

Mental Health Campaigns And Social Representations

Theory: A Consideration

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INTRODUCTION

This paper considers health campaigns, and in particular mental health campaigns, from the perspective of social representations theory. In particular, it focuses on some of the potentially problematic aspects of campaigns that focus on education. It ends with a plea for more campaigns that draw on the theory from the outset, using Lauri's (2005; 2015) use of the theory in a campaign to increase organ donation in Malta as an example of this.

(MENTAL) HEALTH CAMPAIGNS – SOME BACKGROUND

The main goal of many public health campaigns (of all kinds) is behaviour change in the individuals who might be exposed to them. These campaigns have often been based on the classic (and largely individualistic) Knowledge-Attitudes-Behaviour-Practice paradigm (Joffe, 1996): here, the assumption is that an individual acts in accordance with their own ideas and attitudes, and that therefore giving people new or additional knowledge can lead to changes in attitudes, and subsequent behaviour change, which is then maintained over time. In many cases, the behaviours that health campaigns try to change are those that directly affect the same individual, even if there might also be beneficial public health consequences

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through this change. Having safer sex, stopping smoking or eating more healthily are all of direct benefit to the health of an individual who is targeted by a health campaign, but these changes in behaviour will also benefit society more broadly through slowing or halting the spread of viruses or health-related problems, and may lead to decreased spending on healthcare, lower absenteeism at work and so on (Local Government Association, 2013). Some health campaigns aim to change behaviours that may not have specific benefits for those who are targeted and might subsequently change their attitudes and behaviours, but rather the behaviour change of that individual might benefit others quite directly: an individual with the flu who washes their hands after sneezing will not spread the virus to others; an individual who signs up to donate their organs in the event of their death will enable others to receive potentially life-saving organ donations. Inevitably, a variety of techniques and tactics are used in any campaign; indeed, the rise of so-called ‘nudge’ techniques (Thaler and Sunstein, 2008) may even now by-pass cognition altogether and aim to directly change behaviour in the desired direction through more implicit means, such as using smaller wine glasses to encourage customers to drink less alcohol (Pechey, Couturier, Hollands, Matzari, Munafò and Marteau, 2016).

Mental health campaigns may involve encouraging behaviour change aimed at improving an individual’s own mental well-being, but there is usually an additional (or sometimes even primary) focus on encouraging attitudinal and behaviour change towards mental health problems and those with a diagnosis that aims to destigmatise mental ill health within society more broadly: this sets such campaigns apart slightly in terms of their aims from some others. Mental health campaigns are not new: the Mental Hygiene movement was active in several countries from the end of the Nineteenth century onwards (Barnes and Bowl, 2001), and organisations associated with it often transformed themselves into the mental health and education charities still active in today’s society (such as MIND in the UK); psychologists have also documented the design and delivery of specific campaigns for well over fifty years (see the famous Cumming and Cumming (1957) study in Blackfoot, Canada). More recently, in England the Time To Change campaign has been running since 2009: originally intended as a three year campaign, it received an £18 million grant from the National Lottery fund and charity Comic Relief. It initially involved twenty-eight local schemes to promote well-being and thirty-two anti-discrimination initiatives (Henderson and Thornicraft, 2009). Its stated aims are as follows:

“Improve public attitudes and behaviour towards people with mental health problems.

Reduce the amount of discrimination that people with mental health problems report in their personal relationships, their social lives and at work.

Make sure even more people with mental health problems can take action to challenge stigma and discrimination in their communities, in workplaces, in schools and online.

Create a sustainable campaign that will continue long into the future.” (<http://www.time-to-change.org.uk/about-us/what-is-time-to-change>)

Similarly, See Me Scotland, which has been running since 2001, states: “Our vision is to end mental health stigma and discrimination, enabling people who experience mental health problems to live fulfilled lives.” (<https://www.seemescotland.org/about-see-me/>). Such campaigns are varied, and employ numerous different strategies in an attempt to change attitudes. Time To Change provides an excellent example of this variety: it has a significant social media presence, and has mounted large scale sub-campaigns on issues such as mental health in the workplace and supporting a friend with a mental health problem, with television adverts, interviews with a range of individuals including celebrities, and downloadable resources. It has also used cinema and Youtube film clips aimed at challenging expectations; additionally, it has organised a roadshow around different locations, and has worked on similar projects in schools (see <http://www.time-to-change.org.uk/> for archive and current material). The three different strategies for changing attributions for mental illness summarised by Corrigan et al. (2001) are very clear here in different ways: education, contact and protest.

There is considerable debate as to whether these mental health campaigns have any effect on public attitudes and behaviour (Mehta, Clement, Marcus, Stona, Bezborodovs, Evans-Lacko, Palacios, Docherty, Barley, Rose, Koschorke, Shidaye, Henderson and Thornicraft, 2015). Some evaluations do find evidence of some change: Henderson et al. (2016) provide a recent review of various campaigns including Time to Change which maintains that in many cases public attitudes to mental health problems have become more accepting, and the public show a decreased desire for social distance with people with a diagnosis. However, the overall picture is mixed, as Smith (2013) and Nettle (2013) point out: reported changes in attitudes are often small, not always sustained, or, in some cases, completely lacking. In particular, there is a lack of consensus around the efficacy of campaigns that are based on education (Mehta et al, 2015), which will now be discussed in more detail.

MENTAL HEALTH LITERACY AND EDUCATION IN MENTAL HEALTH CAMPAIGNS

Education as a strategy is often framed as (although certainly not interchangeable with) mental health literacy. As Corrigan et al. (2001) state: “the key component to education programmes is replacing myths about mental illness with correct information,” (p. 189). This is also the focus of mental health literacy programmes. There has been a growing interest in the concept of mental health literacy over the past decade, as a review of the number of articles published on the topic in any academic search engine shows. Many mental health education campaigns around the world employ the concept of mental health literacy, either by seeking to add to or to replace existing understandings amongst the general public (Corrigan and Shapiro, 2010). The concept of health literacy has the broader support of the World Health Organisation (see, for example, Kickbusch, Pelikan, Apfel and Tsouros, 2013). Wei, McGrath, Hayden and Kutcher (2015) have recently argued that mental health literacy can be regarded as having four components:

1. Knowledge about how to obtain and maintain good mental health.
2. Understanding about mental disorders and their treatments.
3. Knowledge which decreases stigma.
4. Knowledge which enhances help-seeking efficacy.

They maintain that these four components are also consistent with WHO guidelines. The parallels between these components and the aims of the Time To Change campaign mentioned above are clear. Assessment and evaluation of mental health campaigns has been an integral feature since Cumming and Cumming’s (1957) study, and, indeed, continued funding is often dependent upon it. In fact, it has been suggested that education alone does not lead to the most significant change in attitudes in adults (Corrigan, Morris, Michaels, Rafaaz and Rüsçh, 2012), but this generally remains an aspect of most campaigns regardless, and understanding is measured both before and after many campaigns as part of most evaluations (Corrigan and Shapiro, 2010). Changes to knowledge can be assessed in several ways: the Mental Health Knowledge Schedule (Evans-Lacko et al, 2010) is a good example of an attempt to establish a psychometric scale to examine change over time in such understandings. It combines a few brief items (such as ‘Medication can be an effective treatment for people with mental health problems’) with vignettes identified by professionals

as illustrations of depression, stress, schizophrenia, bipolar disorder, drug addiction and grief; participants are asked how far they see these descriptions as symptomatic of mental health problems. Greater symmetry on the part of the public with professional understanding is seen as greater mental health knowledge, and the success of a campaign is often defined as when change in the direction of professional understanding is discernible (Corrigan and Shapiro, 2010).

SOCIAL REPRESENTATIONS THEORY: CHALLENGING AND CHANGING UNDERSTANDINGS

Such attempts to change understandings in a particular direction (to something which, in Corrigan et al's [2001] words is more 'correct' [p.189]) might raise some concerns from the perspective of social representations theory (and indeed from some other perspectives too). Social representations theory is a deliberate attempt to develop a social psychological theory of common sense understanding (Moscovici, 1984). In several places, Moscovici (Moscovici, 1984; Moscovici and Marková, 1998) makes clear his desire to rehabilitate common sense thinking, reclaiming the concept from the ways in which it has been denigrated and dismissed over time. In his conceptualisation, and indeed in the work of others who have developed these ideas, we see the psychology of a thinking society (Duveen, 2000; Moscovici, 1984) and of the "cognitive prodigal" (Moscovici, 1990, p176) and not of the individualised cognitive miser (Nisbett and Ross, 1980) always keen to take the short-cut in their judgements and thinking. We see a social psychology that challenges notions of a hierarchy of knowledge, with scientific understanding superior to common sense (Jovchelovitch, 2008) and instead takes seriously the differing contexts of the two modes of thinking instead of comparing one with the other (Foster, 2003). The social, historical, political and cultural context of the production and maintenance of knowledge and of communication is paramount.

There is, then, a potential tension when we consider attempts to change understanding from this perspective (Howarth, Foster and Dorrer, 2004). Suggesting that change in understanding is necessary involves making a judgement that existing knowledge is problematic in some way. However, not to acknowledge that people can, and do, hold understandings that can be harmful either to themselves or others would also be naïve, and hugely problematic. There are numerous examples of this stemming from classic social psychology (e.g. Clark and Clark, 1947) onwards: Howarth (2007) shows the harmful effects on children of becoming aware of racist beliefs that others hold about them, and the way that

these can become internalised; Rubinstein and Foster (2013) demonstrate how negative representations of older women and their role in society affects women as they go through menopause. Accepting existing understanding as the status quo also fails to enable the actualisation of the more transformative aspects of social representations theory (Campbell and Jovchelovitch, 2000), as evidenced in numerous studies (Jovchelovitch and Priego-Hernandez, 2013; Krause, 2003; Lauri and Lauri, 2005).

Part of the problem in this case is the character of understandings about mental health problems. There is reasonable consensus that the widely reported negative attitudes towards mental health problems amongst the public (Angermeyer and Dietrich, 2005), seemingly so historically tenacious (Jodelet, 1991), are problematic in that they encourage discrimination against those labelled mentally ill and discourage individuals from seeking help when they find themselves in distress (Rüsch, Angermeyer and Corrigan, 2005). There is perhaps less consensus about what these attitudes and understandings might be changed to.

In light of the above definition and discussion of mental health literacy, it is instructive to consider the perspective of mental health campaigns more specifically on this issue in more depth. Many campaigns start from one of these two premises:

1. The general public lack any understanding about mental health problems, or they hold understandings that are incomplete. Mental health campaigns must therefore seek to ‘fill the gaps’, providing individuals with understanding that they would otherwise lack.
2. The general public hold well-developed understandings about mental health problems that are incorrect. Mental health campaigns must therefore seek to correct these faulty understandings.

These starting points are usually similar for other health campaigns: professionals and others who are interested in increasing immunisation rates in young children might take as their starting point either the possibility that parents lack awareness or understanding of how vaccinations work, or that they might hold incorrect understandings, such as linking the MMR vaccination to an increased risk of developing autism (Provencher, 2007). To some extent, any approach along these lines rests upon the idea that scientific understanding is correct, and superior to any lay understandings that might be in circulation. Adopting a social representations theory perspective does not negate this, or suggest that ‘anything goes’ in relation to forms of knowledge. However, taking a social representations approach does call

for us to take into consideration the context and change in the production of any knowledge, whether in the consensual or the reified domain (Bangerter, 1995; Batel and Castro, 2009). Scientific understanding changes and develops just as common sense understanding does: smoking therapies were recommended as a treatment for asthma until the early part of the 21st century (Jackson, 2010) and the purported link between the MMR vaccine and autism was initially reported in the medical journal *The Lancet* in 1998, then partially refuted in 2004 and fully retracted by the same journal in 2010 (Godlee, Smith and Marcovitch, 2011).

Mental health is a particularly contested area; indeed the very use of the terms ‘mental illness’, ‘mental health’ and ‘mental health problems’ are challenged by many theorists (Johnstone, 2000), concerned that they imply subscription to particular biomedical models that proves too restrictive in both conceptualisation and consequences. While most other areas of health and illness claim a solid basis in science and research (see Wright and Treacher, 1982, for discussion of this), mental health has remained problematic: while it is beyond the scope of this short paper to review all of these, some notable issues should be addressed. Debates continue over shifting diagnoses and their categorisation in volumes such as the DSM (Insel, 2013), and the social and political influences on this process that challenge its claims to scientific objectivity (Kutchins and Kirk, 2001). The success, and perhaps more importantly sometimes lack of success, in the development of pharmaceutical treatments for mental health problems have been well documented (Moncrieff 2007; 2013), as has the way that use of medication in mental health has been used to develop and sustain a disease-centred model of mental illness focused on a ‘chemical imbalance’ (ibid). The search for genetic causes, lesions or abnormalities in the brain and so on continues, but numerous professionals have expressed concern that this has not borne fruit (Leff, 2001) and potentially overlooks other explanations (see, for example, the recent British Psychological Society document on understanding psychosis and schizophrenia which focuses on explanations rooted in trauma [Cooke, 2014]).

This makes mental health campaigns that are based on giving information, and particularly on some of the foundation of mental health literacy, problematic. Can we be certain that the information being given, either in an attempt to address absences in understanding or to change those in existence, is ‘correct’ and indeed beneficial? Some information clearly fits these criteria: there is good evidence to support the fact that people with a diagnosis of mental illness are not more likely to be violent than others (Taylor and Gunn, 1999), despite public understanding to the contrary (Phelan, Link, Stueve and

Pescosolido, 2000) and so conveying this information in education campaigns seems uncontroversial and important in that it is likely to decrease stigmatising approaches to people with a diagnosis¹. However, presenting information that suggests that mental health problems have a physical basis and can be treated ‘like any other illness’, however well-intentioned, may be more problematic given the debates and discussion that continue on this subject, as discussed above.

COMMON SENSE IN CONTEXT: SOME FURTHER THOUGHTS

Some theorists have suggested that when it comes to mental illness, we see a failure of representation because the object can never be familiarised, as Moscovici (1984) argued was the case (Rose, 1996): instead, it remains strange and unfamiliarised. Others have suggested that we do not see a failure of the representational process itself, but that mental illness is familiarised *as* unfamiliar (Morant, 1996). This would mean that individuals and social groups hold existing representations of mental ill health, even if these may not be particularly extensive or fully developed if mental health problems are not particularly salient in their own lives (Foster, 2011). These representations will not merely exist in the abstract, but will have an impact on the way that individuals within these social groups communicate, make decisions, interact with members of their own and other groups and so (Bauer and Gaskell, 1999; 2008). I would argue that this makes the first premise of certain mental health campaigns mentioned above - that the public lack information and are ‘ignorant’ of the facts about mental health - hard to support from a representational perspective. Indeed, health educators assuming a lack of representation of an object has led to some high profile failures of other kinds of health campaigns, such as early HIV awareness campaigns in the UK (Stockdale, 1995).

This then leaves the second premise - that people hold understandings but that these are incorrect and need to be altered. From a representational point of view, these forms of understanding have developed for a purpose - that is, to allow orientation towards the object and communication about it (Moscovici, 1984); the relationship between identity and representation (Marková, 2007) is also critical here. Assuming that representations can (and

¹ Time To Change attempted just this in an innovative way with a mock film trailer ‘Schizo’, which was shown in cinemas. Drawing on many techniques used in horror films (unsteady camera angles, freeze frames, discordant soundtrack etc) it subverts expectations by ultimately revealing a man making a cup of tea who tells us his name is Stuart, and he has a diagnosis of schizophrenia (see <https://www.youtube.com/watch?v=5kh2SpZP4Cg>).

should) be changed without an understanding of the purpose that they serve within any given social group, and the context in which they have developed, is problematic: firstly, new forms of understanding may not be compatible with the particular social and cultural context; secondly, new forms of understanding do not necessarily replace other ways of understanding a concept, and thirdly, new or alternative forms of understanding may have unintended consequences that were not foreseen by the health educators. I will discuss each of these in turn.

An excellent example of the need to consider context in understandings of mental health is the Global Mental Health movement, which is “a coalition of individuals and institutions committed to collective actions that aim to close the treatment gap for people living with mental disorders worldwide” (Patel et al, 2011). As Campbell and Burgess (2012) point out, this translates into arguing for greater mental health provision around the world on the basis of the human rights of individuals who may or may not yet have a diagnosis but would qualify for one using “western understandings of health, healing and personhood” (p.379). On the issues of understanding there are echoes here with aspects of the mental health literacy movement. The assumption is that there are certain universal facts about mental health problems that can be adopted by all, and that there are benefits associated with this process: people correctly recognise potential mental health problems in themselves and in those close to them, are not afraid to seek help from professionals, adhere to the (effective) treatments that they are given, support those they know with a diagnosis and lives are improved as a result. Yet again, it is hard to argue with the reasoning behind this, based as it is within human rights, and on a desire to decrease suffering. However, as Campbell and Burgess (2012) point out, tying the Global Mental Health movement so explicitly to biomedicine risks writing out other definitions, as well as other aspects and reasons for mental distress: they argue that community knowledge and context is an essential part of defining and dealing with what we might refer to in a western context as mental illness. Summerfield (2008) takes particular issue with the way that this is not taken into account in many studies within the movement, arguing that this represents “medical imperialism, similar to the marginalisation of indigenous knowledge systems in the colonial era” (p.992). His point, and that of other critics of similar views, is that rather than improve the well-being of individuals across the world, the global mental health movement risks ignoring local knowledge, customs and practices, promoting instead ‘western’ ideas on diagnosis and

treatment (which may be more or less valid) (Summerfield, 2008; 2013), and that this may end up being detrimental to those involved.

This argument fits perfectly with a social representational approach, and can be applied equally to the mental health literacy movement and ‘western’ ideas on mental health problems. It is no coincidence that Moscovici (1998) drew on concepts from anthropology in developing his social psychology of common sense: the clear message here is that we can apply the approaches we use to study ‘other’ cultures just as confidently in our own cultures, and indeed we must if we are to appreciate the genesis and development of multiple forms of understanding within (and not merely between) societies. On this basis, then, we need equally to understand the understandings about mental health problems in our own society, that is, how and why they develop, the purpose they serve and so on, before assuming that they need to be changed. This does not give carte blanche to those who seek to stigmatise people with a mental health problem, nor does it suggest that it is not problematic for someone to hold fearful beliefs about mental illness that prevent them from visiting a doctor when in distress. Rather, it means that we need to understand the historical and cultural context of those stigmatising or fearful beliefs and the purpose they serve for the person who holds them, in full before we can understand how we might go about working to change them, and, perhaps even most importantly, to what we might seek to change them.

Another contribution from studies largely of other societies’ understandings about mental health problems that should be of utility to mental health campaigns is the notion of cognitive polyphasia. Again, a cornerstone of the theory of social representations is the recognition that contrary to some assumptions within other areas of psychology, such as cognitive dissonance theory, one form of knowledge does not necessarily subsume another, and ideas that may seem contradictory to an outsider can be maintained by individuals within a social group (Batel and Castro, 2009). As Jovchelovitch and Priego-Hernandez (2015) have put it, “there is dynamic coexistence between different systems of knowledge,” (p.164). Many studies of understandings of mental health problems around the world have argued for the existence of this cognitive polyphasia: Wagner, Themel and Duveen (2000) and Arthi (2012) studied representations of mental illness in India and Singapore respectively, and both found that more ‘western’ ideas based on psychiatry could co-exist with (seemingly contradictory) ideas drawn from more ‘traditional’ belief structures. These might be used in different contexts, at different times, or for different purposes, but, significantly, adoption of ‘western’ psychiatric notions of mental illness did not negate other ideas. Again, it is

possible to see how this process might also operate in what we might consider to be ‘western’ cultures. Classic studies on social representations of mental illness such as those of Jodelet (1991) and De Rosa (1987) show how ideas about ‘madness’ that have their roots in medieval notions of contagion through the humours, or of magic-fantastic ideas, continue to be reflected in current thinking, often through non-conscious practices, despite overt denial of their content. One form of understanding does not necessarily subsume or replace another, and these polyphasic understandings of mental health problems will continue to influence decision making, interaction, communication and so on. Mental health campaigns may succeed in passing on new or alternative information about mental health to the public, but this does not mean that other representations will cease to exist, or to be influential: Arthi (2012), for example, detailed how members of the Tamil community in Singapore would deny the possibility of spirit possession whilst also describing stories in support of it, as well as corresponding treatments; Jodelet (1991) found an explicit denial of the notion that mental illness was contagious but a continuing (and sometimes non-conscious) desire to prevent any contact with the bodily fluids of the patients living with foster families in the community she studied.

Assumptions about how understanding is incorporated into public understanding, or the effects that it will have on behaviour, are also unwise. This is not limited to mental health campaigns: as Farr and Marková (1995) and Stockdale (1995) have pointed out in relation to both disability charity and HIV awareness campaigns, such attempts at influence can have unintended consequences. Early HIV awareness campaigns, for example, reinforced fear with images of death which both contributed to stigmatisation of a virus that had already been anchored to the plague (Gilman, 1988); these emotional (and often image-based) evocations of fear and death are likely to promote strategies of avoidance and so are generally regarded as unsuccessful (Joffé, 2008). Other campaigns that played more on images of safer sex as fun and life-enhancing have been regarded as more successful in bringing about changes in attitudes and behaviour (ibid).

Within mental health campaigns, there has often been the assumption that adopting a more biomedical perspective on mental ill health would go some way towards destigmatisation. This is based largely on the conviction that the general public needs to be persuaded that mental illness is, in short, like any other illness. Many campaigners of all kinds express frustration that the public seems to resist considering depression or

schizophrenia in the same way that they would consider diabetes, asthma or heart disease². However, for some time now the failure of many mental health campaigns to convince the public of this has been noted (Sarbin and Mancuso, 1970). The problem is not limited to the fact that these messages do not seem to convince the public (although this would also seem to be the case - see Leff [2001] for more on this), but there is also evidence, including a recent meta-analysis by Angermeyer, Holzinger, Carta and Schomerus (2011), that suggests that greater acceptance of a biological basis to mental ill health is associated not with greater acceptance, but with greater desire for social distance. Although it has sometimes been assumed that a biological model might alter attributions of mental health problems in positive ways (Corrigan, 2000), it is has also been suggested that such a model can make mental ill health seem to be more an integral part of a person which is not likely to change (Phelan, 2005). Instead of thinking that this is a person with an illness “like any other”, the individual is seen as someone who has something wrong with them which is not going to change, something which can remain frightening and difficult to understand (Foster, 2001).

Another unintended consequence is that some campaigns risk replacing one negative representation of people with a mental health problem with another: we might address aspects of representation founded on danger and unpredictability (Nunnally, 1961), but do we, as Henderson et al (2016) have recently suggested, replace these with ideas that people with mental health problems are helpless and pitiful victims? This emerging representation was found by Rätty as early as 1990, and played a dominant role in the way that people with a mental health problem were portrayed in newspaper articles around the time of the proposed changes to the Mental Health Act in the UK (Foster, 2006). Such representations may be different from those founded on dangerousness and unpredictability but are potentially equally stigmatising and problematic: they might sustain the idea that people with a mental health problem are not able to work or present their own views, and their understandings might still be dismissed as less important than those of more powerful others (ibid).

SOME CONCLUSIONS

This paper has argued that considering mental health education campaigns from the perspective of social representations theory highlights a number of challenges: firstly, the

² See, for example, this extract from the Time to Change campaign website featuring celebrity Ruby Wax <http://www.time-to-change.org.uk/news-media/celebrity-supporters/ruby-wax>

assumption that understandings should be changed, and what it should be changed to might be problematic; secondly, the question over how far understandings can be changed, taking into consideration both the historical tenacity and societal context of representations as well as aspects of cognitive polyphasia; finally the problem of assuming that we understand the ways in which understandings might change and their consequences has been considered. At the heart of these criticisms is the suggestion that the social context of knowledge, in terms of its development, maintenance and influence, has to be taken seriously by anyone involved in mental health campaigns.

However, this does not imply that attempts to change and develop understandings using the theory of social representations should not be made: in fact, as shown by other studies (Krause 2003; Jovchelovitch and Priego-Hernandez 2013) using social representations theory to understand the way that knowledge develops in different contexts, the purpose it serves for different groups and the way that different forms of knowledge interact with one another, has real transformative power and potential. However, to date many studies using social representations theory that examine health campaigns have used social representations theory reactively, that is, to examine campaigns that have already taken place (Farr and Marková, 1995; Joffe, 2008; Stockdale, 1995); the most significant exception to this is Lauri's (2015) work on organ donation in Malta, which, as discussed earlier, employs the theory of social representations from the outset in designing and delivering a campaign focused mainly on targeting particular groups instead of individuals, and which enjoyed significant success (*ibid*).

In her summary of this programme, Lauri (2015) argues that social representations theory “brings about a paradigm shift in communications campaign research,” (p.410). The theory undoubtedly has this potential, but I would also argue that mental health campaigns do not, as yet, all reflect this. Those which have started to engage with these processes, for example through targeting different groups with different messages, are likely to have greater success in starting to bring about real change (Henderson et al, 2016), but there is more that could be done through drawing on social representations theory at all stages of any mental health campaign.

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