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**CREATING A STRATEGY OF LEARNING: ENGAGING WITH MENTAL HEALTH
LIVED EXPERIENCE THROUGH THE USE OF MEDIA NARRATIVES**

GARY KEVIN MORRIS

**A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE OF DOCTOR OF PHILOSOPHY**

UNIVERSITY OF HUDDERSFIELD

AUGUST 15th 2016

Volume I of II

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Creating a strategy of learning: engaging with mental health lived experience through the use of media narratives

Volume I

Index:	Page number
Abstract	7
Introduction	11
Background Features	15
Biographical Details	22
Publications	25
Theoretical Framework	28
The Learning Journey	29
Section 1 – The Media Narrative	37
Section 2 – Facilitating Engagement	49
Section 3 – The Reflective Practitioner	61
Section 4 – Collaborative Learning	77
Future Directions	91
Conclusion	99
References	105
Appendices:	153
Appendix 1 - Joint authorship commentary	155
Appendix 2 - Publications summary	161
Appendix 3 - Citations	167
Appendix 4 - International Appeal	179
Appendix 5 - Book Reviews	187

Appendix 6 - Module Assignments	203
Appendix 7 - Seeking Expert Opinion	211
Appendix 8 – Community Mental Health Promotion	227
Appendix 9 - Course Adoption / Recommendations	231
Appendix 10 – Conference Presentations	235

Figs and Boxes:

Fig 1 - Media narrative learning	14
Fig 2 - Framework for publications	28
Fig 3 – Interpersonal reflection	74
Fig 4 - Learning strategy	79
Fig 5 - Service user narratives – <i>the unified whole</i>	85

Box 1 - Learning Strategy (Preparatory Stage)	46
Box 2 - Learning Strategy (Facilitative Stage)	59
Box 3 - Learning Strategy (Processing Stage)	75
Box 4 – Collaborative Learning	89
Box 5 - Future directions	98

Volume II

Index:

Publications:	Appendix item
Publication 1 - <i>Mental Health Media</i>	*
Publication 2 - <i>Dementia Care Workbook</i>	*

Publication 3 - *Connecting with Screen Experience* *

Publication 4 - *Videogames* 1

Publication 5 - *First-Person Media* 2

Publication 6 - *Online Resources* 3

*** See books included in box file with volumes I and II**

Abstract

Creating a strategy of learning: engaging with mental health lived experience through the use of media narratives

Abstract

This commentary examines six of my publications, which collectively create an innovative strategy of learning. It is concerned with engaging mental health practitioners and learners more fully with service user lived experience through guided exposure to selected media narratives. The primary intention of this is to facilitate attitudinal change amongst health care professionals, promoting a greater sense of understanding and connectedness with those experiencing mental health difficulties. My learning strategy is concerned with the following elements:

- The media narrative
- Facilitation / guided learning
- Reflective practice
- Collaborative learning / co-production

The media narrative as a learning resource is critically reviewed and gauged to have huge learning potential where facilitative input is offered at distinct stages of access: before, during and after. It is demonstrated that through engaging with this process over a succession of cycles the development of reflective and reflexive practitioners can be promoted. An essential part of my learning strategy concerns the ‘testing out’ of learning, undertaken through a collaborative inquiry process with service users in practice as well as classroom settings. This fosters empathic understanding, an essential component of professional practice.

My learning strategy contributes significantly to the existing knowledge and practice base concerning the educational use of media narratives, service user engagement and lived experience learning. It has much to offer in terms of promoting empathic understanding and emotional intelligence, developing reflective practitioners and creating closer working partnerships with service users. The impact from my work has been verified through widespread adoption of my teaching resources, complimentary reviews, numerous citations, and invitations to present at conferences and community workshops. Future directions involve furthering my collaborative engagement with service users and engaging in co-production work, as well as facilitating narrative sharing amongst those with communicative restrictions, and extending the educative process beyond the healthcare arena, influencing attitudes through encouraging dialogue and reflection around mental health experience.

Introduction

Creating a strategy of learning: engaging with mental health lived experience through the use of media narratives

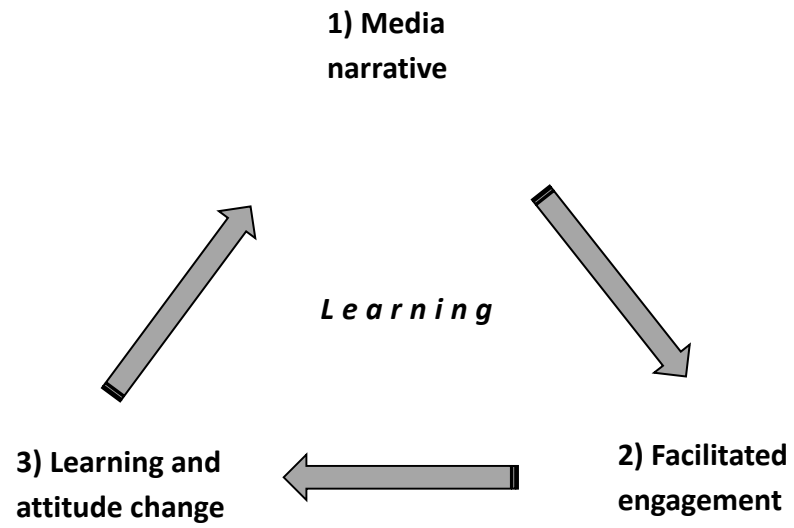
Introduction

This commentary provides a justification of my published work and associated educational developments through the creative use of media narratives around lived mental health experience. It involves six separate publications, comprising two textbooks, one book chapter and three articles. These publications contribute to the knowledge base in an area of key importance to mental health care and education. This concerns approaches to learning which promote greater degrees of connectedness and engagement between practitioners and mental health service users. The need for this is documented within a range of sources including practice guidelines, research studies and reports advocating greater employment of empathic approaches and person centred care (DoH, 2009; NMC, 2015; The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). There is also a need for attitudinal change around mental health issues illustrated by a developing awareness about the levels of stigma experienced and the impact upon those concerned (Mind, 2000; Pinfold & Astley, 2008). These aspects are central to my educational approach which is concerned with promoting the “human connection”, facilitating practitioners in engaging meaningfully with the personal narratives of those experiencing mental health difficulties. This is all encapsulated within a defining characteristic of my work, an innovative learning strategy, created to guide mental health nursing students through their exposure and engagement with lived experience narratives. This strategy has progressively developed along a journey incorporating scholarly endeavour and educational application aimed at mental health professionals becoming more reflective, aware and sensitive around the internal lived experience of service users and carers.

Narratives and personal accounts provide the driving force for my work. Squire, Andrews and Tamboukou (2013), in relation to narrative research highlight the lack of clarity around existing definitions of ‘narratives’, with no clear consensus reached as to what they are, where to locate them, how to analyse them and what significance to attach to them. These questions are addressed by my learning strategy which details a structured process of facilitated engagement with carefully selected media narrative products. Each of my publications examines a particular area concerning: media narratives; facilitative learning approaches; the development of reflective practitioners; and collaborative partnership engagement with service users. As a collective entity they create my learning strategy through their considered examination of each of the related parts, exploring the wealth of narrative resources readily accessible from varying media source types and their educative value for learning about mental health experience. It is critically examined within four key stages, each ending with a part titled ‘*so what*’. This is intentionally meant to be provocative with generated thoughts formulating each stage of my learning strategy.

Nursing students access service user narratives in various ways over the duration of their pre-registration education and training. This includes practice placements; service user classroom involvement; and exposure to selected media products such as film, TV, newspapers, autobiographies and internet sites. The focus of my work is particularly concerned with *one* of these elements, the personal narrative as expressed within media products and its potential for facilitating lived experience learning (see Fig 1). The richness of this experience is affirmed by the variety of narrative accounts to which learners are exposed and the promotion of a capacity to reflect both *in* and *on* action as formulated by Schön (1983). A further development of my learning strategy stresses the importance of this new knowledge being tested and developed *with* service users through a process of collaborative inquiry.

Fig 1: Media narrative learning



Background features

The context for my work can be established through determining why an understanding and appreciation of lived experience is such an integral part of mental health professional practice. One significant aspect relates to emotional intelligence, concerned with the ability of individuals to recognise and engage meaningfully with their own emotions as well as those of others (Evans and Allen, 2002; Goleman, 1995). It can be viewed as lying at the heart of nursing practice (Bulmer Smith, Profetto-McGrath, & Cummings, 2009) and is recommended as a basic component of mental health nurse education (Beauvais, Brady, O'Shea, & Griffin, 2011; Freshwater & Stickley, 2004). This helps to address identified deficits in the predominant technicalisation of nursing practice, better preparing clinicians for the interpersonal elements of care (Hurley, 2013). It also assists practitioners in coping with the emotional and stressful demands of the healthcare environment (Montes-Berges, & Augusto, 2007; Por, Barriball, Fitzpatrick, & Roberts, 2011), reduces the risk of burnout (Moyer & Wittmann-Price, 2008), increases job satisfaction (Pardee, 2010) and enhances feelings of well-being (Powell, Mabry, & Mixer, 2015). Healthcare practice can be emotionally demanding with unresolved difficulties negatively impacting upon one's engagement with service users. The attention therefore being placed upon the beneficial role that emotional intelligence can play within healthcare education is to be welcomed (Landa, Lopez-Zafra, Aguilar-Luzon, & de Ugarte, 2009). Its inclusion within nursing curricula though necessitates the utilisation of learning approaches which facilitate self-awareness and engage learners directly with personal narrative experience (Hurley and Rankin, 2008). Such approaches include expressive, arts-based methods which place greater emphasis upon concepts of care and caring (Freshwater and Stickley, 2004). This encapsulates some of the fundamental qualities needing to be embraced by mental health practitioners and educationalists, attempting to operate effectively within a practice ethos which more commonly promotes

bio-medical precepts. This is challenged by my learning strategy which places the personal and interpersonal dynamics involving practitioners and service users at the heart of the care process.

An element for consideration here concerns the added capacity to which we are able to *care* about people the more we know or understand them. If we take the concept of caring, the word ‘care’ itself can be examined. The Francis Report (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013), an independent Inquiry into the deficient care provided by Mid Staffs Hospital highlighted the need for health carers to provide compassionate care. The term *compassion* relates to care which is given through relationships based on empathy, respect and dignity and can also be described as intelligent kindness (NHS, 2012). It forms one of the six Cs which underpin compassionate relationship-centred care (DoH, 2012). This requires health carers to put service users at the centre of the therapeutic work, an approach strongly advocated by a number of seminal sources (Kitwood, 1997; Peplau, 1988; Rogers, 1961) and current practice guidance (NMC, 2015). Effective care involves practitioners being able to ‘see’, understand and appreciate those they are working with which reflects Honneth’s (1995) concept of recognition, viewing the person through their sense of uniqueness. This is a central part of my work, promoting opportunities for mental health professionals to encapsulate empathic approaches to care, getting closer to *what it feels like* to live with and experience mental health difficulties.

Lived experience

The term *lived experience* has unique meaning for each person, relating to one’s perceptual processing of internal and external dynamics. The internal sphere comprises *self* and the

thoughts and feelings present whilst engaged in daily life. The external sphere consists of the world within which one lives and the multitude of perceptual stimuli to which a person is exposed to. Wilhelm Dilthey (1985) suggested that lived experience is the breathing of meaning, involving our capacity to think, feel and perceive what is happening and what has happened. Gadamer (1975, p.60) sums up this process:

“If something is called or considered an experience its meaning rounds it into the unity of a significant whole.”

As the term *lived experience* signifies, there is a sense of awareness and perceptual meaning concerning what one is encountering. The comprehension of experience is unique for each individual and is influenced by emotive and cognitive factors with feelings and thoughts impacting upon each other. For example:

- The way in which a person feels influences their thoughts.
- The way in which a person thinks influences their feelings.

These elements interact with each other in a fluid, cyclical process as illustrated by O'Connor and Seymour's (1990) interpersonal model which acknowledges internal 'drivers' and their influence upon a person's behaviour. This is examined within my work with regards to 'reframing' externally observed behaviour through a greater appreciation of internal dynamics – thoughts and feelings. It reflects a phenomenological system of interpretation that helps us perceive and conceive ourselves, as well as our contacts and interchanges with others (Wagner, 1983).

Narrative

Reinharz (1983) outlined an initial stage within phenomenology whereby people's experiences are transformed into narratives creating opportunities for lived experience to be shared. One of the clearest channels for learning about a person's inner world, personality and identity is through stories or narratives about their lives (Lieblich, Tuval-Mashiach, & Zilber, 1998). The term *narrative* can be defined as:

"A story or a description of a series of events." (Cambridge English Dictionary, 2015)

This signifies a core function of chronicling and detailing experience. It can also be regarded as one of the primary ways in which human beings make sense of what they are experiencing (Gee, 1985). Our tacit experiential knowledge of the world can be ordered into spatio-temporal patterns with meaning symbolised in movement, sound, colour, shape, line, poetry, drama and story (Heron, 1992). This illustrates the wealth of communicative modes and media source types through which narrative experience is conveyed and within healthcare learning includes types such as digital stories, poetry, literature, art, music and drama. The Tidal Model for example embraces the *personal story* engaging with service users' expressions of their lived experience through narrative and personally meaningful metaphors and symbols (Barker and Buchanan-Barker, 2005). The rich symbolism, abstract imagery and textual structure make narratives uniquely personal as well as providing opportunities for self-expression, even if communicative abilities are restricted through mental health difficulties. It enables healthcare professionals to engage more fully with lived mental health experience, an exceedingly difficult entity to conceptualise especially given the proliferation of misperceptions and erroneous beliefs such as a person's heightened propensity for violence or degree of incapability. As Van Manen (1990, p.53) states:

“When someone has related a valuable experience to me then I have indeed gained something, even though the “thing” gained is not a quantifiable entity.”

This “thing” though can be conceptualised through empathy, an intuitive quality fostered through engagement with personal narratives. It is essentially about forming deeper levels of human connection, promoting opportunities for visceral engagement with individuals’ lived experience (Honneth, 1995). The significance of this can be acknowledged in terms of the benefits to each party with real opportunities created for interpersonal learning. A vital element here concerns the sense of connectedness attained with narratives and personal experience which are relayed in the first-person, enabling service users’ voices to be heard and validated. Historically, such opportunities were limited with a fair degree of mental health experience interpreted and related in the third-person by others deeming themselves as having the expertise to do so. Fortunately such attitudes are rightfully being challenged by a number of mental health advocacy groups promoting the right for service users to represent and speak for themselves. One example here relates to Peter Beresford’s (2013a) argument for a survivor controlled museum of madness, reclaiming historical narratives and more faithfully promoting testimonies and personal accounts. This importantly challenges the *historical maze of psychiatry*, a term created by Coppock & Hopton (2000) to account for the huge diversity of views and layers of subjective meaning and interpretations. My work essentially aims at engaging directly with those experiencing mental health issues first-hand, giving recognition to their status as “experts by experience”.

Mental ill-health and mental well-being

Richard Bentall (2016), in his letter to Stephen Fry, highlights the sense of “fuzziness” that exists around perceptions of mental ill-health and mental well-being. He challenges the prevailing bio-medical model of care as contributing towards stigma and limiting and failing to acknowledge the significant numbers of people living productive lives (with mental health conditions) and making full or partial recoveries without seeking help or taking medication. Similarly, Dorothy Rowe (2002) comments upon psychiatry’s continuing tendency to insist that mental distress is a life-long condition, even though not necessarily being the experience of many service users. This reflects the importance of considering the breadth of experience being expressed with available narratives covering the whole spectrum of from points of struggling to those of coping. It addresses a fluid process with experience fluctuating between the two poles or existing simultaneously. Narratives documenting difficulty can be enlightening and instrumental in contextualising symptoms or behaviour as well as determining a person’s required mode of intervention. At the other end of the spectrum experiences of coping and well-being provide vital examples of *recovery*, a concept which can be conceptualised through conflicting definitions including an absence of symptoms (Warner, 2004) or state of enhanced resilience and ability to live well with various mental health states (Martyn, 2002; Roberts and Wolfson, 2004). As Morrison et al (2013) illustrate, what recovery is understood to represent can also be viewed differently by different parties, with for example psychiatrists focusing more upon a reduction in symptoms, and patients emphasising aspects such as self-esteem, having a valued role in society, and hope for the future. A recovery approach demands a more humane understanding of the human condition and challenges the medical model’s historical viewing of people as diseased or disordered (Stickley et al., 2015). The use of narratives documenting recovery can stimulate emotional and transformational learning around mental health experience (Stacey & Stickley, 2012) and are highly important on account of their projected hope and association with personal

learning and growth (Whitehill, 2003). As illustrated by Anthony (1993, p.527) recovery involves:

“living a satisfying, hopeful and contributing life, even with limitations caused by the illness.”

This personal quote reflects the concept of accommodating and living well with mental health issues and provides a welcome and opposing view to the more commonly framed element of “suffering”. What is important though is that practitioners are aware of the totality of mental health experience with its changing dynamics and that positions such as vulnerability and resilience need not be mutually exclusive but can co-exist. This can be illustrated through some vibrant narrative examples, in particular observed within online discussion forums with the same individuals both requesting and offering support. The spectrum of experience can also be accessed through other internet-based resources with personal narratives shared through blogs (Time to Change; Mind), or interviews (Healthtalk; YouTube). This is complemented by some illuminating examples from television and radio such as the BBC’s (2016) *In the Mind*, Channel 4’s (2012) *4 goes Mad* or Radio 4’s (2016) *All in the Mind*. There are also some excellent print-based edited texts with notable examples including Barker, Campbell, & Davidson’s (1999) *Ashes of Experience*, Ramsay, Page, Goodman, & Hart’s (2002) *Changing Minds*, and Basset & Stickley’s (2010) *Voices of Experience*. It is the facilitated exposure to such narratives and the engendered appreciation of internal mental health experience which forms the basis of my work.

Biographical details

This section traces the starting point for my journey of learning from media narratives. It details personal and professional dynamics which have been instrumental within my developing interest in lived experience and modes of connectedness.

Personal development

Three distinctive features stand out for me here including family mental health experience, fascination with media narratives and engagement with the martial arts. My family experience principally involves my mother's experience of clinical depression which stimulated a need and desire to understand more about the personal dynamics involved within mental health experience. This influenced my decision to train as a mental health nurse and learn more about internal lived and felt mental health experience. I have also had a long-standing interest in the engaging potential of the media narrative, particularly in relation to film, cult TV programmes and graphic novels. Certain examples provided me with fascinating glimpses into manifestations of mental health experience through their tormented or inspiring heroes. They were instructional, engaging and memorable. My training in the martial arts over the past 40 years stimulated a desire to explore the spiritual elements of *Chi* (inner strength), *Zanshin* (awareness) and *Kime* (focus), essential Zen Buddhist qualities concerned with internal dynamics (Iedwab & Standefer, 2000). These provide the driving force behind all external applications - techniques of strikes, kicks and blocks. I have brought these same dynamics to my mental health education approach recognising that internal drivers (thoughts and feelings) influence external behaviour (O'Connor & Seymour, 1990).

Professional and intellectual development

I qualified in 1986 as a Registered Mental Health Nurse. Subsequent practice experience and training incorporated psychotherapeutic approaches such as therapeutic community practice, cognitive analytic therapy, psychodrama and person centred dementia care. This helped develop my understanding around the personal nature of mental health experience and promoted awareness around how this might be internally perceived. A core focus within my training and subsequent practice experience concerned the internally operating dynamics, notably the person *inside* a particular mental health condition. The move into education has resulted in over 20 years of teaching, utilising varied innovative approaches geared towards attitudinal change and empathic learning. My commitment to service user involvement in healthcare education is demonstrated through a number of collaborative initiatives and developmental opportunities including membership of the University of Leeds' *Service User/Carer Involvement Advisory Group* and the nationwide *Lived Experience Network*. These initiatives illustrate my increasing adoption of a humanistic approach to learning and are explored further in section 4 along with a critical review of service user involvement in nurse education.

Publications

Publications

The submission for the award of PhD by publication consists of six pieces of work: two academic textbooks, one chapter in an edited textbook; and three articles in peer reviewed journals. Two of these publications are co-authored and a declaration detailing my contribution is included within appendix 1. The publications presented here have been widely cited, used for teaching and scholarly purposes (nationally and internationally) and have received extensive complimentary reviews concerning their educational value. The abbreviated titles in bold and italicised text are used throughout this commentary to refer to these publications. The numbers given to each publication reflect the sequence through which they are reviewed throughout this commentary. For a detailed summary of publications and full reference details see appendix 2.

Textbooks

Publication 1: Morris (2006) - *Mental Health Issues and the Media*. [***Mental Health Media***]

Publication 2: Morris and Morris (2010) - *The Dementia Care Workbook*. [***Dementia Care Workbook***]

Book chapter

Publication 3: Morris (2010) - *Developing Empathy - Connecting with the Screen Experience*. [*Connecting with Screen Experience*]

Journal Articles

Publication 4: Morris and Forrest (2013) - *Wham, sock, kapow: can Batman defeat his biggest foe yet and combat mental health discrimination? An exploration of the videogames industry and its potential for health promotion*. [*Videogames*]

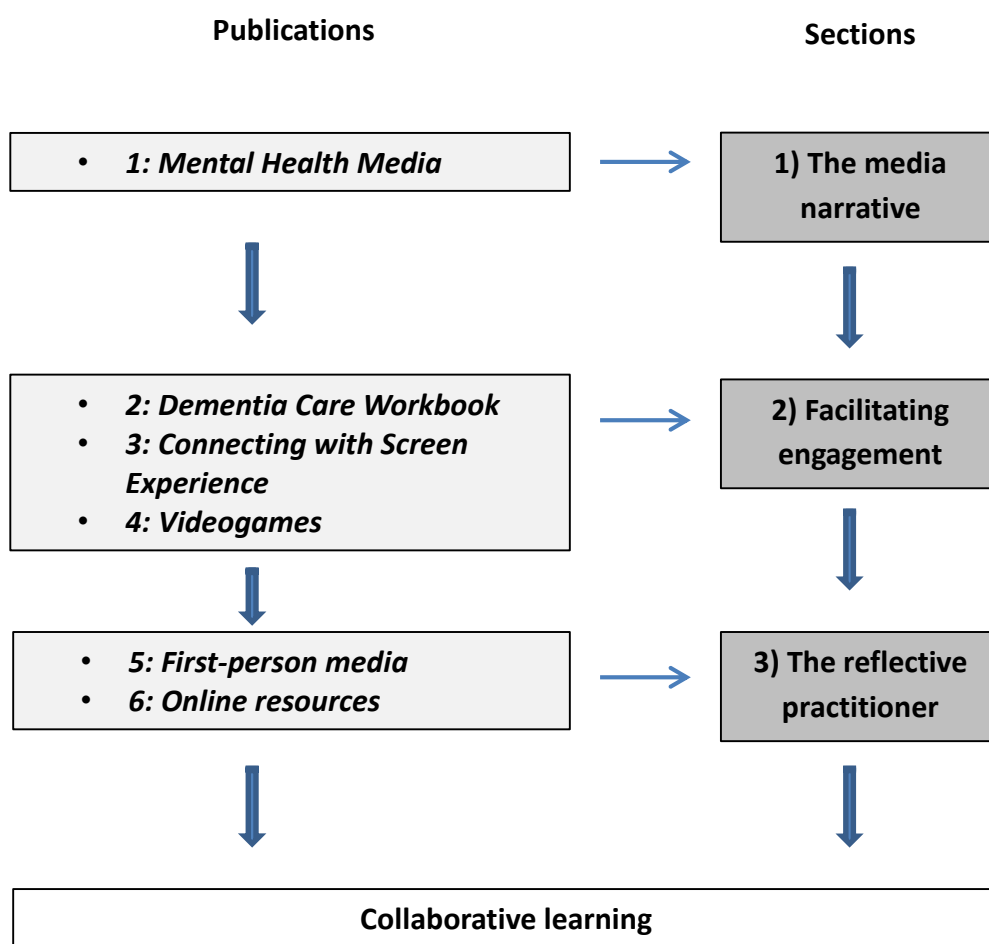
Publication 5: Morris (2014a) - *Developing awareness and understanding amongst mental health nursing students of the lived experience of dementia with the aid of selected first-person media resources*. [*First-Person Media*]

Publication 6: Morris (2014b) - *Education can be fun: a qualitative study exploring the promotion of learning through the use of creative and engaging online resources*. [*Online Resources*]

Theoretical framework / Structure

The diagram in Fig 2 illustrates the evolution of my learning strategy, sequentially detailing a process of learning about mental health experience from media narratives. It provides the structure for the four main sections that my work is divided into. Publications are predominantly explored within the sections indicated although texts are revisited as appropriate.

Fig 2: framework for publications



The Learning Journey

The learning journey

This brief section traces my journey of development, providing the context within which ideas and knowledge relating to my learning strategy evolved. It is intended to act as a contextualised guide only and it should be noted that theoretical issues are critically reviewed later in this work. The aspects covered here have been instrumental in creating my humanistic stance of looking for the *person* inside the mental health condition and valuing the educative potential of the internal narrative.

- ***Pre-nursing / personal experience***

As previously detailed within the biographical details section there have been a number of personal experiences and influences which were instrumental in stimulating my initial interest in the “personal narrative” and acknowledgement of its potency from a learning perspective. This included encountering mental health issues within my family with my mother’s depression; fascination with the media narrative (i.e. graphic novels, cult TV programmes and feature films) and their conveyance of internal mental health experience; as well as my engagement with martial arts and opportunities to pursue the association between internal dynamics and external applications. These varied aspects formulated a strong acknowledgement of and desire to examine the internal lived experience.

- ***Nurse training***

My mental health nurse training commenced in 1983 and followed the 1982 Syllabus of Training for Mental Health Nurses. This emphasised the interpersonal nature of care and the

importance of therapeutic relationships (General Nursing Council for England and Wales, 1982). My experiences as a student nurse provided multiple opportunities to work closely with service users and their families across a wide range of clinical placements. This enabled me to begin to better contextualise mental health experience and appreciate something of its uniqueness as experienced by each person.

- *Clinical practice*

After qualifying as a registered mental health nurse I worked within a practice setting which operated a therapeutic community practice ethos. This approach advocated the importance of partnership work and working *with* service users in what Kennard (2004) described as a “culture of enquiry”. The essence of this involved a dynamic process of interpersonal learning relating to all parties involved, including both clinical practitioners and service users (Rapoport, 1960). My subsequent practice and training included working with psychodrama and cognitive analytic therapy (CAT) approaches, both very much involved with understanding more about the person. Psychodrama examines personal dynamics through dramatic means and very powerfully engages with internal narratives through creative modes of enactment (Moreno, 1946). CAT work centres around the reformulation, a powerful reflection upon a person’s life and their experienced target problems (Ryle, 1991). I then worked briefly within a dementia care unit becoming painfully aware of the disparity between what I understood to be effective person-centred dementia care and what I was actually experiencing in practice. What seemed to be lacking was any real appreciation of the individual inside the condition of dementia, as reflected by Kitwood’s (1997) personhood approach. These rich and multi-varied experiences helped form a deeper appreciation of the

need to appreciate each person's own sense of uniqueness and to engage meaningfully with their internal lived and felt experience.

- ***Nurse education degree and teaching qualification***

My two years working towards qualification as a registered nurse teacher (RNT) were instrumental in becoming more critically aware around the dynamics of the learning process. It also provided me with opportunities to 'test out' and evaluate a range of facilitative approaches involving creative learning applications. Notable aspects for me centred around the humanistic theorists and their emphasis upon autonomous, student-centred, meaningful learning (Rogers, 1983; Knowles, 2015; Maslow, 1970). This was reflected within my dissertation "*Life on a degree course*" which examined the interpersonal dynamics operating between learner and teacher. Another personal landmark was an assignment I wrote examining Mary Shelley's (1818) *Frankenstein*. This detailed the disparity between the creature's internal world (sensitive and longing for love) and the cruel rejection, stigma and abuse experienced on account of his deviant appearance and behaviour. This for me reflected a commonly experienced practice issue of responding more prominently towards externally displayed characteristics, for example the noting of service users' behaviours as "challenging", which fails to acknowledge their internal world. These collective experiences highlighted the varied interpersonal dynamics and processes operating between various parties, reflective of the psychotherapeutic relationship.

- ***Working in nurse education***

Over two decades working in nurse education have provided multiple opportunities for promoting better empathic understanding amongst students. The recognised potency of the media narrative has been tested through many occasions, initially using TV (drama, comedy, documentary), feature film (whole movies, clips) and book extracts (autobiography, literature). This provided opportunities for contextualising mental health experience and fostering a greater appreciation of a person's lived and felt experience. I also utilised a number of experiential learning exercises facilitating self-awareness, empathic understanding and the development of interpersonal skills. The collective learning from these activities were developed into a number of taught modules and learning strategies including the creation of modules *Mental Health Issues and the Media* and *Person Centred Approaches in Dementia Care*. These addressed a variety of key issues including ways in which mental health experience is framed (from stigma to health promotion), differing communicative modes of expression and the personal perspective involved with thoughts and feelings.

- ***Learning strategy***

The emergent knowledge from the journey described above has been instrumental in formulating my strategy for learning. This covers three distinct stages:

Stage 1 – The Media Narrative

This stage is about the potency of the media narrative. It developed through my personal interest in and fascination with the media narrative and the active learning experienced through my taught module *Mental Health Issues and the Media*. Group discussions, student engagement and the quality of submitted assignments illustrated a sense of vibrancy and

insightful appreciation of lived mental health experience. I was also struck by the enthusiasm and level of engagement demonstrated in relation to varying media products and source types. At this stage my work was very much centred around the learning potential of the media narrative. It was noticeable through assignment choices and engagement with various sessions that students demonstrated preferences for certain media source types and narrative products, something investigated further within stages 2 and 3. I progressively became aware of a limitation within my work considering the isolatory nature with which narratives were examined and a need to collaboratively engage with service users regarding this process.

Stage 2 – Facilitating Engagement

The second stage was instrumental in appreciating the dynamic processes involved whilst actually engaging learners with media narratives. It included opportunities to use varied media types, accessing personal experience through visual, audio-visual and textual modes of communication. As with stage 1 there was a growing recognition that certain narrative types were favoured and engaged in to greater degrees by different students. There was also an appreciation developed of service users having preferences of communicative modes for conveying personal experience. This became especially apparent in relation to dementia care where creative forms of communication including visual narratives provided individuals with a continued “voice”, despite ongoing deterioration in cognition. This for me highlighted the importance of matching the communicative mode to the person as a means of facilitating meaningful engagement with individuals and groups who might be seen as “hard to reach”.

Stage 3 – The Reflective Practitioner

This stage is primarily concerned with the learning dynamics and processes taking place. Having provided opportunities for learning the importance here involved evaluating their effectiveness. This essentially relates to students' developing levels of engagement and connection with service users' internal lived experience, elements closely related to the vital process of empathy. The small studies conducted, as reported in *First Person Media* and *Online Resources*, demonstrated a greater sense of appreciation and connectedness with the lived and felt mental health experience. The close scrutiny upon the learning process also indicated needs for student support and supervision with regards to aspects such as emotional overload. This was addressed through widening the scope of reflective dynamics engaged to encompass "self" as well as "other", including the interpersonal dynamics operating between both parties. It has developed alongside my examination of a broad selection of theoretical approaches including reflexivity, reflection *in* and *on* action, double loop learning and emotional intelligence.

- ***Future development***

It can be noted here that my developmental learning journey is far from being completed and can be considered as work in progress. As shown in figure 2, the progression is towards a position of collaborative learning involving inquiry and co-production approaches with service users. This acknowledges the degree of expertise held by service users and the reciprocal process of learning which can be attained. It also picks up on individuals and groups considered as "hard to reach" examining creative approaches and narrative types which can be utilised for enhanced engagement. The collaborative elements also include

seeking opportunities for involvement with community initiatives which help to challenge stigma and raise awareness around lived mental health experience.

- *Learning journey: key points*

The breadth of experience detailed here has been instrumental in shaping and defining my humanistic and person-centred approach to healthcare learning. Firstly, the importance placed upon engaging with internal dynamics, a process which relates to practitioners as well as service users. This engages reflexive as well as reflective practice with self-awareness being a fundamental part of the interpersonal learning dynamics. The overarching philosophy inherent in my practice concerns phenomenological, humanistic approaches to care. This is very much concerned with acknowledging each service user as unique and individual, seeking ways to engage meaningfully with their internal experience and related thoughts and feelings. My work has also developed significantly in terms of facilitative interventions used with learners, helping them to become more self-critical as well as questioning about the personal narratives of those they are working with. This has been complemented by a growing appreciation of the richness of communicative modes available within which personal experience can be conveyed and engaged with. A further emergent theme concerns formulations around my current position and plans for future development involving collaboration and partnership. This was initiated initially through my therapeutic community practice engagement and has developed steadily along with a growing belief in the notion of service users as “experts by experience” and the need to challenge the prevailing balance of power. The power dynamics experienced within healthcare and education are discussed further in section 4 (collaborative learning) and the subsequent future directions section.

Section 1 – The Media Narrative

Section 1 – The Media Narrative

Introduction

This section examines the significance and value of media narratives as communicators of lived mental health experience. It reviews the huge diversity of message types available which inform or misinform about the experience of living with mental health problems. Whilst stigmatising and stereotypical examples predominate there is still an abundance of readily accessible narratives promoting understanding and raising awareness of the reality of mental health experience. These cover almost every conceivable aspect across a spectrum of *struggling* to *living well* with mental health states. The importance of the media narrative from a learning context can be regarded through its powerful and impactful communicative qualities and the vast selection of accessible resources. Indeed, a significant proportion of what is learnt about mental health experience is obtained from the media with audio-visual types and news services featuring prominently (Wahl, 2003). Another primary source for accessing mental health information is the internet with its multitude of resources and facilities (Kirmayer, Raikhel, & Rahimi, 2013). Particular attention can be given to social media which is steadily increasing in use for health-related learning (Betton & Tomlinson, 2013). Whilst there are numerous media narratives conveying mental health experience, the sheer vastness of the media's collective repository creates problems when searching. What is accessed is likely to include messages and content types which entertain and misinform as well as those which educate and promote empathic understanding. Careful attention is needed to sift through what is available and select narratives which engage us meaningfully with people's lived and felt experiences. With an almost infinite array of messages being transmitted through the media's multiple channels of communication what we know and feel

about mental health issues is constantly being influenced. This has implications for the attitudes and beliefs held with a process of ‘closure’ being applied to knowledge or concepts which are perceived as clearly defined (Köhler, 1947). For example, commonly transmitted messages from a multitude of media channels and products regard the “mentally ill” through stigmatising and stereotypical modes of framing (Philo, 1996a; Wahl, 1995). This applies especially to concepts such as the mental health-violence association (Nairn, Coverdale, & Claasen, 2001), which on account of the regularity of its reinforcement is more likely to be accepted. Mental health professionals are not shielded from the media’s pervasive influence and need to maintain a reflective, challenging stance to what they are accessing. It was this need to promote critical thinking and develop a questioning ability amongst health care professionals that led me to develop a taught learning module *Mental Health Issues and the Media*. This was concerned with critically examining media content in terms of the types of mental health messages being conveyed. The theoretical material developed for this module and its application and evaluation with students provided the foundation for the writing of *Mental Health Media*.

Publication 1 - Mental Health Media

The publication *Mental Health Media* provides a critical examination of the communication process whereby narratives about mental health experience are constructed and transmitted by media providers and subsequently accessed by interpretative recipients. It is a comprehensive and explorative text providing the foundation upon which my learning strategy is constructed through its detailed analysis of the media and the range of mental health messages transmitted. On commencing this work, my review of the literature revealed three distinct themes. The first, *the media message* comprised work which critically explored

the type of mental health content being transmitted. The second, *narrative channels* illustrated the varied expressive modes by which messages are conveyed and their communicative resonance. The third, *recipient engagement* concerned the theoretical evidence analysing ways in which media content is accessed and interpreted. The following section examines these themes in depth and highlights the added contribution to knowledge made by my work.

The Literature Base

Theme 1 – The Media Message

The predominant focus upon mental health content appeared to be concerned with what the media ‘*did badly*’. Otto Wahl’s (1995) *Media Madness* and Greg Philo’s (1996a) *Media and Mental Distress* in particular highlighted the stigmatising and poorly informed messages proliferating. Wahl (1995) illustrated the myths and inaccuracies being conveyed by the media and the common framing of the ‘mentally ill’ as “*a breed apart*”. Philo (1996a) and the Glasgow Media Group studied the messages transmitted from a broad range of media and the predominantly stereotypical content being carried. The Royal College of Psychiatrists’ five year anti-stigma campaign *Changing Minds* provided the catalyst for a studied examination of attitude formation and included a significant focus upon negative media coverage (Crisp, 2004). This reflected concerns raised by a number of sources about the proliferation of poorly informed stereotypical content (Sieff, 2003; Williams & Taylor, 1995; Wilson, Nairn, Coverdale, & Panapa, 2000). On the opposing pole there was a growing interest and recognition of the media’s mental health education and promotion potential (Media Bureau, 2001; Mind, 2000; Mindout for Mental Health, 2005). The use of media as a

means of service user expression highlighted various initiatives including the arts based programme *2001: A Mind Odyssey* (Royal College of Psychiatrists, 2001) and the creation of publishing companies such as *Chipmunk publishing* which specifically cater for narratives around mental health experience. The health promotional potential with regards to the media has been steadily recognised over the years through a series of festivals, events and promotions including *Time to Change; Shift*; the *Scottish Mental Health Arts and Film Festival*; *Love Arts*; and *See Me*. Despite these welcome initiatives the main focus within the existing literature was upon media content which misinformed or portrayed stereotypical views. This unequal focus was challenged by ***Mental Health Media*** which sought to create a more balanced perspective to what was available at that time through its exploration of both what was done both *badly* and what was done *well*. This measured investigation reflected and promoted the emerging attention being given to the service user voice, reviewing modes and means for using the media as a vehicle for self-expression.

Theme 2 – Narrative Channels

The literature base incorporated a wide variety of sources highlighting the expressive potential within different channels of communication (McQuail, 2005; Sieff, 2003). Fulton, Huisman, Murphet and Dunn's (2005) *Narrative and Media* provides a detailed analysis of the types of narrative structure located within different media source types and genres. Each communicative channel type has related evidence exploring its sub-components or styles of message framing. This includes written prose and narrative symbolism (Barthes, 1977; Sartre, 1967), linguistic complexity (McNair, 1998), sound and music (Devereaux & Hillman, 1995; Turner, 1999); and visual imagery (Chatham, 1990; Metz, 1982; Wedding & Boyd, 1999). Each of these aspects can be sub-divided with an extensive range of components for each

media type noted, such as *mise en scène* or *point of view* shots applied to visual framing (Martin, 2014). The conclusions drawn within ***Mental Health Media*** concerned the multitude of complementary or opposing messages being conveyed by a *single* media product. If we take the medium of film for example, we are ‘informed’ about mental health experience by virtue of the accompanying imagery, characterisation, scene framing, dialogue, music, incidental sounds, body language, facial expressions and gestures. This publication detailed the complexity and abundance of such transmitted messages and provided a foundation and structure for the educational examination of the media narrative as critically reviewed within my subsequent work ***Dementia Care Workbook, Connecting with Screen Experience*** and ***Videogames*** (see section 2).

Theme 3 – Recipient Engagement

This theme concerns ways in which recipients engage with media content either developing more productive attitudes and learning about mental health or having stereotypical views reinforced. It was evident that recipients’ feelings about media content covered a wide range of perspectives with a prime influencing factor concerning their experience or knowledge of mental health issues. Consequently, my focus upon media recipients placed clear distinction upon the broad range of receivers (for example service users, mental health professionals or the general ‘lay’ public), with each group having their own distinct response to media content. A seminal framework was provided by Hall’s (1974) encoding / decoding model which views individual audience members as having the capacity to accept, adapt or reject media messages. This runs counter to the effects model and proposes the notion of interpretative recipient as investigated by a number of sources (Alasuutari, 1999; Devereux, 2007; Foucault, 1979; Gripsrud, 1999). As Philo (1996b, p.103) reflects:

“The media can exert great influences over audiences, but people are not simply blank slates on which its messages are written.”

The learning that occurs through media exposure was highlighted in ***Mental Health Media*** and examined further in ***First Person Media*** and ***Online Resources*** (see section 3).

Generated Learning / Knowledge Contribution

The themes outlined above have been critically explored in ***Mental Health Media*** and subsequent publications. This work illustrates the importance of acknowledging the whole communication process with influences operating at each stage. Berlo’s (1960) *Communication Model* and the components of sender, message and receiver were chosen as ideally representing the three themes identified above. This provided an effective framework from which to closely examine the diverse range of dynamics occurring. This focus was also broadened to show consideration for *who* was sending the message; *what* they were intending to convey; *who* the recipient was; and *what* their interpretation of received content entailed.

Impact

The scholarly appeal of this work is evidenced within national and international contexts with sales across the world and citations (appendix 3) in books and journal articles from the UK, Portugal, Serbia, Germany, South Africa and the USA. Its educational appeal and effective strategy for learning is evidenced in its adoption by The Fairleigh Dickinson University,

USA. This concerned a module with content built predominantly around book chapters from *Mental Health Media* (appendix 4). Book reviews recommend this work to students on account of its valuable learning potential and breadth of coverage (appendix 5). This publication has been the principal resource for students attending my *Mental Health Issues and the Media* module and its successor, *Media Depictions of Mental Health* – an online module. Their appeal is shown by their collective uptake of over 500 learners, including a regular number of international students. Their feedback reflects:

“The whole module was in my eyes brilliant.”

“The thought and effort put in to create such a stimulating and enjoyable learning environment should be rewarded ... you set a high standard.”

“This has been my favourite module throughout the 3 years.”

“This was a very enjoyable module where I feel I have got a lot about sensitivity to mental health issues.”

My work has provided learners with a theoretical and critical framework from which to challenge and question their engagement with media content. Assignments (appendix 6) submitted for the above modules show real innovation and detailed critical thinking around media content, a core requirement for mental health practitioners. This is supported by external examiner’s feedback:

“I think both the teaching team and the students ought to be congratulated on the work presented. The module can best be described as thoughtful, challenging and inventive.”

One of these assignments, a highly creative piece of work provided the basis for the jointly authored publication ***Videogames***.

So What?

The elements highlighted above detail the educational importance of ***Mental Health Media*** and the contribution made to the existing knowledge base. The scholarly debate within this publication and the measured examination of the media message signifies a degree of expertise which has led to requests for ‘expert’ opinion about contemporary news stories (appendix 7). This work is particularly significant on account of its comprehensive and carefully considered approach to viewing and understanding media content in all its varied forms and levels of complexity. It advocates a balanced approach to mental health media engagement and outlines the educative potential of using both questionable and praiseworthy products as resources to critically review. What is particularly valuable is this work’s promotion of a more questioning and challenging approach to media narratives as evidenced by various sources detailed above. This is aimed at facilitating the development of reflective and better-informed practitioners who have a greater understanding of the complexities and reality of lived mental health experience (Van Manen, 1984). As nursing practice is very much integrated with people’s life experiences a phenomenological inquiry approach is well suited (Streubert & Carpenter 2011). ***Mental Health Media*** is the foundation upon which my learning strategy is built. This commences with the preparatory stage (Box 1) which details

Careful narrative product selection and introductory instruction for learners. It complements and builds upon the work of notable researchers such as Greg Philo and Otto Wahl, whose work relating to mental health highlights the detrimental impact that negative media coverage has upon resultant attitudes towards those experiencing mental health problems (Philo, Secker, Platt, Henderson, McLaughlin, & Burnside, 1994; Philo, 1996a; Philo, 1997; Philo, 1999; Philo & Secker, 1999; Wahl, 1995; Wahl, Wood, & Richards, 2002; Wahl, Wood, Zaveri, Drapalski, & Mann, 2003). This provided the impetus for a number of worthy initiatives as outlined earlier within this section as well as the educative and health promotional approaches I have been involved with. Whilst Wahl and Philo have extensively examined the impact upon attitudinal learning from poorly constructed media narratives, my work establishes a broader base studying both negative and positive representations. The strong impact that media exposure can have upon attitudes and understanding is deliberately engaged and developed into my learning strategy. This seeks to promote attitudinal change through challenging negative representations and enhancing empathic understanding through direct exposure to personal narratives expressing mental health experience.

Box 1: Learning Strategy (Preparatory Stage)

Foundation for media

Selection of narratives

Purposeful selection of media narratives with regards to content and learning potential.

- *Experience type*

Range – acknowledging the uniqueness of each person’s experience.

Balance – across the lived experience spectrum *struggling-coping*.

Representativeness – can be related to wider mental health experience.

Seldom encountered – learning around infrequently encountered issues.

Stigmatizing – generating useful discussion.

- *Learning*

Immediacy – engage recipients in the *here and now*.

Emotional impact – memorable and attention ‘grabbing’.

Core learning themes - provides significant themes for review.

Cultural/contextual issues – reflects the perspective within which people experience their lives.

- *Accessibility*

Freely accessible – products easily obtained.

Narrative – articulateness and expressive ability of narrators.

Differing channels of communication – covering the full scope of media types.

Creative modes – helpful with communicative impairment.

Preparation of learners

- *Introduce related theoretical concepts connected with narrative themes*

Establishes base with which to anchor new material to.

- *Establish preferences regarding learning styles and media source types*

Understanding how students learn with consideration shown to narrative selection and preparation.

- *Outline relevance of narratives to be accessed to current learning*

Alerting learners to what they are going to access and what to attend to.

Section 2 – Facilitating Engagement

Section 2 – Facilitating Engagement

Introduction

The learning process is examined through my work with a *how to* approach being modelled and reviewed. A key element here relates to the facilitated guidance given to learners in terms of their accessing and processing of narrative which is examined in *Dementia Care Workbook; Connecting with Screen Experience*; and *Videogames*.

Publication 2 - Dementia Care Workbook

As the title suggests this text has been specifically designed to be used engagingly and to promote reflective thought. Its intention is to actively involve readers and to facilitate meaningful reflection around the lived dementia experience. It is developed around the theoretical base of *personhood*, Tom Kitwood's (1997) defining emphasis upon the individual with dementia. The lived experience focus is maintained throughout *Dementia Care Workbook* with a series of activities and exercises designed to engage readers and develop empathic understanding.

Publication 3 - Connecting with Screen Experience

This book chapter explores the dynamics of the film narrative in relation to the movie *Some Voices* which features a young man living with schizophrenia. The work is offered as a reflective guide, modelling *how to process* lived experience narratives through the critical viewing of movies. It revisits Berlo's (1960) sender, message, receiver framework utilised in

Mental Health Media placing specific attention upon how the film medium operates as a transmitter of content and its engagement by interpretative recipients.

Publication 4 - Videogames

Videogames looks beyond the negative associations and implications often associated with this exceedingly popular media type reviewing the largely untapped potential for education and health promotion. This article details means of engaging with lived experience and offers recommendations for educationalists, game developers and mental health advocates. This addresses health promotion from a context involving the development of collaborative partnerships. As illustrated within this work, the interactive dynamics and high exposure potential of videogames provides an ideal format for learning about and promoting lived experience.

The Literature Base

The context for my work is defined through the evidence base which shows varied types of media narratives being used within healthcare learning such as television (Chipperfield & Woodcock, 2011; Gabbard & Horowitz 2010), literature (Douglas, 2008), film (Bhugra, 2003; Gorrington, Loy, & Spring, 2014; Oh, Kang, & De Gagne, 2012), drama (Roberts et al., 2007; Wasyliko & Stickley, 2003), poetry (Aadlandsvik, 2008; Shapiro, Morrison, & Boker, 2004), internet discussion forums (Simpson, Reynolds, Light, & Attenborough, 2008), blogs (Wuyts, Broome, & McGuire, 2011), digital stories (Christiansen, 2011; Stenhouse, Tait, Hardy, & Sumner, 2013), and YouTube videos (Foster, 2013). Most of these studies are concerned with examining the use of single media source types although there is evidence of

multiple sources being reviewed (Balen, Rhodes, & Ward, 2009; Wall & Rossen, 2004). My work builds upon this knowledge and practice base maintaining breadth in terms of media sources and a sustained focus upon the learning process from sender through to receiver as detailed in *Mental Health Media*. Whilst *Dementia Care Workbook* covers a range of media types, closer examination of the specific source types of film and videogames is carried out in *Connecting with Screen Experience* and *Videogames*.

There is a substantial literature base evidencing the use of film within a healthcare learning context (Brett-MacLean, Cave, Yiu, Kelner, & Ross, 2010; McAllister, 2015; Silenzio, Irvine, Sember, & Bregman, 2005). This medium offers rich opportunities for learning about the lived experience of mental health service users (Gramaglia, Jona, Imperatori, Torre, & Zeppegno, 2013). Studies and reports detailing the use of film within mental health education include: schizophrenia *Some Voices* (Morris, 2010) and *Das Weisse Rauschen* [The White Noise] (Baumann, Zaeske, & Gaebel, 2003); ECT *One Flew over the Cuckoo's Nest* (Akram, O'Brien, O'Neill, & Latham, 2009); death and dying *Ikiru* (Lu & Heming, 1987); dementia *Iris* (Bag, 2004); counselling and psychotherapy *Good Will Hunting* (Koch & Dollarhide, 2000); and psychoanalysis *Morvern Callar* (Edwards, 2010). Watching films in an educational context promotes empathic understanding and enables different mental health conditions to be explored (Akram et al., 2009). These aspects are critically reviewed within *Connecting with Screen Experience* with a range of educational recommendations made. With regards to video game engagement, the main literature base concerns their negative impact upon players' well-being or stigmatising attitudes towards those experiencing mental health difficulties (Anderson et al., 2010; Barlett, Harris, & Baldassaro, 2007), although there is a body of evidence addressing this medium's educational potential with regards to health care (Wilkinson, Ang, & Goh, 2008). *Videogames* highlights the importance of taking a media source type which is largely viewed with negative connotations and exploring in detail

its huge untapped potential for health promotion and learning. This media source type's immersive and interactive qualities provide a means of affecting beliefs and impacting upon attitudinal change (Klimmt (2009), thereby providing a valuable means of challenging discrimination and stigma.

Generated Learning /Knowledge Contributions

A central feature of the above publications and a core quality of my learning strategy is the modelling of *how to* with respect to guiding learners through their media narrative engagement. It shows how facilitated input is required at distinct stages, *before, during* and *after* the accessing of narratives.

Before

My published work illustrates the importance of preparing learners in advance of accessing media narratives so that a more effective engagement can be stimulated. This reflects assimilation theory where meaningful learning is promoted through the anchoring of new knowledge to an established base, concerned with what the learner already knows (Ausubel, 2000; Ausubel, Novak, & Hanesian, 1978). The importance of this is illustrated by Ritterfeld & Jin's (2006) study with participants receiving prior preparation before watching a movie portrayal of schizophrenia and having a better means of contextualising and making sense of subsequently accessed educational material. This has been developed into my learning strategy, laying the foundation for accessing media narratives through prior theoretical instruction. It also involves discussing and reflecting upon associated attitudes and beliefs

around specific mental health themes. Another key factor identified within my published work concerns the careful selection of narrative products with consideration shown for their topical relevance, communicative potential and impact factor. It includes narratives reflecting breadth of perspectives as well as polarised types carrying stereotypical content or positive health promotion.

During

A particularly significant aspect of the facilitative process is guidance. The *how to* feature within ***Connecting with Screen Experience and Dementia Care Workbook*** was illustrated through the provision of worksheets and instructions guiding learners through their engagement with designated narratives. This alerted them as to what to look for reflecting the Gestalt process of *figure and ground* (King & Wertheimer, 2005). ***Mental Health Media*** illustrates the depth and detail to which media narratives can be processed identifying a variety of communicative mode sub-components for each source type. The process of engaging with media narratives, carefully explored and promoted within ***Dementia Care Workbook, Connecting with Screen Experience*** and ***Videogames*** illustrates a powerful means of learning about lived mental health experience. Each media type has its own interactive qualities with audio-visual types such as film encouraging strong participation in learning (Diez, Pleban, & Wood, 2005; Frisch, 2001) and offering immediacy through the *here and now* experience played out in front of the viewer as found in ***First Person Media***. These provide valuable opportunities for identification with the emotional elements of a screen character's experience and an enhanced awareness of wider contextual issues. This process, as shown in ***Videogames***, is accentuated for game players who are regarded as having a much more immersive and interactive engagement than recipients of other media

source types (Lee, Park, & Jin, 2006; Shaffer, Squire, Halverson, & Gee, 2004). From a health promotion perspective videogames are very attractive owing to their high exposure potential and interactivity which offer great potential for learning about lived experience (Wilkinson et al., 2008). Other media source types advocated in *Dementia Care Workbook* include literature and television where the interactive dynamics operating can be acknowledged through various processes. It includes the construction of meaning in literary texts through the action of reading by interpreting recipients (Bennet & Royle, 2009) or the interacting with screen characters through para-social relations (Horton & Wohl, 1956). The engagement with lived experience narratives through the various source types illustrated above can be extremely powerful, challenging existing attitudes and promoting new learning. The impact can be emotional as well though necessitating sensitive facilitation given the distressing nature of what is narrated.

After

The period following the accessing of media narratives requires learning to be processed and reflected upon. This, as outlined in *Mental Health Media*, is where messages are deconstructed and decoded by individual recipients (Hall, 1974). It has been evident from subsequent reflection and discussion with learners that interpretation can differ significantly for each person with in some instances very polarised impressions formed. A point to note concerns the multitude of messages being conveyed by a single media source type through its varied communicative sub-components. In relation to film, Phillips (2009) outlines the need for interpretative, reflective viewers to make sense of and unite all disparate parts including images and sounds. This can be done following narrative exposure with detailed reviewing of significant elements taking place. *Dementia Care Workbook* details the consolidation of

learning through a processing phase and introduction of new theoretical material. This forms the base for the accessing of subsequent narratives and illustrates the continuous and cyclical nature of this learning process. An example of this as applied to my teaching work can be seen in a cultural learning day built around film screenings (Asian and Polish), where the discussion around emergent themes was followed by presentations from invited speakers representing each of these cultural groups. An important point to note within this learning process concerns the feelings evoked through one's exposure to personal narratives. Mar, Oatley, Djikic, & Mullin (2011) found that emotions experienced during reading can have consequences after finishing a book. This can be applied to all media source types highlighting learner's need for support and sensitivity, particularly considering the expressiveness, vibrancy and distressing nature of what might be accessed.

Impact

It is pleasing to note the impact of my work, including the evidence of *Dementia Care Workbook's* adoption as a module/programme text by a number of educational institutions and its recommended use by a range of organisations concerned with healthcare education such as the Royal College of Nursing, Social Care Institute for Excellence and a number of NHS Care Trusts (appendix 9). It has been highly regarded by academics through book reviews as a core addition to the literature on dementia care and an excellent learning resource for students (appendix 5). This feedback evidences its value as an educational resource for students. Likewise, *Connecting with Screen Experience* and associated chapters detailing creative learning strategies are recognised as promoting student learning and understanding and helping students develop empathy (appendix 5). Further evidence of the

scholarly appeal of *Dementia Care Workbook, Connecting with Screen Experience* and *Videogames* is shown through their citation by a number of sources including peer reviewed articles, books, dissertations and internet sites (appendix 3). Recognition of the health promotion and educational value of my work has led to invitations to present at conferences (appendix 10), talk at local community events (appendix 8) and run private dementia training courses for healthcare professionals.

So What?

This section has been concerned with the facilitative accessing of media products and the process of assisting learners in attending to core expressed themes. It models a *how to engage* approach, an essential feature of my learning strategy. There is a broad structure shown with regards to analysis reflecting Lieblich et al.'s (1998) approach of attending to whole narratives (holistic) or sections (categorical) as well as scrutinising content or form. Guided learning is needed to maintain focus and is especially helpful where narratives contain ambiguities or expression from individuals with impaired communication (Mills, 1997). The facilitative stage is the second part of my learning strategy assisting and supporting learners with their accessing of narratives and processing of content (Box 2). This is particularly focused around helping learners pick out core learning messages and to start to appreciate what a person's expressed thoughts and feelings signify or mean. It encourages a *reflection in action* approach as advocated by Schön (1983) as well as recognising the need to support learners through their exposure to what can be emotionally distressing content. This involves paying attention to the environment within which learning takes place and enabling opportunities for discussion and support.

Consideration as to the effectiveness of the facilitative approaches detailed here involves being mindful of students' engagement and acknowledgement of the learning taking place. This can be done through applying relevant theories of learning as represented within Bloom's taxonomy covering cognitive, behavioural and humanist domains (Bloom, Engelhart, Furst, Hill, & Krathwohl, 1956). Cognitivism is involved with learning how to think (Dewey, 1938), and the ways by which material is processed. This is addressed by Gagné's (1985) information processing model which explores the dynamic of inputted stimuli being encoded, stored, retrieved and later utilised by the brain. The encoding part is impacted upon by the nature of attentional dynamics (Broadbent, 1958) or the perceptual inferences made regarding what is accessed, with Gestalt processes such as *closure* and *prägnanz* shaping learners' understanding (King & Wertheimer, 2005), and promoting the phenomenological goal of enhanced awareness and insight (Yontef, 1993). As mental health content is prone to wide-ranging interpretation with many myths and misinterpretations evident there is a need for supervised facilitation, helping to guide learners through the sense they are making of accessed narratives. This can also be assisted through prior preparation, attending to students' learning *before* the accessing of media narratives with a need to help learners understand and contextualise what they are subsequently accessing. This need is shown by Ausubel's (1968) assimilation theory with new learning anchored to an existing base of previously learned and experienced material. An example of this within my work entailed defining and exploring what a person's experience of dementia entails before engaging with discussion threads in internet sites such as the Alzheimer's Society's *Talking Point Forum*. The behaviourist domain incorporating operant conditioning (Skinner 1974) and classical conditioning (Pavlov 1958) can be considered in terms of learners' ongoing associations and reinforcements made with narrative material. An example noted through my work was the emotional distress felt by some learners when excessively immersed in distressing personal narrative content. Feedback from learners related their need to

psychologically withdraw and distance themselves from such content. This alerted me to the potential for learners feeling overwhelmed and to carefully monitor and support their narrative access. An element connected with my learning strategy concerns the process of learning through observational learning as addressed by Bandura's (1986) Social Learning Theory. This had a dual application within my learning strategy concerned with the narrator (of mental health experience) and the facilitator engaged with their expression. The heart of my work is acknowledged through humanism which involves the study of the whole person, as understood through the eyes of the observer as well as the person doing the behaving (McLeod, 2015). This related very strongly with regards to the intrapersonal and interpersonal dynamics experienced in practice concerning self and other. This will be examined in greater detail in section 3 and reflective learning. Core proponents include Carl Rogers (1957) and Abraham Maslow (1970) and their attention upon the subjective, conscious experiences of the individual. This person-centred philosophy values the lived experience of others and very much encapsulates the heart of my work.

Box 2: Learning Strategy (Facilitative Stage)

Narrative activity

Guided processing - highlighting core themes to attend to utilizing worksheets, guided study material and questions.

Reflection *in action* – opportunities for discussion and processing of themes during the activity.

Immediacy - offered through here and now examples.

Emotional processing – discussion and feedback around distressing content of narratives.

Approach

Timing – consideration for timing and frequency when narratives are offered.

Overload potential – awareness and response to content amount and emotive elements.

Supportive learning environment – creation of an environment conducive to effective learning and feeling ‘safe’.

Modelling – approaches to engaging with narrative material demonstrated.

Section 3 – The Reflective Practitioner

Section 3 - The Reflective Practitioner

Introduction

The previous sections focused upon the richness of lived experience media narratives and certain guided facilitative approaches for accessing them. This section is concerned with critically examining the learning taking place and the quality of the engagement with selected products and media source types. It emphasises the value of lived experience learning and promotes the need for healthcare professionals to be more challenging and reflective in their practice. As my work has demonstrated, learning takes place through emotive as well as cognitive spheres influencing the closeness to which learners are able to get to another person's lived mental health experience. It can be related to numerous different facets such as *what it feels like* to be presented with a diagnosis of schizophrenia or notice one's memory beginning to fade. The meaning of such experiences will be unique to each person and it may be that practitioners can only catch a glimpse of the associated thoughts and feelings. What is important though is a desire to understand more and connect more fully with those we are working with.

Empathic Learning

The connecting with another person's lived experience can be encapsulated through the term *empathy* which consists of both affective and cognitive responses, engaging with others' feelings and understanding why they feel as they do (Howe, 2013). This signifies a connectedness with another person's internal world and a sense of imagining their life as

experienced by them. Venuti (2011) regards empathy as a process of careful attention with a goal of perceiving the subjective experience of another person. It is a mutable trait that can be nurtured through practice and involves setting aside previously formed ideas or formulations about people and connecting more fully with them (Elliott, Watson, Goldman, & Greenberg, 2004). The need to get closer to the internal worlds of service users relates to a primary function of mental health practitioners (Strupp, 1996). It is one of the core conditions identified by Carl Rogers (1957), along with aspects such as genuineness and unconditional positive regard, integral to the psychotherapeutic process and leading to healing. The need for these qualities to be developed is recognised by both service users (Williams & Stickley, 2010) and health care professionals (Neumann et al., 2012). The fostering of learning approaches which enable carers to engage more effectively with those they are working with is critically reviewed within the publications *First Person Media* and *Online Resources*.

Publication 5 - First Person Media

This qualitative study examined the influence upon lived experience learning from a range of first-person media products selected from varied source types. These were all concerned with the personal dementia experience. Emergent themes highlighted core differences in learning dynamics in relation to the media source type being accessed and the specific narrative content being conveyed. These included emotive impact, immediacy, opportunities for reframing internal experience and problems with oversaturation.

Publication 6 - Online Resources

The focus of this qualitative study was about the sub-components in an online learning package and their communicative resonance. It is concerned with style, content and functionality, essentially examining qualities which influence and impact upon the learning process. Emergent themes involved learner styles, attention and engagement, all of which significantly affect the quality and process of learning.

The Literature Base

This part reviews the literature base underpinning the above two publications. These are concerned with comparing media source types for their learning potential and examining the sub-components embedded in an online learning resource.

Comparative Media Source Types

Whilst there are a number of studies exploring the educational qualities of single media source types, research which makes comparisons between them is generally limited. A rough distinction can be made between media types which employ audio-visual modes of communication and those predominantly concerned with textual information. Clearly, there will be a lot of overlap with media sources such as the internet utilising all of these.

Comparative research examining media types tends to contrast *two* different media sources, for example film/video and print (Beitzel & Derry, 2009; Merkt, Weigand, Heier, & Schwan, 2011; Wilson et al., 2010); print and online learning (Emerson & MacKay, 2011); video and internet (Frosch, Kaplan, & Felitti, 2003); TV and print (Beentjes & Van der Voort, 1993; Eveland, Seo, & Marton, 2002; Gunter, Furnham, & Griffiths, 2000). The collective findings from these research studies illustrated a level of inconsistency concerning which the most

impactful media types in terms of learning were. In true *Top Trumps* fashion, each media source type was assigned a preference depending upon the situation and source type it was being compared against. This was borne out by Eveland et al.'s (2002) conclusion that the medium of communication may have different effects depending on the type of learning measured. This literature base highlights the need for further research including studies comparing a broader range of media source types such as that conducted by ***First Person Media***.

Online Learning

The literature base covers a variety of aspects concerned with e-learning design and delivery. The efficacy of online learning is supported through a number of studies which find no significant difference in effectiveness between face to face and online instruction (Garland, 2010; Hadley et al., 2010). As a learning medium, e-learning offers engaging and vibrant learning resources including the use of simulated patients (Rampling, O'Brien, Hindhaugh, Woodham, & Kavia, 2012), role play (Ladhani et al., 2011) and streamed video clips (Rawe, 2013). It is also heartening to note the evidence of online resources being used collaboratively for learning purposes between practitioners and service users (Ashurst, Jones, Williamson, Emmens, & Perry, 2012; Smithson, Jones, & Ashurst, 2012). There are some key studies investigating the varied interactive components of online resources (Beitz & Snarponis, 2006; Magnussen, 2008; Reeves & Reeves, 2008). ***Online Resources*** builds upon this examining learners' engagement with personal narratives through the assistance of a selection of interactive resources and features.

Generated Learning / Knowledge Contribution

The emergent learning from these studies generated a number of themes notably concerning the emotive impact of particular narrative types and learning resources; opportunities for reframing and challenging understanding; and levels of engagement and attention attained.

Emotive Impact / Overload

First Person Media found media narratives having a strong emotive impact with the audio-visual types (film and TV) rating the most highly. The transportation into an audio-visual narrative engages viewers emotionally as well as cognitively (Green, Brock, & Kaufman, 2004; Sheridan & Sullivan, 2013) which increases what learning is retained (Christianson & Engelberg, 2006). Qualitative comments from students related to the enhanced level of engagement promoted through multi-channel communication with imagery, dialogue and music all helping to heighten the emotional experience. For example:

“This film made me very upset ... although it made me realise more about the experience of dementia.”

These communicative channel sub-components, closely detailed in **Mental Health Media**, each have their own individual levels of resonance concerning what is conveyed about another’s lived experience and help promote empathic learning. An obstacle to learning, identified in **First Person Media** and **Online Resources** concerns emotional saturation, the point at which learners felt overwhelmed and unable to assimilate new content:

“It is always sad accessing someone’s personal experience of illness, but especially hard when you can’t stay with it anymore.”

This reflects Kinnick, Krugman, and Cameron’s (1996) construct of *compassion fatigue* or Saakvitne’s (2002) notion of *vicarious traumatization* as phenomena associated with pervasive communication about people’s difficulties. In essence, engagement with the emotive content in people’s lived experience narratives can at certain stages feel too much. The implications here have prompted careful consideration in terms of my learning strategy and its related facilitative approaches. It outlines the need for careful product selection, consideration for the timing or frequency of narrative access, effective preparation of learners, clear guidance and support when accessing narratives, opportunities to process learning and space to discuss thoughts and feelings. A further point of importance emerging from this work concerned the positioning of a person’s narrative along a *struggling-coping* continuum. Whilst narratives detailing despair and distress are important, the collective learning experience is more effectively balanced with the inclusion of personal accounts expressing well-being.

Attention / Engagement

Another theme of importance emerging out of ***First Person Media*** and ***Online resources*** relates to components which attract attention or cause learners to disengage. This builds upon the critical review in ***Mental Health Media*** upon how the uptake and processing of messages can be impacted upon by attributes relating to both the narrative and the recipient. ***First Person Media*** found audio-visual narratives to be attention-grabbing, impactful and

entertaining. Film in particular offered immediacy where narratives were conveyed in the present tense enabling students to experience events, thoughts and feelings ‘in the moment’ along with the narrator. This reflects a *here and now* engagement with a person’s inner world which Rogers (1975) regards as having prime therapeutic value. Textual sources including books and newspaper articles were found to incorporate depth of engagement stimulating closer engagement with internal thoughts and feelings. **First Person Media** highlighted the need for detailed guidance and close structuring geared towards each specific media source type concerning *what to* attend to and *how to* engage. **Online Resources** reviewed the impact upon learners from the various sub-components incorporated within an online learning package. This study found engagement being influenced by individual learning styles and preferred communicative modes reflecting noted approaches (Flemming, 2001; Honey & Mumford, 1982; Kolb, 1984). This demonstrates the need for educationalists to ascertain learner preferences, utilise a range of component types and carefully consider methods for guiding and supporting the learning process.

Reframing

A key learning element stimulated through accessing personal narratives concerned the reflective reframing of ‘challenging behaviours’ which has important implications for professional practice. It is a process which has been closely examined within **Dementia Care Workbook** and **First Person Media** in relation to dementia care, an area where much greater attention upon the *person* above that of the *condition* is needed (Kitwood, 1997). It challenges us to stand back from our preconceptions and assumptions and attend to what others are communicating which is important especially as this is what is being asked by people with dementia (Bryden, 2005; Davis, 1989; Swaffer, 2015). In **First Person Media**

learners cited written textual narratives as being particularly potent in terms of depth of expressiveness and levels of engagement with another's internal world. It is through this medium that readers are able to identify more fully with the contextual aspects of lived experience and embrace another's consciousness (Gennette, 1983; Lothe, 2000). This reflects the dynamic viewing process of *inside looking out* proposed in ***Mental Health Media***. The process of reframing is one of the main features of ***Dementia Care Workbook*** which engages a number of reflective models (Kolb, 1984; Luft & Ingram, 1955; O'Connor & Seymour, 1990) and examples of processing meaning. There is particular attention given to educational activities and approaches within chapter 9, presented in the *Gamester's Handbook* (Brandes & Phillips, 1979) style. The regular and cyclical emphasis upon reflective learning engages Argyris & Schön's (1978) double loop learning through the challenging and redefining of strongly held attitudes about people with dementia. The use of this workbook and its related learning activities with mental health nursing students has demonstrated shifting attitudes, thoughts and feelings:

"Left me with a positive attitude towards dementia"

"Opened my mind and learned a lot. Really changed what my perception of dementia was."

"Trying to see the world through the eyes of someone with dementia provided a good insight."

Impact

First Person Media and *Online Resources* have proven particularly impactful in terms of their critical appraisal of the varied facilitative approaches used with learners and the level of guidance required. This forms a key part of my learning strategy and has been instrumental in shaping the structure and style of my e-learning packages. These employ a blend of features and media source types with learners progressively guided through their exposure to lived experience accounts. The overall approach encapsulates the differing stages of my learning strategy with a careful consideration being shown to the selection of narratives, blend or range of examples, and sequencing. Facilitative approaches prepare learners, guide them through their accessing of narratives and aid in the processing and extracting of meaning. This reflects a Gestalt “unified whole” process which contextualises learning elements and connects them meaningfully (Köhler, 1947). The educational value has been recognised through the awarding of a University of Leeds Fellowship, an invite to join the Faculty Technology Enhanced Learning Working Group and requests to present my work in various scholarly arenas including a University of Leeds’ event showcasing innovative use of technological learning resources and a number of national and international conferences (appendix 10).

So What?

This section is concerned with the learning taking place through accessing lived experience narratives in ways that promote the development of reflective, challenging practitioners (Atkins and Schutz, 2013). Understanding is developed through progressive learning events

with each cycle providing fresh opportunities for comprehension and testing out of understanding (Kolb, 1984). This builds upon Argyris & Schön's (1978) concept of double loop learning involving changes in thinking through each revisitation of the learning material. The importance of this is the ability to 'reframe' practice experience and the development of intuitive, knowledgeable and questioning practitioners as advocated for nurses (NMC, 2015), medical practitioners (GMC, 2013), social workers (BASW, 2012; HCPC, 2012), clinical psychologists (BPS, 2008; HCPC, 2015) and other professional groups. As my work highlights, accessing products which engage learners emotively can prove memorable and thought provoking although can also prove unsettling. Sensitivity is needed along with a 'safe' educational environment allowing learners to feel sufficiently supported. The aspects identified here form the third stage of my learning strategy and are concerned with the processing of narrative learning (Box 3).

There are a number of differing models and approaches concerning reflective practice which can be regarded as lacking in conceptual clarity (Kinsella, 2003) or empirical evidence (Hargreaves, 2004; Tennant, 1997). The emergent knowledge from my learning journey has led to a significant shift both in focus and process involving reflective practice. The limitations, restrictions or periodic low engagement amongst students has given me cause to examine interpersonal dynamics and choice of reflective approach. This has significantly facilitated the evolution from a fairly static and linear process, conducted in isolation by students and teachers to an immersive and broad ranging focus, conducted in collaboration with service users. The starting place for my work was concerned with the learning which emerged through successive cycles of experience and reflection as related to the frameworks of Kolb (1984), Gibbs (1988) and Johns (1995). Whilst providing a clear and useful structure for detailing ongoing learning they were found to be particularly restrictive with regards to the fluid nature of the learning process. The systematically described learning stages for

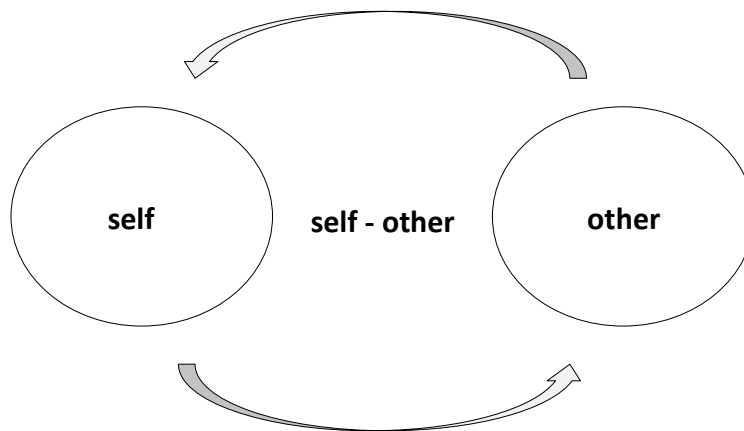
example with Kolb's model, do not necessarily relate to the process engaged in especially where multiple elements are being reflected upon simultaneously and where certain stages are missed out (Bergsteiner, Avery, & Neumann, 2010). It is also notable that there are differences between these models in terms of levels and depth of focus and reflection.

The initial focus upon reflection within my work was upon experience which had already occurred. This can be helpful although preparing students more effectively for clinical practice also requires facilitating approaches for reflecting *in action* as advocated by Schön (1983). This relates to the ability of practitioners to appraise interpersonal dynamics whilst actually in the process of working with service users, although from a practice perspective, carrying out this approach can be problematic given the complexity and range of elements to consider (Eraut, 1995). As a consequence, it can potentially impact upon the depth of reflection engaged in with predominantly surface levels attained. This needs challenging as learners can decline opportunities for greater degrees of critical reflection with the assumption that reflection is already taking place (Reid, 1993). This however needs addressing, supporting learners to move towards what Munhall (2012) terms as a state of *unknowing*, which involves decentring self and achieving a sense of openness. This has been addressed within my work through the utilisation of experiential learning exercises, simulated patient work and media narrative learning. These included opportunities to pause and attend to related interpersonal processes *in action* helping to develop learners' instinctive and intuitive questioning abilities.

The further complexity of elements to attend to within practice encounters involves the component of self. It became apparent through my work that there were occasions where learners were less engaged with personal narratives or cited problems encountered in clinical practice which had a bearing on the emotions evoked in them. This reflects Argyris and

Schön's (1978) double loop learning whereby more dynamic understanding is facilitated with one's personal values and beliefs being re-evaluated. It is a more sophisticated and detailed process of reflection incorporating levels of reflexivity. This widens the practice perspective to encompass "self" as well as "others" as outlined in related frameworks such as Luft and Ingham's (1955) Johari Window, O'Connor and Seymour's (1990) interpersonal model, or Weil's (1998) critically reflexive action research (CRAR). Finlay (2009) reflects upon the importance within qualitative inquiry of maintaining a phenomenological attitude, striving to be open to the "other" and attempting to view the world in a different way. This understanding of the "other" is complemented by a developing awareness of self, including own subjectivity, interests and assumptions (Finlay, 2008). Gadamer (1975) sees this process as involving a shifting back and forth between reflecting upon self and others. It has become apparent therefore that the process of reflective practice involves multiple dynamics and points of foci. This includes the practitioner's ability to establish a rapport with service users, manage their own emotions, and empathize with patients, all essential to providing quality care (Evans and Allen, 2002). As outlined in fig 3: *interpersonal reflection*, the focus for contemplation needs to be broadened to encompass ourselves (self), those we are working with (other) as well as the dynamics operating between us (self – other). The interpersonal dynamics for instance could be examined utilising Heron's (1989) *Six Category Intervention Analysis* or Peplau's (1952) theory of *Interpersonal Relations*. It is a process which can be deepened to ever-expanding levels of complexity such as the inclusion of intersubjectivity and Ogden's (2004) concept of the analytic third. Other elements relate to the climate of learning with terms such as *reflective discourse* (Mezirow, 2000) or *critical acceptance* (Fook, Ryan, & Hawkins, 2000) outlining learners; capacity for weighing information objectively or being free from coercive influences.

Fig 3: Interpersonal reflection



A common problem with reflective practice concerns the exclusion of the “other” within the process of critical reflection (Sandywell, 1996), which can lead to a concealment of the service user’s perspective and a confirmation of the practitioners’ account as accurately representing experience (Taylor and White, 2000). This outlines the need for greater collaboration, extending the reflective process further to engage both health carers and service users. It reflects the psychotherapeutic partnership created by therapist and client as essential to their ongoing journey of discovery (McLeod 2013; Rogers, Stevens, Gendlin, Shlien, & Van Dusen, 1967). This will be examined in more detail in the following section on collaborative learning.

Box 3: Learning strategy (Processing Stage)

Processing

Reflection *on* action - discussion and processing of key themes.

Reframing - alternative perspectives considered.

Reprocessing - re-examination of previously introduced theoretical material.

Summarising - reiteration of core learning material.

Introduction of new theory - further progression of learning.

Approach

Modelling - ‘guide’ to processing narratives demonstrated.

Sensitivity - shown to personal narrative experience communicated.

Saturation awareness - appreciation of potential difficulties experienced by learners.

Supportive environment – ‘safety’ provided for generated emotions.

Reflective/ reflexive approach - promotion of critical, questioning ability and personal learning.

Section 4 – Collaborative Learning

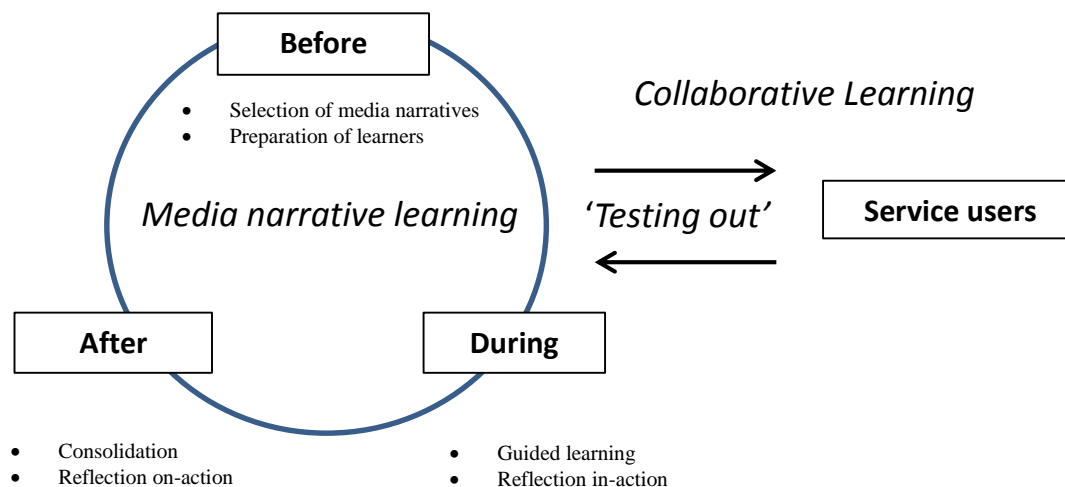
Section 4 - Collaborative Learning

Introduction

The previous sections have critically reviewed the educational significance of my published work and the innovative approaches being utilised for learning about lived mental health experience. This is centred predominantly around the ‘media narrative’ as a potent resource for the facilitation of empathic learning. The structure is provided by my learning strategy (Fig 4), a cyclical process with facilitative interventions occurring at distinct stages, before, during and after the accessing of media narratives. It became apparent that this learning around lived mental health experience needed extending in order to prepare students more fully for practice. This led to a subsequent stage of ‘testing out’ and refining learning *with* service users, an essential aspect within collaborative inquiry (Heron, 1996; Heron & Reason, 2001). This approach is ideally suited to mental health care practice mirroring the partnership detailed by Rogers (1961) in the development of empathy. As will be outlined within this section, collaborative partnership work has significant benefits for both practitioners and service users and forms the next stage for my developmental learning journey.

As illustrated in Fig 4 the learning about lived mental health experience is complemented and further developed through the establishment of a collaborative partnership with service users. This provides opportunities to test out knowledge and has educational as well as therapeutic benefits for those involved. It is also valuable in terms of contextualising understanding within a wider experience base.

Fig 4: Learning strategy



The Literature Base

The literature base illustrates a journey of progressive collaborative involvement with service users increasingly participating as partners in all aspects of health and social care delivery, planning and professional training (Weinstein, 2010). This is a welcome approach which can help to raise awareness and challenge stigmatising attitudes towards people experiencing mental health difficulties (Perry, Watkins, Gilbert, & Rawlinson, 2013). There has been a steady development in legislative emphasis upon service user involvement since the early 1990s with the *Community Care Act* (DoH, 1990); the *Patient's Charter* (DoH, 1991); new Labour's *Patient and Public Involvement in Healthcare* (DoH, 2000a); *The Health of the Nation* (DoH, 1992); *Working in Partnership* (DoH, 1994); *Building Bridges* (DoH, 1995); *The NHS Plan* (DoH, 2000b); *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century* (DOH, 2001a); *Involving Patients and the Public in*

Healthcare (DoH, 2001b); and the *NHS Improvement Plan* (DoH, 2004). Specific attention upon mental health service user involvement is identified within the *National Service Framework for Mental Health* (DoH, 1999a) and the *Mental Capacity Act* (DoH, 2005).

There are clear guidelines for health care professionals advocating working with service users through a partnership approach (NICE, 2011; NMC, 2015) with the NMC's (2010) standards for pre-registration nurse education addressing planning, delivery, teaching and evaluation of nursing curricula. This involvement acknowledges service users' 'expert' status concerning their in-depth contextual knowledge of health experience (Beresford, 2000; Care Quality Commission, 2013; Chief Medical Officer, 2001; DoH, 1999b; Spencer, Godolphin, Karpenko, & Towle, 2011). Professional healthcare recognition of this experience base and its value for education can be seen in the NMC's (2010) *Standards for Pre-registration Nurse Education* which advocates the involvement of service users and carers in the planning, delivery, teaching and evaluation of nursing curricula. Any standard of health professional education and training should include meaningful service user involvement in terms of design, delivery and management (Chambers & Hickey 2012; Hickey & Chambers, 2014). Such initiatives reflect the developing service user's journey from passive care recipient to active teaching role (McKeown, Malihi-Shoja, Downe, & The Comensus Writing Collective, 2010), a progression illustrated by Tew, Gell, & Foster's (2004) *ladder of involvement* or Arnstein's (1969) *ladder of citizen participation*. Such frameworks show the potential for progressive degrees of engagement, signifying enhanced autonomy and the development towards more equitably balanced partnerships although can be questioned on account of their linear and constricted nature. An issue to consider though involves the nature of service users' experiences within what remains a largely hierarchical framework and the extent to which higher levels can be achieved or sustained. Tritter & McCallum (2006) outline the limitations of models which focus upon a single ladder (or single dimension of power) and advocate a multiple-ladder model representing different types of user involvement with

dynamic structures and processes, negotiated by service users themselves. This would reflect the wider picture of engagement illustrating more of the diversity and innovation driven by agencies such as INVOLVE (2015) or Comensus (2016), autonomous service user and carer run groups.

Further recognition of the developing “expert” role is needed, particularly in light of examples where service users feel obliged to show deference to professionals (Curran, Sayers, & Percy-Smith, 2015). The value of service user involvement from an educational perspective is highlighted by a number of studies which show attitudes being challenged and better understanding created (Khoo, McVicar, & Brandon, 2004; Minogue et al., 2009). Engaging with service-user lived experience provides unique insights which can be brought to the educational experience and improves attitudes and empathy towards people with mental health difficulties (Bassman, 2000; Perry, Watkins, Gilbert, & Rawlinson, 2013). The learning potential is acknowledged by students (O’Donnell & Gormley, 2013; Rush, 2008; Schneebeli, O’Brien, Lampshire, & Hamer, 2010), educators (Gutteridge & Dobbins, 2010; Rhodes, 2014) and service users (Beresford, 2015; Crepaz-Keay, 2012; Morgan & Jones, 2009).

Initiating partnerships can be perceived as problematic by both service users (Minogue and Handy, 2010) and teaching staff (Basset et al., 2006). Particular difficulties are encountered in relation to levels of power held by each party (Hitchen et al., 2011), as well as the predominating bureaucratic and institutional systems which can make the process of ascending the power hierarchy for service users seem illusory (Stickley 2006). Service users can find themselves in multiple relationships within their involvement role with very varying types of partnership experienced. Within practice for example, the medically oriented and institutionally focused ethos can leave service users feeling more as consumers than partners

(Collier & Stickley, 2010), a position which rests uncomfortably with the kind of engagement sought by many service users (Beresford, 2003). The notion of power and autonomy within the development of partnerships can be adversely affected by issues pertaining to each party such as a prevailing culture which regards professionals as experts or conceptions of users as lacking the necessary capacity (Percy-Smith & Weil, 2003). For teaching staff, changes in the balance of power can be experienced as threatening or unsettling to their own sense of autonomy and professionalism. This challenges the dominant discourse, referred to by Foucault (1988) as the knowledge and power held by those at the top of a hierarchy. The issues addressed above will affect the degree of *partnership* or equality felt within the working relationship and will impact upon a number of areas including who chooses or is chosen to become involved with this process. In many cases the selection of service users is largely driven by institutional agendas which can exclude those whose narrative experience is not regarded as fitting the organisation's needs. This can lead to the over-use of a limited number of individuals or a restriction in what is expressed limiting the breadth of experience being heard. Whilst professionals are generally found to be supportive of user engagement, there are also discrepancies between expressed levels of support and what is actually experienced (Campbell, 2001). Indeed, Peck, Gulliver, & Towell (2002) found professionals perceiving themselves as more supportive than users perceive them to be. One explanation might be with the challenge posed to professionals, finding it difficult to conceptualise service users as "experts" (Summers, 2003) and finding it difficult to relinquish part of their own "expert" role (Basset, Campbell, & Anderson, 2006). This can lead to the potential for tokenism, where involvement takes place more for show purposes than for any real educational value (McKeown, Malihi-Shoja, Downe, & The Comensus Writing Collective, 2010), and with participants not feeling that their contributions were particularly valued (Clarke and Holttum, 2013). The lack of recognition for service users can also be extended to a belief that they are "ill" all the time or else regarded as an exotic beings brought before

students for them to observe, as with the nineteenth century pastime of asylum tourism, involving the visiting of mental health institutions (Bazar & Burman 2014). It is apparent that service users' involvement is not equitable with some experiencing a much more sustained level of involvement (Minogue and Handy, 2010).

Collaborative Inquiry

The generated insights and knowledge emerging through my work have been tested out through classroom sessions, discussion with teaching and practice colleagues, engagement with service users, hosting community workshops and presenting at conferences. This has highlighted the educational and therapeutic value in the development of collaborative partnerships between teaching personnel and service users. This is supported by those I have been engaged with as the following narrative statement shows:

“A collaborative partnership between professionals and lay people can enhance learning between all parties as well as sharing a variety of skills and values that can take a project forward. It is another dimension to the student’s experience ... it is a great privilege to be a part of helping shape the future of our health professionals.”

As detailed by Reason (1994), this process is effectively carried out with participants engaging cyclically upon narrative material and with understanding being created together. This, as shown through my work corresponds with important qualities, inherent in the learners' emerging professional role.

My focus upon collaborative inquiry has extended to incorporate integration between the varied ways in which lived experience narratives are accessed and as highlighted earlier is only part of the wider learning process (Fig 5). The reviewing of media products linked with direct learning from service users in classroom and practice settings provides rich opportunities for refining learners' developing knowledge base and creating fresh insights. My work has shown the importance of learners being guided through this process through their engagement with individuals who can be regarded as "experts by experience". Part of my approach has therefore involved opportunities for learners to observe this collaborative inquiry process being modelled in practice or classroom sessions. This enabled key elements to be stressed such as the vital requirement when facilitating narrative sharing by service users to be sensitive and aware of their support needs, especially considering that we might be asking them to share painful, difficult and very personal issues. An example of this within my work concerned the invitation given to a service user to share his thoughts and feelings about his father's suicide and his own experience of depression. He related this process to me as:

"Talking about deeply personal matters – the raw experience of mental illness – can be described as a personal holocaust ... Recognition needs to be given to the emotional labour that service users and carers undertake in providing this gift to students."

Negotiation with the service user around ways to present his experience led to a *Parkinson* interview approach being used with students watching as observers/audience members.

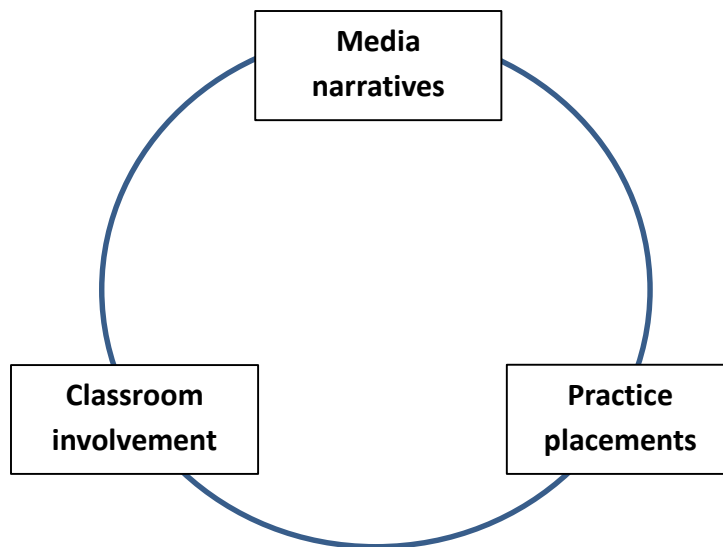
Feedback from students concerning this experience illustrated some thoughtful reflections and important learning:

“I found myself listening as though it was me who had experienced this [depression].”

“Emphasised the importance of our roles as future nurses and the impact we can have in both positive and negative ways.”

This illustrates the educational value for learners in embracing lived experience ...

Fig 5: Service user narratives – *the unified whole*



So What?

As has been shown, the focus upon media lived experience narratives is only part of learners' overall access to personal stories. This is complemented through the inclusion of service users within classroom learning and opportunities gained through practice contact. The essence concerns the ability by learners and practitioners to 'test out' their developing understanding which is most effectively done *with* and not *on* service users. (Box 4). The partnership can be broadened to also encompass facilitated means of expression engaging with various creative and artistic resources, especially where a person's communicative abilities are impaired. Facilitating the 'voice' of service users and attending to their personal stories promotes an important sense of acceptance. It also validates the significance and value of service users' narratives, helping to promote their status as "experts by experience". Engaging with their expressed narratives provides health carers with opportunities to better contextualise and understand the breadth of mental health experience from *struggling* to *living well*. An issue for educationalists to consider regards the impact that differing states of health can have upon the thoughts and feelings of others. As has already been explored, immersion within expressions of distress whilst being educative can also feel overwhelming and appropriate support is required. There is also a need to consider the effect that recovery narratives can have upon those accessing them. There are some very inspiring accounts of coping and resilience as for example seen in blogs by Howard Glick (2016) and Kate Swaffer (2016) who challenge the commonly applied term "sufferer" in connection with their dementia experience. The promotion of recovery within mental health care and learning is being increasingly recognised and valued (Basset, Faulkner, Repper, & Stamou, 2010). Whilst having a therapeutic function for those experiencing mental health issues there are also significant benefits for learners in terms of the normalising of mental health experience,

which helps to tackle stigma (Happell et al., 2015). The concept of recovery though can pose a challenge to students' concept of what caring involves with its challenge to the power dynamics within the healthcare relationship (Stacey and Stickley, 2012), impacting upon the practitioner's sense of self as "carer provider". The promotion of more autonomous service user engagement requires a significant shift in terms of the culture of care found in clinical settings as well as practitioners' attitudes and beliefs. For clinicians in particular, feeling needed and one's sense of purpose can be adversely affected which can be reflected against personal dynamics such as Malan's (2001) helping profession syndrome or Bowlby's (1977) compulsive care giving dynamic. In any case, nursing professionals are called upon to advocate a "duty of care" approach within practice (NMC, 2015) which necessitates a redefinition of what care is when facilitating control taking by service users. For learners, difficulties will be encountered when working in placements alongside practitioners who are less accommodating of service user autonomy. Balancing the power base relies in part upon a relinquishing of control amongst health care professionals whose role then becomes more one of facilitation. As addressed previously, this poses challenges in terms of the dominant knowledge and power discourse which is prevalent within the psychiatric hierarchy (Foucault, 1988). This also calls into question the nature of service user *involvement*, a term considered by Stickley (2006) to represent a historical concept, reinforcing the power positions rather than resolving them and needing to be more about *collaboration*. Clearly, what is experienced in practice in terms of service user involvement or collaboration is very variable – and not neat or tidy. This fits within an ever-changing organisational landscape with services being reorganised, public sector cuts applied and limited resources or funding available. There are obstacles and tensions experienced by each party with regards to the developing partnership work and their sense of autonomy or choice.

My work acknowledges the different types of expertise held by service users and professionals and the mutual benefits attained through the establishment of partnerships. It addresses collaboration from a dynamic and varied perspective with narrative experience being shared in many forms. My learning strategy builds around the media narrative which offers huge scope in terms of experience type and mode of expression. This offers a complementary approach to the engagement with service users in educational establishments or practice and provides learners with expressive accounts covering huge diversity of experience. An important factor here concerns the engagement with those who may not be able to, or perhaps not desiring of being directly involved with student learning. They can contribute significantly to raising awareness and understanding about lived experience through their expressed narratives in forms such as blogs, autobiographies, poems or art work. The richness of these resources concerns the uniqueness and individuality illustrated concerning each person and the encouragement for learners to become more questioning and reflective. The degree of collaboration can be extended in a number of ways including the co-creation of expressive accounts or a shared processing of media narratives. This fits in with my philosophical and humanistic stance which values the importance of the personal narrative and internal mental health experience as the foundation for connecting meaningfully with those we are engaged with in practice. My learning strategy however does have limitations in terms of its application to the institutional culture and restrictions to the levels of engagement formed with service users in practice. My approach therefore should be regarded as work in progress and not a completed process. It is concerned with promoting change and developing reflexive, questioning practitioners who in turn can challenge the prevailing practice culture, striving to engage more effectively with service users and create more meaningful partnerships in care. This provides goals for the next stage of my learning approach which focus around the developing partnership between health care professionals and service users emphasising the value of co-production and the need to facilitate narrative

expression with ‘hard to reach’ groups. It also looks at the wider societal context and the importance of raising awareness of lived mental health experience through engaging in dialogue. These goals are detailed in the following section - future directions.

Box 4: Collaborative Learning

Service user collaboration

Model ‘testing out’ – of understanding *with* service users (Bandura, 1977).

Practice reflection - opportunities for learners to discuss collaborative encounters from practice.

Consolidation – continued processing of learning with service users through social media formats, discussion forums and blogs.

Engagement

Service user involvement with educational agencies - promotion of higher level service user engagement within educational settings (Tew, Gell, & Foster 2004).

Service user support - regarding the emotional impact of narrative sharing.

Negotiation of communicative approaches for sharing ‘stories’.

Student support - promoting opportunities for working with service users and facilitating narrative expression.

Feedback - facilitation of feedback sharing from learners regarding service user involvement.

Future Directions

Future Directions

My future collaborative involvement with service users can be strengthened through attending to a number of limitations with regards to my work. I have been very intimately involved with the process of lived experience learning, which as Wilkins (2000) observes, can influence the degree of objectivity applied. Also, as much of my work was largely driven and run by myself, an aspect to consider involves the extent to which those I was collaborating with felt as equals (Mearns & McLeod, 1984). It would help therefore for future projects to be mutually designed and initiated at the outset by collaborative partners as well as utilising more in-depth supervision, which reduces the potential for certain issues becoming sources of unintended manipulation (Tee & Lathlean, 2004). This involves a process of co-production, strengthening the degree of partnership engaged in and challenging the prevailing power dynamics between practitioners and service users. Other future directions for my work involve facilitating opportunities for narrative expression especially amongst those felt to be “hard to reach”. This recognises the therapeutic and educational benefits involved as well as strengthening the degree of engagement between health care professionals and service users. Finally, my work will seek opportunities for promoting dialogue around lived mental health experience within wider societal groups, thereby helping to raise awareness and challenge stigma. These aspects are summarised in box 5.

Facilitating Narrative Expression

Although my work incorporates a fairly extensive range of narrative accounts, this still only covers a small fraction of the total amount available and to some degree is restricted to

individuals with the expressive ability and means of sharing personal stories. There is a need therefore to review a larger number, at greater depths and to include more creative modes of expression (i.e. art, poetry or music). There are clear therapeutic benefits to be obtained through self-expression and the very act of constructing narratives can impact positively upon a person's physical and mental health (Graybeal, Sexton, & Pennebaker, 2002), as well as helping individuals to better understand their experiences and themselves (Pennebaker, 2000). Goethe for example found writing and drawing as providing the means of acknowledging and coming to terms with whatever was troubling him and fostering a sense of inner peace (Boerner, 2015). Likewise, McKella Sawyer (2015) outlines how painting offers her a means of coping with anxiety:

“Sometimes all you need to do is let that fear out where you can see it, onto a canvas or a blank page, where it's easier to deal with than when it's lurking in the back of your mind.”

This can be widened to embrace other creative modes which help to relieve distressing symptoms such as music (Choi, Lee, & Lim 2008; Gutiérrez & Camarena, 2015), or poetry (Kelly, 2014). The value of such activities is reflected in Van Lith, Fenner, & Schofield's (2011) study where service users described art making as being a transformative activity which enabled them to take greater control of their lives. Similar benefits are noted in relation to blog writing, an increasingly popular format for sharing experience and connecting with peers (Tan, 2008), as well as providing the means of relieving emotional distress and promoting well-being (Boniel-Nissim and Barak, 2013). Acknowledgement of such therapeutic benefits strengthens the call for more creative outlets to be available within mental health care and appreciates individuals' need for self-expression. This facility should be available to all service users including those deemed “hard to reach” by virtue of their

impaired communicative or cognitive abilities. There are some striking examples where creative modes have enabled self-expression or re-engagement with one's external world. One such case relates to a piece of embroidery, found to contain rich communicative meaning, created by a woman with schizophrenia who rarely spoke or interacted with those around her (Blakeman, Samuelson, & McEvoy, 2013). There are also a number of approaches being used within dementia care where service users appear to be re-awakened or reanimated, interacting purposefully with their external environment. This includes the Alzheimer's Society's *Singing for the brain* groups, the *Meet me at MOMA* art sessions in New York's Museum of Modern Art, or Naomi Feil's powerful connection with Gladys Wilson, a woman severely affected through dementia (YouTube, 2009). What these examples illustrate is the importance of persevering and not assuming because individuals appear disengaged that they cannot be reached. It challenges health care professionals to strive towards engagement, seeking communicative channels or modes which fit the person before them. This provides a vital direction for my continued work and rich opportunities for collaboration between health carers and service users.

Co-production

The commencement of this work has led me to explore a range of underpinning theories concerned with the developing engagement between healthcare professionals and service users. This enabled me to reach the position of regarding co-production as a vital way forward. My investigation covered a broad range of theoretical positions examining issues of power and interpersonal dynamics such as Freire's (1970) critical pedagogy, Habermas' (1987) communicative competence and 'lifeworld', Foucault's (1988) dominant knowledge and power discourse, or Rogers' (1961) humanistic person centred approach. Furthermore,

Hopton (1996) comments upon the work of Lev Vygotsky and Frantz Fanon with their shared consensus of oppressed individuals transcending feelings of alienation through political activity, which he asserts has implications for both healthcare professionals and service users with a need to question their respective roles in maintaining the status quo. This can be challenged through co-production work, which involves the coming together of two sets of “experts”, clinicians and clients both with their own specific types of experience and knowledge (Coulter and Ellins, 2006). This particular partnership has been initiated by a variety of factors which include changes within welfare systems and self-organisation by service user groups (Barnes, Harrison, Mort, Shardlow, & Wistow, 1999). Alliances such as these provide opportunities to reimagine care philosophies, attaining a more equitable balance of power and reflecting service users’ transformational goals (McKeown, Jones, & Spandler, 2013). It promotes Albert Dzur’s (2008) concept of democratic professionalism working towards a shift in power relations between ‘service users’ and ‘service providers’. There have been a number of notable initiatives and developments over the past few years geared towards co-production which include the Higher Education Institution’s PPI challenge (CaHRU, 2015) or the Vancouver Statement, with its emphasis upon collaborative work with patients, advocacy organisations, professional agencies and community members (Towle et al, 2016). PRESENT, is a vibrant co-production initiative in Scotland, giving people living with dementia a stronger presence and say within local communities and public services (Brown, Loeffler, & Christie, 2016). Another example relates to a current ESCR (2015) series, *Re-imagining professionalism: towards co-production debating issues relating to democratic professionalism, co-production and power sharing*. This stimulated rich debate around co-production advocating a need for authentic power-sharing between service users, carers and professionals. It recognises the need to afford equal value to the different kinds of knowledge and skills contributed by each party (Boyle and Harris 2009). Co-production and partnership work promotes inclusivity and helps to collapse some of the societal divisions

and boundaries experienced. Whilst true partnership work provides academics and service users with opportunities to develop new vibrant identities the transformation of roles can be experienced as threatening for academic staff (McKeown, Malihi-Shoja, Downe, & The Comensus Writing Collective, 2010). There is progress being made although a persistent imbalance in power relations exists with a need for further developments in service user controlled organisations (Beresford, 2010). Beresford (2013b) further states:

“other people still make key decisions about us and our lives, whether we are talking about the NHS, welfare reform or the education system. And we know that this is inefficient and wasteful.”

As McKeown (2016) observes, whilst democratisation and co-production can be regarded as pivotal for mental health practice, austerity policies and welfare state cuts are impacting upon their development with coercive bio-medical models of provision more frequently observed. Within this climate new alliances are being sought including partnerships between professional trade unions and service user/survivor groups and such reimagined professionalism offers vibrant opportunities for creative change (McKeown, 2016). Co-production can be promoted to healthcare students, who can be seen as ideal recipients to engage in and take this ethos forward. There may be tensions though with what is experienced in practice placements such as acute or forensic care where issues concerning autonomy and power appear very much to be governed by professional staff. My work with students will need to broaden to accommodate such issues, preparing them further through attending to the voice of those in receipt of care, as well as modelling approaches in co-production. This is in part demonstrated by my recently published textbook *The Lived Experience in Mental Health* (Morris, 2016) which examined both individuals' experiences of mental health states and associated care interventions. It included a collaborative inquiry

approach consulting service users at regular points in its production and has led to the initiation of a number of new projects and reciprocal partnership work, such as the assisting in the development of a book being written by a service user. The direction my work is proceeding in involves challenging and questioning the prevailing ethos, creating more balanced partnerships in care.

Promoting dialogue

The positive impact that collaborative service user involvement has upon empathic learning and attitude formation has been illustrated above. Whilst it is of vital importance that practitioners develop understanding and awareness around mental health experience there are also significant benefits to be attained from extending this to the wider societal group helping to promote more accepting attitudes within the community, as recognised by agencies such as Time to Change. My work has therefore utilised opportunities to engage participants from a variety of backgrounds including policy makers, practitioners, educationalists, service users and members of the general public. This includes invitations to present at various events including an Economic and Social Research Council (ESRC) seminar “*Reimagining professionalism in mental health: towards co-production*”, the Love Arts Festival (2015), the Leeds International Film Festival, as well as participation within a panel discussion following a stigma film screening hosted by Gwynned Mind, Wales (appendix 8). These provide important opportunities for promoting collaborative partnership work with service users and challenging prevailing attitudes around mental health. This can be evidenced for example by the Love Arts Festival event, designed as a ‘conversation’ and generating lively debate amongst the eclectic mix of audience members. The thought-provoking impact this created is illustrated by participant feedback:

“Just to say thankyou to you and everyone else who made last night’s conversation so wonderful. She [service user - respondents’ daughter] enjoyed last night so much and talked and talked and talked all night about the event!!!”

The value here is in engaging people in dialogue, raising awareness, challenging beliefs and fostering change. It involves a wide number of people and groups within the process of education and mental health promotion, laying the foundation for the creation of new and productive alliances. .

Box 5: Future directions

Facilitated narrative expression – offering creative means for those with communicative deficits (i.e. cognitive impairment).

Co-production – establishing more equitable alliances involved with therapeutic, educational and research work

Promoting dialogue – multi-agency collaboration. Involvement with community events, arts festivals and school promotions.

Conclusion

Conclusion

This commentary has set out a strategy of learning which enables mental health care practitioners and learners to engage more fully with service user lived experience. It has emerged through a progressive series of scholarly initiatives tracing a journey of development concerned with the selection and accessing of media narratives; facilitating lived experience engagement; promoting reflective practice; and developing a collaborative learning approach. The central point and main focus has been upon the media narrative which has subsequently been integrated with other strands of lived experience learning (Fig 5, p.85) to promote closer engagement with the internal mental health experience. The media narrative as a learning resource is crucial because of its accessibility, breadth of examples and opportunities for collective discussion. It also provides a space of comparative safety from which to engage with emotionally difficult or contentious themes which is important, especially where learners might be apprehensive or overly cautious about how to respond to a person's distress or worried about saying "the wrong thing". My work promotes a clear strategy for lived experience learning, providing an important template for education and practice. This not only stresses the value of narrative learning but crucially demonstrates *how to* with regards to their educational engagement. It is concerned with providing learners with guidance and support, before, during and after narratives have been accessed. This is followed by a process of 'testing out' involving collaboration and co-production with service users.

A core argument made within this critical analysis is that my cited publications and developed learning strategy have made a significant contribution to the practice knowledge in the field of mental health education at different levels:

- Personal
- Practice
- Societal

Whilst it has been the intention for my work to impact primarily within personal and practice spheres, it has also been important to be influential at a societal level. This has been promoted through active dissemination of my work utilising a wide range of scholarly channels including teaching, publications, conference presentations, membership of service user agency groups and the hosting of public workshops. As a consequence, I have found a broad recipient spectrum including healthcare learners, practitioners, service users, media personnel, policy makers as well as the general ‘lay public’. This can all be developed further including project work with children in schools as evidenced by various initiatives (Schachter et al., 2008). This would help to promote greater understanding of lived mental health experience along with a reduction in stigmatising attitudes.

My learning strategy is the culmination of a series of educational endeavours using media narratives as the focal point. It illustrates a developmental journey with continuous evaluation and reflection aiding in progressing my work further. It has been impactful and influential, disseminated widely, trialled and modelled through numerous applications and has earned positive feedback and praise from a wide variety of recipients. It is a ‘journey’ in progress with many future landmarks to discover (Box 5), especially through future collaborative and co-produced work. This includes opportunities for co-creating lived experience narratives with service users, especially where communicative abilities have been affected. It is evident that facilitating self-expression through media use has both educational value and therapeutic gain as illustrated through various projects involving art (Stickley, 2010), film-making (Parr 2007) or digital story writing (Centre for Global Mental Health, 2013). The partnership work

can be employed in various ways encompassing scholarship, research and therapeutic initiatives. All of this builds upon the base already established through my work which is concerned with raising practitioners' awareness of mental health experience, initiating more open attitudes and enabling greater self-expression for service users. The challenge facing clinicians is in creating effective partnerships which take into account issues of power and help to promote personal autonomy. The limitations of my work are concerned with the realities of practice and the largely experienced institutional and medically oriented cultures. The degree of autonomy experienced by service users or opportunities to express themselves in terms of internal experience can be varied. There is a need therefore for the ethos of connectivity and engagement shown through many educational initiatives to be carried into practice. The work I have been involved with has been concerned with promoting attitudinal development amongst learners, facilitating them to become more questioning, reflexive, confident, emotionally intelligent and valuing of the need for meaningful lived experience engagement. It reflects Rogers' (1983) notion of learning how to learn, developing attributes which can be transferred and further developed within a variety of settings. There is much that needs to be done in terms of extending the learning process beyond the classroom and connecting more effectively with the internal lived experience of those we are engaged with. The predominant biomedical culture with its imbalanced power relations needs challenging, building effective partnerships with a diverse range of individuals and groups at local, organisational and national levels. Student nurses are ideally placed to extend this work and help promote change, especially as they belong to the professional group which often experiences the most contact with service users. There are some powerfully ingrained organisational dynamics helping to maintain the status quo although inspired and engaged student nurses offer themselves as powerful agents of change. A final point to note is that my work is not a prescription on how to approach service user engagement but more an ethos of

engagement adding a vibrant and innovative range of facilitative methods for student nurse education.

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Appendices

Appendix 1 – Joint Authorship

Appendix 1 - Joint authorship

Two of the publications put forward have joint authorship. Please note for the purpose of clarity the author concerned with this PhD by publication application is G. Morris. The signed declaration forms are included at the end of appendix 1.

- 1) Morris, G., & Forrest, R. (2013). Wham, sock, kapow: can Batman defeat his biggest foe yet and combat mental health discrimination? An exploration of the videogames industry and its potential for health promotion. *Journal of Psychiatric and Mental Health Nursing*. 20(8), 752-760. doi:10.1111/jpm.12055

This publication commenced with ideas submitted within a module assignment by R. Forrest, a student on the HECS 3189 (media depictions of mental health) module. This module, along with all of its content was developed and taught by G. Morris. The assignment focused upon the video game *Batman: Arkham Asylum* and the predominantly negative mental health messages that were being conveyed to the game player. The student was consulted by G. Morris about seeking joint publication and a series of meetings were arranged to discuss ways of progressing with this. It was agreed to extend the focus of this work to examine the health education / health promotion potential of the video game format. Main revisions and additional material were added by G. Morris with regular consultation carried out with R. Forrest. The original essay was 2,500 words long with the revised and extended piece of work totalling 5,000 words.

- 2) Morris, G., & Morris, J. (2010). *The Dementia Care Workbook*. Buckingham: Open University Press.

This publication was based upon classroom learning material and teaching methods which both authors developed and delivered to mental health nursing students. In writing this book it was decided that individual authors would take a lead with identified chapters and develop these through consultation and discussion with the other. The book contained 9 chapters with 7 of these (2-8) following a similar format. Chapter 1 provided an introduction to this text and chapter 9 contained a series of exercises for group work. The allocation of a “lead” role for chapters was as follows:

G. Morris

Chapter 2 - the felt experience: the person with dementia

Chapter 3 - the felt experience: carers

Chapter 5 - the environment of care

Chapter 6 - the *person* with dementia

Chapter 7 - engagement; connecting with the *person*

J. Morris

Chapter 4 - attitudes

Chapter 8 - empowerment and disempowerment

There was an equal share of responsibilities for:

Chapter 1 - introduction

Chapter 9 - facilitating person centred care: worksheets and activities

G. Morris was responsible for completing the reference list and appendices.

JOINT AUTHORSHIP DECLARATION PhD BY PUBLICATION



Please complete and submit this form with the final version of your thesis at the point it is submitted for examination.

Candidate's Full Name:	GARY MORRIS
Student Number:	9562306023
Title of Thesis:	CREATING A STRATEGY OF COMMUNITY ENGAGEMENT WITH MENTAL HEALTH WORK EXPERIENCE THROUGH THE USE OF MEDIA MATERIALS
Title of Publication (including citation):	WILLIAM SOLO, MARLOWE CAN BATH AND DEFEND HIS BIGGER BEYOND AND COMBINE MENTAL HEALTH DISORDERS

Please clearly indicate what you have contributed yourself to the publication and the extent of the collaboration (%):

Name GARY MORRIS Contribution 50%

Signature [Signature] Date 12/10/15

PhD by Publication Candidate

Name ROBERT FORREST Contribution 50%

Signature [Signature] Date 20/10/15

Co-Author

Name _____ Contribution %

Signature _____ Date _____

Co-Author

Name _____ Contribution %

Signature _____ Date _____

Co-Author

Name _____ Contribution %

Signature _____ Date _____

Co-Author

Name _____ Contribution %

Signature _____ Date _____

Co-Author

JOINT AUTHORSHIP DECLARATION PhD BY PUBLICATION



Please complete and submit this form with the final version of your thesis at the point it is submitted for examination.

Candidate's Full Name:	GARY KEVIN MORRIS
Student Number:	9502306023
Title of Thesis:	creating a strategy of learning engaging with mental health and dementia through the use of media narratives
Title of Publication (including citation):	THE DEMENTIA CARE WORKBOOK

Please clearly indicate what you have contributed yourself to the publication and the extent of the collaboration (%):

Name GARY MORRIS Contribution 50 %

Signature [Signature] Date 14/10/15

PhD by Publication Candidate

Name JACK MORRIS Contribution 50 %

* Signature [Signature] Date 16/10/15

Co-Author

Name _____ Contribution %

Signature _____ Date _____

Co-Author

Name _____ Contribution %

Signature _____ Date _____

Co-Author

Name _____ Contribution %

Signature _____ Date _____

Co-Author

Name _____ Contribution %

Signature _____ Date _____

Co-Author

Appendix 2 – Publications summary

Appendix 2 – Publications summary

These publications are ordered according to the sections of this work within which they are examined.

Publication 1 - Mental Health Media

Morris, G. (2006). *Mental Health Issues and the Media*. London: Routledge.

This academic textbook is concerned with the transmission of mental health content by the media. It is structured around Berlo's (1960) communication model and stages of sender, message and receiver. It critically analyses influences at each stage concerning narrative development, communication of content and engagement by interpretative recipients. The value of this work is provided by its detailed analysis of the media as a communicative entity concerning mental health content.

Publication 2 - Dementia Care Workbook

Morris, G., & Morris, J. (2010). *The Dementia Care Workbook*. Buckingham: Open University Press.

The essence of this co-authored work is the promotion of deeper understanding concerning the lived and felt experience of dementia. It is designed specifically to challenge thoughts and

attitudes held by healthcare learners and practitioners, thereby promoting Kitwood's (1997) *personhood* approach. Readers are engaged through a wide selection of media narratives and theoretical discussions around the lived dementia experience.

Publication 3 - Connecting with Screen Experience:

Morris, G. (2010). Developing Empathy - Connecting with the Screen Experience. In: S. McAndrew, & T. Warne (eds.), *Creative Approaches to Health and Social Care Education* (pp 142-56). London: Palgrave MacMillan.

The impact and learning potential of using feature films in education is examined within this book chapter. It critically explores the use of the film *Some Voices* in promoting understanding and awareness about the condition of schizophrenia. The significance of this work is the modelling of film use within education and the examination of the learning value that this audio-visual medium can provide.

Publication 4 - Videogames:

Morris, G., & Forrest, R. (2013). Wham, sock, kapow: can Batman defeat his biggest foe yet and combat mental health discrimination? An exploration of the videogames industry and its potential for health promotion. *Journal of Psychiatric and Mental Health Nursing*. 20(8), 752-760. doi:10.1111/jpm.12055

Whilst there has been a fair amount of attention upon the negative impact that videogame play can have upon attitudes as well as individuals' mental health states there is a paucity of evidence around their positive learning potential. This article provides a unique examination of the videogame genre and its scope for carrying narratives promoting learning and attitudinal change. It is a highly interactive medium with significant potential for awareness raising and developing empathic understanding. This critical exploration provides clear guidance for ways of enhancing this media type's learning and health promotional potential.

Publication 5 - First-person media:

**Morris, G. (2014a). Developing awareness and understanding amongst mental health nursing students of the lived experience of dementia with the aid of selected first-person media resources. *Journal of Research in Nursing*. 19(5), 434–448.
doi:10.1177/1744987114539343**

This article is concerned with the learning processes engaged in by learners whilst exposed to different communicative modes. It examines students' experience from using five different types of media (TV, film, books, internet and newspaper) finding the audio-visual modes to be the preferred types and carrying the most impact. Important knowledge emerging from this work shows each source having its own strengths and limitations with regards to learning. The implications have been developed into recommendations and guidance for educational use.

Publication 6 - Online resources:

Morris, G. (2014b). Education can be fun: a qualitative study exploring the promotion of learning through the use of creative and engaging online resources. *Open Education Europa*. 10 Mar 2014. Retrieved from <http://openeducationeuropa.eu/en/user/49653>

The focus of this study is upon the process of learning taking place whilst working through selected e-learning packages. These provide learners with direct exposure to personal narratives around mental health utilising different communicative modes. There is particular emphasis placed upon aspects which influence engagement and promote impactful learning. This work provides understanding of the need for resources to be interactive and examines specific features which generate attention or have appeal for learners. It provides educationalists with clear and considered knowledge for creating engaging e-learning materials.

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Jones, S.C. (Director). (2000). *Some Voices*. [DVD]. United Kingdom: Dragon Pictures.

Kitwood, T. (1997). *Dementia reconsidered*. Buckingham: Open University Press.

Appendix 3 - Citations

Appendix 3 – Citations

Publication 1) *Mental Health Media*

Books and journal articles

Clifford, K. (2013). Mental Health crisis interventions and the politics of police use of deadly force. In D. Chappell (Ed.), *Policing and the Mentally Ill: International Perspectives*. (pp.171-95). London: CRC Press.

(Australia) This chapter looks at the process of deinstitutionalisation, care implications and issues for police work.

Ferro, H. (2013). A representação da saúde mental e da doença mental na imprensa portuguesa: um estudo comparativo. *Estudos em Comunicacdo*. 13, 37-86. Retrieved from <http://www.ec.ubi.pt/ec/13/pdf/EC13-2013Junho-02.pdf>

(Portugal) This article explores the discussion of data from a study about the representation of mental health issues in the Portuguese press.

Hazelton, M., Rossiter, R. and Sinclair, E. (2011). Encounters with the 'dark side': New graduate nurses' experiences in a mental health service. *Health Sociology Review*. 20 172-186. doi:10.5172/hesr.2011.20.2.172

(Australia) This article discusses a research project investigating graduate nurses' attitudes towards individuals with mental health problems.

Holton, A.E., Farrell, L.C. & Fudge, J.L. (2014). A threatening space?: Stigmatization and the framing of autism in the news. *Communication Studies*. 65(2), 189-207.
doi:10.1080/10510974.2013.855642

(USA) This article reviews the stigmatising framing of autism within the news.

Ion, R., Pegg, S., & Moir, J. (2014). Nineteenth century newspaper accounts of a murder committed by an inmate of a Scottish asylum. *Journal of Forensic Psychiatry & Psychology*. 25(2), 164-175. doi:10.1080/14789949.2014.903503

(UK) This study explores an incident from the late nineteenth century in which an inmate at the Royal Dundee Lunatic Asylum murdered a fellow patient while working in the hospital grounds.

Miller, G. (2007). Mental health and the mass media: room for improvement. *The Lancet*. 370, 9592, 1015-6. doi:10.1016/S0140-6736(07)61246-X

(UK) This article reviews the shortfalls in media reporting and the need for change.

Milošević, L. (2011). Televizija i promocija mentalnog zdravlja. [Television and the promotion of health] *Sociologija*, LIII (2), 213-30. doi:10.2298/SOC1102213M

(Serbia) Current media campaigns, realized within national campaigns and actions on mental health prevention and promotion, are considered in this paper, in the context of expert public relation, as well as the whole society, towards mental health.

Quass, L. (2012). Federal Efforts to achieve mental health parity: a step in the right direction, but discrimination remains. *Legislation and Policy Brief*. 4(1), 35-72. Retrieved from <http://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1032&context=lpb>

(USA) Policy briefing concerned with improving mental health care services

Scherr, S. (2013). Medien und Suizide: Überblick über die Kommunikationswissenschaftliche Forschung zum Werther –Effect. *Suizidprophylaxe*. 40(3), 96-107. Retrieved from https://www.researchgate.net/publication/257657452_Medien_und_Suizide_berblick_ber_die_kommunikationswissenschaftliche_Forschung_zum_Werther-Effekt

(Germany) Overview of the research examining links between media coverage and suicidality.

Shaw, M. (2009). Health risks and the media. In B. Heyman, A. Alaszewski, M. Shaw, & M. Titterton (Eds.), *Risk, safety, and clinical practice: Health care through the lens of risk* (pp. 137-70). Oxford: Oxford University Press.

(UK) This chapter reviews the issue of risk and depicted through the media.

Smit, M. (2012). The use of social media to advance HIV and AIDS awareness in South Africa: An investigation into how the Intersexions Facebook page is used for HIV prevention, care and support and treatment. In E., Durden, & E. Govender (Eds.), *Investigating communication, health and development* (pp. 429-42). Auckland Park: Jacana Media.

(South Africa) This work studies the impact that a television drama series had upon facilitating social and behavioural changes amongst viewers/participants.

Swantek, S.S. (2009). Media minorities and the stigma of mental illness. In S. Loue, & M. Sajatovic (Eds.), *Determinants of Minority Mental Health and Wellness* (pp. 73-88). London: Springer Science + Business Media.

(USA) This chapter examines the experience of mental health discrimination amongst minority groups.

Verhulenko, I., Humen, K., & Tymets, O. (2013) Modeli reprezentatsiyi obraziv psikhichno khvorykh lyudey i reaktsiyi na nykh sotsiumu v populyarnykh kinostrichkakh [Models of representation images of mentally ill people and their reactions to the society in popular movies]. *Social Dimensions of Society*. 316, 658.

(Ukraine) This article is concerned with mental health representation within movies

Wahl, O. (2014). Mental illness and the media. In W. Cockerham, R. Dingwall, & S.R. Quah (Eds.), *Encyclopedia of Health, Illness, Behavior, and Society*. New Jersey: Wiley Blackwell. doi:10.1002/9781118410868.wbehibs062

(USA) This work examines the depiction of mental illness in mass media, noting issues of concern, research findings, and areas where more investigation is needed.

Internet site

Harrington, N.L. (2012). *The myths of madness. Media depictions of mental health*. Retrieved from

<http://www.gatheringmagic.com/editorial-research-natashalewisharrington-122112-the-myths-of-madness>

(USA) This website is concerned with media depictions of mental health issues.

Dissertations

Bisson, S. (2014). Studying 'psychosis' in medical knowledge, popular film, and audience identities: *A discourse analysis of the naming of clinical psychosis, its filmic representations, and the interpretations of those who have experienced it*. Doctoral thesis, Cardiff University, Cardiff.

(UK) This thesis explores the ways in which those who have experienced psychosis engage with and respond to film texts which feature psychosis.

Karepova, M. (2010). Psychological Counselling in Russia: The Making of a Feminised Profession. *The Making of a Feminised Profession*. Doctoral thesis. University of York, York.

(UK) This thesis explores a television campaign for mental health promotion.

Topping, K. (2010). *The representation of depressive illness in the print media*. Dissertation.
BA (hons) Degree in Journalism. Edinburgh Napier University, Edinburgh.

(UK) This work explores the print media's communication and coverage of depression.

Publication 2) *Dementia Care Workbook*

Books and journal articles

Barker, S., & Board, M. (2012). *Dementia care in nursing*. London: Sage

(UK) This textbook examines experiences for the person with dementia.

Hean, S., & Smith, S. (2013). Interprofessional collaboration when working with older people. In S. Barker (Ed.), *Caring for Older People in Nursing* (pp. 191-209). London: Sage.

(UK) This chapter focuses upon the partnership between health care professionals and older adults.

Jootun, D., & McGhee, G. (2011). Effective communication with people who have dementia. *Nursing Standard*. 25(25), 40-6. Retrieved from <http://journals.rcni.com/doi/pdfplus/10.7748/ns2011.02.25.25.40.c8347>

(UK) This article explores the skills needed for effective communication with people who have dementia. It describes the factors that influence the communication process and the effect this may have on the nurse-patient therapeutic relationship.

Nelson, L., Inglis, S., Howell, F., & Gibbs, M. (2012). Vulnerable Adults. In Wood. I., & Garner, M. (Eds.), *Initial Management of Acute Medical Patients* (pp23-55). Oxford: Wiley Blackwell.

(UK) The chapter here reviews the need for early assessment and identification of abuse amongst vulnerable adults.

Dissertations

Constable, G. (2011). *The experience of caring for someone with dementia: a biographical study*. Doctoral dissertation. University of Southampton, Southampton.

(UK) This research examines the lived experience of caring for someone with dementia.

Reid, R.A. (2015). *Improving the experiences of informal and formal Alzheimer's Disease and dementias caregivers*. Doctoral dissertation. Walden University, Walden.

(USA) This doctoral thesis examines dementia carers' needs.

Publication 3) *Connecting with Screen Experience*

Journal article

Couchman, W., Hafford-Letchfield, T., & Leonard, K. (2014). The practice educator as museum guide, art therapist or exhibition curator: A cross-disciplinary analysis of arts-based learning. *Journal of Practice Teaching and Learning*. 12(3), 48-61.

(UK) This paper reviews the use of arts-based approaches in professional health care education.

Dissertation

McKie, A. (2011). A narrative exploration of the relationship between reading literature and poetry and ethical practice: narratives of student nurses and nurse educators. Doctoral thesis. Robert Gordon University, Aberdeen. Retrieved from <https://openair.rgu.ac.uk/bitstream/10059/659/1/Andrew%20McKie%20PhD.pdf>

(UK) This doctoral dissertation examines the use of literature and poetry within health care learning.

Publication 4) Videogames

Internet sites

Castro, A. (2013). Arkham Asylum and Mental Health: A Review of the Scientific Literature. Retrieved from <http://www.twinfinit.net/2013/10/07/gaming-arkham-asylum-science-whaaaaaaaaat/>

(USA) This online article reviews the videogame format and its impact upon game players and mental health attitudes,

De Leeuw, E. (2014). The 2014 State of the Art in Health Promotion Research. Retrieved from http://lbihpr.lbg.ac.at/sites/files/lbihpr/vienna_presentation_hpi_evelyne_de_leeuw.pdf

(Austria) This work provides a review of health promotional research.

Appendix 4 – International Appeal

Appendix 4 – International Appeal (<http://www.tom-davis.net/FDU.html>)

FAIRLEIGH DICKINSON UNIVERSITY module

School of English, Philosophy & Humanities

TOM DAVIS

Web: www.tom-davis.net

Coping with Life (www.coping-with-life.com)

todavis@fd�.edu

Office hours by appointment

MENTAL HEALTH ISSUES IN THE MEDIA (COMM 2211.51)

Wednesdays, 6:00 to 8:30 p.m.

Spring 2007

This course will identify and evaluate common, media-promoted perceptions of mental health, addressing how images perpetuated by film, print and broadcast media influence families, the healthcare industry, the political establishment and others responsible for the wellness of individuals with mental illness. The course is suitable for communication majors and others, such as nursing and psychology majors, who are interested in media or mental health concerns.

READINGS

The following books may be purchased at the bookstore:

Morris, G. Mental Health Issues and the Media (Routledge)

Carter, R. Helping Someone with Mental Illness (Times Books)

LEARNING OBJECTIVES

At the end of the semester, students should be able to:

- Understand and explain how mental health issues and media interests connect and collide;
- Interpret, explain and critique mental health stigma and its impact on literature, film, newspapers and the Internet;
- Interpret theories in the context of stigma and how they shape the media; and
- Articulate a vision for how mental health and media interests can co-exist.

REQUIREMENTS

This course will follow the lecture/discussion format, with a heavy emphasis on discussion. Students should complete weekly reading assignments prior to the next class meeting. Attendance will be taken and counts toward class participation. Papers must be double-spaced.

Paper 1 (two pages, due Feb. 14)	5 percent
Paper 2 (six pages, due March 21)	30 percent
Final examination (May 2)	40 percent

Class participation

25 percent

Extra credit opportunities will be available during the course of the semester.

SCHEDULE OF LECTURES, DISCUSSIONS AND READINGS

Week 1 (Jan. 24): **Introduction to Mental Health Issues in the Media**

Assigned readings – Morris, Chapters 1 and 2

Discussion: Why are we here? We'll look at the history of mental health and its treatment in the media. A review of language and how words, more than anything, have shaped coverage and, ultimately, the stories. How are people with mental illness portrayed in T.V., film, literature and the Internet?

Week 2 (Jan. 31): **Shaping the Message**

Assigned readings – Morris, Chapter 3; Carter, Chapter 1

Discussion: We'll look more specifically at what drives the media when it covers a story involving mental illness. When the newspaper covers a murder case involving a person with mental illness (or a film, T.V. program or book with a similar plot or subject matter), what is the goal? And, in such a case, what does the mental health profession expect? We'll discuss the different theories behind the mental health/media relationship, and how the relationship is more dysfunctional than cohesive.

Week 3 (Feb. 7): **Stigma**

Assigned readings – Carter, Chapter 2/Viewing of "Me, Myself and Irene"

Discussion: We'll review the above movie and discuss how stigma played a role in the plotline. Do people find the movie's portrayals of mental illness to be particularly attractive or humorous? Could the movie have taken a different approach, and still be successful?

Week 4 (Feb. 14): **Stigma (Part II)**

Assigned readings – Morris, Chapter 4

Paper 1 is due

Discussion: We'll look at how stigma is pervasive in all forms of media – even in a society that's becoming more politically correct. How is stigma any different from, or similar to prejudice? Have other groups – racial, religious, ethnic or otherwise – dealt with similar issues? Can stigma be subtle?

Week 5 (Feb. 21): **Changing the Message (Selling Mental Health)**

Assigned readings - Morris, Chapter 5; Carter, Chapter 9

Discussion: How do we defy stigma? Is that possible? A look at how education – in both subtle and explicit ways – has changed the face of mental health for the better. Long ago, nearly all people with mental illness were portrayed in the media as wild and out-of-control, and exhibiting only violent and murderous tendencies. Now, prominent people, such as Brooke Shields, have gone public with their own mental illness as a way to promote understanding. Has it worked? Who is holding up that change?

Week 6 (Feb. 28): **Loons and Loud People (The Bill O'Reilly Phenomenon)**

Assigned readings – Morris, Chapter 7

Discussion: We'll look more specifically at the news media and its history of mental health portrayals. Despite efforts to better promote mental health understanding, many of the old stereotypes still find their way to the printed page and the screen. We'll look at headlines/teasers, and how the news media relies – more than any other medium – on language to send its message.

Week 7 (March 7): **The Cuckoo's Nest (The Impact of Film)**

No readings

Discussion: We'll look more specifically at film and its history of mental health portrayals. We'll discuss how film is, perhaps, more reliant on images than other media. What are good/bad examples of mental health depictions in film? We'll look at how even the finest directors, such as Alfred Hitchcock, may have used stigma to sell their stories to the movie-going public.

Week 8 (March 21): **Looking Back/Forward – Guest speaker: Richard Codey, state Senate president**

Assignment: Chapter 6

Paper 2 is due

Discussion: A review of what we've discussed so far, and additional discussion on how recent forms of stigma and media perceptions have shaped the current state of mental health.

Week 9 (March 28): **Psycho Killer (Literature)**

Assigned readings – Morris, Chapter 8

Discussion: In murder mysteries, how often is the killer portrayed as someone who is totally sane? Literature has made a living out of vilifying, or even glorifying, the “psycho killer.” We’ll look at how even the finest writers have used mental illness to sell their stories to the public.

Week 10 (April 4): **Starved for Creativity (T.V. and Jerry! Jerry! Jerry!)**

Assigned readings – Morris, Chapter 9

Discussion: We’ll look at sitcoms and reality T.V. and how – similar to literature – a person with mental illness is often portrayed on television as the villain. We’ll look at how T.V. is different from literature, relying more on comedy in its portrayals of mental illness. We’ll also look at the impact of T.V. and how it is, perhaps, more influential than any other medium.

Week 11 (April 11): **The Uncorked Bottle (The Internet)**

Assigned readings – Morris, Chapter 10

Discussion: We’ll discuss how the Internet is either perpetuating the old stereotypes of mental illness, or changing them by offering better access to counseling, support groups and mental health professionals.

Week 12 (April 18) – **What Can We Do?**

Assigned readings – Carter, Chapter 10/Discussion and review

Discussion: We'll discuss the problems with mental health coverage and what can be done to alter the media's ambition for "blood, guts and glory." Can the media find a more sensitive approach to mental illness while still meeting its goals and ambitions?

Week 13 (April 25) – **Where We Are**

Review for Final

Discussion: A review and discussion of the semester's material.

Week 14 (May 2) – **Final**

Appendix 5 – Book Reviews

Appendix 5 - Book Reviews

Publication 1) *Mental Health Media*

A) Foster, L. (2007). Mental Health Issues and the Media. *Journal of Psychiatric and Mental Health Nursing*. 14(6), 616-618. doi:10.1111/j.1365-2850.2007.01107.x

Gary Morris identifies his book as being an examination of how the different elements of the individual/society, the media and mental health issues interact. The subtitle of the book is that it is a guide for mental health professionals; however, I think this is not a particularly easy book to ‘dip into’ and is likely to be read mainly by those who are particularly interested in the topic or pursuing a professional development module. It is properly aimed at its intended readership because there is an absence of media theory unless it is relevant to the author's argument.

The title of this book is telling: unfortunately he does not discuss his use of the term ‘issues’ in the book's title so that the reader is forced to question: ‘issues’ for whom? He is well-qualified to write this book, as he runs a taught module of the same name at a UK university, which is plainly evident in that his arguments and observations are practised, evidence-based and concise.

The book is laid out neatly and logically. I particularly liked the references to contemporary media (movies, newspapers, books, television programmes). I also liked the way that the many references in the book were all laid out at the end of the book – this is perhaps a

personal preference because I find it easier to turn to a few pages at the back to note references than to keep referring back and forth to the end of the current chapter. The index is also extensive; and the book also contains several very useful appendices which give lists of Internet links and media regulators.

The author gives ample evidence throughout the book of the media's signal inability to police itself over the representation of mental health issues; his half-hearted reminders from time to time that the media claims it is merely holding a mirror to society equally failed to wash with me, the reader – as perhaps he intended. The author emphasizes the tension that commercial pressures (such as circulation and advertising) exert on the portrayal of mental health issues in the media; and notes with despair that many journalists themselves admit that they realize their representations of mental health issues fall short of accuracy (or even honesty) for a lot of the time.

Instead he strikes the optimistic note that an increasing number of contributions made to the media by service user organizations is crucial in making it more accurate and informed in its reporting.

The author draws attention to a disturbing absence of positive mental health messages in the media. Reading this book and his arguments made me realize exactly how these affect our work as mental health professionals and also the experiences of service users. I enjoyed Chapter 3, 'Stigma, labelling and the media' the most, because for me it chimed with clinical governance documents which emphasize how minimizing stigma and promoting social inclusion is an important role of the mental health worker; though I would have liked the book to resonate more closely with such clinical governance documents. In a way this is churlish because anybody working in mental health care knows how quickly the field

develops and changes; which must render any book such as this one/out of date/almost as soon as it lands on the publisher's desk.

The author sees the role of the media as twofold: educative and informative. He argues persuasively that the media tends to fall well-short of these ideals. He shows that this is unfortunate, given the potential for good that role has in educating and informing many media recipients of the media who have not in some form encountered mental health issues. Similarly, he lauds several cases of high-profile public figures who discuss or have discussed their own mental health issues (and glamorous people such as movie actors representing such issues in the media) as being positive because such things bring mental health issues to the front of people's minds.

He asserts that an audience will attend to what it wants in order to reinforce its own prejudices, whereas other elements of the audience are open-minded and receptive. This is an interesting distinction to make, because the media has a responsibility for accuracy and honesty either way.

The author very courageously examines the Internet as a form of 'new media'; courageous because he admits that little comprehensive research has been carried out on it. The Internet is something of a sprawling amalgam of information and opinion (some of it he declares misguided or even downright dangerous), but it has the benefit of informing both service users and mental health professionals. Of course, the Internet is notoriously difficult to pin down, and the author must be applauded for considering it as seriously as he does, and acknowledging its important place in contemporary society. One of the appendices of the book contains a checklist for evaluating Internet sites, which is very useful and one that I shall share with students who I mentor.

The main influence of this book has been to make me more acutely aware of the information I seek and receive for myself and that I share with other people. It has made me realize exactly the struggle that I as a mental health professional have in pursuing practice that is socially inclusive and that reduces stigma. That is the reason why mental health professionals must read this book; from it we can see exactly the social context of the uphill nature of the struggle towards social inclusion – an observation that seems to pass policymakers blithely by.

B) Beebe, L. (2007). Review of mental health issues and the media: an introduction for health professionals. *Issues in mental Health Nursing*. 28 (5). 551-552. doi:10.1080/01612840701346394)

Gary K. Morris, RMN, BSc, MSc, has been a nursing lecturer in the School of Healthcare at the University of Leeds, UK since 1993. A nurse for over 20 years, he is an accredited Cognitive Analytic Therapist. He runs a taught module entitled, “Mental Health Issues and the Media,” and is currently developing an online module entitled “Media Depictions of Mental Health.” This is his first book.

This book provides a theory-based discussion of the ways in which various types of media contribute to personal and societal attitudes regarding persons with mental illness and mental illness itself. The four introductory chapters describe the relationship between mental health issues and the media and review our theoretical understanding of the ways in which communication occurs between media and audience. Media depictions of stigmatizing,

negative mental illness stereotypes as well as positive, health promoting mental health portrayals are broadly reviewed. This introductory material is followed by a series of chapters devoted to each of the following types of media: news, literature, film, television, and the Internet. Appendices provide information on Internet resources for professionals and mental health service users, a guide for evaluation of Internet sites, and contact information for those who wish to provide feedback to organizations about media portrayals of mental health issues.

As one example, Chapter 6, “Literature,” begins with a historical overview of this communication medium, which traces its roots to the Ancient Greeks and Romans. Next addressed are the three narrative types of literature: autobiography, semi-autobiography, and fiction. Both positive and negative mental health portrayals in each type of literature are discussed, with specific works cited for further reading. This section is followed by an analysis of the role of perspective and its influence on reader response to a given narrative. This chapter concludes with a discussion of the theme of survival versus destructiveness in mental health depictions in literature. Multiple specific examples of literature illustrating each facet of the discussion are provided throughout the text. Chapters 5–9, which address the specific media types, are each organized in this manner.

This book has a strong theoretical base and includes an extensive bibliography ranging from classical communication and operant conditioning theories to Hildegard Peplau and Carl Rogers. Multiple contemporary media examples are used to illustrate how presentation and perspective can influence both individuals and the larger society. Because the writer resides in the UK, some of the media events and television shows referenced may not be familiar to readers in the US; however many classic examples are used that are widely recognizable, for example the films *Shine*, *The Silence of the Lambs*, and *A Beautiful Mind*.

This book would benefit from expanded and specific discussion of how mental health providers might: (a) assess media contributions to mental health attitudes in our patients and ourselves; (b) therapeutically intervene to ameliorate negative perceptions; and (c) provide feedback about mental health portrayals (either verbally or in writing), to organizations from each type of media. I particularly appreciated the discussion of the complex array of factors that affect the message a given person takes away from a given media portrayal, and the highlighting of the importance of the role of context in evaluating media portrayals. In addition, the number and range of specific works of literature, television shows, film, and Internet sites cited as examples make it easy for the interested reader to pursue further information independently.

A) Daly, L. (2012). Book review - The Dementia Care Workbook. *Nurse Education in Practice*. 12 (3), e23, doi:10.1016/j.nepr.2011.11.006

With growing recognition of the increasing numbers of persons with dementia, the need for skilled dementia care practitioners has never been more pressing. Recognition of the bio-psycho-social nature of this condition has led to the continuing development of evidence-based principles with which to inform the delivery of quality care to improve the well being of those who live with dementia. Drawing on many of these principles, the ‘Dementia Care Workbook’ centralises the building and maintenance of quality caring relationships between dementia care workers and those who live with dementia. Such relationships are conceptualized in terms of three elements “those of self (you the reader), the person with dementia, and the environment of care” (p. 1). Through their creative use of experiential learning techniques, underpinned by a person-centred philosophy, Moris and Moris (2010) have created a stimulating text that challenges us to explore dementia care in an engaged and multi-factorial way. An important attribute is the writers’ acknowledgement that practice environments can present unique challenges to those working within them. As such, there is an emphasis on promoting realistic person-centred approaches that are flexible enough to be adapted to a variety of contemporary practice contexts. This ensures that the workbook appeals to a variety of health and social care educationalists and those providing dementia care across the continuum of care.

This practical book is presented in nine chapters. The consistent approach to the presentation of each chapter enhances usability and reader engagement. Questions, activities and exercises

are strategically presented throughout. Combined with the use of vignettes featuring two constructed persons with dementia, Elsie and Arthur (introduced in chapter one), these promote reflection in tandem with a critical approach to practice considerations, contexts and interventions. Each chapter ends with references and recommended readings of key policies and works by well regarded authors in the field, providing readers with sources to consolidate their learning. Chapters can be worked through sequentially or explored on a chapter by chapter basis, depending on interest and/or particular learning need. Chapter one provides an introduction to the purpose, structure and key concepts underpinning the workbook. Chapters two to eight cover a variety of issues, including: the experiences of the person with dementia and carers; attitudes; environment of care; engagement and connection, and empowerment and disempowerment. The concluding chapter provides expanded details to facilitate groups to engage in the exercises included in earlier chapters and there is a very helpful appendix providing useful dementia web resources.

While the breadth of issues addressed in this workbook are to be commended, so too is the importance placed on considering the perspectives of a range of stakeholders including the person with dementia, carer and healthcare worker. The emphasis on adopting a critical, yet realistic, approach to practice is also to be lauded and contributes to the book's appeal, as the topics and manner in which they are addressed are salient to contemporary dementia care practice contexts regardless of focus or discipline. Therefore, this text is an excellent resource for those delivering or participating in dementia care training and has the additional benefit of being usable by the individual. The text is also a particularly valuable resource for academics and those engaged in more formal dementia care education programmes. Indeed, I have drawn on the text in my own lecturing practice and find that it lends itself to both undergraduate and postgraduate learning contexts. However, it should be considered one of a range of core texts for dementia specific courses to ensure a sound grounding in the

knowledge necessary to underpin skilled dementia care. To conclude, I consider ‘The Dementia Care Workbook’ to be a valuable and inclusive text, focused on practice and suitable for use with a multiplicity of learners and learning situations. This text should be considered a positive addition to health and social care libraries and contexts in which dementia care is delivered.

B) Open University Press

<http://www.mheducation.co.uk/9780335234318-emea-the-dementia-care-workbook/>

“I regard this as a long overdue and highly relevant addition to the literature on dementia care ... the book will play a large part in helping to improve dementia care by presenting a vision and manual for ‘best fit realistic practice.’” (Walsh - University of Nottingham)

“This is an excellent text for both undergraduate and postgraduate students. The strong emphasis on person centred approaches and relationships permeates throughout the book and the activities presented provide the reader with the opportunity to reflect upon their own practice and the best fit options identify interventions for consideration.”

Sandra Fleming, School of Nursing and Midwifery, Trinity College Dublin, Ireland

“I thought this book was a very useful and detailed text exploring the world of the person with dementia and their carer.” Dr Alisoun Milne, Reader in Social Gerontology, School for Social Policy, Sociology and Social Research, University of Kent, UK

“Excellent text which provides a number of useful case studies which helps to demonstrate the application of evidence to practice. Well written, informative chapters.”

Val Howatson, Pathway Leader in Mental Health, Glasgow Caledonian University, UK

C) Oliver, K. (2013). “*Book Reviews*” of books read by Keith Oliver on Dementia.

Retrieved from <http://dementiavoices.org.uk/wp-content/uploads/2013/04/Book-Reviews-November-2013.pdf>

The Dementia Care Workbook – Gary Morris & Jack Morris (2010) – useful for those running courses on dementia care, but probably not so for the general reader. Well written with a mix of factual content, case studies and tasks to explore within a course situation.

Publication 3) *Creative Approaches*

A) Chaloner, C. (2011). Book Review. *Creative Approaches to Health & Social Care Education. Nursing Standard. 25(14), 30. doi:10.7748/ns2010.12.25.14.30.b1144*

Editors Tony Warne and Sue McAndrew offer an innovative examination of the delivery of teaching in health and social care, and lecturers will welcome this useful and accessible book. The contributors provide insights into aspects of education that individually and collectively give considerable scope for reflection. Theoretical and practical aspects of education delivery are proficiently explored in a well-planned structure. I particularly recommend the first three chapters, because they provide an interesting overview of the philosophical basis of health and social care education.

B) Street, P. (2011). Book Review. *Creative Approaches to Health & Social Care Education. Nurse Education in Practice. 11(3), e7. doi:10.1016/j.nepr.2010.12.002*

Facilitating good quality educational experiences is of a prime concern to all educators. This text clearly promotes this ethos. It provides a thought provoking book that encourages educators to consider a range of educational strategies that can enrich both the student learning experience and one's own teaching practice.

The chapters in section one set the scene for the book, by contextualising health and social care education within the domains of both philosophy of health and social care education.

The changing nature of education and the discourse between facilitative education and more pragmatic approaches to education and training within healthcare are considered.

Interestingly the authors state at the outset that this section may be controversial. However, I

did not find it as polemic as I thought it might have been. However it might indeed appear controversial for some educationalists.

Section two focuses on presenting a range of creative strategies aimed at promoting student learning and understanding. These chapters really caught my imagination, particularly the strategies that individual lecturers could use directly after reading the chapter. The poetry and literature chapter for example demonstrates how educationalists can use art forms to help practitioners come to terms with emotion and conflict related to clients who are ill. Other chapters demonstrate how the use of painting can develop student self awareness. Similarly creative approaches such as feature films and reflective questions during teaching can help students to develop empathy. Several other interesting teaching strategies are presented such as: transformational learning; the use of discourse; the impact of simulated patients and scenarios. These latter are considered with respect to their potential contribution to the development of therapeutic skills among students. Other less traditional approaches are also considered such as employing a patient as an educationalist.

Section three explores how health and social care practitioners can shape their own futures and the social process therein, but also outlines how ultimately research and reflection can promote learning. These chapters focus on issues like recruiting pre-registration nursing students who are deaf to work post qualification in and around the deaf community, considering the issues of emotional involvement, and supporting new practitioners on a mentor programme. Hence supporting lifelong learning is a key element here.

Overall, the book clearly has a reflective approach. Indeed I believe that many of the chapters had a very therapeutic feel to them, reflecting the mental health or therapeutic background of a significant number of the authors. All of the chapters provide a good insight into the strategies discussed. However, some chapters provided a greater degree of practical

application than others, giving clear indications of how to use the strategies and how they actually worked when used. In addition some strategies may have limited application for large teaching classes, which often prevail within healthcare education, as many initiatives seemed to have been devised for facilitating learning in small groups rather than large ones. It would have been interesting to know if any of these strategies were used with different sizes of student groups. Overall this book provides a valuable resource for lecturers and educationists at all levels. It provides practice, philosophical and conceptual approaches to education that go beyond traditional education views and challenges the reader to consider how they could enhance their teaching to facilitative learning via non traditional and creative approaches in education.

C) Stickley, T. Book Review. Creative Approaches to Health & Social Care Education. *Social Work Education*. 31(6), 803-804. doi:10.1080/02615479.2012.695470

Creative Approaches to Health and Social Care Education is (as the title implies) a resource for lecturers who teach health and social care subjects. The cover blurb claims that the book explores “...vibrant and engaging alternatives to traditional approaches, and challenging old techniques” furthermore it will “reinvigorate” my teaching. I couldn’t wait therefore to read the book and get appropriately inspired.

This is an edited book divided into three sections: 1] *Philosophy and Sociology of Health and Social Care Education*, 2] *Educational Activities and Creative Activities for Health and Social Care Education*, and 3] *Education Beyond the Classroom for Health and Social Care*. A quick scan of the biographies of the contributors reveals that nearly all of them are nurses by background which is disappointing because of the lack of the “Social Care” element but

the disappointment was soon forgotten once I got stuck into the text which got off to a very stimulating start...

Chapter 1 begins with a “public health warning” as some readers may become upset by reading it. I couldn't wait! I wasn't upset though – I'm obviously not the kind of person who would be upset by a critical thinker (Peter Morall) suggesting that higher education should stimulate thinking (in contrast to a “painting by numbers” approach). The second chapter is authored by Gary Rolfe where the reader is taken on a trip around education by various philosophers, artists and thinkers. The destination is “...*a science of the unique*” as opposed to the science of large numbers that dominates the academy. The chapter is definitely both “*vibrant and engaging*”! Chapter 3 emphasises the significance of narrative to learning and how empathy can be learned by the stories of others.

Chapter 4 is the first chapter of Section 2 and is specific to *Nurse Practitioners*, which is shame as some non-nurse readers may not get past the title. Chapter 5 discusses simulated scenarios including simulated patients in order to help develop therapeutic helping skills. Essentially, what this is all about is using professional actors as patients. Having done this myself many times, I'm already won over by the method, although costs can at times prohibit. Through case studies, Chapter 6 focuses the reader on developing a therapeutic alliance defined in a psychodynamic theoretical context with plenty of opportunity for self-reflection. Chapter 7 focuses upon “*Consumer perspectives in the classroom*”. This is a topic close to my heart but as a UK reader I would have liked more reference to UK contexts, but then it dawned on me that this is maybe an international book. Most of the authors of the book are UK based however there are a number from Australia, and few from New Zealand and Holland. It's great to have international perspectives, however it's also hard to imagine

how easily international readers can identify with some of the language, jargon and contexts in some of the chapters.

Chapters 8, 9 and 10 are more like what I expected from the title (“Creative Approaches”) as they introduce poetry, literature, painting and film and their place in health and Social Care education. For me, this was the heart of the book mainly because that’s what I was expecting from the title – I would have liked more of these kinds of chapters!

Chapter 11 on transformative learning is excellent, but didn’t flow naturally from the previous three in this section as it was more theoretically orientated, it may have fitted better with another section. The final section: *Education Beyond the Classroom for Health and Social Care includes* Chapter 12 that illustrates learning in practice by using an ethnographic approach; Chapter 13 is a thoughtful and challenging inquiry and goes to the heart of caring with a focus on love and emotional involvement in caring. Chapter 14 focuses on deaf people’s access to nurse education, which is a super chapter in itself, but odd in the context of the structure of the book as it is such a specialised topic. The final chapter is of utmost importance: supporting newly qualified professionals.

The entire book is a thoughtful collection of well-written and well-informed essays with relevant messages for health and social care educators. Given its title though I would have liked more on the creative arts and their application in education. Nevertheless, I warmly recommend the book for its positive focus (hardly a word about risk which we hear far too much of these days!) and contents that reassure the creative, thinking and caring educator. I’m not convinced it will re-invigorate my teaching, but I’ve never believed cover blurbs anyway...

Theo Stickley, University of Nottingham

Appendix 6 – Module Assignments

Appendix 6 – Module Assignments

1) HECS 3189 Media Depictions of Mental Health

Module Summative Assessment (2,500 words)

Select a media example whereby mental health issues are being depicted and explore the messages being conveyed. Choose a specific example whereby mental health issues are being portrayed. (Please note a “mental health issue” might relate to a wide variety of aspects such as:

- A diagnostic condition (i.e. Schizophrenia, Depression, Dementia, Eating Disorders etc)
- The environment of care (i.e. institutional care)
- Psychological/relationship difficulties
- Learning disability
- Stress
- Alcoholism or drug addiction

Essay structure

Introduction

Brief overview of the what the assignment is about (chosen media source and example selected)

Main body:

Sender

Brief critique/exploration of the chosen media source and its influence upon public perception of mental health issues

Includes reflection upon:

- Regulations/guidelines governing chosen media provider

i.e. governmental legislation, media regulations, professional or ‘user’ group guidelines

- Medium

Consideration of this particular medium i.e. as a narrative or visual communicator of messages

- Market

What is the market for this media source and what are its influences

The Message

This section essentially provides a clear examination of your chosen example through consideration of aspects such as

- Imagery
- Use of music/sound
- Role models/characterisations
- Narrative
- Handling of mental health themes

This is may be dependent on the media source selected i.e.

- Film/TV (Sound/imagery/dialogue + title)
- Newspaper / Magazines (Headlines/images/narrative)
- Literature (Book cover / narrative text)
- Internet (Title/ imagery/ text/ navigation)
- Music (Song title/ Artist/ Lyrics)
- Radio programme (Title/ narrative/ sound and music)
- Art Product (Title / composition/ underlying rationale)

Receiver

- How are the messages received
- Receipt of message relating to who receiver is (differences due to status i.e. professional, service user, lay public)
- Discuss influences upon the interpretation of the messages

Conclusion

- Outline main reflections and conclusions drawn

2) HECS 5149M Media Depictions of Mental Health (3,000 words)

Critically evaluate the ways in which a selected mental health issue is positively promoted by one chosen media source. Choose a specific mental health issue to focus upon. Please note a “mental health issue” might relate to a variety of aspects including:

- A diagnostic condition (i.e. Schizophrenia, Depression, Dementia, Eating Disorders)
- The environment or culture of care (i.e. institutional care)
- Psychological/relationship difficulties
- Stress
- Alcoholism or drug addiction

Essay structure

Introduction

Brief overview of what the assignment is about including clarification of chosen media source and mental health issue.

Main body:

a) The broad picture

- *The media source*

Regulations and guidelines

Track record of mental health coverage

Brief overview of communicating properties (i.e. visual, auditory, narrative)

- *Mental health issue*

Definition and outline of issue

- *Mental health promotion*

Reflection of health promotion initiatives and campaigns that have been directed towards the media

b) Mental health promotion in the media

This part critically examines the various ways by which your chosen theme has been positively promoted drawing upon examples of related media products.

Processes or issues considered should be examined against related research / theory

Conclusion

Draw main themes together and include your concluding remarks

3) HECS 2192 - Understanding the Lived Experience (3,500 words)

This essay is concerned with your developing awareness and understanding of a person's lived experience of mental health problems. This can relate primarily to service users or carers.

Select a media product where a personal (factual) account of experiencing mental health problems is being portrayed. This can include media types such as:

- *Television documentary*
- *Newspaper / magazine article*
- *Internet blog*
- *Autobiography*
- *Radio programme*

With the support of related literature, illustrate and discuss the nature of the personal experience being recounted.

Implications for practice – discuss the learning taken away from this and how it might influence your subsequent approach to practice.

Appendix 7 – Seeking Expert Opinion

Appendix 7 – seeking expert opinion

A) Advice sought for comment on mental health Halloween costumes for Wales Online news story.

(<http://www.walesonline.co.uk/news/wales-news/what-separates-comedians-exploration-mental-6102092>)

What separates a comedian's exploration of mental illness from a supermarket 'psycho' costume?

07:34, 27 SEP 2013

OPINION



BY DARRENDEVINE

After the storm of 'mental health patient' costumes sold by supermarkets, Darren Devine explores the boundaries between comedy and mental health



Asda's 'mental patient' costume

The best medicine or poisonous parody? Is there a role for laughter and comedy when it comes to mental health?

Perhaps. But as Asda, Tesco and Amazon have found to their cost misjudging the boundaries can leave you looking callous and exploitative.

The retailers have been fighting an embarrassing damage limitation exercise over Halloween costumes criticised for stigmatising the mentally ill.

The storm began when Asda advertised an outfit featuring someone covered in blood and brandishing a machete as a “mental patient fancy dress costume”.

Later Tesco and traders on Amazon were revealed to be selling similar outfits.

Celebrities including former footballer Stan Collymore and ex-spin doctor Alastair Campbell, both of whom have struggled with mental illness, tweeted their disgust before the stores apologised.

But where do we draw the line when it comes to humour and mental health?

If we are too po-faced about mental health and allow it to become a subject we tip toe around isn't that just as damaging as stigma?

Comedian Juliette Burton, 29, uses humour in her act to broach her lifelong battles with eating, body dysmorphic and obsessive compulsive disorders as well as depression.

In her show *When I Grow Up*, which explores her childhood ambitions, she shares with her audience the darkest moments she's endured since being sectioned at 17. She finds the experience liberating and empowering.

Burton, who believes the supermarket products reinforce negative stereotypes about the mentally ill, said: "Within this particular show I'm very open about it. Having had a lot of laughs about all the things I wanted to be when I was a child and showing me growing up I then show people pictures of when I was sectioned.

"The biggest laugh in the whole show comes after that when I say my last childhood dream that I tried to be was a pop star.

"I say a joke about how most adults try to become pop stars now by appearing on *X Factor* and I'm a prime candidate for *X Factor* because I've got my sob story to hand already.

"I'm a recovering anorexic that's been sectioned and that should see me through to the second round before I've even begun to sing."

Burton, who has performed at the Edinburgh Fringe Festival and next year tours the UK, says *X Factor* rather than her ongoing battle with mental illness is the butt of a gag that helps ease tension when her audience seems uncertain as to how to react to her story.

She also uses humour when broaching difficult aspects of her illness with friends and family.

Many other performers, including US comics Ruby Wax and Maria Bamford, also use their battles with mental illness as material to be drawn on in their acts.

And no subject should be off-limits to humour, provided it's approached intelligently and sensitively, says Burton.

“I absolutely think there is room for humour. That’s the whole point of comedy, that nothing need be off-limits. But it’s about being justifiable and being able to justify your own jokes, being accountable for what messages you’re putting across.”

But how easy is it to distinguish between thought provoking routines on mental illness and those going for cheap laughs?

Little Britain’s psychiatric patient Anne, who would throw full, unopened loaves to ducks and lift her skirt in front of anyone who cared to watch, was one of the show’s most popular characters.

Academic and author of *Mental Health Issues and the Media* Gary Morris said the depiction of Anne on the hit BBC show left his students split between those who believed the character satirised the system that cared for Anne and others who thought she was the butt of the joke.

Mr Morris, a mental health lecturer at Leeds University, said: “I spoke to students about it and they seemed divided. Some thought it was more sending up the mental health system and was about the professionals and carers even though here you had a gross stereotype portrayed on the screen in front of you.”

Katie Dalton, public affairs manager with Welsh mental health charity Gofal, said “tone” and “context” are the key factors to consider when reacting to comics who talk about mental health.

Dalton, who tweeted her disgust over the Asda costume, added: “If a comedian has experience of mental health problems I think they are more likely to handle that issue quite sensitively.

“But what we don’t want is for people to perpetuate negative stereotypes as in the Asda costume and mock people with mental health problems.”

B) Advice sought for news reporting of the Germanwings air disaster

From: Yasmine Blackman

Hi Gary,

I'm currently writing my dissertation (BA Journalism) on the recent media coverage of Andreas Lubitz's depression.

The title is: "Germanwings crash and co-pilot Andreas Lubitz's depression: Does the media coverage of Lubitz's depression reinforce the negative stereotypes surrounding mental health and what does this mean for those who suffer from a mental health illness?"

I'm currently reading and reviewing your book "Mental Health Issues and the Media" as part of my lit review.

I'm looking to email interview some professionals in the field to gain some further insight in to my question and thought that you would be able to provide me with the authoritative answers I am looking for. I have also emailed a lot of charities but they do not seem to have the resources to talk with me about my research. I understand that you must be busy but would be really grateful if you wouldn't mind helping me with a few questions. I could send them over beforehand for you to look at if you would like? It would be such a huge help if you could.

Please get in touch if you feel this is something you could help me with.

Kind regards,

Yasmine Blackman

Hi Yasmine,

yes I would be happy to help with this. Please e-mail questions you are interested in.

Best wishes

Gary

From: Yasmine Blackman

Hi Gary,

thank you so much for getting back to me - I really appreciate it. I have attached the questions I have in a word document and also attached some consent forms which just require you typing your name if that's okay.

If you don't want to answer of the questions you may leave them - any insight at all would be really helpful. Thanks again -this is a big help!

Kind regards,

Yasmine

Hi Yasmine,

please find my responses to your questions below. I have also attached the participation consent form.

There has been a lot of media coverage surrounding Andreas Lubitz's depression. How do you think this was handled and why?

This has been handled in different ways with not surprisingly the tabloids and broadsheets taking very different stances. The tabloid response has been more sensationalist and 'clumsy' with some very stereotypical and stigmatising associations made. These strongly equate 'mental illness' with acts of violence and unpredictability. The broadsheet coverage however has been more balanced and considered.

Do you think the media has the ability to reinforce negative stereotypes in terms of mental health?

Absolutely. The emotive choice of words and images fit a broad stereotype which is reinforced prolifically elsewhere across the popular media. These products tend to be high exposure and build up a picture which appears more credible and convincing especially to people who do not have much experience or understanding about the realities of mental

health problems.

Is it possible that the media coverage surrounding Lubitz's depression could be reinforcing negative stereotypes?

It is very possible - The with mental health problems cite negative experiences where they have Sun's "Madman in cockpit" or the Daily Mirror's "Killer pilot suffered with depression" are particularly negatively reinforcing. Some of the responses from people with depression picked up on this with wry comments such as "I have depression and need to drive to the shops - is this safe" etc.

If yes, why do you think this?

As per classical conditioning the steady and pervasive association between 'mental health' and negative themes can be hard for people to deal with. The media coverage as a mass covers a broad spectrum, however the negative, emotive messages will have more impact and will be remembered more keenly.

Do you think it is possible that negative or socially irresponsible reporting on mental health illness could deter those with a mental health illness to talk about it in a work environment and if so, why?

There has long been problems with stigma which can be internally driven as well as externally. There are many blogs and discussion forums where people with mental health problems discuss their fears about opening up to others within the workplace. It certainly differs from job to job with for example pilots, train and bus drivers having more worries.

What impact do you think negative or socially irresponsible reporting on mental health illness

could have on those who suffer with a mental health illness?

A main problem concerns people not seeking help or disclosing problems to others. MIND's (2000) Counting the Cost report for example highlighted problems of people not seeking work, experiencing an increase in symptoms and becoming more socially isolated.

What impact do you think negative or socially irresponsible reporting on mental health illness could have on society as a whole?

It creates barriers between people and marginalises those who are deemed "mentally ill". It reinforces historical aspects of attempting to rid society of 'madness', which led to the creation of the asylum culture. Basically, it creates divisions within society and fosters feelings of intolerance to those deemed "not perfect".

In your opinion, what is the media's motive behind sensationalising mental health illness?

Primarily about boosting sales circulation. Mental illness stories are impactful and help to sell newspapers. Coverage of high profile stories or celebrities have been shown to increase a products commercial appeal.

Anything you would like to add?

A problem facing the news industry concerns commercial pressures. there are many guidelines created by mental health advocacy groups for journalists advising and educating them about the realities of mental health problems. There have also been surveys with approx 2 thirds of journalists feeling that coverage should be better. Within a newspaper though there

will be sub editors and other personnel asking for stories to be 'adjusted' to make more impactful." Person with depression" doing normal things or achieving things does not have the same level of impact and is not considered newsworthy.

I hope this is helpful for you.

Best wishes

Gary

Hi Gary,

Thank you so much for your insightful answers. I really appreciate the time you have taken to provide me with some much needed authoritative opinion. This will really help inform my research- I am very grateful!

Kind regards,

Yasmine

C) Advice sought on representation of mental illnesses in film for student dissertation.

On 17 Sep 2015, at 17:36, Amy Thompson wrote:

Dear Gary,

I am contacting you as I am currently writing my dissertation on the representation of mental illnesses in film. I am studying in my final year at the University of the Arts London, and have chosen cultural studies as my pathway. I have become familiar with your book *Mental Health Issues and the Media: An Introduction for Health professionals*, using it as one of my key research texts. I am interested in the way women are represented in film, particular women with mental illnesses. I am interested in the misconceptions present in these films and the effects they have on their audiences?

I would love to have some personal input from you to include in my dissertation, and was wondering if I could send you over a few questions by email about your opinions of the film industry and the way mental illnesses are represented?

Thank you for taking the time to read my email, I eagerly await your response.

Yours sincerely,

Amy Thompson.

Hi Amy

Yes I would be happy to help. Please send me your questions.

Best wishes

Gary

On 22 Sep 2015, at 18:48, Amy Thompson wrote:

Hi Gary,

Thank you so much for your response and your willingness to help me out.

My questions are as follows:

Please feel free to elaborate where you feel necessary,

In general, do you think people with mental illnesses are portrayed accurately in mainstream cinema?

On the whole no although it is improving. There are more biopics available now reflecting lived experience. Films such as Helen or Still Alice are good examples. There is a lot of overly dramatic content with commercial interests overriding other needs or sensitivity or accuracy. Even biopics such as A Beautiful Mind or Shine have been criticised for "facts" which are distorted or untrue.

What are the biggest misconceptions about mental illness that are being perpetuated by film?

There are still a number of stereotypes such as the violence / dangerousness (which is wholly misleading) although with other misconceptions such as the comic / eccentric or the helpless / incapable characterisations.

Do you think there is a difference in the way men and women suffering from a mental illness are represented? And if so why?

I am not sure if there is a clear distinction although men feature much more prominently in the "psycho killer" type films. Historically there were differences in other media sources such

as the 19th century literature and the "delicate" emotional female condition ie Wuthering Heights. The portrayal of women with mental health problems featured more emotional expressions.

In many films, for example Basic Instinct (1992) and Black Swan (2010), a woman's mental illness is sexualised and there is often a strong link made between woman's sexuality and her mental stability. Why do you think this is?

Again this might be historical. Hysteria for example was derived from a term meaning "wandering uterus", firmly portrayed as a female condition. There is also a commercial angle which will drive certain productions.

In your opinion, is there a film that has portrayed women with mental illness in a particularly negative way?

I could give you plenty of examples with regards to men. There were some stereotypical characterisations in Girl Interrupted but on the whole it was generally favourable. films such as Fatal Attraction would feature here.

Equally, do you feel there are any films that stand out for their positive or realistic depictions of women with mental illnesses?

The film Helen had a powerful and realistic portrayal of a woman with depression.

Do you think the portrayal of mental illness in film has improved over the years? Is there a difference in the way mental illness was discussed in early cinema as to now?

Absolutely. See the book re mental health and film by Gabbard and Gabbard. There were changes over the decades reflecting societal attitudes and views. Now there are much more examples depicting lived experience.

Thank you so much for taking the time to answer these questions.

I hope this answers your questions

Best wishes

Gary

Hi Gary,

Thank you so much, that's all very helpful. That seems to have covered all I need to know for now. Would it be alright to get in touch later down the line with my dissertation, if I need any more questions answered

Thanks again.

Best wishes,

Amy

Appendix 8 – Community Mental Health Promotion

Appendix 8 – Community Mental Health Promotion

1) Love Arts Conversation

(<http://loveartsleeds.co.uk/wp-content/uploads/2012/02/LOVE-ARTS-PROGRAMME-15.pdf> - p14)

PERFORMANCE

Talk and Workshop

Love Arts Conversation presents two free talks from Leeds academics analysing the portrayal of mental illness in film and drama. The Love Arts Conversation was a 2 day conference, part of 2014's Love Arts Festival where we discussed the role of the arts in wellbeing.

Mental health at the movies: promoting empathic learning through watching films.

This workshop examines the use of films for generating insight and understanding around lived mental health experience; as well as challenging stigma.

The films counter stereotypical notions, showing people living well and provide a cultural context too. You can review the learning potential of movies and access thoughts and feelings from the mental health nursing students who have been involved in this work.

Shakespeare and mental health

“Who is it that can tell me who I am?” (King Lear). Shakespeare’s plays feature some of the most well-known depictions of mental illness in stage history. But what do his plays tell us about mental health? Expert Dr Susan Anderson shows you how Shakespearean drama presents the mind. Get involved in reading and discussing extracts from the plays, as well as the chance to ask questions about Shakespeare and mental health in history.

Suitable for non-academic, adult members of the public, service users, carers, health care workers / professionals The sessions will be followed by a Question and Answer session



Date: Monday 19th October

Time: 6pm – 8pm

Venue: The Tetley, Hunslet Road, LS10 1JQ

Cost: FREE

Book: <http://loveartsfestival2015.eventbrite.com/>

2) 29th Leeds International Film Festival 5-19 November 2015

Film to Change: Short Film Screening and Talk by Gary Morris

(<http://www.leedsfilm.com/films/film-to-change/>)

How is mental health portrayed in cinema today? Film makers with personal experience of mental health issues present films that attempt to tell a different story than that portrayed in mainstream media. Featuring films from Mojo Films, Time to Change, Inkwell Arts and others. Followed by a talk by Gary Morris, nursing lecturer and author of Mental Health Issues & The Media. Gary will examine the portrayal of mental health in international cinema.

3) Panel discussion 21st October 2016

Personal invite by Gwynned Mind, Wales to participate in a panel discussion following a stigma film screening

Appendix 9 – Course Adoption / Recommendations

Appendix 9 – Course Adoption / Recommendations

Dementia Care Workbook - recommended resource for dementia care by the following organisations:

Carers Trust Wrexham (www.wrexham.gov.uk/libraries)

Isle of Wight NHS Primary Care Trust

Royal College of Nursing

Social Care Institute for Excellence

Yeovil District Hospital NHS Foundation Trust Academic library

Newport Libraries Carer's collection

Educational

Module / programme text for:

University of Cumbria (HLLG6016 Dementia: Practitioner Values)

University of Derby (Social Consequences of Dementia Care - 6NU538)

Recommended reading

University of Plymouth

University of Stirling;

Australia - <http://alzheimersproducts.blogspot.co.uk/p/dvds.html>

Canada - University of Manitoba Health Sciences Libraries

Appendix 10 - Conference Presentations

Appendix 10 - Conference Presentations

Morris, G. Sep 2015. Facilitating engagement with mental health lived experience through the use of visual narratives. 4th International Visual Methods Conference, University of Brighton.

Morris, G. September 2015. Retaining a voice: Connecting with the dementia experience through selected media narratives. 5th International Conference on Advance Care Planning and End of Life Care. Ludwig-Maximilians University, Munich, Germany.

Holt, I., & Morris, G. June 2015. Leading nurses to guide health role transition from a metasynthesis of dementia literature. Sigma Theta Tau: Phi Mu Chapter Biannual Conference. Weetwood Hall Conference Centre, Leeds.

Morris, G. April 2015. Learning about the experience of depression from service user narratives. PGR Festival. University of Huddersfield.

Gurbutt, R., Gurbutt, D., Morris, G., Nowlan, N., Morley, M., Riesen, E., & Ogilvie, S. March 2015. Making clinical decisions in a virtual world. Madrid, Spain.

Morris, G. Worton, K., Leslie, K., & Berrill, P. January 2015 Mobile apps and mental-health care. Student Education Conference 4 - The Leeds Graduate - the distinctive journey. University of Leeds.

McNichol, E., Morris, G., & Iqbal, K. January 2015 The use of patient and carer stories and narratives in student education. Student Education Conference 4 - The Leeds Graduate - the distinctive journey. University of Leeds

Morris, G. May 2014 The universality of caring - caring across cultures. 35th International Association for Human Caring Conference, Kyoto, Japan

Gurbutt, R., & Morris, G. January 2014 Design factors in a real-world clinical-decision-making simulation. SEC3, Third annual student education conference. University of Leeds, Leeds.

Morris, G. September 2012, Living with dementia. Living with Difference Conference. Leeds

Morris, G. May 2012 Engaging students through interactive and impactful Articulate resources. 4th European Articulate Conference. Weetwood Hall, Leeds.

Morris, G. March 2012. Fictional representations of dementia and their educational potential. 27th International Conference of Alzheimer's Disease International. Excel Conference Centre, London.

Morris, G. January 2012. Audio feedback for students using the reflecting team module for family therapy. Student Education Conference 1 – Excellence. University of Leeds

Morris, G. January 2012, Using Articulate to engage students through interactive and impactful learning material. Student Education Conference 1 – Excellence. University of Leeds

Morris, G. September 2011. ALT/Epigeum Award for Most Effective Use of Video.

ALT-C 2011: Thriving in a colder and more challenging climate, University of Leeds

Morris, G. June 2011 Promoting learning through the use of creative and engaging online resources E-learning in Health. Aston Business School, Birmingham.

Morris, G. and Gurbutt, R. June 2011 Carrot and Stick - promoting staff engagement in e-learning. E-learning in Health Conference. Aston Business School, Birmingham.

Morris, G., Lawton, A., & Turner, J. January 2011. Embracing the lived experience of mental health service-users and carers. “Inspiring Students to Develop Their Full Potential”, University of Leeds.

Morris, G. October 2010 Using first-person media accounts to help understand the lived experience of dementia. Coming of Age: Dementia in the 21st Century, Excel Conference Centre, London.

Morris, G. June 2010. Developing empathic approaches in dementia care - using first person-media products to help students engage with the lived experience of dementia. Real People: The Self in Mental Health and Social Care, Manchester.

Morris, G. January 2010 Using first-person media products to help students engage with the lived experience of dementia. Seventh Annual Learning & Teaching Conference, The Exceptional Student Journey University of Leeds.

Morris, G., & Morris, J. January 2007 Facilitating learning through the use of online resources. "Deliver excellent and inspirational learning and teaching", University of Leeds.

**CREATING A STRATEGY OF LEARNING: ENGAGING WITH MENTAL HEALTH
LIVED EXPERIENCE THROUGH THE USE OF MEDIA NARRATIVES**

GARY KEVIN MORRIS

**A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE OF DOCTOR OF PHILOSOPHY**

UNIVERSITY OF HUDDERSFIELD

AUGUST 15th 2016

Volume II of II

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CREATING A STRATEGY OF LEARNING: ENGAGING WITH MENTAL HEALTH LIVED EXPERIENCE THROUGH THE USE OF MEDIA NARRATIVES

Index:

Appendix item

Publications:

Publication 1 - <i>Mental Health Media</i>	*
Publication 2 - <i>Dementia Care Workbook</i>	*
Publication 3 - <i>Connecting with Screen Experience</i>	*
Publication 4 - <i>Videogames</i>	1
Publication 5 - <i>First-Person Media</i>	2
Publication 6 - <i>Online Resources</i>	3

*** See books included in box file along with volumes I
and II**

Appendix 1 – Publication 4: *Videogames*

COMMENTARY

Wham, Sock, Kapow! Can Batman defeat his biggest foe yet and combat mental health discrimination? An exploration of the video games industry and its potential for health promotion

Authors

- G. Morris RMN Dip TCP RNT BSc (Hons) MSc,

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- R. Forrest BSc (Hons) Nursing (Child)

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Introduction

There are a vast number of media products portraying mental health content carrying both positive and negative messages. While addressing these issues with regards to the media as a wider entity, this article is concerned with video games and the communicative resonance that its products have regarding players' understanding and feelings about mental health themes. The video game industry has tended to attract less attention than for example film, television or the press yet nonetheless having a strong influence upon attitudes and understanding about mental health. It is a richly expressive and creative medium with a powerful potential for health promotion, although largely depicting stigmatizing and misleading notions reflecting what is seen with other media source types (Morris 2006). It is the more-commonly portrayed negative associations which health promoters/educators have to compete against and a specific example *Batman: Arkham Asylum* will be reviewed with comments made about its ambiguous and discriminatory notions of mental health. This is examined with regards to game players' interactive experience and ways in which negative messages and associations are conveyed. A contrast will be provided by some of the educative and health-promotional games available and their impact upon game players' attitudes and understanding. The implications regarding these for mental health practice, and service-user outcomes will be addressed with a range of recommendations made. This includes reviewing specific games for their

therapeutic potential, utilizing this medium for service-user expression and forging collaborative links between mental health professionals and game developers. It should be noted here that the regulatory bodies and the majority of examples cited are applicable to the media industry in the UK. The discussion and recommendations though concerning video games and their implications for mental health professionals are equally appropriate to other geographical regions.

Mental health issues and the media

People's understanding about mental health issues is to a large extent shaped and influenced through exposure to the media (Wahl 1995, Philo 1996, Morris 2006). Examples accessed can be enormously impactful, particularly products featuring struggling celebrities, mentally ill killers or tales of triumph against adversity. These occur regularly within the popular media and strongly influence views about mental health issues. The ongoing distress of celebrities such as Frank Bruno, Paul Gascoigne, Amy Winehouse or Britney Spears is relayed to us in the format of real-life soap opera. Reporting styles include some extremely insensitive and misleading messages as these headlines aptly illustrate – *Bruno put in Mental Home* (Daily Express); *Sick Bruno in Siege Drama* (Daily Star); and *Bonkers Bruno Locked Up* (The Sun). The Sun's coverage in particular was met with fierce condemnation from mental health advocates with an apology requested by the organization SANE (2003). The impact upon individuals can be significant as Bruno's (2006) reflections about feeling humiliated and treated like a national joke illustrate. There is a sense here of vulnerable individuals being exploited by the media, something experienced in other media genres such as reality TV, Chat shows (i.e. Jeremy Kyle) and magazine articles. Products such as these package up an individual's distress as entertainment for the public's pleasure, providing a sense of schadenfreude (Morris 2006). While showing little sensitivity, the attractiveness to media producers from these types of approach is in their commercial appeal (Salter & Byrne 2000). This is also the case with coverage involving mentally ill people who kill. Notable examples within the UK press include Christopher Clunis (stabbed Jonathan Zito to death) and Michael Stone (killed a mother and daughter with a hammer), shocking stories which gained 'front-page' exposure. These types of coverage are emotively memorable and influence the negative associations and erroneous beliefs about the collective body of people who happen to be diagnosed with mental health problems. They are found alongside countless other stereotypical examples (TV dramas and soaps; psycho-killer films; popular fiction) which 'inform' us of the dangerousness potential of mentally ill people. Such products perpetuate stigmatizing views and cause those affected to feel more isolated and less able to cope (Mind 2000). The prevailing message from such examples is to regard mental health experience as an affliction, a form of ailment that does not sit comfortably within an ordered society. The potency of the media's influence upon attitudes can be reflected through the fact that for many people, it is the media which provides the primary source of learning about mental health problems (Mason 2003). It is imperative therefore that the information

obtained from the media is reliable, accurate and trustworthy. A proactive response to this has been to use the media for campaigning and health promotion purposes. This has led to the development of initiatives and strategies such as *Shift, Changing Minds, Time to Change* and the *National Dementia Strategy* (Department of Health 2009) which promote the 'living with' mental health issues message and tackle discriminatory media coverage. An earlier study by Philo (1996) showed that those not accepting the dominant negative media message had personal, professional or family experience which acted as a counter. This brings up the notion of interpretative recipient and illustrates that people can be more discerning and challenge misleading content if having an alternative base from which to view from. The provision therefore of a greater selection of media examples which help recipients understand what *the lived mental health experience* entails is an approach worth examining. These issues relate to each media subtype including that of video games. While the majority of games carrying mental health content are stigmatizing and misleading, there is an emergent range of titles which are proving highly effective as health promoters/educators.

Mental health issues and video games

Issues here can be related either to the detrimental impact upon a player's own health and well-being from game play or their resultant attitudes and feelings towards people experiencing mental health problems. There are a number of negative effects upon the player caused by excessive game play or exposure to certain types of content matter. Evidence shows a causal link between violent video games and subsequent violent behaviour (Barlett *et al.* 2007, Anderson *et al.* 2010). Another aspect relates to the addictive potential of video game playing, particularly with regards to frequent game players. While the evidence concerning the addictive nature of video games is unclear, Griffiths & Meredith (2009) indicate the increasing number of specialist addiction treatment clinics being set up for online video game addiction. Other detrimental effects include social isolation (Porter *et al.* 2010) or decreased scholastic performance as evidenced with elementary school pupils who were engaged in excessive game play (Skoric *et al.* 2009). A further range of mental health problems including sleep difficulties, depression, suicidal ideation, anxiety, obsessions and alcohol/substance abuse have been linked to increased playing time (Wenzel *et al.* 2009). The effects are not all negative and can be contrasted with benefits such as those recognized in Durkin & Barber's (2002) study with video game play having a positive impact upon social engagements, self-concept and school involvement. Video games contain a variety of mental health references and on the negative end of the spectrum, games such as *Batman: Arkham Asylum*; *American McGee*; *Dark Knight*; and *Man Hunt*, reinforce stereotypical and stigmatizing views and perpetuate violence-mental illness associations. This can be contrasted by games such as *Bejeweled*, *SPARX* and *Nevermind* which have significant therapeutic and educational potential. These different types of game will be examined later with regards to their negative influence or potential therapeutic value.

Video games – background factors

Video games belong to a highly engaging medium with players interacting with its various creative products for increasingly longer periods of time. It is one of the fastest growing media forms, presently outstripping sales of most other media types including music (PWC 2011) and film (Wallop 2009). In the UK alone, over 30 million video games and video game consoles were sold in 2007, outselling any other type of toy (Office of National Statistics 2007). Wallop (2011) reported that around eight in ten households in the UK own a dedicated gaming console, although it is worth also considering the potential number of computers that have gaming abilities. The international annual revenues continue to rise with the figure in dollars estimated at 19 billion in 2002 (Squire 2003), 54 billion in 2008 (National Purchase Diary 2008) and 65 billion in 2011 (Reuters 2011). This growth suggests that more people are seeing and playing video games and are therefore subject to the influential nature of their content. An important consideration for the video game industry and how it develops its games is the audience it has to market to. In the UK, 37% of the population between 16 and 49 described themselves as ‘active gamers’ (Nielsen 2008). While the popular conception is that it is mainly children who play them (Jenkins 2007), the reality however is that the majority of gamers are between the ages of 18 and 50 with the average age of video gamers being 34 (Entertainment Software Association 2011). Another statistic, noted by Hunter (2005), is that the majority of video game players are male, although the gender gap appears to be steadily narrowing with current estimates of 40% of players being female (Entertainment Software Association 2011). It is this market which is predominantly catered for by the games industry with regards to content, style and overall themes within video games. The regulators for the video game industry are the Pan European Game Information (PEGI) group and the British Board of Film Classification (BBFC). While most games are now age rated under the PEGI system those showing video footage or including grossly sexual or violent content are classified by the BBFC. The Digital Economy Act 2010 has passed into law and so the PEGI age rating system will shortly become mandatory (VSC 2012).

Batman: Arkham Asylum

This video game, winner of the 2009 British Academy of Film and Television Arts best game award, received a ‘15’ rating from the BBFC because of the large amounts of violence and strong language featured. It is set within the fictional Arkham Asylum, an institution for the treatment of the criminally insane. As the player, the object of the game is to fight your way through the asylum and catch the psychopathic Joker. This process exposes players to varied audio-visual stimuli (sound, music, imagery, characterization and dialogue), serving to engage them further with this interactive world. The player approaches Arkham Asylum along a road lined by dead, skeletal trees. The main building is a dark, imposing gothic

structure, menacingly bedecked with gargoyles. There is a sense of decay all around and the ivy-covered building shows many signs of disrepair. Following this initial unsettling impression, the game player enters the 'detention' section of the asylum, an area designed visually to look like a high-security prison. The player is then led into the 'intensive treatment' area which has a dark and oppressive feel. As players progress through the game, they are introduced to the more 'mentally unstable' inmates housed in the asylum. These patients are depicted as feral and animal-like, walking quadrupedally, using guttural noises instead of speaking and attacking anyone they come across. It represents a historical view whereby the mentally ill were considered less than human or possessed by demons (Dubin & Fink 1992). This is akin to the Hogarthian view of the mentally ill in *A Rake's Progress* where inmates are clearly distinguished from the 'normal' population and reflects Wahl's (1995) concept of the mentally ill being considered 'a breed apart' on account of their distinguishable appearance and behaviour. The stereotypical violence–mental illness association is reinforced here through a number of visual cues which help to underline the feeling of danger or levels of threat the player is exposed to. This is starkly portrayed when encountering the Joker, reported in the game as a 'violent schizophrenic', who is heavily restrained and watched closely by armed guards. It conjures up images of the grossly 'over-the-top' array of restraints used with Hannibal Lecter in the film *The Silence of the Lambs*. The effect upon the recipient though is a powerful one as each added layer of protection serves to heighten the degree of danger associated with the featured protagonist, something which reflects stereotypical notions of mentally ill people being violent or unpredictable (Morrall 2000). The feeling of unease promoted by the visual environment is reinforced by the use of chilling and disturbing music and sounds which serve to further build the tension and fear experienced by the player (Collins 2008). It can be seen in this game with changes in tempo and pitch, reminiscent of Hitchcock's screeching violins (*Psycho*) which occur when an enemy is approaching. Zehnder & Lipscomb (2006) indicate that music can significantly influence the game player's experience by highlighting the issues of importance, heightening tension and emotion as well as communicating when danger is near or approaching. We can therefore consider the impact that music has upon our emotional engagement with a game's environment communicating to us what we should feel about it (Turner 2006). The narrative language used in this game reinforces many stereotypical notions concerning mental health issues. This is observed at frequent points within the game where the player overhears guards discussing the inmates using words such as 'psycho', 'animals', 'insane' and 'freaks'. Byrne (2001) suggests that the use of terms like these help to reinforce commonly held associations about mentally ill people being violent and needing to be excluded from society.

Batman: Arkham Asylum received a 15 rating from the BBFC, although it is to be assumed that many players younger than 15 will have also accessed this game. This represents an age group significantly affected by mental health problems including depression (WHO 2012a), self-harm (Hawton *et al.* 2002) and schizophrenia (WHO 2012b). The game achieved worldwide sales of 2.83 million (Gamrreview 2011), and we can again expect many more individuals to have played this game. The

knowledge or experience about mental illness among game players will clearly be varied with individuals obtaining their information from a range of media sources, work, professional training or through personal experience regarding self, family and friends. The receipt and response to *Batman: Arkham Asylum*'s stereotypical and stigmatizing content will be partly determined by a player's previous experience and appreciation about the reality of living with mental health problems. While many are entertained and captivated by such a game, others might take offence about the issues being portrayed. This reflects elements contained within Mind's (2000) *Counting the Cost* report whereby participants commented upon the fact that discriminatory media coverage of mental health issues had a detrimental impact upon their symptoms and ability to cope. What is notable within a game such as *Batman: Arkham Asylum* is the sense of environment and world to which the game player is drawn into and can be noted through players' reviews: 'Graphics and sound in the game are fantastic, and sometimes it does present a distinct eerie feel when meeting villains' (Amazon 2009); 'For me the greatest aspect of this game is Arkham Asylum itself, the rich environment gives you a sense of wonder while remaining intimidating, without ever getting boring' (Amazon 2010). These are supported by many other game players' reviews with multiple citations about this game's excitement levels, feelings of creepiness, striking graphics, sense of suspense and total engagement. While there are a number of things that can influence how a product is received by the audience, it is clear that the overriding message that is being transmitted by this game is one that shows the mentally ill as violent and unstable.

Video game interactivity

What makes video games particularly unique when compared with other forms of media is their potential for interactivity with the environment and its characters (Shaffer *et al.* 2004). The nature of one's engagement within *Batman: Arkham Asylum* is through violent confrontations as the player is not able to choose how to deal with the inmates, having no option other than to fight them. Although there is a good deal of research into the increase in violence after exposure to violent video game content (Anderson *et al.* 2007, Anderson 2009), there is little evidence as to whether or not interactivity has an effect on the player's perception of the images he is seeing and actions he is performing (BBFC 2009). However, it is undeniable that in *Batman: Arkham Asylum*, the game player is mainly receiving a negative and stigmatizing view of the mentally ill, by seeing them all as violent and unpredictable. This commonly depicted stereotype is reinforced through countless other media products and reflects Bandura's (1986) Social Learning Theory where behaviour and attitudes are influenced by role models. With other media formats, there is a linear flow of messages from the creator to the audience, different for video games where players can actively interact with simulated environments (Lee *et al.* 2006). The video game medium is a richly interactive environment which has communicative properties not found in other media types. We can for example consider books,

newspapers, magazines, television, film and the internet which provide a mixture of written and spoken narratives, images, music and sound. Video games provide all of these as well as levels of interactivity which allows players to choose settings, participate in narrative, pursue goals, accept challenges and experience self efficacy (Ritterfeld & Weber 2006).

It is important to consider the concept of *player*, which according to Sicart (2009) is a subject that comes into being when playing a game. He gives examples of games where players are forced to perform violent or antisocial actions while being rewarded by the system. The difference between novice and experienced game players is that novices might be shocked at gruesome acts they may be compelled to make while experienced players understand that a game is designed to make players enact unethical experiences relating to character (Sicart 2009). This is a significant point bearing in mind the findings of notable social experiments such as Milgram's (2004) obedience study or Zimbardo's prison experiment (Haney *et al.* 1973) where participants were significantly influenced in their responses and engagement. Experienced game players though are not necessarily experienced or knowledgeable when it comes to appreciating what the realities are concerning mental health problems. This might be the case with *Batman: Arkham Asylum* where mentally deranged inmates could be engaged in combat with the belief that that is how residents of a mental health facility act. A further point to note is that while a person's rational understanding might be that this does not necessarily reflect reality, their emotional response could still be one of uncertainty when contemplating the mentally ill as a group in society.

The classifications attempt to ensure that young people are not exposed to content in video games that is unsuitable; however, the BBFC (2009) has acknowledged that the interactivity in video games makes for a very different experience to watching a film or television programme and in certain contexts, subject matter such as violence or drug abuse could have a more profound effect on the video game player than the film viewer. This raises a question over the effectiveness of having the same classification system for the two very different media types. From a mental health perspective, the available regulations governing all types of media can be regarded as particularly ineffective (Philo 1996). Besides addressing suicide, self-harm and substance abuse, guidance from core regulatory bodies such as Ofcom (broadcast media), National Union of Journalists/Press Complaints Commission (print media) and the British Board of Film Classification (film) have only vague mental health references at best (Morris 2006). Media products continue to exhibit discriminatory content and reinforce stereotypical notions concerning mental health issues. What is needed is a regulatory body that takes mental health discrimination more seriously as racially abusive references for instance are much more likely to receive sanctions and widespread condemnation. This is facilitated through highlighting the harmful effects caused by stereotypical and stigmatizing messages as well as the perpetuation of erroneous beliefs. It is beginning to be addressed with initiatives such as *Time to Change* (UK), *Mindframe/Response Ability* (Australia) and *Mental Health America* (US).

Mental health education: building empathy

As with other media types, the video game industry needs a far better range of products which depict mental health themes in a more positive and informative light or provide a means of creative expression for those with first-hand experience. The ever-increasing number of players indicates high exposure rates for its products and the interactive nature of this medium offers rich potential for expression concerning the lived and felt experience of mental health problems (Wilkinson *et al.* 2008). Other media formats provide some very effective examples of what it might feel like to live with various mental health experiences (Morris 2006). Television documentaries for example feature individuals including Freddie Flintoff (depression), Terry Pratchett (dementia) and Stephen Fry (bipolar disorder) talking frankly and openly about the experience of living with a mental health condition. The film industry offers movies which educate as well as entertain audiences about the reality of mental health experience with titles such as *Some Voices* or *A Beautiful Mind* reflecting a more realistic portrayal (Time to Change 2009). We can also look at the rich vein of expression offered by the music industry with artists creating songs and lyrics from their own internal experience, for example Professor Green's *Forever Falling* (about his father's suicide), Amy Winehouse's *Rehab* (a song about drug rehabilitation programmes) or the Eels' *Electro-shock blues* album (songs reflecting Mark Everett's experience of his sister's suicide and his mother's death). A recent mental health promotion initiative run in Leeds from September to November 2011 was the *Love Arts Festival*. This was headed up by Ruby Wax and Phil Hammond and incorporated a range of creative media forms such as art, literature, theatre, music, dance, film and poetry. These events provided an impressive array of creative material concerning themes and experiences of mental health and were informative as well as engaging. It would have been well complemented by the inclusion of products and material from the video game industry. As with many of the featured examples, this need not require the inclusion of commercially produced games but could represent this richly expressive media type as a platform for self-expression. *Batman: Arkham Asylum* depicts the caped crusader fighting mentally deranged foes and ticks a number of classic stereotype boxes. Superheroes can also be employed as emotional *guides*, leading us on more of an educative journey, promoting awareness of the felt and lived experience of 'real' mental illness. Their comic book counterparts have done this on many occasions revealing aspects of their inner, vulnerable side including personal suffering and trauma. Bruce Wayne (Batman) developed his alter ego as a consequence of the tragic death of his parents. Many other heroes, and villains, were created as a consequence of traumatic experience such as Peter Parker (Spiderman) or Frank Castle (The Punisher). Some continue to wrestle with deteriorating mental health states and have expressed suicidal ideation (Hank Pym). Indeed, their tormented suffering and struggles to cope have been graphically depicted through numerous comic books providing readers with a more engaging and empathic awareness of a character's psychological distress. It is a

format that is ideally set up to allow readers unique access to direct thoughts and feelings. All of these elements would perfectly suit the video game format including character driven or role playing games like the *Sims* where game players create virtual people and direct their moods and actions. This is where Batman or other notable role models could act as narrator or guide revealing something of their own personal experience as well as meeting other characters and having the opportunity to briefly enter and understand their internal frames of reference. It would for instance enable the game player to acknowledge feelings of fear, rejection and stigma faced by those with mental health problems, even somewhere like Arkham Asylum.

The immersive and interactive potential of video games is interesting mental health professionals with regards to their educative and health promotional capacity. The variety of game types available include 'serious games', titles developed for learning purposes which incorporate both entertaining and educative features (Ratan & Ritterfeld 2009, Shen *et al.* 2009). According to Klimmt (2009), as well as educating, games can affect beliefs and thoughts bringing about attitudinal change. Changing attitudes and beliefs about mental health issues is needed in order to help tackle discrimination and stigma. A notable example is the video game *Shaded*, created by three boys with Asperger's, which is designed to make players think about mental health conditions with characters such as Manic Panda, SAD Bat, Bulimic dog and OCD squirrel (BBC 2011). This engages Davis' (1980) concept of fantasy empathy, the ability to use one's imagination to transpose oneself into the actions and feelings of fictitious characters. The level of immersion with some games can be such that players become upset when sensing a character's distress (Snodgrass *et al.* 2011). Therefore, by utilizing the right types of games, health-care learners have valuable opportunities to appreciate more of the internal experience of mental health problems. This would help to better contextualize issues and provide education as to some of the realities concerning service-users' lived and felt experience.

Therapeutic engagement

As well as using video games for educational purposes, there are many potential therapeutic applications. They can be employed directly within psychotherapeutic work helping to build engagement and relationships (Coyle *et al.* 2009, Ceranoglu 2010). Games can also have a positive impact upon mood such as the fantasy game, *SPARX*, which has helped young people learn cognitive behavioural therapy techniques for dealing with symptoms of depression (Merry *et al.* 2012). Another title, *Bejeweled* has proven effective in improving mood in adults (Russoniello *et al.* 2009). The game *Nevermind* has helped players confront fearful scenarios and develop ways of coping with stress (Reynolds 2011). Within secure settings, Gooch & Living (2004) report upon the importance of video games in the rehabilitation of forensic service-users which offer access to a safe virtual environment, a useful therapeutic tool when such opportunities are limited. Kahlbaugh *et al.*'s (2011) study illustrates the benefits of using the Wii with older adults, enhancing well-being, reducing

loneliness and isolation and improving mood. One core aspect noted was the recreation of experience of previously enjoyed activities to help regain psychological benefits once afforded. Comparisons here can be drawn with the positive physical and psychological changes noted in Ellen Langer's (1981) classic Harvard study with eight elderly men who were given the experience of living 20 years earlier. She and her team created a living environment complete with food, films and photos from the period, and they discussed news, politics and sport in the present tense as if they had travelled back in time. This could all be replicated in the game world with a stimulating and impactful experience being created, something which would also have great potential as a reminiscence activity to be used within dementia care. There is clearly a huge therapeutic potential for video games being developed in relation to a wide range of health needs and is applicable to individuals across the lifespan.

Recommendations

To sum up, there are a number of recommendations that can be made concerning the use of video games for promoting mental health. These are:

- Review existing game titles for therapeutic potential
- Promote the use of appropriate games for therapeutic purposes for all age groups
- Facilitate the employment of video games for service-user expression
- Include video games in mental health initiatives/festivals
- Encourage collaboration between mental health professionals and game producers to develop specific games
- Campaign to produce effective regulation, tackling inappropriate examples and promote less discriminatory content

Conclusion

This article has explored the video games industry with regards to coverage and presentation of mental health issues. It focused initially upon a high profile game *Batman: Arkham Asylum* which features stereotypical and discriminatory mental health representations commonly found within other video games. This is symptomatic of other popular media types, i.e. tabloid newspapers, television soaps, drama programmes and psycho-killer films which are heavily influenced by commercial incentives. With the video games industry, what is needed is a regulatory body which takes mental health discrimination more seriously. They also need to adopt a stronger educational role with a range of notable role models within games positively promoting mental health. It is something that the film industry and other media types have started to do, and it would be productive to see video games following suit (Portnow *et al.* 2010). This would help to pave the way for a greater understanding of mental health experience and further challenge stereotypical notions. It is a rich medium with a wonderful capacity for education and health promotion, especially on account of its engaging and interactive qualities. There are a number of games and products already being used for therapeutic purposes with

online worlds offering a unique opportunity for narrative content and remote interaction with therapists and fellow service-users (Wilkinson *et al.* 2008). Video games provide opportunities for self-expression as well as valuable opportunities to 'experience' others' lives and learn from their unique perspective. Another special quality of video games is their ability to engage players with worlds and experiences which may take them beyond their bodily or environmental restrictions, offering huge therapeutic benefits for service-users in secure accommodation or those who are elderly, infirm or disabled. In essence, video games provide numerous educational and therapeutic benefits for service-users, health-care professionals and students. This relates to challenging stereotypical views, facilitating service-user expression, raising awareness about the realities of mental health experience and in providing a broad range of therapeutic resources.

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Appendix 2 - Publication 5: *First-Person Media*

Developing awareness and understanding amongst mental health nursing students of the lived experience of dementia with the aid of selected first-person media resources

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Abstract

This study examines the influence that first-person media products (film, television, internet, books and newspapers) have upon promoting empathic understanding of the dementia experience amongst mental health nursing students. A designated mental health nursing learning group ($n=36$) was provided with a series of media products where personal dementia narratives were expressed. A grounded theory approach was used with focus group interviews conducted following each of the five designated media activities. This generated a variety of themes and concepts which were analysed in conjunction with responses from a subsequently distributed questionnaire and module evaluation. The first-person narratives were viewed as having a strong emotive impact upon students as well as promoting a broader understanding of how dementia impacts upon a person's day-to-day life and the experience of family and carers. This facilitated the reframing of behaviours commonly considered 'challenging' with more of a person's internal experience being recognised. A common concern, despite the stated value of these resources regarded the potential in becoming overwhelmed by informational and emotional content. This study highlighted the need for facilitators to carefully select first-person products with consideration shown to the expressiveness of narrators and the range and type of experience recounted. It also indicated the importance of adequately preparing students for what they were accessing and subsequently assisting them in processing the lived dementia experience. Whilst only accessing a small sample of narratives, all students expressed feeling better prepared for practice and having a more questioning and reflective approach towards the internal experience of those they were engaged with. This approach has much to offer

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from an attitudinal perspective and could form the base for training packages involved with dementia learning, especially given the current drive towards person-centred, compassionate and 'caring' practice. Further study in this area is required.

Keywords

cognitive impairment, dementia, grounded theory, nursing education, older people

Introduction

Each individual's experience of dementia is unique and can be contextualised within their personal frame of reference. What a person with dementia might be thinking and feeling though can be very hard for others to comprehend, especially when communicative and cognitive abilities are declining. This gives rise in practice to the potential for misunderstanding and for care needs to be insufficiently met. The need for health care practitioners to be more mindful about the needs and experiences of those they are working with is strongly advocated within the Department of Health's National Dementia Strategy (Department of Health, 2009). It is the intention of this study to examine the influence that first-person media products have upon promoting empathic understanding of the dementia experience amongst mental health nursing students. Whilst a broad spectrum of media types is involved, those featured in this study relate specifically to film, television, internet, books and newspapers. The media products used were purposely chosen for the breadth of personal experience and the types of narrative/'story' being related. They illustrate the fluid states that can exist between vulnerability and resilience as well as ways in which individuals and families are impacted upon. The examples listed below were selected because of the range of experience being recounted, quality of discussions generated with previous student groups and comments within module evaluations about their positive influence upon learning.

- Feature film – *Iris* (British Broadcasting Company and Eyre, 2001). Based upon John Bayley's autobiographical account concerning his wife Iris Murdoch's Alzheimer's disease and the impact it had upon them individually and as a couple. This film has a particularly strong person-centred feel featuring a number of scenes exploring their lives pre- and post-dementia.
- TV documentary – *My Life on a Post it Note* (Clough, 2006). Featured an articulate woman with early-onset Alzheimer's disease trying to maintain her independence in the face of her steady deterioration and the concerns of her daughter and health care professionals. It is a thought provoking and very emotionally impactful resource.
- Autobiography – *My Journey into Alzheimer's Disease* (Davis, 1989). Selected chapter 'The Abnormal Changes so Far' focuses upon the narrator's day-to-day experiences and contextual experience of dementia. This was chosen because of the clarity with which the author contrasts his internal experience (thoughts and feelings) with his subsequent behaviour and responses to others.
- Internet site – *Living with Dementia/Talking Point Forum* (Alzheimer's Society). Guided study offering students a range of personal accounts from individuals with dementia and

carers. This site contains a wealth of first-person narratives and discussion threads concerning day-to-day experiences.

- Newspaper article (Metro) *So near and yet so far* (Stevenson, 2007). Outlines a young woman's experience and feelings about her father's dementia. The important feature concerning this article is the broadening of the dementia experience to consider impact upon the wider family.

Empathic learning and media resources

The recent findings of the Francis inquiry report (Mid Staffordshire NHS Foundation Trust Inquiry, 2010) identified widespread institutional deficiencies and a poor caring culture being demonstrated in the services examined. We can also consider the Department of Health's (2012) *Compassion in Practice* which advocates examination of what is meant by *caring*. The need for empathic, person-centred care for individuals with dementia is recommended by the National Dementia Strategy *Living Well with Dementia* (Department of Health, 2009). This reflects the work of Tom Kitwood (1997) and Naomi Feil (1997) concerning the importance of *tuning in* to an individual's world and recognising something of their internal, *felt* experience. It illustrates the concept of 'mindfulness', a counter to the predominant medicalised perspective with which dementia care still endures. Students who are being trained within health care disciplines need to be aware of the reductive interpretations that can be associated with the medical model where pathology takes precedence to the person. Holistic care or approaches such as the social model encompass a wider range of issues and enhance the degree of person-centeredness applied to those being worked with. The importance of fostering mindfulness amongst mental health students concerns the development of a reflective care approach and the delivery of effective individualised care. This can be regarded through frameworks such as O'Connor and Seymour's (1990) interpersonal model which illustrates the dynamics operating between two parties, in this instance health care practitioner and person with dementia. The importance of this is in being able to contextualise a person's internal experience and better understand their external behaviour, for example reframing 'aggressive' behaviour as stemming from feelings of powerlessness, frustration or fear. Mindfulness in this instance means acknowledging their internal experience and conveying an understanding of this back to them. Compassionate care will only flourish when the whole person (rather than merely their pathology) is recognised.

The media provide a multitude of opportunities for individuals to learn about direct mental health experience with engaging and informative products to be found across all source types (Morris, 2006). Sieff (2003) outlines the media's importance as a primary communicating agent with regard to mental health issues. This is supported by McQuail (2005) who outlines the potency of the mass media as a force for public enlightenment. The internet in particular offers individuals a range of resources for sharing experience and information through social networking sites such as Facebook and Twitter or online discussion forums which include the Alzheimer's Society's *Talking Point Forum*. Neil Hunt from the Alzheimer's Society asserts that media products offer a valuable resource in helping to change attitudes and awareness about dementia (Coventry Telegraph, 2008). Media resources outlining experience from a first-person perspective provide us with

examples which can be impactful and enhance understanding and awareness about the lived and felt experience of dementia.

The use of media products complement what is learnt from other core sources including clinical practice, personal experience and related research. These other sources offer valuable learning potential although have their limitations. Students' practice learning can be restricted to what is individually encountered during a defined timescale. It is also dependent upon the type of placement a student is allocated to (i.e. community, day service or residential care), available learning opportunities, the level of cognitive impairment/communicative ability encountered and the quality of reflective supervision offered by the clinical team. As a consequence, what is experienced and learnt will differ greatly from one student to another. Using media narratives allows experiences to be accessed collectively and reflected upon and discussed within the group, thereby facilitating the quality of learning being taken away (Morris, 2011). It has been noted that students commencing the dementia care component of their training relate varying levels of prior personal experience with some sharing very insightful comments concerning the dementia experience and its impact upon the family. It is notable that others report little or no personal experience. There is a wide range of research available documenting the dementia experience and with regard to the person with dementia includes aspects such as loss (Robinson et al., 2005), worthlessness (Steeman et al., 2007) and anxiety and depression (Bird and Blair, 2010). For the carer, it incorporates elements such as guilt and anger (Davis et al., 2011), stress/burden (Etters et al., 2008) and anticipatory grief (Holley and Mast, 2009). Whilst research articles and text books expound upon many facets of the dementia experience, it can sometimes be difficult to fully appreciate the emotional component or the contextual issues of actually living with this condition. When considering the *felt experience* of dementia, it becomes more clearly understood when placed in context and personalised through biographical narratives.

Methods

Developing person-centred, empathic approaches to working with individuals with dementia requires practitioners to have exposure to phenomenological, auto-ethnographic and other forms of personal lived experience evidence. This study provided mental health students with access to a range of first-person media narratives recounting aspects of a person's lived dementia experience. Narrative communication allows service users and health professionals to understand and constitute illness experiences (Gray, 2009). This reflects Bruner's (1991) view of narratives representing individuals' personal and collaborative construction of reality. Narrative research utilises a range of qualitative methods including that of grounded theory. An example of this relating to media narratives involves Fleischmann's (2005) thematic analysis through grounded theory of websites for parents of children with autism. A grounded theory approach was used with this study, concerning first-person narratives of the dementia experience, generating data through focus group interviews, questionnaires and module evaluations. Grounded theory provides opportunities to see beyond what seems obvious and progress towards more open and imaginative interpretations (Charmaz, 2006). Initial engagement and understanding amongst students was captured through a series of short focus group discussions which followed the accessing of each media product. This inductive phase generated a variety of themes and concepts which were analysed in conjunction with the questionnaire responses

(Corbin and Strauss, 2008). There was an initial open coding and categorisation of data following the focus group interviews with a selective coding and refining of categories after the questionnaires had been completed (Holloway and Todres, 2010). Further reflections were collected through specific responses from students in their evaluative feedback concerning the learning module.

A designated mental health nursing group containing 36 students was involved in this study. They were all at the time of the study in the second year of their training, on dementia care placements and undertaking a corresponding taught module. They had since the start of their programme been required by clinical placement availability to be divided into two sub-groups comprising 18 students each and taught separately. All students were deemed eligible and there were no exclusion criteria. This was felt to be a representative sample with students in these sub-groups matching the background and mix found in previous cohorts. It was a convenience sample utilising the most readily accessible participants for this study (Haber, 2010). Theoretical sampling was signified as no further variation was noted with the second sub-group of students (Wuest, 2007). Focus group interviews and completion of questionnaires occurred at the same point within the module for each sub-group, and no changes to content and design were made. Consent was sought from all participants. Full details about the study were provided, and anonymity and confidentiality were assured. Students were prepared for each of the five media activities through the provision of verbal instructions and opportunities for questions allowed. A corresponding worksheet was given in each instance to help guide reflection. A short focus group discussion followed each activity where engagement with the personal narrative was shared. The media products were evenly spaced and offered at two-week intervals. After all media products had been accessed, a more detailed evaluation was covered through the completion of a questionnaire and later module evaluation (for timeline, see Figure 1). Approval for this study was obtained through the University's School of Healthcare Research and Ethics Committee. As a study it has a strong ethical orientation, encouraging students to see the person and not merely their condition. Information sheets detailing this study were given to all students and consent sought concerning inclusion with the questionnaires. All students were required to be included with the activities, focus groups and module evaluations as part of the learning programme. Anonymity within this study was assured.

The focus groups utilised a semi-structured interview process with questions contained in a guide outlining areas to be considered (see Appendix 1). A benefit of interviewing is the freedom offered to prompt for more information (Holloway and Wheeler, 2010). Questions covered the sub-types identified by Patton (2002) concerning experience, feeling and knowledge. Whilst Goodman and Evans (2010) recommend group sizes of between five and 12 members, in this instance the total group ($n=36$) were divided into two smaller groups with 18 students each. The students had already been together in these sub-groups for over a year and therefore were felt to be able to participate appropriately. As Holloway and Wheeler (2010) state, focus group interviews differ from individual interviews as members respond to the interviewer and fellow participants, stimulating debate about the topic. This was observed within the focus groups with some thought-provoking data collected.

A questionnaire to gather further data was offered at the end of the teaching module (see Appendix 2). This questionnaire was designed in collaboration with colleagues from both research and education backgrounds. Questions were then checked for readability and clarity with other tutorial staff. The use of questionnaires is regarded as a useful data collection method providing respondents with anonymity and enabling a wide range of

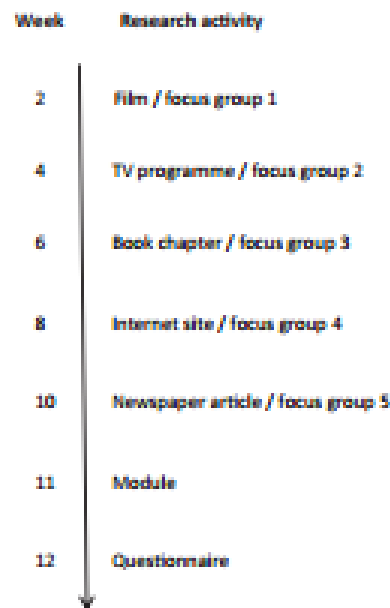


Figure 1. Timeline.

information to be gathered quickly (Bowling, 2002; Polit and Beck, 2010; Sullivan-Bolyai and Bova, 2010). The questionnaire design utilised a range of question types with some open and others using Likert scales. These focused upon respondents' perceptions concerning the media resources accessed. Close attention was given to the questions which were structured along with colleagues' comments. As Fain (2009) outlines, designing good questions that are easy to answer while focusing on the issues and information to be collected is essential to developing a good questionnaire. The questionnaire was completed by 32 respondents (four were absent on the day it was distributed) who are numbered (R1–R32) and listed anonymously. Strauss and Corbin (1998) outline the process whereby researchers differentiate between significant and less important data through developing provisional ideas and themes which are examined over time and confirmed by the data. This was carried out with the assistance of field notes and memo writing, a process outlined by Charmaz (2006) as enabling researchers to create robust categories through moving back and forth between emerging categories and data. Further feedback was gathered through module evaluation, with responses made to specific questions around the first-person narrative activities. These were broad questions aimed at ascertaining students' thoughts about their exposure to these resources as well as what they found helpful and recommendations for further use.

Results

The two audio visual media types of TV and film featured most prominently (see Figure 2), concerning the emotional intensity of these products and the enhanced level of understanding promoted. The added components of spoken dialogue and music were highlighted by students as helping to engage them with individuals featured on screen.

Please indicate in rank order, your most impactful media example, putting 1 next to the most impactful through to 5 for the least impactful
(1 = highest; 2 = second highest; 3 = third highest; 4 = fourth highest; 5 = lowest)

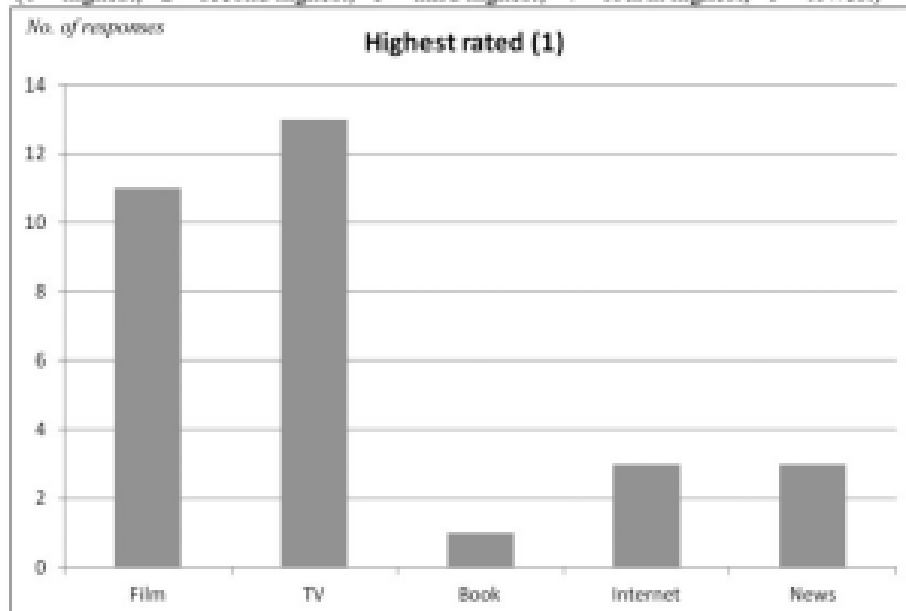


Figure 2. Highest rated media resource.

The film *Iris* was very moving and sad. However it helped me to develop an understanding and appreciation of the experience of individuals with dementia. (R.7)

The importance of emotive engagement is that it evokes the psychotherapeutic concept of 'here and now' (Inskipp, 2000), illustrating the immediacy of what is experienced and a real feeling of involvement with those featured. This demonstrates Horton and Wohl's (1956) *parasocial relations* with recipients feeling emotively connected with those featured. In this study, the majority of students noted an enhanced appreciation of the person residing within the condition of dementia and their changing relationships. It reflects Kitwood's (1997) concept of personhood and acknowledges the wider context of *dementia* as a societal problem (embedded in social relations) rather than a condition that merely affects individuals. This was an important connection for students to consider concerning influences from family, carers and the social environment.

A frequently commented upon theme related to a person's ability to cope, with polarised aspects such as *struggling* and *coping well* both featuring strongly. Media examples featuring people living positively with dementia were seen as thought provoking with attention directed more towards what individuals *can do* as opposed to the more frequently considered *can't do*.

I found this documentary both humorous and sad as it showed how dementia can affect somebody positively. It was refreshing to get a more positive insight into the lived

experience, whilst taking into account the more challenging effects on family and independence. (R11)

The personal 'story' recounted in examples such as this refocuses the dementia experience away from the more commonly depicted tragic narrative. In other words, life can be good sometimes even with dementia. This perspective was developed further through the identification of strong personal characteristics being held by some people with dementia. Comments in particular centred upon the woman in the documentary with terms such as 'resilient', 'humorous' and 'engaging' being used. Likewise, students reading Robert Davis' book chapter admired his firm determination to cope positively with life despite facing increasing limitations. Examples such as these bring to life the National Dementia Strategy's (Department of Health, 2009) and the Alzheimer's Society's notion of *Living Well with Dementia*.

The written narratives in particular were acknowledged by students as containing depth of expressiveness concerning personal thoughts and feelings. This was valued as helping to appreciate more fully the person's internal world.

It was good learning from someone with the disease and how they felt and dealt with it. (R15)
Showed feelings and emotions surrounding early onset dementia, including anger towards the illness and people's concepts towards it. (R1)

There was a sense conveyed by students about having greater insight about the impact that dementia has upon a person's life. This helps to contextualise theoretical aspects by relating them more meaningfully to individuals' felt experience. There was a broad consensus amongst students that 'challenging behaviours' need reframing and acknowledging from a person's internal perspective which supports Feil's (1993) assertions of there being reasons behind all disoriented behaviour. There are many practice implications here with feelings such as frustration, fear and helplessness being recognised and responded to instead of merely a person's observed behaviour (Morris and Morris, 2010). This was recognised by students in the need to attend more fully to the internal 'drivers' behind a person's behaviour.

A further issue of importance concerning the variety of narrative perspectives featured was the hearing of relatives' 'stories'.

This article was an eye-opener. It was refreshing to see the frustration and guilt the family were feeling as well as the person with dementia. (R23)

Many other responses supported this statement illustrating the need to broaden understanding to encompass the impact that dementia has upon the whole family group. Whilst breadth of experience was valued, an interesting problem identified by students concerned levels of saturation with information and emotional overload being reached. The internet in particular with its vast array of resources was regarded by some students as daunting concerning the amount of material available.

Although insightful I did find this a lot to digest in one session. As a point of reference though it is excellent. (R12)
Was really good but too much information to be read at once. (R22)

These responses highlighted the need to carefully structure the students' experience, as whilst they were directed towards specific discussion threads the temptation to browse further was

Media resources accessed on this module have made you more appreciative of a person's internal experience (thoughts and feelings) with regard to people you have been engaged with in clinical practice.

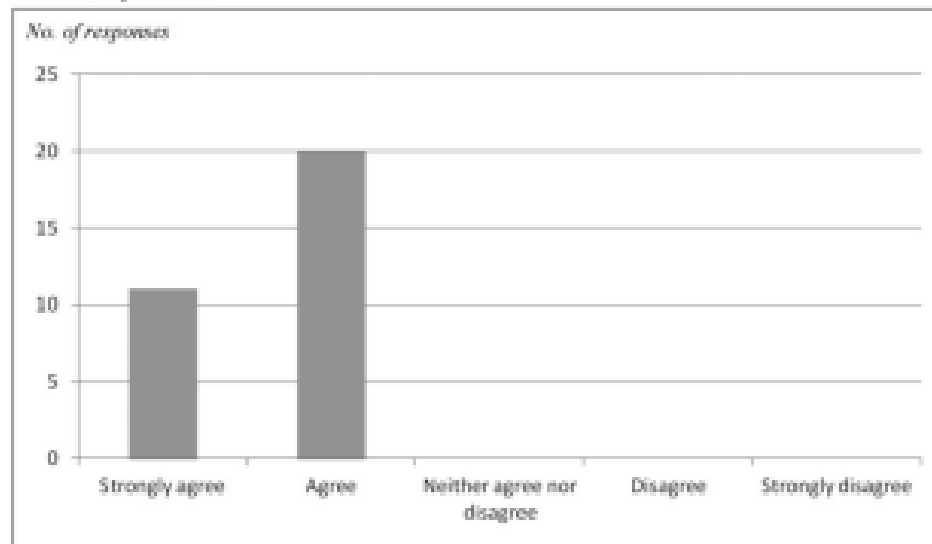


Figure 3. Understanding internal experience.

clearly apparent. The feeling of overload also concerned prolonged exposure to distressing narratives.

It is always sad to read someone's personal experiences of any illness, but with reading I just get to the point of saturation. (R5)

Whilst the thoughts and feelings within personal narratives can be enormously thought provoking, consideration clearly needs to be given to students' overall experience of immersion within content which is distressing. Potential problems here would involve becoming detached and distant from individuals' internal experiences.

A particular point of interest concerned students' deeper levels of critical reflection as dementia learning progressed. This related to their progressive exposure to the first-person media products during the course of this study as well as those they had accessed before.

I had watched this film before knowing about dementia and it didn't make sense then. Very educative, informative and eye-opener. (R8)

This reflects Kolb's (1984) experiential learning cycle with deeper levels of understanding being generated through successive reflective episodes. The notion of interpretative recipient is reflected here illustrating how perceptions can be modified in light of on-going learning and experience. It also acknowledges the quality of the facilitated learning experience which enabled students to become 'tuned in' to specific elements. The process of accessing the selected media narratives was regarded as helpful with all participants agreeing that it had made them more appreciative of a person's internal experience of dementia (see Figure 3), with specific comments reflecting the need to recognise the person within the condition.

Discussion

A key aspect concerns the emotive impact that personal narratives can have upon those accessing them. This relates particularly to the audio-visual media types (film and television) which appear from students' feedback to have been the most influential. It can be regarded through Gestalt theory which illustrates a process of *figure and ground* whereby certain components from our perceptual field stand out and become more noticeable (King and Wertheimer, 2005). This can be related to the influence of emotive learning upon memory which is enhanced for central details and impaired for peripheral ones (Shafer et al., 2011). It operates at various stages of the retention and consolidation process, with emotive arousal increasing what is retained (Christianson and Engelberg, 2006; Laney et al., 2004). From this, we can reflect upon the process of exposing learners to material which is rich in expressive and emotive content. This was commented upon as impacting upon and helping to shape their resultant understanding. Whilst this claim would warrant further testing, the heightened attention upon *lived experience* offers students a valuable point of reference when engaging in practice. This was indicated in subsequent discussions when processing and reflecting upon media examples with students. The television documentary for example challenged a number of previously held ideas and understanding about 'dementia sufferers'. What they witnessed was a multi-faceted view of a woman's dementia experience. Whilst she had periods of despair (including thoughts of suicide), she also expressed herself with a great deal of warmth and humour and demonstrated on the whole a sense of living positively with her deteriorating condition. This prompted further thoughts and discussion amongst students around the theme *Living with Dementia* which is notably addressed by the Alzheimer's Society and the National Dementia Strategy (Department of Health, 2009).

Students commented upon enhancements in awareness and learning concerning a person's internal dementia experience. This reflected a development of insight whereby a range of 'challenging' behaviours were newly reframed and understood. What became evident during this process was the need for guidance, helping students to prepare for the media products accessed and subsequently to reflect upon and process new learning generated. Ausubel's (1968) assimilation theory highlights the importance of initial input in helping to prepare learners for accessing new material. This was facilitated through the provision of introductory input (classroom tutorials and reading material) concerning the dementia experience. Worksheets were provided for use with each media resource helping students to tune in to salient aspects and acknowledge the significance of what they were looking at. This was followed by opportunities for personal reflection and classroom discussion. This approach relates to Kolb's (1984) experiential learning cycle where reflection upon experience allows new concepts to be formed which can subsequently be tested out in practice. The reflection upon media products (*experience*) promoted discussion around a range of themes, a core aspect concerning the appreciation of internal experience and its influence upon external behaviour (O'Connor and Seymour, 1990). This enabled students to begin reframing some of the commonly observed 'challenging' behaviours. The biographical narrative (book chapter) accessed was cited as being particularly helpful in enabling underlying emotions and thoughts to be glimpsed. It highlights a particular strength of this media type whereby first-person narratives offer readers a view of a person's inner world through the perspective of *inside looking out* (Morris, 2006). This reflects Lothe's (2000) assertion of the reader becoming active within the body of writing. We can also regard Genette's (1995) concept of internal focalisation where narrative is recounted through the consciousness of a character (factual or fictional). This enables a degree of identification and helps to promote empathic learning. The

importance here is the ability of learners to subsequently question what they are encountering in practice, including the observed behaviours of those with dementia and their family/carers. This would help decrease the use of less appropriate interventions, i.e. automatically offering sedative medication for agitated behaviour and instead promote responses which meet the internal needs and well-being aspects of those concerned.

A potential difficulty with accessing personal narratives involves becoming overwhelmed and needing to withdraw from what is being accessed. It concerns two particular components, informational and emotional content. With regard to the latter, there were some very clear comments from students stating how sad certain media products made them feel. Whilst this can promote impactful learning, feeling oversaturated is likely to evoke distancing responses or dissuade engagement with further examples. The process of empathy requires individuals to 'connect' and engage with another's felt experience. The problem though relates to the degree of distress that individuals can remain with before becoming emotionally overloaded and needing to psychologically distance selves (Gladstein, 1983; Haugh and Merry, 2001). Saturation also related to informational content with internet resources being specifically commented upon. The proliferation and scope of available material on the internet can easily cause information overload (Cooke, 2001; Scrivener, 2002). Particular mention was made about the Alzheimer's Society's *Talking Point Forum* to which students were directed. This has over 25,000 discussion threads and 300,000 individual posts. The problem of overload was minimised in this instance by offering clear guidance restricting them to designated examples and asking them to comment solely upon the experiences posted. What is evident is that students can quickly become overwhelmed by both informational and emotive components. The need is to facilitate what is being accessed and learning that can be taken away. Over saturation will mean the impact factor becomes diluted and the process can become stressful and wearisome. There is a need therefore to attend to the amount of first-person narrative material offered to students as well as the available timeframe for accessing it. Guidance and support is needed to prevent feelings of saturation.

Given the above discussion points of emotive impact, learning potential and saturation concerns, there is a significant issue concerning that of media selection. One factor clearly related to is that of the expressive ability or charismatic appeal of the narrator. Other issues concern source types with some more captivating and engaging than others. Audio-visual resources were clearly seen as being the most emotively impactful with comments about the realness of the experience and the opportunity to live the moment along with the narrator adding potency. Written narratives offered depth in terms of expression concerning the person's thoughts and feelings. This helped reframe and appreciate experience from another's internal frame of reference. It is essential to recognise though that each first-person media example is unique, reflecting Kitwood's (1997) assertion that there are as many types of dementia as there are people with dementia. What appears to be particularly significant with regard to first-person dementia narratives is the difference in the types of experience recounted. 'Stories' reflect an ever-changing view with both resilience and vulnerability featured. Narratives might feature heroic figures coping valiantly or overburdened individuals struggling to cope. Each person has their own unique story to relate with the totality of narratives representing an ever-changing plateau featuring both highs and lows. There is a need therefore to help students appreciate this point and to not 'fix' their understanding based upon a restricted sample of experiences. Therefore, sufficient breadth of narratives is needed featuring experiences of coping and struggling, different stages of the condition, as well as the perspective of the person with dementia and

family members. Different types of media source offer further variety and examples other than those used in this study can certainly be considered, i.e. works of art/paintings, poetry, radio programmes, songs and plays. This is all complemented through opportunities for reflection and processing of what is being accessed to maximise learning potential.

Conclusion

The results of this study highlight the value of accessing first-person narratives in terms of broadening understanding and heightening appreciation of the lived dementia experience. Whilst individual narratives cannot simply be generalised to fit a wider range of experience, accessing first-person accounts can help those involved in health care to become more questioning and mindful when working in practice. The study being reported here is only based upon a small number of mental health nursing students although indicates a valuable learning potential of using first-person media accounts within dementia care learning. Its use in practice could also be considered by students and clinicians across a wide range of educational and service establishments forming a core component of dementia care training. There are a number of issues for educationalists to bear in mind though when selecting such resources including type and range of examples. These can be chosen for their expressive potential, range of perspectives and content. It is important to sufficiently prepare students for what they are being exposed to with opportunities to reflect upon what is being learnt and experienced. The potential problem from saturation needs to be considered with adequate opportunities for students to break off and process what they accessing. Appropriate levels of support and supervision from teaching personnel are needed given the acute level of emotional resonance such resources can have. It is not intended for this approach to be carried out in isolation but to be offered as a complementary learning resource, alongside related clinical practice placements. As well as helping to develop understanding, this approach has much to offer from an attitudinal perspective. With the current drive towards person-centred learning and service-user involvement, it is essential that practitioners are more mindful and aware about the internal world of those they are working with. This helps us more effectively develop partnerships with individuals experiencing dementia and carers. Further study in this area is clearly needed with a larger number of students accessed as well as continued evaluation of the learning impact from using these resources.

Key points for policy, practice and/or research

- Audio-visual resources have the potential to engage recipients very powerfully on an emotive level.
- Written narratives offer a deep level of engagement with narrator's thoughts and feelings.
- First-person narratives help recipients better understand internal experience and reframe observed external behaviours.
- Facilitators need to be mindful of the potential for over saturation amongst students of lived experience material.
- Support for students is needed before, during and after the accessing of first-person narratives.

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Appendix 1 – Focus group questions

- (1) How did you feel about accessing this media product?
- (2) What did you like about this media product?
- (3) What did you not like about this media product?
- (4) How was your understanding about the lived experience of dementia enhanced through accessing this product?
- (5) Do you have any further comments about this experience?

Appendix 2 – Questionnaire

Developing awareness and understanding of the lived experience of dementia with the aid of selected first-person media resources

- (1) Please comment upon how your understanding of the *lived experience of dementia* has been influenced through your exposure to the following media sources:
 - Film – *Iris*
 - TV documentary – *My Life on a Post it Note*
 - Book Chapter – *My Journey into Alzheimer's Disease* (Robert Davis)
 - Internet guided study (*Alzheimer's Society*)
 - Newspaper article (*Metro*)

- (2) Please indicate in rank order, your most impactful media example, putting 1 next to the most impactful through to 5 for the least impactful

(1 = highest; 2 = second highest; 3 = third highest; 4 = fourth highest; 5 = lowest)

Media source	Allocated rating
Film – <i>Iris</i>	
TV documentary – <i>My Life on a Post it Note</i>	
Book Chapter – <i>My Journey into Alzheimer's Disease</i> (Robert Davis)	
Internet guided study (Alzheimer's Society)	
Newspaper article (<i>Metro</i>)	

- (3) Please comment on what made your highest rated choice the most impactful for you
- (4) Media resources accessed on this module have made you more appreciative of a person's internal experience (thoughts and feelings) with regard to people you have been engaged within clinical practice?

PLEASE CIRCLE THE TERM WHICH MOST APPLIES

Strongly agree *Agree* *Neither agree nor disagree* *Disagree* *Strongly disagree*

- (5) With regards to your response in question 4, can you give an example from practice
- (6) What else, besides the selected media resources accessed on this module, has influenced your understanding of the *lived experience* of dementia

Many thanks for taking the time to complete these questions

Appendix 3 - Publication 6: *Online Resources*

Education can be fun: A qualitative study exploring the promotion of learning through the use of creative and engaging online resources

Introduction

This study examines the interactive qualities of an e-learning course and participants' views about their involvement with the different types of learning materials offered. It reflects specifically upon aspects such as style, content and functionality and the impact that these features have upon attention and engagement. The e-learning course in this instance concerns a University teaching module *Media Depictions of Mental Health* where content is delivered exclusively through a series of online tutorial sessions. A grounded theory approach was utilised with themes drawn from small group discussions and the subsequent completion of a questionnaire.

E-learning approaches

The literature indicates a variety of resources and features being used within online materials for healthcare learning. This includes animations, audio clips and interactive exercises (Goodyear et al, 2011); interactive images (digital photographs and illustrations) (O'Byrne et al, 2008); visualization technologies, interactivity and feedback mechanisms (Levesque & Kelly, 2002). Indeed, there appears to be a wide variety of creative and interactive products being offered although these perhaps sit at the top end of the spectrum with some low quality products also available.

E-learning versus face to face instruction

The most effective educational approach between face to face instruction and e-learning appears inconclusive with available studies highlighting a variety of conflicting and contextual factors. A large number of studies however report no considerable difference in degrees of knowledge learnt between these two approaches (Garland, 2010; Hadley et al, 2010; Hugenholtz et al, 2008; Wutoh et al, 2004). The majority of students in Burnett's (2010) study found online learning to be an effective educational experience offering flexibility and engaging resources. Learners' level of Information Technology (IT) experience appears to be a contributory factor as found by Browne, Methra, Rattan and Thomas (2004) with inexperienced staff showing a preference for face to face instruction, whereas the speed and manageability of e-learning was welcomed by busy, more experienced staff. Problems for healthcare learners attending some classroom instruction relate to factors such as shift working patterns (Curran-Smith & Best, 2004; Nevill et al, 2010). Blended learning, incorporating both types of approach is more frequently being applied (Kozlowski, 2002; Warnecke & Pearson, 2011).

Issues for students

It is evident from the literature that e-learning materials are perceived as having both benefits and limitations. Whilst technology offers some very exciting learning opportunities it is important not to assume that e-learning will be welcomed by everyone with much depending upon prior IT learning experience. A number of studies highlighted high levels of satisfaction

and enjoyment being experienced with e-learning (Mazzoleni et al, 2009; Nevill et al, 2010; Simons et al, 2001). Problems were encountered though by learners who have low levels of computer confidence (Kenny, 2002; Smedley, 2011) and indeed as Levesque & Kelly (2002) highlight, for many the concept of *e-everything* invokes a sense of scepticism and dread. Age appears to be a factor and Thomas' (2011) study found older registered nurses (who didn't grow up with computers) encountering greater barriers regarding technical ability and confidence than younger nurses. This raises a clear issue as there will be a sizable number of learners who require extra support to feel confident and be able to embrace e-learning. It is a useful educational approach for healthcare professionals from geographically diverse populations (Pullen, 2006), an ideal resource to fit around busy work and home responsibilities.

Issues for instructors

Considerations for using e-learning involve addressing factors such as time, cost, available technology and support (Childs et al, 2005). Time is a pertinent issue especially as the initial development of e-learning resources can be a fairly lengthy process (Needham and Thomas, 2005). Adequate support is therefore needed with recognition as to how this is fitted in with other workload responsibilities. As noted by Huweniek et al (2008), the success of e-learning is dependent upon curricular integration, sound educational design and having appropriate support structures in place. There is also a need for academic staff to sufficiently appreciate the various design components that can be implemented into online courses and have a vision of what can be created (Reeves and Reeves, 2008). E-anxiety may be present for instructors as well as learners and sufficient guidance and training will be required.

Setting and participants

The purpose of this study is to develop a clearer understanding of the impact potential of an e-learning module's design features, which in this instance concerned the level 3 module *Media Depictions of Mental Health*. This study took place at the UK University where students were registered for this module. The participants sampled comprised two consecutively running learning groups totalling 36 students (24 female and 12 male). All were deemed eligible and there were no exclusion criteria. Consent was sought from all participants, full details about the study were provided and anonymity and confidentiality were assured. Approval for this study was obtained through the University's School of Healthcare Research and Ethics Committee. The participants selected were felt to be a representative sample with learners in these groups matching the background and mix found in others. It was a convenience sample utilising the most readily accessible participants for this study (Haber, 2010). Theoretical sampling was signified as no further variation was noted with the second sub group of learners (Wuest, 2007). Content validity was supported through checking the wording of questionnaire items and design with teaching colleagues who have research and IT experience. Initial reliability measures were noted with similarity of responses between the two sub-sample groups. Group discussion and completion of the questionnaire occurred at the same point in both modules and no changes to content and design were made. The e-learning resources used by participants contain a variety of interactive features which stimulate active involvement with the learning materials (see screenshots in appendix 1). This includes things to read (narrative text), things to look at (video clips, images and animations), things to listen to (audio narrative/dialogue) and things to do (internet sites to visit, buttons to click on, questions and exercises to engage with). A paper copy workbook is offered as part of this module with all questions appearing within the e-learning resources. This is offered so that students can vary their mode of engagement

writing answers as opposed to typing on screen, which aims at promoting their attentiveness to the material being worked through.

Design

The study of this e-learning material reflects an emic view (Streuber, 2010), providing the researcher with an understanding of what it is like to experience e-learning materials as a student. A grounded theory approach based upon the framework of Strauss & Corbin (1998) was used with data analysis proceeding through several levels. The inductive stage commenced with reviewing previous module evaluations and related literature as well as carrying out small group discussion with current students at the midway point of their e-learning. This generated a variety of themes and concepts which were analysed in conjunction with questionnaire responses (Corbin & Strauss, 2008), completed at the end of the module. As Charmaz (2004) states, simultaneous involvement in data collection and analysis can be beneficial in aiding data to become more focused. There was an initial open coding and categorisation of data which brought up a wide range of categories and themes and was followed by selective coding, highlighting recurring themes and helping to refine categories (Holloway & Todres, 2010). Strauss & Corbin's (1998) emphasis upon being theoretically sensitive was heeded with differentiation between significant and less important data, aided by the researcher's experience with e-learning development and evaluation received from a wide number of programmes and modules.

A short questionnaire (see appendix 2) was developed using the Bristol Online Survey resource. The offering of a questionnaire provided respondents with anonymity and enabled a wide range of information to be gathered quickly (Polit & Beck, 2010; Sullivan-Bolyai & Bova, 2010). The questionnaire design utilised a range of question types with some open and others using Likert scales, which were aimed at particular perception responses to online resources. The preliminary data gathering was carried out through discussion in small groups, an approach which can pose potential problems as outlined by Holloway & Wheeler (2010) with members avoiding disclosure because of the presence of others. As the main purpose was for gathering preliminary data it was not deemed a problem with subsequent opportunity offered through the questionnaire for individual feedback. The questionnaire was completed by 30 respondents who are numbered (R1 – R30). Results were collated and checked with participants to ascertain whether these accurately reflected their opinions of the e-learning package, to which full assent was given.

Results

Attention and engagement with learning materials was positively influenced through resources which were interactive, visually appealing and not containing too much information. The interactivity concerned having things to read, listen, watch or do including the presence of on-screen buttons to engage:

R9: "Allows more information per slide without it seeming overwhelming."

Many students commented positively upon the accessibility and ease of navigation around the learning materials which enhanced engagement. The visual layout was regarded as important with positive engagement enhanced through resources where there was clear and attractive arrangement, accompanying shapes and images, contrasting colours and varying styles. Difficulties were encountered with lengthy video clips and slides or text boxes with too much to read which had a negative impact upon engagement:

R 3: "Pages/slides with too much text seemed daunting at first sight and was tempting to skip that page."

This also related to slides featuring a significant number of animations. Readability of text was a problem in places where words were too small or where there was a poor contrast

between words and the background. The core issue related here by respondents concerns the amount of stimuli exposed to as well as the ease of accessing material. The most highly ranked elements, all receiving similar ratings were *presentation of theory / related info*; *video clips*; and *exercises/questions*. *Guided internet links* was the lowest ranked item surprisingly only listed by three respondents within the top three ranked items. Specific responses with regards to each of the online session components are outlined below.

Presentation of theory / related info

This feature was widely welcomed by respondents who found it helpful in developing their theoretical understanding:

R1: "Really engaged me and emphasised theory required for the essay."

Most respondents commented upon the variety of modes with which theoretical information was presented and how stimulating they found this. This was generally regarded as being well complemented by other learning components.

Video clips

Video clips were very positively received with their value cited as helping learners to contextualise and better understand the accompanying theoretical information:

R11: "helped demonstrate what the written points were highlighting."

The particular clips chosen were regarded as being both engaging and instructional as well as helping to refocus respondents upon theoretical learning material.

R21: "Held your attention and taught you something while being entertaining."

Significant mention was made regarding the need for clips to be relevant and not too long. It was evident from respondents that appropriately chosen clips provided an engaging stimulus for impactful learning.

Guided internet links

A large number of responses commented upon the wealth of thought provoking and instructional material that students subsequently became aware of when linked with internet sites:

R15: "I had access to sites I would not otherwise have acknowledged."

However, a significant number of concerns were raised in connection with the abundance of information available or lack of clarity concerning which elements to focus upon:

R22: "Sometimes ambiguous. Not sure what specific information I should be looking at."

The outcome here for some respondents was that some internet sites were only superficially reviewed with key learning material overlooked.

Exercises / questions

Questions and exercises were largely felt to be relevant, interesting and assisting independent thought:

R14: "Really helped to embed into my mind the things that I was learning about."

Particular mention was made about the importance of keeping them brief and not too complicated. The answering of each session's final questions and feedback received from the module facilitator were regarded by many students as strengthening comprehension of the content studied: R30: "Feedback exercise at end is a good way to reflect on what you have learnt."

Audio Narrative

This feature was welcomed as being interesting and stimulating further thought:

R13: "Some things explained better in audio narrative than text. Nice change from reading the computer screen."

A significant and highly important element regarded the sense of connection established between students and teaching staff:

R29: "Added a 'human touch' to the module"

There were also a wide number of responses made about the use of audio narrative for engaging attention:

R12: “much easier and more engaging to listen to an explanation of something than reading long texts.”

Workbook

The workbook was generally considered to be easy to follow and work through and helpful for learners to develop their own thoughts:

R29: “Made me think about topic more thoroughly and understand it more.” Another particular benefit of the workbook was the added degree of engagement with learning material through the documentation of on-going reflections.

R27: “Very helpful, allowed me to write my thoughts about the material discussed in the presentation, as opposed to just reading it.”

The online learning materials being reviewed here in comparison to other online learning materials received very complimentary comments:

R22: “Better, easier, simpler.”

R2: “I was very impressed with these e-learning materials. In comparison to other materials, they were far more interactive, informative and interesting, which made the learning experience thoroughly enjoyable.”

All respondents stated that the e-learning material helped them to learn effectively about the featured topic (see table 1).

Discussion

Learner styles

Engagement with learning resources can be influenced by particular learning styles and preferences as was evident from this study with participants favouring differing components. The reason behind these responses may be multi-varied and we might consider learning style frameworks such as those developed by Kolb (1976), Witkin (1977) or Honey & Mumford (1992) which illustrate ways in which individuals bring their own distinct makeup and preferences to learning. It is also worth bearing in mind Fleming & Mills’ (1992) learning framework which recognises that *visual* learners have a preference for seeing, *auditory* learners fare best through listening and *kinaesthetic* learners prefer to learn from doing. Specific online resources have been developed with particular learning styles in mind such as the use of interactive images for anatomy learning aimed specifically towards kinaesthetic and visual learners (O’Byrne et al, 2008). The feedback from respondents in this study demonstrated a wide range of learning styles and preferences for particular components such as:

R6: “Much easier and more engaging to listen to a description or explanation of something rather than reading long texts”.

There were also comments about the way in which particular components complemented each other, for example:

R21: “The video clips helped me understand what the written points were highlighting”.

As McKeachie (1995) states, learning styles can be regarded mainly as preferences and habits with each individual having the capacity to utilise new styles. In order to maximise learning it would be helpful to challenge potential barriers such as disinterest and disengagement by offering a variety of learning components. This could incorporate things for learners to see, hear and do with resources such as pictures/diagrams; written and spoken narratives; video clips; exercises and activities; and web searches. Responses from participants strongly demonstrated that the range of creative or complementary components worked well together. What is important is that the total *menu* of learning components on offer is broad enough to provide something of value for each learner. A further element to consider for different learners concerns content and Huweniek et al (2008) stress the need with e-learning to find the right level of complexity and cognitive load. Marton & Saljo (1976) illustrate contrasting

approaches amongst learners with those adopting a deep approach commencing with the intention of understanding whilst those employing a surface approach focused upon memorising important points. Respondents' pointed towards a number of components including the workbook and activities/exercises as prompting them to think further about the theoretical information they were accessing. The essence here seems to be one of engagement, moving learners away from a passive reception of material to one of active involvement. The importance of interactive components for encouraging deeper approaches to learning within e-learning environments is recognised by Gormley et al (2009). The variety of interactive resources was designed to generate deeper thought and stimulate curiosity and desire for further learning. It gave students opportunities to reflect upon and process content at various intervals, challenge their thoughts and proceed progressively towards more complex theoretical material. Most participants commented upon the enhancement in their overall learning and the fundamental change in how they subsequently viewed media products. It illustrates a double loop learning process whereby underlying values and assumptions are changed and more complex problems are solved (Argyris 1976). An important issue therefore for the overall learning approach appears to be in facilitating learners returning to theoretical material on a cyclical process with progressively deeper levels of examination enabled.

Attention

As Broadbent's (1958) filter theory states, of the multitude of stimuli we are exposed to only a fraction are registered or attended to. With the wide array of content and components utilised within the e-learning material it is important therefore to consider what promotes or impedes attention, which includes both internal and external factors (Child, 2004). Firstly, it is worth considering the level of flexibility offered through the e-learning approach. Ruiz, Mintzer & Leipzig (2006) found that e-learning technologies offer learners control over content, learning sequence, pace of learning and time. These findings were reflected by respondents in this study with a number of participants welcoming the ability to work at times and days of their choosing and attend to distracting physical needs such as hunger, thirst or fatigue. Interest was engaged through providing a broad spectrum of 'things to do' and as one respondent illustrated:

R3: "When there was an exercise to complete I knew I must pay attention to the material associated with it."

This was an intentional device aimed at refocusing learners and exacerbating theoretical points of importance. It was aided through the accessing of a range of features stimulating curiosity such as boxes to click on to reveal further information. Types of stimuli which attract attention include those that are new, unusual, changing, of high intensity or relating to specific needs (Child, 2004). This reflects the Gestalt process of *figure and ground* with items "standing out" and gaining notice (King & Wertheimer, 2005). Within a face to face learning situation we are able to accentuate specific components of importance by virtue of our expressiveness and verbal prompting. Within the e-learning material an attempt to draw attention towards key material was done through cueing, utilising animated images or textual prompts i.e. "click here to reveal further information". Some components stood out by virtue of their emotional intensity such as service-user narratives which memorably recounted individuals' personal experience of mental health problems. Another influencing attention factor, as reflected in Dark's (2009) study relates to material which learners need or want to know. With the study being recounted here, respondents specifically valued material which enhanced their ability to attend to the module assignment. A worrying aspect however was the tendency to 'skip' parts when encountering lengthy sections of text which were perceived as arduous or overwhelming. The preference was for clearer, shorter and less fatiguing resources.

Engagement

Having gained and held attention it is worth considering the factors which promote sustained interest and engagement. This is particularly important given the independent, self-directed approach fostered with e-learning (Park et al, 2010). Although advocated by notable educational theorists (Knowles, 1978; Rogers, 1983) some learners prefer more pedagogical, teacher-centred styles of learning. In the case of the learning module featured in this study, it was chosen by students opting specifically for e-learning although it needs recognising that *e-anxiety* could still be present. Levesque & Kelly (2002) highlight the high levels of anxiety and trepidation felt by many learners concerning anything connected with computers. In many cases it is caused a lack of IT skills with learners requiring a component of face to face teaching (Childs et al, 2005). It is important therefore for e-learning design frameworks to include learner-friendly formats which facilitate easy navigation through the content. This incorporates resources with engaging qualities and attractive virtual environments, elements which help to motivate students (Mehrdad et al, 2011). This brings up the notion of gratification with attention needed to include components which are ‘fun’ and which provide a sense of learning and progression. Respondents recognised the quirky and unusual pictures, features to play with and explore, buttons to click, quizzes and exercises and entertaining video clips as strengthening their engagement with the learning material. Aspects which were less gratifying included those which were perceived as containing too much stimuli to easily attend to. This included lengthy sections of text, long video clips and some of the guided internet searches which respondents tended to skip. It helped though when text was broken down or returned to following the completion of a complementary exercise.

Recommendations

The findings of this study highlight a number of important features to consider with regards to developing online materials. This can be related to the following recommendations:

- 1) *Engagement* - promote active learning through offering things to do, look at/watch and listen.
- 2) *Variety* – create a range of resources and content types to meet differing learning styles and attention levels.
- 3) *Flexibility* – provide choice for students to choose access times that suit them.
- 4) *Cyclical learning* – enable students to revisit theoretical content with deeper levels of critical reflection promoted on each occasion.
- 5) *Attention grabbers* – periodically engage attentiveness through cues and resources of high intensity (i.e. visual effects, sound, textual details or even emotive content).
- 6) *Don't overwhelm* – show consideration to what may appear too much for students.
- 7) *Rest stops* – enable opportunities for learners to break off from work (i.e. allow progress with material to be saved or divide sessions into parts).
- 8) *Initiate curiosity* – offer resources whereby students *want* to solve problems or locate answers.

9) *Entertainment and education* – develop resources with a view to students enjoying the process of learning and periodically having fun..

10) *Feedback* – facilitate opportunities for students to share learning with peers and obtain feedback from tutorial staff.

11) *Menu of resources* – ensure that the total *menu* of learning components on offer is broad enough to provide something of value for each learner.

12) *Learner-friendly material* - design learner-friendly resources which facilitate easy navigation through the content.

Strengths and limitations

- ☐ Whilst e-learning has previously been studied in depth, the specific focus here upon learners' attention and engagement adds depth to this area of study.
- ☐ The sample size is relatively small.
- ☐ All of the participants had ongoing established relationships with the researcher, whilst presenting an element of bias also facilitated sharing of thoughts and feelings.
- ☐ The study examines a single style of online resource. There may therefore be issues concerning the generalisation of findings to other types.
- ☐ Recommendations are provided to guide other online learning resource developers.

Conclusion

Findings from this study highlight the value in having resources and activities which stimulate curiosity, are perceived as enjoyable and absorbing as well as instructional and thought provoking. This is productively done on a cyclical basis with learners returning to theoretical concepts at regular intervals but at progressively deeper levels of cognitive processing. A range of appealing and enticing components is valuable in terms of attracting learners' interest although for this process to be meaningful it has to then incorporate opportunities for specific reflection and examination of core concepts. Clarity and simplicity of materials and ease of navigation are important, as is variety especially given the wide range of learning styles/approaches for different learners. It is important that those involved in developing e-learning resources have appropriate supportive structures in place. There is also need for individuals to integrate sound educational design with creative and innovative resources. The recommendations provide other educationalists with areas for thought considering the engagement of their learners with the online course materials they are building. Further research in this area would be beneficial and a follow up study using focus group interviews would help exploring aspects in greater depth. It would also help to sample a wider range of e-learning types.

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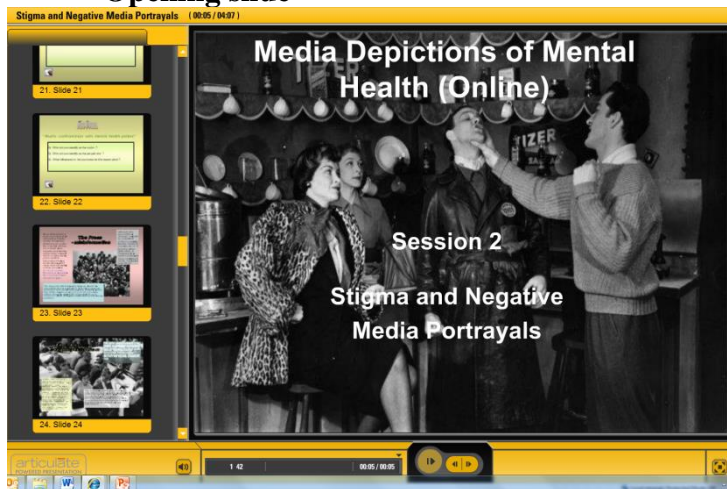
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Online Resources Appendix 1 E-learning resources – Screenshots

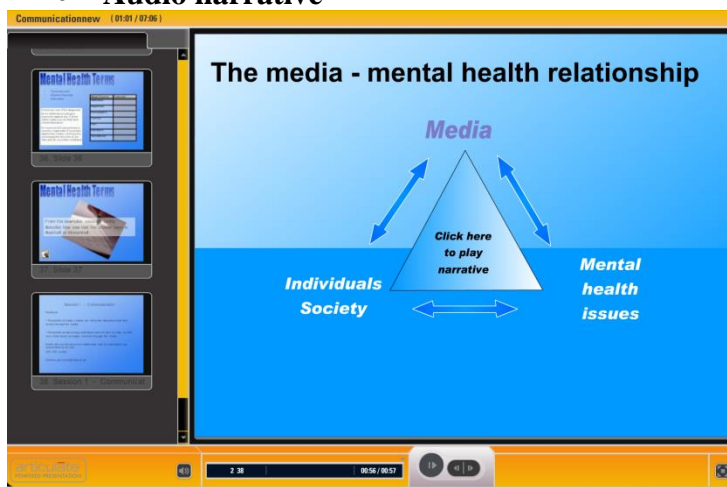
- Opening slide



- Buttons



- Audio narrative



• Video clips

Stigma and Negative Media Portrayals (03:47 / 04:07)

Do any of the following apply ?

- Dangerousness-aggressive
- Simple / childlike
- Unpredictability
- Failures/unproductive
- Asocial
- Vulnerability
- Dangerousness-
- Incompetence
- Untrustworthy
- Caring/empathic
- Social outcast

This clip features an episode from the TV drama *Casualty* where a mentally ill woman attempts to get possession of her baby

• Questions / exercises

Stigma and Negative Media Portrayals (00:55 / 04:07)

With regards to the criticism levelled at the media concerning their negative depiction of mental health issues, what are your thoughts about the following justifications offered by various media groups ?

- The media have the right to inform the public about issues of potential concern
- The media are merely reflecting/ mirroring the values and attitudes held within society
- Media groups are faced with very real commercial pressures and have to produce certain products in order to survive

• Internet links

The Internet (07:31 / 08:29)

Activity 2

Select one of the following terms below and see what type of material is included on You Tube

- Anorexia
- Schizophrenia
- Bipolar Disorder

Q - What do you think about the type of video clips featured ?

Activity length - 10 minutes

Click here to visit You Tube

Online Resources Appendix 2 – Questionnaire

1) Whilst working through this online material which features or approaches helped to engage you and hold your attention?

2) Whilst working through this online material which features or approaches made you feel less engaged and harder for you to hold your attention?

3) Please comment upon how your learning from the online session material has been influenced with regards to:

- a) Presentation of theory / related info*
- b) Video clips*
- c) Guided internet links*
- d) Exercises / questions*
- e) Audio Narrative*
- f) Workbook*

4) Please indicate in rank order your most impactful e-learning element

5) Please comment on what made your highest rated choice the most impactful for you.

6) With regards to the visual layout of material please comment upon what you liked and why

7) With regards to the visual layout of material please comment upon what you disliked and why

8) Please comment upon how helpful; or engaging you found the use of buttons to reveal further information

9) How do these online learning materials compare to other e-learning products you have seen

10) This e-learning session material has helped you to learn effectively about the featured topic. In relation to this statement, please indicate which of the following most applies