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Framing, filtering and hermeneutical injustice in the public conversation about mental health

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Abstract

This article describes how the narrative construct is used in the *Power Threat Meaning Framework* to refer to personal narratives, cultural narratives and as a meta-theoretical language, synthesizing a range of different theoretical perspectives. It identifies ways in which this approach to narrative may differ from its use in a number of therapeutic traditions. Focusing on medicalization and drawing on the concepts of ideological power, framing, filtering and gatekeeping, it discusses the processes which facilitate the dominance of a medical frame in the public conversation about mental health, proposing that such dominance is an example of hermeneutical injustice. The article concludes, firstly, by suggesting some practices which therapists and other professionals could use to broaden and contextualize therapy conversations and, secondly, by making some proposals for how the public conversation about mental health could be re-balanced.

Approach to narrative in the Power Threat Meaning Framework

This special issue includes an article on each of the two aspects in the 'Meaning and narrative' chapter of the main Power Threat Meaning Framework (PTMF) document (Johnstone & Boyle, 2018). John Cromby's article (this issue) discusses the different facets of meaning: language; feeling; culture; materiality; habit; and memory. The present article focuses on one of the most pervasive sources of linguistic meaning – narrative.

The notion of narrative is used in three ways within the PTMF:

- As *personal narratives* which are those which people construct about themselves (e.g. to understand their distress or troubling conduct)

- As *cultural narratives* which are the frameworks of values and meaning conveyed within culture which shape how we see and experience the world

- As a meta-theoretical language for the PTM conceptual framework in order to synthesize a range of different theoretical perspectives. These perspectives are based on the recognition that there is a relationship between narratives and circumstances, including other sources of meaning (Cromby, this issue) and social structures and power relations (Pilgrim, this issue)

Within the PTMF, distress and conduct which troubles others, are seen as a legacy of threat responses developed in response to adversities in life, the occurrence of which reflect the negative operations of power in society. Since the framework was a response to the limitations of current conceptualisations (e.g. causal models) it was important to find a way of presenting the PTMF in a manner which could be understood by a range of different audiences like users and survivors of psychiatry, researchers, therapists and the general public. Following the "narrative turn" of the late twentieth century, the narrative construct was seen as able to fulfill each of these functions.

Definitions of narrative can be overly constraining and normative and so the PTMF adopted a deliberately broad definition. Following Squire et al.'s (2014) approach, narrative was viewed as a set of signs (e.g. writing, sounds, images and so on) where

meaning is produced by movement between those signs, for example between the words of a written narrative or between images in a film. Thus, within the PTMF, narrative is not seen simply as a cognitive representation of an internal state or trait. This broad approach was useful in conveying the inter-relatedness of the individual and culture and this was accomplished in the PTMF in three key ways. Firstly, it emphasized that personal narratives are shaped by cultural narratives through processes of learning and internalization. Thus, from an early age our memories and self-narratives are shaped within interpersonal relationships with caregivers and others. As Vygotsky's studies demonstrated, private thought emerges, developmentally, through the internalizaton of external language. So, too, we gradually learn and internalize those narratives which are made available to us and which carry the values of the surrounding culture (e.g. about distress, gender roles etc). Secondly, these narratives deploy dominant frames and metaphors (e.g. psychological distress is like being medically ill) and provide an array of potential positions in which we can locate ourselves and others (Davies & Harré, 1990). A medically framed narrative makes available certain objects (e.g. illness and treatment) and certain roles or positions (e.g. patient and doctor). However, we can also be positioned by others and, indeed, we can be positioned by narratives themselves since each narrative is both constructive and constrictive, opening up some ways of constructing understandings of reality and closing down others. Thirdly, since the elements from which we construct personal narratives are drawn from wider culture, then how we conceptualize distress and troubling conduct – what Harry Stack Sullivan referred to as "problems in living" -- will depend on what narratives are available in our culture and this, in turn is shaped by ideological power (Boyle, this issue). Different cultural narratives about troubled and troubling conduct compete,

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different institutions promote particular narratives and their relative influence changes in respond to societal change.

Within the PTMF, cultural narratives are seen as encoding a set of social norms and we are regularly exhorted to compare both ourselves and others to these norms. Problems in living are examples of forms of social norm transgression, leading both to internalized shame (as we fail to meet these idealized norms) and prejudice and discrimination from others (Read & Harper, this issue).

How the use of narrative in the PTMF might differ from its use by therapeutic traditions

The notion of narrative is likely to be familiar to readers of this journal including those influenced by narrative psychology (Bruner, 1991; Sarbin, 1986) personal construct theory and cognitive constructivist traditions (e.g. Neimeyer & Winter, 2007), social constructionism (Gergen, 2015) and those approaches, like Narrative Therapy (e.g. White & Epston, 1990), influenced by post-Structuralism.

The PTMF, as Cromby (this issue) notes, was influenced by fourteen different theoretical perspectives: cognitive approaches; radical behaviorism; interpretative and hermeneutic approaches; constructivism; social constructionism; critical realism; process philosophy; systemic approaches; spiritual perspectives; liberation and social justice approaches; New Social Movements like the psychiatric survivor movement; feminist perspectives; indigenous psychology; and narrative approaches.

There are obviously important ontological and epistemological differences between these different perspectives. However, although each approach has some limitations and there are obviously areas of overlap and disagreement, taken together:

> they offer an extremely rich resource of ideas, theory, research and practice specifically focused on human behavior and experience, with some more than others incorporating the social and political contexts and power relations within which these develop. Johnstone and Boyle (2018, p.67)

Those working in the field of psychotherapy have advocated using the narrative metaphor so that therapists from different traditions can communicate with each other (e.g. Angus & McLeod, 2004). Although the Framework may be used in therapeutic settings, it is not, strictly speaking, a therapeutic document or tradition. However, we, similarly, found that the metaphor provided a means of "pulling together the conceptual threads" of the 14 different conceptual perspectives (Johnstone & Boyle, 2018, p.66).

Since therapeutic schools are often influenced by a dominant philosophical tradition, the pluralistic theoretical heritage of the PTMF is likely to lead to some differences with them. Cromby observes, for example, that, in the PTMF, meaning is seen as having a number of constitutive aspects. Another potential difference concerns the use of medicalizing language. Many practitioners, regardless of therapeutic orientation, have to communicate in more medicalized language when they interact with third-party payment systems or the broader psychiatric system and this can lead to an ambivalent relationship with diagnosis (Strong, Gaete, Sametband, French &

Eeson, 2012). Whereas there are traces of diagnostic and medicalizing language in some versions of narrative practice in psychiatry, there was a strong consensus amongst the PTMF project team about the need to avoid this as we sought to develop a conceptual alternative to diagnosis.

It may be helpful to briefly summarize some of the other ways in which the use of narrative in the PTMF may differ from how it is used in different therapeutic traditions.

- Narratives are not seen as inherently pathological and, consistent with continuum models, there is no sharp distinction between "normal" and "abnormal" experience

- Narratives are not seen as just verbal and cognitive entities but are also viewed as embodied (e.g. through biological capacities and habit)

- Narratives can be developed in a broad range of media and in a range of forms (i.e. not just in verbal, chronological linear forms)

- Narratives developed in psychotherapy contexts are not privileged; rather, "therapeutic" narratives can be constructed in a range of contexts (including peer support groups and other forums where first person accounts and testimonies are witnessed, like activist communities etc)

- Although people are seen as having agency, it is not assumed that people can easily re-author their narratives at will – what Smail (2004) refers to as "magical voluntarism" (Smail, 2004). Rather, as Parker (1992, p.32) argues, "people 'make' discourse, but not in discursive conditions of their own choosing"

- Narratives are seen as shaped within interactions with others. As a result it is important not to obscure the role of, for example, the diagnoser in diagnostic interviews (Georgaca, 2004)

- Narratives are potentially colonizing of experience and thus the role of power and cultural availability need to be attended to (Russo & Beresford, 2015)

- Research *descriptions* of narratives have been inappropriately used as a basis for *prescriptions* but they should not be used to enforce normative assumptions and scholars have rightly criticized prescriptive notions that life stories are or should be coherent (Hyvärinen, Hydén, Saarenheimo, & Tamboukou, 2010; McAdams, 2006). Similarly, we must be careful not to imply pathology if narratives are not "integrated" or "insightful" and we should also be wary of the assumption that we all experience life narratively or that we must do this in order to have a well-lived life (Strawson, 2004).

Because psychiatric diagnostic categories purport to be scientific constructs they are best judged by their reliability and validity, though they perform poorly against these standards (Johnstone & Boyle, 2018). However, reliability is not the most appropriate evaluative criterion for personal therapeutic narratives because of the "highly contingent and synergistic nature of causality in human affairs … the multiplicity, complexity and interacting nature of the factors involved, and … our roles as meaning makers and active agents" (Johnstone & Boyle, 2018, p.250). Instead, we might need to consider the level of fit between a narrative and our lived experience, accept that, within therapeutic settings, there might be both similarities and differences between how different therapists might develop a formulation with a client and acknowledge that, when constructing personal narratives, there is a difference between "historical

truth" and "narrative truth" Spence (1982).

Within the PTMF, personal narratives are seen as shaped by culture which, in turn, is shaped by ideological power. Our self-narratives are "what you can say you are according to what they say you can be" (Johnston, 1974, p.68). Ideological power is defined in the PTMF as involving:

> control of meaning, language and 'agendas', so that certain issues or groups may be held back from public scrutiny or people may be brought to see their interests and wants in particular ways. Ideological power also involves power to create beliefs or stereotypes about particular groups, to interpret your own or others' experience, behaviour and feelings and have these meanings validated by others, and the power to silence or undermine. Johnstone and Boyle (2018, p.95)

Lucy Johnstone's article (this issue) explores how culture and power can be conceptualised as coming together in provisional patterns from which personal narratives may be derived. The rest of this article will discuss the cultural narratives from which these personal narratives are constructed, focusing on how it is that certain narratives of problems in living become dominant in the wider culture whilst others are marginalized. Medicalization will be used as an illustrative example throughout.

The cultural availability of narratives in the public conversation about mental health

People encounter ways of understanding problems in living in conversations with friends and family members, at school, college and places of worship, in the workplace and in varied forms of news and entertainment media, including advertizing and social media. This public conversation includes discussion of books and research studies, reports by government bodies and thinktanks, and campaigns by advocacy organizations.

In this public conversation, stories are framed in particular ways (Elwell-Sutton, Marshall, Bibby & Volmert, 2019) and, indeed, some of the actors in this conversation seek to promote particular frames. A frame is a concept used within political science and in media and communications studies:

> [t]o frame is to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described. Entman (1993, p.52)

Media stories about distress and distressing conduct commonly draw on a medical frame (Hess, Decker, Lacasse & Foster, 2016; Leo & Lacasse, 2008) as do television dramas (Henderson, 2017). They are framed as illnesses which, because they are seen as caused primarily by biological disease processes, require psychiatric interventions, primarily psychiatric drugs. This is viewed as an inherently moral enterprize and it is assumed that a medical approach avoids attributions of personal moral blame.

Although the medical frame is now so taken for granted, it is important to remember that it only became dominant in Europe and North America in the mid-nineteenth century and only through the active and concerted efforts of medical practitioners and other advocates in the context of optimism based on some early successes in the medical field (Cromby, Harper & Reavey, 2013). But, over 150 years later, medicalization remains a powerful cultural narrative. How is this dominance maintained?

Facilitating medicalization

There is no single factor that can account for the continued dominance of medical explanations. Rather, it is a complex process with a number of actors and influences (Rose, 2006, 2019).

One major influence is the media and marketing campaigning engaged in by (often well-intentioned) advocates which sociologist Howard Becker termed "moral entrepreneurs": mental health charities, psychiatrists and other mental health professionals. Examples include the UK's 'Defeat depression' campaign (Paykel, Tylee, Wright & Priest, 1997) and the Movement for Global Mental Health.

A key player in such campaigns is the pharmaceutical industry. It is in the interests of the industry's shareholders to increase the number of potential consumers of its products by advocating: to have drugs prescribed for new problems; to lower the diagnostic thresholds of psychiatric disorders; and to broaden the boundaries of diagnosis – so-called "disease mongering". In addition, the industry seeks to shape

the public conversation through a medicalized frame via a variety of marketing strategies. Ben Goldacre, a British physician, academic and journalist devotes well over a quarter of his book *Bad Pharma* (Goldacre, 2012) to these:

- Advertizing to both patients and doctors (often continuing to promote ideas like the serotonin hypothesis of depression long after the supporting research has been invalidated: Lacasse & Leo, 2005)
- Celebrity endorsements
- The funding of apparently grassroots patient advocacy groups (so-called "astro-turfing")
- The employment of pharmaceutical sales representatives which accounts for half of the marketing budget of drugs companies. According to Goldacre, there is approximately one representative for every six doctors and 17 of 29 studies have found that doctors were more likely to prescribe a company's drug after a representative's visit
- Academic "ghost authorship": For example, a Danish study reported that 75-91% of industry-funded drug trials showed evidence of this (Gøtzsche et al., 2007)
- Involvement in medical training (e.g. funding lectures, lunches etc)

The well-documented financial ties between the industry and academia, publishing, the development of the DSM and even mental health charities cause significant conflicts of interest (Whitaker & Cosgrove, 2015).

Biomedically-oriented mental health campaigns have had some success in persuading

the public to adopt a biomedical view. One US study reported that, between1996-2006, public belief that depression was attributable to biological causes rose from 77% to 88% whilst the proportion of respondents prioritizing medical interventions (seeing a doctor or psychiatrist or taking psychiatric drugs) rose from 48% to 60% (Blumner & Marcus, 2009). Yet a belief in biomedical causation is associated with an increase not a decrease in stigma (Read & Harper, this issue).

However, although Big Pharma is a major factor, as Rose (2006) notes, the general public, too, play their part in the dominance of medicalized narratives:

> Companies explore and chart the experienced discontents of individuals, link these with the promises held out by their drugs, and incorporate those into narratives that give those drugs meaning and value … In engaging with these images and narratives, in the hopes, anxieties and discontents they shape and foster, individuals play their own part in the medicalization of problems of living.   Rose (2006, p.480)

In other words, companies choose which products to invest in and how to frame their marketing based on research into what we want and we then engage with these narratives by requesting psychiatric drugs when we visit physicians.

We have focused here on medicalization but, although it is still the dominant media frame for understanding problems in living, narratives of psychotherapeutic culture and of psychologization (De Vos, 2012) are increasingly encountered due, in part, to

the moral entrepreneurship of psychologists and the therapy professions. In the UK

for example, the New Savoy Partnership (https://www.newsavoy

partnership.org/declaration.htm) is an important advocacy group. Indeed, Rose

(2019) has argued that the PTMF itself may be an example of moral entrepreneurship,

by seeking to replace psychiatric conceptualisations with more psychological

constructs like threat responses. Given the dominance of medicalization there seems

little immediate danger of alternative frameworks like the PTMF becoming

hegemonic, we need to remain vigilant since any alternative narrative frame has the

potential both to become hegemonic and to colonize.

So far we have seen that the public conversation is not a level playing field since

some narratives are promoted by institutions with societal power and significant

financial resources. But there are also filters which may prevent some narratives

being heard.

Hallin's spheres: Media gatekeeping and filtering

Hallin (1986) has argued that media organizations serve a filtering and gatekeeping

function and he proposes that there are three spheres of public discourse. The "sphere

of consensus" is where certain ideas are assumed to be shared and are accepted as

valid with journalists feeling no need to present an opposing viewpoint. The "sphere

of legitimate controversy" is where it is recognized there is a legitimate debate and

opposing viewpoints are presented. The "sphere or deviance" includes ideas seen by

journalists as so outside the bounds of legitimate debate that they can be safely

ignored or even ridiculed.

How might we apply this to media coverage of problems in living? To some extent we will need to be speculative here as much of the research on media coverage of mental health is based on categories of content whilst research on framing in health (Elwell-Sutton et al., 2019) and mental health (Hess et al., 2016) is in its infancy.

The default narrative frame in mental health is a medical one and opposing viewpoints are rarely presented, thus indicating it lies well within the "sphere of consensus". For example, a study of over a thousand articles on the BBC's website between 1999-2008 found that mental health was 'represented as being essentially neurobiological in origin' since 75% of articles concerned 'biological aspects of mental disorder – brain function, genetics, physical environment, nutrition, and pharmacological and other biological treatment', whilst only 1% of stories focused on psychotherapies (Lewison, Roe, Wentworth & Szmukler, 2012, p.440). Moreover, stories about biomedical research are frequently based on narratives of "genetic optimism" (Conrad, 2011; Wilde et al., 2011). The wealth of research evidence which contradicts these narratives is rarely covered.

Within the medical frame, distress and distressing conduct are explained and legitimized at the level of the individual without appearing to blame them, and the assumption that psychiatric drugs are effective means that, as Henderson argues, in relation to mental health storylines in television dramas, "medication provides a relatively simple on-screen solution to resolve complex stories" (2017, p.106).

In the "sphere of legitimate debate" we might find stories concerning the need to remove barriers to accessing mental health services (Hess et al., 2016). Where

psychosocial aetiological factors are covered (e.g. childhood abuse, poverty and inequality), these are presented as triggers of biological disorders (Hess et al., 2016) rather than as a challenge to biomedical aetiology. As with media coverage of health problems the narrative frame focuses at the level of the individual thus ignoring psychosocial and structural causes (Elwell-Sutton et al., 2019).

Lying on the borderline between Hallin's spheres of "legitimate controversy" and "deviance" are the much less frequent stories about the problems of psychiatric drugs (e.g. over-prescription or the adverse unwanted effects referred to as 'side effects' etc). There may be occasional stories about medicalization but these are often episodic (e.g. aligned with newsworthy moments like the publication of the DSM-5) and they have not prompted media organizations to routinely give space to alternative perspectives in everyday mental health coverage. Moreover, the force of such stories may be undermined by presenting this simply as a "turf war" between psychologists and psychiatrists (e.g. Doward, 2013), drawing on the familiar media frame of a dispute between two rival interest groups (Sweeney, 2015). Alternatively, stories may be framed in a manner likely to generate debate and so be "newsworthy", for example whether or not a particular form of distress "exists" or whether those experiencing distress are just the "worried well".

Within the "sphere of deviance" lie all the ideas about problems in living which could be presented but are currently ignored, like the idea that the medical frame and its associated concepts are contested within the psy professions and, as Henderson (2017) notes, by many survivors. Other things ignored include, for example:

- The very substantial empirical and conceptual research literature (summarized in the PTMF) highlighting the limitations of biomedical approaches

- The alternative explanatory models suggested by researchers (including that distress and troubling conduct may be the legacy of socially-patterned adversities) and summarized in the PTMF

- Discussion of 'upstream' public mental health primary prevention (as opposed to secondary prevention like 'early intervention' approaches)

- The influence of the pharmaceutical industry in the construction of psychiatric knowledge and diagnostic manuals (Whitaker & Cosgrove, 2015)

- That some, though not all, service users/psychiatric survivors prefer a social model (Beresford, Nettle & Perring, 2010)

- That a variety of explanatory models are available for understanding experiences like voices and visions within the Hearing Voices Movement (Corstens, Longden, McCarthy-Jones, Waddingham & Thomas, 2014)

- That there is a debate amongst mental health professionals about explanatory models (e.g. Read et al., 2017)

How these spheres operate can be illustrated by considering news coverage of homicides by people with a diagnosis of schizophrenia. Stories within the sphere of consensus often simply report that the person experienced delusions and/or hallucinations and had stopped drug treatment. Within the sphere of legitimate debate would be concerns about whether mental health services had acted adequately. However, other information that might render these actions meaningful (though obviously not in any way justified) currently lie within the sphere of deviance: for

example, the content of the person's beliefs and voices, the reasons why they had

stopped taking the psychiatric drugs prescribed and so on. Since what makes such

cases unusual (e.g. their unpredictability) is considered more newsworthy then this is

given more prominence rather than the similarities they have with other homicides

(i.e. that they are often committed by young men in the context of drug and alcohol

abuse: Hiday, 1995).

Cultural availability, dominance and hermeneutical injustice

A particularly useful concept in understanding the cultural availability of narratives is

that of *hermeneutical injustice* which occurs "when a gap in collective interpretive

resources puts someone at an unfair disadvantage when it comes to making sense of

their social experience" (Fricker, 2007, p.1). If, for example, you hear voices but have

only encountered the notion this is a symptom of schizophrenia and never heard that it

could be a dissociative threat response associated with trauma like childhood sexual

abuse, then we might consider that you had experienced hermeneutical injustice. A

more epistemically just situation would be one where the wider culture makes

available to us a range of different explanatory narratives and information on their

respective costs and benefits.

The injustice of the situation is worsened if the only narratives you have access to

have significant limitations. Thus, whilst a medical approach to physical health has

been largely successful, the same cannot be said of its application to distress and

distressing conduct. Psychiatric narratives have a number of problematic

characteristics: they are deficit-focused (Gergen, 1990); they tend to locate the causes

of problems (and thus imply solutions also lie) primarily in a simplistic and reductive

interpretation of biology and the brain; they can obscure the personal and social context and erase human agency; and, although at face value they do not appear to blame the individual, they are strongly associated with prejudice from others and the desire for social distance (Read & Harper, this issue). Moreover, although the purported benefits of a medical framework are commonly presented, its potential costs are much less frequently presented, as studies regularly reveal. For example, Billcliff, McCabe and Brown (2001) interviewed 68 long-term psychiatric inpatients in Scotland in the UK and found that 81% did not know any of the adverse and unwanted effects of psychiatric drugs and few realized that they had any choice in whether to take them.

Implications for therapists and other mental health professionals

Mental health professionals not only have a gatekeeping role in relation to accessing mental health services but they are also gatekeepers to the narratives on which people draw to understand problems in living. Currently, many professionals tend to explicitly or implicitly promote their preferred explanatory models, which appear to vary by professional training (Read et al., 2017). One option, therefore, might be to develop skills in curating a range of narratives which might explain or give meaning to these problems. Open Dialogue therapists (e.g. Seikkula & Arnkil, 2006), influenced by the ideas of Mikhail Bakhtin, have shown how therapists might facilitate such pluralistic dialogues in people's social networks. Research indicates that people seem able to move between different narrative frames and so this process could involve developing idiosyncratic blendings and ways of synchronizing and co-ordinating different narrative frames.

However, as this article has discussed, currently, medicalizing narratives have much more power than alternative narratives. Can medical narratives like psychiatric diagnosis simply be seen as just another narrative when their contested scientific status and potential limitations and costs have been obscured, when some categories are experienced as deeply stigmatizing, when people have not been given equal access to other narratives and when rejection of a medical narrative may result in being seen as "lacking insight" and even being detained and given psychiatric drugs without one's consent?

Given the power of the medical frame, most professionals are in a position where their clients have been diagnosed by others or may have diagnosed themselves and this poses a number of dilemmas for therapists (Strong et al., 2012). Sutherland et al (2016) propose that therapists could enhance their reflexivity by drawing on discursive methods to notice when they are engaging in individualizing, medicalizing and pathologizing kinds of talk and to identify opportunities to engage in more socially contextualizing conversations. They suggest some types of questions which might support such conversations and the PTMF (e.g. its Provisional General Patterns – Johnstone, this issue) might also be a valuable conceptual resource in this endeavour. Such practices could be used in supervisory contexts (e.g. peer-supervision).

Many therapists' clients may be prescribed psychiatric drugs and, given the way in which their use is portrayed in culture as a treatment of an underlying biological disorder, therapists could inform themselves of alternative conceptualisations. For example, as Yeomans, Moncrieff and Huws (2015) suggest, one can use psychiatric

drugs within a non-diagnostic framework for "symptomatic relief" without needing to accept biomedical causal models, adopting a "drug-centered" rather than a "disease-centered" approach (the implications of this are discussed in Johnstone and Boyle, 2018 pp.304-306). In addition, the late Michael White (1995) has suggested that therapists could ask questions aimed at assisting their clients to:

- Fully inform themselves about the various adverse effects of psychiatric drugs.
- Monitor the effects of different drugs, and of different levels of these drugs.
- Establish criteria to evaluate the effects of psychiatric drugs. For example, to what extent do they contribute to, or subtract from, their quality of life? What effects do they have on their relationships?
- Identify which people are most and which least invested in compliance with regimes of psychiatric drug prescriptions, and the particular interests of these parties.

Given the implicit preference for individual therapy amongst many therapists, we need to bear in mind that the support it offers may be limited and that some kinds of solidarity can only found in collectives where we can learn from others (e.g. in peer groups; see SHIFT Recovery Community – this issue) and where the effects of others witnessing and validating our stories can be powerful as seen in Hearing Voices Movement peer groups and Collective Narrative practices (Denborough, 2018). Therapists could inform themselves and clients about such networks and support their development as allies. Such initiatives are also more likely to facilitate social action, taking us beyond more individualized notions of recovery.

Although such developments in therapeutic practice are likely to be beneficial, any change is likely to be assimilated or negated unless there is a change in the broader culture since it is, as we have seen, still dominated by medicalization.

Re-balancing the public conversation

Since the public conversation about mental health is unbalanced by the dominance of a medical frame, it needs to be re-balanced, and this will require concerted action from new social movements comprized of users and survivors of psychiatry, allies from the mental health and psychotherapy professions, and the wider public. Since these groups include people with a range of viewpoints, presenting an alternative approach like the PTMF can raise questions and concerns for those who believe that psychiatric diagnosis legitimizes distress and provides access to information, services, welfare and support. These issues can only be resolved through further discussion of the alternative ways in which these apparent functions of diagnosis can be fulfilled, which we outline in the final chapter of the main PTMF document (Johnstone & Boyle, 2018) and elsewhere (e.g. Johnstone et al., 2019).

Such new social movements need to develop strategies and tactics to consistently challenge media organizations so that currently marginalized narratives move from Hallin's sphere of deviance to the sphere of legitimate debate and narratives from that sphere move to the sphere of consensus. Such campaigns would need to anticipate how those promoting a medical narrative will respond with counter-frames like viewing psychosocial adversity as simply a "trigger" of mental illness. Common media frames found in coverage of other topics could be utilized, like the importance

of human rights including access to information and choice and the need to hear the user/survivor's voice not simply that of professionals. Useful metaphors could also be mobilized, for example the need to have a pluralistic and democratic dialogue rather than a (psychiatric or psychological) monologue (Hart, 2018; Watts, 2018). A recent and increasingly popular slogan which expresses the link between problems in living and adversities is 'Instead of asking what's wrong with me, ask what has happened to me'.

This is now more possible than ever as the traditional gatekeeping role of media organizations and the privileged status they have given to psychiatric expertise is increasingly being challenged by the internet and social media (Shullenberger, 2017) although this also means it can be easy for alternative frames to be drowned out. Such campaigns need to find ways of cutting through this noise, extending this debate beyond traditional mental health circles, finding broader constituencies of support as with large-scale public campaigns against the over-prescription of benzodiazepines in the UK in the 1980s. For example, a recent UK campaign highlighting the difficulties in withdrawing from "anti-depressant" drugs (Rhodes, 2019) offers the possibility for further involvement of the public given the extensive prescription of these drugs internationally. And we also need to remember the important role that can be played by the arts and entertainment media in broadening the conversation.

Imagine what could be done by well-supported organizations which could critique the claims of research studies, offer well-evidenced alternative interpretations and persuade media organizations to adopt a more pluralistic editorial approach[1]. Imagine

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[1] Some of the ideas presented here were first developed in conversations with Jacqui Dillon.

how such organizations and their supporters could facilitate the development of content based on alternative frames through online resources, building a network of media contacts and running workshops for authors (e.g. mental health users and survivors, friends, family members and allies). Imagine if they could be active across social media platforms (e.g. YouTube, Twitter, Instagram etc) perhaps combining concise critiques and alternative framings with irony and humor.

In conclusion, it should be noted that this article has largely focused on the public conversation, primarily the media. There is a need for further research both documenting biomedical dominance and identifying how alternative frames can be introduced. Researchers could also investigate other domains of discourse, like the priorities of research funding bodies, professional trainings, textbooks and so on. Only through continued and concerted action will we increase the availability in wider culture of alternative conceptualisations of problems in living and so address the hermeneutical injustice currently endemic in the public conversation about mental health.

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