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Popular television and public mental health: creating media entertainment from mental distress

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ABSTRACT

This paper explores how tensions and power differentials within public mental health interact with the practices of media production in entertainment television. I present the findings of a qualitative study involving semi-structured interviews with story consultants from mental health organisations and Senior Executives, Producers and script-writers from UK television series ($n = 14$). Story advisors welcome the opportunity to reach larger and younger audiences in distinct ways and to share the 'lived experience' of mental distress through well-researched characters. They accept their relative lack of power to negotiate dramatic storylines which conflate mental distress with criminality and may undermine their anti-stigma ideals. The 'medical model' is prioritised in mainstream television drama and the causes of mental distress framed in biomedical terms. Storylines tend to emphasise the certain benefits of medication and marginalise self-management of conditions. Television industry professionals recognise their anti-stigma public service role and are receptive to working with programme consultants to help create authentic characters. Perceptions of the nature of drama as requiring resolution may help to explain the principal focus on biomedical conceptualisations of mental distress. Medication provides a relatively simple on-screen solution to resolve complex stories. Entertainment television operates within limited ideological frames. Mental distress and stigma are addressed at an individual, not collective level. Debates within the survivor movement and public mental health concerning medication, treatment and recovery tend to be obscured. These might provide a productive alternative vein of storytelling that could broaden our understanding of the social meaning of suffering and thus help challenge stigma.

Introduction

Collaborations between media and health professionals are now routine but are they mutually beneficial? Public health messages can reach large or hard-to-access audiences through popular media formats including primetime television drama series. Creative professionals can develop storylines that are entertaining and credible. We still know little about the occupational practices nor much of the embedded ideological assumptions that help shape these collaborative encounters. For example, we might ask, to what extent do the tensions and power differentials within public mental health interact with the practices of media production? How do the dynamics of these encounters reflect wider debates concerning anti-stigma initiatives?

To explore these questions, I draw first upon literature within public mental health, media sociology and entertainment for social change and highlight some of the central debates concerning media, mental distress and stigma. Next, I introduce my qualitative research study which explores perspectives of media and mental health professionals involved in producing soap opera and drama storylines 'with a theme of mental distress'. I highlight examples where television industry professionals and story advisors from mental health charities and organisations appear to share a professional vision and common goals. I also identify areas of potential conflict to shed light on how these tensions might speak to wider debates concerning stigma and the role of popular media in public mental health.

Conceptualising public mental health

The 'global mental health' movement, led largely by the international psychiatric community, has been instrumental in highlighting the burden of unmet mental health needs in high and low-income countries (Cooper, 2016; Patel, Flisher, Hetrick, & McGorry, 2007). Global mental health promotes a programme of ideas and interventions to address socioeconomic inequalities concerning access to treatment for mental health disorders (Cohen, Patel, & Minas, 2014). The movement has been critiqued particularly by anthropologists and transcultural psychiatrists for marginalising local 'traditional' systems of understanding mental distress and side-lining important debates concerning the applicability of diagnostics and treatments of Western psychiatry in other cultural contexts (Ecks, 2016). Global mental health is also criticised because the biological determinism which underpins their approach links to the economic interests of the pharmaceutical industry (Cooper, 2016).

Effective public health promotion is now looking beyond the realm of public health experts to include community-based participatory forms of health promotion (Freedman et al., 2009). By contrast, the mental health literacy movement remains dominated by the 'reach paradigm' which has the aim of disseminating expert clinical perspectives to lay publics to enhance early recognition of symptoms and help-seeking (Jorm, Korten, Jacomb, et al., 1997; Knibbe, de Vries, & Horstman, 2016).

International news media campaigns are often framed in a similar 'public deficit model' way. The underlying assumption is that media campaigns inform 'the public' about the 'reality' of common mental illnesses and reduce the stigma associated with certain conditions (e.g. Paykel et al., 1997). A recent English campaign 'Time to Change' (led by mental health charities Mind and Rethink Mental Illness) used online blogs and television advertisements to raise awareness of stigma of people with mental ill health. Campaigns tend to be aimed at people 'without mental health problems' to behave in a non-stigmatising, socially inclusive way (Green, Hayes, Dickinson, Whittaker, & Gilheany, 2003). Anti-stigma initiatives frequently omit the perspectives of service users entirely (Thornicroft, 2006). In public mental health, 'the stigma associated with mental disorder is a key challenge' (Patel et al., 2007, p. 1302). Mental health stigma relates to attitudes, prejudice and behaviour as well as misconceptions of the danger that people in mental distress represent to others. For sufferers, this stigma is said to be 'worse than the illness' (Lasalvia et al., 2013, p. 55). In the classic study of psychiatric patients by Goffman (1963), he defines stigma as:

> an attribute that makes a person different from others in the category of persons available for that person to be, and of a less desirable kind -in the extreme, a person who is thoroughly bad, or dangerous, or weak. (Goffman, 1963, 12)

Stigma is thus a product of social interaction between 'the normal' and 'the stigmatized'. During the process of stigmatisation, people with mental illness are distinguished and labelled. Individuals who display certain characteristics which are culturally defined as 'deviant' thus become linked to undesirable features ('labelled') and open to discrimination. Labelling increases fear and perceptions of dangerousness which in turn increases social distance. Goffman's work remains important in emphasising the social or cultural functions of social stigmatisation. For example, people may anticipate stigma, concealing their condition and adopting a 'cycle of avoidance' as a strategy (Angermeyer & Matschinger, 2003; Issakainen, 2014). Psychiatric diagnostic labels applied to certain disruptive behaviours can potentially act as a political device to care for but also control people (Moncrieff, 2010). The influence in psychiatry of the Diagnostic and Statistical Manual (DSM) which contains supposedly objective lists of criteria for the

application of different diagnoses has been critiqued in that clinical labels (e.g. 'depression') marginalise the social meaning of non-clinical idioms of distress ('stress', 'life problems'). This serves to individualise and obscure social and material inequalities (Knibbe et al., 2016). Others argue that stigma should be more properly situated as a structural problem of discrimination and thus framed in broader terms of disability rights and legislation (Pescosolido & Martin, 2015, p. 88).

Mental illness and public stigma: the role of media

Younger people are least likely to disclose or seek help for mental distress (Biddle, Donovan, Sharp, & Gunnell, 2007). This makes popular media entertainment formats desirable to charities and mental health organisations who are keen to engage with young audiences in the assumption that media portrayals can promote prosocial messages about mental distress, dispel stigma and encourage people to access support. This view is supported by various studies which emphasise that stigmatising media coverage contributes to negative public perceptions and fuels prejudice (Hallam, 2002; Philo, Secker, & Platt, 1994).

The authors of several studies have concluded that television fiction is a primary public source of information about mental illness (Coverdale, Nairn, & Claasen, 2002; Wahl, 1992). Pirkis, Warwick Blood, Francis, and McCallum (2005) reviewed the literature concerning fictional film and television portrayals of mental illness and argued that entertainment television exerts more power than news media in shaping community attitudes towards mental illness. People with mental illness are frequently linked with violence to others (Sieff, 2003). Their dangerousness is underlined by camera angles, lighting and discordant music designed to shape fear on the part of audiences (Wilson, Raymond, Coverdale, & Panapa, 1999). Rogers and Pilgrim (2011) believe that negative framing of mental health problems becomes self-reinforced:

> Journalists and storytellers play upon existing public prejudices (to entertain or to create a dramatic effect). They also use their own tried and tested frames of analysis and depiction from past stories [...] a conservative vicious cycle, with the assumed link between mental illness being rehearsed and reinforced by new events or story lines. (Rogers & Pilgrim, 2011, p. 39)

Pirkis et al. (2005, p. 3) emphasise the potential for close collaboration between the public mental health sector and entertainment industry, 'to explore the potential for positive portrayals to educate and inform, as well as entertain' but there has been little attention paid to the dynamics between television drama professionals and programme story consultants in helping to shape narratives about mental distress nor of the assumptions about stigma that underpin these collaborations.

Entertainment and social change

Popular television plays a crucial role in public understandings of medical information and can, under certain circumstances, raise the profile of certain health issues and modify behaviour (Henderson & Kitzinger, 1999; Karpf, 1988; Papa & Singhal, 2009; Singhal & Rogers, 1999). Audiences for TV news are declining, but soap and medical drama programmes attract larger, younger and more diverse audiences which makes these formats attractive to advertisers and means they raise vital commercial revenue for the television channel.[1] Fictional rather than factual media may have a greater impact in representing the lived experience of ill health especially for audiences with lower educational levels (Bouman, 2004). Soaps are a site of intense audience identification (Brunsdon, 2000). The genre can represent multiple viewpoints which means that soaps and drama have a definitional role in society providing 'open' space for progressive or unconventional representations of important societal issues in comparison with factual formats (Klein, 2011; Schlesinger, Murdock, & Elliot, 1983). Audiences also appear to have high levels of trust in the credibility of UK soap opera health messages (Davin, 2003).

BBC drama is considered to exemplify the 'entertainment-education' approach (Cody, Fernandes, & Wilkin, 2004). British scriptwriters and producers do, however, resist the idea that their primary goal is 'education' (Buckingham, 1987; Coleman, 2008; Henderson, 2007; Klein 2011, 2013). Nonetheless, these

programmes have become the focus of intensive lobbying by various health organisations seeking to promote specific prosocial messages.

In this paper, I aim to bridge some empirical gaps concerning television professionals and their sources and to examine the tensions which may exist between charities/organisations and media professionals over media representation. However, it is important to note that the production of meaning within television narratives is itself a particular practice rather than a mere reflection of reality (Hall, 1997; Henderson & Carter, 2016). I am not, therefore, concerned with representational 'accuracy' and verisimilitude of the issue (Harper, 2005). Instead, I focus on the negotiations over story development and scripts during the process of production, the 'process of policing meaning' (Miller, Kitzinger, Williams, & Beharrell, 1998). I explore power differentials, how these are enacted during negotiations over representation and how they speak to tensions within public health specifically regarding labelling, diagnosis, medicalisation and recovery.

Method

I am building on research which explores news media and mental distress (Philo, 1996) and the role of entertainment media in public understandings (Henderson, 2007; Klein, 2011). I conducted semi-structured interviews ($n = 14$) with a sample of industry professionals and story consultants. These include senior management Controllers and Executive Programme Producers ($N = 3$), script-writers ($N = 6$) and story advisors ($N = 5$). The story consultants represented a mental health charity which provides advice and campaigns against discrimination; a Government funded organisation with an anti-stigma focus; a patient advocacy group; and a charity supporting people who are living with a particular condition.[2] Interviewees had extensive experience in working on mental distress storylines in UK television formats (soap opera, medical drama, single series and independent productions: BBC1 Doctors, BBC1 Life on Mars, E4 Skins, ITV Emmerdale, C4 Hollyoaks, BBC1 EastEnders, BBC1 Holby, BBC1 Casualty, ITV Coronation Street, C4 Shameless). Some programme titles have been removed to minimise the identification of interviewees.

My interviews with story consultants address their personal motivations and professional vision; the routine practices involved in collaborations and their views concerning the possibilities and challenges of mental distress in television. Interviews with TV production professionals address their personal motivations and professional vision; how decisions regarding mental distress stories are made; how they compare to other health storylines and the challenges of mental distress in drama. The aim is to explore internal and external factors that influence representation (the overall programme ethos; occupational culture; established versus new character). Interviewees were encouraged to give their own accounts and meanings and to make comparisons with different health issues within the same programme and across the spectrum of television drama. Interviews were audio- recorded with permission and transcribed verbatim.[3] I conducted a preliminary analysis after the first interview (Silverman, 2011) and reviewed recordings and notes to help me develop a tentative coding scheme by categorising extracts into broad themes. I analysed data manually using an open coding framework in which numerical codes were applied to each interview to highlight variation in response (e.g. exploring different understandings of 'good' collaborations or storylines). I marked key passages according to analytical themes using some of the principles of grounded theory, developing analytical constructs which were then applied to the sample allowing me to confirm, reject or modify concepts, in discussion with colleagues. Data were analysed for recurring or dominant themes among participants regarding their knowledge, beliefs and experiences related to mental illness storylines.

Findings

Perspectives of story consultants: new audiences, lived experiences, being a 'good source'

Story consultants are a standard feature of entertainment television, but their role and professional vision are rarely addressed. This contrasts with the wealth of literature concerning relationships between

news journalists and their sources (e.g. Henderson & Kitzinger, 2007). During my interviews, participants expressed the view that television drama has tremendous potential to challenge public stigma and prejudice. As one story consultant explains:

> It's the way (soap opera) resonates with the public. It's not just the people who tune in and watch it – it's all the coverage it gets in the newspapers. You don't have to be a fan to have heard about it or to know what's going on. (Story consultant, mental health organisation)

Collaborations are believed to create significant opportunities to capture distinct audiences who might be hard to reach or have little incentive to learn about mental distress:

> If we get someone coming to our (organisational) website then they are already engaged […] the soaps are reaching entirely different audiences, somebody who has never had any experience (of mental illness) […] That's why it's so valuable to get that message out. Everyone knows soaps aren't real but (they are) a lot of people's initial experience of an issue. (Story consultant, mental health organisation)

Collaborations with drama programmes involve considerable demands on time and resources and story consultants do not necessarily accept every invitation to advise because organisational resources are scarce. They are more likely to work with established series rather than help to develop new programmes that may not be commissioned. Advisors described acting regularly as a crucial conduit for translating medical information. This includes perspectives on patient experience and props. Consultants advised on the correct colour of tablets to treat a condition, the appropriate response from a community health team in that specific area and suitable patient information leaflets to add visual credibility to hospital scenes.

Consultants work directly with programme researchers and sometimes actors involved in high profile story arcs such as a character being detained against their will under the Mental Health Act ('sectioned'). Although it is common to give feedback on first or second drafts of the script, the consultants interviewed were not shown final drafts. Interviewees highlight how important it is to nurture a positive relationship with production teams. Story advisors with a mental illness diagnosis are particularly keen to help develop authentic characters which share the lived experience of mental distress:

> I can be creative in my work, I can facilitate in my work as well and in that sense, be at the centre of my own drama. My life isn't always dramatic but my condition at times allows me to make a more positive contribution to the work that I do than perhaps other people would do. (Story consultant, mental health advocacy organisation)

Television drama is not homogenous, and some programmes are more trusted than others to deliver 'low key' mental distress stories. A widespread view is that having members of the cast or production team with experience of mental distress frequently leads to those more nuanced storylines.

Programme consultants spoke of the competition amongst charities and organisations in mental health. Programme makers rarely work with a single organisation because as I discuss later, this allows them to access different perspectives on the issue, to maintain a higher level of editorial control and preserve tenets of public service broadcasting. Consultants perceive a 'good collaboration' as involving face to face rather than telephone meetings to discuss story development. Closer contact means that consultants acquire a detailed working knowledge of the programme character biographies and better understand the professional world of television production:

> People see that it's not just somebody who works for a charity looking at (their) script but it's someone who understands the mechanics of the particular issue of mental health. Also the production process and the speed with which you may have to work in order to get something done […] That provides a kind of production safety net. (Story consultant, mental health organisation)

Story consultants praised the commitment shown by some programmes towards more established characters. One recalled spending time with an actor and having lengthy discussions concerning masculinity and mental distress:

> I worked directly with the actor on what they called a 'depression' storyline but it was a breakdown (involving) his unravelling, his health being recovered, being supported by the community and beginning his life again. We talked about how mental health issues affect men, how men tend to hold things in, isolation […] Turnaround was quick […] I covered all the scripts within a month. (Story consultant, mental health charity)

Consultants from different organisations share the view that drama formats are well suited to representing the everyday experience of mental illness. Certain characters were singled out for praise in being, 'researched properly, not sensationalist or exaggerated'. It is worth noting that these were characters that the interviewees had typically been involved in developing and some vested interest is understandable.

Perspectives of story consultants: medical model, narrative devices and lack of power

I asked interviewees to reflect on whether they believed that certain dimensions of mental distress were routinely omitted, overplayed or misrepresented. The aim is to explore their assumptions concerning how mental illness is conceptualised and how this maps onto beliefs regarding anti-stigma ideals. A recurring theme is that there are still surprisingly few representations of characters managing mental distress successfully without medical support. Interviewees highlight that the 'medical model' is prioritised in mainstream television drama with the cause of mental distress typically framed in biomedical terms as being physiological rather than psychological. This has repercussions for how conditions are treated within the storyline with a strong emphasis on the benefits of medication.

We can see how this plays out within typical television drama story arcs where the character who is referenced by others as being in mental distress must recognise that they are exhibiting signs of being unwell and that they require help (from professionals). Characters are encouraged or coerced to seek help appropriately and are pressured by medical professionals or policed by members of their social network in the regular taking of medication. Medication, usually in the form of tablets, appears to function as a plot device to resolve the story neatly. Advisors emphasise the importance of self-management where people have agency, watch for 'triggers' and take charge of their treatment. They identified how fictional characters with a mental health diagnosis often became 'pathologized' or labelled in the programme. As one advisor explained 'If she's tired (other characters) say "Oh she needs to take her medication" but not everyone with bipolar needs medication'. This important point is supported by the *Hearing Voices Network.* An open letter from them criticises the BBC for recent mental health coverage because it promotes the assumption that psychiatric medication is the preferred option for treatment. In the UK, people diagnosed with bipolar disorder can be encouraged to access lifestyle and psychological skills training rather than medication (Hearing Voices Network, 2016).

Popular programmes are also criticised because of the intense focus on characters when their behaviour appears disturbed, and they are 'losing contact with reality'. The same characters then become marginalised during their period of 'recovery'. One story consultant explained that programmes 'throw it in again a year later, and everyone has forgotten they even had a mental health problem![4]' At the same time consultants appear to accept that, for dramatic purposes, programmes will be more interested in depicting a character who is exhibiting visible signs of becoming unwell:

> Clearly, you're doing a peak and a trough within a story arc. Obviously, you are going to pick the most dramatic bits. (Story consultant, mental health charity)

Programmes are also criticised for certain scenes such as episodes of psychosis where manifestations are revealed to be the product of hallucinations. The concern is that sequences involving characters 'seeing visions' can fuel public perceptions about psychosis and bipolar disorder that perpetuate the division between 'normal' and 'abnormal' thus supporting stigmatisation.

Story consultants are often involved in advising programmes about their established characters with mental distress storylines. By contrast, programme teams appear to abandon their commitment to an 'anti-stigma' discourse with temporary characters:

> When they are deciding to introduce a mad, bad character they don't try to show the complexities of whatever illness the character might be dealing with. They just throw the character in as being crazy. Usually, there is no explanation, and you see them being carted off by the police. (Story consultant, mental health advocacy organisation).

This is supported by other research which finds that media representations in news and popular television frequently conflate mental illness with criminality and violence (Olstead, 2002; Philo, 1997).

There appears to be a potential conflict for story consultants. Working with mainstream entertainment drama series means gaining access to new audiences. Compelling stories may encourage people to recognise symptoms, share experiences and ultimately seek treatment (though the process of labelling and the value of medication is contested). Storylines can thus help communicate the lived experience of distress, the social meaning of suffering. Alternatively, media professionals may seek advice for the purposes of social realism ensuring that the details of storylines are accurate regarding medical 'props'. They can exclude story advisors entirely from certain sensational plots which link mental illness with violence. These storylines risk enshrining divisions between 'us' and 'them', supporting prejudicial attitudes and beliefs and undermining anti-stigma ideals.

Perspectives of TV production personnel: authenticity, didacticism and vested interests

Creative professionals tread a delicate line between entertainment and education (Klein, 2011). Television production professionals commonly express the view that television drama can help challenge the stigma of mental distress, but their primary concern is to produce characters that are 'authentic':

> Most characters are 'normal' and struggling to make a living and survive but within that soap is about pushing them to extremes. That's what soap is. You take these characters, make audiences fall in love with them and stick bombs in their lives and see how they cope. […] I say to my writers, 'the biggest things that are going to happen to us are birth, marriages and deaths not a mystery virus or killer helicopter landing on your head.' The minute you depart from these things the audience stops believing you. Sensation is of limited value, and in soap, it tends to be quite damaging. (Senior Executive)

Writers and producers are faced with the challenge of packaging a well-researched story of mental distress that is credible for mental health organisations as well as entertaining for audiences. Working with story consultants is an accepted part of the production process. When asked about the key attributes necessary to become 'a good advisor' one senior programme executive summarised, 'they've just got to know what you're talking about, be on call and be prepared to do it for no money' (Producer, Medical Drama).

A working knowledge of the demanding production cycle and requirements of drama are also crucial and the issue of 'time' is a key area for potential conflict. Medical events being condensed into an unrealistically short time frame on screen was justified on the grounds of dramatic licence:

> We need to have these turning points in the progression of the disease […] it might happen (on screen) in two weeks whereas in real life it might happen in six […] We're not trying to lie about your expert field we're just trying to fill it in as dramatic way as possible. (Producer, Soap Opera)

Sources see themselves as lacking power over the content and direction of storylines. However, this view is not shared by some script-writers:

> I think they've got loads (of control)! […] I am in this well-monitored world where we get notes through saying 'the research says this' […] we have to think of a way around it or rather to work with it. (Script-Writer, Medical Drama)

Writers are aware of the burden of responsibility that comes with producing long-standing primetime drama. Most engage in everyday conversations about the impact of specific health storylines that they have written when they encounter members of the public:

> You're not there to educate, but you are there to put it on the table […] Once you watch that documentary you turn over, and it's forgotten but with (soaps) you have got that issue two hours a week for three or four months so how can you not learn or think about it? (Script-Writer, Soap Opera)

An additional structural constraint is UK public service broadcasting, and BBC programmes must be careful to avoid accusations of bias (Scannel & Cardiff, 1991). It is crucial that a diverse range of organisations are consulted on storylines. This means that regardless of how 'good' a source they become, in the end, charities are competing with other organisations for access to BBC programmes:

> We have to be careful with charities and organisations because they all have a vested interest in promoting their illness we need to make sure we don't promote (one) so much it gets undue exposure. The BBC gets into trouble with that! (Producer, Medical Drama)

Apparently, this not only preserves requirements of balance and diversity in line with the BBC charter, but it also means that programme makers have a range of perspectives from which they can select the view that is in line with the story that they choose to tell. One Executive Producer justifies this because it reflects the diversity of experience:

> whether it was with them from childhood or came on in their late teens, […] whether they wanted to be medicated or not […] whether being sectioned was a good thing or a bad thing […] you won't be able to please everyone who has that condition. What you have to do is create a version that works for that character and is in itself credible. (Executive Producer, Soap Opera)

Drama reflects societal anxieties of the period in which it is produced, and interviewees drew distinctions between how mental illness and other health topics were portrayed in the past as compared with current practices. Public health storylines once considered 'ground-breaking' regarding health promotion (e.g. HIV and AIDS) would not work in the same way for contemporary audiences as they would be regarded as didactic. Some visual cues to signify acute mental distress were disregarded as being dated:

> There was a (past) story with someone who was schizophrenic and had covered their room in tin foil. That has become a mental health cliché and something we would never do now […] we've wised up, we're cleverer, and I think the public understanding about mental illness has improved over the last 10 years. (Producer, Medical Drama)

Perspectives of TV production personnel: dramatic pace, golden rules and fear of 'the other'

Television professionals were asked to reflect on challenges associated with developing storylines with the theme of mental distress. The ongoing nature of conditions presented unique problems. It was considered vital that stories come to a resolution with characters making a 'recovery'. The enduring concern is that programmes risk losing audiences because a mental health storyline lacks sufficient narrative pace (Henderson, 2007). One experienced media professional explained the 'golden rule of drama' where 'in every scene, there has to be some progression and if there isn't you get bored'. Another highlighted that conditions such as depression are challenging dramatically so require specific measures:

> You have to ring the changes […] hide it from the other characters and the audience where he appears to be okay and is creating a mask of 'I'm alright Jack' (but) underneath there's a whole other world. We won't see it every day because that becomes monotonous and grinding. The audience go 'Oh why can't he just pull his socks up?' (Producer, Medical Drama)

British drama is forged in social realism, but some storylines are off limits. This is in response to media being blamed for presenting sensationalist portrayals of suicide (Corbo & Zweifel, 2013) and possibly provoking 'suicide contagion'. The rise in self-harm and attempted suicide amongst young men appeals to writers but tends to be avoided in programmes that are popular with younger people particularly when the character concerned is 'an icon'. Para suicide storylines generate significant public and media attention (Gunnell, 1994). Senior members of the production team are thus cautious about attracting British tabloid newspaper opprobrium:

> If a character attempts suicide and they don't succeed and then they are redeemed it sends a message that's saying somehow 'suicide will save you' […] we tried to have a character who was going to jump off Canary Wharf. At the last minute, they pulled the story […] you wouldn't want anyone to copy that or be seen to encourage that …it's about how much the media enhances some messages. (Senior Executive, Drama)

Some interviewees also reflected more broadly on the cultural role of mental illness or 'madness' in popular media. Thus, representations of health issues often play on the 'imagined danger' of modern life, a ripple of disturbance to the underlying security of viewers (Seale, 2003, p.67). One senior executive perceives popular images of 'madness' as performing a vital societal function:

> […] we fear 'the other'. Society gets (the drama) it deserves because these (stories) are manifestations of our collective psychology. When they are successful, it is because they express the fears that we all feel on some subconscious level. That's why the stalker, mad person is not just in soaps and is generally prevalent and very current. You can't really say this now, but it is also why in classic literature the villains are deformed in some way, and they have some physical or mental deformity because they are manifestations of our fear projected onto external characterisation. (Senior Executive, Drama)

Physical impairment of fictional characters in drama signifies both moral superiority and moral degradation (Ross, 1998, p. 3). While this view might be considered to undermine anti-stigma ideals, it is valuable to reflect on the function of 'madness in society' through more cultural perspectives (e.g. Cross, 2010). Formal medical labels associated with mental distress can risk labelling and pathologizing individuals. By contrast, the term 'madness' exceeds psychiatric discourse and has been reclaimed by pressure groups such as Mad Pride (Harper, 2005, p. 463).

Conclusion

Mental distress in television drama is a thorny issue and reflects the complicated socio-cultural positioning of what it means to be 'mentally ill' (Signorielli, 1989). Unlike other health issues such as immunisation or healthy eating where audiences can be directed towards or away from certain practices, there are no simple prescriptive measures for modelling a 'good' or 'positive' mental distress story. Public mental health debates concerning labelling, treatment, medicalisation and recovery are complex and appear to be largely absent in the negotiations between media and health professionals. Programme consultants are keen to work with prime-time television and organisations have potentially a great deal to gain. Charities can reach new diverse audiences and advising on a television show helps to raise funding, improve the standing of the organisation and possibly influence government policy (Miller et al., 1998, p. 129).

Popular drama plays a vital role in the public sphere and in the democratic functioning of society and can help raise critical societal questions while offering alternative perspectives (Murdock, 1999, p. 12). Yet these are possibilities and certainly not a given with storylines involving mental distress. Indeed, the organisations who worked regularly with mainstream UK series were mainly 'official' bodies as opposed to smaller charities and groups. Smaller groups tend to have a more radical approach to the field and disrupt assumptions about treatment and recovery. In this regard, we can see that certain voices which are marginalised in news media are potentially also silenced in popular mainstream drama. This means that alternative views that might focus more on the social meaning of suffering can risk being side-lined for medical models of disease.

Story advisors appear to be reconciled to their relative lack of editorial power. They consider it to be disappointing and yet inevitable that care is taken over representations of mental distress involving established characters (using the 'correct' terminology, mapping symptoms to the appropriate diagnosis). New 'crazy/criminal' characters involved in sensational stories are introduced intermittently and without consultation to generate narrative pace and intensify audience engagement. While expert advice is sought on 'prop' related issues and medical aspects of story trajectories this is not the case when it comes to more important matters concerning the function and role of medication, treatment and recovery. This risks ignoring vigorous and ongoing debates within the field of public mental health regarding service users and the burden of medication (Robotham et al., 2016).

Entertainment television is important commercially and operates within rather limited ideological frames. Mental distress is addressed typically at an individual level rather than examining structural problems or collective responses. In fictional storylines, the issue of stigmatisation lies with a few unenlightened individuals who can be 'taught' a lesson as a surrogate for the viewer (Buckingham, 1987, p. 84). It is worth noting that professionals in mainstream television are under considerable public scrutiny. This may restrict the scope of storytelling. It is entirely possible that independent producers working on single drama series awarded greater freedom from the constraints of genre and public service would hold different views and have different practices.

Organisations and charities have a role in shaping mental illness storylines in popular programmes, but it is important not to assume that these inevitably engage with or challenge social definitions of 'what it means to be mentally ill'. Nor will they necessarily change societal attitudes and behaviour concerning people in mental distress positively. Debates circulating within the survivor movement and public mental health arena must feed into anti-stigma media strategies. There is an important wider political context concerning the ongoing struggle over medicalisation, treatment and recovery

(Rose, 2014). These perspectives might provide a productive alternative vein of storytelling that could broaden our understanding of the social meaning of suffering and thus help to challenge stigma.

Notes

1. 8 million people watch one episode of BBC EastEnders, 20 million people watched live episodes in 2015 with 43 million and 36 million people engaging with storylines via Twitter and Facebook http://www.bbc.co.uk/mediacentre/latestnews/2015/eastenders-20-million-viewers accessed 5 April 2016.
2. Interviewees were contacted by email or phone. Interviews were conducted by telephone or in person at convenient times and locations (e.g. organisational/production offices, quiet venues in central London).
3. Ethical approval was awarded and to preserve anonymity names have been removed as well as identifying markers where these would obviously reveal the identity of the interviewee. There are considerable commercial concerns involved in working in television and more critical material was disclosed with the proviso that it would be unattributed. Details of story consultants and the organisations that they represent have been altered to avoid jeopardising their relationships with programmes as discretion is a central requirement.
4. The term 'mental health problem' risks labelling individuals as problematic and 'non-healthy'.

Acknowledgements

Disclosure statement

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