-seeking intentions and behaviour over MoodGym and Control. The study relates to depression. **Secondary aim(s):** Depression scores will be reduced **Interventions** 1. BluePages - Information about a range of evidence-based psychological, medical and alternative treatments. 2. MoodGYM - Provides online cognitive behaviour therapy (CBT). 3. Control - No access to the website interventions. Brief weekly telephone contact where asked about factors that influence depression **Procedure** • Participants in intervention groups given instructions to complete programs over a 5 week period. • All group received telephone contact weekly for 10 minutes per session. • Outcome measures given pre-intervention, post-intervention and at 6-week follow-up.	**Sample** Screening questionnaire sent to 27000 individuals on electoral role. 6130 (22.7%) response rate. 657 met inclusion criteria. Group had to have a score greater than 12 on the K-10 (indicating clinical depression) Total pre-intervention n= 525 Follow-up n= 414 (78% of original sample). 300 female, 114 male, mean age =36.6 years. **Groups** BluePages: n = 165; follow-up n = 136), MoodGYM: n = 182; follow-up n = 121 Control: n = 178, follow-up n =157) **Measures** 1. CES-D 2. Help-seeking measure created by authors Yes/ no measures of treatment activities e.g. Seeking from a particular source: GP, psychiatrist, psychologist.	**Help-seeking** 1. MoodGYM more associated with professional and complex help and more likely to have used CBT than Bluepages or control. 2. BluePages users had lower use of professional treatments and decreased use of family/friends help. No difference in accessing evidence based treatments. 3. In general for all conditions, there was a low level of help-seeking from professional services compared to everyday treatments. Other treatments and everyday activities increased more than use of professional mental health services. 4. No results showed that BluePages led to initiation in evidence based professional treatments compared to control condition at all time-points. 1. **Other secondary results** 1. Bluepages and MoodGYM significantly reduced depression symptoms at post-int. 2. Higher drop-outs from people who scored higher in distress

Corrigan, Powell, & Al-Khouja (2015)	**Study design** RCT – Two intervention and one control group **Primary hypothesis/aim:** The intervention groups will show improved help-seeking attitudes, empowerment, and perceived differentness and reduced stigma. The study relates to depression. **Secondary aim(s):** **Interventions** 1. The beyondblue PSA video showed three men individually discussing experiences of depression and support services. 2. The recovery video introduced a man telling his story of depression and recovery. It ended with a recovery message. 1. The control received a dental health giving directions related to brushing and flossing. **Procedure** All conditions were exposed to their videos, each of which was 30 to 90 seconds long. Outcome measures were given immediately before viewing the assigned video, immediately after the video condition and at 72-hour follow-up.	**Sample** Recruited using Amazon Mechanical Turk, an online crowdsourcing resource. Pre-intervention N= 514. beyondblue (n= 173), Recovery story (n=166), control (n=175). Mean age= 36.4, Gender =52% female, 48% male Ethnicity:82.8% European American, 7.8% African-American. Post-intervention N= beyondblue (n= 100), Recovery story (n=91), control (n=96). Intent-to-Treat analysis used **Measures** CASC	**Help-seeking** 1. No significant improvement in help-seeking intent for either the recovery or beyondblue conditions post-intervention or at follow-up compared to control group. **Stigma and empowerment** 1. Recovery video led to greater reduction in stigmatising attributions than beyondblue and control post-intervention and at follow-up 2. Help-seeking failed to improve despite improvements in stigma and empowering attitudes for the recovery condition.
Costin, Mackinnon, Griffiths, Batterham, Bennett, Bennett, & Christensen (2009)	**Study design** RCT – Two intervention groups and one control group **Primary hypothesis/aim:** The two e-card intervention groups will be more likely to seek help for depression from a GP or mental health professional in the 3 weeks post-intervention compared to the control group. **Secondary aim(s):** Intervention groups would be more willing to seek professional help for depression in the future, hold more positive beliefs about treatment efficacy and health professionals, and have improved knowledge and recognition of help-seeking process and depression	**Sample** Screening questionnaire sent to12000 individuals aged 19 to 23 on the Australian Electoral Roll. Response rate was 1764 (14.7%). Pre intervention N= 348, stratified into low and high distress using K-10. **Groups** Low distress n =198: control n=65, basic intervention n= 63, enhanced intervention n=70 High distress n= 150: control n=52, basic intervention n= 51, enhanced intervention n=47.	**Help-seeking** 1. Formal help-seeking behaviour or intentions did not increase post intervention across any of the conditions. 2. No intervention more effective than control 3. No difference across conditions improving beliefs about depression treatments, recognition of depression, knowledge of the help-seeking process, or depressive symptoms 4. Interventions had more positive

	Interventions 1. Basic intervention: information on symptoms of depression, case vignette, where to find information and treatment from professionals. 2. Enhanced intervention: Same as basic plus what to expect in interventions, practical tips and strategies to seek help, 3. Control: received information on unrelated physical health condition **Procedure** All participants received personalised emails containing an embedded URL to their intervention in the form of a webpage.	85% completed pre and post measures. 48% completed all intervention tasks **Measures** K-10 GHSQ AHSQ Beliefs about help-seeking Vignette about spotting depression Vignette about help-seeking knowledge	beliefs about formal help sources 5. With people in treatment removed from analysis, results remained the same. 6. Pre and post intervention, the high distress group had higher intentions to seek help, higher help-seeking knowledge and positive beliefs about professional help.
Demyan & Anderson (2012)	**Study design** RCT – One intervention and one control group **Primary hypothesis/aim**: The intervention group would endorse fewer belief-based barriers to help-seeking, higher positive attitudes and greater help-seeking intentions compared to the control group. **Secondary aim(s)**: If greater intentions to seek help were found in the intervention group, higher positive attitudes would also be found **Interventions** 1. Intervention- Two-minute PSA in between commercial television programmes aimed at improving help-seeking 2. Control – Usual commercial advertising between television programmes **Procedure** All participants watched four 10-min video segments made up of musical performances (participants were told music in advertising was the focus of the study) Between the music videos were PSA made to look like usual television adverts	**Sample** Recruited from undergraduate psychology classes at an American university Pre-intervention N= 228. Control n= 122, intervention n=99 57.5% female, 42.5% male. Mean age of females 20.47 years, for men, the mean age was 19.93 years. Ethnicity: Caucasian, 83%; African American 8.8%; Hispanic 1.3%; Asian 1.3%; Native American 1.3%; other 3.5%. 33% had previously sought mental health services 84.4% at follow-up (demographics not given) **Measures** ISCI ATSPPH SSRPH TAPS DDI	**Help-seeking** 1. No significant change in intervention group compared to the control in endorsement of expectation and the belief-based factors (stigma, treatment fears, disclosure distress, self-concealment, treatment risk, and treatment utility) 2. The intervention group showed more positive attitudes toward help-seeking than the control group. 3. The intervention increased intentions to seek help for interpersonal problems, but only for those with prior treatment exposure and higher distress

	Two sessions a week apart followed this procedure. Measures given after second session	DES OQ-45 SCS SSRPH	
Gulliver, Griffiths, Christensen, Mackinnon, Calear, Parsons, & Stanimirovic (2012)	**Study design** RCT – Three intervention and one control group **Primary hypothesis/aim:** Participants in the three intervention groups would have improved professional help-seeking attitudes and intentions post-intervention and at 3 month follow-up compared to the control group **Secondary aim(s):** Improvements would be greatest in the mental health literacy/destigmatisation group **Interventions** 1. Mental health literacy/destigmatisation condition provided electronic information about symptoms, prevalence, evidence-based therapies, stigma reduction and help-seeking. 2. Feedback condition used interactive quizzes to feedback about the participants' level of depression then anxiety. 3. Help-seeking condition delivered three pages per week, including an introduction, help-seeking source page and a congratulatory page. 4. Control condition received emails to the online measurement surveys only. **Procedure** Participants received an email each week with an embedded link to the outcome measures or interventions	**Sample** Elite athletes recruited through athletic bodies in Australia. Coaches and Director of sport approached to aid in recruitment. Pre-intervention n= 120, 59 completed (49.1%) n=29 control condition, n=30 help-seeking list condition, n=30 feedback condition, mental health literacy/destigmatisation condition. Mean age =25.42 years, 43 (73%) female, 16 (27%) male. Mean K-10 score = 15.39 **Measures**: K10 GHSQ ATSPPH-SF AHSQ D-Lit A-Lit DSS GASS	**Help-seeking** 1. None of the intervention groups showed improvement in mental health help-seeking attitudes, intentions, or behaviour compared to the control condition post-intervention or at 3-month follow-up 2. No effect of any of the interventions on overall help-seeking intentions, formal or informal. 3. Mental health/destigmatization intervention showed a significant reduction in stigma for depression and anxiety compared to other conditions.
Hammer & Vogel (2010)	**Study design** RCT – One intervention group and one control **Primary hypothesis/aim:** The intervention brochure	**Sample** Pre-intervention N=1397, all male Mean age = 29.44 years, 69.0% White, 11.8% Asian, 100 7.2%	**Help-seeking** 1. New RMRD brochure significantly improved help-seeking attitudes compared to the RMRD, but not

	will improve both general attitudes toward seeking counseling and the self-stigma associated with seeking counselling for men who are depressed but have not sought professional support. **Secondary aim(s):** **Interventions** 1. Intervention one- Real Men Real Depression (RMRD) brochure. Facts specific to men and depression, testimonials and photographs of men of various racial groups who have experienced depression and the symptoms. 2. Intervention two – Gender neutral brochure. Similar to RMRD but with the male focus 3. Intervention three- Improved RMRD brochure. Focused on being compatible with male gender roles, perceptions of weakness and benefits of counselling.	Hispanic, 5.3% Black, 4.4%, Multiracial and 0.6% Native American. **Measures** ATSPPHS SSOSH CES-D	compared to the gender–neutral brochure. 2. Male sensitive brochure reduce self-stigma significantly
Han, Chen, Hwang, & Wei (2006)	**Study design** Controlled trial – One intervention group and one control **Primary hypothesis/aim:** Interventions to increase biological attributions and decrease blameworthy attitudes towards depression would increase willingness towards professional help-seeking. **Secondary aim(s):** Both types of presented together will be more effective than when delivered separately. **Interventions** 1. Biological attribution of depression group. Five written paragraphs about biological factors including genes, neurotransmitters, endocrine systems, and physiological characteristics of depression presented. 2. Destigmatisation education group. Information used psychological theories or clinical observations to reduce stigmatising beliefs.	**Sample** Student sample gathered from Taiwanese university Pre-intervention N=299, Biological education group (n =75), destigmatisation group (n= 76), combined group (n =72), and control group (n=76). Follow-up N= 252 (84.3%) Mean age =20.3 years. 73% female, 27% male **Measures** BAS PBS HSWS (Developed by authors)	**Help-Seeking** 1. Biological education had a main effect on increasing willingness to seek professional help 2. Destigmatisation education did not have a main effect on increasing willingness to seek help 3. No interaction effects between the two approaches

	3. Combined group received both biological attribution and destimatisation interventions. 4. Control group read no information		
Hernandez & Organista (2013)	**Study design** RCT – One intervention group and one control **Primary hypothesis/aim:** The use of a *fotonovela* (a comic-booked style pamphlet with photos instead of drawings) in a Latin- American population with low literacy and mental health knowledge would increase mental health knowledge, help-seeking intentions and reduce mental health stigma. **Secondary aim(s):** **Interventions** 1. Intervention group exposed to a fotonovela called Secret Feelings developed using social cognitive factors and cultural models theory. Storyline presents adaptive illness perceptions and help-seeking information. Intervention read out loud and given copies to participants. 2. Control group exposed to a 45 minute discussion about family communication.	**Sample** Sample recruited from community health fairs, health education classes and through special community workers. Pre-intervention N=142, intervention n=75, control n=67. All females aged 18–55, predominately of Mexican origin living in United States. Group mean was at clinical threshold for depression. **Measures** Intent to Seek Treatment Scale DMV-V symptom checklists SCMHC LSAS Self-Efficacy to Identify the Need for Treatment CES-D s-TOFHLA	**Help-seeking** 1. Significant increase in help-seeking intentions for the experimental group when compared to the control group. Moderate effect size. 2. **Other** 1. Significant increases in depression-related knowledge, self-efficacy to identify the need for treatment, and reduced stigma towards antidepressant medication for the experimental group compared to control.
Hui, Wong, & Fu (2015)	**Study design** RCT – One intervention and one control group **Primary hypothesis/aim:** To evaluate the effectiveness of an online campaign targeted at enhancing help-seeking attitudes **Secondary aim(s):** Improvement in mental health literacy for depression for the intervention group **Interventions** 1. Intervention - Email messages using TPB to provide information about factors of depression, attitudes toward help-seeking, subjective norms, and perceived behavioural control 2. Control – Email messages containing official	**Sample** Participants recruited in Hong-Kong through Chinese-language Facebook. Pre-intervention N=197, intervention n= 98, control n=99 Post-intervention N=116, n=54 intervention, n=62 control. Primarily 18-29 year olds 70% of sample reporting mild to extremely severe depressive symptoms. **Measures** Authors developed own measures using TPB three factors	**Help-Seeking** 1. No significant improvement in help-seeking attitudes, perceived behavioural control, and subjective norms of intervention group compared to the control group. **Mental health literacy** 1. Significant improvement in mental health literacy in the intervention group compared to the control.

	mental health material prepared by the Hong Kong Hospital Authority. **Procedure** Each week for four weeks, emails were sent out to participants containing either the intervention or control information.	3. Attitude toward help-seeking 4. Subjective norm 5. Perceived behaviour control Secondary outcome measures (not named by author)encompassed mental health literacy, attitudes toward seeking professional help and supplementary factors including action and view toward family and friends with depression, perceived barriers, and attitudes toward treatment.	
Jorm, Griffiths, Christensen, Korten, Parslow & Rodgers (2003)	**Study design** RCT – One intervention group and one control **Primary hypothesis/aim:** A written consumer guide would produce greater changes in attitudes to treatments, more actions to deal with depression and improvements in depressive and anxiety symptoms and disability than a general brochure. **Secondary aim(s):** **Interventions** 1. Intervention group received a consumer guide called Help for Depression: What Works. Gives information about depression symptoms, causes and 45 treatments covering medical, psychological, and lifestyle and alternative treatments. 2. Control group given a brochure called "What is Depression?" produced by the Australian Government which provides basic information on depression, possible causes and treatments.	**Sample** 27000 people were selected at random from the electoral roll Pre-intervention N= 1094, intervention n=525, control n= 569 63.1% female, mean age= 44.83 years. At follow-up: intervention n=332, control n= 335 Measures GADS K10 Help-seeking questions developed by authors	**Help-seeking** 1. No significant difference in attitudes towards treatment between intervention and control group at follow-up. 2. 2. Both groups showed improved attitudes towards help-seeking intentions and actions to help themselves. **Symptoms** 1. Both groups showed a reduction in symptoms of depression.
Kaplan (2009)	**Study design** RCT – Two intervention groups: one exposed to intervention 3 times; one exposed to intervention once; and a control group.	**Sample** Pre-intervention N = 290, 34% male and 66% female, 90% White-American Intervention Repeated condition (IRC)	**Help-seeking** 1. No significant differences between any of the groups on any variable except peer norms.

	Primary hypothesis/aim: Repeated exposure to a mental health video will improve undergraduate students' help-seeking attitudes, peer and perceived norms, outcome expectations, stigma, and help-seeking intentions over 6 weeks. **Secondary aim(s):** Repeated exposure will create more change than either single exposure or the control. **Interventions** 1. Both interventions developed from reality TV show, designed to show peer identification, emotional appeal, education about counselling, benefits, support, and encouragement for counselling and perceived norms for help-seeking behaviour. 2. Intervention repeated condition (IRC) exposed to intervention video 3 times (2 x 7 minutes version, 1 x 4 minutes condensed version) over a 6 week period 3. Intervention single condition (ISC) exposed to one 4-minute intervention video 4. Control – exposed to video from same reality TV show featuring the same character but no scenes or mention of mental health.	n=98, Intervention Single condition (ISC) n=98, Control condition (CC) n=95. Post-intervention N=144 (49.65%). IRC n=42, ISC n= 58, CC n=44. **Measures** ATSPPH Peer norms Perceived norms DES SSOSH SSRPH ISCI	2. No significant difference between groups for attitudes, perceived norms, anticipated risks, anticipated benefits, self-stigma, social stigma, and willingness to seek help 3. Peer norms significantly higher at time point 2, 3 and 4 between IRC and CC. Between IRC and ISC, difference between peer norms at time point 2, but not 3 or 4. 4. ISC and CC – no differences at any time point. 5. IRC significant improvements in peer norms over time, ISC no changes over time, CC significant decreases.
Lindsley (2013)	**Study design** RCT – One intervention group and one control **Primary hypothesis/aim:** The intervention group will show improvement in attitudes toward help-seeking compared to the control group peers post-intervention and at 4-week follow-up **Secondary aim(s):** Whether previous psychological counselling, gender, or clinical caseness for depression will affect the efficacy of the intervention. **Interventions** 1. Intervention group exposed once to a 10-minute	**Sample** Pre-intervention N= 120, intervention n= 64 and control n= 56. Median age = 20; range 18-34; 79 women and 41 men; 90% Caucasian-American (90%). Follow-up N=78, intervention n=41, Control n= 33. 66% female, 34% male. **Measures** K10 IASMHS ISCI	**Help-seeking** 1. No significant difference between intervention and control group for overall attitude change (IASMHS total) over time, although a significant attitude increase from time 1 to time 2, and decrease from time 2 to 3 across both treatment and control groups. 2. No significant differences between groups on intent to seek counselling or attitudes toward seeking services

	audio and video presentation addressing basic knowledge about mental health, why people seek treatment, treatment options and providers, expectations and outcomes of therapy, and how/where to obtain treatment. 2. Control group followed the exact same procedure and factors but with physical health information.		over time. 3. Significant difference between genders on the attitude measure reflecting help-seeking propensity, with females showing greater improvement in positive attitudes towards help-seeking. 4. No significant differences between clinically distressed and non-distressed groups or previous or no-previous psychological help groups.
Lienemann, Siegel, & Crano (2013)	**Study design** Controlled trial – 2 group although not reported in the study **Primary hypothesis/aim:** Depressed people exposed to a D-PSA will report reduced help-seeking intentions. **Secondary aim(s):** Self-stigma will mediate the relationship between depressive symptoms and help-seeking intentions such that exposure to the depression ad will decrease help-seeking. **Interventions** 1. Intervention exposed to a written D-PSA, Intervention PSA includes phrases like "You are not to blame for the cause of your depression. Depression is treatable if you are willing to seek help." 2. Control exposed to an unrelated PSA.	**Sample** Pre-intervention N= 271 undergraduate students; mean age= 22.51 years; 63.1% female 36.9% male; 37.3% White, 31.9% Hispanic, 12.9% Asian, 6.8% multiethnic, 3.4% were Black, and 7.6% reported. **Measures** SSOSH GHSQ (adapted for the study and factors analysis completed for items) BDI-II	**Help-seeking** 1. Exposure to the D-PSA did not have a significant total effect on professional help-seeking intentions for control group. H 2. owever self-stigma mediated the effects of depressive symptoms on professional help-seeking intentions for those who viewed the D-PSA. 3. Depressed people who viewed the D-PSA perceived greater stigma associated with depression than depressed people who received the control ad
Siegel, Lienemann, & Tan (2015) (study 1 & study 2)	**Study design** Two Controlled trials in one paper Study one: Two groups: targeted printed D-PSA and mistargeted D-PSA. Study two: three groups: targeted video D-PSA, mistargeted D-PSA, and control group **Study 1 primary hypothesis/aim:**	**Sample** **Study 1** Pre-intervention N= 324; mean age = 31.66 years; 62.7% female, 37.3% male. White/Caucasian (80.6%), Black/African American (5.9%), Asian or Pacific Islander (5.9%), Hispanic (3.1%), multiracial (2.8%).	**Study 1** Help-seeking 1. No relationship between levels of depressive symptomatology and help-seeking intentions from a professional. 2. Mistargeted D-PSA was significantly more effective than the direct D-PSA

	The D-PSA) with a mistargeted approach would increase favourable attitudes and intentions towards help-seeking. Elevated levels of depressive symptomatology would be associated with less favourable attitudes toward help-seeking and reduced intentions to seek help post intervention **Study two primary hypothesis/aims:** Attempted to replicate study one with a different form of media (video) and added a control group **Interventions** 1. Both studies - One group received targeted print targeted D-PSA and the other group recived mistargeted D-PSA. *Mistargeted communication* refers to the technique of leading the target of a message to believe the message is intended for someone else i.e. "do you know someone who suffers from depression?" 2. Study 2 only had a control group that received no D-PSA 3. Study 1 used print media, Study 2 used video media	Sample not currently seeking treatment for depression. 9.1% current depression. No reporting of n of each group. **Measures**. BDI-II GHSQ **Sample** **Study 2** Pre-intervention total N=1,152 participants; mean age =30.30 years; 57.7% male and 42.3% female; White/non-Hispanic(77.0%) Asian (8.9%), Black/non-Hispanic (5.9%), Hispanic (4.1%), multi-ethnic (2.7%), Native Hawaiian or other Pacific Islander (0.5%), and American Indian or Alaska Native (0.2%) No reporting of group allocations **Measures** BDI-II GHSQ (adapted to ask about help-seeking from a website) Help-seeking outcome expectancies scale written for study	at persuading people with elevated depressive symptomatology for help-seeking intentions from a close friend and a romantic partner, but not a professional. **Study 2** **Help-seeking** 1. A negative relationship found between depressive symptomatology and attitudes and intentions towards help-seeking from a depression website. 2. The relationship between depressive symptomatology and attitudes toward help-seeking was significantly less negative among participants exposed to the mistargeted D-PSA compared to the no D-PSA and direct D-PSA groups. 3. The negative relationship between depression and help-seeking was significantly less negative among people assigned to the mistargeted D-PSA condition in comparison with those assigned to the no D-PSA or the direct D-PSA conditions.
Taylor-Rodgers, & Batterham (2014)	**Study design** RCT – One intervention and one control group **Primary hypothesis/aim:** The intervention group would have more positive attitudes and intentions to help-seeking, increased mental health literacy, and decreased stigma compared to the control group. **Secondary aim(s):** **Interventions** 2. Intervention – Psychoeducational online information links emailed to participants.	**Sample** Recruited using posters and social media at the Australian National University only. N=86 responded Pre-intervention N= 67, Intervention n= 33, control n= 34 Post-intervention N= 56, Intervention n= 28, control n=28 75.8% female, 24.2% male, Mean age 21.9 years, 77.2% Caucasian, 16% Asian, 6% other.	**Help-Seeking** 1. No significant main effect for group or time. However, a change in attitudes toward help-seeking is significantly greater in the psychoeducation condition with a moderate effect-size (*d*= 0.58) compared to the control group. **Mental health literacy** 1. Significant increase of anxiety

	3. Control – Dental hygiene, common medications and nutritional information online links emailed to participants. **Procedure** Participants emailed content weekly over the course of 3 weeks.	**Measures** D-Lit LSS DSS GASS SOSS ATTSPH-SF GHSQ PHQ-9 GAD-7	literacy scores in the psychoeducational intervention compared to the control condition, with a moderate effect size between conditions over time (*d*= 0.65). Depression and suicide literacy had no significant results.
Wong & Chan (2015)	**Study design** RCT – One intervention group and one control **Primary hypothesis/aim:** A brief video media intervention will improve attitudes towards help seeking in 18-23 year olds in Hong Kong. **Secondary aim(s):** **Interventions** 1. Both groups were exposed to a 17-minute music video split into 3 segments. In-between the segments advertisements were played. 2. The intervention group received 30 second advertisements promoting help-seeking for mental health and suicidality. 3. The control group received general health advertisements. 4. Both groups were exposed to sales advertisements to blind the participants.	**Sample** Participants were from Hong Kong colleges. Recruitment procedure not fully described. Pre and post-intervention N= 60, intervention n=30, control= 30. **Measures** ATSPPH	**Help-seeking** 1. Significant increase in help-seeking attitudes for the intervention group. However, there was also a significant increase in help-seeking attitudes for the control group 2. No significant difference found in the changes in scores between groups.

Key to terms

Abbreviation	Full title	Author
A-Lit	Anxiety Literacy Questionnaire	Gulliver et al. (2012)
AHSQ	Actual Help Seeking Questionnaire	Rickwood, Deane, Wilson, & Ciarrochi (2005)
ATSPPH-SF	Attitudes Toward Seeking Professional Psychological Help: Short Form	Fischer & Farina (1995)
BAS	Biological Attribution Scale	Han et al. (2006);

BDI-II	Beck Depression Inventory II	Beck, Steer, Ball, & Ranieri (1996)
BHS	Beliefs about help-seeking	(Jorm, Christensen, & Griffiths (2006);
CASC	California Assessment of Stigma Change	Corrigan, Gause, Michaels, Buchholz, & Larson (2015)
CES-D	Centre for Epidemiological Studies Depression Scale	Radloff (1977)
D-Lit	Depression Literacy questionnaire	Griffiths, Christensen, Jorm, Evans, & Groves (2004)
D-PSA	Depression Public Service Announcement	
DDI	Distress Disclosure Index	Kahn & Hessling (2001)
DES	Disclosure Expectations Scale	Vogel & Wester (2003)
DSS	Depression Stigma Scale	Griffiths et al. (2004)
GAD-7	Generalized Anxiety Disorder- 7	Spitzer, Kroenke, Williams, & Löwe (2006)
GADS	Goldberg Anxiety and Depression Scales	Goldberg, Bridges, Duncan-Jones, & Grayson (1988)
GASS	Generalised Anxiety Stigma Scale	Griffiths, Batterham, Barney, & Parsons (2011)
GHSQ	General Help-Seeking Questionnaire	Wilson, Deane, Ciarrochi, & Rickwood (2005)
HSWS	Help-Seeking Willingness Scale	Han, Chen, Hwang, & Wei (2006)
IASMHS	Inventory of Attitudes Toward Seeking Mental Health Services;	Mackenzie, Knox, Gekoski, & Macaulay (2004)
ISCI	Intentions to Seek Counseling Inventory	Cash, Begley, McCown, & Weise (1975)
K10	Kessler Psychological Distress Scale	Andrews & Slade (2001)
LSS	Literacy of Suicide Scale	Batterham, Calear, & Christensen (2013a)
LSAS	Latino Scale for Antidepressant Stigma	Interian et al. (2010)
OQ-45	Outcome Questionnaire-4	Lambert, Gregersen, & Burlingame (2004)
PBS	Psychological Blame Scale	Han et al. (2006)
PHQ-9	Patient Health Questionnaire	Spitzer, Kroenke, Williams, & Group (1999)
PSA	Public Service Announcement	
s-TOFHLA	Short Test of Functional Health Literacy in Adults	Baker, Williams, Parker, Gazmararian, & Nurss (1999)
SCMHC	Stigma Concerns About Mental Health Care scale	Interian et al. (2010)
SCS	Self-Concealment Scale	Larson & Chastain (1990)
SOSS	Stigma of Suicide Scale short form	Batterham, Calear, & Christensen (2013b)
SSRPH	Stigma Scale for Receiving Psychological Help	Komiya, Good, & Sherrod (2000)
TAPS	Thoughts About Psychotherapy Survey	Kushner & Sher (1989)

Data extraction and quality assessment

In line with recommendations within the Cochrane Handbook for Systematic Reviews of Interventions (Higgins & Green, 2011), Table 4 provides a summary of the data extraction. For each study the following information has been reported where available; the type/nature of intervention; the sample size; comparison treatments if conducted; the dependent variables and measures used; biases in the methodology; analysis; and outcomes

A quality assessment framework is essential in evaluating the quality of included studies. For this review, the Effective Public Health Practice Project (EPHPP) assessment tool has been used (Thomas, Ciliska, Dobbins, & Micucci, 2004). It is cited as an effective tool for assessing the quality of papers in systemic reviews (Deeks et al., 2003). The EPHPP allows quality review of a range of study methodologies including RCTs and controlled clinical trials.

The EPHPP allows the quality of studies to be evaluated on number of components. The evaluation allows for a uniform approach to assessing probability of bias affecting internal validity of studies. This is expressed through an overall quality rating; strong, moderate, or weak. The tool has been demonstrated to have fair to good inter-rater agreement for individual domains and excellent agreement for the final grade, and adequate content and construct validity (Thomas, Ciliska, Dobbins & Micucci, 2004; Armijo-Olivo, Stiles, Hagen, Biondo, & Cummings, 2012).

Table 5 provides a completed summary overview of the quality assessment.

Table 5: Quality Assessment using the EPHPP

Author of Study	Selection Bias	Study Design	Confounders	Blinding	Data Collection Methods	Withdrawals & Dropout	Global Rating
Christensen, Leach, Barney, Mackinnon, & Griffiths (2006)	1 - Weak	3 – Strong	3 - Strong	2 – Moderate	2 – Moderate	2- Moderate	**2 – Moderate**
Corrigan, Powell, & Al-Khouja (2015)	2 - Moderate	3- Strong	3 - Strong	2 – Moderate	3 – Strong	1 - Weak	**2 - Moderate**
Costin, Mackinnon, Griffiths, Batterham, Bennett, Bennett, & Christensen (2009)	1 - Weak	3 – Strong	3 – Strong	2 – Moderate	3 – Strong	2 - Moderate	**2 - Moderate**
Demyan & Anderson (2012)	2 – Moderate	3 – Strong	3 – Strong	3 - Strong	3- Strong	3 - Strong	**3 - Strong**
Gulliver, Griffiths, Christensen, Mackinnon, Calear, Parsons, & Stanimirovic (2012)	1 - Weak	3 - Strong	3 - Strong	2 - Moderate	3 - Strong	1 – Weak	**1 - Weak**
Hammer & Vogel (2010)	2 – Moderate	3 – Strong	3 – Strong	2 – Moderate	3 - Strong	1 – Weak	**2 – Moderate**
Han, Chen, Hwang, & Wei (2006)	1 - Weak	3 – Strong	2 – Moderate	2 – Moderate	3 – Strong	3 – Strong	**2 – Moderate**
Hernandez & Organista (2013)	2 – Moderate	3 - Strong	3 - Strong	2 - Moderate	2 – Moderate	3 - Strong	**3 – Strong**
Hui, Wong, & Fu (2015)	2 – Moderate	3 - Strong	3 - Strong	2 - Moderate	1 – Weak	1 – Weak	**1 - Weak**
Jorm, Griffiths, Christensen, Korten, Parslow & Rodgers (2003)	1 – Weak	3 – Strong	2 – Moderate	2 – Moderate	1 - Weak	2 - Moderate	**1 - Weak**
Kaplan (2009)	1 - Weak	3 – Strong	2 - Moderate	2 - Moderate	3 - Strong	2 – Moderate	**2 – Moderate**
Lindsley (2013)	2 – Moderate	3 – Strong	3 – Strong	2 - Moderate	3 – Strong	2 - Moderate	**3 - Strong**
Lienemann, Siegel, & Crano (2013)	2 - Moderate	3 – Strong	1 – Weak	2 – Moderate	3- Strong	2 – Moderate	**1 - Moderate**
Siegel, Lienemann, & Tan (2015) (study 1 & study 2)	2 – Moderate	3 – Strong	1 – Weak	2 - Moderate	3 – Strong	1 – Weak	**1 - Weak**
Taylor-Rodgers, & Batterham (2014)	1 – Weak	3 – Strong	3 – Strong	2 - Moderate	3 – Strong	3 – Strong	**2 - Moderate**
Wong & Chan (2015)	1 – Weak	3 - Strong	2 - Moderate	3 - Strong	3 - Strong	3- Strong	**2 - Moderate**

The efficacy of media interventions in changing help-seeking attitudes and intentions

For ease of reading, the overview and synthesis of these studies will be written by each media channel. Where possible, theories used in developing each intervention, methodological issues, and reporting issues will be discussed and critically evaluated.

Website and internet-based interventions

Five studies examined the use of internet-based interventions (Christensen et al., 2006; Costin et al., 2009; Gulliver, Griffiths, Christensen, Mackinnon, et al., 2012; Hui et al., 2015; Taylor-Rodgers & Batterham, 2014). There was some homogeneity within interventions, with the primary methods being websites or emails containing mental health information, psychoeducation or Cognitive Behavioural Therapy (CBT) designs created by the authors or another evidence-based media campaign. In regards to control groups, only one study (Gulliver, Griffiths, Christensen, Mackinnon, et al., 2012) used a control group exposed to no intervention. The other studies used comparison groups exposed to information about depression but no access to the authors' internet media intervention (Christensen et al., 2006; Hui et al., 2015), or information about physical health conditions (Taylor-Rodgers & Batterham, 2014). This creates methodological limitations in respect of differences between the intervention and control groups, with theoretical similarity between the intervention and control exposure.

With regard to the theoretical basis of the interventions, two studies (Costin et al., 2009; Gulliver et al., 2012) used Rickwood, Deane, and Wilson's (2007) model of adolescent help-seeking for mental health problems; one study (Christensen et al., 2006) used CBT theory (Beck, 1979); one used the Theory of Planned Behaviour and Theory of Reasoned Action (TPB/TRA; Hui et al., 2015); and one used previous literature (Taylor-Rodgers &

Batterham, 2014) to develop the interventions. All of the interventions used credible theoretical models to describe the need for interventions; however, the links to specific development of intervention elements was unclear. Three of the studies focused on help-seeking for depression only (Christensen et al., 2006; Costin et al., 2009; Hui et al., 2015) and two focused on help-seeking for depression and anxiety (Gulliver, Griffiths, & Christensen, 2012; Taylor-Rodgers & Batterham, 2014).

Samples were generally made up of younger females of Caucasian ethnicity, with screening measures used to examine levels of depression and anxiety. The samples varied in those presenting with a mental illness. Christensen et al. (2006) used only participants with a screening score indicating depression, Costin et al. (2009) and Gulliver, Griffiths, Christensen, Mackinnon, et al. (2012) used groups defined as 'at risk' or stratified for depression by the authors and Hui et al. (2015) and Taylor-Rodgers & Batterham (2014) both used general population samples with screening of distress levels.

Recruitment methods included Facebook adverts, use of the electoral role, and emailing through sports clubs and organisations. The studies reviewed made novel and innovative attempts to recruit representative samples, with one study approaching 27000 possible participants (Christensen et al., 2006). However, there are unknown limitations and biases in these recruitment methods; for example, to what extent a Facebook sample might be representative of the general population the studies are aiming to recruit. Secondly, there were several difficulties with study uptake being low or not reported. A strength across the studies were attempts to address these limitations through attempting to re-recruit, randomisation, and exploring and controlling for possible confounders between groups.

There was significant heterogeneity of outcomes measured. All the studies used self-report measures, with more robust studies using validated and reliable psychometrics of help-

seeking attitudes and intentions. Several studies used questionnaires developed by researchers for each study. This raises the issue of using measures not tested for reliability or validity. All the studies also employed secondary measures that examined depression or anxiety symptomatology to enable examination of differences between distressed and non-distressed participants.

With regard to the blinding of interventions, group allocation was very unlikely to be known by participants across studies due to the anonymity of the internet protocols. What is less clear in studies is whether assessors were aware of group allocation and outcome as blinding procedures were not reported. There is some likelihood due to the intervention materials and outcome measures that participants were aware of the research question, leading to unknown bias.

Examining only help-seeking results, most of the studies showed no significant main effect of the intervention compared to the control or comparison. Only Gulliver et al., (2012) reported effect size for findings, which was small to moderate. Taylor-Rodgers & Batterham, (2014) was the only study to find a significant interaction between time and condition of the intervention and also reported a moderate effect size of the intervention (*d= 0.58).* These results report that attitudes towards help seeking showed significantly greater change in the psychoeducation group than in the control condition. With the studies that measured distress levels, the distressed participants experienced greater positive change toward help-seeking attitudes and intentions. The studies also suggested that females experienced greater positive change in help-seeking attitudes and intentions. However, studies do not report effect size and there is higher female participation across all the studies, creating possible bias.

A general theme across studies was significant attrition bias or poor adherence/non-reporting of adherence to the intervention. Only two studies (Christensen et al., 2006; Costin

et al., 2009) report over 80% completion of the intervention materials. However, Costin et al., (2009) report only 48% of participants completed all the intervention tasks. The other studies report no information on intervention adherence, so the bias is unknown. Two studies (Gulliver, Griffiths, Christensen, Mackinnon, et al., 2012; Hui et al., 2015) have significant attrition, with 49.1% and 58.8% respectively completing post-intervention outcomes. Only Taylor-Rodgers & Batterham (2014) completed intention-to-treat analyses in an attempt to manage these problems, adding to the confidence in their significant results with moderate effect size.

In summary, good practice was in evidence as most of the studies attempted to recruit to their studies, used theoretical frameworks or models to develop their interventions, and used randomisation and controlled for confounders. Methodological limitations lie in poor study uptake, bias in sampling, limited coherence and agreement within the theoretical literature, use of several different interventions and outcomes, and significant attrition bias. In addition, despite the use of novel and ingenious methods to recruit to their studies, all of the aforementioned studies were underpowered and the representativeness of the samples is unknown. None of the studies were rated as strong on the quality assessment and all contained at least one methodological issue. Concerns also lie in the theoretical basis of interventions, with limited explanation of how the intervention would target elements outlined by the theoretical model and why interventions did not work considering that they were based on theoretical models.

These limitations, in combination with a lack of significant results or small effect sizes in significant results, suggest that it is difficult to recommend any one internet or web-based approach as efficacious or beneficial over another. In considering the use of internet/web-based interventions for help-seeking for mental health, the results suggest that at present there

is limited or low evidence of effectiveness. However, the confidence in this assertion is also low. This is due to methodological biases that are either present or unknown within the studies. Studies will need to develop more methodological rigor and would be improved by reporting effect sizes, monitoring intervention adherence, better sampling methods in some studies, completing intention to treat analyses conducted.

Audio-visual

The review identified six studies examining the use of audio-visual interventions (Corrigan, Powell, et al., 2015; Demyan & Anderson, 2012; Kaplan, 2010; Lindsley, 2014; Siegel et al., 2015; Wong & Chan, 2015). Examination of the interventions showed core elements to audio-visual interventions as including psycho-education, normalising help-seeking, emotional appeals, identification between the messenger and the audience, direct and peripheral messages about mental health and a narrative vignette of a person's experience, such as a person experiencing mental health difficulties or a professional.

All the studies showed interesting and innovative designs to address the research question. Four studies used a public service announcement (PSA) style intervention or advert (Corrigan, Powell, et al., 2015; Demyan & Anderson, 2012; Siegel et al., 2015; Wong & Chan, 2015), one study (Kaplan, 2010) used pre-existing video material from a reality TV show featuring a woman who was experiencing depression and focused on help-seeking. One study was a multi-media approach (Lindsley, 2014), which used videos, audio, and narrations in a presentation. All of the designs expressly targeted help-seeking for depression and anxiety only.

With regard to control groups, studies used non-intervention videos, a talk about dental hygiene, a presentation about general health and wellness, or they asked participants to write about how they currently felt. Three designs had more than one intervention group or a

comparison groups. Corrigan et al., (2015) used two interventions, a recovery story and a PSA; Kaplan (2010) used a repeated exposure group, a single exposure group, and a control; and Siegel et al., (2015) used a mistargeted exposure, targeted direct exposure, and a control group. The use of these different types of designs enables comparison to be made against no intervention and alternative theory driven interventions, direct versus indirect interventions, and repeated versus single exposure. However, there was some theoretical overlap between interventions that may have made it difficult for interventions to find differences between groups.

A range of theoretical models were used to guide the interventions. The Theory of Planned Behaviour (TPB; Ajzen, 1985) and Theory of Reasoned Action (TRA; Ajzen, 1985) was the most used theory to develop four of the interventions, two interventions used multiple explanatory or theoretical models; Kaplan (2010) used TPB, cultivation theory (Gerbner, Gross, Morgan, Signorielli, & Shanahan, 2002) and Elaboration Likelihood Model (ELM; Petty & Cacioppo, 1986); and Lindsley (2014) used TPB, Protection Motivation Theory (Rogers, 1975), Yale Model of Persuasion (Chaiken, 1987) and the ELM. Although studies have often explained the theoretical model well, a limitation within the literature is that explanations of how their intervention targets specific theoretical elements were unclear, other than reducing stigma which was well documented. This may limit the explanation of how interventions work in changing attitudes and intentions.

The studies used general populations (Corrigan, Powell, et al., 2015; Siegel et al., 2015) or student populations (Demyan & Anderson, 2012; Kaplan, 2010; Lindsley, 2014), and within samples identified distressed, depressed, or anxious individuals. Others mental health diagnoses were not included. Studies were generally susceptible to selection bias and frequently used opportunity sampling, especially within student samples. Two studies made

good attempts to reduce bias. Both Corrigan et al., (2015) and Siegel et al. (2015) used Amazon Mechanical Turk, an online system, which provided better recruitment of diverse individuals from a range of different cultures and backgrounds. Samples however were predominately Caucasian female and middle-socioeconomic status. There was some diversity in age groups compared to other media interventions, with more adults above 25 years. Studies need to better report how many declined to participate or self-referred, which in the present studies has meant biases in selection are unknown. However, good attempts were made to address these limitations through randomisation and exploring possible confounders between groups. A strength across most of the studies was exploring, controlling and analysing possible confounders between groups. However, due to the selection biases it is unclear whether the results of the studies will be generalizable to larger groups despite these attempts to manage bias.

Three studies made good attempts at trying to blind participants to interventions (Demyan & Anderson, 2012; Kaplan, 2010; Wong & Chan, 2015) by placing the intervention between other video segments to mask the purpose of study. However, there is the possibility that participants have not given attention to the intervention. In this regard, Wong & Chan (2015) examined the attention and found a high level of attention was given to the intervention. One limitation of all the studies was failure to report explicitly whether assessors were blinded, although research procedures would suggest they were. Interventions and outcome measures in this area are difficult to blind, and although good attempts were made to address these difficulties, some performance and detection bias may still exist due to the outcome measures and content of the media.

In respect of measures, studies used appropriate measures regarding the concept being asked and reliability and validity data were well-reported. Secondary measures that examined

mental health symptomatology, primarily depression, were also used to examine differences between distressed/clinical participants and non-distressed/non-clinical participants. One concern is the maximum follow-up period of 4 weeks, which may not be long enough to observe changes in attitudes and intentions.

With regard to results, three studies found non-significant results between intervention groups and controls exposed to no intervention (Corrigan, Powell, et al., 2015; Kaplan, 2010; Lindsley, 2014) in terms of positive changes in help-seeking attitudes or intentions, despite reductions in stigma attitudes.

Demyan & Anderson (2012) found no significant change in belief-based factors such as stigma and treatment fears between intervention and control groups. However, they did find that the intervention group endorsed more positive attitudes toward help seeking than the control group. Interestingly, these findings do not fit with the theoretical rationale of TPB used to plan the study. There is a disconnect between the theory and the results, with the results not being consistent with theory. Due to the methodological strengths of the study, this suggests that understanding of the elements of interventions that actually change help-seeking attitudes and intentions remain relatively unexplained. Corrigan et al. (2015) interestingly found a small-effect size for change in stigma, which did not translate into significantly improved help-seeking attitudes. This again suggests that other elements beyond reducing stigma are at work and need to be further investigated. Siegel et al's (2015) results imply that the other interventions may not have been successful due to their direct approach in giving information. Their mistargeted approach showed that providing information aimed at another can actually help the individual with their own mental health help-seeking, suggesting vicarious change in other elements beyond stigma is useful.

Limitations are observable across all the studies. Firstly, all the studies measure self-reported help-seeking intentions and attitudes, which do not necessarily translate into actual help-seeking behaviour. Secondly, the populations in the groups are often poorly conceptualised, particularly "general populations". Thirdly, all the studies also have a short length of follow-up, which may prevent observable changes over time. Finally, studies have variance in the dosage of intervention, with the shortest being a single 4-minute video and the longest being repeated exposure to 2-minute videos.

In summary, the evidence for audio-visual interventions in promoting help-seeking attitudes and intentions is that they are *moderately effective*. The confidence in this assertion is also moderate due to possible selection bias limiting generalisability, a lack of reporting of effect size, non-significant results, attrition bias, and a lack of intent-to-treat analysis. Despite these limitations, the evidence would suggest some utility in the use of audio-visual media in improving help-seeking intentions and attitudes. The greater confidence lies in the significant results, which all come from studies with stronger designs. Results also add to the evidence that specific factors, including gender, previous treatment, and level of distress act as moderators, although the direction of effect is sometimes unclear, especially for distress levels. Confidence in results can be improved by considering the methodological and theoretical limitations, and improving reporting about study uptake, unknown selection bias, reporting analysis of group confounders or providing a CONSORT diagram. Further, improving the limited reporting of effect-sizes, addressing attrition bias, and replicating studies that showed effective blinding would also improve future studies.

Print

The review identified six studies that utilised print media (not based on the internet; Hammer & Vogel, 2010; Han et al., 2006; Hernandez & Organista, 2013; Jorm et al., 2003;

Lienemann et al., 2013; Siegel et al., 2015). The studies used a range of interventions, primarily using psycho-educational approaches or mental health information, a printed PSA and a *fotonovela* (a photographic book in a comic book style). Core elements across the interventions were psychoeducation and vignettes of people experiencing mental health difficulties.

Studies compared their interventions against varying conditions including a group discussion around family communication and intergenerational relationships, a control brochure on depression material provide by the Australian Government; a US Government advert on conservation; and a targeted PSA as opposed to the mistargeted PSA. One study focused only on men experiencing depression and specifically used their male-sensitive brochure against a gender neutral brochure group. The effectiveness of some studies may be masked by the similarity of the intervention to the control. Only Han et al., (2006) used both active and inactive control groups.

Print interventions used a range of theoretical models to develop interventions, including prior research on psychoeducation, mental health literacy, and social-cognitive theory. The review has identified that all the studies used a theoretical rationale for the intervention; however the links with specific elements in the interventions was unclear in many studies. This may limit the explanatory power of why and how an intervention worked or did not work.

Four of the studies use either a general population or student samples and used screening measures of depression in three of the studies to stratify data. The remaining study used a population scoring within a clinical threshold for depression on a screening measure. The final samples were predominately younger, female and Caucasian. Two studies are targeted at specific sub-populations: Hernandez & Organista (2013) focused on help-seeking

in a female Latin-American population; and (Hammer & Vogel (2010) focused on men experiencing depression. Several of the studies made excellent attempts at recruiting a representative sample using a range of methods including through local community members, internet adverts, posters, the electoral role, and Amazon's Mechanical Turk. Despite these attempts, there is either unknown bias or selection bias in terms of uptake of the studies. This may impact upon the generalisability of the results or applicableness to specific populations.

With regard to blinding of the participants, it is unlikely that participants in any of the studies would have known their group allocation. However, several of the studies did not report their procedure in blinding and in two studies (Lienemann et al., 2013; Siegel et al., 2015) the randomisation process was not adequately reported. Interventions and outcome measures in this area however are difficult to blind and although good attempts were made to address these difficulties, some performance and detection bias may still exist. A limitation of all the studies was a failure to report explicitly whether assessors were blinded.

There was significant heterogeneity of outcome measures used across designs, although all used self-report measures designed to examine help-seeking attitudes or intentions. No studies measured actual help-seeking behaviour. The measures used were appropriate to the designs and most studies reported reliability and validity data. Pre and post measures were used, with the maximum follow-up period being 6-months. Secondary measures were often used to examine mental health symptomatology, primarily depression, to scrutinise differences between distressed and non-distressed participants.

In respect of results, Hammer and Vogel (2010) reported a significant result of the intervention versus a previous male help-seeking brochure, with a small-medium effect size. Results may be significant due to using a group that reach clinical cut-off for depression, meaning the intervention became more relevant.

Hernandez and Organista (2013) quote "marginally significant" results and quoted the effect size as moderate (*d= 0.47*). However, on further inspection the result is non-significant, which the authors explain with a stringent p-value to control for type-1 error. This result is considered to be non-significant despite the stringent p-value and is used herein as indicative of the effectiveness of the intervention. Jorm et al. (2003) also found non-significant effects of the intervention compared to the comparison group.

Han et al's (2006) results state that increasing the belief in biological attributions improves willingness towards help-seeking, whereas decreasing blameworthy attitudes towards depression does not improve help-seeking attitudes and intentions. No interaction effect was found between the two approaches. Their conclusion alludes to the biological approach being more simplistic and concrete than the de-stigmatisation approach; therefore the intervention did not successfully intervene in these complex elements of destigmatising help seeking.

Lienemann et al. (2013) and Siegel et al., (2015) argue that the level of distress/depression does not have an effect on help-seeking intentions. However, they found that this effect is mediated through stigma towards professional help in the intervention group. Interestingly, both studies found depressed individuals had fewer positive attitudes toward help-seeking and their results support a hypothesis that a targeted intervention approach unintentionally activates attitudes or beliefs that would not have been activated otherwise. These findings are useful in considering why other media interventions may or may not have worked.

In summary, the results for print media suggest a significant effect of the interventions over control groups with no intervention, but they are no more effective that pre-existing interventions. The results suggest a *small-to-moderate effect* of the interventions on

improving help-seeking attitudes and intentions compared to controls not exposed to the intervention. Confidence in the effect is also *moderate* due to methodological limitations of the studies. A strength of the studies includes the interesting results from sub-populations, which have added to evidence that print media interventions may be appropriately targeted at sub-group populations. Confidence in results would be improved by improving participation rates to reduce selection bias, better links between elements of the intervention and theory so that how and why interventions work can be explained, addressing attrition rates, better attempts and reporting of blinding of participants and assessors, and use of behavioural outcomes.

Discussion

Examining the literature, this is the first systematic review on the efficacy of media interventions in targeting help-seeking attitudes, intentions and behaviour. Two other reviews were identified that focused on similar areas. Gulliver, Griffiths, Christensen, and Brewer (2012) reviewed the use of interventions that promote help-seeking for depression or anxiety. Kauer, Mangan, and Sanci (2014) reviewed the use of online approaches to improving help-seeking in young people. The current review took a more broad approach than these two reviews by adding other types of media, and having no restriction on age or the nature of mental health difficulty.

Results and implications for researchers

In considering the evidence for media interventions and the impact on help-seeking intentions, attitudes and behaviours, three key questions need to be summarised; Do they work?; How well do they work?; and how do they work?

With regard to the first two questions, this review suggests there is moderate evidence that media interventions work. Results were mixed with approximately half the studies finding significant effects and half finding null results. In considering how well interventions work, a small-to-moderate effect size was found. The studies which found an effect had few similarities, making it difficult to identify the elements of the studies that attributed to significant results. Samples were generally participants from a student or general population, who were then screened using a depression or distress measure to enable stratification or exclusion. Across the samples, it is apparent that many of the studies utilised similar populations with issues around diversity. No studies used a sample experiencing any other mental health difficulty other than either depression or anxiety. As such, the results are applicable primarily to Caucasian females from a student population experiencing depression.

Key issues that limit the confidence in these results fit into two general areas: methodological and theoretical. Methodological issues were present in all studies, some of which can be addressed by improvements in design and reporting, whereas others remain a challenge for the study area. In respect of design issues, the most frequently encountered problem was attrition and selection bias, and future studies need to address these difficulties through better recruitment uptake and definition of population groups. Secondly, control groups that were often not significantly different from the intervention may have masked the effect size and significance of results. Finally, blinding has been a particular issue across studies. This is both a reporting error with regard to not reporting whether assessors or participants were blinded, but also a methodological issue in terms of attempting to blind participants to the research question. Two studies (Demyan & Anderson, 2012; Wong & Chan, 2015) showed that blinding of the intervention was possible, although outcome measures are still difficult to blind. Reporting issues observed included the lack of a CONSORT diagram, reporting group allocation, several studies omitting all of the results in tables or reporting effect size, and reporting of possible selection bias and attrition bias in studies.

The theoretical issues and the 'how' and 'why' interventions work are possibly the more difficult areas to rectify and require more research to explore. Across the studies, a broad range of theoretical approaches were used to inform interventions, as a consequence of there being no universally agreed model in the help-seeking literature. Despite lacking this common framework, studies tended to examine help-seeking attitudes, beliefs and intentions about help-seeking. The rationale of the studies was that improving these or reducing barriers will improve actual help-seeking behaviour. In this regard, it is important to consider the

theories used and the examination of mediators and moderators, primarily stigma, gender, level of distress and previous help-seeking behaviour.

Firstly, several studies focused on reducing stigma to improve help seeking. The existing evidence highlights that stigma provides only a small to moderate negative effect on help-seeking behaviour (Clement et al., 2015). It can therefore be argued that attempting to reduce stigma, as many of the studies attempted, will only have a small-to-moderate effect at best on improving help-seeking intentions and attitudes. Authors have argued that erasing stigma is not sufficient in itself to promote help-seeking, and interventions need to also promote affirming attitudes of social inclusion (Leff and Warner, 2006; Lloyd et al., 2008). Reducing stigma was the primary approach of most studies, which possibly explains both null results and small effect sizes that occurred outside methodological limitations. Further exploration is needed of media interventions' use of affirming social inclusion as opposed to a primary focus solely on stigma reduction if help-seeking interventions are to be improved.

Studies often explored other moderating or mediating factors through stratifying their samples. There can be some confidence about moderators and mediators that alter the efficacy of media interventions; gender, age, previous therapy or help-seeking behaviour and level of distress. The results show that being female, older, or having a previously established pattern of help-seeking all influence the effect of the intervention positively and with greater magnitude. However, the direction and magnitude of level of distress remains unclear due to mixed results. These findings add to the evidence that particular groups, including males, military veterans, younger people and ethnic minorities in North American and European countries are less likely to seek help (Leong & Zachar, 1999; C. S. Mackenzie, Gekoski, & Knox, 2006; Nam et al., 2010; Rickwood, Deane, Wilson, & Ciarrochi, 2005b).

The theoretical model used by the studies also needs to be considered, with TRA/ TPB being the most commonly used. However, there have been some theoretical issues faced by TPB; primarily that by adding in past behaviour relationships between attitude and intention and between intention and behaviour are significantly attenuated (Hagger et al., 2002). Three studies in this review controlled for past therapy experience in their analysis, and all found a mediating or interaction effect of the intervention. In addition, other research has shown that the model's prediction of behaviour varies by the behaviours attempting to be explained. For example, HIV- and AIDS-related behaviours are relatively well predicted (42.1% of variance) compared to clinical behaviours (15.1%). McEachan, Conner, Taylor and Lawton (2011) highlight that the nature of the behaviour and population group important factor that change the predictive utility of the TPB and therefore it's use in developing interventions. At present the evidence of the predictive utility of TPB for changing mental health help-seeking behaviour is unknown.

In summary, the 'why' and 'how' of interventions working could be better explained. For example, why intentions to seek treatment were raised and what specific elements of the intervention allowed for or promoted this. The specific elements that improved help-seeking are not well argued and explored; therefore, the interventions have little explanatory power at present. This creates an issue for future media campaigns that promote help-seeking behaviour as it still remains relatively unknown which factors within a media campaign can change behaviour. At present the approach is to use a model at the "general population" level, whereas evidence from this review suggests that targeting specific sub-populations within a theoretical framework, and considering mediators and moderators to design specific elements of the intervention, may improve efficacy. Some of the studies in the review have

done this well and in light of new information from reviews (i.e. Clement et al., 2015) interventions can be designed with the above considerations in mind.

Finally, the biggest limitation is the targeting only of intentions and attitudes with small follow-up periods, and most importantly the absence of recording of behavioural change. The small-to-moderate effects in changing help-seeking intentions and attitudes are important as Webb & Sheeran's (2006) meta-analysis showed that a medium-to-large sized change in intention creates only a small-to-medium change in behaviour. This is significant as the small-to-moderate effects are likely to result in small and negligible changes in behaviour. However, without behavioural measures, this cannot be reliably ascertained.

In summary, future researchers need to pay close attention to the aforementioned methodological and theoretical issues in future research. Reporting issues are easiest to rectify and have already been detailed. The methodological issues require attempts at recruitment, recruitment of sub-populations rather than broad "general populations", more attempts at blinding, and analyses that handle attrition such as intent-to-treat. Finally, theoretical issues require further examination of the use of TPB, consideration of mediators and moderators, use of behavioural data, better explanations of how and why interventions work, and which specific elements promote help-seeking attitudes and intentions in specific populations.

Clinical implications

The evidence suggests there is utility in using media interventions, particularly print and audio-visual media. Media can have a moderate effect on promoting help-seeking attitudes and intentions under the circumstances that it is targeted at the appropriate population. None of the articles described the cost or time implications of media interventions, however, figures from Clement et al. (2013) highlight that media interventions

can be relatively low cost to reach large amounts of individuals. In addition, media interventions can reach large groups and populations that are difficult to engage due to their flexibility.

The evidence highlights the need for consistent media approaches that target a range of factors to improve help-seeking attitudes, intentions, and behaviour. Core elements of interventions would be psychoeducation, normalisation, identification, relevancy, and emotional connection. The evidence at present suggests a lack of certainty in terms of what is needed to make these elements successful and requires further exploration. In addition, several studies have highlighted the need for frequency of delivery in improving outcomes. Therefore a combination of media channels, careful evidence-based content of the intervention targeted at the correct population, and a high frequency of materials are likely going to generate the most successful interventions.

Limitations of this review

There are limitations that exist in the current review which may impact upon the confidence in the conclusions drawn. The biggest limitation is within the conceptualisation on the media and what constitutes help-seeking.

Firstly, the media is conceptually heterogeneous with several categories of media being poorly defined or overlapping. In addition, due to advances in technology, media is no longer bound to specific formats, for example, videos are accessible on mobile phones, TV, and the internet. Crosbie ((2002) describes this as new media, whereby there is no longer the "one-to-many" and unidirectional nature of the media from an organisation towards an individual. New media is also personalised to create personal relevance for the individual.

These issues are relevant for both this review and the included studies. Newer media can utilise this understanding to create more personalised media to influence the attitudes and beliefs of the individual rather than as a group process. It is recommended that future reviews and studies focus on developing media that can be constructed across platforms using newer modes of media. With media and technology changing, researchers need to remain up-to-date with the methods used by people in accessing information. These difficulties have also led to complications in identifying literature and what constitutes a media approach. The search strategy used was unable to identify all the papers in this review, suggesting that some articles may have been missed.

The second limitation of the review is that only RCTs have been included. Due to the wide reach of the media, the studies and therefore this review may have little ecological validity. Future reviews need to also explore whether RCT results can be replicated on a larger scale and in more ecologically valid environments.

Finally, publication bias and being unable to obtain papers has been an issue for this review. Four studies were unobtainable, representing 20% of the literature identified. Inclusion and exclusion criteria could be more rigid in the future.

Despite these limitations, this review contributes to the understanding about how media interventions can influence help-seeking attitudes and intentions for mental health difficulties.

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THE EXPERIENCES OF THE MEDIA AND THE IMPACT ON THE RECOVERY OF MEN IN A FORENSIC SETTING

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Introduction

Mental health in the media

The proliferation of media representations and influences can be observed across topics ranging from those of world importance to those of local interest (Brannstrom & Lindblad, 1994; McCombs, 2013; Seale, 2003). As a result, the media has been identified as a powerful influence in shaping individual and societal beliefs, attitudes and behaviours (Edney, 2004). One such area of influence is in shaping societal notions about mental illness (Anderson, 2003).

A considerable body of research exists examining mental health representations within the media, including several reviews and editorials (Klin & Lemish, 2008; Nairn, 2007; Pirkis, Blood, Francis, & McCallum, 2005; Pirkis & Francis, 2012; Sieff, 2003; Stout, Villegas, & Jennings, 2004). These have captured data across a number of studies, contexts, media channels, and populations.

This evidence consistently demonstrates that portrayals of mental illness are often skewed (Francis, Pirkis, Dunt, & Blood, 2001), and endorse stereotypes of dangerousness, unpredictability, and strange or peculiar behaviours (Caputo & Rouner, 2011; Pirkis, Blood, Francis, & McCallum, 2006; Signorielli, 1989). These depictions promote stigma and perpetuate common myths about mental illness. However, these ideas rarely have basis in reality or in research findings, for example mental illness is a poor predictor of violence and this group are more likely to be victims of violence (Douglas, Guy, & Hart, 2009; Fazel, Gulati, Linsell, Geddes, & Grann, 2009; Large & Nielssen, 2011).

The reviews also identify that "positive" stories about mental health are significantly underrepresented (Sieff, 2003). This is problematic when evidence suggests realistic and

representative portrayals are beneficial in reducing negative stereotypes (Chopra & Doody, 2007; Nairn & Coverdale, 2005). Media depictions do offer some sympathetic views, however, these often portray individuals as sorry victims which reinforces concepts that people with mental health difficulties are unable to care for themselves and reduces optimism about their situation (Pirkis & Francis, 2012). Several analyses show there has been few changes in media depictions, with themes of dangerousness and stereotypical behaviour still prevailing (Goulden et al., 2011; Wahl, Wood, & Richards, 2002).

As the media is a substantial source of information about mental illness for the general public, these issues raise concerns. Research identifies several negative impacts of this misinformation and skewed narratives on both people with and without mental health difficulties (Borinstein, 1992; Coverdale, Nairn, & Claasen, 2002; Kalafatelis & Dowden, 1997). Media stereotypes increase desire for social distance in the general population towards people with mental health difficulties (Angermeyer, Dietrich, Pott, & Matschinger, 2005; Dietrich, Heider, Matschinger, & Angermeyer, 2006), reinforce negative stereotypes and myths, and reinforce views of them as tragic and deserving of pity or as dangerous outsiders (Philo, Henderson, and McCracken,2010). In addition, these portrayals prevent new awareness, accurate information and knowledge about mental illness being learnt by the general population (Lauber, Nordt, Falcato, & Rössler, 2004). Evidence from positive media campaigns identifies that reducing the negative images of stigma and presenting a positive image of mental illness can reduce the aforementioned effects (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012; Evans-Lacko et al., 2013).

For the impacts on those experiencing mental health difficulties, it is important to highlight evidence and theories that suggest self-concept is socially constructed and profoundly shaped by how we believe others see us (Lucksted, 2015). Vogel, Wade and

Hackler (2007) illustrated public stigma and the perception of mental illness can be internalised by the individual. Known as self-stigma, this theory proposes an individual loses their previously held or desired self-concept and instead adopts the stigmatised view of themselves (Vogel, Bitman, Hammer, & Wade, 2013). Reported internalised media representations include ideas of worthlessness, helplessness, dangerousness, and unpredictability. However, there is an interesting paradox whereby not all individuals internalise media stigma to the same degree (Corrigan & Watson, 2002). For instance, some individuals may respond with righteous anger and indignation, others by internalising or avoiding the stigma. How individuals make sense of their experiences of public stigma and come to internalise these attitudes is of particular interest. Exploring experience enables a deeper understanding of how individuals perceive and make sense of stigma in the context of their self-concept.

Internalised-stigma has been linked with a vast range of negative outcomes for individuals, including diminished self-esteem and acceptance, decreased empowerment, feelings of isolation and exclusion, and depreciated self-value and loss of identity (Brohan, Elgie, Sartorius, & Thornicroft, 2010; Corrigan, Watson, & Barr, 2006). In addition, there is reasonable evidence to suggest that it reduces treatment success (Fung, Tsang, & Corrigan, 2008; Sirey et al., 2001), reduces self-efficacy (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001), and help-seeking (Golberstein, Eisenberg, & Gollust, 2009), as well as several other negative impacts (see Evans-Lacko et al., 2012; Wahl, 2012 for more comprehensive lists).

For this study, a particular area of interest is the impact of media portrayals on the recovery of males in a secure mental health setting. Individuals in these settings are subject to triple stigma; mental illness, criminality, and race (West, Yanos, & Mulay, 2014; Morrall,

2000). Media coverage of this group engenders ideas of these people as having no social identity, as continually violent and antisocial, and as deviating from the norm, stripping away their human qualities (Anderson, 2003). Stout et al (2004) argue this arises to help the general public make sense of the world as ordered and rational, and that a person's actions can be attributed to their mental illness. This, however, reinforces dichotomous, polarized ideas, for example normal and abnormal, good and bad. Experts within the field highlight that although offenders will have committed offences which are of sociological concern, these narrow and lazy stereotypes prevent society from understanding the complex nature of offending and mental illness in any depth (Asma, 2011) and restricts individuals to a 'psychiatric offender' identity. In addition, within forensic mental health there is an over-representation of Black or Minority Ethnic (BME) groups. Research suggests that BME groups make up around 25 per cent of forensic mental health populations (Rutherford & Duggan, 2007). This adds a further dimension about how BME groups with mental illness and forensic histories are represented within the media, whether there is over-representation, and how these portrayals might impact upon this group. However, there is a paucity of research into these experiences for this group resulting from being subject to these narratives around mental health, criminality and race.

The impact of mass media on recovery

Recovery is an idiosyncratic, non-linear process that holds personal meaning and understanding to each individual, moving them towards a satisfying and hopeful life regardless of the presence of symptoms. A recent narrative synthesis of qualitative studies led to a conceptual framework of recovery (Leamy, Bird, Boutillier, Williams, & Slade, 2011). Five core domains of recovery were identified; connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. The review also maps recovery onto a trans-theoretical stages of change model, illustrating the domains of recovery over a change

process (see Appendix 1 for more information). These domains have also been identified in people with a forensic history (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010). Importantly, public-stigma and self-stigma restrict individuals experiencing self-acceptance, empowerment, self-efficacy, connectedness, and developing an identity beyond diagnostic labels; important factors within the conceptual framework (Yanos, Lucksted, Drapalski, Roe, & Lysaker, 2015).

However, despite these overlaps in theory, there is limited research available to examine the links between the media and recovery. This study aims to examine experiences of media narratives and the impact upon recovery in a group of men in a forensic mental health hospital. This group is significantly under-represented within the literature about media, recovery and stigma, despite being subject to triple stigma and importantly, the nature and impact of these experiences are unknown. In fact, no study has been identified that explores how people make-sense of media discourses and recovery. Considering the difficulties this group experiences in finding a voice within the media, this study aims to listen to individuals' experiences and sense-making of media discourses and from their perspective the impacts it has on their recovery.

Methodology

Context

This research took place in male only medium-secure units (MSU) in the United Kingdom. Individuals in MSUs are usually detained under the Mental Health Act (1983) and have either committed an offence or are deemed to be a significant risk to others. Individuals are subject to a number of restrictions, primarily that they are not free to leave under their own volition. These services use a recovery model and offer specialist treatment through a range of occupational, medical and psychological interventions. Individuals generally work towards leaving the MSU through a graded process of lessening restrictions.

Ethical Approval

Ethical approval was obtained from the University of Birmingham (UoB) as sponsors of the research (Appendix 2), and an NHS Research Ethics Committee (REC; Appendix 3). Local ethical approval was obtained from the NHS Trust's Research and Development (R&D) department, which included approval for recruitment from the research sites (Appendix 4).

Sampling

To create homogeneity in the sample, the intended participants needed to be male, detained in an MSU and diagnosed with a psychotic mental illness as defined by the DSM-V (APA, 2013). To source this sample, potential participants were identified and approached through multi-disciplinary teams (MDTs), who are responsible for the care of detained service users (recruitment information in Appendix 5-8). If potential participants showed interest, the Responsible Clinician was asked to provide consent for the researcher to approach the participant. Once approved, participants were approached and verbal and written information about the project was given. Participants were given a minimum of 24 hours to make a decision about participation. If interested in participation, a first interview was arranged with

the participant and consent obtained. Table 1 illustrates the inclusion and exclusion criteria applied in the recruitment. A schizophrenia spectrum and others psychotic disorders were defined as any mental disorder that are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganised thinking (speech), grossly disorganised or abnormal motor behaviour (including catatonia), and negative symptoms. This is the definition provided by the DSM-V (American Psychiatric Association, 2013) and used for inclusion criteria.

Individuals with a diagnosis of personality disorder were excluded from the study. The rationale follows that personality disorders are represented different within the media compared to mental illness(Cronin, 2016).However, there is little research at present examining these differences. Further evidence suggests social attitudes and experiences of stigma are experienced differently for people with personality disorder in comparison to people with a mental illness (Dinos, Stevens, Serfaty, Weich, & King, 2004). Although few studies have explored these differences, this study considers the examination of media portrayals around personality disorders worthy of another independent study. As such, this study focuses only on experiences of media with people diagnosed with a psychotic mental illness. People with co-morbid mental illness and personality disorder were also excluded.

Table 1: Eligibility and Exclusion Criteria

Inclusion	Exclusion
Male	Diagnosis of a co-morbid personality disorder
Aged 18-65	Participants whose proficiency in English would make it difficult for them to participate in the interviews and complete self-directed work on the media.
A primary diagnosis of Psychotic illness as defined	Service users who through mental illness, significant cognitive impairment or any other reason, are unable to sufficiently understand the nature of the study and the information provided to provide informed consent
An offence committed during the course of illness / illness developed or identified during the course of imprisonment	Service users whose clinical team believe that it is unsafe/not feasible for them to work with a researcher on a one to one basis
	Service users that have previously worked psychologically with the Chief Investigator

Participant demographics

In total, eight participants were interested in the study, with the final sample comprising of six individuals. The two participants whose data was removed were a 58 year old male and a 33 year old male. The removed participants consented to the interviews, but the data gathered from the interviews was not of the required quality for analysis. This was primarily due to the participants not being able to answer the questions posed during the interviews or becoming distressed by the process, leading to interviews being ended. The result transcripts were too short or not of any detail to enable analysis.

Table 2 identifies participant demographics of the final sample of 6 participants.

Table 2: Participant Demographics

Name[1]	Age	Ethnicity	Current period of admission[2]	Age of onset of illness	Time involved within mental health services*
Andrew	42	White British	3 years	13 years	33 years*
Baljeet	45	British Indian	4 years	14 years	29 years*
Cameron	26	Black British	3 years	15 years	4 years
Chris	31	Mixed British	7 months	13 years	11 years
Jerimiah	33	Black British	6 years	15 years	13 years*
Malakai	32	African	1 year	19 years	9 years

1. Names have been anonymised to protect participants identity
2. This is the period of current admission, not the cumulative time of all admissions
*some of the time periods are approximate based on participant estimates rather than official documentation.

Data collection

Materials

It was decided during the course of developing the research that the link between the media and recovery may be difficult for participants to conceptualise. In order to support participants in framing the ideas, *cultural probes* were deemed appropriate. Cultural probes provide an alternative method to gather information about people and the lives, often through self-documentation tasks outside of qualitative interviews (Gaver, Dunne, & Pacenti, 1999; Thoring, Luippold, & Mueller, 2013). This was particularly relevant for this study as many of the concepts may have been hidden to the participants, and the probes provided a way to stimulate and provoke further understanding.

A range of cultural probe tasks were initially planned. However due to MSU audio-visual, internet, and photography restrictions, the study was limited to paper-based postcards and a media diary. A balance was sought in the types of stories delivered through the postcards and the media diary asked participants to document media they observed regarding mental health between interviews. On the reverse of the postcards and in the media diary the same questions were asked and can be found in Appendices 9 and 10 -. The aim of the questions was to prompt novel discussion points and deeper understanding of lived experience.

Procedure

Participants engaged in two interviews lasting between 100 and 140 minutes plus completing the cultural probes in between. The overarching aim and research questions stemmed from the epistemological and theoretical position of the research, and formed the basis of an indicative topic (Appendix 11). Interviews took place in quiet rooms on the units in the MSUs and were recorded on encrypted digital recording devices. The indicative topic

guides were used flexibly with each participant, with the researcher exploring interesting points arising during the interviews. The researcher has previous interview experience, psychological training and qualitative research experience to facilitate this approach.

During the course of the interviews, there was an ongoing process of capacity assessment. Capacity and the distress of the participant was assessed prior to and during each interview. During one interview, the participant became too distressed to continue and the interview was ended after 11 minutes. The researcher has received training in capacity assessments to allow continual assessment of capacity to participate, and also worked with each participant's clinical team to ensure capacity to consent.

After the interviews, participants were given 2 weeks to decide whether they wanted to withdraw their data. After this period, audio files were transcribed. Participants were offered the opportunity to have a written copy of their interview. Any identifiable information within the transcripts was subsequently removed.

Analysis

Interpretative Phenomenological Analysis (IPA)

This research took an idiographic focus which offers insights into the subjective experience and sense-making of participants in relation to a specific phenomenon (Smith, Flowers, & Larkin, 2009). IPA does not search for a specific truth, but takes a phenomenological, epistemological position whereby interpretative methodology is used to understand and observe the individual's inner world (Larkin, 2014). These experiences are unique to the person and based in their own personal context.

This research aimed to identify participants' lived experience of media stories about mental health and forensic labels. IPA provided a method to create an in-depth, experientially-

focused understanding of these experiences, events, and states within the context of their recovery. Therefore, the second aim of the analysis was to understand the significance, impact, and consequences of media experiences on the participants' recovery from mental illness.

Assessing validity

Yardley (2000) identifies four broad principles to assess the quality of qualitative research. I assessed the study continually using these principles, although many will only be obtained through independent observation. Table 3 illustrates these criteria.

Table 3: Characteristics of Good Qualitative Research (adapted from Yardley, 2000)

Essential qualities	Examples
Sensitivity to context	Theoretical; relevant literature; empirical data; sociocultural setting; participants' perspectives; ethical issues.
Commitment and rigour	In-depth engagement with topic; methodological competence/skill; thorough data collection; depth/breadth of analysis.
Transparency and coherence	Clarity and power of description/argument; transparent methods and data presentation; fit between theory and method: reflexivity.
Impact and importance	Theoretical (enriching understanding); socio-cultural; practical (for community, policy makers, health workers)

The first is *sensitivity to context* whereby the researcher should be aware of, but not exclusively, personal context, social context and theoretical context. Regarding personal context, I have worked for six years in forensic settings. This has involved running groups concerning the media, mental health and offending, and research into the antecedents of violence with this population. As a general member of society, I am exposed to various media narratives about mental health and illness. I hold particular knowledge of people in a forensic setting which has been in contrast to the media narratives I am exposed to. These experiences in forensic settings may have biased my interpretation, however, may have also helped with the interpretation of the data.

The other issues of assessing the quality of this research can only be done by independent observers. However, several steps have been taken to ensure validity and credibility. This research was developed from the starting question through to the analysis by the chief investigator with the support of a research supervisor, another researcher at the University of Birmingham (UoB) who has conducted a number of qualitative studies. We developed the research question and procedure, ethical application, and research materials. Interviews were checked by these people for qualitative validity, thoroughness, and appropriateness to the research question. The data was analysed and themes identified by the chief investigator, and assessed for credibility through triangulation by the research supervisor, the UoB lecturer, and through peer support of other trainee psychologists at the UoB. Finally, a number of verbatim extracts were used to reflect participants' voices and the corresponding interpretations to aid in promoting the commitment and rigour of the analysis.

Transcripts were read to identify objects of experiential concerns for participants in terms of the media and their recovery. Following this, interpretations were made as to the meaning of those concerns for each participant (Appendix 8). Patterns were then identified for each

participant in order to create an understanding of emerging themes (Appendix 9). This was conducted for each participant to allow for comparison across cases which establishes convergence and divergence of those emerging themes. Themes were then triangulated with other researchers and peers. Finally, the identified themes were checked for credibility with a research participant. This credibility check took place as a discussion about the final paper and created some minor changes to theme wording. For example, the original theme of "not seen outside of illness" was changed to "I'm never seen living well". These changes did not affect the understanding of each theme, but added to the descriptive quality and voices of the participant within the themes.

Results

Using the above methodology, the themes outlined here will first explore experiences of the media in terms of their significance for the individual then how participants make sense of these experiences in the context of their recovery. It is relevant to know that participants appear consistently made sense of the media as having both a positive or negative effect on them, as a *"double edged-sword"*, and this is how I have understood the data. There was consistent convergence on all the themes, with little divergence. The data also indicate that personal situation and context often affected how media experiences were internalised and impacted recovery, which will be discussed in "*the transformative nature of the experience*". These two themes are considered over-arching and within which the others themes are understood. Table 4 provides an illustration of the final thematic structure and the participants who endorsed each theme.

Table 4: Final Thematic Structure and Participant Agreement

Theme	Sub-theme	Participant					
		Andrew	Baljeet	Cameron	Chris	Jerimiah	Malakai
Double-edged sword		✓	✓	✗	✓	✗	✓
Blind to my experience	*My suffering and struggle are omitted*	✓	✓	✓	✓	✓	✓
	I'm never seen living well	✓	✓	✓	✓	✗	✓
No escape from an unwell me	*Branded by the label*	✓	✓	✓	✓	✗	✓
	Outcast	✓	✓	✓	✓	✗	✓
	Reawakened shame and trauma	✓	✓	✗	✓	✓	✓
	Stolen hope	✓	✓	✓	✓	✗	✗
Hope and growth	*I'm an expert in my recovery*	✓	✗	✓	✓	✓	✓
	Strength through adversity	✓	✓	✗	✓	✓	✓
	Accepted and seen as a whole	✗	✓	✗	✓	✗	✓
The transformative nature of the experience		✓	✓	✓	✓	✓	✓

In addition to the main themes, it is important to include in the analysis the meaning of recovery for each participant. This was not done using IPA; however, themes identified the qualities of recovery important to each participant within the conceptual framework of recovery (Leamy, Bird, Boutillier, Williams, & Slade, 2011). Each participant identified elements within the five core domains of recovery which Table 5 illustrates.

Table 5: Core Domains of Recovery and the Endorsements by Each Participant

Core domain	**Sub-categories**	Andrew	Baljeet	Cameron	Chris	Jerimiah	Malakai
Connectedness	Peer support and support groups	x	x	x	x	x	x
	Relationships	x	x	x	x	x	x
	Support from others	x	x	x	x	x	x
	Being part of the community	x	x	x	x	x	x
Hope and optimism about the future	Belief in possibility of recovery	x	x	x	x		x
	Motivation to change	x	x	x	x	x	x
	Hope-inspiring relationships	x					x
	Positive thinking and valuing success	x	x	x	x	x	x
	Having dreams and aspirations	x	x	x	x	x	x
Identity	Dimensions of identity	x	x	x	x	x	x
	Rebuilding/redefining positive sense of identity	x	x	x	x	x	x
	Overcoming stigma	x	x	x			x
Meaning in life	Meaning of mental illness experiences	x	x	x	x	x	x
	Spirituality		x			x	x
	Quality of life	x	x	x	x	x	x
	Meaningful life and social roles	x	x		x		x
	Meaningful life and social goals	x	x		x		x
	Rebuilding life	x	x	x	x	x	x
Empowerment	Personal responsibility	x		x	x		x
	Control over life	x	x	x	x	x	x
	Focusing upon strengths	x	x	x	x		x

Table 5 illustrates there was significant homogeneity in what participants considered important in their recovery. Connectedness was the most shared goal and all of the participants talked about wanting to have meaningful relationships, and be part of their community and society.

Participants frequently talked about rebuilding their identity outside of their diagnosis. Descriptions of identity changes included wanting to "understand myself better" and "knowing me". Participants highlighted that understanding and accepting themselves even in the presence of symptoms was one of the most important factors for their long-term recovery.

Hope was also another strong theme in the recovery data. Participants reported that having hope in recovery helped them to keep motivated and focused towards their personal goals. Empowerment was an important part of this, particularly having their own responsibility for change. However, for a few participants empowerment was not thought of as useful, with one participant saying at present he wants someone to "look after" him whilst he engages in a process of understanding himself.

Participants each had an idiosyncratic way of describing their recovery, although these fitted broadly into the conceptual categories. Understanding what is important to participants' recovery, at least in broad terms, is central to conceptualising how their experiences of the media interact with recovery. This interaction is discussed within each theme; firstly their experience of the media, then how they make sense of these experiences in the context of recovery.

The Double-Edged Sword

In understanding media experiences, it is first relevant to draw attention to the phenomenon of the media being experienced by participants as simultaneously creating negative or positive consequences. For example, it was noticed that media could make mental illness more visible to the public, whilst simultaneously creating stigma. Participants held concerns over how the media held power and responsibility over positive and negative experiences for both themselves and others, as illustrated by Baljeet:

> *Baljeet - "I think the media is a powerful source you see it's a paper and pen and paper together make words that are powerful you know and that power can be abused or used wisely."*

Baljeet holds a common concern with the power the media holds, and participants make sense of the media as a proxy driver of social messages around mental health. Therefore, there is a sense that they feel significantly less powerful than the media in changing beliefs about mental health. Malakai's comments illustrate this point:

> *Malakai – "if the message and… story's crafted in such a way to show [how] unacceptable that language is, then it becomes unacceptable. If it only shows someone as dangerous then that becomes the view."*

This interpretation meant themes were mapped out in terms of the negative experiences of media, organised into two themes: *"Blind to my experience"* and *"No escape*

from an unwell me"; and the positive experiences of the media, organised into one theme: *"Hope and growth"*. Within the themes, there is also space to understand power and responsibility and how these feelings and experiences of participants go on to impact upon their recovery.

Blind to my Experience

This theme was generated as an interpretation from participants' descriptions of their stories being often omitted or ignored by the media, denying them an opportunity to give a personal account of their lives outside common frameworks of mental illness. Particular omissions of their journeys through suffering and adversity left participants feeling particularly angry and frustrated. It is suggested these feelings arise from perceiving their lives are unimportant and not worth consideration by others. As Andrew described:

> *Andrew - "they don't really know me, they don't understand us, don't understand what we are going through. It is like they can't see past the headline, there is a person behind that headline."*

This comment is a representative illustration of how participants often feel hidden, misunderstood and unrepresented within the media. This has been understood within two sub-themes. Firstly, that their *"suffering and struggle is omitted"*, and secondly, that they are *"never seen living well"*, which focuses on the feeling that aspects of their normal human experience and lives are missed, misunderstood, and misrepresented.

My suffering and struggle are omitted

Throughout all the themes was a thread of suffering, struggle and adversity, and the title of the theme reflects these key words used by the participants. This theme focuses the omission of these significant aspects of the participants' lived worlds. The suffering and struggle appear to be significantly important means for participants to feel human and connect with other, yet there was a real sense that participants felt that this key experience was taken away by media. Andrew's comment reflects this across the group:

> *Andrew – "You know, they don't see the fact that these are people with broken lives and I include myself in that… they just see the headline, and they don't see that the person is suffering and in crisis."*

There is a real sense that participants feel their story of suffering cannot be seen behind the headlines. This leads to feelings of anger and sadness about this, with Malakai summing it up as:

> *Malakai - "having been through it myself, it makes me feel sad, that people are suffering and seem to be on their own, and have no sympathy into it, in terms of what they're going through. It makes me quite angry at times… they just don't see how hard it is."*

Further interpretation suggests by being stripped of their struggle and suffering, participants feel less human by means of their shared human experience being denied.

Suffering and struggle also held deep personal meaning for participants and was part of their strength and resilience, taking it away made them feel weak and pathetic. This creates a barrier to others understanding their perspective and lived-experience. Andrew alludes to this in his comments:

> *Andrew – "We're people with damaged lives that just need help and recovery, how can people ever see that in these stories… It's alright to sensationalise it to sell newspapers, but newspapers don't know what it's like to be that person."*

> *Andrew – "I was suffering as well, maybe for different reasons, but… as I say, I always felt that, if someone can see your suffering, they can try and, sort of, show compassion and help."*

These comments are reflective of all the participants' experiences, that in essence, if their suffering and struggle are omitted by the media then they cannot be seen as a person who has needs and is more than just a 'psychiatric offender'. Without suffering and struggle being observable, processes of connectedness, compassion, and empathy with others is prevented leaving many participants feeling their recovery was hindered.

I'm never seen living well

Following on from the previous theme, participants also felt their everyday lives, experiences and qualities are omitted within the media. When interpreting participants' comments as a whole, there is a sense of dissatisfaction and frustration with the absence of

details beyond an acute stage of illness. Being seen only in this way left participants feeling deeply misunderstood. The theme title was generated by a participant within the study. Baljeet and Chris reflect the general sentiment of the sample:

> *Baljeet- "Come and live here, work here for a year and you will know what, how we think feel, understand and then you can get an insight into what being mentally ill really means."*

> *Chris "We don't always commit crime. We don't always look ill. We go to work, they go down the job centre, and different people who commit offences… there is a lot of people with illnesses who just get on with their everyday lives fine. They work, they raise families. They do this they do that… Sometimes in their life, they might have a blitz in the life."*

Their comments are representative of the participants' frustration in being represented as just the illness. At a deeper level, their lived experience is an undue focus on their mistakes, periods when they have been acutely unwell and behaviour that might be considered unusual. As Chris says:

> *Chris – "It just focuses on one aspect of people with mental health, their mistakes. There [are] people who have got jobs who are working looking after families, doing this doing that. And the bad stuff is just a small fraction."*

Participants frequently reported feeling sorry and remorseful for their actions when unwell, however feel that the media does not present these aspects. It focuses solely on one side to them has little value in creating a sense of their lives. The above extracts are representative of the views expressed by all participants that the media limits other people seeing them living well. Common human experiences such as relationships, occupations and everyday life are omitted. They feel their life is distilled into a restricted and misrepresented caricature which does not accurately reflect their real lived experience. Cameron expresses his frustration with these misrepresentations:

> *Cameron – "you know what, it's their [the media's] truth right. But this is what everybody out there think is the truth and the media just reinforces that, but it's not the truth. So how can I be seen for anything else because unless they come here, they ain't gonna know".*

Cameron's comment encapsulates the feelings of powerlessness he experiences and the detrimental effects of feeling misunderstood and unrepresented were shared by several participants, causing feelings of disconnection from others. Again, connection with others is an important part of the participants' recovery and by their stories being omitted they experience concern with how much others will understand them and their lives.

In summary, *blind to my experience* illustrates participants' feeling that their life stories have been omitted by the media. Participants commonly remarked that this takes away from them

the chance to connect with others through shared human experience. Following on from the omission of qualities that allow human connection were the addition of stereotyped qualities, which are covered in the next theme.

No Escape from an Unwell Me

Participants were overwhelmingly concerned with being held back and unable to escape from preconceptions about them due to mental health difficulties. This prevents them from being able to accept themselves, be at ease around others, and generally move on with their lives beyond their illness. The theme title reflects an interpretation of these experiences. As Baljeet explains:

> *Baljeet – "The media makes it so it's [mental illness] still there at the back of your head. It's always hiding there and you're always reminded of it, but not in a useful way…. A way that makes you feel bad."*

Baljeet using words like "still there" and "always" suggests the idea it is hard to move on from his past. Baljeet talks about little utility in the media in this instance as it only reminds him of "bad" events and possibly of shame and trauma and does not encourage growth and acceptance.

Participants gave similar concerns about the media preventing them moving outside or escaping a mentally ill persona, bringing up a range of feelings; fear, sadness, anger, and hopelessness. This superordinate theme has been divided into four subthemes to describe

these lived experiences; Branded by the label; Outcast; Reawakened shame and trauma; and Stolen hope.

Branded by the label

Participants' accounts show thinking that the media brands them with a whole host of negative stereotypes and judgements. Participants expressed being "branded", as within the theme title, and gave subsequent descriptions of various labels. Chris articulates this idea well within two comments:

> *Chris – "So the bigger picture out there they'll be tryna say of schizophrenia is means he's mad, he's nuts, I wouldn't wanna know him… You can get automatically judged just because you've got that illness."*

> *Chris –* "*they got a certain picture of people you've got a mental illness. Basically, those people, with mental health are all the same… They judge you for when you're unwell, people only focus on when you do something wrong and expect you to be out of control or elated or depressed like all the time."*

These comments show Chris's perspective that the term schizophrenia has a number of negative connotations attached to it. Firstly that he is subject to pejorative terms such as "mad" and "nuts", which suggests he feels others view him as perpetually odd, out of control and unpredictable, which has no basis in his current reality. Chris also identifies the idea of automatic judgement; that he is subject to immediate assumptions based solely on the label that has been attached to him, rather holistically viewing it with other qualities about him. In

addition, he emphasises the idea that people with mental health difficulties are "all the same", suggesting he feels there is a homogenous quality to the label schizophrenia. This might be considered as Chris experiencing being judged for qualities he does not possess, based solely on a diagnosis or label, or as the result of someone else's actions. A deeper interpretation suggests that this is a particular barrier for Chris in being seen anything beyond the label he has been assigned, which limits his chances of moving towards his recovery goals.

Cameron talked about how labels were commonly used by the media and the effect upon him:

> *Cameron – "we got a media like um saying aw look at him he's a madman or he's a druggy, a crackhead, medicating on his own drugs, he's fat an ugly he's fat like an that's what I thought of mental health when I first came in here… You know, those ideas stick with you."*

Cameron's comment highlights the number of labels assigned to mental health and from his experience how he had taken on these labels. What is particularly interesting is Cameron's comment around the ideas sticking, suggesting he feels unable to get these ideas out of his mind, and possibly feels others will also be bound by these labels. Jerimiah goes on to say:

> *Jerimiah – "I felt like it was going to be hard for me to prove to my team that that I haven't got that, I don't I haven't got one [a mental illness]"*

This comment is representative of the participants' concerns of being in a constant struggle against the misconceptions and judgements provided by labels. This difficulty in getting away from labels and having to "prove" themselves suggests the labels stick; once they are given, it is hard to escape from them. One of the participants' biggest concerns was the power of the media to ascribe negative labels with ease as Baljeet describes:

> *Baljeet – "schizophrenia can be used that way as well to say people are mad that's why I did it. So the word schizophrenia can be used anyhow people want it to be used, but usually negatively."*

Baljeet highlights he feels the media is powerful and that they have taken possession of the word schizophrenia to use against him. This has allowed them to talk about Baljeet in any way they feel is acceptable. Andrew highlights that this is a problem because:

> *Andrew – "We revert, er, we, as a species, as it were, and race, revert to type, and say, 'We don't like this, we don't understand it. We don't want to know. We're too frightened to deal with it,' and, erm… you know, the shutters come down".*

For Andrew and several of the participants, the branding using labels means others revert to type with fear and misunderstanding of him. At a deeper level and in terms of his recovery, he is fearful of others automatically rejecting him due to the label. That the "shutters will come down" alludes to the fact he is concerned at a social disconnect and being

ostracised. In addition, Malakai adds concerns that branding with stigmatising labels would prevent people seeking help.

Malakai – "I feel there is the kind of stigmatising language that causes people not to talk about their mental and emotional wellbeing, and, thus, potentially deny ourselves of available help and intervention."

Interpretatively, this could be experienced as shame and the fear of judgement and blame caused by the label. These particular fears create a sense that they would experience isolation and segregation, which is continued on as being an outcast.

Outcast

The accounts of participants strongly alluded to and were described as feeling like outcasts; segregated, mocked, and feared by the rest of society. The word outcast was a word used by two participants. Strong threads lay around being dehumanised, stripped of value and worth to society, and unworthy of affection or compassion. Andrew articulates his experiences of media in terms of how he came to see himself:

Andrew – "I just felt I was a worthless lunatic with no right to live on God's clean earth, and a 'weasel'."

Andrew's comment shows how strongly disconnected and shunned from society he felts as a result of a media story. At its most extreme, Andrew has felt so worthless he believes he is undeserving of living. Several other participants describe similar experiences:

Cameron – "You become outcast, outlawed or black sheep of the family"

Baljeet – "It made me feel angry inside, why are we being treating like lepers? Keep them away from me, don't let them out."

Andrew – "They, they just see us as… a second class, second or third class citizens. They're not prepared to give us the time."

All of the participants likened having a mental health difficulty and a forensic history as becoming an outcast, reinforced by the media, and is associated with a range of feelings; anger, sadness, and rejection . Various words used by participants explain how they perceived media depictions of mental illness, including lepers, monsters, second and third class citizens, black sheep, demonised, diseased, and animals. This long list highlights the strength and variety of experiences of either feeling as a devalued human or in its extreme, not even a human at all. These experiences all conjure up the image of being distant from society, outcast and shunned. Baljeet's comment particularly highlights this when he perceives a general societal tone of "keep them away from me, don't let them out".

In terms of recovery, all of the participants reported being part of society and community as an important part of their recovery. Whilst all of the participants felt strongly that they were in a caring community in hospital, the media had led to them feeling it was not going to be the same in the community. Cameron stated his particular fears:

> *Cameron - "I feel like it's horrible man it's horrible you know that knowing that I feel that I mean they have to be careful round me an you know what I mean an I feel like people can't be honest with me or people can't trust me… in the community I'm gonna find it hard to find people who aren't my friends to just accept me as a person"*

This statement is shared by two other participants, who all express how horrible it is to feel others have to be careful around them. These concerns seem to have arisen out of others feeling on edge around him after what they have seen in the media. He highlights a common shared experience of the participants in anticipating struggle against being an outcast, particularly when outside the relative safety of hospital.

Reawakened shame and trauma

Participants used the words shame and trauma in their narratives, whereas the idea of is being "reawakened" is an interpretation generated from the participants' descriptions. Four of the participants referenced that seeing media stories, particularly ones similar to their own, led to reawakening experiences of shame and trauma for them. Initially, participants talk about what the media does to them in the moment.

Malakai – "when I committed the horrible crime, terrible crime, it took me quite a few years to adjust to it; to normalise that within my everyday range of experiences… but when I see these TV shows or stories, it brings me back to where I was… that I should not be allowed to get on"

Malakai describes his struggle with coming to terms with his past criminal behaviour, which is observable within his speech as he cannot name his offence. What is particularly interesting is that he has begun to normalise this experience as a facet of himself and his history, whereas media stories bring him back to experiencing shame and trauma from what happened, hindering him psychologically. Baljeet expands upon this view provided by Malakai:

Baljeet – "You feel like sometimes you've got this monster inside of you and it's hard to live with that that feeling and stories like this sort of feed that story about yourself so feed your own view that you are dangerous and sometimes can do bad things."

Baljeet describes a "monster" inside of him and the difficulty of living with this feeling. His metaphor of the media feeding this monster beautifully illustrates how the media reawakens and reinforces his shame, guilt, and feeling that he is a "bad" person. It also demonstrates that it prevents him moving on, always being pulled back to his trauma and this historic, dangerous image of himself, even if that is not the case now. Baljeet also goes on to describe how he ruminates on those past experiences for which he feels he requires further punishment.

Baljeet – "These stories mean I think about what happened. I mean every night I go to bed I think about what I did and I regret it, it seems like I'm punishing myself"

These experiences suggest how it interferes with recovery, firstly by causing shame and blame, and secondly preventing them integrating their experiences into their concept of self. Chris shares this difficulty in managing this whilst simultaneously trying to integrate it into his concept of self:

Chris – "I don't think the media see all the sides of it. That struggle all of the time, they don't see the sorry stuff because it's hard on that person doing something doing something wrong, and then realising "what have I done, I'm going to be so sorry." And it's a genuine reason of being sorry. These stories bring that up, like it's hard for me to just sit with it."

Chris is struggling to "just sit with" his experiences, suggesting when he sees these stories, he connects with a side of himself he has yet to fully accept and come to terms with. It brings up trauma and shame he has yet to resolve. This was an experience for several participants, and in the extreme, a punishment for the participant which prevents them accepting their past but also making the less hopeful about the future.

Stolen hope

This theme deals with the idea that all of the other sub-themes within *'no escape from an unwell me'* can be integrated by participants in different ways. Amongst the group, there was variability in how they integrated specific experiences like shame, dehumanisation, self-acceptance, and feeling like an outcast. For some participants these ideas were either rejected completely, had a temporal short-term effect, or a longer-term effect with a more pervasive, destructive nature. Stolen hope encompasses this latter experience, recounted by four participants, with one participant explicitly citing that the media had stolen his hope of a different life. This gave the idea for the name of the theme. Firstly, Andrew highlights a common experience of participants in integrating the experiences:

> *Andrew – "I feel very negative sometimes and think, 'Oh Christ, another day". Am I ever going to get out of here? What do I do when I get out?' I feel… quite overwhelmed by what has happened… and once you're labelled by a newspaper or a TV, news item and, even worse, on the internet, you're finished.*

This comment illustrates common thoughts of negativity about the future and he has questions about how things might go for him. What stands out from his comment is the idea that being labelled by the media means "you're finished". The questions appear to have some hope about them but it appears that Andrew experiences the media stories as completely crushing any remaining hope he might have about recovery. Andrew further expresses that viewpoint:

Andrew – "It hurts and feels that, if that's the kind of mentality. If that's the sort of philosophy that people have, I think I've got a hard job on my hands trying to, sort of, get back into… you know, being accepted into society, and, sort of, the, sort of, having a full recovery and, hopefully,… never having to, sort of, have a, kind of, three-year stint here again."

Andrew exemplifies common fears in the group about not being accepted and how the media reflects society's view about him drains his hope of a recovery. He articulates his experience of this media narrative creating difficult conditions for him to recover and leaving him feeling there is little hope for him to remain out of hospital.

Cameron explains how he has come to integrate some negative views purported by the media.

Cameron - "I saw on TV that once you get into these places it's hard for you to get out or you probably never get out, you know what I mean so I had that on my mind when I was locked up in here, so I've already been told things about mental health hospitals so you think "I'm never gonna get outta here".

He highlights his concerns about being able to get out of hospital and his experience is that TV simultaneously reinforced the view he cannot recover and eroded his confidence in his own skills to change his situation. Baljeet exemplifies these concerns and the experience of stolen hope:

Baljeet – "There is no hope for people like me in these hospital, there's no glimmer of hope. The story makes us look like there's no recovery for us. That there's no sign of recovery at all and that takes away all the hope the one thing you hope for. The hope to get well, the hope to move somewhere in the community, get a job or something, charity shop or whatever. So reading stories like this it puts a foot down on it and it stops us from moving on from hospital."

Baljeet expresses how damaging negative stories about mental health have been, completely stealing his hope of recovery. A poignant part of the experience is the long-term and pervasive nature of it. Far from being a temporal feeling, Baljeet feels is crushes his hope at present and for his future in all domains of his life. This is in contrast to more positive aspects of the media that offer hope and growth.

Hope and Growth

Although there was a disproportionate focus on negative experiences of the media, participants also gave contrasting positive experiences. The theme title is an amalgamation of key words used by participants within the study. Aspects of this hope and growth were experienced if three main ways: *I'm the expert in my recovery*; *my strength through adversity*; and *accepted and seen as a whole person*. Particular key experiences within the themes are personal growth and change, self-acceptance, connectedness, and feeling 'normal' in their experiences. Malakai encapsulates the theme when he describes his perspective on positive media:

Malakai – "it is quite uplifting when you see an article about someone who's been through difficult days, erm, and then achieved something, and was looking forward to greater achievement… It's empowering to my sense of recovery, and shows me there is a community to connect with at various stages of recovery… that it's possible to contribute something back, to grow, to make a difference to wellbeing in others."

Malakai's sentiment illustrates the aspects of the theme. He feels inspired by seeing another's struggle through adversity and the subsequent recovery. The benefit of which is feeling empowered in his own recovery, that he can grow and enrich other people's lives.

I'm the expert in my recovery

This theme deals with feeling expertise and empowerment in recovery from observing other's recovery within the media, with the wording of the theme is an exact phrase used by one of the participants. This process is simultaneous to their own recovery, acting as reinforcement for their empowerment and expertise. Malakai describes his perspective, that by seeing people similar to him it encourages him to see his own expertise and the unique perspective he can offer:

Malakai – "it's difficult to appreciate what mental illness is unless you've experienced it yourself… you see people who have been there,… gone through it, and seem to have, kind of, normality in their lives. It's kind of inspiring".

Malakai highlights his sense of being a unique expert through his experience, which is reinforced by seeing others recovery in the media. He appears empowered by this inspiration; that he can achieve and aspire for the same recovery and normality in his life. Chris also shares this experience:

> *Chris – "Its good stuff you know [a media story], it shows that there's a light at the end of the tunnel…that you can get there despite what anyone else says, you can do it like them."*

Chris supports the idea that the media story creates a sense within him that he can follow the same path. It empowers his sense of expertise and that he is the one with the ability to change his situation. When Chris says "you can do it like them", it gives the sense the media gives him confidence that he can recover similarly to his peers. This was a common experience across the sample; seeing recovery in the media reinforced their own sense of expertise in their recovery.

My strength through adversity

This theme is concerned with the participants recognising their strength through adversity by seeing other's stories within the media, with the theme title being generated as an interpretation of these experiences. This is a reflective quality, by seeing it in the media they identify their strength through their struggles more. Their journey of struggle and suffering is also seen by themselves and others. Chris captures the idea of this theme:

Chris – "it makes me think how my life at a young age was difficult. I was in the system, I've commit [sic] crimes that I'm not proud of, you know what I mean? I'd love to write a book about my story and everything I've gone through. But I believe it's maybe a stronger person… I think to myself I'm a survivor of a mental illness not a victim"

Chris's description shows how he connects to this story, recalling his early life experiences and difficulties he has been through, especially his forensic history. It appears he experiences this not as reawakening shame or trauma, but allows him to reflect upon his adversity and the strength and resilience. He also describes himself as a "survivor" rather than "victim", which suggests he feels empowered and not as a helpless victim of his circumstances. In the context of recovery, he feels more able to accept his traumatic history and is empowered to change his situation. Several of the participants identified with this idea of strength through adversity. Jerimiah describes his hope by seeing media stories:

Jerimiah – "it gives you hope looking at them in the spotlight and they're suffering from mental illness, just makes you feel good to know that even though you're suffering from mental illness you can still achieve what you want to achieve. You have strengths, which this helps you remember"

His description highlights the real reflective capacity of this theme. His hope is generated not just by seeing others achieve, but reminding him of his strengths. This experience of self-insight and remembering of skills takes him away from feeling hopeless

and towards hope that due to his strengths he can overcome his adversity and achieve his recovery.

Accepted and seen as a whole person

Participants described seeing a range of media stories that helped them experience a sense of wholeness, normality, and acceptance, which have been incorporated as an interpretation into the theme title. Chris describes the comfort stories that are true to life bring him:

> *Chris – "It makes me feel a bit more normal as a mental health patient. You want to know that you're not the only one that's going through what you're going through, the stress the pressure. It kinda makes you feel comfort in that you know. You think to yourself I'm not the only one that that's need some kinda support not the only one that's going through this."*

Chris experiences feeling more "normal" from the story, which suggests a reduction in feelings of disconnection and being different from others, the opposite of the *outcast* theme. Experiencing comfort appears to show the positive impact this has upon Chris, and feeling connected to others is an important aspect of his recovery. Malakai related his experience of by seeing the journey, and he can be seen in a new light:

> *Malakai – "if you see someone's journey, you can relate to that journey as a story, but you can also relate to it in terms of your experiences, and you can empathise, you*

can connect, you can appreciate their journey and recovery to, kind of, what your journey and recovery might be like, because you do have questions at early stage of recovery: Will I recover? Will I get a job? Will I ever have a girlfriend again? Will I love/not love?"

For Malakai, he highlights the importance of seeing the person and their journey, which enables a person to be connected and empathised with. For him, it helped to begin answering questions he had about his own recovery. At a deeper level, it enables him to reflect on his own inner experiences and to feel connected to others going through similar experiences. This reinforces his journey of self-reflection and that he can achieve his recovery.

The Transformative Nature of the Experience

Common across the sample were their positive and negative experiences resulting from media stories. However, what is interesting is the transformative nature of these experiences; how experiences were internalised, avoided, or rejected. These were interpreted as 'transformations' arising from the participant's experiences, lending to the theme title. These transformations often had a temporal aspect and were dependent on the participants' personal coping skills and circumstances. For example, Chris talks about initially being put "on a downer" when reading a media story. However, he went on to say:

Chris – "I'm not really the sort of person who gets affected by that because deep down I know I'm a good person. I know I'm sorry for making those mistakes. I've done my

time for those mistakes. I don't care what you say I'm a strong character…me being in hospital has given me good learning about myself and about life. I've got good insight into my illness into myself….I keep myself a close group of friends and my family and close group of people who know me and all accept me."

Chris identifies the key elements of being able to reject the negative experiences; his own sense of self, acceptance, and social support as protective factors. Malakai talked about the transformative nature of the negative narrative in terms of "vulnerability" of his situation.

Malakai –"it would have a very real psychological impact, and such a statement might even to add to my symptoms, … if I am in a particular vulnerable state of mind…, if I was in a more vulnerable position, I'd consider that more.."

His comment encapsulates several ideas around being at risk of taking on the negative experience when he is psychologically vulnerable. This is interpreted as occurring when the narrative and experience fits more with personal feelings about the self and others, and eludes to elements of psychological flexibility as key to understanding the transformative, internalising process. Andrew illustrates this point:

Andrew – "I used to take on the negatives, but now I only connect with the recovery stories…now that I realise that I am a human being with a number of emotions, and, erm, I, I've got a serious mental health problem that is being treated, I can function

now,… and I'm starting to be a lot less harsh on myself, and say, 'Well, I'm a human being… I'm me. And that story is more like me now."

Andrew really highlights in the early stages of recovery he internalised negative experiences constructed by the media. However, as he developed psychological flexibility and acceptance, he connects more with recovery stories as a more accurate representation of him. This indicates the power of the media relative to other aspects of the person's life, and the balance of these aspects determines whether the narrative is internalised.

Discussion

This research aimed to understand the impact of media about mental health for a group of six men in a forensic mental health setting. Using interviews and cultural probes, this study identified core lived experiences of being subject to media narratives and the subsequent impact upon their psychological well-being and recovery experiences, which were unknown previous to this study. Overall, the sample experienced similar core experiences, however the impact of these experiences on their recovery varied across the sample.

All of the participants shared beliefs that the media disregards and omits both their *struggle and suffering* and them *living well*. These omissions left them with concerns that society does not accept them, have compassion for them, see them functioning as part of that society, and will only be seen by their mistakes.

The participants similarly shared feeling *outcast* and *branded by labels*, which encompassed reflections of feeling stigmatised, stereotyped and outcast. This left participants perceiving themselves or believing others to view them as "abnormal" or "monsters", creating a sense of disconnect and judgement from society with participants struggling to accept and value themselves. Participants often identified that these negative experiences ultimately inhibited their recovery.

Several participants recognised positive experiences born out of realistic and compassionate media, where the voices of people with mental health difficulties were heard. Participants particularly experience a sense of *strength through adversity* and *feeling like an expert* in their recovery. This enabled participants to reflect on the strengths and skills they developed over their recovery journey, encouraging a sense of empowerment, acceptance, connectedness, and building a life beyond being perceived solely as a psychiatric offender.

Theoretical implications

The findings can be explained by a number of theoretical models and findings about the media, stigma, and recovery.

This study reaffirms stigma research that the media leaves individuals experiencing mental health difficulties feeling further disconnected from society, dehumanised, unaccepted, and stigmatised (Corrigan, Larson, & Rüsch, 2009; Corrigan et al., 2006). Interestingly, this did not come from concerns arising from the media depicting mental illness being linked with violence, but with the judgements, blame and labels, for example being "evil", attributed to individuals without consideration of the context of a suffering, distressed individual and social issues, like oppression and disadvantage. Without these considerations, participants internalise ideas of self-blame and stigma, believing that they are "a problem". The themes revolving around being an outcast, labelled and lacking a voice exemplify this and can be thought of within Foucault's conceptualisation of madness (Foucault, 1988). He argues authority, such as the media, has the power to label and define groups, thus distinguishing the 'normal' from 'abnormal'. Therefore participants' concerns reflect a "them and us" paradigm, that narratives about them are constructed by others. This lends itself to the descriptions of the participants as feeling like outsiders, disconnected from society and prevented from articulating their conceptualisations of experience.

Therefore, important aspects for both theories and the media to explore could include hearing the person's voice and story, realism, and seeing the individual outside the context of illness. These factors resonated with participants as positively impacting recovery by reducing dichotomous thinking of people being for example, either good or bad, and normal or abnormal. This opens up opportunities to be understood and heard, moving beyond being trapped by their diagnosis.

One of the standout findings of interest was the varying degree of acceptability and internalisation of the media narrative for each participant, as theorised by Corrigan and Watson (2002). The participants generally fitted into the three types of reactions to stigmatisation; those who go on to internalise stigma, those who demonstrate some form of righteous anger against the injustice, and those who merely avoid or are indifferent to the narrative. The data also supports some elements of Yanos et al's (2008) model of pathways between internalised stigma and recovery, which suggest individuals can internalise negative evaluations, which affect hope and self-esteem. Participants reflected on how the media encouraged self-evaluations, social comparisons, or personal success, which are more associated with self-esteem. However, these findings also raise a question around whether more contemporary constructs of self-acceptance and self-compassion are also relevant and need to be incorporated into theories. Participants described media stories creating increased or diminished kindness towards their difficulties and recognition of the common humanity of these experiences which fits more within concepts of self-compassion and acceptance (Hayes, Strosahl, & Wilson, 1999; Neff, 2003).

A number of CBT theories exist that may also explain findings, for example schemas from cognitive theory (Young, Klosko, & Weishaar, 2003), compassionate-self or the conceptualized-self from Acceptance and Commitment Therapy (ACT, Hayes et al., 1999). These theories fit with participant explanations that their self-conceptualisation, cognitive flexibility, acceptance and compassion, social support, and community integration had a significant bearing on how they responded to the media. Within this are concepts of psychological resilience and flexibility in response to media narratives, however, how this is done needs to be understood through further research. An interesting future direction may be

to focus on first-person perspectives of acceptance, self-compassion and psychological flexibility shaping the internalisation of experiences arising from media narratives.

Another way to understand these findings may be through narrative theory, which draws upon Foucault's ideas and posits that individuals perpetually construct stories and meanings to their experiences leading to internalised self-representations (Parry & Doan, 1994; White & Epston, 1989). Narratives are semantic arrangements that comprise of a plot, characters, and settings constructed in a social, cultural, and political context. In terms of recovery, personal narratives create opportunities for managing distress, living with challenges, and maintaining well-being regardless of illness (White & Epston, 2004). From the experiences outlined by participants in this study, it can be suggested that media narratives can interfere with these processes through perpetuating narratives of socially constructed views of dangerousness, 'them and us', incompetence and unpredictability. This is borne out by those individuals who internalise these narratives and the subsequent impact on their recovery progress. Those who appear able to re-author, organise and coherently frame their own personal narratives, in spite of dominant oppressive media narratives, appear to be more robust in the face of media narratives relating to stigmatising views.

There are several other ways to understand the results in the context of theory. However, what is universal is the importance of the transforming nature of media narratives into internalised concepts of self and the reinforcement of societal dichotomous thinking about mental illness. These are important aspects for theory generation and future directions for theory.

Clinical implications

Clinicians and individuals need to be aware of wider social messages about mental illness and offending. Participants thought that hospital settings offered them positive opportunities to recover; however, being subject to wider social influences can undermine this progress and needs to be addressed in any work being undertaken.

With regard to individual recovery, this research shows the dynamic, idiosyncratic and fluid nature of recovery. Even within a relatively homogenous group, the progress of recovery is affected to varying degrees by the media and wider social messages. Particularly fascinating is the essential need to address self-stigma; appropriately identifying it and creating interventions to support individuals in making sense-making of their experiences of stigma. Suffering and struggle appear to be significant in this process, and validating participants suffering and struggling would be important factors in any intervention.

Other findings identify the importance of having their voices heard and stories seen. Clinical activities could support individuals in creative outlets to express themselves and develop deeper, first-person, counter-narratives to those that dominate the current media representations of dangerousness, unpredictability, and stereotypical behaviours. This could help promote compassion and empathy for these concerns and move away from current simplistic and dichotomous ideas, such as good or bad, and abnormal or normal. These ideas could be seen as helpful to individuals in their recovery, particularly in developing hope, empowerment, connectedness and development of identities outside of mental illness and the forensic label.

Strengths and limitations

This is the first study of its kind and begins to develop a better understanding of the influences of societal level messages within the media on recovery from mental illness. This study highlights a number of theoretical and clinical affirmations and new directions to explore. The results also show the imperative to change societal attitudes to mental health and offending, and by changing media representations can have a significant impact on this group's recovery. The findings also illustrate the expertise of participants in building new theories and conceptualisations of mental illness beyond current medical and societal frameworks.

This study explored the media and its effect on recovery. However, it was difficult to distinguish the media as a definition. Many participants focused on news media, which may be an area that requires further clarification and distinction in further research. The distinction between media and other influences of self-conceptualisation were also difficult to separate. This has implications in that it cannot be identified whether internalised views are constructed by the media, or the media merely reflects and activates pre-existing concepts and views. This is a shortcoming and further research will need to address this.

This study is limited by the generalisability of the results. The sample was a very specific group of people who experience both mental health difficulties and have committed offences. These findings therefore may not be applicable to all members of this group or the population as a whole. This study is also not in a place to build a model into how the media representations may become internalised and but offers ideas for theoretical consideration.

IPA has an essential role for the researcher in making sense of the personal experiences of participants (Smith, 2004). However, this subjective approach limits the generalisability of the results and the subjective identification of variables means there may be

several other explanations of the data (Smith et al., 2009). The findings present one idea of the data, but not the only one. This has attempted to be managed through triangulation.

IPA relies on the homogeneity of a sample, and although this study made efforts to manage this, there is some heterogeneity. Important factors that were observable in the data were ethnicity, culture, socio-economic and educational background. These areas were relatively diverse in the group, yet had important contributions in how participants made sense of their experiences. This is an issue; however the convergence of themes in a broader group may help transferability of the results to theory.

The cultural probes for this study were constructed by the researchers informed by research. However, there were no validity or reliability checks of these resources and there is a risk that the stories selected created bias in the views of participants. There is an argument that these were stories already available in the media and therefore bias may have been limited.

Despite these limitations, this paper has hopefully reflected a credible explanation of the voice of this marginalised group of people and given an honest and reflective account of their experience of the media.

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PUBLIC DOMAIN BRIEFING PAPER
THE IMPACT OF MEDIA ON MENTAL HEALTH

by

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May 2016

SYSTEMATIC REVIEW

A SYSTEMATIC REVIEW OF MEDIA INTERVENTIONS PROMOTING HELP-SEEKING FOR MENTAL HEALTH DIFFICULTIES

Introduction

Evidence suggests that despite the prevalence of mental illness, around 52 to 89 per cent of people will not seek formal treatment. This is important as longer durations of untreated illness lead to significantly poorer outcomes for individuals. Low help-seeking behaviours can be attributed to personal beliefs, internalised norms, personal coping skills, and perceived stigma. Edney (2004) and Smith (2015) report that the media is a significant influence upon these factors, therefore it has the ability to change help-seeking attitudes, intentions, and behaviour.

Aims

The review had two primary aims:

1. Are media interventions more, equally, or less effective at changing help-seeking behaviours, attitudes and behaviours for mental health compared to a non-active control group (e.g. versus a non-mental health related intervention) or compared to a comparison group (e.g. another media intervention focused on mental health help-seeking).
2. Which channels of media are most effective at improving help-seeking attitudes, intentions and behaviours?

Secondary objectives evaluated the theory used to guide the intervention, how it is targeted, the intensity, nature and content of the intervention and the channel of media.

Methodology

A systematic electronic search for studies using media interventions to change help-seeking attitudes and intentions was conducted using PsycInfo, Embase, and OVID Medline databases. The references of retrieved papers and Google's 'cited by' function were also used.

Results

Using the search strategy, and inclusion and exclusion criteria, a total of sixteen papers were identified for review. The studies encompassed as range of media channels, including web and internet based, audiovisual and print media. These interventions targeted a range of help-seeking attitudes and intentions through various theoretical methods. Quality was assessed using the Effective Public Health Practice Project (EPHPP) assessment tool (Thomas, 1998)

Conclusions

There was little consistency in the theoretical approaches, intervention designs and outcomes measured. There were few results showing significant changes in help-seeking attitudes and intentions. Those with significant results showed only small changes in help-seeking attitudes and intentions, which is likely to results in negligible behavioural change.

Across the studies there were significant reporting and methodological issues, which limit the confidence in the results. At present the results would suggest there is limited evidence for the use of internet based media interventions, but moderate evidence for the use of video or print interventions. However, the how and why interventions work remains unknown. Further evidence is required to recommend media interventions for clinical use. Future research needs to focus on developing better reporting and addressing methodological issues, including

recruitment, blinding of samples, focusing on specific populations and the theoretical elements of the designs.

EMPIRICAL PAPER

THE EXPERIENCES OF THE MEDIA AND THE IMPACT ON THE RECOVERY OF MEN IN A FORENSIC SETTING

Introduction

A considerable body of research demonstrates that portrayals of mental illness are often skewed in the media (Francis, Pirkis, Dunt, & Blood, 2001), and endorse stereotypes of dangerousness, unpredictability, and strange or peculiar behaviours. These depictions promote stigma and perpetuate common myths about mental illness. This has several negative impacts on both people with and without mental health difficulties, including an increase desire for social distance towards people with mental health difficulties and public stigma. These perceptions can be internalised by the individual leading to diminished self-esteem and acceptance, decreased empowerment, feelings of isolation and exclusion, and depreciated self-value and loss of identity. Importantly, public-stigma and self-stigma restrict individuals experiencing self-acceptance, empowerment, self-efficacy, connectedness, and developing an identity beyond diagnostic labels; important factors of recovery.

Aim

For this study, a particular area of interest is the impact of these media portrayals on recovery of males in a secure mental health setting. Individuals in these settings are subject to triple stigma; mental illness, criminality and race. No previous study has been identified that explores how people make-sense of media discourses and recovery.

Methodology

Following NHS ethical approval, eligible participants were recruited in medium-secure units through local multi-disciplinary teams. Participants were given information about the study, and following consent were invited to take part in two interviews. Interviews were separated by two weeks, in which time participants were asked to complete postcards and a diary relating to mental health in the media. Six participants completed all parts of the study and were included in the analysis. Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) was used to design the study, interview and between session work, and to analyse and interpret the data.

Results

Five themes were identified within the data. Each represents the researchers understanding of the sense-making of participants in relation to the media and their recovery.

The Double-Edge Sword represented participants' experiences of the media having two sides; one positive, one negative. Participants saw the media as both a representation and driver of social messages around mental health.

Blind to my Experience described participants' experiences of their stories and lives often omitted or ignored within the media. Particular omissions of their journeys were their suffering and struggle through adversity, their everyday lives, and recovery progress, leaving participants feeling frustrated, misunderstood, and misrepresented.

No Escape from an Unwell Me discussed participants concerns and experiences of being held back and unable to escape from preconceptions about them due to mental health difficulties. This prevents them from being able to accept themselves, be at ease around others, and generally move on with their lives beyond their illness.

Hope and Growth recounts positive experiences arising from the media of personal growth, change, self-acceptance, and feeling their experiences normalised. This gave them a sense of expertise in recovery, strength through adversity, and being seen and accepted as a whole person.

The Transformative Nature of the Experience explains how experiences were internalised, avoided, or rejected depending on each participant's psychological flexibility, social circumstances and coping skills.

Conclusions

This study reaffirms stigma research that the media often leaves individuals experiencing mental health difficulties feeling further disconnected from society, dehumanised, unaccepted, and stigmatised. However, it can also promote the opposite experiences depending on its nature and content, and the qualities of the individual.

One important finding was the varying degree of acceptability and internalisation of these media narratives across participants. A number of narrative and CBT theories exist that may explain findings. These theories fit with participant explanations that their self-conceptualisation, cognitive flexibility, acceptance and compassion, social support, and community integration had significant bearing on how they responded to the media.

These ideas of psychological resilience and flexibility in response to media narratives need to be understood through further research. This study is limited by its generalisability, difficulties in understanding the media and the subjective nature of IPA.

APPENDICES

A SYSTEMATIC REVIEW OF MEDIA INTERVENTIONS PROMOTING HELP-SEEKING FOR MENTAL HEALTH DIFFICULTIES

NO APPENDICES

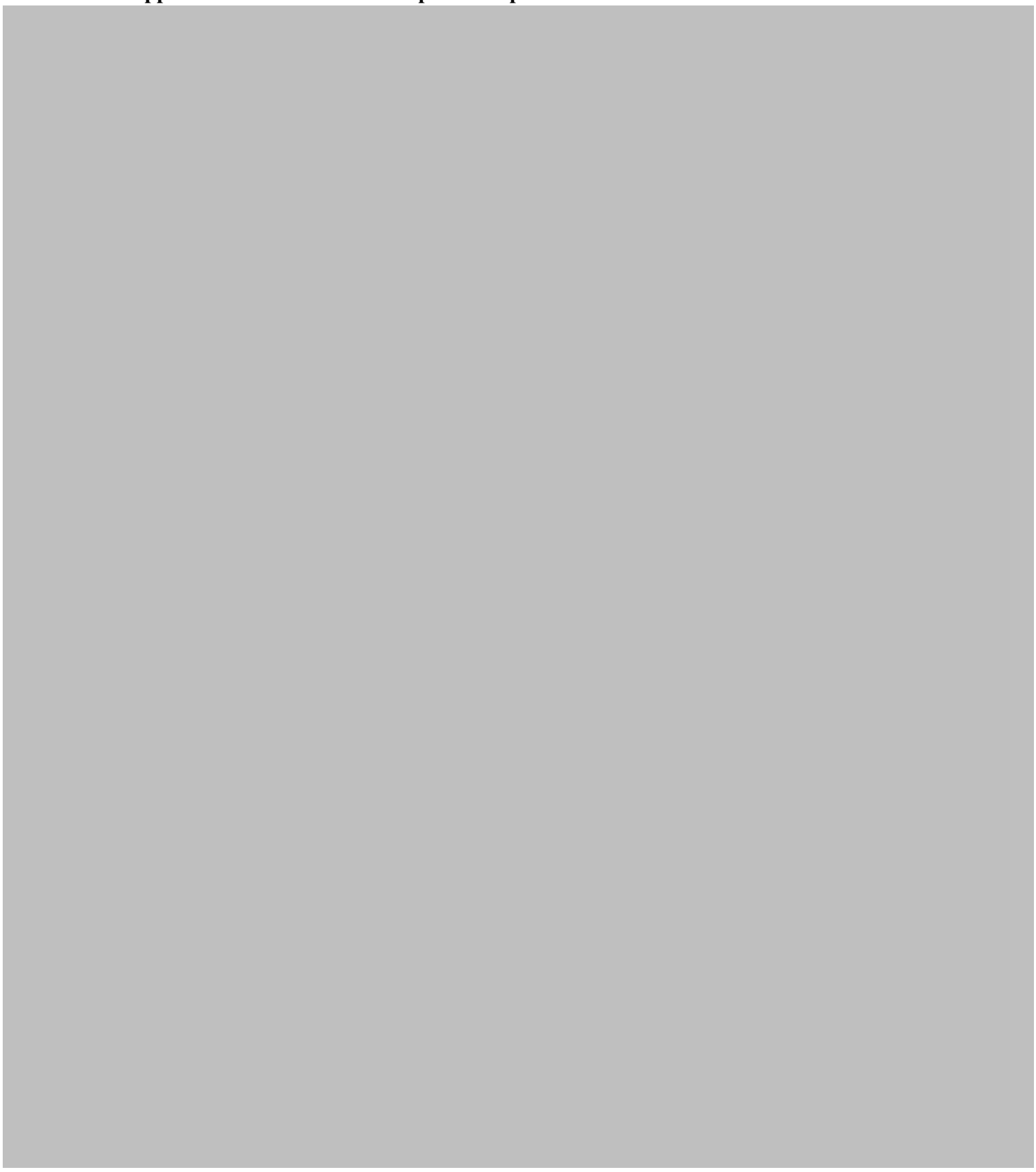
THE EXPERIENCES OF THE MEDIA AND THE IMPACT ON THE RECOVERY OF MEN IN A FORENSIC SETTING

APPENDICES

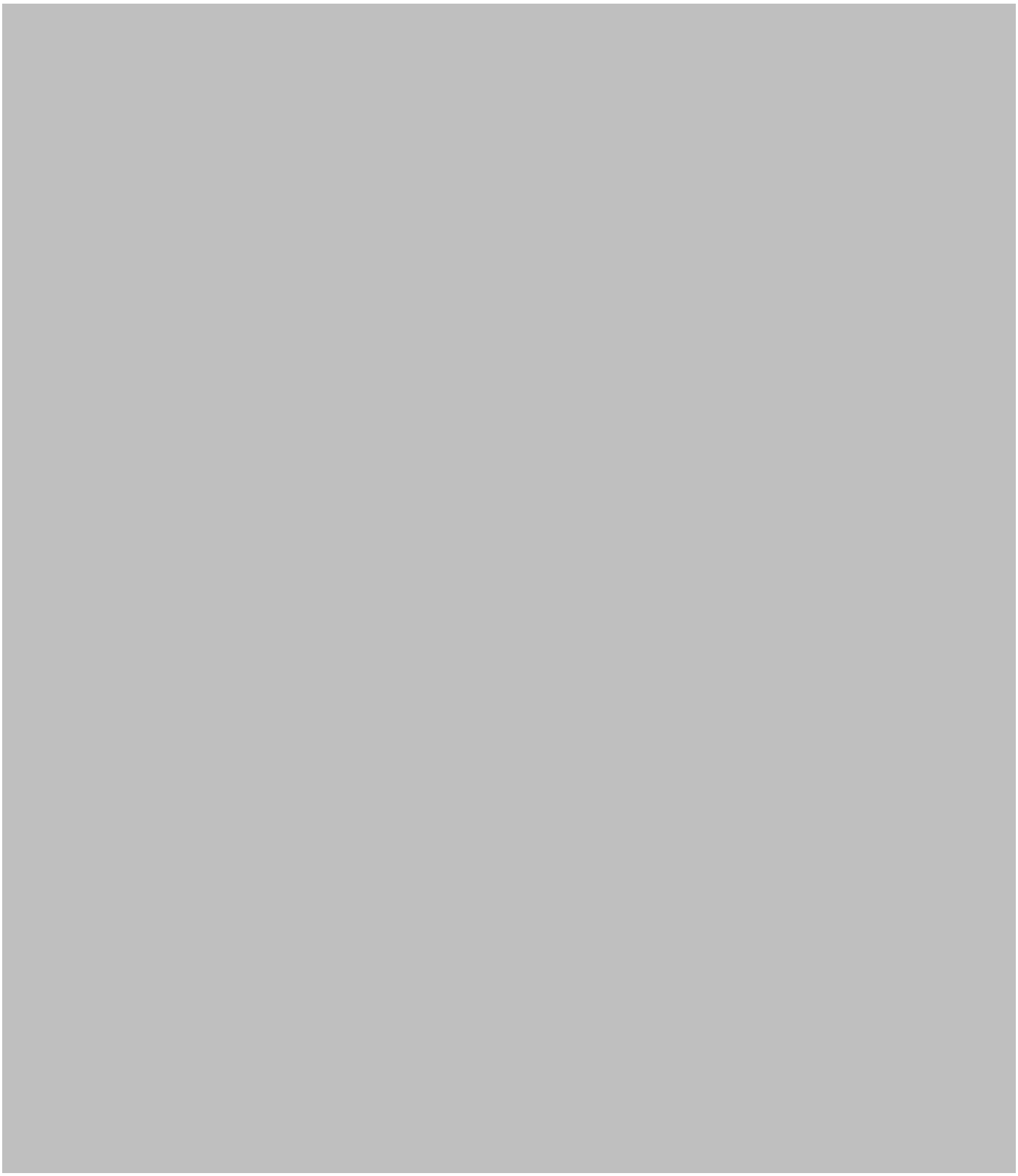
Appendix 1: Recovery processes (adapted from Leamy et al., 2011)

Core domain	Sub-categories
Connectedness	Peer support and support groups
	Relationships
	Support from others
	Being part of the community
Hope and optimism about the future	Belief in possibility of recovery
	Motivation to change
	Hope-inspiring relationships
	Positive thinking and valuing success
	Having dreams and aspirations
Identity	Dimensions of identity
	Rebuilding/redefining positive sense of identity
	Overcoming stigma
Meaning in life	Meaning of mental illness experiences
	Spirituality
	Quality of life
	Meaningful life and social roles
	Meaningful life and social goals
	Rebuilding life
Empowerment	Personal responsibility
	Control over life
	Focusing upon strengths

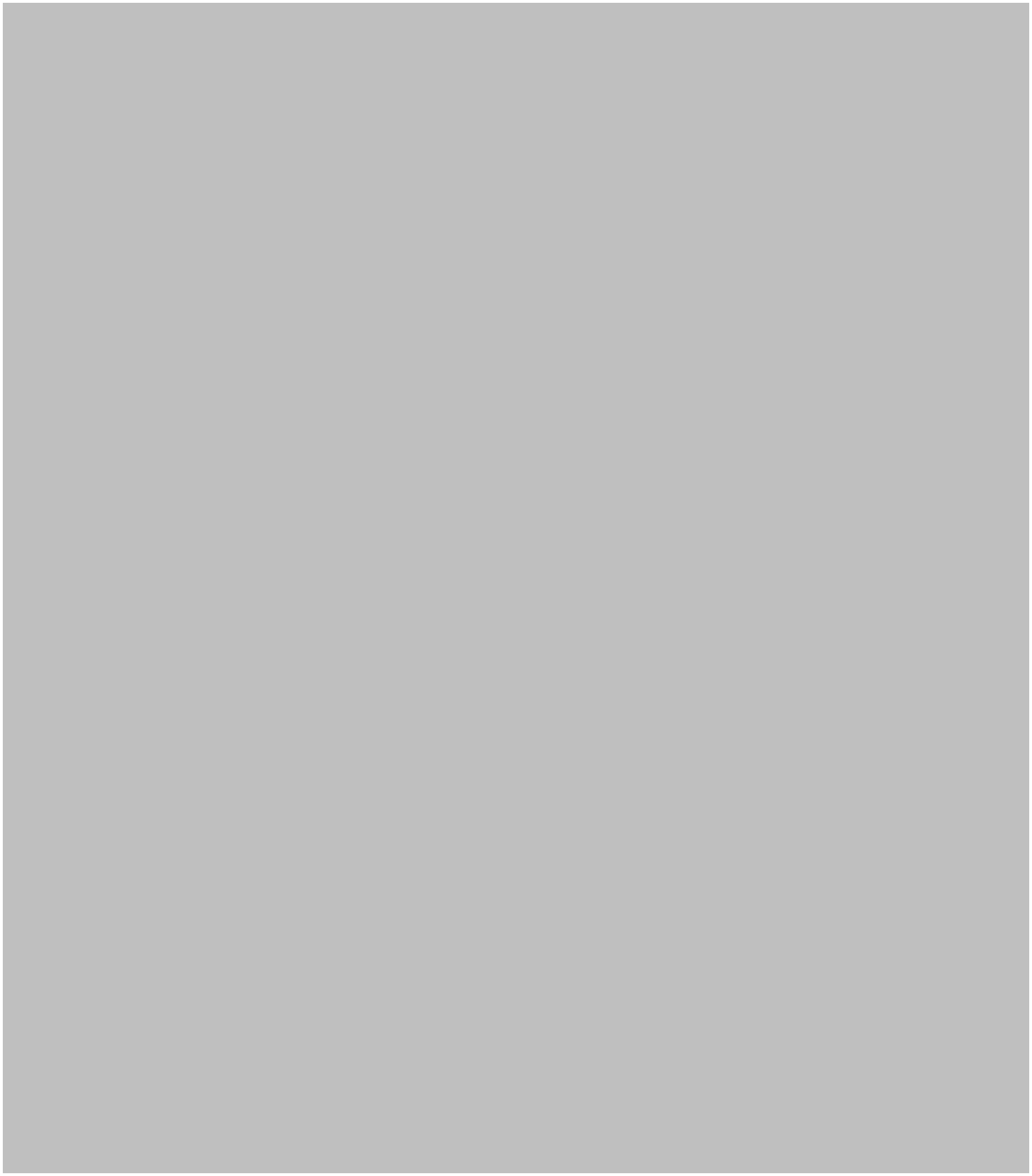
Appendix 2: Confirmation of Sponsorship



Appendix 3: NHS Research Ethics Committee Apporaval Letter



Appendix 4: R&D Ethical Approval Letter



Appendix 5: Participant Information

Participant Information Sheet

Experiences of Mass Media Portrayals of Mental Health and the Impact upon Personal Recovery

Hello, my name is Jeff Arnold and I am a trainee Clinical Psychologist at the University of Birmingham. I am running a research project asking about peoples' experiences of mass media portrayals of mental health and recovery. I would like to invite you to take part in a research study. Before you decide whether or not to take part, it is important that you understand why the research is being done and what it will involve. Please take your time to read this information sheet and feel free to discuss it with your family and/or mental health care team. Please ask if anything is unclear or if you would like more information. Thank you for taking the time to read this information.

Why have I been invited to take part?
I am hoping to listen to experiences of the media from men who are in secure hospitals. You are being asked to take part in this study as your clinical team have said you might be willing to take part.

Do I have to take part?
No, it is up to you to decide. I will explain the study to you and go through this information sheet with you. You can ask any questions and keep the information sheet. If you agree to participate in this study, you will be asked to sign a consent form to show you have agreed to take part. You may also keep a copy of this. You are free to leave the study at any time, without giving a reason. This will in no way affect the standard of care you receive from your mental health care team.

What will happen to me if I agree to take part?
First, you will be asked to take part in two interviews two weeks apart. These interviews will be audio-recorded for analysis purposes and will be kept safe and secure. The first interview will ask you to give consent to take part and to share details of your personal history, which will cover topics such as how you came to be in hospital and your recovery. This interview will take at most, 60 minutes

Between the two interviews, I would like you to complete some activities. These include answering questions on postcards that will be provided, and a media diary for you to write down and comment on any media stories you see or hear, for examples in the new, in the period between the interviews. I would like to ask you to spend a minimum of 30 minutes and a maximum of 60 minutes on these activities.

In the second interview you will be asked more questions of the media and the activities will be discussed. I will ask you about your views, opinions and experiences to do with the media and recovery. This will take a maximum of 60 minutes

What are the possible risks of taking part and what will happen if I don't want to or cannot carry on with the study?

Following review, we think that the possible risks associated with taking part in this study are low as you only have to share what you want to share. The questions involved in the study should not cover any topics that ask particularly sensitive information. However, it is always possible that people taking part in interviews may become upset. If you do become distressed, I will offer time out or finish the interview, either at your request or if I think it is needed. If this happens, I will discuss this with your care team in order to ensure your safety and that of other people.

You are free to leave the study at any time and you do not have to give a reason. If you withdraw from the study we will use the data collected up to the point of your withdrawal but no further data will be collected. The care you receive from your mental health team will not be affected in any way if you decide to withdraw from the study.

Will my taking part in the study be kept confidential and what happens to any information I give?

Your care team has already discussed with you whether you would like to be approached about taking part. We will inform your Responsible Clinician in writing if you do decide to take part. Those outside your immediate care team will not be informed of your participation.

If you decide to take part, only I will have access to your identifiable information and raw interview data. The only exception is in the rare situation where I believe something you had told us meant that there was a significant risk to yourself or somebody else or criminal activities had been disclosed. In this case I would inform your clinical team or Responsible Clinician, but I would always discuss this with you first. This is in line with Birmingham and Solihull Mental Health Foundation Trusts' Confidentiality Policy, Section 3.9. This states that:

"staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service."

More details of this policy can be made available if requested.

All information to be used in the study will have your name and personal details removed and replaced with a pseudonym on the date of collection so you cannot be recognised.

All information you give during the study will be kept electronically on secure computers that are protected by passwords. Only I will have access to identifiable

information. Only authorised researchers will have access to interview transcripts (their details are at the bottom of this sheet). The information provided by you will be stored for up to 10 years at the University of Birmingham, after which it will be destroyed. The data is stored for research purposes only and will not be passed on to any external agencies.

What will happen to the results of the research study?
We intend to publish the results of the study but you will not be individually identified in any publication. This study is also part of my qualification. As such, a panel of university academics will examine the final research and publication. The same confidentiality arrangements apply for this document and you will not be identified individually at any point. You will be able to request general feedback on the results of the study from the researchers once the study has been completed.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people called a Research Ethics Committee, to protect your safety, rights, wellbeing, and dignity. This study has been reviewed and given favourable opinion by a Research Ethics Committee. In addition, this research study has been peer reviewed by tutors at the University of Birmingham and given favourable opinion.

What are the possible benefits of taking part?
We cannot promise this study will help you as an individual but the data from this study may help people understand the impact of the media upon people in your situation.
You will be offered £15 (fifteen pounds) for the time you have given in the study once it is completed. This is only offered if you complete both interviews and the self-directed work.

What if there is a problem?
If you are unhappy about any aspect of this research you may contact the researchers, whose details are provided at the end of this form. We will do our best to answer any questions or concerns you have about the study. If you require support after taking part in the study you can speak to a member of your care team. You may also contact your local Patient Advice and Liaison Service (PALS), which is independent of the research study. PALS can support you with any issues, complaints or problems you experience with the research; however they may not be able to offer any specific advice regarding the details of the project itself.

LAST PARTS OF DOCUMENT OMITTED FOR ANONYMITY

Appendix 6: Study Information for Clinical Staff

Information sheet for recruiters

Experiences of Mass Media Portrayals of Mental Health and the Impact upon Personal Recovery

Dear potential recruiter,

My name is Jeff Arnold and I am Trainee Clinical Psychologist at the University of Birmingham. I am conducting a study at secure hospitals within Birmingham and Solihull Mental Health Foundation Trust. I am writing to you to ask for your assistance in recruiting participants for a research study.

What is the purpose of the study?

The study aims to explore experiences of mass media portrayals of mental health of service users in secure forensic settings. Research suggests that media portrayal of mental health can affect psychological well-being, but little is known about what the impact is upon recovery.

What will happen in the study?

I will hope to complete two interviews, each around a maximum 60 minutes long, and encourage participants to complete self-directed work, lasting a minimum of 30 minutes and a maximum of 60 minutes.

What am I being asked to do to help?

I am looking for enthusiastic individuals to help recruit participants. This would involve approaching individuals who have already been identified as suitable participants by the team psychologist and care teams. You would discuss the research study and the Participant Information Sheet with potential participants, and answer any questions they may have. If the potential participant is interested in taking part, you would arrange a meeting with me to gather consent and complete the interviews based on your knowledge of their needs and availability.

LAST PARTS OF DOCUMENT OMITTED FOR ANONYMITY

Appendix 7: Responsible Clinician Consent Form

Responsible Clinician Consent Form

Experiences of Mass Media Portrayals of Mental Health and the Impact upon Personal Recovery

Study Number: …… **Researcher:** ……
Study site (circle):

Dear Responsible Clinician,
Please take the time to read the below statements and tick the boxes to confirm you consent for …….. (service user) to take part in the study.

I confirm that I have understood the information sheet dated..... (version …..) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I confirm that the above named service user meets the inclusion criteria provided in the team information leaflet at the time of signing this form.	☐
As the above named service user's Responsible Clinician, I agree for this service user to be approached for participation in the above study.	☐
I confirm that the service user has capacity to consent to the study and the service user is able to participate in all parts of the study.	☐
I agree that the above named service user's participation is voluntary and that they are free to withdraw at any time during the research interview, without giving any reason, without their care being affected.	☐
I agree that the above named service users participation (or lack of) in the above study will not affect the care that they receive	☐
I understand that, with the exception of risk or criminal activity disclosure, no part of the interview data will be made available to me or any other member of the NHS team responsible for the above named service user.	☐

……	……..	……..
Name of RC	Signature	Date
……	……..	……..
Name of researcher	Signature	Date

Appendix 8: Participant Consent Form

Consent Form

Experiences of Mass Media Portrayals of Mental Health and the Impact upon Personal Recovery

Study Number: …… **Participant No:**……

Researcher: …… **Study site:** ……

*If you are considering taking part in the study and have carefully considered all the information provided, please read this form and **initial** the boxes.*

I confirm that I have understood the information sheet (version .....) for the above study. I have had the opportunity to consider the information and have had any questions answered. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time during the research interviews. I may withdraw from the study at any time, without giving any reason, without my medical/social care or legal rights being affected. I understand if I leave the study or change my mind about participating, I can withdraw my data for a period of two weeks after this decision. After this time, any data collected from me will be used in the study. ☐

I understand that the research interview will be audio-recorded on an encrypted audio recording device. ☐

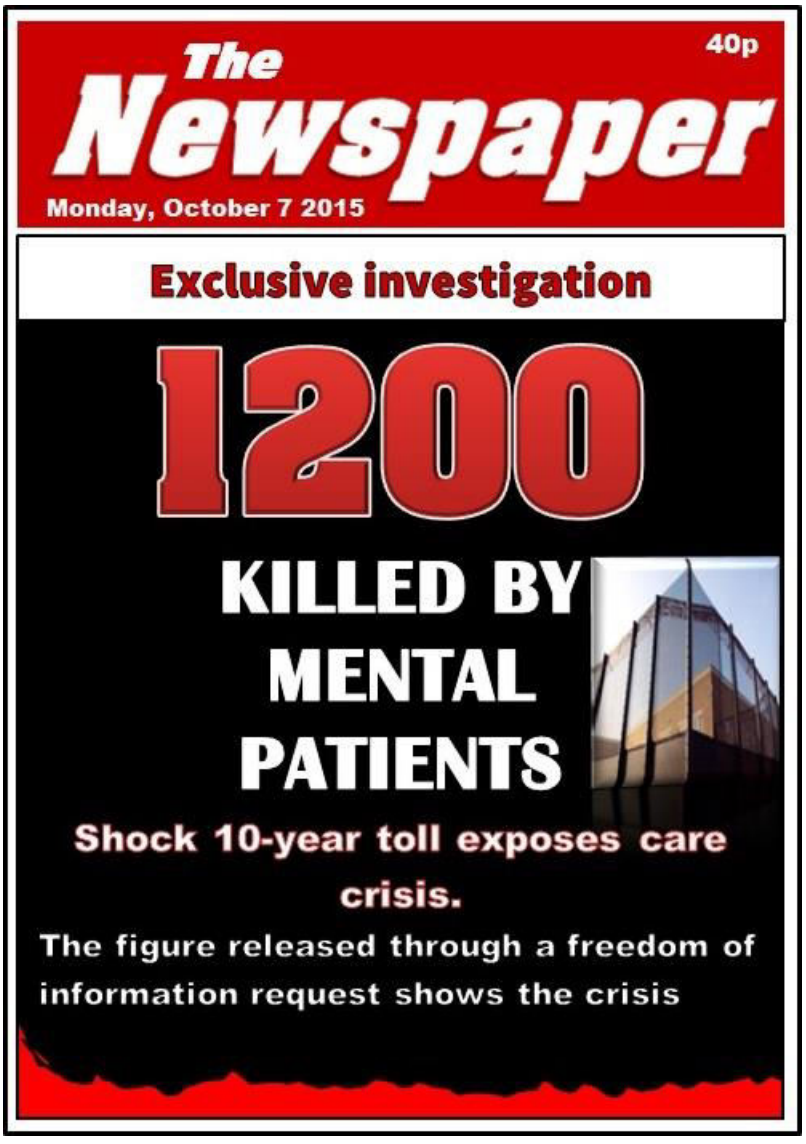
I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. Parts of the data may also be made available to the NHS team responsible for me but only if any previously undisclosed issues of risk to me or other people's safety should be disclosed. ☐

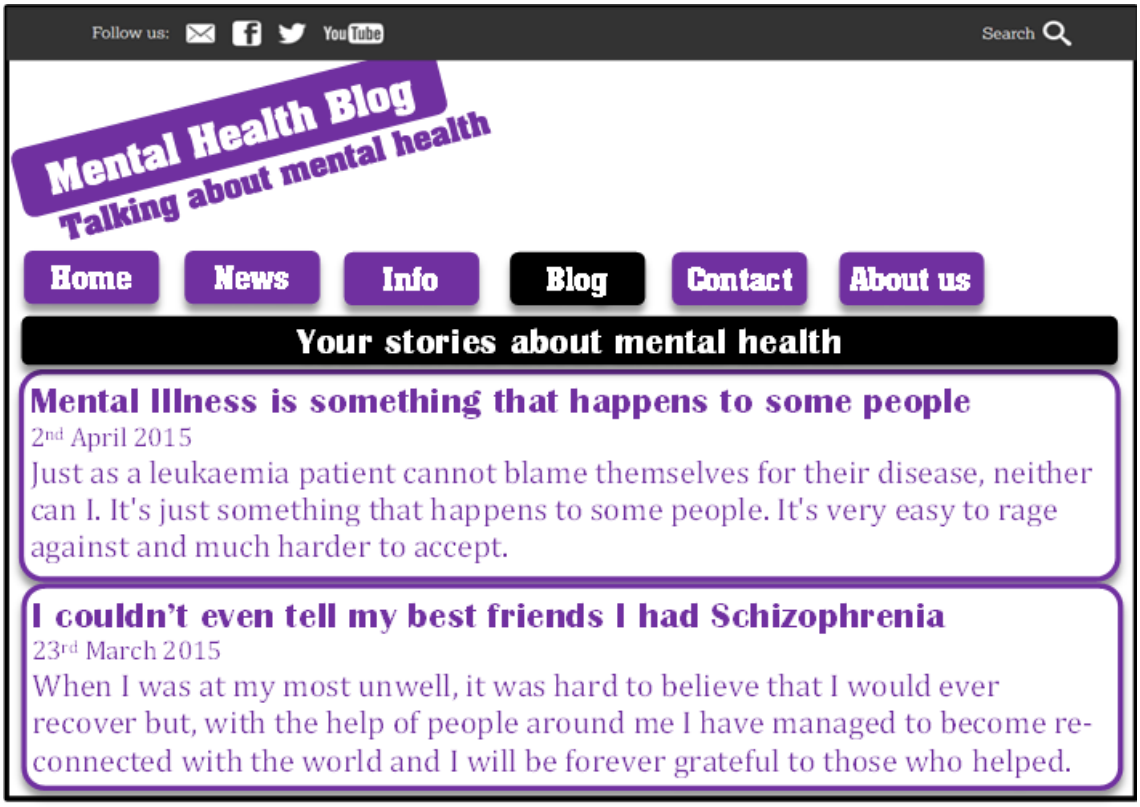
I understand that data from my interview may be published and used for training purposes. My data will be anonymised, meaning that any information identifying me will be removed. ☐

I agree to take part in the above study. ☐

……	……	……
Name of participant	Signature	Date
……	……	……
Name of researcher	Signature	Date

Appendix 9: Cultural Probes: Postcard Examples





These questions appeared on all the postcards:

What impact do statements like this have on you? What do you think and feel about comments like this?

Do you relate to the person in the story?

Do stories like this change your view on your own recovery? How about your family and friends views?

Appendix 10: Cultural Probes: Media Diary

What did you see/ hear about mental health?	**What source was it in (i.e. Newspaper, radio, internet, movie, TV, News)**	**What did you think and feel when you became exposed to this?**	**How did you relate to the person in the story? What type of experience was it?**
EXAMPLE: I watched Coronation street and there was a character with depression in it. He was constantly crying and getting angry with his friends and family.	**EXAMPLE**: TV soap	**EXAMPLE**: I felt annoyed. I didn't think it was a very real example of a person who feels depressed	**EXAMPLE**: I think it shows a poor image of people who feel depressed. I've felt depressed before and I was not doing these things. I did not show anything else about him other than his mental health difficulties.

Appendix 11: Indicative Topic Guide

Indicative Topic Guide

Experiences of Mass Media Portrayals of Mental Health and the Impact upon Personal Recovery

The indicative topic guide provides an outline of the topics and questions that will be asked within the research interviews. This is a guide and not necessarily the exact questions that will be asked, although questions will fall within the general themes. The indicative topic guide is designed to be used flexibly and responsively to the language, needs and concerns of each participant. This ensures that the interview process follows standard procedures but is also responsive to participant differences.

Interview One

Interview one will cover a general overview of the participants personal history. It will cover topics relating to the participants understanding of their mental health and recovery.

Topic A. Mental health

- Can you give me a brief history of your experiences of mental health
- If you were to explain mental health to another person, how would you describe it?
- How do you feel about being told you have a mental health diagnosis? Do you see yourself as having a mental health difficulty?
- What is you understanding of the words 'mental health'?
- Does it affect your life and if so how does it? Prompt for physical well-being, psychological well-being, everyday activities, and relationships.

Topic B. Recovery

- How do you expect your well-being to change over time?
- Do you think you mental health will change over time? If so, how will it change?
- What changes have already occurred since your admission into hospital? Are there positive or negative changes you have noticed?
- Have you heard of the term recovery, and if so what does it mean to you?
- What do you see as the long-term future for yourself? Does your mental health play a role in this at all?
- Do you see your mental health affecting you and your goals in the future?

Self-directed activities

- Between our meetings I would like you to complete some small pieces of work. Firstly, you will be given these postcards with pictures on. Take some time to read the information on them. Then think about how you feel about the stories.

Consider how you felt when reading them, how it affects you, does it affect your future and the way you see yourself?

- Secondly, I'd like you to keep a diary of anything you see or hear in the media about mental health. Again, I'd like you to consider how you felt seeing/hearing it, how it affects, and the importance of this experience upon you.

Interview two

Interview will focus on the participants experience of the media, and then consider how it might be affecting their recovery. The second interview will also be more flexible due to the different experiences they may bring back from the self-directed work. Interview two will use these completed resources as topics for discussion.

Topic C. Media portrayals of mental health

- Can you tell me more about what you have written on the post cards and in the diary
- What did that story mean to you? Why have you picked that story?
- Did you relate to the people in that story? How are they similar/dissimilar to you?
- What do you think and feel when you see stories like this in the media? What is your opinion of their content?
- Do these stories change how you see and what you know about mental health?
- Do these stories make a difference in the way you see yourself, and if so how?
- What impact do they have on your life? Do they change what you do and how you think and feel about yourself? If so, in what way?
- How do you think they affect how your family and friends see you?
- How do you think they affect how wider society sees you?

Topic B. Recovery

- Does the media affect how you believe things might be for you in the future? Will it shape your recovery?
- What are the most important factors to you for change?
- Do you see the media change the path of your recovery?
- Has it already changed your view of recovery?

Topic D. How the media could be different

- What could the media do differently?
- What could they do to promote mental health and recovery?
- If you could sit a journalist down, what would you say to them? What would you ask them to change, take away or add?
- If you could tell your own personal story in the media, what details would be important to include.

End of interview

Appendix 12: Initial IPA Notation

Descriptive comments and objects of concern **Conceptual** *Linguistic comments*		**Experiential concerns**
Wanting a focus on recovery – recovery is important. *Too many* – a feeling that they are all around Real focus on how hard it is – *trauma, suffering, hard, hell* Needs to be 'emphasised' in the media'- **is it missed?** Usefulness of seeing light at the end of the tunnel **The 'light', has it made him feel in the dark?** *You 'don't hear' about the person* Missing the person **An undercurrent of something missing from the media** You only see the headlines – as opposed to what? He makes progress but it isn't reported **Missing the person in stories –**	P: I think there should be more emphasis on recovery. I mean, I think there's too many stories, as I said, that concentrate on the negative. If, if someone can say, 'Well, this, this person had this massive breakdown, they go through the trauma, they go through, they start their journey, it's, it's difficult, it's hard, it's hell at times,' and, I think, if that can be shown that they actually come, there is a light at the end of the tunnel, and they can see… see a, sort of, more, better future, that, I think, needs to be emphasised a lot more, because that's what you don't hear. I mean, you only hear the headlines, and there's people behind the headlines that are suffering. And, if they, if someone, say, came back from a year, a couple of years down the line, through like, 'How have you done?' talked to their team, would, 'They've done really well, we, we can focus on this,' it's… it's a more positive slant on a very, sort of,… tricky, erm… learned situation I: So, the media needs to get into the experience of both the mental health but the, also the experience of recovery as well? P: Definitely, definitely .Yeah, as I say, it doesn't need to be just one person, it can be a lot of people, and that would, maybe… hopefully, change a few more perceptions. I: Were there any of the postcards that you thought had, had a nice focus on recovery.	Emphasises his suffering/hardship – hard, suffering, trauma, massive breakdown, hell However, he feels this is missed – that it is not emphasised There is a real sense of feeling something is missed – not just the suffering/hardship but also the progress. It feels these important parts of him; in fact all common human experiences are missed. He seems angry or disappointed that his progress is not talked about. He can't be seen as anything different if it only focused on the acute stages as shown in

he feels the real him is missed Numbers bring change Statistics help it feel more normal Noting a 'little thing' that happened **Relating his own experience to the media helps internalise the experience?**	P: … Erm… [thinking]… this one where it said, 'Did you know 1 in 4 of us will have a mental health problem in any year? Sometimes it's the little things that make a big difference.' Erm… I mean, I mean, as, I'll just mention this, I was down the dining hall ages ago now, and somebody, I, I, for some reason, I hadn't taken a yoghurt for my… for my pudding at lunch, and someone offered me a yoghurt. And it was just, it was just… it was, it was a small thing, but it was a nice gesture.	the headlines – makes him feel a failure? Relating his media experience to an internal experience feels really important – it helps him makes sense of the little things and the importance of connectedness.

Appendix 13: An Example of an Emerging Super-ordinate and Sub-ordinate Theme for One Participant

Super-ordinate *Sub-ordinate*	**Andrew's supporting quotes**
Missing the adversity	
Can't see the sufferignives	You know, they don't see the fact that these are people with broken lives, and I include myself in that… they they they just see the headline, and they don't see that the person is suffering and in crisis
Can't see the person	And, from one thing, one thing I've learnt is that… they're people [strongly]. They're people with damaged lives that just need help and recovery, to try and work out why they went ill try to, sort of, make sure it doesn't happen again, and, erm… if possible, and try to, sort of, have some kind of inner healing.
Half the story	I think it's, I think it's less than a snapshot, because, you know, you can't really, sort of, get to know someone in about, however long they spend, maybe, say, half a day, but… they just don't seem to see us as people
Not the full picture	whatever was written,… they didn't see the full picture.
Missing their experience	It's alright to sensationalise it to sell newspapers, but newspapers don't know what it's like to be that person, and, also, what they're going through at that particular time.
Can't see the person	they just see the headline, and they don't see that the person is suffering and in crisis
Can't see the person in crisis/suffering	they don't see the person in crisis, and they don't see the person, the person, they see us as, like, a, sort of, an illness, and, even though, even though the illness is part of them, they're not the illness. We're, sort of, , we're human beings and… it would, it would be, in an idea world, it would be nice to have, erm… everybody treat you with equal respect
Missing the person and the human cost	I think the media, as I say, they need to concentrate on the human, they say, they talk about the human cost and the human story, but, I think, if they could do that and, sort of, recognise that someone is a

	person… They're illness, they're illness is a part of their condition, but they're able to, sort of, see past you and, sort of, look at the person and say,… 'This is a… this is a human being, and trauma and tragedy in their lives,… we focus, we can, we, we want to see them as a whole person, as a human being, which they are.' And, if there was more emphasis on that, I think it might help.
Missing their suffering experience	We're people with damaged lives that just need help and recovery, how can people ever see that in these stories… It's alright to sensationalise it to sell newspapers, but newspapers don't know what it's like to be that person

Appendix 14: Emerging Theme: Blind to My Experience Across Participants

Theme One – Blind to my expereince	
Participant	**Example quotes**
Andrew	You know, they don't see the fact that these are people with broken lives, and I include myself in that… they they they just see the headline, and they don't see that the person is suffering and in crisis It's alright to sensationalise it to sell newspapers, but newspapers don't know what it's like to be that person, and, also, what they're going through at that particular time. they just see the headline, and they don't see that the person is suffering and in crisis they don't see the person in crisis, and they don't see the person, the person, they see us as, like, a, sort of, an illness, and, even though, even though the illness is part of them, they're not the illness. We're, sort of, , we're human beings and… it would, it would be, in an idea world, it would be nice to have, erm… everybody treat you with equal respect I think the media, as I say, they need to concentrate on the human, they say, they talk about the human cost and the human story, but, I think, if they could do that and, sort of, recognise that someone is a person… They're illness, they're illness is a part of their condition, but they're able to, sort of, see past you and, sort of, look at the person and say,… 'This is a… this is a human being, and trauma and tragedy in their lives,… we focus, we can, we, we want to see them as a whole person, as a human being, which they are.' And, if there was more emphasis on that, I think it might help. We're people with damaged lives that just need help and recovery, how can people ever see that in these stories… It's alright to sensationalise it to sell newspapers, but newspapers don't know what it's like to be that person
Malakai	"having been through it myself, it makes me feel sad, really, that, that people are suffering and seem to be on their own, and have no sympathy into it, in terms of what they're going through. It makes me quite angry at times… they just don't see how hard it is" having been through it myself, it makes me feel sad, really, that, that people are suffering and not be, seem to be on that, on their own, and

	have no sympathy into it, in terms of what they're going through. Anyone can suffer emotional mental, emotional, er, suffering, cope or suffer with, er, emotional wellbeing. They sometimes forget that if it changed the tone, if it changed the tone, if it changed the tone the message if it changed if it changed the narrative as well to a more sympathetic narrative that we all go through things we all experience things and there's some compassion to be had in terms of what people are experiencing in mental illness um if that narrative were stronger I think, I think there would be more acceptable to speak about mental illness.
Baljeet	Nothing is ever good said about people with such I've never heard anyone say a good thing about people never ever have I heard of a good sign a good word said always on the mend you don't hear that you don't hear and even if you do you don't hear it that often you don't hear it from any media the newspapers are cruel. Come and live, come and live here, work here for a year and you will know what, how we think feel, understand and then you can get an insight into what, what being mentally ill really means They can't see you for you, you know they twist it and miss stuff so you look like some sort of freak. They can't see what it is really like for us, here what it is like.
Chris	We don't always commit crime. We don't always look ill. We go to work, they go down the job centre, and different people who commit offences and stuff like that and they find it harder, you know, I'm trying to say? They find it harder is a bit of a mixture of people all-around of people with mental illness there is a lot of people with illnesses who just get on with their everyday lives fine. They work, they raise families. They do this they do that. I've been there done that myself, you know, I mean. Sometimes in their life, they might have a blitz in the life There's a lot of people who are ill, and have been really good in themselves. They never pick up on that point of a person working, doing this doing that, doing positive stuff. When you hear about in the media, is was mainly negative stuff… But maybe not always, but the majority of stuff. Is normally this that this that it's happened this person was bad the media can change people's points of views that, but it ain't a balanced

	view. They don't know me, they don't know what I've done to get better. They don't know how hard it's been for me. So they can listen to the media all they want, but it won't affect me. I know will get better and stay the community
Cameron	They're getting on there's a lot positive things going on. This just looks at the negatives. It shocking, but it doesn't show the whole picture and away. And yeah, it makes you think maybe that's not nice that that happens and I feel really sad that people who have died and to the things that have happened. it does give mental mental health a bad name, a bad name an an like I'd say to them well I'd say that I've been through it and through um um you know all this I've been through mental health, I've been through mental health institutions an I've been with mental patients an that is not what they're about, know what I mean. It's not all bad It doesn't actually tell you anything about the individual crimes or how people how people how how it happened you know what I mean. It just gives you a number and and what what what and um that that's that's how much were killed by mental health patients