

**'Mental Health is Something We All Have':
Shifting Ideas and Practices Regarding Mental Health in the United Kingdom**

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To everyone struggling with their mental health

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Abstract

In the United Kingdom today, people who aim at improving social understandings of, and attitudes towards, mental illness have developed a number of innovative campaigning strategies. Among a multitude of media representations, individual narratives, social actions and discussions, new ways of presenting mental health problems have emerged; I consider these jointly under the rubric of mental health activism. Of our particular interest is the activist notion that mental health is something ‘we all have’. This suggests that mental health problems could affect all of us, and therefore responsibility for mental health is (or should be) universal. In aiming at maximum reach, activists deploy a wide range of broadcast and social media in the hope that positive representations of mental health problems will lead to better understanding of these issues, and encourage widespread interest in mental health.

During fieldwork between January 2009 and March 2011, these new practices and notions of health were explored in a range of locations across the UK and on the Internet. Fieldwork included participant observation in activist events, projects and users’ groups aiming to develop a coherent voice; non-participant observation on Facebook; interviews with individuals concerned with mental health problems, and volunteering work for a mental health-focused project in South-West London, during which I filmed individual and collective strategies for recovery.

On the basis of the data collected, I explore shifting ideas and practices of mental health and related forms of sociality by investigating the limiting and enabling potential of language and environment in mental health-focused actions. I show that practices of discussing personal experiences of mental health problems are critical to activism. They carry with them a potential for desired social change and lead to the redefinition of meanings of mental health and illness by pointing away from their individual or aetiological extent and towards their social, or we could say, environmental dimensions.

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List of Abbreviations and Acronyms

BME - Black and Minority Ethnic

CEO - Chief Executive Officer

C32 – Centre 32

DSM - Diagnostic and Statistical Manual of Mental Disorders

DH – Department of Health

ECT – Electro Convulsive Therapy

IoP – Institute of Psychiatry, King's College

NAHM - National Association for Mental Health

NHS – National Health Services

RBM – Richmond Borough Mind

RT – Rethink Talk

TAMH – Twickenham Association for Mental Health

TAO – Together as One

TTC – Time to Change

WHO – World Health Organisation

Prologue

‘Excuse me! Could you, please, tell me where is the Speedwell centre?’ I ask a trader on a busy market street in south-east London. ‘Ah! That *nutters* place!’ replies the woman after having carefully inspected my look head-to-toes as if checking if everything with me is in order. Realising that I appear to be no different than a usual pedestrian her gaze of curiosity quickly turns into that of understanding. She explains that the centre is just behind the block. As I say thank you, she pats me on the shoulder and with a voice full of sympathy asserts: ‘Life is good, young man. Dontcha’ worry!’

My destination is, indeed, just round the corner, hidden away from the tumult of the market. Located in a regularly shaped brick building from the 1950s and surrounded by dilapidated council houses from the same period, the centre merges with its immediate environment. Inside I first sign on the outpatient list and then, whilst waiting for my appointment, examine the walls of the reception area. These are covered with posters and notices regarding local events, meetings and support groups.

One section differs markedly from the others because of a symmetrical arrangement of leaflets. A note explaining ‘Please ask for your copy in the reception’ hangs below a series of eye-catching brochure covers featuring dazzling, geometrical patterns and the now disused logo of the national mental health charity, Mind. Each of the publications focuses on ‘understanding’ particular mental illnesses or conditions ‘Understanding Schizophrenia’, ‘Understanding Post-Natal Depression’ and ‘Understanding Obsessive-Compulsive Disorder’ are among several dozen titles. I ask a receptionist for a copy of ‘Understanding Manic Depression’ and of ‘Understanding Mixed Diagnosis’ but he explains that the series is no longer available.

In the absence of information booklets, a pile of worn-out gossip magazines constitutes the sole choice of literature available in the waiting room. On one of the covers I find a picture of a British media personality with accompanying title printed in alarmingly red font: *‘Jordan and her fight against post-natal depression’*. However, as the time of my appointment arrives I do not get the chance to read the feature.

Introduction

Development of the Research and its Questions

My first ever encounter with mental health services in the United Kingdom had raised some immediate questions regarding the availability of information about mental health problems, its mainstream media depictions as well as the success and outreach of mental health-focused organisations and campaigns. Subsequently, I became interested in how media practices might enhance or hinder expressions of individual experiences and group sentiments as well as aid in the organisation or transformation of social environments. Meanwhile, the emergence and proliferation of social media and its almost immediate embracing in projects and campaigns focused on issues surrounding mental health projects provided a fertile ground for investigation of mediated attempts of making mental health problems better understood and accepted. All in all, the combination of these concerns and interests inspired the ethnographic investigation, the findings of which are discussed in this thesis.

The initial premise of the research was to examine processes of production, distribution as well as use of media made by people concerned with mental health problems. However, in the course of the fieldwork, the focus on media necessitated consideration of a number of interrelated issues. These included the characteristics of contemporary mental health-focused action, and in particular the cooperation and discontinuities between various groups and social actors concerned with mental health problems: central was their novel outlook and new demands for social change, the use of language and personal experiences in attempts to bring this change about, transformations of the voluntary services and, finally, the role of place in mental health-focused practices including various forms of recovery.

In the course of the fieldwork I came to identify a huge amount of activity between loosely networked groups across the UK as mental health activism. The notion of activism recognises that, despite divergent experiences of mental health problems and varying personal perspectives on matters of mental health, there is a need for an organised and mutually supported collaboration. Among the characteristic elements of this cooperation, which I discuss in more detail later, we could single out the focus on similarities between experiences of various mental health problems, the employment of the concept of universal mental health, calls for thorough transformation of attitudes towards mental illness and attempts to develop a coherent, unified voice. These shared aims, means and practices, I would like to suggest, allow us to consider diverse forms of participation with a collective term.

Throughout this thesis I use mental health activism as an umbrella term denoting practices, which, explicitly, as declared in organisations and campaigns' mission statements and in everyday utterances, or, implicitly, by involvement and

participation, hope to bring about change in regards to mental health including: eradication of stigma and discrimination, improvement in services and living conditions for the mentally ill as well as increase in social awareness and responsibility for mental health. This intention to make mental health problems better understood and, consequently, socially accepted is of particular interest as on one hand it explains activists' increasing reliance on media and on the other, it speaks to the novel non-antagonistic outlook.

The choice of the term 'activism' over 'movement', an expression employed to describe groups formerly functioning in the mental health field, points towards the heterogeneity of contemporary projects and campaigns that aim to work collaboratively towards the transformation of social perceptions and attitudes towards mental illness and health and, in doing so, have embarked on what I came to conceive as a more general and less contentious outlook than preceding forms of participation. I use the term non-contentious in direct reference to Crossley's (2005) conceptualisation of competition for visibility and resources between mental health organisations and supporting them movements in the United Kingdom in the past as 'field of psychiatric contention'.

As we shall see, the novel, collaborative and non-contentious orientation of contemporary activism could be seen as a consequence of the success of former movements that engendered radical transformations of both public and voluntary mental health care in the United Kingdom including the closing of asylums, introduction of care in the community and policies encouraging patient involvement all of which could be seen as diminishing possibilities for autonomous or what Graeber (2009) conceived of as direct action. More specifically, the cooperation between previously opposed groups of influence and specialisation seems inevitable because of the ways in which post-asylum mental health care was organised including emphasis on patients' needs and responsibilities, dependencies of the third sector from state funding and grants as well as blurring of the boundaries between public and voluntary services, all of which rendered antagonistic claims and demands increasingly difficult to articulate and also seemingly less effective.

It is important to note that some groups remained committed to propositions voiced by mental health-focused movements in the past. Mad Pride, for example, continues the agenda of the antipsychiatry movement by focusing on challenging the discipline of psychiatry and staging protests in public spaces such as in front of hospitals or the Department of Health (DH). However, in my research I focused specifically on the novel forms of participation in mental health action for two reasons. Firstly, because actions of former mental health movements have already received considerable academic attention (Crossley, 1998a; 1998b; 1999; 2004; 2005; 2006). Secondly, because groups that opposed professional establishments and governmental institutions and policies have lost their considerable influence due to the success of their own actions (Crossley, 2006).

Consequently, the original contribution I hope to make in this thesis is to account for the previously undocumented forms of participation or mental health activism that has an aim of widespread social concern with matters of mental health. What is more it is characterised by being non-contentious or non-antagonistic towards any particular group or establishment, and by innovative employment of media in promoting new notions of mental health. On the basis of data collected during ethnographic research across locations in the UK and on the Internet, I aim to:

1. discuss and contextualise the new orientation and novel aims of contemporary projects and campaigns focused on mental health problems,
2. explain the activist notion of universal mental health and, associated with it, the idea of widespread responsibility for mental health,
3. explore how media, both broadcast and social, are being used in making issues surrounding mental health better understood and how they might aggregate new senses of sociality,
4. account for my research participants' diverse approaches to recovery from their mental health problems.

As we shall see, practices of sharing and discussing experiences of mental health problems are critical to both activism and practices of recovery as they bring about realisation of commonality in experiences of various mental health problems, encourage reflection on meanings of participation, carry with them a potential for desired social change and lead to redefinition of meanings of mental health and illness by revealing their contextual or, we could say, environmental dimensions. Before going into further detail, however, I would like to account for the practical execution of the research.

Methodology

The research unfolded over a period of two years between January 2009 and January 2011 with one event preceding the commencement of the fieldwork and marking the research's effective beginning. On 19th January 2009, in the course of fieldwork preparation, the Time to Change (TTC) campaign was launched with a series of television advertisements and its own Facebook Page and Group. Looking retrospectively, the start of this campaign could be seen as a defining moment in the development of contemporary forms of mental health activism. This was not evident to me at that time although TTC's aims, objectives and practices provided with an immediate sense of a novel campaigning approach to matters surrounding mental health problems.

The birth of the project, supported by a number of key and smaller mental health charities and involving a diverse range of grassroots groups and campaigns as well as

individuals, allowed for a more grounded imagination of the field. Consequently, my ensuing and, as it turned out naïve, intention was to work as a volunteer in TTC's campaign offices in Stratford, east London which I thought would provide me with ample opportunities for participant observation. This, however, turned out to be unfeasible as my offers of cooperation were, ultimately, unsuccessful.

In fact, the initial four months of the fieldwork between October 2009 and January 2010 appeared as a mere chain of failed attempts to develop lasting relationships with activist groups. It was during that period that I began attending service users meetings at several mental health social centres in south-east and north-east London in the hope of identifying local projects focused on mental health media. It was in one of the centres, where in January 2010 I got to know Chandra, an employee of a mental health charity and London coordinator of Open-Up, the grassroots branch of the TTC campaign.

Chandra's contribution to the development of the research was invaluable as he provided me with an important insight into strategies as well as issues of the contemporary activist outlook. It was Chandra who also took me to an event that took place in early February 2010 in Euston, London. This one-day conference organised by volunteers at a mental-health focused quarterly magazine 'One in Four' focused on practices of talking about mental health in media and attracted the presence of employees of public and voluntary sector organisations and institutions, journalists, politicians, participants in local mental health groups from across the country and users of TTC's Facebook Page.

Over the following year I attended one to two similar events each month that focused on issues of mental health campaigning, challenging discrimination, social or broadcast media and even physical activity. The majority of these events had closer or more distant affiliations with TTC or one of its supporting charities. On these occasions I got to know more closely workers and directors of TTC and other charity organisations as well as individuals and groups involved in local mental health-focused projects from across the country. Presentations and panels during these events revealed an overarching activist concern with media representations of and social attitudes towards mental health problems while discussions regarding experience of campaigning pointed to attempts to unify activist effort. Meanwhile coffee and lunch breaks in-between provided me with ample opportunities for non-structured discussions with people in attendance.

These casual conversations would then lead to follow-up meetings and/or unstructured interviews in charity offices, social centres or less formal settings such as cafés across London during which my research participants would discuss their personal experiences of mental health problems, engagements in mental health-focused actions as well as their opinions on participation. Of particular importance to the further development of the research was one such meeting with John who helped

me to identify an opportunity to volunteer as a filmmaker in a local mental health-focused project called Reflections.

The Reflections project, initiated by Richmond Borough Mind (RBM) and sponsored by the Heritage foundation, focused on documenting personal accounts and histories of mental health in the south-west London area of Richmond and, from the perspective of the research, it provided me with an opportunity for a context-specific participant observation. Over the period of a year between March 2010 and March 2011 I would take part in preparatory activities, including the training of volunteers as well as formal and informal organisational meetings, attend relevant events, most notably the graduation ceremony for peer-volunteers and film presentations, participate in research in the National Archives in Kew and in local libraries, work as a light and sound technician during the filming of the documentary about history of mental health in Richmond made by another volunteer, help in preparation for the exhibition and partake in a session evaluating the project.

My key role in Reflections, however, was that of a filmmaker and I spent the majority of my time in this fieldsite researching and recording visual and sound material for what initially was intended as two documentary films focusing on my research participants' favourite outdoor places in Richmond and RBM's mental health centres respectively.

I would often visit the former locations unintentionally in the course of transit within the field or while taking a break between project-related activities. Meanwhile, casual conversations with my research participants as well as oral history recordings made by fellow volunteers provided me with further detail in regards to 'specific feel' of the area. In the end, I filmed four accounts of my research participants' favourite places in Richmond, which I then edited as individual vignettes varying between two-and-a-half and four minutes in length.

Meanwhile, research in the context of social centres involved regular visits to three locations where I met service users, workers and volunteers. Once I was sure that my research participants would be comfortable with the presence of the camera, I filmed the centres and, where possible, daily practices therein. Film recordings also included interviews conducted with twelve research participants who provided both individual and collective accounts on their relationships with and perceptions of social centres.

For the purpose of this documentary I also filmed the closing of another user group in Ham and visited an independently organised group Together as One (TAO) in Twickenham. In the latter context I also occasionally volunteered in the kitchen cooking lunch for group members. Unfortunately, the film about social centres was not completed as it touched upon the controversial issue of recent transformations of services. I discuss these changes with reference to the material collected during

filming as well as personal accounts collected in the course of working with Reflections in Chapter 7.

Throughout the period of the research and thereafter I continued non-participant observation of posts, comments and discussion unfolding on the TTC Facebook Page and Group. In order to contextualise this participation I also engaged in a dialogue, both in person and over email and social media, with two employees at Rethink, responsible for management of TTC's social media as well as Rethink's Internet-based mental health-focused forum. Social media only recently came to interest anthropologists, however, as we shall see later, activity in the particular context of the TTC Facebook Page and Group came to play a crucial part in mobilising interest in the campaign's causes and provided me with a variety of views and opinions on media, taking mental health as their subject.

I also followed both mainstream and activist-made media representations of mental health, collected activist brochures, magazines, publications and conference handouts as well as DVDs or CDs that featured activist-made media representations or documented their projects. Meanwhile, during the writing up period I engaged in personal correspondence with two medical professionals including one psychiatrist and one cardiovascular diseases specialist as well as in conversations with one mental health worker. Accounts of these three professionals provided me with additional perspectives on matters of mental health and health more generally.

Finally, while researching and writing up, I was also informed by personal experiences of public mental health services, including regular visits to my GP and psychiatrist in a local mental health centre in south-east London, individual and group therapy at the Psychotherapy Department of Maudsley Hospital, King's College and service users' meetings therein. These first-hand encounters with the public health sector provided me with a sense of what it means to undergo psychiatric, therapeutic and pharmacological treatment in the modern-day United Kingdom as well as with a more general sense of possibilities, limitations and practices characteristic to contemporary mental health care. Ultimately, these encounters helped me to understand my research participants' everyday struggles with access to professional help and to the limited availability of services, to talking therapy in particular.

While I recognised that ethnography and participant observation traditionally involve a range of related contexts, often addressing different aspects of the same people's existence, in my research, I focused on one particular yet fundamentally crucial dimension of life, that is, mental health. Since my research participants took to discussions and portraying of issues related to mental health in the public sphere of media in the hope of transforming their social milieus I considered it only appropriate to remain involved in this particular, activist, domain and not to intervene into the household settings or kinship networks. What is more, propositions to enter my research participants' domestic sphere would certainly surprise the majority of them,

as there was no rationale for doing so. In the course of the research I was invited to private homes on three separate occasions only, which I took as an indication of that people operating in the mental health field preferred to keep their activist endeavours and private lives apart.

Although prohibiting access to certain spheres of my research participants' lives, this separation was untenable in my research participants' experience-based stories and narratives of mental health problems in which they often elaborated in some detail on matters of family life, housing, employment, and relationships with friends or co-workers. In addition to this, it emerged in the course of the research that the subject of mental health involves a wealth of interrelated spheres including social participation and responsibility, transformation of attitudes and language, public and voluntary services and care, media, representations and narratives and senses of unity and of community. My consequent assertion was that by exploring these diverse dimensions of mental health through the prism of my research participants' accounts I would satisfy ethnography's requirement (hunger, perhaps) for the detail of everyday life, albeit detail evoked and uttered for a very particular reason and, therefore, necessarily narrative and reflexive.

These reflexive accounts of mental health I collected neither bore similarity to medical records of illness nor did they focus on matters of identity or suffering, as it is often the case with sociological and anthropological studies of illness and related movements (Brown et al. 2004; Milewa, 2009). At the same time there was something that my research participants' accounts had in common. Whether recorded on film, taped during a conversation or interview, posted in form of a written text on social media or personal blogs or websites or featured in an activist-made television advertisement, it seemed that contemporary accounts of mental health problems necessarily focused on the possibilities of being or getting better or of recovering. What is more, some of these accounts focused on how possibilities for recovery or for improvement in the sense of wellbeing are hindered or facilitated by factors such as language, social attitudes, presence of others or activity or stillness in specific locations.

These diverse concerns, understandings and approaches to recovery from mental health problems that emphasised the role of place invited me to consider mental health as an environmental phenomenon, an issue to which I shall come back soon. What is more, this similarity of emphasis in my research participants' accounts helped me to partly overcome a sense of incoherence that came as a consequence of the multisited character of the field where, as we shall also see, different settings would necessitate focus on divergent aspects of mental health problems. More specifically, the focus on bettering of mental health as a form of engagement with the environment expressed and enacted by my research participants across the fields was something that connected its diverse locations.

However, since research locations were sometimes hundreds of miles apart, it was not always possible to follow up on conversations with specific people in person and, instead, email or telephone was used whenever possible. At the same time, several of the research participants have experienced recurring mental health problems, which made follow-up meetings or interviews not possible at all.

The most challenging issue I encountered in the course of both research and writing up, however, was that contemporary forms of participation with regards to mental health were taking shape as I was trying to understand them. Consequently, some characteristics of activism made sense only from the perspective of passing time while certain aspects still require further investigation. The activity on TTC's Facebook Page and Group is probably the best example here, as it provided me with a continually expanding material which required me to rewrite major parts of Chapters 3 and 4 multiple times in order to include new features and changes to the social medium that transformed the possibilities for interactions and discussion.

I came across some further limitations in understanding the fieldsite due to my non-native yet long-term inhabitation status in the UK. In Poland where I come from, it is common to share details of your personal life even with people you know very remotely or do not sustain close ties with. What is more, in my home country, no one would publicly frown on a person talking about his or her medical conditions or problems in quite some detail on, for example, municipal transport. It might perhaps sound as a sweeping generalisation, but I think my countrymen would agree that in Poland we accept talking openly about suffering, pain and misfortunes and, in particular, when it comes to accounts of our history.

Meanwhile, in the United Kingdom, I found that people are, in general, less likely to talk about serious or personal problems, which might partly explain the existence of the linguistic institution of small talk. What is more, the hidden and often reverse meanings behind idioms and expressions in British English never ceased to surprise me as, for example, was the case with expression 'that's not bad', which I found out was a pronunciation of positive approval or 'that's quite good' which, I realised, communicated disappointment. Consequently, after having lived in London for six years it was somewhat counterintuitive to hear my research participants speaking so openly about their health problems and, as we shall see at the beginning of Chapter 1, their use of certain expressions, such as for example mental health, was puzzling.

Finally, my potential research participant sometimes seemed wary of a foreigner researching in the United Kingdom: 'There was no English student to do your work?' I heard once. I also surprised, positively I hope, at least three people who thought that Polish people living in the UK perform manual labour only. These stereotypes, however, were not as preventive to the development of the research as the reluctance towards the discipline of anthropology and/or academia more generally that I encountered in my attempts to develop contacts in the field.

Rapport (2002a) explained that ethnographic work in the UK was, for a long time, considered as being of secondary importance to the research overseas. This seems to be changing as, in recent years, many of my fellow students decided to embark on fieldwork in different parts of England, Scotland and Wales. I nonetheless found in the course of my research that anthropology and its methods and aims are still relatively unknown among the British society. I thus hope that my colleagues' and this current work could lead to a more widespread recognition of our discipline's capacity to shed valuable light on matters important to all of us.

Ethical Considerations

Prior to the research I gained the ethics approval of the Ethics Committee of the Department of Anthropology, Goldsmiths, University of London and throughout the fieldwork and writing up I was informed by the ethics guidelines of the Association of Social Anthropologists in the UK and the Commonwealth (1999 [1987]). Given the proximity of the field to my institution, I was able to consult my supervisors in case of specific ethical issues arising from the research activity.

I found the matter of the confidentiality and anonymity of my research participants particularly challenging given their focus on public articulations of personal experiences of mental health problems. My research participants and other people I have met in the course of the research talked openly about their experiences of mental health problems in order to make issues surrounding mental health better understood. Consequently, withdrawing their names could be perceived as further stigmatising their experiences and, thus, counterproductive to my research participants' goal. What is more, my research participants often had a sense of pride or personal satisfaction in being able to talk about their experiences publicly.

Nonetheless, I considered it a good practice to change some of my research participants' names, in particular of those who explicitly suggested that I do so. However, throughout the thesis I also refer to accounts of people who are identifiable and do so in the conviction that they shared their stories and experiences with the intention of transforming their social reality for the better and that this current work could be seen as an extension of this aim. With regards to users of the TTC Facebook Page and Group I decided to use original names because the activity on Pages and Groups is not only available *to* the general public, but, as we shall see, also has an explicit aim of addressing and changing the views held *by* the general public.

With regards to informed consent I made sure that my research participants had as much information about my project and its aims as possible. In the field, I would always introduce myself as a postgraduate research student and state that the purpose of my work is to research contemporary forms of mental health activism in the United

Kingdom. It is important to recognise that on many occasions, such as, for example, activist meetings and conferences there was no specific need and, indeed, possibility for doing so, as the events attracted large numbers of participants and were open to members of the public interested in matters of mental health. When a more manageable number of participants were present, I would always seek verbal permission to use the accounts shared or parts of conversations.

In the specific context of Richmond I explained my presence as having two concurrent reasons: making films as a volunteer for RBM and collecting material for a doctoral research. Prior to filming, Helen, the person overseeing the project, collected release forms from all the participants, in which they agreed that their image and voice could be used in films produced and distributed by RBM. On these occasions, I would say or restate that I might use the accounts collected in written work.

Throughout the research I always tried to make sure that my research participants do not suffer further due to sharing their personal experiences with me. In particular I strived to ensure their comfort while filming as I realised that few people feel naturally comfortable in front of the camera lenses. Whenever possible, I would always try to visit a particular place prior to recording and get to know people who worked there or visited there. I also recognised that sharing one's personal story might bring up upsetting feelings and, prior to interviews or filming, I would inform the participants that they were free to halt or stop the interview or conversation at any time without giving a reason.

I did not seek informed consent from users of Internet Groups such as the TTC Facebook Page because doing so would most likely cause them unnecessary distress, especially, as I show later in Chapter 3, discussions in the specific context of social media have taken on a very particular and highly public character. I did however let members of TTC's social media team know that I am looking at the activity on their Facebook Group and Page as part of my research. In response, they invited me to their offices to discuss our respective observations. Their willingness to cooperate and engage in a dialogue signalled that not only they approve of my activity but also support it.

Overall, I see my work as an extension of the efforts of my research participants and use all the accounts and data collected in the course of the research in the hope of contributing to my research participants' aims of making issues surrounding mental health more understood and accepted. I devote more attention to the outcomes of my participatory approach throughout the thesis, especially in its second part and in the conclusion.

Looking retrospectively, one of the risks that I underestimated while planning the research was the protection of my own mental health. Before embarking on the fieldwork, I was convinced that having dealt with my sibling's and my own mental

health problems I would be prepared emotionally to listen and record other people's accounts. Instead, I have often felt overwhelmed by my research participants' suffering and distress and, in consequence, in agreement with my psychiatrist, I decided to enhance my pharmacological treatment. However, my research participants and their accounts of many different ways of addressing mental health problems inspired me to look beyond pharmacological treatment and to seek for alternative solutions and activities that helped me to address my own issues better and, ultimately, to come off medication.

Data Analysis and the Theoretical Outlook of the Thesis

The data collected during the research included notes written either in the field where possible, immediately after or retrospectively, notes taken during interviews, voice and video recordings in high definition format, MP3 recordings from oral histories collected by volunteers as part of the Reflections project, promotional materials published by campaigns and groups active in the mental health field, and activist-made media representations in the form of DVDs or accessible on the Internet. All identifiable data in digital form were stored on password-protected computers and I ensured that I was the only person to have access to it.

The cross-examination of the data led me to identify three key themes, which I discuss below. These include the meanings and practices around health and illness; place and environment; and notions and senses of community. As this research concentrated on reflecting on mental health; and acting to change conditions, its focus is necessarily on intentional representations and engagements with the environment that enable health or create illness, as well as senses of unity or sociality that emerge or are articulated alongside this.

Health and Mental Health

Anthropologists, along with other scientists seem to have found it more difficult to define health than to define ill-health. Consequently, we have a number of related terms in the category of ill-health with contrasts in the English language between disease, illness and sickness. Moreover, so-called negative definitions that focus on the absence of disease have proved to be more workable than positive ones that focus on senses of well-being. Meanwhile in my research the emphasis was on health, as contemporary activism suggested and promoted novel understandings of and attitudes towards mental health. However, as we shall see later, along with mental health, my research participants operated with a wealth of notions and expressions that they found helpful in articulating their experiences and in the making of experience-based representations.

One of the most popular and often-quoted definitions of health is that of the World Health Organisation's (WHO) which purports health to be '*state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*'. Lewis (2011), notes, that this definition is useful as it conceives of health as an ideal and not merely an acceptable state.

Earlier works, however, suggest that such consideration of health, as a state, is untenable. Dubos (1959) for example, suggested that health is not a fixed condition but the ability for and the practice of adaptation to the environment. Consequently, argues Dubos, health would be possible only in brief periods characterised by an absence of environmental change. Since striving for better health is a form of transformation in itself, health is effectively unachievable and, therefore, it is a 'mirage' (*ibid.*) or a utopian ideal.

Fine and Peters (2007) asserted that Dubos' notion of a mirage is, in fact, not a definition but an explanation of the paradoxical character of health and they saw Illich's take on the subject as complementing that of Dubos'. Illich, explained the authors (*ibid.*), also proposed health as an adaptive practice but, rather than emphasising absence of change as the precondition for health, he focused on suffering as the mechanism of meaning-making while also highlighting issues with the commodification of illness. With regard to the two arguments Fine and Peters (2007) concluded that Dubos and Illich's respective interpretations of health are useful because they conceive of health in terms of individual ability conditioned by environmental, social and cultural factors.

With regards to the forthcoming discussion of my research participants' practices and in the light of Ingold's work (1993, 2000) we shall see, however, that health and specifically mental health is neither a mere adaptation to the environment's constantly changing character nor a result of environment's impact. Instead, I hope to show that health could also be considered as a form of being- or movement-in-environment or attunement to it.

The notion of health as a more comprehensive environmental matter speaks to some of the anthropological approaches to the subject. Kleinman and Petryna (2001), for example, saw health as a complex social phenomenon that goes beyond the individual body and encompasses personality, kinship, community, cosmology, ethics and beliefs. Although such broad definitions could be seen as trivialising health, the authors make an interesting assertion that 'health is at once an end and means' (2001: 2). Consequently, it seems that on the one hand health eludes any specific definitions and on the other that, rather than being a state or a constant, health is necessarily grounded in cultural systems of thoughts and beliefs and, therefore, notions of health will necessarily transform alongside cultural or social change.

This difficulty of defining health as well as its cultural variations might explain anthropological preoccupations with notions of illness and disease. Strathern and Stewart, for example, suggest that differentiation between illness and disease ‘became foundational to the cultural approach in medical anthropology’ (1999:191) where disease is considered as a diagnosis-driven and curing-oriented category grounded in Western biomedical models while illness is understood as a culturally and socially contextualised experience of disease (see also Kleinman, 1980; Finkler, 1981). Wikman et al. (2005) expanded this distinction to include the notion of sickness as well and, according to them, disease is a professionally diagnosed condition, illness is the personal experience of ill health while sickness denotes related social practices, understandings and ramifications of illness. These three terms correspond to biological, psychological and social perspectives, focused respectively on medical aetiology, symptoms or experience of suffering and observable behaviours as originally suggested by Frankenberg in 1980.

In the case of mental health, anthropologists seem to have focused primarily on the critique of biomedical disease models. Initially, medical anthropologists were able to function within a multidisciplinary framework. The work by Muriel Hammer (1961,1972) on schizophrenia initiated in the 1950s is a notable example of such cooperation that accounted for both anthropological and medical perspectives. In the following decades, however, anthropologists, along with other social scientists, influenced by the writings of Foucault, Fanon and the Dakar School developed an antagonistic attitude towards psy-sciences, including their ideologies and practices, as well as their dubious relationships with pharmaceutical industries.

Lakoff (2005), for example, explained that in Peronist Argentina, a period of ‘explicit anti-liberalism’ and focus on social and citizens’ rights there emerged a very specific notion of ‘*salud mental*’ (‘mental health’) supported by Argentine professionals working in the mental health field who, heavily influenced by European psychotherapeutic thought, highlighted societal aspects and the social aetiology of mental illness. Furthermore, in Argentina, psychiatrists have shown awareness of their positionality and agency in relations with patients.

However, in the case of an Argentine hospital discussed by Lakoff, a proposition from a pharmaceutical consortium led to the reclassification of some patients with a previously undiagnosed bipolar spectrum disorder in line with the biomedical and psychiatric models of illness. Within this matrix of ‘pharmaceutical reason’, suggests the author, mental diseases came to be defined not through syndromes-oriented diagnosis but by matching experiences and behaviours to the already established medical blueprints and, accompanying them, pharmaceutical treatments. Lakoff also points that, looking globally, it seems that it is the psychiatry in the United States that is out of sync with the rest of the world.

A similar point was also made by Tsao (2009a, 2009b) who saw psychiatry working to the advantage of pharmaceutical industries by participating in the invention and imposition of rigid categories of mental illness as encapsulated in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Meanwhile Hacking (2013) explained that the DSM, based around both dubious and instrumental diagnosis criteria, leads to the classification of an increasing number of behaviours as mental disorders: helpful predominantly for bureaucrats and insurance brokers. Critique of psychiatry also highlighted individual docility while portraying the discipline as a tool for social management (Rose, 1996a, 1996b, 1998). Meanwhile, pharmacological treatments were described as ‘political weapons in the hands of the powerful’ (van der Geest, 2006:303). However, Van der Geest (*ibid.*) also remarks that perspectives from ‘the inside’ of pharmaceutical and psychiatric fields are scarce and research in such contexts would provide better understanding of the logics, principles and values organising them.

Others, for example Pilgrim (2007), believe that the critique of psychiatry is overdeveloped and, consequently, it is necessary to turn away from the well-researched faults and shortcomings of psy-sciences and towards the question of why psychiatry survived at all. As we shall see later, in the contemporary context of the United Kingdom, psychiatry has indeed seemed to lose some of its influence on the direct management of mental health problems. At the same time, some of my research participants valued biomedical approaches to mental illness and pharmacological treatment, whilst they also recognised that these forms of therapy constitute only a part of a much broader trajectory of recovery and health. Among popular non-pharmacologic forms of recovery were physical activity, gardening, mindfulness techniques such as yoga and meditation and social contact among others.

All in all, we could conclude that not only illness- and sickness- but also disease-models are necessarily context-specific (see also Lock and Nguyen 2011). Nonetheless, disease-oriented biomedical procedures and standards of hygiene have been portrayed as yielding a substantial impact on people’s health practices and, effectively, reproducing and maintaining a ‘neoliberal global health economy’ (Nguyen & Peschard, 2003). Within this biopower-oriented framework, health came to be considered as an inherently political process (Bambra et al, 2005, Bambra, 2011), but also as a matter of rights (Farmer, 1999, 2005) and responsibility which also informed various notions of ‘biological citizenship’ (Petryna, 2004; Rose and Novas, 2005; Rose, 2010).

Rising emphasis on individual accountability has also been noted by Navarro (2009) who in the analysis of the WHO Commission on Social Determinants of Health’s 2008 Report explained that the introduction of neoliberal ideology into policy from the 1980s onward resulted in the transfer of responsibility for one’s health from the state to individuals. Similar transformations in the United Kingdom over the last thirty

years are of specific relevance to contemporary mental health activism and in particular its outlook and possibilities for participation.

This interest in the individual dimension for health points to another anthropological focus which Obrist et al. (2003) interpreted as a U-turn from medical anthropology to anthropology of health, which highlights the role of human agency in health practices. A substantial effort in the discipline was made to consider subjective experiences and individual practices of making sense of health and illness. In particular, a considerable ethnographic attention has been paid to matters of suffering.

For Kleinman, suffering as a form of experience is an inherently moral issue contextualised and remade by the local contexts in which it unfolds. However, Kleinman (1995) also suggested that the anthropological focus on suffering contravenes the depth of experience and, although in a different way to biomedical disciplines, it is also responsible for producing distorted representations, blurring the importance of experience itself. Kleinman's consequent suggestion for anthropological research on suffering is to focus on '*what is at stake for particular participants in particular situations*' (1995:98).

Jackson (2005) problematises this exact proposal by noting that it is not possible to objectively prioritise particular experiences. This leads him to conclude with reference to Arendt's take on the subject of pain that there is a fundamental difficulty with communication and understanding of traumatic experiences. Meanwhile, Das (2007) with regards to the research on experiences of Partition of India that followed its independence in 1947 noted that social suffering is a marker of everyday life responses to danger rather than a marker of superior or 'transcendent' experience. I understand this assertion to propose that suffering, perhaps similarly to health, is never really only an individual matter but that both the source of suffering and possibilities for dealing with it are conditioned socially or, perhaps, we could say, environmentally.

As my research participants concentrate on similarities between various mental health problems such as that of stigma and discrimination and on various possibilities for recovery and to represent/see/talk about their experience as a potential tool for change, this research falls directly neither within the rubric of medical anthropology nor within the ethnographic focus on suffering. In her analysis of Lewis' (2000) differentiation between three types of accounts of health that include medical records, narratives of illness and ethnographies of illness, Day (2007) describes the latter category as being:

neither about an apparently 'objective' disease from the perspective of a clinician, nor the 'subjective' experience of suffering produced or ghosted by an anthropologist, but about multiple perspectives and activities in a crisis (2007: 31).

With regards to this, I see this ethnography as an attempt to account for manifold interpretations and understandings of mental health and illness in the UK today, as reflected through the narratives and actions of my research participants in line with their accounts, which, I show, go beyond the specificity of illness and point to the broader environmental dimension of mental health.

Place, Space, Landscape and Environment

Categories of place, space and environment and their relation to time are as important to understanding the research subject as those of health and in fact, they cannot be understood independently. I therefore would like to introduce them by recalling the ethnographic account I started the current Chapter with and, specifically, the description given to the mental health centre by a market vendor in Deptford. ‘That nutters’ place!’ indicated to me that associations between particular locations and mental illness are easily made and socially reproduced (and, also perhaps, that use of language is capable of conflating the two).

I came across such a tendency to identify mental illnesses with particular places also while explaining the subject of my research to friends or casually met people. Upon hearing that the focus of my work was mental health, they would often assume that my research took place in a hospital and were surprised to hear that, in my work, I actually avoided institutionalised settings. All in all, it emerged that popular understandings of mental health and related problems confine them to or associate them with specific kinds of locations and particular hospitals.

Most crucial to the analysis, however, were my research participants’ actions and words that emphasised the crucial role of places in both practices of recovery and in activism. In short, and paraphrasing Basso (1996) we could provisionally say that illness and health, similarly to wisdom, ‘sit in places’ too.

Anthropological studies have provided some interesting insights into the role of places in both individual and collective process of dealing with mental health problems. Goffman’s (1961) seminal book on asylums (along with works by Stanton and Schwartz (1954), Dunham and Weinberg (1960) and Strauss et al. (1964)) was one of the first to account for perspectives of patients closed in a psychiatric institution. Goffman’s approach was distinct because of the ethnographic methods used.

In the course of four essays, Goffman (1961) presents his critical outlook on asylums’ procedures, treatment of and expectations towards patients, which enacted, explains the author, amount to the process of institutionalisation. In part three of the book, for example, Goffman discusses how patients are required to respect the asylum settings which he sees as a reinforcement of the institution’s norms but he also shows that

these norms can be subverted by the patients. It is also worth noting that Goffman's critical outlook on psychiatry presented in the 'Asylums' is seen as having initiated the process of deinstitutionalisation (Weinstein, 1994).

More recently, on the basis of his ethnographic work in a closed ward of a mental health hospital, van Dongen (1997) argued that patients re-embody spatial limitations of the institutional settings that control their day-to-day experience. Incorporation of spatial norms was also the case in non-institutional settings as noted by Parr (2000) in her account of a drop-in service in the post-asylum Britain. Parr notes that service users actively participated in the spatial organisation of the social centre and on the basis of their opinions about the place incorporated a discriminating attitude towards a severely ill individual whose behaviour was deemed inappropriate. Both these accounts are important to the understanding of how controlled spatial settings might preclude or necessitate particular illness-related behaviours.

With regards to this research, my analytic interest in space came as a consequence of my participants' accounts and practices that emphasised the importance of certain locations to health-related practices. What is more, the multisited character of the field prompted me to consider the, familiar to anthropology, space-place dichotomy. The distinction between space, often considered as a philosophical or mathematical category, and place, commonly related to as inhabited or specific space, led anthropologists to question the subjective, practical and theoretical relevance of these classifications. Casey for example argued that: 'for the anthropologists, Space comes first; for the native, Place; and the difference is by no means trivial' (1996:15). The author further suggests that it is the local knowledge, which provides real insight into experience because it comes from the most fundamental sense of being in a particular place.

Darling (in preparation) suggests that in its early colonial beginnings anthropology was, effectively, making the unknown spaces into known places with specific anthropological fieldsites serving as templates for understanding particular regions. Darling then explains that anthropologists stick to the category of place because of its functionality and adds that the postmodernist critique of the field failed to go beyond this centrality of place. Place was redefined, remodelled, but remained at the core, while, space, although mentioned, implicitly or explicitly became orphaned and unaccounted for, suggests the author (*ibid.*). Ultimately, Darling calls for anthropology to continue working locally but embracing the place-space dichotomy.

One of the solutions to the dilemmas regarding categories of space and place was to utilise the concept of landscape. Hirsch and O'Hanlon (1995) explain that landscapes, unlike space or place, can never be 'absolute' as they are socially and culturally constructed. Landscapes, continue the authors, are temporal and timeless, idealized and lived through. This leads to suggestions that landscape, as points where

relationships and tensions between place and space unfold (*ibid.*), allow for more effective objectification of the field.

In his analysis of changing cultural forms and processes in the context of globalisation Appadurai argues that in order to account for discontinuities of distribution of power, of meaning-making and social practices in general it is necessary ‘to look at the relationship between five dimensions of cultural flow’ (1990:296) which include ethnoscapes, mediascapes, technoscapes, finanscapes and ideoscapes. For Appadurai –scapes:

are not objectively given relations which look the same from every angle of vision,

but rather they are deeply perspectival constructs, inflected very much by the historical, linguistic and political situatedness of different sorts of actors (1990: 296)

The author suggests that –scapes might encompass nation states, diasporas, movements, local and global communities for whom their –scapes constitute the basis for what Appadurai, following Anderson conceives of as global ‘imagined worlds’. These worlds, according to the author, are neither inherent nor well-established, but rather characterised by uncertainty and disjunction. On the whole, we could say that Appadurai’s notion of –scapes points both to the necessarily positional perceptions of the cultural environments they entail and also to the author’s concern with instability of modern life on the other.

This points to some more fundamental issues with the category of landscape. Hirsch and O’Hanlon (1995) explain that the word landscape derives from Dutch word for painting and came to embody idealised perceptions of space, in particular outdoor spaces and, consequently, the notion is also capable of romanticising groups of people researched by anthropologists in the similar way notions of place do (Cook et al., 2009; Darling, in preparation). This positive association is why we should consider the etymological origin of the word landscape in more detail.

The suffix -scape used in English language originates from Dutch suffix *-schap*, the latter being a cognate of the English suffix ‘-ship’, which indicates a condition, state, position or skill. The contemporary combining form ‘–scape’ thus indicates a scene, a stage, a set for some form or activity, phenomena or form. Words using –scape denote unity between the activity or phenomenon and its location/context where the latter part of the word come to denote characteristic of the former. In short, and in line with Ingold’s (1993) argument, -scapes connote spatial expressions or form of specific human activity or environmental features such as cityscapes and ethnoscapes or, even ‘lifescapes’ (Edelstein, 1988; Day, 2007).

In his demanding yet appealing take on the subject of landscape Ingold (1993) initially focuses on what the category is not: it is neither geological nor cultural and it belongs neither to the world of man nor to the natural world. Instead, the author

contends that: ‘landscape is the world as it is known to those who dwell therein, who inhabit its places and journey along the paths connecting them’ (Ingold, 1993:62).

With regard to the above, Ingold notes that the environment could also be defined in the same way yet he points to a minute difference between the two which, in his view, negates arguments (Tuan, 1979) that the environment is a natural entity while landscape cultural or cognitive one. Instead, argues Ingold, the difference between environment and landscape is analogous to that between categories of organism and body. So while environment and organism are categories concerned with function, both landscape and body are domains of forms and features (Ingold, 2000).

Ingold adds that forms and features are not fixed, but processes, just as embodiment is an expression, movement or incorporation rather than an inscription of bodily features. So, just as the body is a living expression of an organism (both are also considered as domains of landscape), landscape is a processual expression of the environment; ‘it makes men; it is made by them’ (Ingold on Inglis 1977: 489). Consequently, landscapes are constantly in the making, they are ‘never complete’ (Ingold, 1993:67) and this unfinished character points to their key feature, namely, temporality.

It is through actions unfolding over time, or ‘tasks’, that the landscape is made while also becoming layered with meanings, stories, activities, patterns, features and movements (*ibid.*). Ingold concludes that the task of the anthropologist is to work like an archaeologist and dig deeper into the diverse meanings of landscape rather than interpreting its layers as separate entities.

Ingold incorporated these ideas about landscape into the discussion in *The Perception of the Environment* (2000) volume consisting of twenty-two interrelated Chapters taking as its lead subject relationships with, practices in, and perceptions of environment. It is virtually impossible to account in full for the sheer diversity and complexity of Ingold’s persuasive argument. This is why I would like to recall here my anecdotal account of the volume made in response to the question ‘what is this book about’ asked by a young, ten year-old perhaps, boy who sat next to me on a ferry boat. Wanting to avoid academic expressions I responded more or less as follows:

Well, before starting the book, I used to say that my cat really enjoys eating. Now, having read it, I would rather say that it is me who likes feeding him each time he stares into my eyes and miaows in desperation.

In the course of the ensuing conversation I explained that some people tend to characterise the world or its parts according to their views and expectations, and consequently, present them as being true. My fellow passenger was rather happy with the answer although I realise that the reader might expect a more sophisticated interpretation.

We could say that among the key aims of Ingold's work is to combine 'biophysical' and 'sociocultural' approaches to human beings. Ingold argues that all human action is necessarily grounded in experiences of the environment and therefore experience is indivisible. Meanwhile, environment constitutes the continuum of this experience including individual and social forms of life. Accordingly, he suggests, we should avoid distinctions between biological, somatic or social dimensions of experience and between nature and culture.

This is followed by a thorough critique of the understanding of the environment in the so-called Western tradition that purports that the natural world exists to be explained, classified and managed through cultural, social and/or scientific means. In the West, writes Ingold, environment is considered as:

a resistance to be overcome, a physically given, material substrate that has first to be 'humanised', by imposing upon it forms whose origins lie in the imagination, before it can be inhabited (Ingold, 2000:58)

However, according to Ingold, any kind of human activity is necessarily a form of being or movement in the environment and that also goes for what we conceive of as culture, social relations and science which are necessarily born out of and grounded in experiences of the environment and, as such, its constituents. Consequently, separation between the natural and cultural world is merely an expression of priority based around the convictions of primacy of human reflexive capacities (see also Latour, 1993) This, in turn, is used to challenge the so-called Cartesian separation of body and mind, as Ingold suggest that thinking cannot be reduced to a cognitive sphere. Instead there is always a complete response to the environmental conditions.

Ingold goes on to argue that: (1) Cultural diversity is essentially a variation of skills developed in specific environmental conditions; (2) These skills, such as for example walking or language, are not innate capacities but are result of training, repetition and experience that necessarily entail the indivisibility of a body from a mind, and (3) Social relations that both condition and emerge from processes of skills-development and -use are, consequently, considered as a '*sub-set of ecological relations*' (Ingold, 2000:5).

In summary of Ingold's argument we could distinguish between two kinds of perceptions of environment, one of them (the Western perspective) conceives of environment as an external entity that needs to be conquered and managed but also yields influences on humans, while another, what Ingold following Heidegger and Merleau-Ponty calls a 'dwelling perspective' is a form of concurrent assimilation with and participation through the environment, living with it and along it – or what Ingold refers to throughout the volume as 'being-in-environment'.

These two perspectives are, of course, not innate. However, they have tangible influences on how various cultures or groups of people conceive of their activities, forms of living, dwelling, travelling, material and artistic productions etc. In this volume I follow the latter, ‘dwelling perspective’ in the analysis of my research participants’ practices around mental health and suggest that mental health could also be understood as forms of engagements with, transformations alongside and movements in the environment rather than its management, control or impact of its characteristics. Meanwhile the temporal and reflexive character of my research participants’ actions leads me to consider their practices as landscapes of mental health.

Such a focus on mental health as an environmental matter and actions around health as forms of landscapes neither precludes nor prioritises biomedical notions of illness and anthropological concerns with subjective experience and suffering or power relations and inequality. Instead, it sees all these dimensions and interpretations of health as expressions of different niches within a broader ecological continuum of what Ingold refers to as ‘fields of relations’.

The impact of environment on health has been of scientific interest for approximately five hundred years and was first discussed at length by Paracelsus, a Swiss XVIth century scholar. Aside from his better-known discovery of zinc and seminal work on poison, which gave him the reputation as the originator of modern pharmacology, Paracelsus also proposed that environmental conditions determine health outcomes. Among his evidence was the identification of diseases associated with metalwork as discussed in *‘On the Miners’ Sickness and Other Miners’ Diseases’* (see Sigerist, 1996), a publication that initiated interest in occupational health.

Some four hundred years later, the German doctor and anthropologist Virchow put forward a similar argument regarding environmental conditioning of health on the basis of his research into typhus in Upper Silesia. In his article on the subject, Virchow (2006 [1849]) undermined aetiological understandings of the disease and proposed that ill-health is dependent on a wide range of factors and predispositions including social norms and standards of hygiene as well as the environment. What is more, Virchow’s conviction of medicine being a social science (see Pridan, 1964) and his multidisciplinary work inspired many of the subsequent ideas on health including those of Dubos.

Interestingly, both Paracelsus and Virchow are considered to have contributed to the disproving of Hippocrates’ theory of humors and it is perhaps their respective focuses on how health and illness are dependent on a number of different external and internal aspects and conditions that undermined the belief in bodily imbalance being the cause of disease. With regards to mental health, it should be noted that the humorism’s explanation of disease origin bears some important resemblance to contemporary biomedical models of mental illness that purport its cause to be chemical imbalance in

the brain. It seems then that further attention to environment in health related practices might provide more comprehensive models for understanding mental illness and mental health, and this thesis could be considered as an attempt of doing so.

However, as with the articulation of suffering and pain (see note on Jackson above), there are limitations to the communication of people's relationships with environment. Sauer, for example, argued that certain dimensions of landscape are beyond science and can only be captured by means of creative and/or artistic expression (Sauer, 1925; see also Cosgrove, 1984, 2004). My research participants, for example, operate with various categories and notions that help them make sense of their collective being-in-environment and of their landscapes-specific actions. One such category relevant to anthropology more generally and to the matters of mental health and illness in the United Kingdom specifically, is that of community.

Community

In an edited volume devoted to ethnographic accounts of rural United Kingdom, Cohen (1982) asserted that the term community should necessarily be understood in line with the ways in which people who feel part of these communities operate with (or that academic considerations of community should reflect people's use of the term). In the particular context of this research, we could helpfully point to three different uses of community. Firstly, we have both historical and nostalgic notions of community in the United Kingdom denoting favourable forms of organisation of social life (see Young and Willmott, 1962). Notably, demise of these communities after World War II was also seen as the ultimate collapse of social relations (*ibid.*). Secondly, we have subjective notions of community used by groups of people to signify their connectedness and/or common aims. Both Cohen's work in the Shetlands (1988) and the current volume discuss such reported subjective senses of community. Finally, with specific reference to issues of mental health, we have care in the community – a set of legislations and services' transformations in the United Kingdom, which I discuss in Chapter 1.

Given these various notions, 'community' emerges as an ambiguous category. Hillery in his famous study concluded that the sole commonality between almost one hundred different approaches to the subject was that they 'all dealt with people' (Hillery 1955:117). There are, however, some other features of communities which appear in theoretical considerations more often than others. For example communities have often been portrayed as a feeling of belonging together (Calhoun, 1980; Cohen, 1982), where belonging can be understood as an expression of social relationships in reference to geographical or physical proximity or, as in case of diasporas, emotional proximity. With regards to this we could conceive of communities as essentially territorial entities.

Cohen's (1985) seminal work on the subject allows us to further the argument regarding spatial characterisation of communities. Cohen sees community as a group of people sharing common interests or traits, which differentiate it from other groups. In this view, community is characterised by concurrent sense of similarity and a difference. Cohen continues, to say that these differences are maintained through boundaries of both tangible and imperceptible kinds and, effectively, community is 'a boundary-expressing symbol' (Cohen, 1985:15).

Cohen further explains that the experience of being in a community amounts to senses of belonging but that community is not an 'integrating mechanism' but an 'aggregating device' (1985:20) where 'commonality' rather 'uniformity' is foundational to such senses. Consequently, it is argued that successful communities thrive on difference between their members while maintaining a unified image based around vague symbols that denote community's similarity rather than homogeneity. As we shall see later, my research participants also operate with approximating notions of mental health that help them to conceive of their actions as unified whilst emphasising commonalities in experiences of different mental health problems.

With regards to my research participants' reliance on media practices, we should also mention Anderson's *Imagined Communities* (1991) where he suggested that broadcast media and mass events aggregated senses of 'simultaneity', which, in turn, led to the emergence of senses of belonging to modern nation states. We shall see in Chapters 3 and 4 that discussions on social media also facilitated very particular senses of unity based upon sharing of experiences of mental health problems. However, rather than emphasising media's effects on senses of sociality, I see the inevitably reflexive character of communication in the social media as contributing to the realisation of common experiences.

Finally, in *Trouble with the Community* (2002) Amit and Rapport explore different, and sometimes contradictory, stances on community as both a scientific and socially relevant category. Similarly to Cohen (1985), who claimed that rapid social change in the second part of the twentieth century threatened community boundaries, Amit and Rapport asserted that modernity brought an end to communities. More specifically, following Hastrup and Olwig (1996), they argue that due to an increasing number of social phenomena no longer being bound to particular locations the category of place has lost some of its significance. Consequently, it is suggested that other, alternatives to communities, forms of collective identities have crystallised (Amit and Rapport, 2002) with some examples being diasporas, ethnic groups, subcultures or Internet-based groups.

In the same volume, Amit (2002) suggests that the focus in community studies should be on individual experience, subjectivity and relations between individual and the group because communities are not ascribed or imposed but negotiated between its particular members. This emphasis is markedly different from that of Cohen who

focused on dynamics between communities. Amit goes on to argue that communities rather than signifiers of cultural similarity might be ‘categorical identities’ made through social dynamics and interactions as well as collective participation.

Meanwhile Rapport (2002b), also in the same volume, is altogether suspicious of the usefulness of the concept of community, which leads him to a general critique of social science’s categorisation of people into coherent groups. He then suggests that anthropologists should turn away from searching for cohesion and unity. However, it would be equally important for anthropologists to recognise that people themselves search for unity and some groups might continue using the notion of community to describe their actions while others not. This is also the case for different groups of research participants and it will become discernible in Chapters 3-4 and 7-8 that different senses of health-related unity are conditioned by the contexts in which they arise and which they also constitute.

All in all, Amit and Rapport (2002) make an important point that the category of community has lost some of its original appeal and, in line with this argument, we will see that in reflexive considerations of their actions my research participants operate with several different notions of unity. In the specific case of mental health care and legislation in the United Kingdom, however, various notions of community continue to inform collective action as well as policy and the organisation of health services.

I discuss care in the community in the forthcoming Chapters, as its introduction and history is of direct relevance to possibilities for action available to contemporary activists. Suffice it to say for now that, in this thesis, I consider care in the community as a form of radical spatial or, more precisely, environmental rearrangement of ideas, practices and legislation regarding mental health and illness in the UK. However, we shall also see that community care is just but one of many territorial expressions of ideas and practices that connote health with environment.

Chapter Outline

The thesis is divided into two sections that reflect research activity in what we could provisionally call national and local contexts of activism. Part 1 consists of Chapters 1-4 and accounts for projects and forms of participation aiming to bring about a comprehensive social change across society whereas Part 2, which includes Chapters 5-8, considers practices around mental health in the specific context of Richmond.

In Chapter 1 I discuss the characteristics of contemporary forms of mental health activism, its notion of mental health as something we all have and the embracement of an all-encompassing and non-contentious outlook as outlined in mission statements of campaigns, groups and organisations. I then contextualise the

contemporary forms of activism and its characteristics vis-à-vis the history of mental health movements in the United Kingdom, the role of psychiatry in the management of mental illness, changing spatial ideas and practices with regards to mental illness and health, relevant transformations of policy and services over the last sixty years as well as notions of recovery. In Chapter 2 I discuss different types of occasions on which people concerned with mental health problems meet, including local service user groups as well as activist events and conferences. This leads to discussion of how there emerge in these contexts divergent and sometimes conflicting ideas and concerns as well as notions of unity as referred to by my research participants including that of a movement. In Chapters 3 and 4 I pay particular attention to activist use of media. In Chapter 3 I account for the emergence and subsequent employment of Facebook in the TTC campaign and do so with reference to administrators' accounts, the changing architecture of the medium and different practices of communication between users of TTC's Facebook Page and Group. Chapter 4 continues with this focus but concentrates specifically on users' discussions of mainstream and activist-made representations of mental health problems. Reflexive realisations of meanings given to practices of sharing experiences of mental health problems that are at the heart of activist media and emergent notions of unity in the context of the Page lead to discussion of activist uses of the notion of mental health as a form of language that is at the same time magical and demystifying.

In Part 2 I focus specifically on the Reflections project in Richmond. In Chapter 5 I first outline the features of the fieldsite as well as details of the project. I then discuss individual accounts of mental health problems collected during the project which leads to consideration of the strategic use of narratives of mental health problems. In Chapter 6 I discuss four accounts of favourite places in Richmond, which I filmed as part of the Reflections project and which lead to consideration of recovery from mental health problems as a form of movement in environment and to the notion of landscapes of mental health. In Chapter 7 I present my research participants practices and accounts of social centres in Richmond, reported senses of community developed therein and collective dimensions of the recovery processes. Finally, in Chapter 8 I discuss recent transformations of mental health services in the area as well as an example of an independently organised mental health focused group. There, I also summarise the Reflections projects and point to the inherently environmental dimension of practices around mental health.

In conclusion I explain in more detail why I embarked on the two-part approach and discuss how they work together, outline outcomes of the research, my potential contributions to the intersection of various anthropological fields and suggest further avenues for research.

Part I

Locating the Mental Health Field

Chapters 1-4

Chapter 1

Mental Health and How Come We All Have It?

‘Mental illness?’
‘No! Mental health’ replies Helen.
‘Mental illness’ I assert.
‘No! No! It has to be mental health.’
‘Why?’ I ask.
‘This is how we have to do it...’ explains Helen.
‘How come?’
‘This is how it works and this is how we have to use it... [long pause] it’s more politically correct and better, anyway.’
‘Why is it better?’

‘This is just the way it is... and that’s how we’re going to write it.’ Helen cuts the conversation short.

In July 2010 in a small mental health centre in South-West London, Helen and I discuss end credits for a film we have been working on together for the past months. The documentary takes as its subject the history of mental health services in the borough of Richmond.¹ We have just finished recording an art group, recently re-established as part of a radical transformation of mental health centres in the area.

I pack the equipment, say goodbye to Helen and members of the art group and leave the building. While sitting on a train back home, I recall Majra, an attendee of a mental health-focused conference that took place some weeks earlier in Birmingham. There, she repeatedly referred to a period of depression by saying ‘when I had my mental health’. Still on the train, I check the Facebook Page of Time to Change (TCC), an England-wide anti-stigma campaign. This is in order to follow the discussion about a film representation of schizophrenia, which began this morning. As the content of the web loads slowly, the screen of my phone freezes on TCC’s slogan –‘Let’s End Mental Health Discrimination’. Struck by the occurrence of the term ‘mental health’ in these various contexts I note in my fieldwork diary:

‘AVOIDING MENTAL ILLNESS?’

I stare at these three words written down in capital letters on an otherwise clean sheet of paper and come to realise that the central theme of the contemporary activist struggle and, consequently, of my research is not, as I have been thinking for many months, mental illness but, in fact, mental health.

Still on the train, I recognise that without me realising it, conjuncts consisting of ‘mental health’ and another noun have entered my everyday vocabulary, including, among others, ‘mental health’ services, problems, issues, activism, awareness, stigma and media. Previously, on the basis of observations from the field, I considered the organisations, groups and individuals involved in activism and campaigning to be related to each other through often loose structural and bureaucratic ties as well as

1 This film constituted part of the ‘Reflections’ project, which I discuss in Part 2 of the thesis (Chapters

financial interdependencies. Now, it appeared that the term mental health is something that consolidates this immensely diverse array of projects, efforts and actions. However, it also emerges that the concept of mental health is not at all intelligible.

Mental Health as ‘Something We All Have’

The first traceable, publicly visible and, at the same time, semantically problematic use of the term mental health I encountered during the research preparation period was through the TTC campaign, mentioned above. This project, which I discuss in more detail below, was launched on 19th of January 2009 under the slogan ‘Let’s end mental health discrimination’, which delineated TTC’s ultimate aim quite clearly, although the employment of mental health in this case could be seen as a euphemism for mental illness. With time, the notion of mental health came to be used more widely on the activist scene and in particular in the formulation of activist aims as well as people’s accounts of personal experiences. However, the concept of mental health has never been critically assessed or analysed and, thus, was taken for granted as was the case for Helen who, whilst she was not sure why the term should be used, insisted that it was ‘more politically correct’, and for Majra who used mental health to denote her mental illness.

Lessa (2006: 285), following Foucault, claimed that discourses are ‘systems of thoughts composed of ideas, attitudes, courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak’. Given its inconsistent use in activist practices of communicating, constructing and telling narratives and making of media representations, mental health is yet to achieve a status of an established or structured discourse. However, the concept does seem to assist activists in imagining a new society in which all people share responsibility for mental health.

‘We all have mental health’, ‘mental health is something we all have’ ‘we all need to take care of our mental health’ or ‘we all have responsibility for mental health’ were the expressions I heard increasingly frequently from my informants as campaigning, activism and, correspondingly, the research progressed. Such tactics of making mental health an all-encompassing social concern could be considered as an innovative strategy for encouraging social change. This is because mental health activists who have proclaimed mental illness to be ‘the last great form of discrimination’ do not demand acceptance or tolerance of differences, as social movements in the past have done. Instead, they are promoting social recognition of sameness embedded in the universality of (having) mental health. It is worth recording then, how these notions regarding universal mental health were incorporated into the mission statements of some of the mental health-focused campaigns and projects I investigated in the course of the research. This should help us in understanding how activists imagine a realisation of universal mental health.

‘What Do We Do?’

For example, TTC’s slogan stands for a complex set of objectives and associated strategies proposed in Time to Change’s mission statement, made accessible on its website.² First, TTC aims to spread knowledge about mental health problems among the general public and, as a result, eradicate ignorance. Second, it challenges attitudes in order to eradicate prejudices. Third, it encourages change in social behaviours and, as a consequence, hopes to eliminate discrimination. At the same time, it aims to ‘empower’ people who experience mental health problems by ‘giving them voice’ and by helping to create ‘a stigma-free world’. TTC’s ultimate ‘vision’ is thus: ‘to make lives better for everyone by ending mental health discrimination’.

On numerous occasions my informants who were involved in organising and running the TTC project explained that, rather than people experiencing mental health problems, the campaign is directed at the ‘general society’, the term by which they meant everybody without previous experience of mental health problems, whether primary or secondary. As the changing of public attitudes and behaviours was considered the ultimate goal, TTC did not aim to tackle the issues experienced by individuals but, instead, focused on wider societal circumstances in which people experience stigma and discrimination.³ Such a direction of action might, at least partially, explain why TTC decided to emphasise mental health, here, in an attempt to build a widespread recognition of the universal possibility of experiencing mental health problems and to counteract stigma against mental health problems.

At the same time, TTC relied on the participation of people affected by mental illness and on their lived experience of illness and personal recovery accounts, which were incorporated into the campaign’s media representations. Given that TTC managed to bring together a wealth of projects and individuals and that the outlined audience of its actions was the whole of the society, it seems that mental health was a convenient denomination capable of supporting a dialogue instigated between these various social actors. Its success at connecting them, however, cannot be attributed to this one expression. Such mobilisation and the emphasis on widespread concern with matters of mental health would not have been realised without previous experience of campaigning and the know-how of two well-established mental health charities – Mind and Rethink, which together with the no-longer existing Mental Health Media group conceived the Time to Change campaign.

2 <http://www.time-to-change.org.uk/about-us>

3 The same argument was made for the TTC Facebook Page, which, contrary to expectations, did not attract the attention of the general public but, instead, drew participation of people affected by mental health problems, (see Chapters 3-4). At the same time, despite its emphasis on general society TTC also organised projects designed to specifically help people with mental health problems – like the ‘Let’s Get Moving’ Campaign that encouraged outdoor activities such as walking and running.

Mind is the largest and longest-running mental health-focused charity organisation in the United Kingdom. Initially called the National Alliance for Mental Health (NAMH), it has been functioning under its current name since 1972. Mind used to be well known for its anti-establishment (anti-psychiatry) outlook (Crossley, 1998a, 2006). In recent years, however, it has taken on a non-antagonistic stance in a sense that it no longer focuses on challenging psychiatric practices or government legislation. In its mission statement Mind also refers to the universalising concept as it sees itself as a ‘force of change’ ‘for better mental health’ that works:

vigorously to create a society that promotes and protects good mental health for all - a society where people with experience of mental distress are treated fairly, positively and with respect.

Rethink, the second of the organisations supporting TTC until recently (2002) functioned as The National Schizophrenia Fellowship.⁴ The name changeover took place in the course of what I conceive of as the compromise on illness specificity in mental health activism, which is a counter-trend to mental health movements’ focus on particular illnesses observed by Crossley (2006) at the end of the 1990s and the beginning of the 2000s. In line with this compromise Rethink also resigned from its earlier contentious anti-anti-psychiatry stance and decided to work with its former adversary Mind by co-founding Time to Change.

Still, the organisation retained its former emphasis on supporting people experiencing mental illness as in its mission statement we read that Rethink is ‘working together to help everyone affected by severe mental illness (to) recover a better quality of life’. It should be noted that Rethink, together with Mind are among the key voluntary sector organisers of mental health services on the national scene, while also providing advice information and support to all people affected or concerned with mental health. By founding and supporting TTC, however, both Mind and Rethink highlighted an urgent need to change public opinions about and social attitudes towards mental illness and this new emphasis might be among the key reasons as to why the notion of mental health came to be employed.

Initiatives funded directly by the government also aim to make change across the social spectrum. The now discontinued project Shift supported by the Department of Health, for example, was an

initiative to tackle stigma and discrimination surrounding mental health issues in England (which) aim(ed) to create a society where people who experience mental health problems enjoy the same rights and opportunities as other people.

⁴ Rethink is the operational name of the organisation and Rethink Mental Illness its full name.

Activists working in local or small-scale contexts also share these wide-ranging concerns with the change of behaviours and attitudes across the society. Open-Up, a grassroots network supported financially by TTC has an objective of a ‘world without mental health discrimination’, which is to be achieved by ‘sharing experience, raising awareness, challenging discrimination’ and by working ‘together through networking, mentoring and training activities to share their ideas, resources and experiences’.⁵

Preoccupation with the eradication of stigma and prejudice is also the case for media projects such as, for example, ‘One in Four’ magazine, which

inspires people with mental health difficulties to get the best out of life while
challenging stereotypes and spreading information that would help everyone to
understand mental health difficulty better.

Making Waves, a local organisation in Norfolk, is one of the few that clings on to the discourse characteristic of mental health movements of the past, specifically the anti-psychiatry movement as it ‘challenges ideas about madness and current understandings about people who have experienced mental distress’. Although this group does refer to madness and not to mental health as most of the current projects do, just as its contemporaries, Making Waves looks forward to changing attitudes and to making mental health problems more socially accepted.

Mission statements point to key aims of contemporary mental health activism, which, in turn, are revealing of its key characteristics and strategies. Most importantly, activists emphasise a need for a fundamental change in the society. Along with the notion of mental health, activists hope to galvanise the universal responsibility for mental health by providing better visibility for mental illness and the mentally ill, producing or demanding more balanced representations in the media and through improvements in existing and the rescuing of imperilled services. All these actions aim at ending stigma and discrimination and, consequently, at bringing a better life for people experiencing mental health problems, and therefore creating a better society for all. This convergence of interests among people experiencing mental health problems and the society as a whole can be brought back to this critical activist claim that mental health is a universal feature of all people and, consequently, responsibility for mental health is also ubiquitous.

Although transformations of social attitudes and behaviours have had always been on the agenda of mental illness-focused movements in the UK (Crossley, 2006), regardless of their ideological outlook, the whole of the society has never been at the centre of struggle. By choice, former movements challenged, supported or demanded change from the professional, bureaucratic and political establishments that regulated mental illness and the lives of the mentally ill (*ibid.*). Furthermore, the movements and, associated with them, organisations competed with each other for recognition,

⁵ <http://open-up.org.uk/about>

visibility in the public space and resources. For a number of reasons, which I discuss in what follows and which include past movements' successes (and their consequential demise) as well as change to psychiatric practices, legislation and organisation of services, resistance and discord had been replaced by what I suggest is a non-contentious or non-oppositional stance. I mean non-contentious in a sense that contemporary projects and campaigns no longer challenge each other, neither do they struggle against particular professions, legislation or government agencies but, instead, collaborate on bringing about the change across the whole social spectrum.

In this context, the employment of the concept of universal mental health could be seen as an attempt to channel wide-ranging alliances and to build an overarching realisation in the society that mental health problems can affect anybody, ultimately leading to a recognition of mental health as a universal social concern. To put it another way, the concept of universal mental health is both a product and bonding component of contemporary activism that, at least at the level of mission statements and aims, allows activists to elicit formulate and communicate its aims while also denoting the novel non-contentious outlook.

The concept or slogan of mental health together with its emphasis on universal similarity also fed the abovementioned trend of activists' compromise on illness specificity. As part of this tendency, activists started to emphasise similarities in experiences of various mental health illnesses problems. A number of resemblances such as experience of stigma and discrimination and of recovery were identified and informed the ways in which activists formed their objectives, actions and representations. It is clear from mission statements that the elimination of discrimination and stigma was among the key activist goals. Meanwhile, recovery became the central theme of activist-made media and, supporting them, lived experience-based narratives (Chapter 4) conceived of by activists as most fruitful in counteracting stigma and discrimination.

While this emphasis on commonalities of experiences could be seen as allowing for all-encompassing and, therefore, for supposedly more forceful and vigorous claims and demands, we shall also see that it helped to accelerate senses of unity and solidarity experienced by my informants (Chapters 3-4 & 7-8). However, it shall also emerge that this generalising focus is problematic since it is directly responsible for activist-made media representations that are sanitised in the details of the suffering and struggle characteristic to the experience of mental illness.

On Media

If the concept of mental health, a non-contentious stance and compromise on illness specificity are ideological keys to present-day activism, then, media practices are, undoubtedly, its primary vehicle. Contemporary activists seized the newly arising

opportunities provided by the recent proliferation of cheaper media technologies, especially digital cameras, camcorders and voice recorders (both in standard and HD quality). They also took advantage of greater accessibility to channels of media distribution such as YouTube and Vimeo, Internet-based radios and publications as well as the emergence of social media and, in particular, Facebook and Twitter. This myriad of activist media practices could be divided practically accordingly to their mode of use.

First, there are media produced in attempts to address what my research participants spelled out as the general society. These media encompass adverts and films broadcast on television and on the Internet, posters and advertisements, radio programs, leaflets, magazine and newspaper publications. Examples discussed in the thesis and specifically Chapter 4 show that this type of media tends to present mental illness and mental health in a positive light, in line with the activist perception that existing mainstream representations are, in general, overtly negative and stigmatising and, therefore, need to be counterbalanced with affirmative ones.

Second, contemporary activists use social media, mainly Facebook and Twitter but also specialist chat rooms such as Rethink Talk to communicate with each other, share experiences of mental health problems and of campaigning, exchange information, formulate ideas and to discuss both activist and mainstream representations of the mentally ill and mental health.

As we shall see later, debates regarding both the above types of representations constitute a significant proportion of the ongoing dialogue in this sphere of social media. At the same time, questions, concerns and ideas appearing in the latter context have an impact beyond its boundaries as they feed, encourage and inform both activism more generally and productions of the media of the former type specifically. Such mutual influences as well as a common focus on achieving key activist aims demonstrate that the two spheres of media practice should not be considered as separate but, instead, as complementing each other.

In line with the objectives and strategies outlined, activist-made media representations take as their principal subjects the common experiences of mental health problems: of stigma and discrimination and of the processes of recovery. The underlying assumption of such narratives is that through getting to know the details of an experience, a member of the audience would step down from his or her discriminating or stigmatising position, especially as it was often highlighted by those who share those stories that mental health problems could affect anyone. Yet, among a wealth of representations there exist only a very limited number of productions that provide detailed experiences of particular illnesses. My research participants across the fieldsites claimed that they purposely avoided making media content that might be seen as upsetting or controversial.

Consequently, representations designed to encourage more consistent knowledge about mental health problems among the general society showed little of the everyday, grim reality of living with mental illness: dim waiting-rooms with worn-out gossip magazines, the side-effects of medications, the inability to connect to others, loneliness, desperation or disturbing moods. This absence of detail in the sphere of the broadcast media, however, was offset in the sphere of social media where discussions of experience tended to be more detailed, ‘experience-near’ and somewhat less sanitised. Meanwhile both types of accounts tended to consider experiences of illness in terms of life-learning, as an opportunity to discover and understand oneself and were accompanied by a ubiquitous emphasis on recovery.

I discuss the notion of recovery as a marker of a paradigm shift in policy and services further down in the section contextualising contemporary activism’s outlook and characteristics. At this point, however, it is necessary to point out that in the context of the research, recovery or its possibility was not only the key theme of activist mental health media but a fundamental process to people suffering from mental health problems; a process that held potential for what my research participants regularly described as ‘leading a full life’. Recovery, thus, denoted the time, space and actions separating mental illness from mental health and, analogically, the difference between ‘disrupted’ and ‘full’ life’. Recovery seems to have allowed evasion of a focus on troubling experiences and suffering while, at the same time, signifying a hope for a better future. As such, recovery, or its promise, seemed to have also reconciled the difference between people who experienced mental health problems and those who did not, perhaps by making mental illness appear to be less scary and more manageable.

Mental Illness, Mental Health or Recovery?

In everyday conversations and in the media representation my research participants used a number of other expressions that allowed evasion of the term mental illness including ‘wellbeing’, ‘getting better’ and ‘being’ or ‘staying’ fine’, etc. Recovery, however, seemed to be the term referred to most commonly, possibly, due to the prevalence of recovery-based discourses in policy and services. At the same time, out of all these utterances, recovery indicated most clearly a temporal transformation from mental illness to mental health. This trajectory was put eloquently by Max, a schizophrenia sufferer who, following a series of what he described as ‘serious psychotic episodes’ and a ‘painful recovery’, developed an educational programme about mental health for school children in south London. In a casual conversation during a mental health-focused conference Max said:

You only really find out you have mental health once you’re ill, once you’ve lost it... and this experience [of illness and of recovery] helps you understand what it means to be healthy, and learn how to get your health back.

For Max, mental health went beyond the linguistic formulation denoting a universal human possibility and used in intention of mobilising change in public attitudes. Mental health was something you needed to work towards, something to be responsible for and not a state but a continuous action. Meanwhile, recovery provided with a framework for thinking about mental health in periods of mental illness and having an active role in this process was to put responsibility into action.

As we shall see in Chapter 4, the issue that activists face is that members of the general public who are being addressed through the activist-made media have no previous experience of mental illness and, therefore, might fail to comprehend the representations made by activists, especially as they are largely devoid of illness' details, suffering or controversial themes.

One of the explanations of this incongruity in activist aims and their mediated execution might be the limiting character of publicly articulated narratives of illness. Stacey (1997) noted that experiences of illness often find their expression in narrative and indicated a certain inevitability of experiences being formulated in the form of stories (the point to which I come back to in more detail in the conclusion to Chapter 5). Stacey follows on to explain that illness-driven narratives are often restricted in scope. Her conclusions in this regard, informed by a lived experience of cancer, are relevant to the limitations contemporary activist-made representations of mental illness and health:

We [cancer sufferers] are encouraged to think of ourselves as coherent stories of success, progress and movement. Loss and failure have their place but only as part of a broader picture of ascendance. (Stacey, 1997: 9).

Stacey continues to say that the available narrative tools for making public sense out of the experience of cancer require person affected by the illness to assume the role of 'hero', one that successfully overcomes the disease or dies trying (*ibid.*).

In the mid-2000s an analogous example of portrayal of mental illness emerged in the United Kingdom (Blackman, 2007). Blackman notes that in accounts of British boxer Frank Bruno's mental health problems, mainstream British media followed the sequence of victor-victim-victor narrative. Consequently, argues the author, representations of Bruno's recurring depression and recovery resulted in the image of mental illness as 'a site of self-knowledge and identity-work.' (Blackman, 2007: 8-9). Blackman saw this as a discernible incorporation of psychiatric models and discourses into the language of the mainstream British media.

Contemporary mental health activists seem to have managed to overturn, at least partially, these discursive dynamics, as TTC has used Frank Bruno's story of successful recovery in their projects while the boxer himself became one of the

celebrity personalities supporting the campaign and the activist struggle. This re-appropriation of the story together with the positive portrayals of mental illness are all intentional attempts to modify mainstream media discourses and representations, which activists believe to be largely responsible for stigmatising and discriminating views of mental illness held by society. My research participants strongly believed themselves to be capable of bringing better and more informed views on mental illness and health by focusing on mediating personal accounts. Interestingly, the practice of breaking the stigma by speaking about the experience was fundamental to mental health movements in the past and in particular to psychiatric survivors (Reville, 1988; Coleman, 2008). However, it is also argued that psy-disciplines have later appropriated patients' narrative accounts (Costa et al., 2012), a point in accord with Blackman's (2007) analysis.

It is thus worth considering previous mental health movements in the United Kingdom, which should help us gain a better understanding of the characteristics of contemporary mental health-focused activism outlined above. Explanation of contemporary activists' reliance on media in their projects, for example, cannot be narrowed down to media's increased availability and variety. Instead, I would like to suggest that the historical, social, economic and ideological contexts that influenced the emergence of current forms of activism have lead to the non-contentious stance, compromise on illness specificity and growing focus on media practices and the making of media representations.

The starting point is that previous movements' successes, such as changes to medical practices and organisation of care and services rendered any activist struggle directed at political and professional establishments considerably less effective than it was the case in the past. As a consequence, activists were required to formulate new objectives and turn to addressing the general society and we shall see that these key activist strategies and ideas are as much a matter of resourcefulness as of inevitability. Below I review five interdependent factors, which are pivotal to understanding contemporary mental health activism including (1) mental health movements in the past and their efforts at changing the language used to describe mental illness, (2) the changing role of psychiatric practise in management of mental health problems and, by extension, in activist agenda, (3) changing spatial organisation of mental illness and mental health care, (4) care in the community and associated notions of belonging and (5) the recent turn to the notion of recovery in services and policy within the wider (neoliberal) socio-economic context in which contemporary activism has been unfolding. All five have shaped opportunities and possibilities available to contemporary mental health activists and, implicitly or explicitly, influenced their ideas, discourses and practices.

Mental Health Movements

The most exhaustive sociological exploration of the history and development of mental health movements in the UK has been completed by Crossley who documented political and organisational overlaps between various organisations and actors that entered mental health politics throughout the twentieth century. Crossley (2006) identified five distinct, yet, interconnected movements: (1) mental health hygiene, (2) civil rights, (3) anti-psychiatry, (4) survivor and (5) anti-anti-psychiatry and also noted further developments at the end of 1990s, which he did not consider as a formal movement due to the absence of an explicit ideological outlook or perspective.

That recent period, explained the author, saw activists putting more emphasis on particular illnesses and the popularisation of media practices in their projects. Crossley's (*ibid.*) prediction for the future was that mental health movements would continue to focus on addressing issues related to specific medical conditions. As we have seen, the situation turned out to be the opposite and, rather than specialising, activists compromised on illness-specificity and concentrated on universalising notions of mental health. The increased reliance on media noted by Crossley, however, became to characterise mental health activism in the late 2000s and set it apart from its predecessors.

Crossley (2005) also considered past mental health movements as interrelated and in a state of continuous rivalry and, thus, theorised relationships between various organisations and groups focused on issues of mental health as 'fields of contention' where competition for resources, public attention and success characterised their interactions. As explained above, in the contemporary context, previously antagonistic groups have resigned from competition and have attempted to build a coherent activist voice and wide ranging alliances, further ethnographic evidence of which can be found in the following chapters.

Although Crossley emphasised contention as characterising movements in the past, a synthetic approach to his account of movements (2006) brings forward a number of important similarities that help us understand the shape of contemporary activism. First, all movements' discussed by Crossley (*ibid.*) focused, to a smaller or greater extent, on giving visibility to issues surrounding mental illness in diverse public spaces and on addressing a variety of audiences and in particular the medical, professional and political establishments. As we have seen, contemporary activism continues to emphasise the necessity for more information regarding to, and a greater public presence of, these issues. What separates it from its predecessors is that it takes as its audience the whole of the society and not only its sections such as particular groups of influence or specialisation.

Second, we have past movements' successes in generating some change in social attitudes towards mental illness and in particular the language used to describe mental illness and the mentally ill. Transformation of popular discourses and social

behaviours in relation to mental illness and health is, as I already mentioned, also the ultimate goal of contemporary activists. Third, all the mental health movements in the past shared the overarching concern with living conditions of mentally ill, whether in institutionalised or non-institutionalised settings. I shall demonstrate in this thesis that contemporary activists could be seen as continuing this negotiation of the spatial organisation of mental health and illness. In short, mental health-focused politics in the UK have continued to address matters of language, social attitudes and locations in which practices around mental health take place, although different strands have emphasised different dimensions of these issues.

Despite these similarities, contemporary activists make sporadic reference to past movements, while sustained analysis of their predecessors' achievements and failures is, effectively, non-existent. My research participants rarely mentioned earlier movements and only occasionally suggested that their actions should be inspired by former accomplishments. At the same time, terms coined by participants in former movements such as 'survivor' were still employed by my research participants although never really accompanied by demands similar to that of the survivor movements and, consequently, we could think of the use of such expressions as a form of linguistic sediment from the past.

However, given the current activist emphasis on media- and representation-making, the focus on past movements' successes in the negotiation of language used to refer to mental illness would appear germane. For example, the current notion of mental health bears some similarity to the language of 'not being mentally ill' as documented by Crossley (2004). The latter idea, argues Crossley, emerged as a result of the successful replacement of the term 'patient' with 'survivor' by the movement of the same name. However, Crossley adds that modification of nomenclature is in itself insufficient to generate real change:

It is not individual terms which make a difference, of course. A word can only function positively within the context of language games and shared forms of life, instituted by the movement, which allow it to do so (Crossley, 2004:169).

Contemporary activists' concept of mental health is also disseminated through various 'forms of life' such as the wide range of media representations and uses. However, as we will see in the next chapter, the contemporary activism is yet to be consolidated as a social movement, despite sporadic claims for its existence. Consequently, activist support for terms and words they use might not be as substantial as was the case for former movements discussed by Crossley. At the same time, a much-expanded availability and diversity of media outlets, including social media, seems to make it considerably more difficult to promote particular expressions or terms than was the case in the past.

While considering the usefulness of past movements' practices for contemporary activism, it should be noted that former groups have used media with considerable success. For example, media events accompanied the creation of new alliances and strains of the movement, such as for example the formation of the Mental Patient Union following a broadcast on Radio 4 in 1973 (Crossley, 2006). Furthermore, knowledge of media and journalistic practices played a key role in the establishment of SANE in 1986 and the subsequent expansion of the anti-anti-antipsychiatry movement. Yet still, some mental-health focused projects are believed to have failed in using media and, by 'normalising psychopathology' in their campaigns are believed to have contributed to further stigmatisation of the mentally ill (Blackman, 2007).

This mixed success with the use of media by movements focused on mental illness in the past, suggest that media could be seen as a double-edged sword in campaigning and hence our concern with sanitation of activist representations of mental illness. None of the previous movements, however, focused on media to such an extent and with such a degree of reflexivity (see Chapters 2-4) as the present-day activist have, and it is the comprehensive and widespread use of media at all levels of organisation and action that makes contemporary activism not only fascinating but also distinct from its predecessors.

Given its emphasis and the fact that some of the organisations that supported former movements continue their contributions, albeit in altered form, contemporary activism could be seen as a continuation of the decades-long struggles for better treatment and social position of the mentally ill as well as a negotiation of ideas about, and terminology used to describe mental illness. Such similarities between past movements and present forms of activism indicate one overall conclusion: that mental illness and matters surrounding mental health are still poorly understood among society and that there is a continuing need to change this state of affairs. Meanwhile, the distinctive features of contemporary activism including the use of the notion of mental health, compromise on illness specificity and a non-antagonistic outlook could be seen as implicated by the transformations instigated by the former movements and, in particular, their success at negotiating psychiatric practices.

Psychiatry in Context

Over the period of the last seventy years, psychiatry has stood at the centre of mental health-focused politics in the UK and, depending on particular movements' ideological stances, the discipline has been seen either as their main foe or ally (Crossley, 1998b, 2006). The anti-psychiatry and the survivor movements in particular have had considerable success in changing psychiatric practices, either by protesting against the discipline's dehumanising character, as was the case for the former movement, or by demanding improvement to and/or expansion of services and treatment, which was on the agenda of the latter. The anti-psychiatry movement, for

example, undermined the very rationale of psychiatry by embracing the notion of madness. Meanwhile the replacement of the term ‘patient’ with the notion of ‘survivor’ allowed those suffering from mental health problems to ‘socially deconstruct’ and resist psychiatric practices (Crossley, 2010). Actions of all former movements are seen as having partially changed the face of psychiatry in the UK by undermining the discipline’s legitimacy and effectiveness or improving its knowledge and, consequently, transforming its overall impact on the management of mental illness. Ironically, the movements’ success led to their own demise as changes to psychiatric practice cancelled out their *raison d'être* (Crossley, 2006).

Rogers and Pilgrim (2010) argued that the legitimacy of British psychiatry decreased substantially in recent years due to deinstitutionalisation and the emphasis on recovery in services. More specifically, they argue that psychiatric professionals’ identities were challenged by the reorganisation of services introduced throughout the years of the New Labour governments. The policies of involvement in decision-making and choice of treatment initiated by the end of 1990s, for example, provided patients with possibilities for renegotiation of their relations with medical practitioners and the treatment they received. As a consequence, suggest the authors, the monolithic character of psychiatric knowledge and practice seems to have been considerably undermined.

A number of other authors (e.g. Lakoff, 2005; Van der Geest, 2006) connected political and economic conditions to the position held by psychiatry in a national context. In the contemporary UK, the situation of both the state of the economy and of psychiatry is uncertain although it is fairly clear that the unfavourable financial situation of public services has led to a decrease in access to health care more generally, including possibilities for psychiatric interventions. More specifically, the so-called spending cuts introduced by the Conservative and Liberal-Democrat coalition government have led to the closing of hospitals and services and withdrawal of funding to services all of which have limited patients’ access to medical professionals. However, it must be noted that in 2010, in the midst of severe cuts to all public services, it was announced that the NHS budget for mental illness would actually be increased in line with the ‘No Health Without Mental Health’ policy guideline (DH, 2010).

Activist organisations and groups, as well as individuals affected that I spoke to at that time, welcomed this decision and, in particular, the promise for more funding to non-psychiatric services in out-of-the-hospital settings such as talking therapies. This increase was seen as positive yet not because the people concerned demanded an increased influence of psychiatry but because in times when many services were terminated, any possibility to talk with a professional were deemed precious and potentially useful. We should also note that, in recent years, access to some day services at social centres have become available only upon referral from a psychiatric

professional and some, of my research participants went to see a psychiatrist only for that reason, claiming they would not do so otherwise.

Instead of challenging psychiatry, as movements in the past have done, contemporary activists are trying to involve medical professionals into its coalition in order to achieve the aims of eradication of stigma and discrimination in the society. Notably, such an alliance has already been partially realised. Local branches of Mind, for example, cooperate with psychiatrists in the context of their services. Meanwhile, the Institute of Psychiatry (IoP) works together with Time to Change on evaluating the results of the campaign. The workers at the IoP involved in this assessment examine changes to knowledge about and social attitudes towards mental illness and health, also within their own professional environment. In addition, individual psychiatrists support and sometimes promote activist campaigns and projects, as they also recognise the benefits of eradication of stigma and prejudice within society to their patients' mental health.

Rose (2006, 2007) suggested that 'psychopharmacological' societies of the US and Europe provide with to a multitude of opportunities for subjection to psychiatric practices, medicalisation and self-diagnosis as well as the burgeoning of psychiatric notions of illness in mainstream discourses. Instead of challenging this alleged widespread and penetrating presence of psychiatry in everyday life, the dominant activist emphasis is on a need for a more profound recognition of the high prevalence of mental health problems within society. This became apparent in the activists' often-quoted claim that one in four people in the United Kingdom will experience a period of troubling mental health problems in the course of their lifetime. This statistic featured in numerous media campaigns and also provided a name to one of the activist publications: the '*One in Four*' magazine (2010-2013).

Given all this, one would expect activists to call for the expansion and diversification of mental health services. However, while voicing such a necessity was the key motif of the anti-anti-psychiatry movement (Majerus, 2008), contemporary activists have focused on such demands to a much smaller extent. I see this to have come as a result of three interrelated factors: first, the widespread recognition among my research participants that psychiatric interventions are not necessarily the main or the only response to mental health problems, second, the termination, downscaling and the generally uncertain situation of mental health services that have rendered demands of their expansion or improvement unproductive, and third, in the current context, activist attention has turned to rescuing or transformation of threatened services rather than demanding new ones (see Chapter 8).

Rose explained that individuals experiencing mental health problems he talked to 'came to identify their own distress in psychiatric terms, believed that psychiatric expertise would help them and were thankful for the attention they received' (Rose, 2001b: 23). With the emergence of the concept of universal mental health and the

activist emphasis on recovery, along with the diminishing access to medical services, it no longer seems viable to consider psychiatric diagnosis as a basis for identity. More specifically, such an assertion is at odds with my research participants' understanding of their mental health problems. 'One is never only bipolar or only schizophrenic but also a sibling, a parent, a worker and a neighbour' explained a male attendee at a conference in Bristol indicating that experience of mental illness might, indeed, be the dominant one in a given period in time, but never the only one.

The observation I made in the course of the research, as well as in my private life, was that a psychiatric diagnosis could provide a template for an individual in processes of dealing with the experience of mental health problems. In Chapter 5, for example, we find evidence of the multiple ways in which people affected by mental health problems in Richmond understood their diagnosis: as a signpost, direction, system of organisation of experiences but never as a form of identity centred around biochemical or biomedical models of disease. Furthermore, while diagnosis was relevant within the realm of making sense of experience at an individual level, recognition of similarities between mental health problems that came along with the compromise on illness specificity provided possibilities for making sense of experiences in collective contexts and outside the scope of the medical gaze.

Such emphasis on the similarity of experiences between mental health problems appears fundamental to contemporary activism's attitude towards psychiatry. By eschewing emphasis on individual treatment, this non-illness-specific approach is pointing towards the collective dimension of recovery as well as contextualising it within wider societal circumstances. Contemporary forms of participation in mental health action could thus be seen as, perhaps non-intentionally, undermining psychiatry's focus on the individual. In two key fieldsites of the research: the TTC Facebook Page and the social centres in Richmond, sharing of experiences led my research participants to collective senses of belonging. More specifically, in Chapters 3-4 and 7-8, I focus on how discussions with others who experienced all kinds of mental health problems led to mutual understandings and a sense of well-being and came to be considered as beneficial to recovery.

In her critique of psychiatry, Tsao (2009a, 2009b) challenges similar forms of collective belonging and argues that mental health movements and groups '*are sustained on the basis of psychological difference [from the rest of society] alone*' (2009b: 71). She argues that such factions do not challenge systematic inequalities ingrained in psychiatric diagnoses and practices because they perpetuate the division between those considered to be mentally ill and those considered mentally healthy. Contemporary activism that hones the concept of universal mental health and emphasises similarity rather than difference in experience, on the other hand, aims at crossing this divide between people with and without the experience. This process takes place at the level of activist language and their accounts and claims that give prominence to health and recovery, rather than to illness. Given the importance of

narrative practice to the success of mental health movements in the past (Crossley, 2010; Costa et al., 2012), we can expect new possibilities for the definition of mental illness and health where collective participation and responsibility, rather than psychiatric models, are at the core of our understanding of these issues.

This point is also relevant to the history of mental health care in the UK, where concern with mental illness could be seen as much a matter of control as of continual relegation of responsibility to various social actors. The next section briefly consider these transformations in support of the argument that the influence of the discipline of psychiatry has diminished due to decreasing opportunities for psychiatric interventions that came with the closing of the asylum and the introduction of care in the community. As we shall also see in what follows, these transformations of mental health care have necessarily been accompanied by changing spatial conditions.

Spatial and Temporal Dimensions of Illness and Health

Prior to the seventeenth century, suggests Foucault (1989, [1961]), there was no direct control of madness. Instead, *Stultifera Navis* or the Ships of Fools filled with mad people of all sorts, circled around the waters and ports of Europe. In that period, suggests the author, madness was considered as a source of knowing the truth and also part of everyday experience. In the period of the Enlightenment, however, European states' coercive tendencies led to the physical control of the mentally ill (*ibid.*). Legal and professional control of mental illness in Britain also appears to have always had an intrinsic spatial expression. Among the first recorded regulations regarding the mentally ill in the UK was the amendment to the Poor Law in the late sixteenth and early seventeen century which deemed local parishes accountable for their 'mad'. These decrees did not introduce any form of physical restraint but sanctioned responsibility and care for mental illness to the local communities where a person deemed 'mad' resided. Interestingly, until the present day, many congregations in the UK continue to support or organise mental health groups and/or services and most of the mental health centres I visited throughout the research were, in fact, located in local, mostly Baptist, churches.⁶

The physical incarceration of the mentally ill in asylums, workhouses and hospitals did not commence until the early stages of the industrial revolution. In Goffman's (1961) and Foucault's (1989, [1961]), writings we find evocative functionalist and historical accounts of such institutions designed to restrict the mentally ill. For both thinkers, asylums are sites of enforcement of particular social norms, or in Foucault's words 'continuity of social morality' (1989: 257). Upon closer inspection it appears

6 It appears that care for mentally ill came to be rooted in these particular locations. This could be because priests have had played an important role in the treatment of mentally ill, including exorcisms. On the other hand, congregations sometimes charge mental health organisations and groups rent, so their relationships are not always of a purely charitable nature.

that both authors note that subjugation to psychiatric practice and restriction of mentally ill to particular locations rendered asylums as instruments of both spatial and social control yielded by nation-states in cooperation with and/or through the control of medical disciplines.

An alternative explanation for the emergence of institutionalisation sees the rise in the numbers of mentally ill patients in the nineteen century to have come as a result of admissions by patients' families, who, unable to cope with the difficulties of the industrialising world, delegated responsibility for their suffering relatives to the state. (Wright, 1997, a similar point is also made by Scull, 1993).

We are presented with two divergent accounts on the management of mental illness throughout the nineteenth and a significant part of the twentieth century, one emphasising the state's and psychiatry's power, control and coercive tendencies (Foucault, Goffman) and the other social pressures and relegation of accountability for care from families to the state (Wright, Scull). What these explanations of the rise of asylums share in common is the indication that modern nation states employed a very particular, restrictive, we could say, model of spatial organisation of mental illness, which continued to dominate care and treatment for years to come and, effectively, until the late 1980s.

Radical change to the institutional organisation of mental illness began in the period following the World War II, which saw a thorough rearrangement of the British state's attitude towards health more generally. The epitome of these transformations was the establishment of the National Health Service (NHS) in 1948, considered as one of the key founding blocks of the modern welfare state (Webster, 2002). The NHS was often portrayed in mainstream media and in my research participants' accounts as essentially British, reflecting British values. The NHS 'is an example of how we respect and value each other' wrote *The Daily Telegraph* (5 August 2012). The establishment of the NHS is considered an important part of UK's history, evidence of which could be found, for example, in the 2012 London Olympics Games Opening Ceremony performance watched by a billion-strong global audiences (see figs. 1 & 2). The NHS also appears to be invested with a sense of national pride as it is often presented as one of the best health care systems in the world (Adams, *The Daily Telegraph* 9 November 2011), most efficient (Pritchard and Wallace 2011) and also the most equal one (Ramesh, *The Guardian*, 19 November 2010).



Fig 1. The 2012 London Olympics Opening Ceremony, Source: Google Image Search



Fig 2. The 2012 London Olympics Opening Ceremony, Source: Google Image Search

Concerns regarding the NHS were eminent throughout the period of the research but particularly during the campaign leading to the 2010 General Elections. During that time, the NHS's integrity and the threat of its privatisation were among the most frequently debated issues and had a widespread public presence in both mainstream media and public debate. These concerns also featured in Conservative Party's 'I'll cut the deficit but not the NHS' poster advertisements, which subsequently came to constitute a basis for numerous jokes, Internet memes and remakes expressed widespread concern with the health services in a particularly funny way. (see figs. 3-5)



Fig. 3 The original Conservative Party 2010 Election Poster, Source: Internet image search



Figs. 4 & 5. Internet users-generated spoofs of the original election poster. Source at mydavidcameron.com

The establishment of the NHS emerged within a framework of thinking about health care as a national concern and could be seen as leading to a new spatial imagination of health. The ideas of health promoted by contemporary mental health activism bears some similarity to the ideas that led to the foundation of the NHS. This is in the sense that they promote a widespread recognition of mental health and associated with it responsibility. However, while the NHS was founded upon a stance that saw the state as carrying the predominant burden for health, activists highlight that the responsibility for health is across-the-board and needs to be taken by all members of

the society. This shifting emphasis could be seen to have come as a result of former transformations and recently decreased availability of services on which more below. I would not, however, consider contemporary activist outlook to have come as a result of neo-liberal policies but would rather see it as a form of their reinterpretation. This is because the activist stress that responsibility for health is also collective or social and not only individual.

Vis-à-vis its strong symbolic and national associations, the NHS and its public image has suffered from malfunctioning bureaucracy, reduction of services, spending cuts, rising concerns over its efficiency and effectiveness, long queues, scandals regarding care and concerns over equal distribution of resources. The projects localising services initiated in the 1970s did not lead to the desired improvements and, instead, offloaded financial responsibility for health care to local authorities (Walker, 1997). Similarly to the NHS, activists faced the polarisation of the issues along national-local lines as, whilst they voiced a need for change at the level of the society, at the same time they continued to attempt to make change in specific local contexts.

These cross-locational concerns seem to have generated a certain inconsistency in spatialised claims regarding activist actions. For example, TTC receives funding to operate within England, while Scotland and Wales have their own parallel campaigns. At the same time, TTC campaigns never spoke specifically about mental health in England or claimed that the issues they address are England-specific. As we will see in Chapter 2, the disjunction between local and national issues, led to misunderstandings and arguments between activists and, consequently, fuelled the dynamics of their interactions. Meanwhile, in Chapter 3 we will explore how the use of social media, and Facebook in particular, allowed for national concerns and ideas to be made relevant locally and for local issues to be articulated in the wider national context.

All in all, it appears that in the UK, changing ideas and legislation regarding mental illness rearranged the conditions in which mentally ill recover which, in turn, influenced the spatial/territorial understandings of and associations with these issues. What seems characteristic to these spatial contexts of mental illness is the shifting emphasis between centralised and localised responsibility for mental health care and a continual relegation of these responsibilities to various social peripheries. Meanwhile, contemporary activism brings mental health to the forefront of social attention and I show throughout the thesis how, in attempts to do so, my research participants also create and remake various spatial contexts. Firstly, however I would like to focus on one set of transformations that revolutionised mental health services in the United Kingdom, the lives of people suffering from mental health problems, and the spatial position of mental illness. We are speaking, of course, of community care. If we agree that the treatment of the mentally ill in the UK has been a matter of changing spatial dimensions of illness and responsibility for health, then deinstitutionalisation is, probably, the most profound and complex example of this process.

Care in the Community

Earlier I discussed some analytical approaches to communities as well as various meanings of and practices around community as relevant to the discussion. I explained that the notion of community is crucial to understanding the systematic reorganisation of social relationships in post-WWII Britain, and the development of the welfare state and related changes in official approaches to mental illness. Here, I would like to consider briefly the notion of community specifically in relation to mental health services. Such a focus is pivotal to understanding the background of mental health activism, as the closing of asylums and new community-based forms of care radically transformed possibilities for campaigning and protest.

The development of the welfare state in the UK and the associated idea of state responsibility for health is also very much a matter of reshaping of communities in the post-WW II period (Bornat et al., 1997) or, as some prefer to argue, their demise. Young and Willmott (1962), for example, saw the social, urban and economic transformations of the 1950s as a reason for the gradual disintegration of communities in Britain. Such a break up of strong social relations between local populations was characterised by ‘privatisation’ of family life (Pereira, 1997) that run parallel to the state’s increasing responsibilities embodied in new projects such as the establishment of the NHS, which saw the state taking control of communities’ welfare as well as relations between them (*ibid.*).⁷

One of the key concerns of this newly emerged welfare state was to address the treatment and living conditions of mental health patients (Pereira, 1997), issues that were under discussion for a number of years and between various social groups of influence. In 1957, the Pearcy Report that relied on hygienist discourses borrowed from the first form of mental health movements of the same name suggested a burning necessity for new approaches to mental illness services (Crossley, 2006). Subsequently, the Report gave way to the first Mental Health Act of 1959, which highlighted benefits of community-based care of mentally ill patients.

The closing of the asylums was announced soon after in the famous 1961 Water Tower Speech by Enoch Powell and devised in the 1962 Hospital Plan. This new way of tackling mental illness, which encouraged moving of patients from hospital confinement back to their homes and communities, was a spatial rearrangement of both care and ideas about mental illness, as the physical restraint of the mentally ill was no longer considered suitable or necessary. However, community care did not

⁷ The term ‘community care’ was used in official documentation prior to the welfare state reforms and, specifically in the 1930s legislation regarding out-of-institutional arrangements of care for the mentally ill (Busfield, 1997).

accelerate until the late 1970s with the first asylum shutting its doors permanently only in 1987 (Walker, 1997).

The economic and political situation of the 1980s encouraged some questions in regards to the underlying rationale of such transformations (Busfield, 1997). It has been widely acknowledged that the revolution in the pharmacological treatment of psychiatric patients, which took place from the 1950s onwards, significantly improved patients' ability to function on their own and outside of confinement and thus allowed for consideration of closing of the asylums. Critique of this approach suggested that the process was not a result of a changing mindset or good intentions in regards to patients' wellbeing but, instead, was dictated by financial constraints (see Crossley, 2006).

Busfield (1997) develops a complex model for understanding the introduction of care in the community. He proposes that, in addition to pharmacological developments and economic rationale, there also emerged a recognition of the varying necessities of patients suffering from distinct mental disorders, more illness-specific treatments, as well as developments in out-of-hospital care, and an increasing conviction of the positive role of the community environment for recovery process. All of these factors combined and, further reinforced by what Busfield considered as 'general optimism' undermined the asylums' credentials and their very *raison d'être* (*ibid.*).

Walker, on the other hand, focuses on the economic, political and ideological context of the late 1970s and early 1980s which underpinned radical changes to services generally and mental health services in particular. The author explains that a 'shift from consensus to conflict in the policy arena' (1997:197) during the period of Thatcher's government saw the state's withdrawal from the matters of everyday life such as health. This retraction, continues Walker, accelerated the introduction of care in the community in a move that aimed to ensure cost-efficiency, encouraged private sector's participation in provision of services, and the transfer of responsibility for healthcare to local authorities. Walker suggests that, as a result, the effectiveness of community-based services was compromised.

The decentralisation of healthcare came to have partially positive results, with services beginning to address the needs of specific communities and social groups such as women and ethnic minorities (Bornat et al., 1997). However, due to the gradual decrease in funding at the end of the 1980s and throughout the first part of the 1990s, consecutive Tory governments incorporated numerous third sector services into statutory services. Consequently, argues Walker (1997), a further shift of responsibility for mental illness took place, as care in the community turned into 'care by the community' where families and charity organisations ensured continuity of services.

Others, such as Scull (1989), also argued against romanticising ideas of 'community' in this context and claimed that, following the closing of the asylums, communities

did not readily embrace or accept deinstitutionalised patients. Meanwhile both Rose (1998) and Crossley (2006) refer to ‘scare in the community’, that is, fear and a perceived sense of threat from the released patients perpetuated by the mainstream media association of mental illness with violence. By focusing on the eradication of negative representations of mental health problems in the media, contemporary activists are trying to tackle fear as well as negative associations with mental illness as violent that could come partly as a consequence of community care policies and, in particular, the discharge of mental health patients.

My research participants viewed a community-based approach to services in generally positive terms and, in casual conversations, conceived of community care as an important development that recognised mentally ill people’s capacity to function as part of the general society. At the same time, I was left with an impression that service users talked about the subject positively because the dominant discourse of charity organisations they encountered through third sector services presented community care as superior to institutionalization and without consideration of its negative or controversial aspects. In short, there was simply no other choice but community care.

It is not at all cynical to state that the introduction of care in the community allowed third sector organisations, many of them currently supportive of the activist cause, to flourish. However, throughout the 1990s some voluntary services became incorporated into statutory and thus the charity organisations’ independence was compromised. To summarise, care in the community both provided opportunities and enforced the necessity for new forms of voluntary and activist practices around mental health in out-of-hospital settings. At the same time, it defused tensions between psychiatry and activists by meeting the latter’s demands for deinstitutionalisation. Consequently, care in the community could also be seen as leading to a gradual demise of earlier movements while also limiting the possibilities for contentious politics.

Health movements have been considered as operating along the rights versus responsibilities nexus (Landzelius, 2006) where access to mental health services has been presented either as a matter of entitlement or of accountability. The change from institutional settings to care in the community could be seen as a shift in mental health care, informed by movements’ demands and discourses, from the concern with citizen rights to widespread social and localised responsibility. This shift seems to have been developed further by more recent transformations, which saw a simultaneous increase in the importance of responsibility and decrease in the significance of rights in activist agenda and discourses. We are speaking here specifically of patient involvement and the emphasis on recovery in policy and services. These recent changes to both the structural and ideological character of services are the last factor influencing contemporary activist aims and actions. It appears that, in the unfavourable economic context, activists compromised on demands for rights almost entirely and, instead, fully embraced the emphasis on responsibility and recovery.

Involvement, Recovery and Responsibility

Since the late 1990s, government authorities in the UK have encouraged greater patient participation in decision-making and choice of treatment. Policies of patient involvement introduced by New Labour (DH, 2000, 2006, 2008) were designed to instigate more dynamic dialogue between authorities, the medical establishment and service users (McKevitt et al., 2010). However, it is important to note that the effectiveness of such a dialogue is a matter of some debate (Fudge et al. 2008). Involvement has been scrutinised as the permeation of neo-liberal discourses through policy (Tritter, 2009) and as a marker of growing individualisation and individual responsibility in health services (Forster and Gabe, 2008) or, conversely, as merely controlling medical professionals (Dent, 2006).

At the same time, the emergence of involvement policies is linked to former movements' demands for greater patient independence and freedom as expressed within the anti-psychiatry framework. From the perspective of present-day activism, it seems unfortunate that the official interpretation of survivor movements' demands not only led to policy change that gathered a considerable critique, but also brought former movements into their demise. Contemporary activists' claims and objectives face similar misapprehensions and appropriation of their demands, especially as responsibility for services and for mental health more generally continues to be directed towards the individual. A specific example of such a tendency I discuss in this thesis is that of the peer-led services in Richmond, which serves to illustrate how state, third sector, individual and social accountability for mental health intersect with each other in the contemporary context. As we will see, peer-led services formalised senses of belonging formed in well-established social centres and, to an extent, necessitated the participation of users.

Peer-led services were only one part of a more profound transformation of services in Richmond, which saw an increased emphasis on individual recovery, and, more generally, users' individual capacity to function independently in every-day life situations, and appeared to mark the ultimate shift of responsibility for mental health within the framework of the welfare state. Recovery's recent rise to prominence, however, is not specific to services in Richmond, as the last decade saw a recovery-based paradigm shift in policy and services across the Western world (Howell & Voronka, 2012) and also across the UK (Harper and Speed, 2012).

Howell and Voronka (2012) argue that the turn to recovery came as a result of 'political resistance' against institutionalised care and the subsequent transformation of services (community care) within an explicit neo-liberal framework where mental health services became target-driven and required to provide evidence of their effectiveness. As responsibility for services was offloaded to the third sector and

individuals, medical establishment and policy makers appropriated the recovery discourse from anti-institutionalisation movements (*ibid.*).

The authors, however, fail to note an important fact that some of the organisations around which these movements were built, such as for example Mind, created their own services, some of which were subsequently incorporated into statutory services. Consequently, recovery discourses were not simply appropriated but incorporated into the public sector as a result of services merging. Howell and Voronka also argue that reliance on recovery in the psy-disciplines cements in individuals a sense of responsibility for their conditions and lead to acceptance of psychopathological models of illness. Consequently, they also believe that the emphasis on recovery has left the disciplines of psychiatry and psychology intact as professionals developed new expertise in the area.

This seems like an overgeneralisation and Pilgrim (2008), for example, has shown that there exist at least three different notions of recovery, with professional and patient understandings of the term being significantly different. The transformation of services in Richmond discussed in Chapters 7 and 8 shows that emphasis on recovery and on individual responsibility in services is not clear-cut. There we learn that the focus on recovery and responsibility has some positive aspects but that users and charity employees differ in their interpretations. Meanwhile, the example of a self-organised, grassroots mental health group in Richmond indicates that opportunities for recovery do not necessarily fall into, or are dependent on, medical jurisdiction and, furthermore, that the crisis inspired the creation of new possibilities rather than apathy. Finally, both peer services and self-organised groups show that the focus on recovery does not necessarily individualise social problems, as recovery in these settings is a collective and deliberately organised social process.

Harper and Speed (2012) argue that recovery-based approaches to services rely on reductionist ideas of mental illness centred on the deficit model which reproduces inequality between people who are considered healthy and those who are sick and therefore lacking in health. However, in the context of activism, experiences of mental health problems were never really thought of as a deficit. Instead, experience was considered as a useful resource, as it informed action and encouraged participation, helped in the formulation of activist goals and was believed to carry the capacity for social change. Meanwhile the increasing emphasis on individual responsibility and participation might have helped in building a greater recognition that such change is necessary.

Conclusion

With the appropriation of the recovery discourses into services and professional jargon, activists might have needed a new term that would help them to address what we have seen to be a continually changing reality of services, legislation and ideas

about mental health in the UK. However, their employment of the concept of mental health presents us with a number of new issues. As pointed out earlier, mental health could be perceived as coming across as euphemistic, especially as, instead of giving depth to knowledge about mental illness and details of its experience, activist made-media focus on counteracting negative representations. Mental health might thus carry a potential for homogenising heterogeneous experiences, and, instead of instigating more accurate understandings it might be encouraging puzzling explanations and, like recovery discourses, be seen as normalising mental illness.

Although all these issues could have negative consequences for action, I would like to suggest otherwise, namely that the term mental health carries with it a possibility for radical social change. However, in order to expand on the argument, further ethnographic evidence needs to be presented. Suffice it to say for now that mental health shall be considered in what follows as an element of a special type of language that helps activists to visualise their ultimate goal of a stigma- and discrimination-free world where mental illness and its experience are better accepted and understood.

All in all, I suggest that contemporary activism could be considered as a continuation of the work instigated by former mental health movements and specifically in terms of their shared focus on health-related language, social understandings of illness and concern with locations in which recovery from mental health problems take place. Unlike former movements, however, present-day activists have decided to compromise on illness-specificity and focus specifically on experiences shared by all people affected by mental health problems, most notably, stigma and discrimination.

This change of outlook has resulted from a number of factors. First there is the decreasing importance of psychiatry in the management of mental health problems, with which came increasing recognition that medical diagnosis and pharmacological treatment are just one of many ways in which to deal with mental health problems. This we should see in relation to changes to services including care in the community, policies of involvement, appropriation of recovery discourses into professional practice all of which fall into a trajectory of transfers of responsibility for health from medical professionals and governmental bodies to communities and individuals. Shifting responsibility, in turn, led to an overlap between previously opposed groups of people concerned with issues surrounding mental health and made boundaries between them less distinct.

We also have contemporary requirements for measurements and evaluations of campaigns, which, in turn, necessitated activist groups to put forward less solitary funding proposals, relevant across the whole spectrum of society. Finally, all these changes could be conceived as the spatial reorganisation of ideas and practices of mental health and, as we shall see, this concern with environmental circumstances continues until now.

All in all, in the absence of an antagonistic agent, cooperation between various organisations, groups and individuals might have been a matter of necessity and convenience, rather than active willingness. Consequently, activists, instead of focusing on change to specific policies or professional practices, as former movements have done, focused on instigating a change of attitudes and understandings across the society, while also recognising that their collaboration is required if such a comprehensive transformation is to be achieved.

As we shall see in what follows, this outlook was criticised for failing to represent or account for particular groups or communities and led to discontent and conflict, with disagreements expressed during activist meetings and on the Internet. The next chapter takes as its subject activist conferences and events that aimed at developing a unified activist voice and consolidation of practices but, inevitably, led to quarrels and arguments. I shall also introduce the full range of meetings I attended so as to indicate how the commitment to unity was asserted, the range of problems it ignored or caused and the different responses of participants associated with their positions in the meetings.

Opposing views and divergent priorities indicate that, despite mission statements, we are not speaking about activism as a coherent, unified group. I, thus, hope that the next chapter will help in recognising the sheer variety of people who try to work together towards a common ideal in spite of differences in their experiences and ideas. In particular we shall see that assertions of unity and sporadic claims to existence of a movement point to a conviction that activists' practices need to be unified, or at least come across to the public as such. Furthermore, I hope to show that although, campaigning floats free of its moorings, in practice it remains connected, integrated and active in the local level.

Chapter 2

The Search for Activist Consensus and a Unified Voice

EKTA

From the centre of London it takes over an hour to reach Harrow-on-the-Hill, one of the final stops on the Metropolitan line. The journey leads through an assemblage of urban, post-industrial and green terrains unveiling the sheer diversity of the city's landscape. Harrow's main street is similar to other suburban areas of the capital with its generic high-street shops and banks but, distinctively, all the street names are written in both Latin and Devānagārī scripts. Several hundred yards away from the station stands a Baptist Church where a monthly mental health-focused meeting organised by a regional branch of Mind is about to take place. Chandra, a Harrow Mind employee, participant in a number of other activist projects and organiser of today's event, arrives almost the same moment as I do. He asks me to help unload a stack of food that he has been preparing throughout the night. Chandra does not seem tired, quite the opposite, energy and enthusiasm are emanating from his face as he moves swiftly between different rooms inside the church while greeting people and assigning them tasks and responsibilities.

The congregation's foyer gradually fills with conversations in several different languages, two of which I identify as Hindi and Gujarati. Most women present wear saris and traditional jewellery. A couple introduce themselves to first-time attendees, making sure everybody feels incorporated into the group. Soon after, the lunch is served in the so-called small hall where the food cooked by Chandra according to non-violent principles of Jainism is arranged across several tables. For the duration of the meal I am invited to sit together with the employees of the local Mind and we discuss issues they encounter in their day-to-day work. These include limited service provision for ethnic minorities and, in particular, for members of the local communities who do not speak English. EKTA, (transliterated as 'Ēkatā' which stands for 'unity' in Hindi) as this group is called, is supposed to fill this gap and Mind employees are happy that it has been attracting a steadily increasing number of people, all of them of South Asian background.

Once the lunch is finished, chairs are rearranged so everybody can face the back of the room. Then, a couple of traditional songs are sung, followed by an official welcome. Chandra greets the group of approximately fifty people in several different languages. He then introduces a recently recruited employee of Mind and the new members of the group. The 'Mindful Eating' seminar begins shortly after. Leander, today's presenter and specialist in the area of dieting, explains that what and how we eat has impact on our stress levels, family life, sleeping patterns and effectiveness at work. All these factors, he explains, have a direct influence not only on physical but, crucially, on one's mental health.

Mindful Eating, continues Leander, encourages a return to the 'natural' ways of consuming. We find out that food should be enjoyed with all our senses, chewed properly and celebrated in peace, not hastily, together with others but without

distractions such as television or newspapers. During his presentation, Leander says ‘When you eat – just be normal’. No one, apart from the visibly flustered Chandra, seems to find the reference to being normal inappropriate and it appears that sensitivity to political correctness of language honed by mental health activists in other contexts has not infiltrated the group.

As the meeting comes to an end and everybody leaves the room, I notice piles of leaflets arranged on a small table by the exit. Handouts encourage participation in local projects and meetings such as, for example, South Asian Women group. There are also some information materials from one of the national campaigns. The stack of these remains untouched, possibly because they are printed only in English, or maybe because EKTA attendees have greater interest in, or more possibilities for, participating in local events.

Once the room and the kitchen are cleaned and door to the church hall locked, Chandra invites me to a nearby café. There, we talk about Leander’s linguistic gaff. Chandra explains that issues surrounding mental health are still rarely talked about in South Asian communities in the UK, among which ‘immense stigma’ continues to surrounds mental illness. When mental health issues are occasionally acknowledged, continues Chandra, they are bound to be understood and dealt with depending on spoken language, spiritual beliefs, social status as well as family relations and obligations.

As we turn to a discussion of the lack of representation of South Asian communities in contemporary mental health media campaigns, Chandra tells me, with a noticeable dose of irritation, about Time to Change’s failure to address issues relevant to minorities and the consequential discontent among some of the contributors to the campaign who, in their day-to-day work, focus on mental health problems among BME (Black and Minority Ethnic) communities. Chandra also notes that the use of English as the sole language in media representations and promotional materials prevents widespread engagement with campaigns and their causes, as some of the attendees at EKTA simply do not understand the national campaigns.

The visit to EKTA and the conversation with Chandra showed that terms such as ‘mental health’ or even ‘mental illness’ were almost altogether absent from the event, as they simply did not carry much meaning for the attendees. It could thus be suggested that the notion of universal mental health might be helpful in organising activist ideas and making representations that address the widest possible audiences, but that it leaves little space for the specificity of local and cross-cultural needs and issues. Chandra was not happy that contemporary campaigns and projects compromised on diverse culture- and context-specific experiences of mental health problems in favour of a universal emphasis on mental health and pointed out that this compromise was a source of disagreements between various parties involved in mental health field.

Discord between groups and individuals and their diverging ideas, interpretations and needs became more evident during various events and conferences. These activist meetings were organised in attempts to develop a unified activist voice and to build consensus around practices and, more specifically, how to talk about mental health, organise campaigns and make media representations. They attracted a wide range of people concerned with issues of mental health – whether from experiential or professional perspectives. Discussion at these assemblies aims at a better understanding of the complex web of meanings, alliances and discontinuities as well as relationships between the different parties involved in mental health activism.

Although the events in themselves as well as statements and declarations made on such occasions might appear routine or even mundane, I hope to show that they stimulate activism by engaging people and drawing their participation, while looking beyond bureaucratic configurations and discursive imaginations of activist goals and towards their ability to stimulate coalitions capable of transforming society's attitude towards mental illness and health. In short, in this chapter I explore how contemporary activists put their aims into practice.

Attempts to produce a unified activist voice fuelled the idea of a wide social movement as pronounced by Chief Executive Officers (CEOs) and directors of campaigns and organisations. I suggest that the notion of movement was used partly for participants to recognise a common cause and partly because directors and CEOs of the campaigns must have seen merits of activism being identified as such. I suggest, however, that since mental health activism goes beyond the identity-politics framework characteristic of participation in the past, the notion of movement might actually be confusing.

Crossley considered mental health-focused movements as 'emergent discourses within a society or subsection of society which constitute or connect to a political demand' (2006:4). In order to understand movements, continues Crossley, it is necessary to look at their actions across space and time as previous mental health movements unfolded over years and the results of their actions were almost never immediate (*ibid.*, see also 2002). Since contemporary practices, ideas and concepts characteristic of contemporary activism appeared only recently we might have reservations towards consideration of actions centred around the notion of mental health as solidifying as a social movement. Furthermore, it might be problematic to place the astonishingly large array of actions, projects and media representations, views, opinions and issues under the umbrella of one movement. On the one hand, the concept of universal mental health is used to consolidate these various factions but, on the other, there exist divergent issues as well as understandings and attitudes towards mental health and illness that, as we have just seen just, are necessarily context-specific.

Nonetheless, attempts to create unity and concord under the umbrella of the concept of mental health are telling of a possibility and plausibility of activism becoming unified. I document the initial period of this new orientation in activism and its attempts at developing common strategies, as well as the differences that emerged between various fractions involved.

One in Four

On an unusually beautiful and sunny February morning I nervously stare at my reflection in the glass façade of University College Hospital Education Centre in Euston, central London. Here, in half an hour, an event will begin during which I will have the first opportunity to encounter various, diverse people involved in mental health activism in one location. CEOs and directors of key mental health charity organisations and campaigns as well as NHS representatives, policy makers and journalists are all expected to attend today's conference organised by '*One in Four*' magazine as one of the Open-Up initiatives – grassroots local projects supported by a grant from Time to Change. Chandra, organiser of EKTA and Open-Up initiatives coordinator in London who invited me, also arrives early and we walk together to the second floor.

There, I sign my name by the reception desk and receive a name badge and an informational pack with the programme for the day. Chandra introduces me to a number of mental health activists from all walks of life. I also meet a couple of people I have previously made contact with over Facebook. I then briefly talk to Mark, the editor of the *One in Four* magazine, who together with a team of co-workers organised today's event. As indicated in its title – 'Talking about mental health – getting it right', the aim of the conference is to develop an effective, unified activist voice and, as Mark explains, to change the ways in which mainstream media report on mental health problems. Since there are some high-profile journalists and politicians among invited guests and speakers, the conference is an opportunity to both discuss and propagate activist ideas and demands and, as Mark hopes, change journalistic practices.

Just before the event starts I stop by a table covered with magazines, handouts and leaflets. These publications strike me as being quite alike - printed on the same type of glossy paper, bearing similar fonts and colours, predominantly orange, blue and white. People photographed featured inside seem happy, content, and, in some cases, even energetic. I find only one photograph of a person who does not smile below which there is a quote criticising the recent New Horizon governmental policy on mental health and wellbeing as not addressing sufficiently issues relevant to 'Black communities'. A few pages down in the same magazine there is a statement by Sue Baker, the director of TTC, in which she explains that the New Horizon policy shares

the same aims as TTC: better mental health for everybody and the end to stigma and discrimination.⁸

In the main conference room I sit down in one of the middle rows next to a middle-aged, distinguished man who introduces himself as James. He immediately tells me about a housing association he has established from two decades ago in Sheen, south-west London. As the conference is focused on representations of and publicity about mental health, James explains, he is here to learn about promoting his project, to open new channels of communications and, possibly, to identify new funding opportunities. James then asks about my ‘specialisation’ and carefully listens to details of my research. He expresses a willingness to help and we arrange to meet in a couple of week’s time. Meeting James will prove instrumental in gaining access to one of the key fieldsites for my research – the Reflections project in Richmond.

The conference that attracted approximately a hundred and fifty guests starts with a manifesto read out by Mark, in which he anticipates a consensus in regards to speaking about mental health. This is followed by first speaker of the day - Deborah Tyler, Chief executive of the Directory of Social Change, Chair of the Small Charities Coalition and a member of the Charity Commission’s SORP who begins by recounting her history of depression and the support she received from her bosses and co-workers throughout the period of illness. She concludes her talk, which concentrated on mental health discrimination at work, with a statement that ‘mental health should be treated normally’.

The next presenter, Heather, a ‘media action worker’, also describes her own illness before elaborating on the example of activist cooperation with local journalists in Warwickshire and what she identifies as the problem of ‘no mental illness in posh areas’. James nods his head in approval and whispers that he encounters similar problems with a high level of stigma related to mental illness amongst the white upper and middle classes in south London where he works.

Meanwhile, Heather turns to practices of working with the press and explains that, while dealing with journalists, activists should keep their expectations low, focus on a specific issue and that everyone concerned should be encouraged to participate. This, claims Heather, should result in ‘deep understanding of the problem’ and help in developing appropriate and convincing media representations of mental health and illness. She finishes by enthusiastically encouraging people to talk openly about their experiences and claims that no one should be scared of journalists but ‘be brave’ instead.

The next speaker Jacqui works as the editor of *The Sun*⁹ newspaper’s health section. She claims that negative representations of mental illness in the mainstream

8 TTC Update Magazine, Issue 5, Winter 2009/2010

9 A tabloid and UK’s most widely read newspaper

media are a result of the lack of insightful discussions on the subject in newsrooms. Furthermore, explains Jacqui, case studies, which journalists use for articles, appear at random and are not always suitable for the purpose. Jacqui then agrees that a ‘unified voice’ in speaking about mental health is needed. This comes as a surprise to many people in the room, as Jacqui works for a newspaper infamous for its extremely prejudiced and discriminatory representations of mental illness and for use of language that activists deem inappropriate and harmful. Some attendees are keen to confront Jacqui but the planned Q&A session is cut short as the keynote speaker Alistair Campbell arrives.

As with other speakers, Campbell, former communications manager in Tony Blair’s government, begins by discussing his own ‘mental breakdown’, documented in BBC’s film ‘Cracking Up’ and in soon-to-be published memoirs. He briefly mentions issues of employment before focusing on his collaboration with TTC. With reference to the gay right movement in the U.S., he explains that public and political debates around mental health and illness also require coming-outs but that social attitudes change over time. Campbell alludes to successes of cancer movements and claims that narratives focused on the lived experience of mental illness give visibility to issues that cannot otherwise be seen. By the end of his speech, he turns to general political statements in relation to the upcoming general elections.

Questions that follow are far removed from the subject of the conference. Attendees are mostly interested in the insider’s perspective on working in the government, employment policies, NHS funding and planned financial cuts, which points to their concern with immediate issues affecting people suffering from mental health problems. Once this part finishes, people move to the next-door room for refreshments. Conversation held among a group of attendees I stand with indicates that the presence of an important and well-known politician provides a sense of confidence and importance of the cause. Meanwhile, an orderly queue forms in front of tables piled up with Campbell’s memoirs, which has not yet been officially launched and is offered at a discounted price. One happy buyer says the hardback featuring the author’s signature will sell for a good price on eBay.

In the following sessions, we are divided into six colour-coded groups and I find myself in the blue one, where quite different opinions on Campbell are voiced. It is claimed that, due to his controversial background, Campbell is not an appropriate person to represent TTC. One person argues against the use of celebrity personalities in campaigning altogether. The discussion carries on with journalists, campaigners and charity workers focusing on the necessity to change nomenclature used to describe people experiencing mental health problems. Other groups debate ways of involving local press and communities in the campaigning, NHS resources, clinical models versus service users’ perspectives and strategies for sharing individual stories of mental health problems.

Once the session comes to an end, a representative of each group provides feedback on their respective conclusions. James, who participated in the red one, voices a necessity for a centralised resource base that could be used by all activists. He is surprised that such a resource is not yet available and other people nod their heads in agreement. Such a resource, explains James, could be helpful in creating unity in speaking about mental health and could also provide journalists with suitable accounts and stories for their publications. A couple of hours later, in the final remark of the conference, Raza, Open-Up coordinator for the South-East, makes short reference to the anti-psychiatry movement and leaves the audience with a rhetorical question of what could be learnt from previous generations of activists.

Following the event some of the attendees decide to eat out together. In a nearby vegan restaurant a group of activists from Norfolk reflect on the conference. Torsten, who actively participated in the anti-psychiatry movement and his colleagues from Making Waves, a small organisation in Norwich, are critical of the event. They feel that speakers were selected randomly and that topics were inconsistent as not all the presentations addressed the subject of talking about mental health. The group also agrees that the conference did not ensure continuity of action, nor did it encourage some form of lasting local cooperation between the attendees.

Although my encounter with Making Waves was brief, it provided me with an important critical insight into the event and, also contemporary activism and its difference from former movements. For Torsten, the only person in the group who saw the change brought by anti-psychiatry, emphasis on cooperation and non-contention characteristic of contemporary situation was decidedly different from the times when the main aim of mental health politics was to destabilise and change the system. Some nostalgia regarding these former times seemed to have permeated across the group as it became clear through jokes about releasing patients from closed psychiatric wards, that these research participants would like activism to take a more direct-action based approach.

Recognising the fact that a militant form of protest might be less effective or needed in the contemporary situation, members of Making Waves agreed to take part in contemporary activism and had attended the conference. Torsten himself held a prominent role within Time to Change campaign as Open-Up coordinator for East England. He and his group were fully aware of the inevitability of cooperation with government-sponsored projects, medical establishments and the mainstream media but thought that discussions during the conference should have been more consistent and theme-specific. By acknowledging that the success of previous movements relied on re-appropriation of the language used to describe mental illness, the group also indicated integrity in activist practices could help in framing aims and in formulation of demands that could be easily identifiable and understood by all members of the society.

Contemporary activists demand a kind of change that is more overarching but, at the same time more ambiguous, which might render execution of the broad aim of changing social attitudes more time- and resource-consuming than was the case of former movements that focused on negotiation of specific policy or medical practices. Presentations during the conference showed that certain canons of speaking and communicating already exist. Sharing of one's experience of mental health problems might have been among the practices developed and successfully employed by former movements such as the psychiatric survivors (Costa et al., 2012), but it is also fundamental to current forms of activism and with the advent of social media, new possibilities for speaking and sharing of stories have also emerged. Similarities between printed activist publications and the talk by Heather indicated that the form of activist message has, at least partially, been agreed on. It was the content that appeared to require further discussion.

Both the conference and, following it, critiques identified a necessity for a strong, unified, activist voice. Such search for unity among activists might explain why they evoked other movements including the anti-psychiatry and gay movements, and why Q&A sessions were cut short and attendees were not given a chance to question the speakers whose position appeared to some as controversial. It could be suggested that activists did not wish to quarrel in the presence of the non-activist element (here journalists and politicians), in order to maintain a non-contentious image. This is because, on other occasions, where no representatives of mainstream media or government were present, there appeared much more articulated and vocal complaints and disagreements.

'Challenging Discrimination Together'

The Open-Up conference 'Challenging Discrimination Together' took place in Birmingham several months after the One in Four event in London. Challenging discrimination is one of Open-Up's aims (see Chapter 1) and ideas and examples discussed during the event were to be drawn from first-hand experience of campaigning. Although this particular conference did not focus specifically on media, the subject of representations was interwoven in nearly all the talks and presentations. Furthermore, social media were employed to give people who could not be present a chance to participate in designing the conference's program and, also, to provide live updates during the meeting.

Three weeks prior to the event, posts on Time to Change's Facebook Page¹⁰ encouraged people to propose questions that would be addressed during the conference and, in particular, for the 'What next for challenging discrimination?' panel concerned with the issue 'what do we need to do to keep the anti-discrimination

10 <http://www.facebook.com/#!/timetochange/posts/129337043745545> accessed 7 August 2010

growing and succeeding?’ It is worth noting that it was the first time I encountered the campaign employing the term movement to frame its own actions. The post attracted queries regarding nomenclature used to describe mental distress: ‘*How about changing Depression to something that doesn’t make a regular mention in the weather [news] or used when people are... feeling a bit blue?*’¹¹; legal framework that would prevent discrimination: ‘*When is the government going to introduce legislation that makes it specifically [sic] unlawful to discriminate against people with mental health problems?*’; access to services: ‘*how could you make things more transparent/easier for those seeking help?*’ and the disproportional focus on depression in campaigning: ‘*Why is the focus always on depression?*’. Furthermore, a suggestion was made to include teaching about mental health as part of the school curriculum. The author of this post, encouraged by numerous positive responses ended the conversation with the following comment: ‘*Thanks to all of you that have supported my idea; I really hope we get some movement on this!*’ These two different uses of the term movement indicate its perceived relevance to both general and specific issues surrounding mental health.

The conference spreads across the second floor of a 1980s high-rise hotel-like building in the centre of Birmingham. One sizable main room is dotted with thirty tables arranged in front of a podium with another long table on top and seven chairs standing behind it. Adjacent rooms host workshops and exhibitions. There is also a ‘chill-out room’ where attendees can rest, sit or lie down in silence and relax. The atmosphere of the event is friendly, exciting and anticipatory as attendees talk loudly, kiss and hug friends and co-workers who arrived from various parts of the country. Those who seem lost or unacquainted are helped and included into conversations.

The variety and number of speakers, workshops and participants is impressive and it is exciting to see people with such diverse backgrounds and experiences trying to cooperate and to share their expertise. Among those present are charity organisations and campaigns’ CEOs and heads of communications as well as representatives of mental health trusts, counsellors, therapists and community organisers. There are people who tackle mental health issues through disciplines as diverse as art, press publications, radio, embroidery, fashion, drama and street dance, music, film, design, poetry, creative writing and research. Projects presented range from workshops at schools and training for medical staff or students, to sporting events, discussion groups and tea parties. Finally, but equally importantly, there are local people from Birmingham and neighbouring areas, who have experienced mental health problems but never participated in mental health campaigning or activism.

Sue Baker starts her opening speech with a story of one of them – Rachel, a young anxiety sufferer. Sue explains that meetings like today’s conference are important because they facilitate realisation of shared experiences, which, in turn, galvanises

11 All posts from Facebook as in the original

recognition of common aims and encourages participation, which Sue sees as fundamental to the growth of the movement. She then carries on to say that TTC is aiming to empower at least one hundred thousand people by encouraging physical activities. Among other topics mentioned are the upcoming campaign ‘burst’ as well as, as reported by the Institute of Psychiatry, a 6% improvement in media reporting since the start of TTC around a year and a half ago. Sue finishes on a positive and ambitious note and with reference to actions concerned with counteracting global warming calls for a ‘Mental Health Climate Change Movement’.

Sue considered change to be dependent on large numbers of participants but also recognised the importance of individual experiences and stories as pivotal to what she saw as a movement. The allusion to concerns with global warming indicates that she wanted mental health to be recognised as an equally burning social issue. Meanwhile reference to the increase in positive media reporting indicates her belief that actions and results of campaigning can be numerically evaluated.

The subsequent presentation is by Paul, Mind’s CEO who begins with a statement that stigma is an issue experienced universally by all people suffering from mental health problems. He then emphasises ‘community-based approaches to tackling discrimination’ and highlights the importance of links between ‘networks’ of activists. Such ‘networks’, according to Paul, can be strengthened by participation on the Internet, which allows for coming out and counteracting loneliness. Paul was clearly speaking in code as within several minutes he employed all the terms characteristic of contemporary activism. Furthermore, his speech came across as sterile and managerial, because, unlike Sue he did not refer to a personal story.

The next talk is by two female participants in one of the London Open-Up initiatives, the play *Khamoshi*. Developed and performed by members of EKTA, this project tackled issues of domestic violence and its repercussions for mental health among South Asian women in north-west London. Placing this presentation at the very beginning of the conference suggests that TTC has taken on board criticism of their insufficient concern with ethnic minorities and with mental distress being caused by social realities including discrimination by gender, and is attempting to untangle the discontent.

The Q&A session, however, immediately sees expression of grievances, particularly in relation to the functioning of local branches of Mind. A number of attendees explain their difficulties with accessing its services and with communicating with service providers. Two people shout out their dissatisfaction, as they seem to have finally found an opportunity to talk about their experiences in front of a person who seems to be in the position to bring about change, here, the CEO of Mind. Paul responds that he is unable to provide any solutions, as local Minds remain beyond the jurisdiction of national Mind and function independently. In attempts to address these concerns, arrangements for talks in more private settings are made.

One of the subsequent workshops entitled ‘Getting Your Message Across’ focuses on the use of media in activism. In a large meeting room, an energetic and enthusiastic woman called Alison engages audience of approximately thirty people. She claims that media ‘is not magic’ and that, in representations, the ‘most important is you!’. Alison’s advice, which echoes TTC campaign tactics, is to define particular goals such as ‘raising awareness’, ‘influencing perceptions’ or ‘changing behaviours’. Alison adds that clarity of message is also important, which can be achieved by focusing on local audiences, testing and rethinking ideas, ‘being a trouble’, telling stories rather than enumerating facts, using diverse material such as case studies and photographs, making oneself available for interviews and inventing a catchy headline. Other suggested strategies include having an anniversary or ‘opening something’ such as event or a group, ‘having (using) animals’ and ‘wearing ridiculous clothing’.

With the emphasis on a target audience, specific aims, convincing imagery and interesting narrative, the strategy for making mental health media proposed by Alison bears many similarities to marketing campaigns. This apparent necessity to conform to contemporary mediascapes where representations are required to have both an attractive form and an easily understood content has had very particular consequences for activist media practice. We shall see in Chapter 4 that making representations of something as profound and troubling as mental illness rendered fulfilment of these two demands difficult to achieve. Consequently, some activist-made representations come across as sterile and normative and were, thus, scrutinised and/or criticised by users of TTC’s social media.

The last part of the conference is the anticipated ‘What Next for Challenging Discrimination?’ panel that consists of five people with various backgrounds in mental health activism. Questions addressed are those suggested by Facebook users and discussion evolves around issues relevant to all people experiencing mental distress: legislation, medical models of illness, media and financial strategies in campaigning. The notion of movement is mentioned yet again, as a middle-aged man claims that a ‘mental health movement’ can benefit from power, which comes with numbers. He then encourages people to talk publicly about their experiences during the upcoming World Mental Health Day.

The use of the notion of movement by people I encountered in the field proliferated around the time of the conference in Birmingham in May 2010. First used by the TTC campaign and CEOs and directors of charity organisations it was then also employed by Facebook users and attendees at the activist-organised events. The first example of the word ‘movement’ written in official documentation I encountered was in a registration form for a new Time to Change scheme picked up during another conference in Bristol in September 2010. The headline printed on top of a leaflet in bold font, read: *‘Thank you for your interest in joining England’s most ambitious movement to end mental health discrimination’*.

I suggest that it was in attempt to frame their participation as unified, that activists evoked other movements including those focused on gay rights, cancer and anti-psychiatry. Despite the increasing popularity of the notion of movement, however, it was used in very different senses than in the past as divergent ways of employing it denoted various meanings my research participants ascribed to this term. In the TTC post, ‘movement’ stood for actions focused on challenging discrimination and, as such, it framed the main objective of the campaign. To the respondents to the post on Facebook ‘movement’ indicated support aiming at changing a more specific issue such as the school curriculum. We have also seen that ‘movement, meant a coalition of people concerned with mental health. However, the term always indicated instigation of some form of social change and it could, thus, be suggested, that the notion of movement seemed helpful in framing and imagining collaborative action.

Interestingly, as in the case of the concept of mental health, the frequency of use of the expression ‘movement’ seemed to increase proportionally to the involvement with various forms of activism and I observed that people who became engaged with nation-wide organisations would start to use the expression when they came across in campaigns or during meetings and conferences. Conversely, in projects concerned with smaller-scale or local issues, the notion of movement was absent as it seemed that the shared language useful for activism at the national level was not necessary in these contexts. Instead of framing their actions as a movement, local groups denoted unity in their names. That was the case for example for EKTA and Together as One in Richmond. While such groups often functioned under the jurisdiction of larger organisations, as was the case for EKTA, others, like TAO, have been operating separately from the mainstream organisations and remain beyond the influence of the key charities and campaigns. Regardless of the status or degree of autonomy, however, the shift in emphasis was striking every time I would visit a local group or meeting.

Together as One

In a petite but well maintained rose garden of a neo-gothic Baptist church in South Twickenham a group of smokers sit close to each other on two conjoined benches. In contrast to the outside, the entrance hall is dark and somehow uninviting. Inside, however, I am immediately greeted by Ron who introduces me to other members of the group including its informal leader. David, as this is his name, treats me with suspicion and distance, as he is aware that I am volunteering for Richmond Borough Mind (RBM). Recent actions of this organisation, including closing of a well-established centre angered its service users, which, ultimately, led to the formation of TAO. It takes over half an hour for me to explain that for the purpose of the film about the history of local mental health services I would like to get to know both sides

of this ongoing conflict between ex-service users and RBM. In the end, my clarification is accepted and I am invited to come again.

Next week I arrive at TAO's meeting with a backpack full of vegetables, staples and some kitchen utensils necessary to prepare dill soup. In a kitchen, I work along a couple of group members who volunteer in the kitchen. Every few minutes someone comes inside the kitchen, says 'hello' or introduces her- or himself and asks for a drink or a snack. Lunch is served at 1pm and everybody enjoys the soup. At least half the group comes back for seconds despite initially sceptical opinions. After three hours of hectic cooking and serving food for over twenty people I join others and listen to discussions that have been unfolding at the table. Although people sit very close to each other, there are a number of parallel debates taking place on loosely related subjects, which include politics, history and religion. Disagreements are rife and radically opposed opinions are expressed. At some point one man makes a homophobic comment, which, in turn, offends another member of the group who subsequently leaves.

Once the discussion turns to mental health services and the charities that run them, I hear a mixed bag of views that range from the explicitly negative and of disapproval, to willingness to participate in the running of newly established services. The dominant feeling, however, is that of being let down by the local charity mixed with pride in being able to organise a new social group with minimum dependence on other organisations. Members of TAO highlight on several occasions that the group is self-determining but recognise that their meetings would not be possible if not support from Grassroots – an organisation providing small grants, which in the case of TAO is sufficient to cover the rent of the church's hall.

What I hope to show with the example of TAO is that one of the key concerns for people experiencing mental health problems is to be able to interact with others in understanding social settings. Meanwhile, the priority of campaigns and activist projects is to eliminate stigma and discrimination by changing social understandings and attitudes towards mental illness, which could also be considered as a creation or negotiation of such safe settings although on a much larger scale and through different means. The two spheres of activity, one focused on addressing mental health problems directly on the local level while the other doing so indirectly on the level of the society, could, therefore, be considered as constituting parts of the same field. Notably, in both these spheres, the process of sharing of personal experiences is crucial to the solution of the problem

The ultimate goal of experience-sharing in these various settings, however, is markedly different. In TAO and in similar local groups it constitutes part of a collective recovery process, whilst during conferences and events, the same action acquires a more politicised, we could say, dimension. In both cases experience-based personal accounts and stories aim for the same end, that is mental health. Their mode of execution, however, is markedly different with local groups. All this might explain

why members of the groups like TAO do not operate with a discourse of radical social change or resort to the idioms like movement, as, unlike in the case of actions that address the general society, there is no need to frame actions within a broader perspective. Meanwhile, we shall see in Chapter 3 & 4 that in one context, the TTC Facebook Page specifically, participants in discussions managed to combine these two distinct motivations for sharing of personal experience: here as a form of dealing with personal experiences of mental health problems in collective settings and in attempts to bring about social change.

That the two spheres of action aim at improving mental health in different ways; one through recovery and one through campaigning, is not necessarily a weakness of activism but different means imply different priorities that might not be reconcilable. It seems crucial for the overall success of activism, however, to ensure that both spheres are informed of each other's actions and means. Conferences and meetings provide the possibility for people campaigning in the national sphere to come to realisation of local needs. At the same time, people meeting in local groups often had minimal awareness of national campaigns and projects.

For example, only a handful out of over thirty TAO members I talked to only a handful heard about Time to Change. Some weeks later, I had a chance to ask Sue Baker, the director of TTC, what she thought about this unfamiliarity with the campaign. Her response was that the target audience of the campaign was the people with no former experience of mental health problems. However this intention had not always materialised in the ways expected. As we shall see later, in Chapters 3 and 4, TTC's Facebook Page was created with intention of addressing the 'general public' but immediately became the domain of people with experience of mental health problems and concerned with the activist cause.

Conclusion

The various meetings I have discussed in this chapter suggest the existence of two divergent approaches to issues surrounding mental health. The difference between them appears to be of scale as well as of the reflexive consideration of meanings groups ascribe to their actions. In the context of conferences that attracted the attention of diverse activist participants we have seen claims and aspirations for making a change relevant across the whole of society underpinned by the suggestion that, in bringing about such transformation, a unified language is required. In the context of small local groups the primary concern was with day-to-day prosaic activities, basic sociality and, as we shall see in more detail in Part 2 of the thesis, with collective processes of recovery. In attempts to conceive of their actions as unified, in the former context, my research participants employed the notion of movement, while in the latter local contexts, the term community was preferred (see Chapter 7 for more detail).

Meanwhile, the discontent expressed during these social occasions (during conferences, on social media and by members of the local groups) are telling of a certain discontinuity and disagreement between these national and local strands of participation and especially between large charities and organisations, with their logistic and financial potential on the one side, and dependent on the groups that focus on addressing personal issues on the other. A number of issues were identified including under-representations of ethnic communities, ignoring of rural areas in campaigning and provision of services, inadequate services or use of celebrities in campaigns. Discontent was also expressed in regards to the shift of focus from particular issues or illnesses to a more general concern with mental health or excessive focus in campaigns and media representations on depression and on what was sometimes framed as ‘mild’ disorders which were seen as ‘less controversial’. Parallel critiques were also prevalent on the Internet and especially on TTC’s Facebook Page, which I discuss in more detail in the following chapters.

However, it would not be accurate to think of contemporary activism as being in a state of continuous contention as it was the case for movements in the past. Instead, with respect to numerous reasons for participation and the multiplicity of issues addressed, the local and the national forms of activism intersect during events and meetings. What is more, they are connected through particular individuals such as Torsten in Norfolk, Chandra in Harrow or Ron in Richmond, who participate in various projects that boast varying degrees of financial or bureaucratic independence from the public and voluntary sector. Extensive efforts of such individuals sustain connections between various groups and give contemporary activism its vibrancy.

Although people involved in activism are concerned with different needs, niches and concerns, they, nonetheless seek opportunities to work together and learn from their respective experiences of participation. Regardless of the scale of their actions and differences in opinions, we could say that activists are aiming for essentially the same goal – better lives of people who experience mental health problems. It is the execution of this aim that is markedly different with local groups focusing directly on processes of recovery and national campaigns on changing the social understandings and attitudes towards mental illness.

In both instances, however, a need for unity was articulated as suggested by the name of groups and events such as ‘Challenging Discrimination Together’, ‘Talking about Mental Health – Getting it Right’. In case of TAO their search for unity did not preclude arguments and differences between group members and we shall see later (Chapters 7 and 8) that contentious dynamics was characteristic to interaction in these collective recovery contexts. Meanwhile, we have seen that in case of conferences, there seemed to be no space for such disagreements. Instead, a need for unity was expressed through the notion of movement.

Further explanation of the use of the notion of the movement could be that activists strive to ensure the autonomy of their projects. We have seen in the previous chapter that activism's outlook came as a result of a number of factors including deinstitutionalisation, introduction of community care, policies of involvement and, more recently, appropriation of recovery discourses into policy and services, all of which led to the blurring of boundaries between the public and voluntary sectors and, consequently, took away possibilities for contentious protest.

Milligan (2000) explains that as a consequence of radical changes to mental health services in the UK, the third sector came to be seen as more capable of addressing local needs and of providing more effective services to the mentally ill and was, thus, endowed with more responsibility. At the same time, points out Milligan, the third sector was treated unequally due to its alleged 'non-professional' background vis-à-vis employees in statutory public services. Consequently, it appears to have had little political influence since the 1980s despite the significant financial resources it operated with (*ibid.*). Milligan concludes that the voluntary activity 'may in reality come to represent little more than an alternative form of state institutionalisation' (2000:198) and function as a 'sub-state' where not-for-profit organisations are, practically speaking, devoid of their independence and integrity.

Contemporary mental health activism, with its close association with voluntary organisations could thus be seen as being indirectly contingent with the state. Evidence of this growing reliance could be found in transformations of services that now require service user participation and thrive on their senses of responsibility. What is more, numerous charity organisations, and, thus indirectly, activist campaign and projects, receive part and, in some cases, most or even the entirety of their funding from various governmental sources. Running parallel is the deepening withdrawal of state support from many areas of public life, exemplified by the notion of the Big Society, which necessitated an increased individual and social accountability for both services and social issues such as mental health. The example of peer-led services discussed in Chapter 8 indicates that transformations of services are taking place within the already existing bureaucratic frameworks of charity organisations. Meanwhile, further ethnographic evidence from TAO, which I present in Chapter 8, shows that although it is initially possible to organise groups outside of the framework of the state or large organisations, bureaucratisation is unavoidable if such independent groups are looking to attract wide sources of funding for their activities.

Graeber (2009) explains that indirect action aims to make social change through the means that involve bureaucratic, civil, legal or administrative establishments, while direct action goes beyond these structures by, temporarily or permanently, treating them as non-existent. Service users I met throughout the research often expressed a strong sense of entitlement to services and an accompanying reluctance to change their existing status quo. In that sense they envisaged a presence of a state that is both

generous and inclusive in character. Meanwhile, it was the closing of services and withdrawal of state support or funding that inspired various forms of participation, also beyond the jurisdiction of the public and voluntary sectors. Such forms of participation, however, appeared to be a matter of practical necessity rather than choice.

I therefore suggest that in the contemporary context of mental health activism there is no clear-cut distinction between independent (or direct) and subsidised (or indirect) actions because of the indistinct boundaries between previously opposing groups of interest that came as a result of the continuous transfer of responsibility for services and for health more generally. This, in turn points to the inevitability of the contemporary orientation of national forms of activism. The inability to confront the state structures helps to account for the way individuals turned their discontent at directors and CEOs of charity organisations and campaigns during the conferences and events. It was in response to this critique, that executives employed a notion of movement and pointed to necessity for unity in action. All in all, it seems that the notion of movement was helpful in imagining action and releasing tension existing between various factions involved in mental health activism. What is more, it was claimed that being (portrayed as) a movement or at least the public perception that this movement is unified would make campaigns and activism more effective. Such claims for united action were also made on social media, as we shall see in the following two chapters.

Although it might seem essential for movements to have a capacity for presenting clear and understandable goals and demands, they do not necessarily need to speak with a unified voice. Cohen, for example argued that ‘any great social movement is invariably a coalition of interests’ (Cohen, 1985: p18) indicating that movements do not amount to one voice but a consortium of them. Crossley makes a similar point and claims that ‘we would have very few social movements in our analytical pot if our definition of them required that they speak with a unified voice in respect of a relatively unchanging discourse’ (2006:94). Furthermore, following the classical Resource Mobilisation theory (Zald and McCarthy, 1977; Jenkins, 1983), which emphasises efficiency at utilising all available assets, whether human or material, it could be suggested that a multiplicity of voices, rather than one activist voice has the potential for supporting a vibrant and cogent movement.

Donner and Chari (2010) explain that ‘new’ social movements that came about post-1968 faced a number of difficulties including the creation of new audiences while also having to address those that already existed. Consequently, argue the authors, there emerged new ways of bringing about social change that relied on representation of the ‘other’ and reconsideration of categories such as sexuality, ethnicity or gender. These changes, in turn, led to diversification of concerns, issues and perspectives and also the transformation of activist identities, all of which, argue the authors, proved difficult to comprehend academically.

In addition to Donner and Chari's argument, I suggest that these 'new' ways of making politics, with more diverse and specialised scope on the one hand, and resulting from it ambiguity of practice on the other might also influenced former and contemporary forms of mental-health focused activism. For example mental health movements in the past and specifically the anti-psychiatry movement tried to disestablish the view of mental illness as 'bad', which seems to have left the possibility for solely positive and non-contentious notions and representations of mental illness. What makes the current situation even more puzzling is the concurrent withdrawal of the state support from services, dependency of activism on state funding and the inevitability of addressing the shortcomings of the system between each other.

The notion of movement however was only one of the aspects of meetings and conferences telling of attempts at developing unity. Activists I talked to on these occasions, similarly to people I met in the context of local groups, reported that interactions with other people provided them with a sense of strength, happiness with the ability to participate, of being part of something and realisation that others also strive for change. My research participants saw their meetings as galvanising a sense of unity that they sought and imagined in the future across the society. More specifically, this took place through exchanging skills and ideas, discussing the most effective ways of campaigning, training and supporting each other. What is more, personal narratives of illness and recovery that invariably accompanied these activities led to the realisation of shared experience including that of mental health problems and that of campaigning. In short, practices of sharing experience with fellow activists proved fundamental to a sense of unity, perhaps, more effectively than any notions of movement.

Charmaz (1991, 1992) suggested that individual illness identity includes personal experience contextualised by social and medical knowledge as well as attitudes towards illness. Brown et al. (2004) drew on this argument in their account of embodied health movements and proposed that collective illness identity might come as a realisation of shared experience. With reference to these as well as other arguments (see Anspach, 1979) that conceived of mental health politics as a form of identity making we could provisionally assert that the sharing of experience by activists becomes politicised through realisation of common aims and subsequent formulation of objectives and demands for social change. Activist meetings could, thus, be seen as helping in aggregation of politicisation of experience and, perhaps, leading to a sense of identity.

This however, I would like to suggest, is not the case because activists do not realise shared experience of particular illness but, instead, concentrate on experiences characteristic of all mental health problems. Such emphasis on what we have in common might render collective action more difficult, but, possibly also more

effective. Meanwhile focus on identity might limit the understanding of activism to the sphere of subjective meanings while carrying a potential for obscuring the importance of practices of participation aimed at bringing about desired social change and the wider context in which such actions take place. Graeber (2004) usefully pointed that anarchists as well as other politically-oriented groups often suffer from media- or popular-discourse-enforced badges of identity that disturb the outlook and aims of their actions the, prominent example given by the author being the indigenisation of political struggles in Chiapas.

Taking this into consideration, I hope to show that mental health activism goes beyond the identity politics framework and suggest that mental illness and health are more than just identities people take on, but collections of occurrences, utterances, actions, expectations, anticipations and behaviours characterised by the capacity for self-reflexivity and by their inseparability from the environment in which they take place.

Evidence of the possibilities for health-related actions being environmental in scope can be found, for example, in activists meetings, which provide a safe and accepting context for sharing personal accounts of experience. These practices, in turn, could be seen as establishing a specific code for speaking and we shall see in the following two chapters how this code proliferated into the sphere of social media and in particular on the TTC Facebook Page and Group. There, sharing of personal experiences came to be seen as advantageous from both personal and activist perspectives and in that sense we could see participation therein as amalgamating divergent concerns, which as we have seen above, led to arguments and disagreements.

Chapter 3

Self-Proclaimed Technophobes Discover Facebook

Social Media Workshop

On a sweltering late May morning, deep in suburban south-east London, in an upstairs room of a neo-Tudor mansion converted into a hotel and conference venue, a young woman carries on preparing her presentation. A delicate smile does not leave her face as she patiently untangles a Gordian knot of wires and cables. She nods with affirmation each time a person sticks a head through the door and timidly asks ‘is this the social media workshop?’ Within minutes the capacity of the room is exceeded and attendees sit literally arm in arm. Everyone seems to be nervous as indicated by the absence of small talk or friendly banter that would normally be heard prior to such presentations.

The workshop leader notes the uneasiness and initiates an icebreaking session during which each person introduces him- or herself and explains their involvement in mental health activism. Some attendees are just starting; others have many years of experience. Although in their projects they engage with diverse groups of people and operate in different parts of the country, all attendees share something in common: they all want to become competent in using social media while hoping to expand the reach of their respective campaigns and projects. This anticipation, however, faces a fundamental obstacle, as almost every person in the room reveals some degree of apprehension with regards to computers and the Internet. Once one woman declares herself as a ‘technophobe’, others pronounce that they are technophobes too.

The last person to introduce herself is Abigail, today’s speaker and media officer at Rethink responsible for running TTC’s social media campaigns. In a reassuring voice she starts by saying that technology is nothing to be afraid of. Using the projector and screen connected to a laptop, she carefully explains key features of TTC’s Twitter and Facebook pages. Upon a question from the audience of how to sign up to Facebook, she logs out of her account and goes through the process of creating a new one. Abigail emphasises social media’s functionality, and remarks on their indispensability to activism. More specifically, continues Abigail, Facebook, and to a smaller extent Twitter, played a key role in promoting the TTC campaign, connecting people concerned with the issues of mental illness and health and helping to ‘spread a positive message’. This claim is immediately supported by one of the attendees, Pamela, who explains that Facebook proved to be of invaluable help in recruiting volunteers for her local anti-stigma project in west London also indicating that use of social media can benefit not only large but also small-scale projects.

Numerous questions concerned with the day-to-day running of a Facebook Page and Twitter account as well as privacy follow. In response, Abigail elaborates on safety features and measures that should be considered when using Twitter or running a Facebook Page. These are mostly common sense like avoiding giving away personal details and respecting the rules and regulations. Once the workshop finishes, attendees leave the room visibly excited. Some are eager to create profiles, groups or pages;

others exchange cards and arrange ‘becoming friends’ on Facebook. Those who initially pronounced themselves to be wary of technology no longer seem to find navigating social media frightening.

One immediate observation that emerged from the workshop was that the success of social media has its origin in their accessibility and simplicity of use. Devoid of the necessity for coding or encryption, and being user-friendly, social media lent themselves to what has, arguably, become a phenomenon emblematic of the beginning of the twenty-first century, although this is still to be more widely and academically acknowledged. At the same time, analysis of the subject poses numerous challenges since social media are both relatively recent and yet already deeply engrained into social interactions.

There have been some attempts to provide algorithms-based analysis of the social media (Bucher, 2012). Other strands of inquiry into the subject focus on sociological patterns (Hui and Halpin, 2012) or political economy of social media (Langlois, 2012) and their monopolies with emphasis on expansion of marketing and advertising practices (Evans, 2012a). Meanwhile, it is less common to focus on context-specific uses of social media by particular groups of people or to highlight complex and often hard-to-account-for webs of meaning produced in their contexts. Miller’s (2011) ethnographic account the use of Facebook in Trinidad is a notable exception here. There also exist some carefully optimistic approaches that do not offer definite conclusions but, instead, think of social media in terms of their potential. Stiegler (2008, 2012), for example, suggested that, despite emphasis on the individual, social media carry a capacity for new forms of socialites.

Among doubts and concerns two conclusions could be made with some certainty. First, that the advent of social media came as a result of technological advancements including increased accessibility, faster broadband, portable devices, greater network capacities and software development. Second, we have, resulting from these transformations, the potential for new forms of socialisation: participation, sharing of content in both text and media form, replication of an already existing social relation, all of which is elevated by possibilities for presentation and reflection of individual preferences, views, choices and opinions or what Stiegler (2009, 2012) conceives of as a process of individuation.

Such emphasis on presentation of self was noted in Miller’s (2011) account of the uses of Facebook in Trinidad, which leaves us with an important question of what, if anything is social in social media. This concern underpins the current and the following chapters where I discuss mental health activism through the prism of the TTC Facebook Page and its appropriation by users. We shall see in what follows that focus on the individual in this context, and in particular sharing of personal accounts of mental health problems, contributed a new and important dimension to activist

practice and led participants in discussions to new senses of unity. While discussions of representations of mental health on the Page constitute the main theme of the following chapter, the current part of the thesis is concerned with a detailed description of the architecture and development of this environment, which will help in understanding the technological possibilities and limitations of the medium as well as the continually changing mechanisms of participation.

I am not proposing that the attendees of the workshop or activists more generally can fully realise their campaigning potential and achieve their aims as a result of using Facebook. Instead, in these two chapters I am hoping to show how the TTC Facebook Page could be seen as an extension and important addition to activism, how some of the issues and concerns discussed in Chapter 2, most notably media representations of mental illness, were also addressed in this context and how participation therein could be seen as an important support to the activist aim of making mental health problems widely understood as discussed in Chapter 1. Consequently, I would like to suggest that with the assistance of social media, new ways of using, engaging and making of social and individual experiences, including experience of mental health problems, recovery and activism became possible.

Several weeks after the social media workshop, on a sunny, yet cold and windy summer morning, I enter a modernist high-riser that stands tall by the South Bank of the Thames in Vauxhall. The building, its sleek interior and well-dressed people coming in and out bring to mind an image of a corporation office, rather than the charity organisation I came to visit. The list of residents by the reception reveals that majority of the sixteen stories are occupied by third sector organisations.

Rethink's reception area located on the fifteenth floor boasts a panoramic view of London with the river cutting the city in half like an emerald serpent, with the Houses of Parliament and the skyscrapers of the Square Mile and Canary Wharf sitting along its banks. I only manage to glimpse on the western side of this extensive urban mass as Abigail arrives. She first shows me around Rethink's office, which is a large open space reminiscent in layout of an advertising agency. One person is giving information about mental health services over the phone while others are planning an upcoming campaign. The atmosphere seems relaxed and various paraphernalia, such as family pictures and mascots sitting above desks, make the office seem like a relaxed working environment.

Instead of one of the adjacent meeting rooms, Abigail invites me to sit in the staff kitchen, where we make a selection from a wide range of teas, exchange a banana for half a flapjack and where the initial impression of corporate distance and sterility gradually disappears. On a screen of a laptop Abigail shows me a compilation of statistical information on the TTC Facebook Group and Page. Unlike many sites or Facebook-based causes that experience a sharp rise and subsequent loss of attention

(see Shirky, 2008), the data shows a steady increase in the number of people who maintain their interest in the campaign by commenting and posting. Abigail sees this as an indication of a sustained concern with the TTC, which, as she adds, is fundamental to the success of the campaign.

Abigail then tells me about the beginnings of TTC's relationship with Facebook. The suggestion to use social media was made by a London-based creative agency, which helped in the initial development of TTC's media profile including its name, slogan, graphics and presence on the Internet. Abigail adds that TTC was the very first social marketing campaign in the United Kingdom to use Facebook. What is more, further possibilities created by social media greatly exceeded initial expectations, as no one involved thought that the Facebook Group and Page would come to play such a prominent role in the TTC campaign.

The unpredictability and indeterminate effects of social media is considered to be one of the key problems for activism and social movements (Shirky, 2008; Coleman, 2010). In fact, as soon as social media were used for political purposes (the 2008 protest in Iran is probably the first example), their potential for contributing to social change was immediately rebuked with the notion of click-through activism.¹² The critique of so-called clicktivism (White, *The Guardian*, 12th August, 2012) focused on highlighting a lack of palpable results, ineffectiveness and replication of already existing offline relationships. What is more, social media were also considered as a double-edged sword if used by oppressive state regimes (Diamond, 2010; Warnke, 2012). As movements and political groups of all breeds from across the world resorted in their actions to Facebook, Twitter and other social media Internet-based communication tools, at times in comical ways, such as for example anti-Gaddafi insurgent forces' impromptu tactics of using Google maps (*Russia Today*, 17th June, 2011, also reported by *BBC News* in early April 2011), the usefulness of social media for activism is prone to suggestions of the triviality of such practices. Coleman (2010), however, sees this banality to be an important element of social media's more 'profound' character.

At the same time, social media are also considered to be responsible for the expansion of marketing practices by encouraging new forms of targeted advertising based on data collected from the snippets of information posted by users. This point is expanded by Lovink and Rasch (2012) who acknowledge that social media help in creating new social spaces but argue that with the 'facilitation of free exchange' on the one hand and 'commercial exploitation of social relationships' on the other, social media, rather than bringing about a promise of a social change, are symptomatic of contemporary capitalism. The authors point out that social media redefine divisions between 'commercial and political', 'informal networks and the public at large',

12 The first use of the term in an article in *the Washington Post* from the 2nd July 2009 is attributed to Csikszentmihályi, see Nisbet 2009.

‘users and producers’ and ‘democratising and disempowering’ and that as a result of the blurring of these categories, class struggle is effectively non-existent on the Internet (Evans, 2012b).

This amalgamation of practices and meanings in the social media, however, came to be of advantage in the context of mental health activism. More specifically, TTC’s use of Facebook is an evocative example of how the social medium’s marketing-oriented design came to be successfully employed by a non-profit campaign and we could suggest that the blurring of the boundaries between commercial and political in this case fitted the contemporary situation in which activists had to promote their ideas in a similar way to private enterprises.

Lovink and Rasch (2012) also argued that due to the continually changing character of social media it is more helpful to look at their architecture rather than their impact. This is why in this chapter I look into features and transformations of the social medium that enabled interactions in the context of TTC’s Facebook Group and Page – an example of, arguably the most vibrant and popular use of social media by contemporary mental health activists. We shall see in what follows that the Page failed to become a marketing device and, instead, was appropriated by people concerned with mental health problems, and turned out to be an aggregating device for activism. First, however, it is necessary to say a few words about the medium itself, its functional basics as well as changes it has undergone in recent years.

The Basics of Facebook

Facebook, a brainchild of Harvard undergraduate student Mark Zuckerberg, within a few years transformed from what initially was intended as a prank female student comparison site into one of the most-often visited web pages and, arguably, the most prolific social medium known thus far. With over one billion registered profiles worldwide and thirty million in the United Kingdom by mid-2013, half of them logging in on a daily basis, Facebook has become an element of daily routines and social lives that, through posted content including written text and visual material, sees continuing activity even at times when users are not logged on. In this sense, activity on Facebook, which always leaves possibilities for further contributions or interactions, is like a retold joke, story, gossip, lie or anecdote that continues to attract the attention of other people without necessarily the participation of the original author. As we shall see in the account and discussion below, an emphasis on various forms of utterances is also fundamental to activists’ practices in this context.

The presence of Facebook is also, in a sense, inescapable, as even those people who refuse to sign up cannot avoid the constant stream of information or discussions on or around the topic. Facebook has entered numerous personal, social, political spheres and its rise has brought changes to how people interact, how news is reported and

disseminated, how social events are organised and, as I would like to show here in relation to contemporary mental health activism, to the ways people use and portray experiences of mental health problems.

Creating an account for personal use is free of charge¹³ and fairly simple. At the registration stage one has to provide basic details including name, date of birth, sex and age. One is also required to devise a memorable password, which allows for repetitive log-ins. The final stage involves activation of the account via text message or email. Once logged in, a Facebook user can build his or her profile (see fig. 6) by adding and editing personal information, such as his or her profile and background picture, relationship status, place of residence and origin, education, workplace, interests or languages spoken, among others. Users can also personalise their account settings to allow different groups of people to have access to particular information, or posts making them either ‘public’ or ‘visible’ only to friends or groups of friends.

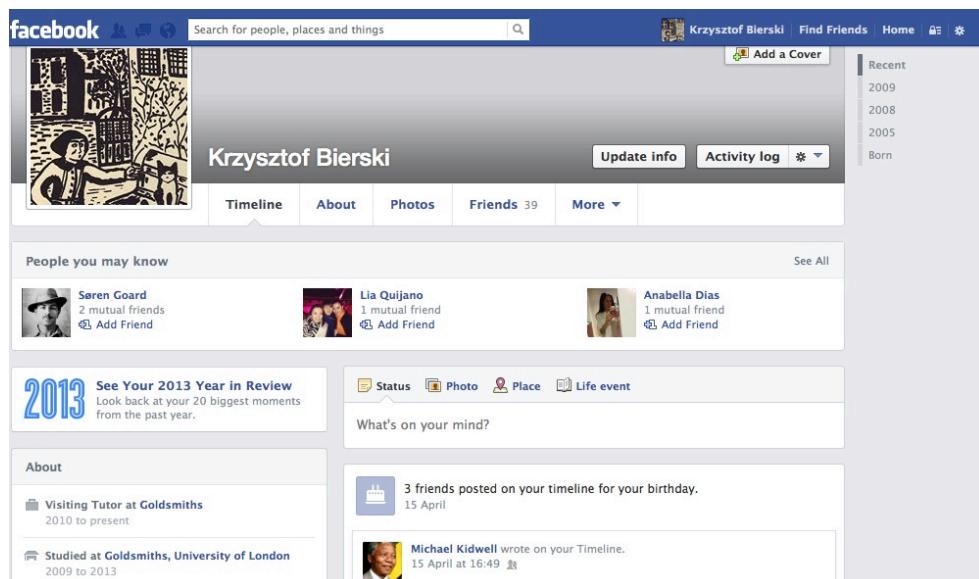


Fig. 6: Example of a personal Facebook profile

Posts are pieces of information generated by users and can include written text, photographs, videos and links to events, pages, external websites or one’s current geographical location. Since 2010 it is possible to ‘tag’ oneself and other users in any post and, from 2011, privacy settings on individual posts can also be changed. Posts appear in inverted chronological order on the personal section, which until the end of 2011 was called ‘wall’ and, since then, ‘timeline’. Posts simultaneously come into the

¹³ Rumours spread throughout 2009 and 2010 that a monthly user fee would be introduced. These reports were then denied by Facebook and the ‘Is free and will always be free’ motto is now visible upon entering the log-in page. Commercialisation of Facebook activity, however, increased with time as some paying options were introduced such as promoting one’s material posted on Facebook or a one-off payment for messages sent to people one is not a friend with – in a way treating private interactions between users who have not formalised their friendship on Facebook as necessarily involving a transaction of a commercial character.

view on news feed, (sometimes, rather confusingly, also called wall), which is an algorithmically generated extract of activity by friends and liked pages. Stiegler (2012) considers the action of posting to be one of the two fundamental practices on Facebook, the other being the formation of friendships and we shall below that posting and commenting on posts is the key activity in our example too.

The news feed, from 2011 accompanied by the smaller real-life feed, facilitates many-to-many communication through options of commenting, sharing and liking a post. The ‘Like’ option can imply a variety of attitudes but generally is a way of showing interests in a particular post. In terms of one-to-one and/or one-to-many communication, users post on their friends’ timelines, use live chat and, recently integrated with it, a private messaging system. Users can also create events, respond to event invitations and create and/or become members of a group as well as like various Facebook pages, on which more below.

Facebook Friendships and the Question of Individuation

Facebook friends are, effectively, users who mutually agree to share access to each other’s profiles upon one user’s ‘friend request’ and another’s positive response to that request. Facebook friendship could be between people who already known each other and it is not uncommon for people to encourage their friends to become members of Facebook and sometimes even accompany them in this process. One’s Facebook friends might also include strangers one adds with the intention of further contact, ‘stalking’, which here means the action of continual following of activity on someone else’s account, as well as a number of other reasons.

In the course of the research as well as in private life I have observed that, rather than swap phone numbers, it is now also common for two people (especially younger, but certainly not exclusively those) who meet for the first time to exchange Facebook details (i.e. become friends on Facebook, sometimes immediately if both have access to their accounts and sufficient bandwidth on their mobile devices). Two research participants and a number of friends of mine explained that exchanging numbers was an indication of the intention of meeting face-to-face in the future, in which case a telephone call was considered both more appropriate and convenient. Meanwhile forming a friendship on Facebook would indicate that future contact between people was less specific and obliging but, nonetheless, possible.

Such attitudes might come across as contradictory, given that Facebook users make available considerable information about themselves on their profiles, whereas exchanging phone numbers limits the amount of details known to a row of numbers. However, this practice might be telling of the new ways in which people make their lives more publicly visible and, at the same time, maintaining distance from others if this is considered necessary. Of course, I am not trying to suggest that use of

Facebook allowed for some new form of exhibitionism. Instead, I am trying to point to a new feasibility for sharing elements of personal lives with others much more easily. To put it another way, it could be said that Facebook friendships allow users to enter relationships characterised by an undemanding sociality¹⁴ – where it is possible to be in a relation with someone without any obligations, and, at the same time, choose tactically when to engage and what information to share with that other person.

Concerns with the absence of social obligations seem to inform the critique of the relationships made in the context of the social media. However, they seem to be underpinned by not very helpful comparisons between so-called ‘real’ and Internet-based forms of activity as if the two spheres were separate from each other, yet need to be measured by the same yardstick of expectations and norms. Hui and Halpin (2012), for example note that to the initial category of Facebook ‘friend’, ‘close friend’ and ‘acquaintance’ have now been added. This leads them to point out that relationships on Facebook are necessarily positive, as the category of an enemy or a foe does not exist in that context. Such lack of antagonism, which implies an overt concern with positive social relations, seems to be the reason why Hui and Halpin (*ibid.*) consider development of meaningful, or what they call ‘close friendships’, in the context of the social medium to be unlikely.

Conversely, we should note that it is possible to ‘unfriend’, block or report other users and/or traces of their activity. So, as in ‘everyday life’, there exist mechanisms on Facebook that allow its users to prevent social contact if deemed undesirable. We could even say that with security settings that allow for a change of visibility of individual posts, there exist possibilities for selective prevention of contact or interaction.¹⁵ Furthermore, we should note that in so-called ‘real life’ there is no tendency to proclaim other people as official ‘enemies’ in the same way as we might want to consider some people our official friends.

It is self-evident that people, in general, show preference for and capacity to invest in relationships that they see as meaningful to them. Meanwhile, Facebook might be seen as providing opportunities for connecting with others in ways that do not require a deep sense of social obligation. Such a possibility for undemanding sociality or for sharing just elements of one’s life with others, however, does not automatically preclude the potential for meaningful relationships in the context of social media.

14 The use of this expression was suggested by Prof. Emma Tarlo during one of the Goldsmiths Anthropology Department writing-up seminars and made with specific regard to the draft version of Chapter 6 of this thesis. I consequently decided it is also fitting to the analysis of activity on Facebook.

15 For example in order to avoid being contacted by a particular person on Facebook it is sufficient to ‘block’ them, whereas in so-called ‘real life’ one might need to make a police complaint, engage in a lengthy trial and ask for a restraining order in order to achieve the same result.

Stiegler (2012), meanwhile, sees the creation of a Facebook profile and friendships as a formalisation process by which one makes oneself and his or her social relationships available and known to others. The formal and public character of these relationships (i.e. Facebook friends would see other users becoming friends; Facebook friendship needs to be confirmed by both parties) argues Stiegler, raises some questions regarding the meaning of such relations. However, he ultimately concludes that a Facebook friendship could indeed be considered as a form of friendship, as it is underpinned by the human need for socialisation. Stiegler also notes that formalisation of relationships is not alien to social interactions and that, in fact, it is often necessary or required.

It is such a process of formalisation of social relationships, alongside the process of individuation – or presentation of self in the sphere of social media that, according to the author (*ibid.*), opens up possibilities for new forms of sociality, a point to which I return below. Facebook, rather than simply putting emphasis on positive interactions, seems to be drawing on the preference for social contact rather than animosity, while also allowing for such social contact to be more selective and less obliging or, we could say, less demanding.

Features of individual profiles described above are accurate as of late 2013. They are, however, prone to change as a Facebook site, its usability, user interface and interactivity undergo constant, and sometimes substantial modifications. Although these transformations are dictated from the top down, that is Facebook to its users, it is through the latters' practices, opposition or lack of response that the architecture of the social network is redeveloped. Citizens' groups and the European Union have also had some success in changing Facebook's policy and, due to their actions, users are now able to close their accounts permanently, something which was not previously possible. It is also worth noting that one of the consequences of each of the major changes to usability is an automatic downgrade to the lowest possible account security settings. However, in recent years there seems to be an increased awareness of this problem, evidence of which can be found in user-generated posts that provide instructions on how to adjust one's settings accordingly.

Concerns with privacy seem to originate from, first, the necessity to provide personal information at the point of registration of a Facebook account and, second, because by posting users make a considerable amount of information available to friends, to Facebook that collects, analyses and stores this data and, often unknowingly to the users, to so-called third parties or companies that are granted or request access to users' personal information. Lovink and Rasch (2012) point out that social scientists inspired by Goffman's *Presentation of Self in Everyday Life* and Foucault's *Technologies of the Self* produced a 'moral panic' regarding issues of privacy and identity theft. Meanwhile, Miller (2011) argues that the expectations regarding privacy towards social media are contradictory and unrealistic as it is impossible to have an increased sociality without a necessary compromise on privacy.

These issues of privacy might also be among the reasons why academic attention (including in anthropology) on Facebook has focused on individual profiles and interactions between people who already know each other rather than on activity and relations between strangers in the context of Facebook pages and groups. It has been suggested that users' activity through individual profiles are interesting, because they replicate, further or reconstitute previously existing social relations (see Miller, 2011) while also having a real impact on everyday life. Gershon (2011) has shown this evocatively with her ethnographic account of people ending their relationships on Facebook. Other notable examples of novel practices include employers scanning Facebook profiles of their potential employees for information, or workers being made redundant for posting social media content deemed inappropriate.

From an anthropological, or, a more general social sciences' point of view and specifically in relation to the notion of undemanding sociality, the focus on Facebook Pages and Groups seems more worthwhile than on individual profiles. This is because pages, to a much more significant degree than individual profiles, entail interactions between people who might be strangers and are also loci of activity focused on particular social issues, interests or phenomena. Following Stiegler's (2012) explanation that profiles are markers of progressing individuation and subsequent compromise on the concern with the social, we could, perhaps, see Groups and Pages on Facebook as providing opportunities for 'grammatisation' (*ibid.*) here, the appropriation of individuation for the purpose of creating opportunities for new forms of sociality. Grammatisation, or what Stiegler saw as a reflexive process of realisation of meanings of participation in the context of social media, is also how we could conceive of activity on the Time to Change Facebook Page and Group. Meanwhile, a closer look at the Page and Group is also capable of turning our interest away from issues of privacy and towards matters of the reconstitution of meanings, both public and private.

Facebook Groups and Pages

Pages, formerly known as fan pages and groups, are the public spaces of Facebook. As of 2013, Groups, which used to dominate the social media's landscape, are of a more private character with a limit to the number of its members.¹⁶ Pages, on the other hand, are available to all and do not have a limit on the number of users. The nomenclature of becoming associated has also changed over time as, initially, one would 'join' a Group or 'become a fan' of a Page. Currently, one 'become(s) a member' of a Group, usually following an invitation from another member and 'likes' a Page, in a similar way one likes an individual post. Liking a Page or becoming a

¹⁶ At some point there was also a requirement that members of a group also had to be Facebook friends. This is no longer in place.

member of a Group will result in posts made in these contexts being displayed on the users' news feed. Throughout this and the following Chapters, I refer to people who interact in the contexts of the TTC Page specifically as 'users' and Group members as 'members', and sometimes simply as 'participants' when denoting a shared practice.

Pages can be set up by individuals, organisations, or companies and allow for the promotion and discussion of ideas, products, persons, objects, social phenomena or cultural artefacts, some random examples include: Coca Cola, Flying Spaghetti Monster, Smell of Petrol, LGBT section of the English Defence League along with Pippa Middleton's behind among a myriad of others. All these Pages share the same functional structure with exactly the same layout, allowing for minor modification, depending on the type of the Page's intention but permitting for different content. Such uniformity of media form, as we have seen in the previous chapter, was also symptomatic of activist-made publications.

Pages, just like personal profiles, are based around Timelines. There, both users and administrators can share posts, or snippets of information or links to other web pages with posts by users displayed as thumbnails in smaller font on the right hand side of a page, and posts by administrators taking up the majority of its space. By liking, commenting and posting one uses/interacts on a Page in a similar way one connects (interacts) with a Facebook friend.

Abigail pointed out that the ubiquitous use of Facebook by companies and charities was not yet the case in January 2009 when TTC launched its campaign and thus the employment of the social medium could be seen as an innovative practice. At first TTC operated both a Group and a Page as the two existed parallel to each other, with the former being initially more popular and vibrant. In the summer 2010, following Facebook-induced changes, the Group was replaced by a Fan Page and all of the Group's eight thousand members automatically became associated with this. A few months later the TTC Fan Page, just like all Fan Pages, came to be known simply as a Page.

I discussed the implications of these transformations with Abigail during our chat in Rethink's office. For her, the changeover from the Group to the Page was important for practical reasons. For example, she was receiving a great number of messages from Group's members to her personal Facebook account, which featured on the Group's wall as the administrator's profile. In this correspondence, users often expressed discontent, not only as regards the TTC campaign, but also in relation to personal experiences and issues and it took Abigail a considerable time to respond to all the messages. Currently, the Page does not feature the name of the administrator, while new options for differentiating between personal and page administrator accounts are also in place.

At the same time, as a result of modifications to the Pages' usability, Abigail's ability to communicate with users improved greatly. With the new functions, for example, she could message all users of the Page at once, rather than having to select members one-by-one, as was the case in the Group. The most important part of the upgrade, in the eyes of Abigail, however, was the commenting option, which enabled instant and continuous communication between users and also with TTC on the Wall and, later on, the Timeline.

Initially, in the context of the Group, users were able to write posts that stood on their own and, thus, coherent discussions were not feasible. With the new option of commenting, the Page flourished, as the possibility for interactions and discussions appeared, and the number of users rose from eight to 35,000 between the summer and winter of 2010.

According to Abigail, users did not find it difficult to adjust to the changes and immediately utilised the new features. However, commenting also led to arguments, some of them overtly personal or derogatory. Consequently, Abigail was required to monitor the Page more carefully and remove any offensive content. During our chat, Abigail explained she considered most of the arguments unnecessary and a result of misinterpretations and/or misunderstandings between users, which might have been simply a matter of a more limited ability to express oneself in instant text-based communication than is the case with the spoken word.

I would like to propose that these arguments could be seen as attempts to balance individual experiences and expectations with the aims and objectives of the campaign. Disagreements and quarrels, as we have seen in the earlier case of activist meetings, reflect a wide spectrum of voices, opinions and agendas held by those who join and use the Page. As we shall see, they also tell of the Page's vibrancy and its appropriation by people experiencing mental health problems.

Transformations of TTC Facebook Group and Page

The most recent and, so far, longest-lasting layout of the Pages was introduced in April 2012 with some minor modifications made in April 2013. Within this arrangement (see fig. 7), Time to Change's logo featuring the 'Let's End Mental Health Discrimination' slogan, which previously had a central position on the TTC Page, is now dwarfed by the background picture that changes periodically in relation to current concerns of the campaign. Below the logo, a short note about the campaign reads: '*Time to Change is England's most ambitious programme to end the stigma and discrimination faced by people who experience mental health*'.

The right and top side of the Page (see figs. 7 & 8) also includes links to photos, ‘likes’, here, other Pages and profiles recommended by Time to Change including Mind and Rethink’s Facebook Pages among others as well as other options including messaging and recommending the Page to friends as well as thumbnail profile photos of one’s Facebook friends who also liked the Page.

The main part of the Page (fig. 8), the Timeline, features the comment box through which users and TTC can share posts. These appear below in reverse chronological order. The timeline features all posts made by Time to Change and also a selection of posts by users. Previously, upon entering the Page, the default settings made visible only those former posts. Regardless of the layout, posts by others were never immediately discernible and none of them appeared on other users’ individual news feeds, which was the case of posts by TTC. Abigail saw settings, which did not immediately reveal users’ posts, as a practical reason for which the majority of these remained without response. Although this software-determinist explanation seems valid, as we shall see soon, other reasons might have played their part too.

Among users’ posts we find appeals for support for local anti-stigma projects, invitations to social centres, community groups and to mental health-focused events. Posts also include links to blogs, websites or other Facebook Groups and Pages. Users also share information about opportunities for participation in media projects, which range from photography to press, books and multimedia installations. They also write about mainstream or activist-made media representations and about everyday life issues including housing, employment, friendship, legislation, celebrities and religion.

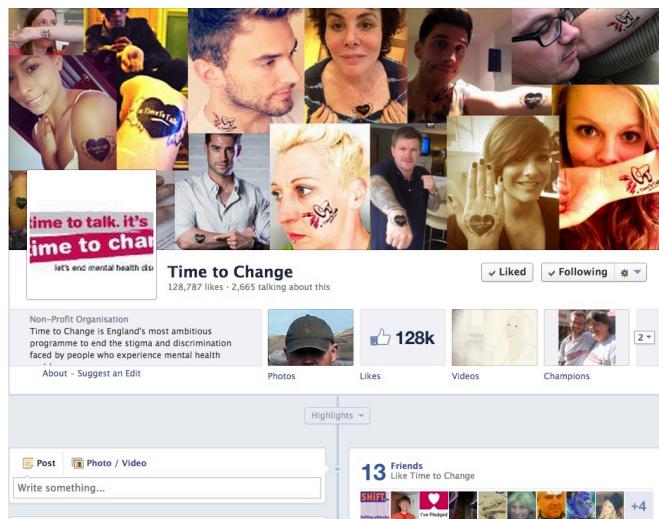


Fig. 7 Screenshot of TTC Facebook Page, 15 December 2013

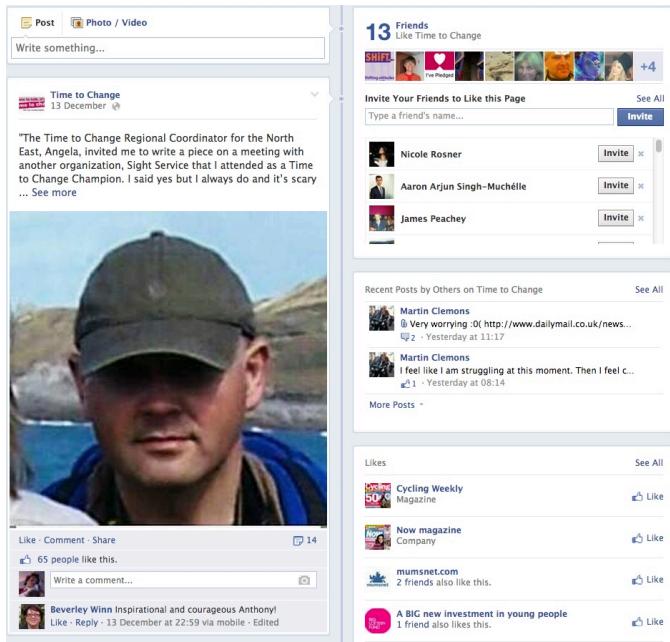


Fig. 8 Screenshot of TTC Facebook Page Timeline, 15 December 2013

All of these posts are normally very short consisting of usually not more than three sentences. Meanwhile, the quantity of individual posts has risen with time and while in 2009 and 2010 there was usually one, sometimes two, posts every day, by 2011 their daily number rose to at least half a dozen. By 2012, the variety of these user-generated posts had also increased with posts cheering or criticising the TTC campaign, the former also from users from other countries.¹⁷

The majority of these individual posts do not attract any comments from fellow users. However, the layout of the Page, as indicated by Abigail, does not seem to be the only reason for this reluctance to respond. It seems that fellow users have found it difficult to react to personal utterances. At the same time, a reply to an individual post could have been interpreted by its author as inclination for further contact or have led to a friend request - something users tended to avoid as indicated by the lack of responses to individuals' posts in which they expressed willingness to make new Facebook friends. Such hesitancy towards developing relationships that would go beyond the context of the Page was also evident in comments to posts by TTC. More specifically, once suggestions of meeting outside of Facebook were made, discussions would quickly be terminated. Therefore, it seems that the majority of users found the structure of the Page fitting for the purpose of interactions, but not for establishing private relationships and commenting on each other's posts carried a potential of being considered as such.

¹⁷ Including US, New Zealand, Philippines, Malaysia, Germany, Iceland, Singapore, etc.

Posts by TTC which are put up on the Page by Abigail or other employees at Rethink or TTC differ from posts by users precisely in the sense that they do entail responses to and discussions of both the original post and following comments. As a matter of fact, TTC's posts are concerned with exactly the same issues and topics as users' posts, and can include invitations to future events or videos and photographs from the on-going and past activist meetings. TTC also shares updates about the campaign and its activity as well as news related to mental health, including legislation, policy, or changes to the health system. It also encourages networking by sharing web links to various other organisations and charities. In addition to this, there are posts asking for participation in surveys and evaluations of TTC and its projects. As we shall see later, these posts are often met with users' critiques and complaints regarding the scope of the campaign, but these responses also reveal subjective meanings people give to their collective participation on the Page.

The predominant concern of the TTC post, however, is accounts of individual struggles with mental health problems. Unlike many of the stories in users' posts, however, narratives posted by TTC entail partial or full recovery. Given the wealth of responses to TTC's posts and their respective lack of this in case of posts by users it seems that it is easier to react to stories that have a positive outcome and, at the same time, more difficult to respond to persisting or unresolved issues as featured in users' posts. It could also be that users of the Page preferred to comment on more official posts by TTC as this allowed them to interact while also maintaining distance from others. To put it another way, in the context of the Page, its users seemed to prefer many-to-many to one-to-many or one-to-one forms of communication, as the former kind of interaction appeared to be less threatening or demanding.

The Discussion Board

The Discussion Board constituted part of the TTC Group and was used for a period of over a year from January 2009 until the transformation of the Group into the Page the following summer. As the function of commenting was not available at that time, the Board was the first context in which users could engage in many-to-many dialogue. The Board was not immediately visible upon entering the Group but accessible through a link displayed at the top of the site. Thus, hidden away from the main site and providing opportunities for non-obliging interactions, the Board was the initial safe haven for discussion and it was there that members of the Group started to share and relate to each others' accounts of mental health problems.

Days after the official launch of the Group in late January 2009¹⁸ discussions began to unfold on the Board in response to a post made by TTC on the subject of relationships

¹⁸ <http://www.facebook.com/#!/board.php?uid=29813531299&f=2>, accessed on 29th January 2009 and 16th of March 2010 but no longer available since the Group was discontinued.

with family and friends. This post attracted fifty-four comments including contributions from people suffering mental health problems and from carers. It should be noted here that family and relations with friends and co-workers constituted an important trope in discussions and were later addressed in numerous videos and advertisement produced by TTC. Therefore, the posts on the Board I discuss below could be read as an attempt to elicit opinions on issues central to people affected by mental health problems and to campaigning and activism more generally.

Personal experience established grounds for the discussion as participants introduced themselves by relating to their specific mental health problems. Wendy started her posts with a confession: '*For many years I have lived with depression*'; Julie wrote '*I was diagnosed with depression and anxiety post-natally [sic] nearly 12 years ago*'; Peter explained '*I was diagnosed with severe depression after I was made redundant*'; Mark wrote '*I was diagnosed with bipolar affective disorder in Dec 2004*'.

These introductions were then followed by elaborations on personal histories of illness and on coming out with their mental health problems to friends and family. Users who shared their stories described the failure to make themselves heard or understood and talked about disappointment, loss of hope and need for support. What they found particularly disturbing was the lack of understanding from those whom they expected to provide help. Those who were lucky enough to receive support from their immediate families pointed to an inability to talk about their experience of suffering with workmates, friends or more distant acquaintances.

In response, other users provided words of comfort, which were followed by claims that recovery from mental health problems benefits from the presence and support of other people. John, who, following a summary of his experience of anxiety and depression, stated: '*Reading these pages has also been a huge help, as have other groups on here [Facebook], and I've made contact with several people in the same situation*' while Clara seconded: '*Reading all these posts has really helped and I can understand a lot where you guys are coming from.*' These comments indicated that processes of dealing with experiences of mental health problems could acquire a fundamentally social character. What is more, they also pointed to users' recognition that their practices of commenting and sharing of personal experiences in the context of the Board resulted in better understandings of these problems which, in turn, brought a sense of consolation. More precisely, these reported senses of relief were grounded in the users' realisation of shared experiences and common difficulties. What is more, participation was also an antidote to loneliness, a feeling that often dominated my research participants' experiences of mental health problems.

This discussion was emblematic of the activity on the Board, which rapidly (but only for a short period of several months) became a context where people could talk freely about their mental health problems without fear of rejection or of being judged, and came to appreciate their experiences and to support each other. As such, participation therein points to the shifting contours between public and private, as it was on the

Board that often very personal experiences of mental health problems came into the potential view of everybody. It was, arguably, the Board's more intimate character, hidden from the immediate visibility of the Group but technically accessible to all, that encouraged sharing of stories of illness, which in turn led to reported mutual experience-based understanding between those who participated. However, it was, perhaps, also due to its concealed character that the Board did not gain such popularity as the Timeline of TTC's Facebook Page.

Just as was the case during conferences and activist meetings, sharing of personal accounts on the Board led to an establishment of a code for speaking, or rather, for commenting and posting, and we shall see in the next chapter how this code was subsequently expanded, and helped in channelling communication between users, while also generating calls for a toned down and non-antagonistic approach to discussions.

Posting or 'dialogue' in Stiegler's (2012) words is the second, after profile creation, 'mode of functioning' on Facebook. As we have seen, such dialogue and discussion is of fundamental importance to the TTC Facebook Group and Page and it is through conversations that meaning is made and reflexivity encouraged. Such potential for reflexivity is, according to Stiegler, one of the most interesting and promising features of social media, a point to which I return below.

Another key characteristic of the Board is related directly to this practice of speaking. Notably, as we have seen above, participants in discussions introduced themselves in relation to their specific mental conditions. This changed considerably once commenting moved to the more easily accessible Timeline (and initially Wall) of the Page where, instead, users spoke about mental health problems and recovery or would mention their specific mental health problems in the course of their comment, rather than as a form of introduction. This transformation, I suggest was inspired by circulating activist notions and ideas around mental health.

However, discussions on the Board also revealed an already exiting sensitivity to expressions employed in mental health-related situations. For example, in the discussion of relationships with friends and family, participants deemed the notion of 'pulling yourself together [from mental breakdown]' to be 'out-of-order' and 'discriminating'. The Board was thus one of the initial contexts within the realm of what I defined as contemporary mental health activism that saw challenges to stereotypical and stigmatising notions of mental illness. This, however, was only a beginning of even more comprehensive critiques of language and media representations that flourished with the advent of the Page.

All in all, the Board enabled users to interact with each other in a more structured way and to tackle the issues that were of key importance to both people experiencing mental health problems and, by extension, to activism, more generally. As such,

participation on the Board managed to achieve something that activists seemed to struggle with during gatherings and meetings, namely, to account for the everyday struggles with mental health problems, while also instigating possibilities for social change without compromising on details of experience. I thus conceive of the activity on the Board as facilitating understanding and cooperation between various national and local strands of activism. This, in turn, would not be possible without a new non-location-specific context (the social media) that also seems to be aggregating various kinds of elective affinities (see Miller and Slater, 2001) and, in this particular example, illness- and health-based affinities.

In October 2010, Abigail invited me to Rethink's office once again but on this occasion we were joined by Chris, social media manager at Rethink. While reflecting on the first twenty months of the campaign the two also discussed Rethink Talk (RT), an Internet-based forum managed by the organisation. When asked to compare it with the TTC Facebook Page, they proclaimed RT to be a more 'politicised' space where grievances, discontent and arguments were much more common.

Within the unsupervised part of the RT, the so-called 'Kitchen', users enjoyed complete freedom of expression. There, explained Chris, discussions could be very 'heated' as guests to the 'Kitchen' seemed to have a much higher degree of animosity and distrust towards each other but also greater concern for their own wellbeing than users of the Page where individual needs became overridden by collective concerns. Or to put it another way, it seemed that in the context of Rethink Talk users focused on making sense of experiences for themselves while on the Page this process became collaborative.

Chris saw the reason for the more antagonistic attitudes on RT to be a result of anonymity as the forum's users operated with nicknames and, thus, did not reveal their personal names. This in turn might have inclined them to speak about their personal and often traumatic experiences in more detail. Meanwhile, in the case of Facebook, users' full names and profile pictures featured right next to each of their comments or posts and were, thus, visible to anyone who visited the Page. It seemed then that the widely available character of the Facebook Page resulted in a toned down approach to discussions, as participants became aware of the public life of their comments. This realisation might also partly explain why, once discussions moved from the more concealed Board to the more visible Timeline, users began to refer to their mental health problems and mental health but not to particular illnesses. What is more, as I suggested above, users also came to employ the language characteristic to the campaigns, as these unfolded and progressed.

Arguably, it was the concealed character of Rethink's forum, which provided the possibility for greater anonymity and, consequently, led to discussions of specific detail of individual experience and to discord between participants. With the rising

public profile of a Facebook group and greater possibility for being identified, we saw the reverse happened, with emphasis on collective participation, attempts at reaching consensus and eschewing of troubling aspects of illness in favour of discussion of shared experiences. All of this, in turn, provides a useful example of how in the context of social media, initial emphasis on individual experience might, through reflexive realisation of its relevance to others, transform into a collective concern and practice or what Stiegler (2012) conceived of as grammatisation of individuation.

In the context of the Facebook Page the compromise on illness-specificity is an element of what Chris thought to be a less ‘politicised’ outlook. It seemed that to him ‘politicised’ meant more contentious and antagonistic. The TTC campaign, by contrast, aimed at the breaking of stereotypes, eradication of stigma and discrimination, for education, but not for outright protests or controversial presentations of the issues. The same could be said about the campaign’s Page, which was initially conceived of as a marketing device but was later appropriated by its users. However, rather than demonstrating a distortion between ‘commercial and political’ (Lovink and Rasch, 2012), our example points to the hybridisation of activist practice that cuts across categories including those of marketing and participation and, with the sharing of personal accounts of mental health problems in the open (widely accessible) context, homogenises the distinction between public and private.

When asked about the current main purpose of the Page, Chris replied enigmatically ‘capturing people’, and then immediately added that no one expected such a degree of honesty, disclosure and freedom in talking about experiences of illness. He also thought that discussions on the Page provided its users with an atmosphere of comfort, validity and understanding, where people felt supported because of being surrounded by people sharing the same life difficulties and because of the ability to discuss these difficulties with others. The character of the Page turned out to be quite different from what it was originally planned to be. TTC’s presence on Facebook, in line with the objectives of the campaign, was aimed at addressing people with no previous experience of mental health problems. Instead, the Page became the domain of people already concerned with these issues, and it became evident that such dialogue with a general society was not possible without their direct participation.

The majority of users who responded to question ‘why did you join the Page?, posted by TTC on the Page around a year after the launch of its campaign, had personal experience of mental illness. People claimed they participated on the Page because they themselves were directly affected by the issues addressed in the campaign and they found it a context for discussing them. There were also other answers but they almost always implied a considerable concern with mental health problems prior to the campaign. Some users were associated with mental health issues through their work. Others joined because they wanted to understand mental illness more in order

to provide effective help to their family or friends. Finally, some used Facebook to promote their own activist/campaigning work and to expand their networks.

In only a handful of posts did I find, across the TTC Page, users who claimed that they had no former experience of illness and therefore they were looking to expand their knowledge, and according to one of the surveys conducted by Rethink, 95% all Page users have had some experience of mental health problems. In Abigail's opinion, the fact that people participating on the Page were already concerned with issues of mental health was not an obstacle. Conversely, she saw discussions based on experience of mental health problems as beneficial to what she saw as a 'wider social movement'. Meanwhile the 'army of people', as she described members of the TTC Page, was spreading the information to their Facebook friends and also outside the social network and, by doing so, contributed significantly to the activist aim. In short, the users took on the role of promoting the campaign and eliciting its aim to the wider public, that was initially intended to be that of the Page.

What is more, bringing mental health problems into everyday conversations became TTC's new strategy. Based on a conviction that 'social contact' brings better understanding of social issues, the new Time To Talk campaign emphasised the importance of communication between people with and without experience of mental health problems. In the light of this particular campaign and the discussion above, the TTC Facebook Page appears as a kind of foundry for ideas and ways of speaking, which are then promoted and/or implemented in other contexts. This dynamic is also the premise of the next chapter, which takes as its subject users' discussions of media representations of mental health.

Finally, to my question 'why are Facebook Pages of charities such as Mind or Rethink not as popular as the TTC Page?' Abigail responded that the institutional character of these organisations might be discouraging participation. She also noted that it was easier for people to identify with a dynamic campaign, because it had clearly defined aims such as eradicating prejudice and stigma. Furthermore, Abigail recognised that the Page gave people 'structure' where they 'create(d) a new context' and explained that she and Chris attempted to document and organise users' subjective opinion on the Page. They did so by asking questions on the subject on TTC's Wall where they also posted links to Internet-based questionnaires

Reflecting on Participation

According to one of these questionnaire-based studies conducted by TTC by the end of 2009, here less than a year into the campaign, users felt more confident as a consequence of using the Page. This, reportedly, was mainly due to the realisation that other people were also affected by discrimination and prejudice. These findings inspired further surveys and, for example, several months later, on 29th April 2010

TTC asked users of its Page: '*Do you feel more empowered as a result of using TTC Facebook Page?*'

Among many positive responses, Paul maintained a particularly upbeat tone and explained that TTC got him '*hooked on facebook*' and gave him '*confidence to do what I'm doing now*'. Just like users on the Board, Paul saw an explicit link between participation on the Page and getting better. Two users did not share this outlook and protested against questions not being framed properly. Jessica, for example, wrote: '*I don't feel more confident in challenging MH [mental health] stigma after joining the site, but that's because I already was confident*' and, in the same comment, she added: '*the site doesn't 'give confidence' per se*'.

Jessica's comment raised an important point regarding users' interaction with the Page: while some felt empowered or better as a result of participating, commenting and through realisation of common experience and purpose, others gained confidence in different ways and, thus, the results of participation on the Page should not be thought of as universal. A less direct question, such as '*how might participation in discussions on Facebook aid recovery?*' would, perhaps, bring less polarised and more detailed answers regarding how users perceive/understand their activity on the Page. However, in practice, the critique of the campaign inspired others to write engaged and elaborate responses.

For example, in response to a post asking about opinions on the campaign from 26th May 2010, Julia claimed that TTC was 'biased'. However, she did not give any further explanation. Susie contested and claimed that the feedback is most likely to be used in improving the effectiveness and scope of the campaign. TTC also replied saying that surveys help them '*get our priorities right*' but Julia insisted that TTC '*fail(ed) to help*'.

A number of users disagreed with Barbara, for example, writing: '*Time to Change helps me to never give up. Carry on with the good work.*' Meanwhile Susie and Nicola both replied at length:

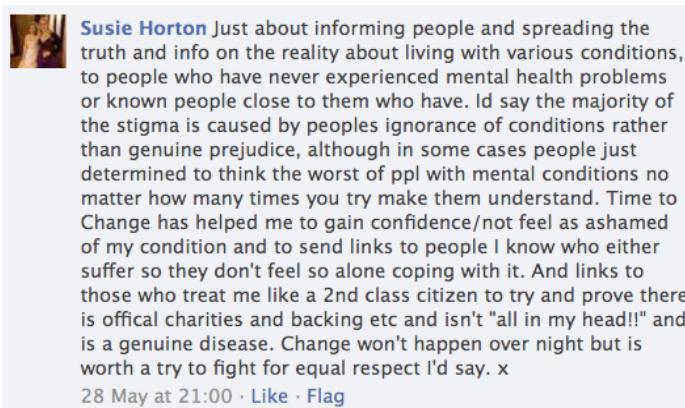


Fig. 9 Screenshot of a comment on TTC Facebook Page (also figs. 10-18)

In defence of the campaign and its use of Facebook, Susie thought it was necessary to restate that the practice of sharing of experiences was fundamental to the activist cause and pointed to the resolutions that come with such practice at the level of both personal concerns and social prejudices and attitudes. Susie was also explicit about how participating in the campaign, and in particular talking openly about her mental health problems, had a positive impact on the wellbeing of her but also of others. In short, the TTC campaign, including its Facebook Group and Page, was successful at encouraging people to speak publicly about their very personal experiences and those participating, such as Susie, noted both the beneficial and transformative capacity of such actions.

Nicola seconded Susie's claim and focused specifically on the campaign's use of Facebook.

Nicola Dawson What do you want from the app Julia? Time to Change (as far as I understand it) is a campaign, to help people de-stigmatise mental illness, to ensure that people are treated equally when they're ill, etc.

I too suffer from a long term mental health illness, and am really pleased to see this campaign on a forum like facebook. I have found the app useful in that it highlights the events that the campaign is running.

Having "liked" posts, and shared some, I've had other friends join up. I've always been very open about my own mental health issues and I'm happy to share about it. This app is a nice way of encouraging more people to share their stories and experiences and to open the minds of some other people.

Fig. 10

Nicola explained how the aims of TTC can be supported by activity on the Page and how the process of sharing experiences is not only about feeling better but also has an explicit activist purpose in the sense that it brings a capacity for change in views and perspectives on mental illness. Nicola also pointed to a need for balance between individual' expectations and needs on the one hand and execution of the campaign on the other. In short, we can say that some users recognised that participation on Facebook brought possibilities for better personal understandings of mental health problems, for aggregation of collective senses of purpose, and the possibility for change.

With this in mind, we should now consider how users conceived of their actions as a collective. This practice, which as we have seen was characteristic of other activist contexts such as conferences or local groups, also appeared on the Page. More specifically, as discussions proliferated, users started to employ the pronoun 'we' more often.

For example, in response to a call for participation in a social experiment, details of which I discuss in the next chapter, Terry criticised a requirement to send a

photograph and wrote '*we look like any other person, we haven't got horns or smmit [sic] ??????????*'. Michael agreed and contested: '*anybody can be used* [in the experiment]- *we're all the same*'. In both these comments 'we' referred to all people experiencing mental health problems and while Terry insisted that it is not possible or necessary to single out a mentally ill person on the basis of their looks, Michael thought that all people struggling with mental health problems were, essentially, the same.

Carole responded also with a reference to this alleged similarity. However, she also hinted at the responsibility implicated by this commonality in experience as she wrote: '*overcoming biases about what mentally ill people look like is a part of what we have to do if we want to break through the stigma*'. In this case 'we' also denoted all people experiencing mental health problems but, rather than pointing to some essential shared quality, it was accompanied by a call for action. To put it another way, for Carol, similarity in experience of mental health problems was not only a feature of a group of people but also the key reason to participate.

In response to another post by TTC, which contained a sentence 'we (TTC) are running a survey', a dissatisfied user wrote: '*We, we, we - what's in store for us, mentally ill folk?*' arguing that the campaign needed not to concern itself with evaluation of its own projects but, instead, should have focused on the issues experienced by people suffering from mental health problems. Cathy responded that such contention might be contributing to furthering wrong perceptions about mental health problems, and was, therefore, unhelpful. She then added '*we are here* [on the TTC Facebook Page] *because we don't want all people with MH issues to be wrongly stereotyped*'.

Cathy who, like Carol, saw people experiencing mental health problems as collectively responsible for standing up against misrepresentations and mistreatment of mental health problems, pointed to the necessity for cooperation between individuals and organisations concerned with the issue. Her use of 'we' in specific reference to users of the TTC Page also carried with it an explicit assertion that collaborative participation is capable of bringing about social change and, specifically, better understandings of mental health problems.

Finally, 'we' was also used in relation to society at large. Loraine, for example, wrote '*we are still so in the dark ages* [in terms of accepting mental illness]', while Keith confessed: '*I hate to use the Tories' spin but this time it's TRUE, WE ARE ALL IN THIS TOGETHER*'. These two comments, along with many others, denoted that responsibility for mental health should be recognised across society and not only by people affected by the issues.

All in all, in the context of the Page the pronoun 'we' came to stand for all people experiencing mental health issues, mental health activists generally, TTC Page Fans

specifically, the TTC campaign, or general society. These diverse meanings do not indicate incoherence in users' understandings of their social positions but, instead, point to strategic ways in which they considered the collective context in which they made sense of their experiences. It seemed that the meaning of 'we' was dependent on a degree of appreciation of activist dimension of practices of sharing experiences of mental health problems.

It is possible that the realisation of the benefits of collective action came at a cost to concerns with individual experience, which in turn might further explain the activist compromise on illness-specificity. To put it another way, some users turned their attention away from making sense of their personal experiences only and focused on a commonality of experience. Such a tendency, however, did not make personal experience obsolete. Instead, in the context of the Page, users came to recognise their personal experiences as fundamental to collective action. Ultimately, I suggest that activity on the Page led to the crystallisation of activist awareness between people affected by mental health problems.

Intermediate Conclusions

I see some important similarities between participation in the context of the TTC Facebook Page and Group and conferences and activist meetings as discussed in the previous chapter. In particular I draw attention to the common practice of sharing stories of mental health problems, subsequent realisation of similarity in experience and resultant notions of unity. However, activity on Facebook rendered sharing of experiences a simultaneously personal and activist practice, whereas we have seen earlier that there was a clear demarcation between discussions of experience aimed at personal recovery (local groups) and accounts of experience seen as a vehicle for activism and its media representations (meetings and conferences).

This amalgamation of personal concerns and activist practices on TTC Facebook Group is linked to its two features. First, there was an explicit non-differentiation between the local and the national as users considered the Page a viable platform for participation in its own right, where all kinds of concerns and issues could be addressed. Second, we have the specifics of communication on the Page where written traces of activity in the form of posts and comments create the possibility for interactions similar in its dynamism and form to spoken conversation that, in turn, seems to have invited reflexive assessment of participation. More specifically, the use of written word in discussions on social media created possibilities for contemplation of what is being said, as through text such discussions become immediately discernible in their entirety to both participants and people visiting the Page.

As a form of both material evidence and replicable account, written, or for that matter recorded, filmed or documented word seems to bring greater accountability to its

author but also carry with it greater practical potential, for example for future reproduction in other social contexts. All this, in turn, might help in explaining why the sharing of personal stories on the TTC Facebook Page came to be understood by some participants as a practice bringing resolutions to individual concerns and, concurrently, creating possibilities for addressing social issues. Meanwhile, a more general conclusion suggests that in the context of social media, activities of saying and doing are very closely related, perhaps more than in other social contexts, because saying something on a social medium is necessarily accompanied by an action of writing (or making a written record). This, in turn, implies a close connection between word and action, which I explore in more detail in the next chapter while discussing the activist notion of mental health with reference to Tambiah's work on magical language.

This social media's capacity to invite reflections led Stiegler (2012) to argue that using an individual Facebook profile is a form of auto-ethnography where meanings, intentions and awareness of one's actions are explicit in the action. Such self-reflexive practices, continues the author, carry a potential to reshape social life through the rise of new forms of benevolence, new forms of friendships and sociality and greater awareness of one's position within the 'social', all of which might amount to the process of grammatisation. The TTC Facebook Group and Page provides such an example of a collective environment where new forms of social engagements transform the already existing spaces, social relationships and rules while creating new, previously non-existing, possibilities for interactions and socialisation.

Users' reflexivity in the context of TTC's use of Facebook, however, was not only inspired by the *functionality* of conversations (or its form) but also by the *topics* of posts on the Page and in particular the subject of mental health problems (here, the content). Discussions of activist and mainstream representation provided opportunities for further consideration of meanings of participation, and, since media and representations are the central concern of contemporary activist projects and campaigns, of activism more generally.

Chapter 4

Discussions of Media Representations on TTC Page

'What's the matter with you? Your father and I feel down now and again, but you don't see us wallowing, innit?' says a worried looking woman.

'I'm sorry mate but I feel really uncomfortable talking about this sort of thing', explains a man in a pub cringing nervously.

'This has been going on for long enough! I think you need to take long hard look at yourself and back up', shouts a young woman.

A corporate-looking woman with a pitying expression on her face pronounces: *'Thank you for coming but... uhm ... I'm afraid the job has already been taken'*.

As an unidentifiable person enters a poorly lit tunnel, a female voiceover reads: *'People who have mental health problems often face prejudice and discrimination. For some, it's too much to bear'*. As the light fades completely, the voiceover continues:

'Visit time-to-change.org.uk and find out how you can help end the stigma'.

A TV advertisement that followed the above dialogue launched the Time to Change Campaign on 19th January 2009 with an aim of exposing the many facets of stigma encountered by people who experience mental health problems. The video was broadcast in prime time on all mainstream British media and also posted to TTC Facebook Page's Wall and on YouTube. Within 24 hours the link to this film attracted over 200 responses. Each one of them stood as a post on its own as, at that time, neither the 'like' nor 'commenting' option was available.

A significant proportion of these responses consisted of simple expressions of approval or support for the campaign, some of them humorous such as the one by Billy who wrote that the campaign is '*mental*'.¹⁹ Users agreed that, indeed, it was '*time to change*', that the campaign has been awaited for a long time and that social change must take place: '*powerful and long overdue*' and '*more needs to be done*' wrote the users. A number of people referred to their personal experience of mental health problems, doing so either in one sentence like Judi who wrote: '*i know how they feel. i got memtal health problems*' and Anna who revealed '*i have a mental healthproblem n i get sick of people treatin me like ive come off a banana boat*' or, in a few cases, at length, like Claire, a post-natal depression sufferer, who explained how her family helped her through difficult times.

Not all the posts, however, were supportive as some users thought the video was '*boring*', '*crap*' or '*too general*'. These were also comments exhibiting explicitly negative attitude towards people experiencing mental health problems. Jo, for example, contended that '*I would (be more accepting) if i didnt have people with mental health problems pissing on my front doorstep and shouting and swearing on my fucking road*'. Alan seemed to have ignored the message of the video and wrote: '*Slap them (people experiencing mental health problems) in the face & tell them to pull themselves together*'. It is worth noting that such comments appeared on the Wall

¹⁹ All post spelling as in the original.

only on this particular occasion, perhaps because the challenge to stigmatising views was immediate.

Graham replied by locating stigma surrounding mental illness among other forms of discrimination and positioning the experience of illness as key to understanding the problem:

Alan, until you have experienced the prejudice shown in the ad, plus the verbal and physical abuse that comes with it, then you will realise it's the bigots that need good slapping. They are not better than homophobes or racists.

The quarrel continued over the following days, with Jimmy claiming that the ad was pathetic and that it is possible to pull oneself out of mental illness easily. He also added that in countries with a high quality of life and developed social care system people just '*feel sorry for themselves*'. Debbie was quick to oppose his views by writing that one cannot '*just snap out of mental illness*'. Visibly irritated, Richard responded:



Richard Foulkes All i can say to the idiots posting negative messages is that their time will come...They either haven't been kicked in the 'right' spot by life yet, or don't have the intelligence to observe how their behaviour has been affected by events in their lives.

I've lost count of the number of times i've heard 'normal' people utter phrases such as 'this is really doing me head in' (sic)...

12 February 2009 at 06:13 · Like · Report

Fig. 11

Like Graham, Richard saw experiences of both mental health problems and of discrimination as fundamental to understanding the socially disadvantaged position of the mentally ill. Furthermore, he also pointed to the problematic use of language in this context.

The post to the video that launched the TTC campaign and the wealth of individual responses on TTC's Wall are of significance for a number of reasons. Short positive responses show that the campaign was recognised as necessary to users who immediately related to the issues identified by the film. This realisation of a shared struggle was connected to users' references to their personal experiences of mental health problems, which they saw as a form of challenge to stigmatising attitudes. Thus the link to the video not only delineated the aims of the campaign but also encouraged users to speak out and to share their experiences. With this, a certain order was immediately established. As responses to negative comments indicated, there was no space for discriminating or stigmatising views in this context and the Page was to remain the domain of people affected by the issues from the very beginning. Also, we have posts critical of the video. These constitute a preamble to impending debates of different kinds of media representations of mental health problems, which with time came to constitute an important part of activity on the Page.

I focus specifically on the discussion of media representations in the context of the TTC Facebook Page as we have seen that the media practices as well as the language used to describe mental health and illness are a central concern of contemporary activism. Practices of commenting on these representations show how people concerned with the issues surrounding mental health relate to the campaign and participate in new ways of speaking about mental health, while also having influence on what is being said in the media about their experiences. That the commenting option was not available at the time of posting the video explains the responses that followed. With new features of commenting, ‘like’ and ‘sharing’, discussions became linear and organised. Nonetheless, responses to the first post exemplify the inherently participatory and lively dimension of the Page that came to characterise it from the earliest stages of its functioning. In particular, they indicate how experience of mental health problems came to be employed in addressing the issues of stigma, discrimination and inequality and emphasise the importance of sensitivity to the language used to describe mental health problems.

Schizo

A silhouette of a man moves across a shady space as an unidentified scream cuts short an uncomfortable silence. A scared eye and a masculine hand appear suddenly on the screen, only to vanish equally rapidly. The sound of a cut film reel accompanies the words ‘Schizo, He’s Amongst Us’. The camera pans towards the end of a dark hallway. As the door opens, the scenery changes dramatically into a vast, surgically clean and bright kitchen. A man pours boiling water into a teacup, gazes at the camera and says:

Hi there! I’m sorry to disappoint you if you were expecting some sort of lunatic with a knife on some sort of rampage... My name is Stuart and I was diagnosed with schizophrenia twelve years ago. People like me with the diagnosis of mental illness face stigma and discrimination every day.

Accompanying him a woman picks up a cup of freshly brewed tea and sits nearby. Stuart continues: *‘Luckily for me I had the support from friends and family who helped me lead a full life’*. He then engages in a conversation with his female companion while a voiceover explains: *‘Visit time-to-change.org.uk and find out how you can help to end the stigma’*.

Schizo was a TV advertisement broadcast as part of TTC’s second ‘campaign burst’ in the early autumn of 2009. It aimed to challenge prejudice against mental illness by subversively exploiting associations between schizophrenia and violence and by showing the negative aspects of the language used to describe the mentally ill, and in this particular case, the term ‘schizo’. With this advertisement the tone of the campaign was transformed. We have seen how the first video aimed at highlighting the prevalence of stigma and discrimination towards the mentally ill in day-to-day

situations and social relations. The current campaign looked more specifically at linguistic and thought processes that underpinned these issues – or to put it more simply – at how stigma and discrimination are reproduced in language.

The Schizo advert was also based on a different kind of narrative, as it no longer focused on highlighting difficulties and discrimination but a story of successful recovery. As such, it projects a very particular image of schizophrenia and, given the scope of the campaign, of mental illness more generally: one that is treatable and manageable and also, diametrically different to the ways schizophrenia is often imagined among the general society or portrayed in mainstream media as violent and scary.

The choice of the character and his surroundings is also worth our attention. Stuart is white, middle-class and, unlike the unseen protagonist of the former campaign, seemingly privileged. Not only is his kitchen beautiful and full of expensive, modern equipment but he also has a loving family and understanding friends, who helped him through a period of difficulties. When asked about the rationale and consequences of such a particular representation, one of the employees at TTC explained that white middle-class men are the most unlikely to talk about their mental health problems and, therefore, they were one of the key target groups of the campaign.

Responses to the video and the new burst of the campaign on TTC's Facebook Wall were positive but scant and did not include any discussion. This is because the commenting option was not yet in use at that time. The discussions over the use of the term 'schizo', however, came back to the Wall just over a year later on 17th November 2010, inspired by *The Sun* newspaper's article about a schizophrenia sufferer entitled: '*Fury at escape of killer schizo*'. Almost immediately, TTC encouraged users of its Facebook Page to contact The Press Complaints Commission (PCC), although it was recognised that individual complaints referring to discrimination fall out of the commission's operating procedures.²⁰ TTC then posted a suggested text for a complaint and also provided the address of *The Sun* newspaper along with a guide on how to write a letter to a publisher. This included suggestions on how to keep the letter short, and advice on personal data protection.

Some users on the Page replied to the article with anger and rage expressed with the aid of pejorative vocabulary. Others claimed that the use of the word schizo was 'appalling' and 'should be made illegal'. Some suggested abstaining from buying the

20 The Post read: We already know The Press Complaint Commission currently feels shortening the word schizophrenia or schizophrenic to schizo in a headline is acceptable. We also know that the Press Complaint Commission does not uphold complaints from third parties on the grounds of discrimination. But we still think it is worth complaining. It is through a groundswell of opinion that society's views are challenged and changed.

paper while one person said her local mental health trust stopped their subscription precisely because of the article. Jennifer, however, questioned the negative associations:

On the term schizo. It's just a word. Get over it. As Mata is latin for mother. Mata in shona means rectom. It's a word. So depending on what schizo means to you then that's the problem, the meaning. I do not mind being called mad when I am ill but when I am sane then yes it irritates me.

Jennifer's argument made the interesting point that the use of language and the degree of offensiveness depends on the context in which it is being used. Kirsty did not agree and claimed that the article appals people and this is exactly why the use of the word should not be allowed. Peter argued that 'sensalisation' of mental illness by the press is unnecessary and gives bad impressions to the public. He, along with a number of other users, proclaimed insensitive language to be directly responsible for the prevalence of stigma and prejudice and accused the article of perpetuating ungrounded associations between mental illness and criminality.

Meanwhile it was also claimed that words such as 'queer', 'darky', 'homo' or 'paki' are no longer acceptable, that mental health activists could learn from the successes of previous social movements and that the achievements of civil rights and LGBT movements came precisely as a result of persistent challenges to discriminating language and attitudes. Discussion on the Page brought a realisation that such change is also possible with regard to language used to describe mental illness.

As TTC attempted to address more complex issues and untangle social understandings of mental illness and challenge stigma and prejudice with its media projects, users on the Page took to active negotiation of these meanings as well as the outlook of the campaign. Comments show that users held different understandings of how language perpetuates stigma associated with mental illness, but they also exemplify evolving sophistication of discussions on the Page, as well as attempts to reach consensus, despite differences.

Further evidence of this sophistication came as the focus moved from particular words and expressions such as 'schizo' to representations of specific illnesses. Depression, for example, would always entail heated discussions and considerable disagreements. Three media representations of depression I discuss below, including two mainstream, one negative, one positive and one activist, point to this diversity and proficiency.

'Big Dose of Depression'

'Along with the Sam Cam handbag, the latest must-have accessory is a big dose of depression' wrote Janet Street-Porter in an article for the British tabloid, *The Daily*

Mirror, in May 2010. The article was followed by a sharp-tongued response from Alistair Campbell, former director of communication for Tony Blair and supporter of the TTC campaign, known for his personal struggle with depression. In a letter also published by *The Mirror*, Campbell argued that Street-Porter's article was badly written, prejudiced and not researched properly. He backed his argument by elaborating on his personal experiences and explained that mental health problems are extremely widespread in society and affect all kinds of people.

Both the original article and the response letter posted by TTC to its Facebook Page triggered a heated argument among the users. Campbell's riposte was praised for being insightful, honest and well written with people expressing gratefulness for having a high-profile public figure speaking out for people experiencing mental health problems.²¹ Street-Porter's article, on the other hand was seen as a deliberate attempt to cause controversy in order to maximise revenue and the author was called 'stupid', 'ignorant cow', 'out of reality', 'awful human being', 'attention seeker' and even 'stuck up bitch'. Eddy contested these derogatory remarks reminding others about the aim of the activist struggle:



Fig. 12

Stephen was the first to refer to experience as a precondition to the understanding of mental illness: '*if Porter suffered the same way then I can guarantee she would not have said the thins [sic] she did*'. Others followed suit. Jen wished she could swap places with Street-Porter so the journalist could find out what mental illness and suffering that comes with it '*really feels like*' while Marty claimed that Street-Porter should have spoken '*to sufferers like ourselves*'. Finally, Hannah went on to suggest that only experience of illness allows for understanding of stigma.

Responses to the article show how the Page came to serve as a locus for opposition to uninformed representations of mental illness: opposition, which proposed its own solution. While some users focused on attacking the writer, others, like Eddy, Stephen or Jen offered a point of view that was not contentious but, instead, based around the notion that understanding mental illness comes along with lived experience. These users recognised the importance of expert knowledge deriving from their experience (see Epstein, 1996; Fox et al., 2005) while claiming that it is not entirely possible to comprehend mental illness without having experienced it first.

21 Celebrities often featured in the TTC campaign - with mixed responses from my research participants. Stephen Fry became the director of Mind and, while the presence of celebrities was seen by some as advantageous, others were explicitly against it (on the subject see also Blackman 2007).

Experience was thus recognised by users as providing legitimacy for speaking, which in turn was seen as leading to better, but not necessarily complete, understanding of the issues of mental health in society. This realisation could also be seen as contributing to a certain sense of belonging, which was cemented on the Page. The use of the plural pronoun ‘ourselves’ by Marty is particularly telling here and it could be seen as implicating collective responsibility for mental health and in particular the practice of speaking about these matters. The conviction here was that only a unified voice characterised by patience and persistence could overcome bad journalism and its sensationalisation of mental illness.

It is also worth noting that the discussion did not focus specifically on depression but on mental health problems more generally. Like Campbell in his official response, users also thought that mental illness is widespread and affects all kinds of people – also journalists themselves. Meanwhile, a negative representation, here, the article by Street-Porter did not incline users to elaborate on their experience in more detail. Instead they focused on how understanding experiences of mental health problems could contribute to the eradication of negative attitudes. The response of users, however, was markedly different in the case of other, more insightful, mainstream media representations of depression.

Hooray for Everybody!

On the 2nd of August 2010, TTC posted to its Facebook Wall a link to a *Guardian* article entitled ‘Depression - the illness that’s still taboo’ by Rice-Oxley. Based on a journalist’s struggle with depression, the piece followed a very particular chronology of illness that entailed falling ill, mental and physical deterioration, loss of hope, talking to friends and family and, finally, recovery, which ultimately led to reflection on meanings of life.²²

With the trajectory of the author’s life first disintegrating and, subsequently, rebuilt as a result of persistent attempts to get better, the article’s narrative bears a close similarity to what Blackman (2007) framed as a transformation from the ‘victim to victor’ characteristic of some representations of mental health in the UK from the beginning of the 2000s. The journalist’s story is also similar to narratives of cancer as discussed by Stacey (2002) where accounts of illness necessarily entail a heroic struggle that ends up either in death or in successful recovery. Furthermore, by relying on psychiatric models of illness, the author of the article presented a very particular, and somewhat inconsistent, view of depression as illness that on the one hand is aetiologically physical and neurological and, on the other, is more common among specific social groups. By taking statistical data for granted, the author also failed to

22 <http://www.guardian.co.uk/lifeandstyle/2010/aug/02/depression-mental-health-breakdown>.

understand the range of possible reasons for the greater proportion of the diagnosis among women and the economically disadvantaged.

Over 200 people liked the link to the article and engaged in a long and fascinating discussion, which also serves as an excellent example of the then recently established order of interactions on the Page. Users did not find the details of the narrative important and, instead, focused on the impact of the ‘story’. Some were unhappy about the comments made in regard to the article on *The Guardian* website. Others, like Richard who wrote ‘*It’s a good article, the more we can talk the better the chance we have of recovery*’, expressed approval towards another public coming-out story whilst also acknowledging the importance of speaking to recovery.

These short utterances were followed by posts in which users embraced their mental health problems. Jess, for example, wrote: ‘*depression made me who i am an i wouldnt change it*’, while Kerry explained: ‘*i am not ashamed of having ...mental health problems, I spent far too long being ashamed. Speak up and be open is my advice*’. Comments by Jess and Kerry echoed the tone of the article, which encouraged a readiness to accept mental health problems as part of a wider life trajectory. They also pointed to a certain pride in the experience of mental health problems and with the ability to manage the experience and engage it for other purposes. Embracing one’s personal experience reinforced public speaking as a chief strategy for making issues surrounding mental illness better understood and it points to users’ abilities to distance themselves from trauma and suffering, and to use experience to meet particular objectives.

Such an ability, we could suggest, was possible due to the perceived benefits of sharing of one’s experience of feeling better, in this particular case exemplified by a series of comments made by Greg. Having firstly established himself within the discussion by comparing stigma related to AIDS and to mental illness, Greg then revealed his story of two attempts to commit suicide. Three minutes later he added another comment ‘*I can't believe I just told you guys that, but maybe that's what needs to happen to change things*’. In another comment he added:

Sharing your experiences, even in a forum like this, is actually a way to get better. I think the comments are supporting that. (...) just talking to someone about your problems is an effective treatment in itself.

Greg’s coming-out story and his immediate realisation of the effects of a public sharing of stories appear to have had an immediate positive and therapeutic-like result. The possibility for such a process, however, seems to depend on the context. We have seen previously that a negative representation, here, the article in *The Daily Mirror*, did not encourage a disclosure of personal mental health problems. A more balanced account, such as the article in *The Guardian*, on the other hand, inspired users of the Page to follow suit and share their personal experiences. We should, thus,

conceive of practices of sharing of experiences on the TTC Facebook Page as strategic and yielding two convergent functions. First, sharing of experience can be of benefit to the individual and, second, through realisation of the commonality in experiences, this practice could be seen as cementing a collective sense of a common purpose.

An understanding atmosphere with no arguments appeared to be capable of facilitating both these functions. But disagreements and controversy were not considered beneficial and were, thus, toned down. This was also the case in our current example, as in the course of the discussion some users have shown rather divergent opinions on the origins of depression. Bio-chemical explanation of causes of the illness as referred to in the article was challenged by Sue who, in response to a comment by Pest, explained the difference between reactive and endogenous depression. This upset Pest, who posted several offensive comments, which she deleted some time later.

Meanwhile, Greg, who also opposed the idea of ‘chemical imbalance’ as the main cause for mental illness, tried to terminate the discussion in what seemed like an attempt to prevent further arguments: *‘This has been a good thread with some thoughtful discussion. I’ve gotten a lot out of it. Hooray for everybody!’*. Sandra also responded with a general comment: *‘that’s it really, we are human.’* Some time later Greg finalised the discussion with another generalising statement: *‘we are not weak; we are sick. We do not give up; we are stricken down. That we can share with others in the aftermath shows that we have not given up’*.

The last part of the discussion shows quite clearly that users expected that speaking openly about experiences of mental illness would bring some change to the social status quo while also recognising that acts of speaking constitute part of a wider trajectory of recovery, and, ultimately, something fundamentally human. Here we are presented with a very particular view of illness that positions it as a part of human experience. To put it another way: users’ comments implied that to be, or to fall, ill is also to be human and that it is also human to recover. At the same time, the discussion indicated that the users saw the Page as a space for speaking about experience in affirmative ways without quarrels and arguments within what we could see as an emergent order for speaking that requires a short consideration.

The Commenting Sequence

We have seen earlier that disorder and lack of coherence characterised early interactions on the Page with individual posts often unrelated to each other or to the original posts. We have also seen that with the new options of commenting, there appeared a greater focus, sensitivity to the issues explored, and mutual understanding both between the users and in regard to the purpose of the Page. Alongside, there has also emerged a specific sequence of commenting.

The origins of the sequence could be located in the Discussion Board of the TTC Facebook Page where topics were clearly indicated and users could relate to each other's comments. With the possibility to join and leave discussions at any given time and a sense of what I noted in the previous chapter was undemanding sociality, as I have suggested, users were encouraged to share their personal experiences. Practices developed in the context of the Board then spread to the public spaces of the Page (Wall and Timeline), and this spontaneously organised practice of commenting points to the ways in which users actively moderated their discussions.

Examples in this chapter follow this sequence: commenting would normally begin with (1) brief statements of support or disapproval of the issue in hand. We could see these short comments as the formation of the orientation of the discussion, for example, a critique or support of a specific media representation of illness. This was usually followed by (2) brief comments about personal experience of illness and/or stigma. Such utterances both expressed and cemented the experiential and personal relevance of the issues to the people involved in the discussion. Subsequently, (3) more elaborate stories of suffering were shared. Personal accounts and stories were, then, followed by (4) words of hope, encouragement to continue fighting and persevering and practical solutions to problems at hand. Such mutual help and support could be interpreted as deriving from users' sense of responsibility for each other and, at the same time, sustenance of the collective effort. Finally, discussions would be terminated with (5) general remarks about activism and its goals, often made in reference to the universality of experiences of illness or of human experience in general. These universalising notions often served to extinguish quarrels and arguments, whilst also reminding everyone of the common goal. Additionally, in later stages of the discussion, fans would frequently become immersed in moments of (6) self-reflexivity in regard to participating in discussion on Facebook and the sharing of experiences.

This sequence of commenting could be seen as conditioning a non-contentious order for speaking that allowed individuals to share their experiences, and its structure seems to carry both therapeutic and activist dimensions where repetition serves as a reassurance helpful in dealing with personal experiences and as a continuous reminder of the ultimate goals of participation. We should not, however, think of this sequence as an exact template for conversation, but more as an analytical attempt roughly to organise practices involved in the discussions among the users and how these aggregated or disabled a specific way of speaking and interacting on the Page.

The notion that everybody is the same is of particular interest here, not only because it averted disagreements but also because it echoed the activist notion 'we all have mental health', which carried a specific attitude towards the social and individual responsibility for health. The universal notion of mental health, as I explained earlier, was used to present and justify activist claims in both casual conversations and during

formal activist meetings. However, it seems that it was the capacity for self-reflexivity in the context of the Page that brought the metaphorical flesh to the bones of this expression. More precisely, through realisation of similarities in experience, users were linked to each other and, consequently, felt a sense of unity that, by the sheer fact of mental health problems being universal, extended to the whole of society.

Through commenting, users of the Page gained a thorough reflexive understanding of their experiences and of the meanings of their participation, which, in turn, brought a sense of collective purpose. This is also relevant to the following and the last example of representation of depression, which serves as an evocative illustration of how users of the Page negotiated activist-made media as well, and which brings us to conclusions regarding practices of using Facebook, its usefulness for organising as well as consideration of the notion of mental health as a special kind of language.

The Social Experiment

On June 16th, 2010 TTC posted on its Facebook Wall a call for participants in a ‘unique social experiment that explores mental health prejudice.’ Those willing to contribute were expected to be between 25 and 50 years of age, comfortable speaking publicly about their experiences of illness in media and to send a personal photograph. These requirements immediately brought tension to users of the Page.

Some were discontented since they wanted to participate in the project but did not want to disclose their identity, others were not happy about the age range. Subsequently, the discussion focused on political correctness in campaigns and of media representations as two opposing opinions developed. On one side it was argued that anybody who suffers from mental health problems could be a representative regardless of looks, background or experience. It appeared that this group of users was concerned that their sense of unity could be threatened by the new project, which, instead of fulfilling its intention of eradicating prejudice, would actually further discrimination. This group opposed marketing style campaigning.

Others emphasised the specificity of the campaign and pointed that its details were still to be revealed. Among them Alison, one of the presenters at the Open-Up event in Birmingham (see Chapter 2), shed some light on the somewhat harsh reality of media- and representations-making as she explained that in order to bring desired social change some tendentious compromises needed to be made.



Alison Brumfitt Hi all, I don't think anyone is discriminating- 'experiments' require parameters and criteria- there can always be other parameters and criteria for another/the next one.
Also, it is a truth that to resonate with a target audience in the media/social marketing- no tick box, no get coverage- sad but true. No coverage- no messages get across.

We have to start at the beginning and take it from there
17 June at 17:38 · Like · Flag

Fig. 13

The argument continued and became so heated that several people threatened to stop using the Page if the quarrel persisted. Cathy, for example, expressed a concern regarding a potentially negative impression the disagreement and harsh vocabulary might make on casual visitors to the Page and explained that inappropriate language and lack of unity could only reinforce stigma and prejudice. For Cathy a sense of unity stood as an unequivocal priority, regardless of whether the consensus regarding specific issues existed or not. Rebecca summarised her point in an attempt to neutralise and terminate the discussion: 'we have to agree to disagree'.

By recruiting participants for the experiment on its Facebook Page, TTC was able quickly to reach a large number and a wide range of people. By doing so, however, it also exposed the project to immediate criticism. The impasse seemed to touch upon the practical impossibility of making a media representation that stands for a multitude of heterogeneous experiences of illness while it also revealed a need for concentrated and united effort and for a compromise. It was interesting, then, to see how TTC executed the experiment and its new campaign burst.

Meet Eric

A young man is cycling across various locations in London as a male voiceover reads: Meet Eric. He's 30, got a good job, a great flat, a stable relationship and a wide group of friends. So you might not think, by a look of him that Eric also has a mental health problem... Eight years ago he was diagnosed with severe depression...

The protagonist then speaks directly to the camera describing his problems, concentrating on the physical consequences of his illness. As we see Eric conducting various activities, which suggest his condition has now significantly improved, the voiceover explains: 'For several years now Eric has received regular treatment to help him manage his depression and lead a full life.'

The remaining part of the video follows Eric who, in the course of the experiment, advertised a room to rent in shared accommodation and created a profile on a dating website. Initially, he had not disclosed his history of depression and received numerous responses, particularly on the dating portal. In the next stage of the project,

he revealed his mental health problems and, in the majority of cases, he was either ignored or informed that the other side was no longer interested. In concluding the experiment, Eric remarked that he saw this shift in responses as a proof of stigma towards the mentally ill.

The ethics, methods and conclusions of the experiment require some consideration, as it seems that it was designed specifically to prove that stigma and discrimination have an effect on real lives. The film focuses solely on the identification of the problem and does not demand change or offer any solutions. Yet it is the representation of illness that is most striking. The story focuses on successful recovery and social adaptability, while Eric is presented as a model citizen: a white, young, middle-class successful man who 'leads a full life' in spite of depression. The film also emphasises the physicality of mental illness, in a dual way: through its debilitating impact on corporeality and pointing to the absence of visible clues to one's condition. A user commenting on the video on the Page noted that physical suffering is more easily understood by the general public. However, the focus on the biochemical aspect of mental illness in mental health campaigning did not bring the desired result in the past. Quite the opposite, it seemed to have further perpetuated stigma and prejudice (see Blackman, 2007). In this light the criticism of the experiment on the TTC Page appeared well-grounded.

The majority of initial responses to the campaign on the Page were positive and supportive. However, users also highlighted a number of issues, especially during the live chat with Eric that TTC organised on its Wall. On that occasion Eric explained that there was no follow-up to the experiment so the reactions of the people involved were not known. He also revealed that the whole process was a daunting experience, as he had to face his everyday life difficulties in addition to emotions that emerged as a result of participating in the project. He noted, however, that he benefited greatly from the support of his family and friends.

In response, users began to share their personal stories of illness and stigma, while others replied with words of support and encouragement. Among users who emphasised problems with the practical execution of the project, Elysia was the first to point out that 'mental health problem' is not a very helpful description 'as it might imply several things'. Catherine agreed and said that such vague descriptions are suspicious and might contribute to more confusion. These concerns about language and specifically the use of the term mental health were then re-formulated by Angie:

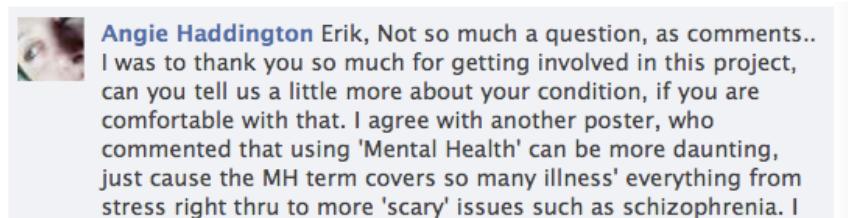


Fig. 14

Eric claimed that he was ‘curious to see what people would think of when they read the words mental health problems, particularly considering the bad press it often gets’ and his response indicated that the project could be seen as a, perhaps unintentional, test aiming to elicit public responses to expressions containing the term ‘mental health’. The answer to this concern might, indeed, have been as indicated in users’ comments – that the term mental health problems is confusing and discouraging because of its ambiguity and vagueness and, if used in inappropriate circumstances, it might generate a negative response.

‘Mental health problems’ might well be understood implicitly in the context of the Page with its myriad of stories of illness, comments and discussions on the subject, where it plays a role of a synonym for a wide range of experiences and, as we shall see below, a form of special utterance. However, it might not make as much sense in day-to-day encounters between people with no previous experience of mental health. Another comment that would be worth making here is that the chat put Eric in the spotlight of questions regarding the experiment and his first-person responses indicated that he took personal responsibility for the project and its execution.

Further critique of the project appeared on the Page several days after the chat. Eamon proclaimed the video to be ‘stupid’ but gave no further explanation, while Tina contested: ‘I don’t think it’s all black and white’. Meanwhile, Beki conducted her own experiment:

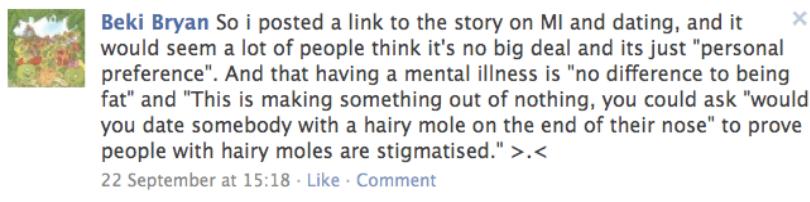


Fig. 15

Chris also provided a quite detailed critique that indicated that certain ways of presenting mental health problems, like that in the TTC Experiment, are inappropriate and/or misleading:

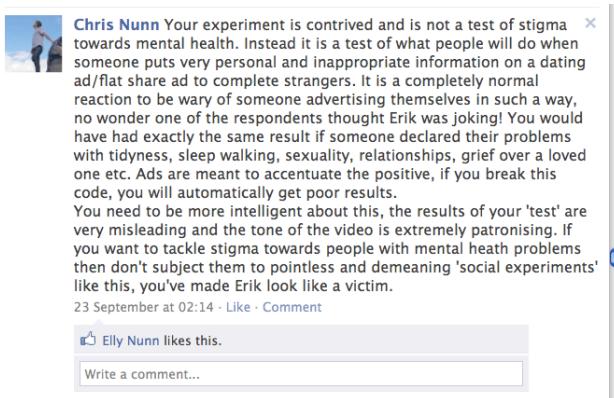


Fig. 16

These two posts critical of the campaign did not attract any responses, which might indicate that other users did not want to get involved in discussions that would inevitably lead to arguments. What is also possible is that, since these two posts were added considerably later, other users were already engaged in discussions of other representations, issues and posts on the Page. Indeed, the duration of all conversations on the TTC Facebook Page did not exceed a week as conversations tended to be dynamic yet short-lived.

The posts by Chris and Beki point out that the experiment and the language used in it was, on the whole, confusing and misleading, especially to the people who in the course of experiment responded to advertisements. Consequently, both users believed that the project was manipulating its participants including Eric. This demonstrates that campaigns towards some notional ‘general public’ require different language than in the context of groups on Facebook, as the expressions ‘mental health’ or ‘mental health problems’ might be effective in discussions between people affected by these issues but not necessarily understood by audiences of activist-made media representations.

TTC seems to have taken on board these criticisms and, in the following years, launched a new Time to Talk campaign. With this project TTC emphasised the importance of challenging stigma and discrimination at the grassroots level and, specifically, the many different ways in which people could talk about their experiences to people around them. By encouraging talking and sharing experiences on a one-to-one basis as opposed to mediated campaigns the Time to Talk campaign addressed the issues highlighted by users on the Page, namely, the impossibility of talking about all mental illness in one media representation.

Time to Talk promoted sharing of experiences of mental health problems in various social situations – at home, work or in casual encounters, etc. In a sense it was an extension of the practices that proliferated on the Page into everyday circumstances. This part of the campaign, however, is to remain a subject of further ethnographic investigation that would necessarily require research activity outside of the sphere of the TTC Facebook Page. The Page, in the meantime, attracted an increasing number of people, reaching over 100,000 users following the launch of Time to Talk and continued to enjoy vibrant discussions and commenting.

Words and their transforming capacities

As we have seen, accounts of personal experiences of mental illness and its mediated representations that became the central focus of participation on the Page were on the one hand very personal and on the other, acquired a public presence and resonance. This duality, in turn, is the most prominent characteristic of the sense of unity

pronounced by users, unity which does not imply any particular form of identity but denotes common experiences and goals including a perceived responsibility to take an active role in the ways mental health problems are talked about and represented. In short, we could say that the focus on speaking about personal experiences contributed to their sense of unity but it also carried with it potential for change in social understandings and attitudes towards mental health and illness.

Such creative use of language in the hope of transforming the circumstances of the situation at hand has been a matter of considerable anthropological debate, for example, by Tambiah (1968) whose notion of the 'magical power of words' is of particular interest here. Tambiah borrows elements of his notion of magic from Leach, as actions accompanied by words, and he asserts that there exists an intrinsic trajectory in human action from words to power and deeds. Magic with accompanying rituals, continues the author, might focus on either words or actions, or alternatively encompass both.

Healing and initiation rituals in particular often rely on vocalised expressions with some being limited to words only. Their effectiveness, it is suggested, is based around 'a formally expressed belief that the power is in the 'words', where words present, delineate and help in imagining the desired outcome of a magical spell. All religious doctrines, points out the author, refer to the 'creative power of the word' (1968:182) or language's ability to bring realisation of desired outcomes.²³

Among the examples discussed by Tambiah are Thai Buddhist rituals in which the words are understood neither by those who recite them nor by those who hear them. Considering communication as a form of creation of understanding, Tambiah asserts that non-contemporary language in religious practices makes it unintelligible to worshippers. Use of such language is explained as a process of validating and mystifying particular sets of dogmas by positioning them as ancient and primordial. The language of religion and magic thus differs from the language of ordinary situations through the 'special style' that is employed in order to indicate an exceptional occasion and specifically in a religious context, to differentiate the sacred from the profane. Following Tambiah's reasoning we might suggest that illness, or in fact any interruption of or change to the status quo, could amount to an extraordinary situation and require a special language.

Tambiah then argues that magical spells accompany such special occasions because they 'excel in expressive enlargement, physical actions in realistic presentation'. Words and language mimic activity and aid in imaging the desired outcome. Consequently magical spells should be considered as logical and commonsensical but

23 Tambiah uses this point to criticise Levi-Strauss and Mauss's respective notions of magic, claiming that, by concentrating on actions, both failed to account for the special role language has in magical rituals.

used in a way that disagrees with the basic function of communication, here, the creation of literal understanding. This is discussed with specific reference to the use of magical spells in the Trobriand Islands as accounted for by Malinowski, whose interpretation of magic pays particular attention to words and language. Malinowski, notes Tambiah, saw magic as forms of utterance through which Triobrianders made sense of uncertainties of the world and which accompanies important activities of garden work and building of canoes.

Tambiah challenges Malinowski's psychological explanation and points out that magical spells are 'part of' as well as 'equivalent to actions' and rather than words being mystical in themselves, it is suggested that they give humankind a 'sense of power over his environment' where the objectifying property of language allows for human activity to make sense, continue, repeat and/or improve.

Tambiah then focuses on two different uses of language: 'scientific', which expresses and describes the reality as it is and 'evocative or emotive', which helps in the articulation of what cannot be perceived by the senses. These two different uses of language, suggests Tambiah following Jakobson (1956), function accordingly to two distinctive properties, one being metaphorical or operating on the principle of similarity (or of being-like quality), and the other metonymic based on contiguity and characterised by closeness or being in close contact with.

Metaphor combines 'truth and fiction', brings the understanding and resolution to the problem, and is prone to misinterpretation if literal meaning is sought. It is used as a 'transfer of an attribute to the recipient'. Metonym, on the other hand, complements the expression by substituting through close association and providing more realistic imagination of the issue at hand. Both metaphor and metonym are employed in Trobriand magical rituals helping both to imagine and represent a desired effect by 'building a whole through fragments' (1968:190). This leads Tambiah to criticise Frazer's notion of magic as a form of primitive religion and to conclude that magical spells are not simply an expression of archaic beliefs but applied technical and social knowledge, which renders magic similar to science. Therefore, magical words are not functioning on a basis of random associations, but are concerned with anticipation where uttering magical spells unites action and intention through various language games that help in the visualisation of the desired effect, while also making sense of the world in important and special situations.

The magical and demystifying properties of 'mental health'

If 'the logic of magic' is in its 'anticipatory effect' (*ibid.* 202) and magical words serve as a 'blue-print and self-fulfilling prophecy' we could also regard the language used by mental health activists as a form of special or indeed magical language - one that helps to imagine desired effects and helps in the visualisation or articulation of

possibilities for changing the social status quo. If magical language with its metaphorical and metonymic devices carries a capacity to recall things, events and occurrences that are not presently at hand, we could also think of the expression mental health as playing a matching role. Mental health recalls an absence of illness and suffering, whilst denoting recovery. In the context of activism, this expression could also be seen as an amalgamation of individual anticipations of a better future into a collective demand.

Just as magical words play multiple functions such as denoting a system of belief or the world of gods while also organising the world of (hu)man (Tambiah, 1968), mental health stands for both individual recovery and connoted with it social reality and, thus, denotes a special kind of situation that is both personal and collective in scope. In short, mental health points to both imaginations of personal aims and, at the same time, expectations of change.

What is more, the term mental health, like the mystified language of magic, is not fully understood by those who operate with it as indicated by discussions and comments on the TTC Facebook Page where users would sometime pose questions regarding meaning of the term.



Fig. 17

Yolanda's attempt to deconstruct the notion of mental health remained unresolved and it seemed that other users did not find it necessary to consider the meaning of the expression. One comment by David, however, broke this silence and indicated that mental health was a euphemism designed to denote illness.



Fig. 18

David's comment pointed to a tendency on the Page to use the expression mental health instead of mental illness and suggested that the reason for doing so was the inability to talk about specific conditions or illness. Meanwhile the response by Diane suggested that the term was not as significant as the practice of speaking of it in itself.

A similar conclusion might have led other users on the Page to resort to expressions such as: ‘Mental health is still a very much misunderstood invisible illness’, ‘mental health is such a tough illness’, ‘I’ve been suffering from mental health’, ‘my mum recently experienced mental health due to breaking her ankle’, ‘I was struck by mental health’ or ‘my mental health started five years ago’. Such casual, and only apparently contradictory, employment of the expressions points to the fact that mental health, similarly to magical language, is also ‘broadcast but not understood’ (Tambiah, 1968:179).

Given that both users and media campaigns attempted to contradict negative terms used to describe mental illness (e.g. schizo), ‘mental health’ helps in avoiding such connotations. However, mental health is also an attempt to categorise and organise all kinds of experience of mental health problems under an umbrella term that stands not for any particular illness or disease but allows for consideration of personal experiences in their collectivity. Mental health might thus be considered a metaphor by allowing us to imagine figuratively what is not presently at hand (by denoting a state of health as opposed to illness) yet, at the same time, is also of metonymic character in a sense that it denotes closeness between various mental health problems as well as proximity between health and illness.

As with magical language, the term mental health should not always be taken literally and, instead, we should appreciate the multitude of meanings and experiences that are associated with it in an attempt to make sense out of the lived reality. At the same time the expression mental health is also a force transforming the social reality that is believed to be partly responsible for the situation in the first place, specifically, by challenging stigmatising and discriminating words and behaviours. To put it yet another way, in these actions of formulating and speaking about experiences and recognising their collective relevance seems to lie the ‘magical power’ of the expression ‘mental health’.

Tambiah’s argument allows us to extend our discussion beyond the particular expression of ‘mental health’ and to the process of speaking about health more generally. In this endeavour, Tambiah’s description of Buddhist healing rituals in Northern Thailand is particularly helpful in understanding the role of language in health-related situations:

In the rite the myths are sung in order that evil and disease can be defined, objectified or personified and presented realistically on the stage so that the appropriate action of changing the undesirable to the desirable (...) can take place. The redundancy, lengthy recital and staging are contrived to achieve that crucial understanding by the patient of his illness which is a necessary prelude to and a condition of the cure.
(*ibid.* 177).

Tambiah, maintains that the patient's understanding of his condition comes about through the agency of the healer who, with the help of dialogue that accompanies ritualistic action, expresses the situation at hand in an abstract form, delineates the problem and, subsequently, envisages a solution, where such articulation of the problem might already bring a resolution of the issue.

Discussions on the TTC Facebook constitute a similar kind of verbal actions or utterances that objectify and present a set of problems while also fathoming a resolution in action. All these practices aim to explain what it means to live with mental health problems and, concurrently, hope to transform through mediated action, social perceptions and attitudes towards the mentally ill. Meanwhile, the repetitive and organised character of these utterances, including the sequence of commenting as well as expectations regarding what cannot and what should be said in particular contexts, renders them similar to magical healing rituals.

What is more, as in the example discussed by Tambiah, activists address a particular set of issues by imagining a new idealised reality such as a world without stigma and discrimination, where the ideal helps in envisioning both a goal which one works towards as well as a possibility of a better world. The idealised or utopian future gives direction to actions that, at the same time, have releasing and creative properties in themselves. In this example, expressions of the ideal, that is universal mental health, help in organising experiences, bring a realisation of commonalities in people's experiences, which, in turn, leads to a sense of unity.

At the same time, we find some fundamental differences between the language used in magical rituals as discussed by Tambiah and activist utterances. For example, redundancy and over-expressiveness is an imperative element of magical language. Its richness, suggested Tambiah, is an information-conveying apparatus that serves to denote the distinctiveness of the situation. Meanwhile, in the context of activism it has been suggested that representations and narratives of mental health problems cannot afford stylistic redundancies, as this would prevent coherence and the effectiveness of the message. Activists, thus, face a paradox with the notion of mental health allowing for grouping various experiences under one rubric yet at the same time and, as we have seen with the example of social experiments, limiting possibilities for intelligible and uncontroversial mediated expressions of these experiences. Consequently, audiences might understand some parts of the activist language, whereas some other expressions might remain misapprehended.

The absence of stylistic redundancy in our case, I would like to suggest, is linked to another distinctive characteristic of activist use of language. More specifically, the mystifying property of language that in magic serves to sustain the dogma, is absent in the activist case. This is because the aim of activist utterances is also to create understanding and transform authority with regard to mental health rather than to prevent the latter and to maintain the former. Clearly, discussions on the TTC

Facebook Page, and also in activism more generally, are operating in ‘profane’ time and space, at least in certain respects, and it is unclear if the structure of revelation, sharing and building on common experiences will last or not. However, it is important to note that language used with regard to mental health is continually transforming and that this changing character is directly related to its demystifying capacities. This is in the sense that speaking about illness from a position of experience reinvents the authority to talk about illness while also rendering the position of the mediators of health messages (healer, doctor, psychiatrist) less important or, in some cases, altogether redundant.

Relationships between medical professionals and patients are often characterised by disparity in knowledge and we could assert that what makes a medical professional is his or her scholarship and an ability to apply it in suitable circumstances, here illness. Meanwhile part of medical (and indeed magical) practice is keeping its knowledge as the domain of the expert. For example, the convention of writing down medical diagnosis in Latin as opposed to vernaculars was still widespread across Europe until several years ago and particularly common in cases of malignant cancers. We could further observe that Latin was used not only in Christian liturgy (*ibid.*) but also in Western medicine in order to denote special kinds of situations (illness), but also to maintain the gap in expertise.²⁴ In personal correspondence with dr. Izabela Gosk-Bierska, Reader in cardiovascular diseases at the Medical University of Wroclaw, she noted that medical professionals might create such knowledge boundaries in order to prevent patients from fully understanding their conditions for a number of reasons, including concern for the individual’s wellbeing, the professional’s inability to diagnose the patient and, sometimes, commercial rationale.

The last 50 years saw intensifying attempts to deconstruct this knowledge- and authority-based barrier with the shift inspired by patients who publicly shared and organised their experiences. Alcoholics, encouraged by medical professionals and therapists, were the first to speak about their problems (while also defining their dependency as an illness) and to make sense of the experience in the social context of fellow sufferers (Makela, 1996). A surge of patient groups soon began to transform the medical authority and its practice with cancer and, in particular breast cancer, HIV and AIDS and depression sufferers all taking to the formulation of experience and/or illness-driven narratives that started to play an important role in shaping processes of recovery as well as in challenges to illness-based social inequalities.

24 This, in turn, might suggest a more general conclusion that, in spite of a clear division in the European/Western traditions between religion as a set of spiritual beliefs and medicine as a scientific practice the two are closely connected through reliance on and protection of a special kind of language where the distinction between sacred and profane or the known and the unknown is maintained with the help of the same tools as the difference between the patient’s and the professional’s knowledge. At the same time, we could note that biomedicine, and in particular its disciplines psychiatry and neurology, often rely on speculation and anticipation, which render them similar to magical practices.

We have also seen earlier that the appropriation of language, and, in particular, the control over illness accounts were fundamental to former mental health movements in the UK. These movements' concern with language and practices of speaking about experience have been trying to transform ideas about illness from a taboo, something to be ashamed of and refrained from talking about, to something that needs to be articulated and worked through in order to be resolved. Consequently, we could conclude that contemporary mental health activism is a continuation of this wide and profound transformation of ideas about health and associated authority. We should note, however, that while former movements focused on challenging medical and governmental authority with its diagnostic and linguistic control over meanings of illness with considerable success, the current forms of participation suggest that health is as much an issue of authority as of responsibility and that concern with and capacity to speak about surrounding it matters and experiences is universal.

What also differentiates contemporary activists from former movements is their comprehensive use of media that allows for the dynamic formation of new ways of speaking about health, experience and illness. Communication in the sphere of social media, specifically, provides the immediate capacity to reflect on participation and meanings of actions while also mobilising large groups of people to speak about their mental health problems more openly. By doing so (i.e. speaking openly about problems) this critical mass or, to use Abigail's expression, 'army' of people hopes gradually to achieve the activist aim of making mental health better understood.

This leads me to conclude that activism in the realm of social media should not be considered against expectations of direct 'results', neither should it be measured according to its 'effects'. Instead, it should be understood with regard to its capacity to change possibilities for raising a multiplicity of voices and for mediating ideas, oppositions, views and demands. What is more, we could also see participation in social media as capable of facilitating senses of unity. It would, thus, seem important to describe and analyse uses of social media in a variety of contexts and to think in more minute detail how the novel ways of communicating they provide, could help in developing new responses to and reflections on burning social issues such as mental health.

Making sense of the Internet or a case for 'internets'

The focus on the possibilities provided by social media rather than explicit outcomes, seems like a well-judged approach to a phenomenon that is characterised by continuous change. However, the academic critiques of social media specifically but also of the Internet generally are often underpinned by what Coleman (2010) conceived of as an erroneous assumption of the 'universality of digital experience', or a focus on its sweeping impact that disregards contextual differences in uses and perception. Meanwhile, the changing nature of the Internet and its tools has

necessitated rethinking of universalising claims. For example Miller (2011) labelled his 15 theses on Facebook as ‘tentative’ deducing that the rapidly changing situation in the sphere of social media might require prompt reconsideration of practices taking place therein.

We should also note that social media rendered the Internet diametrically different to the one in its public beginnings in the 1990s, when the key concern was authenticity, or the Internet at the turn of the millennium, when it was posed as a threat to security. The more contemporary problem, that of privacy, seems to have emerged precisely together with opportunities for new ways of presenting oneself on the Internet and for relating to others. While some emphasise the necessity to bring back privacy on social networks (Langlois, 2012), the example of the TTC Facebook Page shows that participation in the sphere of social media redefines meanings of what is public and what private and that ‘return to private’ (*ibid.*) is simply not viable.

This shift of concerns from authenticity, through security, to privacy necessitates a brief consideration of the nomenclature used to describe the Internet, an issue that has baffled linguists in recent years. Terms such as cyber, virtual, wired, online, or even web-based all suggested, some more evocatively than others, that the Internet was not ‘real’ and that whatever happened in its contexts was to some extent separate from authentic experience. Anthropologists contributed to arguments against that and, for example, in his account of *Second Life*, an Internet-based world Boellstorff argued that ‘an exaggerated concern with actual-world meetups’ (2008:201) resulted in questioning of the value of ‘cybersocialities’ (*ibid.*). Boellstroff consequently suggests Internet-based practices should not be considered as secondary to ‘real’ experience as they always entail real involvement, whether technological or corporeal. Meanwhile the example of activist use of Facebook indicates that: (1) it is possible to participate and create new forms of interactions in the context of social media; and (2) practices in this context carry with them a capacity for remaking of experiences and for imagining new, social realities.

This rather dramatic transformation of the Internet we are witnessing at the moment with the advent of social media and involvement of individual and social sentiments and relationships might indicate yet one more thing. Namely that, instead of the Internet, we could be talking about ‘internets’; a de-capitalised, plural version of the word that is currently in use. The term ‘internets’ would indicate the plethora of uses, meanings and practices that are of significance to people and which would imply that there is not one coherent thing – Internet. The term is also suggestive of an approach that centres on qualitative exploration, which would allow us to say something specific both about the working mechanisms of people’s use of social media and the personal and collective perceptions of such actions. Ultimately, it could be suggested that the Internet (or internets) is not anything in particular but, potentially, something (or anything) that we want it to be.

Finally, with regard to activism, participation appears as rudimentary to the survival and/or effectiveness of the cause and Facebook is a tool that allows for such constant engagement. The importance of sustaining participation is as true for projects concerned with change at the wider level as much as for the local contexts like the one I discuss in the second part of the thesis.

We have seen in the first part how activism unfolds in relation to particular words and utterances and how context impacts on possibilities for formulation and reflection on experiences. In the second part I consider how language, and specifically various kinds of narratives, helps in the organisation of experience of mental health problems that unfold in particular locations, and, therefore, our concern will be with how words might help or limit the expressions of relationships between mental health and the environment.

In order to ensure stylistic coherence I would like to say a few words about the beginning of the next chapter at this point. What might appear as a protracted description of events in the following chapter will introduce the fieldsite and some of its characteristics, and outline the scope of issues and forms of participation relevant to my research participants in that context. More specifically, in the four chapters I look at mental health activism through the lens of Reflections - a local mental health-focused project in Richmond initiated by a key mental health charity in the area Richmond Borough Mind (RBM) and accomplished by volunteers and RBM workers.

PART II

Chapters 5-8

Richmond and its Landscapes of Mental Health

Chapter 5

Richmond and the Beginnings of the Reflections Project

A warm spring morning sees platform six at London Bridge station filled with a crowd of people dressed in navy, grey and black business attires. Their monochromatic uniforms make an uncanny match with the colours of the Shard, the tallest skyscraper in Western Europe, the construction of which has started to dominate not only the local area but also the capital city's skyline. Once a train bound to Charing Cross arrives, a nervous dance between those getting off and those boarding it commences. Everybody adheres to the unwritten principal rule of London's public transport: let the passengers off the train first whilst continuing to move towards the inside of its carriages. An announcement informing those desperately wanting to reach their destinations that the next train heading in the same direction is scheduled to arrive within a minute is met with unanimous indifference.

A few moments later the carriages pull into Waterloo Station, another of London's transportation hubs. The terminus bustles with motion and urgency exaggerated by an enormous clock that hangs disconcertingly from the ceiling high above the urban tumult. I squeeze against a stream of commuters freshly arrived from the residential areas on the outskirts of the city and manage to reach platform 19 seconds before the doors of my next train close.

Fellow passengers' loud and happy conversations create a striking aural and emotional contrast to the muteness of rushed workers in central London as the carriages escape the metropolitan hustle and head towards the greenery of south-west London and Surrey. A quarter of an hour later I arrive at Barnes station, leave its appealing neo-Tudor building and find myself in what appears to be a dense forest. Silence falls on my ears. Heavy and confusing at first, it soon provides me with a sense of satisfying peacefulness. A quick glance on a map confirms that Barnes, as an administrative part of the Borough of Richmond, does indeed belong to the capital city. Yet, with its quietness and calmness, this London differs acutely from its busy and rushed central counterpart.

John

John arrives in Barnes with the punctuality of a Swiss train, exactly at 10.30 am. Our first meeting took place during the One in Four conference in Euston (see Chapter 2) a couple of months ago where he came across as a pragmatic person devoted to the improvement of the lives of people experiencing mental health problems. As he drives along in the suburban woodland John remarks on the difficult situation of mental health services in the area. What he proclaims to be a conflict between service users and the main local mental health charity commenced over half a year ago in mid-2009 and culminated in the shutting down of several well-established mental health centres. Services in one of them were terminated only a week ago, in late February 2010.

The story is interesting but I initially downplay its importance, assuming that it has little relevance to the research. Over the following year of researching in Richmond, however, I am to be proven wrong and learn that the conflict and accompanying transformation of services are, in fact, of fundamental importance to local people affected by mental health problems, as well as a driving force of activist participation in this particular area.

John explains that he would like to show me Sheen Home – a full-time care facility for people experiencing long-term mental health problems that he set up over two decades ago with money fundraised through his professional and local connections. As we meander along a labyrinth of curved streets and opulent mansions John presents the history of the home intertwined with the story of his life. It was the ‘ineffectiveness’ and ‘lack of professionalism’ in the provision of care for his sons who suffered from mental health problems that inspired John to quit his engagements in business and become a manager in a local social service users’ centre. In 1991, with the aid of fundraising, he opened the care home.

Throughout the years, John came up against a multitude of changes in mental health services, ‘some of them good, some of them bad’ as he says. Despite the constantly changing legislative framework, helping other people mentally has been a ‘tremendous experience’ and for John ‘working in mental health’ spans his intellectual interests, professional engagements, and past employment as a businessman. John parks the car on one of the suburban streets whilst elaborating on the finances of his own and other local mental health projects. His passion seems to be analysing costs, finding unnecessary expenses and preventing wastefulness of resources.²⁵ Indeed, his account of running the centre and the care home appears managerial, almost corporate. However, he explains that his sons’ illness made him more understanding of service users and carers’ needs. In his project John is, thus, making use of both his professional and personal experiences. As we leave the vehicle John continues explaining the difficult state of mental health services in the area while pointing towards an ample Georgian house. With its well-maintained front garden and intricate floral patterns on its façade, Sheen Home does not stand apart from the neighbouring buildings.

As soon as we enter the care home’s hall, staff and tenants greet us with smiles and immediately start discussing some practical and logistic issues. The home comes across as a perfect illustration of John’s attitude – clearly handwritten rotas, lists of schedules, regulations and events hang in order on the walls and carers’ office doors. The house is thoroughly clean, almost sterile, but pleasant to be in. Energy saving

25 John says he always shares the results of his investigations with others. However, his analyses were not always welcomed as they often exposed wastefulness and incompetence. In spite of this, I found out that John has a lot of respect among the local community, which he gained through his contributions to mental health services in the area.

light bulbs and motion-generated lamps brighten up the corridors. John introduces me to Sheen Home's tenants as we pass through the kitchen and a neat garden. Once we reach a large, brightly painted room he explains with an unconcealed satisfaction that an extension was built a couple of years ago. Nowadays, residents use this part of the house for socialising.

When asked whether he himself has any chance to socialise, John insists that he devotes very little of his time to working and that, in recent years, he resigned from numerous professional obligations. He says he enjoys going to the theatre and concerts as well as rowing. However, it is also apparent that John is continually engaged in Sheen Home-related issues and that providing high quality living space for the mentally ill is his passion and mission.

Several hours later John drives me to Richmond station. As I leave the car, he promises to put me in touch with some local mental health workers who run a media project. John fulfils his promise, as some days later I receive an email from Helen Robinson, worker at Richmond Borough Mind and we arrange to meet in a café in Richmond.

Meeting Helen

The coffee shop indicated by Helen is conveniently located just outside Richmond station. Pedestrians and cars pass by unhurriedly while I sip on an oversized latte. I do not know what to expect from the appointment as, so far, we have only communicated with each other via brief emails. As a woman passes my table and enters the café I have no doubt it is Helen so I call her name. She puts a bundle of bags down on the floor in order to shake my hand and insists we sit inside.

Helen means business and as soon as we settle at a table, her attention is devoted to the project. However, every few minutes she stops the conversation in order to greet people who enter the café. At some point she stands up and initiates a conversation with a newly arrived customer. Although we spoke for not more than a quarter of an hour and no official arrangements between us have been made so far, she introduces me to this female friend as one of the filmmakers. I am immediately incorporated into the project.

Some minutes later Helen admits that she has never been involved in a venture of this kind. She seems overwhelmed and, at some point, claims that the project is 'scary'. Nonetheless, she outlines a rather detailed plan of work. We discuss dates, specifications and themes of the documentaries including the deadline for the film, which is 9th October 2010. As she turns to the issues of budgeting, Helen asks what kind of payment I expect. She seems relieved when I tell her that I would like to work on a voluntary basis and also promise to arrange filming equipment.

Helen then says that the films are to document the history of mental health in the borough over the period of last 50 years and should be based on the diverse experiences of service users and mental health workers in the particular context of Richmond. She says that they also have an anti-stigma and anti-discrimination outlook. The ongoing conflict, which I first heard about from John, is also to be tackled. Helen explains that some of the accounts might come across as controversial since the organisation that initiated the project, Richmond Borough Mind, is also the one that recently terminated some of its services without consulting the users.

Once I try to inquire into details of the disagreement, Helen checks the time on her wristwatch, stands up and shakes my hand. While picking up her bags she asks if I could come to a meeting in a social centre in a local mental health hospital in a couple days' time.

I have described the occasions for meeting John and Helen at length for two reasons. First, from the methodological point of view, their willingness to co-operate with me has significantly advanced the development of the research and it is their enthusiasm and trust that led me to work on the Reflection project and, consequently, to pursuing research in Richmond. Second, John and Helen's respective histories and experience provide a glimpse of the variety of forms of activist participation in this context. While John's housing association has been running successfully for over 20 years, the Reflections project, as we shall see, was a participatory innovation that aimed at addressing contemporary issues and concerns surrounding mental health, aiming to bring a resolution to the conflict, remembering the past, bringing people together and anticipating the future of services.

It is worth highlighting that both Helen and John used to hold the same position as social centre managers in Ham, although at different times. This is an indication that in Richmond, individuals who work on the same projects concerned with the issues surrounding mental health problems might have rather divergent personal backgrounds and professional training. The multiplicity of reasons for which people of various experiences and credentials get involved in addressing mental health problems became evident in the course of the Reflections project.

What is more, Reflections became a vehicle for learning and framing, both ethnographically and cinematographically, different meanings and practices of mental health in Richmond. The perspective I offer in the following four chapters is, thus, at once, that of an anthropologist and that of a volunteer filmmaker. These two roles – of a volunteer and of a filmmaker – are, from the point of view of my involvement in the field, largely undistinguishable. This is because my aim as a filmmaker as well as researcher was to explore Richmond as seen and experienced by people concerned

with mental health problems, to investigate meanings of participation in local activist projects and, subsequently, to create an account of events and subjective meanings. The key difference between film and ethnographic work is, thus, in the final products of these undertakings – films and the thesis respectively. Despite different form, these artefacts share something important in common, namely, they are all accounts of mental health problems, recovery and participation in the particular context of Richmond.

The above description of arrival in Richmond also points to a number of features of this research context: important was the availability of green outdoor spaces in Richmond. Other characteristics included the initially impromptu character of the project, the web of personal and professional relationships between service users, workers and inhabitants of the area concerned with mental health problems and the challenges encountered during the project. On a less positive note, also mentioned was the conflict between RBM and users of its services. All these aspects of the field receive attention at different points in the current section of the thesis. First, however, I would like to account for the inception of the Reflections and its intended aims.

Reflections

Reflections was originally conceived by Darren, Richmond Borough Mind's Services Manager but the project was run and overseen by Helen, who, for its duration, held the position of Project Coordinator. It unfolded over a period of just over a year between January 2010 and March 2011 and turned out to be much more of a comprehensive activist endeavour than I initially understood during my first meeting with Helen. Besides films, Reflections encompassed recording of oral histories, research in the National Archives and local libraries, collection of service user-made artwork, historical objects and material artefacts from hospitals and social centres, newspaper cuttings and photographs as well as a public exhibition.

All these activities aimed at documenting the development and metamorphosis of mental health services as well as changing social attitudes towards mental illness in Richmond as experienced by people affected by mental health problems, their families, health professionals and workers at charity organisations. Given this variety, the project was not aiming to produce a single coherent idea or concept of mental health but, conversely, to explore the multitude of perspectives on mental health and illness in Richmond against a backdrop of transformation of mental health care and services. As we shall see in this chapter the oral histories proved particularly helpful in gathering a wide range of accounts.

The accomplishment of the project would have been impossible without the participation of the volunteers, the majority of whom were also RBM service users.

Posters and leaflets distributed around RBM social centres and local NHS hospitals encouraged participation with a slogan ‘Explore Your Stories and Stories Around You’ (an indication that the emphasis of the project was on first-hand personal accounts of people concerned with mental health problems). The recruitment of volunteers also involved informal conversations and the spread of information across local volunteering services. In total, 30 volunteers, 62 oral history participants and 17 film participants, including three filmmakers, worked on the project with a number of RBM employees and Richmond locals who also made smaller, but vital, contributions. Several volunteers left the project, sometimes due to recurring health problems, while others joined in its later stages, for example, during the exhibition in the autumn and winter of 2010/2011. Those involved in the project acquired multiple roles: researchers in the archives, for example, participated in managing the exhibition, while oral history collectors also had their accounts recorded.

Initially called ‘Reflections – Celebrating Richmond Borough Mind’, the project was also referred to by workers and volunteers as the ‘RB Mind’ or the ‘Heritage’ project, the latter name an allusion to its key sponsor, the Heritage Lottery. In the end, however, it was re-titled ‘Reflections: Conserving Richmond Borough Mind, 50 Years of Service, 50 Years of Mental Health Heritage’. The name was changed for a number of reasons. Reference to heritage aimed at honouring the sponsor while the word ‘celebrating’ was dropped as it was found in personal accounts collected during the project that, as a result of closing the centres, not everybody felt there was anything to celebrate. Hence ‘celebrating’ was replaced with ‘conserving’, indicating organisations’ recent difficulties as well as attempts to ensure the continuation of services. Regardless of the verb used, however, all the titles point to RBM’s key role in the local mental health field: if Reflections was to focus on the history of mental health in Richmond then Richmond Borough Mind and its founding organisations were an intrinsic and pivotal element of this history, and the driving force behind changes and developments to services as well as social attitudes over the years.

Richmond Borough Mind

Richmond Borough Mind is indeed the oldest and, given its history and scope of services, best-established mental health charity in the borough of Richmond. It originates from the Twickenham Association for Mental Health (TAMH) founded in 1959. One of TAMH’s first projects was to run a volunteer bus service, which took families on visits to patients at the Horton and Long Grove local mental health hospitals. The bus also brought inpatients home on their day leave and, as hospitalisation decreased and care in the community was introduced, the bus took discharged patients back to their homes. In its early years, TAMH also opened a charity shop and organised fundraising events. The money collected was used to

support social meetings and gatherings for local people who experienced mental health problems.

In 1971, the Richmond and Barnes Mind was established to serve people in these areas and a year later, TAHM officially changed its name to Twickenham Mind, just as the NAMH was renamed Mind. In 2001, in order to reflect the new administrative territory of the borough and to minimise expenditure, Twickenham Mind and Richmond and Barnes Mind were merged into what is now called Richmond Borough Mind.

Currently, the organisation enjoys the status of an independent registered charity and, like its local counterparts across the UK, functions independently from the national Mind in terms of staff, finances, funding and projects. RBM, however, like all other branches, uses national Mind's logo. There are further connections between the local and national organisations. For example, the building of one of the closed down social centres was leased to Twickenham Mind in 1970s but constitutes the property of the national Mind.

At the same time, the latter organisation maintains its charity shop in Richmond, which is run by Mind and not RBM staff, while profits from the shop benefit the national rather than the local organisation. It is worth remembering here that Mind focuses on addressing mental health stigma and discrimination at the national level, while RBM and its local counterparts across the country do so in local contexts and, therefore, their respective activities should be considered as linked in general but separate both bureaucratically and campaign-wise.

In the 1970s the first meetings for people suffering from mental health problems were organised in a local vicarage with the help of Canon John Oates. Several research participants, including Helen and the Canon himself, pointed out that it was exactly in this period that the treatment of the mentally ill gained prominence as an urgent social issue. They saw this change to have come as a result of activity of mental health movements of that time including the anti-psychiatry movement, which Mind was supporting.

People meeting in the vicarage endeavoured to give mental health issues some public visibility and initiated a number of projects. Among the most notable was Mind Week in the mid-1970s. Canon Oates invented its slogan: 'Elephants Never Forget, Mind You, Remember Mind Week' and, as part of the event, rode an Indian elephant through the streets of Richmond. This, explained the Canon, drew considerable attention of the press and, consequently, brought the issues surrounding mental health problems to the attention of the local public for the first time. The Canon also claimed that, as a result, people in Richmond became more aware of mental illness and started to talk about it more openly. We should note, however, that the two main concerns at

that time were the conditions in mental health hospitals and asylums and the opening of social centres.

In the late 1970s, new centres were established in the Richmond area including Centre 32 (C32) and The Vineyard, managed at that time by Twickenham Mind and Richmond Mind respectively. In the 1990s two large mental hospitals serving south-west London closed down, as part of the care in the community reforms and, subsequently, a greater need for day services was identified. Among the most important developments in the 1990s was the opening of new social centres and drop-in services, including Ham Friends. Late 2010, however, saw the number of drop-in and day services gradually decreasing and, by the beginning of the next decade, most of the long-established social centres in Richmond Borough were closed.

In 2012, RBM provides a range of services mainly on site at the Social Centre in Richmond Royal, currently its only day centre, where the organisation cooperates with the NHS in the provision of therapy and psychological support. Since 2010, RBM has also initiated a number of new projects, including Reflections. Among the organisation's most recent undertakings is the peer-volunteering scheme through which volunteers recruited from current service users are gradually replacing paid employees in the running of the mental health groups that were closed down and subsequently re-established. Meanwhile, also as a result of a difficult financial situation, the number of permanently employed staff has been gradually decreasing, for example, the end of the Reflections project was also the end of Helen's contract.

Reflections, peer-volunteering as well as other initiatives were initiated when possibilities for socialisation between people affected by mental health problems decreased due to the closing of the social centres. Despite the rapidly changing situation of mental health services in the borough, or what in the eyes of service users was seen as a disruption of a state of equilibrium, RBM continued to provide new opportunities for meeting, sharing stories, establishing relationships and communicating, although in a radically altered and less formally structured form. In chapters 7 and 8 I look in more detail at these changes and both the users' and employees' thoughts on the subject.

Besides the history of developments of mental health services, another key concern of Reflections was to explore the meanings of living, visiting, working and/or attending services in Richmond. Therefore, it will be important to provide background on the socio-geographical context of the project and on Richmond as a fieldsite.

Richmond

Richmond, officially called Royal London Borough of Richmond upon Thames, is located in the south-west part of the metropolitan area of Greater London in which it

was incorporated in 1965. It comprises 18 districts, including Barnes, Sheen, Ham, Kew, Mortlake, Teddington, Twickenham and Richmond among others. One of the capital city's medium-sized boroughs, it happens to be one of the smallest municipalities in England and Wales ranked 262 out of 326. Richmond is also one of the least densely populated councils in London with two hundred thousand people living within an area of 22.17 square miles.

A brief glance at a map reveals that Richmond is not as densely urbanised as other parts of the capital. Concentration of green spaces makes the borough stand out from the rest of the city and it is for its greenery that Richmond is known among inhabitants of London and the thousands of tourists who visit the area each year. Locals and visitors alike are attracted by Richmond Park, one of the largest municipal parks in the world as well as other green areas including Kew Gardens, Hampton Court Park, Marble Hill House and Bushey Park. Richmond is the only London borough to spread across both banks of the river Thames with Thames Path, a long-distance footpath, running along it.

Richmond Village constitutes the downtown part of Richmond Borough and, as in other parts of London, its main road is filled with heavy traffic from the early mornings until the late evenings. Local trade is dominated by high-street fashion chains which, together with three supermarkets, a large upmarket department store and a range of smaller retail and service points, constitute the shopping district, further encircled by small streets that house some handsome pubs and elegant restaurants. Wealth is omnipresent in the area with expensive cars and magnificent mansions reminding the visitor that many of Richmond's inhabitants are considerably wealthy. Some districts of the borough, however, are far removed from this opulence. A detour off tourist tracks to parts of Ham or Twickenham offers an unsettling contrast in terms of living conditions and amenities. Limited public transport, run down council estates, and the absence of shops and facilities constitute daily realities for many local people.



Fig. 19 Richmond Bridge, looking upstream; K. Bierski



Fig. 20 Thames Path in Richmond, looking downstream; K. Bierski



Fig. 21 View from the Treetop Walkway in Kew Gardens; K. Bierski

Similarly to other parts of London, then, Richmond is characterised by social disparities. Yet, in this particular context, these differences appear to be more concealed behind the façade of prosperity and high price tags on shop window displays.

There is, however, something that makes Richmond egalitarian as a space, namely, access to the parks and open areas. It should be noted that some of them are exclusive and, for example, a single entrance to Kew Gardens stands at £13. Nevertheless, my research participants, including inhabitants and visitors to Richmond, often emphasised the possibility of enjoying the greenery and the riverside as one of the greatest advantages of the borough.

Some of them, like Q or Paul, whose favourite places in the area became the subject of films made for the Reflections project, travelled considerable distances from other parts of London in order to relax in Richmond. Others, such as Helen and Christine, whose stories were also filmed, lived locally or relocated to the borough specifically because of access to parks and nature. The accounts of these four research participants constitute the premise for the discussion of individual practices around mental health in the context of the green areas of Richmond, which is the key theme of Chapter 6. First, however, I focus on the initial stage of the project, the oral histories.

Volunteers Training in Richmond Royal Social Centre

In the RBM Social Centre in Royal Richmond, a group of volunteers sits close to each other on low worn-out sofa seats arranged in front of a whiteboard. Helen, who is the only person standing, faces the gathering and presents two younger women and myself to the rest of the group as ‘the film people’. Subsequently, everybody introduces her- or himself using terms such as ‘service user’, ‘Richmond local’ and/or ‘volunteer on the project’. Friendly mocking indicates that members of the group already know each other well.

Soon, however, the group of 15 people quietens and begins to listen to an enthusiastically speaking man. David is a director of another local branch of Mind in West London and a member of the Oral History Society. David’s role is to instruct the volunteers on how to collect and record accounts of people who agreed to share their life stories for the purpose of Reflections. With reference to experience of running a similar project in his local area, David says ‘we need clear outcomes’ and highlights the necessity for ‘determining aims’. His indications are reminiscent of strategies for campaigning prevalent in media workshops during the mental health-focused conferences (see Chapter 2).

Helen breaks the silence: ‘we should explore the history’, ‘collect and document varied experiences’ and ‘demonstrate evolution and development of services’. Her formal suggestions indicate that, as the person responsible for the project, Helen is bound to ensure that it covers these particular areas. Subsequently, a ‘brainstorm’ is initiated in order to identify key themes and questions, which will help in eliciting relevant accounts. A middle-aged man proposes that oral histories should focus on ‘human experiences’ and, in particular, ‘experiences of illness’. Another advises to ‘ask questions that reflect the history’ as well as to inquire into the ‘impact of changes to legislation’ and ‘stigma in different aspects of people’s lives’. Others suggest ‘asking people about favourite places to hang out’ and ‘getting someone to talk about working in an institution’. David looks pleased and encourages volunteers to devise further questions for the next session.

During the practical part of the tutorial, trainees familiarise themselves with the recording equipment, a cumbersome but professional looking device. As an exercise, John, one of the volunteers, leads a mock interview with Helen. Both of them struggle as they follow the sequence of launching the machine, introducing themselves, stating the place, date and time of the recording at least half a dozen times. Some trainees look confused, others seem bored and a couple appear to be asleep. I guess that the volunteers, who are also service users, find it difficult to remain focused over a prolonged period of time due to their mental health problems, and might also be experiencing side-effects of medication, such as drowsiness or fatigue. Throughout the project volunteers continued to struggle with their health issues, which occasionally affected possibilities for continued contributions, but as we shall see in Chapter 8 they later reported participation to have had a positive effect on their sense of wellbeing.

Once the training comes to an end, the room livens up again with casual conversations. Helen introduces me to two other filmmakers. Alice is a psychology graduate from Italy. She is interested in cinematography but has no previous experience in the field. Kaarina is an adept documentary filmmaker, a life-long resident of Richmond and former service user. We agree to divide filming responsibilities on another occasion.

Some weeks later in April, the four of us met again in the Social Centre at Richmond Royal. On that occasion, Helen presented us with two documents: a draft questionnaire, based on suggestions made during the training, which was to be used during the collection of oral histories and a summary of the film project. The first file indicated that the original open-ended character of a ‘life history’ has been compromised in favour of a questionnaire. The second document claimed that films were to constitute an integral part of the project by referring to oral histories as well as archival work done by volunteering researchers. Six seven-minutes long features based on ‘user-led story lines’ were to be made with clear aims of ‘celebrating 50 years of Richmond Borough Mind’, ‘raising awareness’ and ‘creating something valuable and tangible for future generations’. The suggested execution of the project, however, was ambiguous. On the one hand, Helen indicated that the narratives should be ‘free flowing’, on the other, she specified that films should follow a particular timeline of events and that they should be scripted.

By the end of our meeting we agreed that each filmmaker would work on her or his own and make two films each. Alice’s films were to focus on the history of RB Mind and transformations affecting services and carers. Kaarina’s films were to take as their subject ‘mental health buildings’ and legislative changes relevant to mental health. I was assigned films about ‘local perspectives’ and about social centres. The former was to be based on experiences of living and visiting Richmond. Making this film would involve getting to know individuals and collecting their accounts. The second

was to explore sites where mental health services are provided while also addressing the conflict between RBM and users of its services.

Oral Histories

A couple of weeks after dividing filming responsibilities, in mid-May 2010, I received the first recordings made as part of the oral history collection. Over the next two and a half months I obtained 143 MP3 files in total that ranged from several seconds or minutes to two hours in length with the shorter recordings being failed attempts to launch the equipment or to commence an interview. Eight volunteers collected accounts of 62 people with some interviews conducted by up to two volunteers and, occasionally, also by Helen. Her participation was sometimes necessary, especially in the early stages of the data collection process, because volunteers were not always certain as to what they were aiming to achieve. This, I would like to suggest, was due to the schematic organisation of the questionnaire which, despite being designed to help, caused some issues for interviewees unaccustomed to the interview process, an issue to which I come back in the conclusion.

Given that a key reason for the collection of oral histories is their difference from official and/or dominant narratives and records (Abu-Lughod, 1991), aiming to elicit accounts of the organisation through a project run and overseen by the same organisation appeared problematic. What is more, rather than providing accounts organised along lines of time (Portelli, 1981; Grele, 1991), the accounts collected in the course of Reflections were non-sequential elaborate responses to questions on mental health-related subjects and themes. Nevertheless, I decided to continue to refer to the accounts as oral histories, as this was the term used by participants in the project.

A short overview will give some sense of the accounts as a whole. At least 11 respondents did not provide their personal details or any information that would identify them although nine of these accounts were clearly those of former or current service users who spoke about experiencing mental health problems in the first person. I estimated that the number of respondents directly affected by mental illness was 43. The remaining 19 accounts were those of mental health workers from both the public and the third sector including RBM employees and directors, one psychiatrist, two mental health nurses as well as people actively engaged in local mental health activism.

In the course of a recording, an interviewee was first asked to introduce him- or herself by providing their name and age. This was not compulsory, yet participants in the project explained to me that they wanted to make their stories ‘public’. Such public articulation of troubling experiences is considered to be common in processes

of recovery (Kleinman, 1988; Stacey, 2002) and dealing with life issues more generally (Das, 2001) although the public sharing of experience is not always possible as, for example, in the case of sex workers (Day, 2007).

In oral histories, an important issue about having experiences of mental health problems and being a representative member of the public became evident through the second question, that asked interviewees to identify themselves as a ‘service user’, ‘worker’, ‘volunteer’, ‘stakeholder’ or ‘member of the public’. Individuals affected by mental health problems who added that they also speak as a ‘member of the public’ or ‘member of the community’ appeared to have shared the destigmatising assumption that mental health problems do not render an individual a less valuable member of society. On the contrary, having experienced mental health problems was seen as a good reason to speak about it to others, and also to counteract stigma and discrimination.

In response, four interviewees also added: ‘oral history collector in the Reflections project’ revealing that participation in the project was considered a serious role. It also emerged that experience of mental health problems prompted participation and, for example, a number of interviewed employees in the mental health field (seven out of 17 respondents) have also experienced mental health problems in the past. Having gone through illness themselves and, as their accounts show, often struggling with access to or with the quality of services, these people decided to work towards improving the situation and making the recovery easier for others.

The next question asked in the course of the oral history interviews - ‘How did you first hear about Richmond Borough Mind?’ – pointed to one of the overarching emphases of the Reflections project, namely, the organisation’s central role in the formation and maintenance of mental health services in the borough. Only a handful (three to my count) of the interviewees had never heard about the organisation while the rest knew RBM well, although they showed little awareness of the structural and bureaucratic changes to the organisation over the years. There was an overarching concern with current transformations of RBM services and the organisation’s uncertain future.

Responses to the question about RBM varied, depending on the interviewee’s experience and position. Current employees, for example, often came into contact with the organisation first as volunteers and, encouraged by the ‘friendly atmosphere’ and the ‘service users’ enthusiasm’,²⁶ applied for paid positions. Meanwhile, respondents suffering from mental health problems were often referred to RBM services through the NHS. One medical worker highlighted that this practice has become more common in recent years with the majority of drop-in centres closing

26 Oral history quotes from two RBM employees.

down. Formerly, service users would come directly to a centre on an informal basis, often encouraged by friends or family members, who might have been service users themselves.

These data show, however, that the process of becoming a user of mental health services in Richmond has become more institutionalised and bureaucratic in recent years. Meanwhile the rise in NHS referrals point to the public sector's increasing dependency on its voluntary counterpart, something that was noted by service users and employees alike, and a tendency I highlighted earlier as a characteristic of contemporary mental health care in the UK.

Interviewees were also asked about their first impression of the organisation. These were not necessarily favourable. Martha, a former service user and current employee recalled the situation: 'once I got to the (social) centre I thought: oh my God, this place is full of nutters'. She added that she was unhappy about having to come to the centre because becoming a service user and, effectively also a nutter, cemented in her a sense of being ill. Martha's long-term experience of services, however, was, on the whole, positive and she remembered her fellow users very positively. The initial moment of encountering services often brought realisation of mental health problems and of the associated stigma, as with Malwia, who said that upon entering the social centre 'it suddenly dawned on me that I was not a picture of health, that I am not in control'.

Prompted with a question regarding diagnosis, interviewees who faced mental health problems often referred to the medical aetiology of illness and how it helped them to make sense of their experiences. For Jim, a service user, diagnosis:

was a relief because it meant.... I was imagining something was wrong and my doctor, he was very good about it, he said: 'what you have is a chemical imbalance in the brain'... and that it wasn't just me imagining it.

Jim's account evokes Rose's (2011b) description of the process of psychiatric diagnosis which, as the author explains, provides people experiencing mental illness with a contrived sense of consolation. However, Jim saw his illness as deriving from three factors: 'mental', which he also called 'character predispositions', 'chemical' and 'social'. He believed that if it was not for societal factors, which included being bullied at work, his illness might not have been so severe. Although Jim pointed to a certain inevitability of illness by claiming he would have fallen ill regardless of the circumstances, he was aware of the social factors that played a role in the development of his illness, and he did not limit his understanding of the origins of his mental health problems to bio-chemical models.

Other respondents also found medical diagnosis helpful but did not consider it to be the sole framework for organising experiences of mental illness. For Christine, a

social worker, ‘diagnosis [was] a signpost for the person concerned, family and carers’ as well as ‘a guidance to know how to act’. Katie, a volunteer worker, thought diagnosis was ‘essential’ and added: ‘if you know what’s wrong with you, that’s already half the battle’. Radeem described his diagnosis of bipolar spectrum disorder (BSD) as ‘helpful’ as it allowed him to understand his ‘ups and downs’.

Meanwhile, parents of children affected by mental illness showed most support for diagnosis. In line with the ideas of the anti-anti-psychiatry movement in the 1970’s (see Crossley, 2006) Elaine, a mother of a daughter suffering from mental illness, said ‘how do you know how to treat a manifestation without knowing what is causing it’ and went on to highlight the importance of the ‘medicalisation of mental illness’.

Elaine’s daughter, who also shared her story, saw the process of diagnosis rather differently: ‘I was 24 and it was really hard being given the diagnosis because it seemed like a life sentence (...) cuz I had everything ahead of me and was a quite promising medical student’. While the question of diagnosis led the mother to emphasise the possibility of intervention, the daughter saw it in terms of the difficulties she would face.

More than diagnosis, people criticised hospital treatment. At least ten respondents did not even remember the period of hospitalisation: ‘It’s all been wiped out from my mind (...) because the experience was so disgusting’ claimed Graham. Claire provided more details on her negative experiences of staying in a medical institution:

The [hospital] staff were appalling; they were turning people into nutters and calling people names and things... They were always abusive to us; they didn’t treat us like human beings, but like animals. (...) I wouldn’t put a dog in [name of hospital in South West London].

Such negative views of medical institutions were also shared by Christine, a mental health social worker, who admitted that for many clients the hospitals were ‘very, very scary’. It seems, then, that diagnosis was not considered as serious a problem as the treatment it could entail.

In oral histories, we also find accounts of the transformations of mental health services. Change was observed by Radeem, a service user and former in-patient who compared two hospitals, where he was sectioned on two separate occasions. He claimed that ‘one of them was pre-Victorian and another ‘real twenty-first century’ indicating a radical improvement in architecture, the hospital building, the access to green spaces along with small details such as the colour of the walls. Angela, who was involved in legislative changes relevant to the treatment received by mentally ill patients, said she saw a ‘dramatic improvement as a result of the introduction of care

in the community, especially when the doors of the hospital opened and patients gained an ability to move more freely'.

A male psychiatrist practising in Richmond claimed that the medical establishment had been aware that hospital buildings were 'old fashioned and did not suit the needs of patients' and added that necessary modifications were implemented. However, he also admitted that changes 'might have taken more time than they should'. All in all, in accounts of transformations, from patients and professionals alike, highlighted the positive change to the spatial settings in which recovery from mental health problems takes place.

This was linked to the increased effectiveness of medication as, according to both patients and medical professionals, this improvement has enabled more care in the community. Almost all interviewees who experienced mental health problems, with the exception of two individuals, underwent some form of pharmacological treatment. The majority reported side effects that ranged from minor to serious including sweating, weight gain, fits, and speech impairment among others. Still, there was a general conviction that the benefits of the medication outweighed the side effects. At the same time, few remembered what drugs they were prescribed in the past while also noticing a constant stream of pharmacological innovations. A psychiatrist offered a perspective on the issue: 'patients are more likely to comply because the side effects [of modern medication] are not so obvious'. This conviction matched views of those affected by mental illness who thought that, over the years, pharmacological treatment had become more effective at targeting symptoms.

For Katy, for example, 'change of medication caused [her paranoia and persecution complex] to almost disappear'. She explained that for a couple of decades none of the administered treatment led to recovery and it was only recent pharmacological innovations that helped her to manage her mental health problems. Lisa also noted improvements: '[t]he medication got better. Since the eighties it all improved vastly, medication, everything, really'. In the early stages of her illness, however, Lisa was not aware of the necessity to continue taking her tablets after being discharged from hospital and, consequently, fell ill again.

Mike was among three respondents who did not take any medication despite experiencing serious mental health problems. He explained: 'I don't mean that medication should be abolished but I think they should be looking at the cause of the problem'. Mike was the only respondent to have claimed that pharmacological treatment was not sufficiently effective in addressing mental health problems. A rather different account was provided by Maria who, within a year of stopping pharmacological treatment, fell ill again. She described her experiences as follows:

What happened was a situation when I was told that it was all my fault because I wasn't taking my medication. I was absolutely livid and decided that, if I wanted to get better, then I would have to take my meds. So, if anything went wrong, it wouldn't be my fault. I was very cross about being responsible for my illness so I decided that I would comply and if it worked it worked.

It seems to have worked, as Maria was never hospitalised again. Such a decision to continue with pharmacological treatment and a personal sense of responsibility for illness could be seen as a form of voluntary submission to unequal power relations perpetuated by the medical establishment and pharmacological industry (Tsao, 2009a, 2009b). Another outlook on the situation is that medication helped Maria to reach a state in which she could participate in other forms of treatment, such as talking therapy or attending day services in social centres, and medication was, thus, an intermittent and pragmatic solution to the problem.

There were also accounts of earlier forms of treatment such as electro-convulsive therapy (ECT). Among three respondents who were administered ECT was Malcolm who talked about the experience in some detail:

Yes, I first had that in Springfield Hospital- that was about 1969 and... then in 1973, 74, 78 in Horton [local mental health hospital]. It's possible I had some in 1982. I'm not sure that they were that effective... you had to go without breakfast and come 9.30 or 10 am and prepare for treatment and then we would make our way back to the ward and have a light breakfast... The one thing I can say, though, was that it made me a bit more outgoing as I was very introverted earlier in my life. I'm not sure whether it had an effect on me. Now, my memory is not as good as it used to be.

Malcolm was not entirely clear about the repercussions of ECT yet he was pleased that it was no longer administered. A psychiatrist noted during his interview that ECT 'can be very effective' but that there was no 'tendency' to use it any more. He also added that, nowadays, patients have a greater freedom and choice when it comes to therapy. Indeed, ECT is sometimes portrayed in mainstream and activist media representations as the epitome of psychiatry's inhumanity, while the discontinuation of this practice as a marker of a shift towards a more humane and understanding approach to mental health care.

Continued change of treatment and attitudes towards mental health and illness were commonly recollected in oral histories. Lady, for example said: 'since the eighties it all improved vastly, medication, everything, really'. Given recent issues with services in Richmond, it would not be correct to say that the trajectory of change has consisted solely of continuous improvements. Equally important has been increased patient, family and/or community participation in the provision of treatment as mental illness has become a more encompassing concern and, rather than being confined to the walls

of asylums and hospitals, it has come to be addressed in new contexts such as, for example, social and community centres.

Questions concerned with these locations were also asked and interviewees' responses aid the discussion that follows. Let it suffice to say for now that accounts of non-institutional contexts such as social centres showed clearly the importance of places other than hospitals to recovery processes.

Recovery was another of the key themes discussed in oral histories. For Marc, for example, it meant 'living life more to the full'. Hannah thought of recovery as the 'promise of a better life', while Ron saw recovery as 'a belief in what you can do and what you're capable of doing'. In numerous other oral histories recovery appeared to be an ideal possibility to lead a complete life, implicitly or explicitly juxtaposed to a life disrupted by mental health problems.

However, some of the interviewees did not think that the future held a promise of 'normality' or a full life. Martha asserted during her oral history: 'Dare I say this but I don't think schizophrenics ever recover... I think I will be a schizophrenic that needs medication possibly till the end of my life'.

Blackman explains that the psychiatric concept of insight 'views recovery as tied to the person's acceptance of their experiences as being biological in origin' (2007:4) and Martha's understanding of her mental health might point to such insight. However, of all the accounts collected during oral histories, only two respondents affected by mental health problems thought of recovery as a purely medical process. More commonly, recovery was associated with a fundamental capacity to function on a day-to-day basis, which indicated that respondents affected by mental health problems felt they needed to get better not only medically but holistically. This, in turn, points to understandings of health that do not see it as an ideal state, biological or otherwise, but, instead, as a proactive process of coping/adaptation/functioning.

Such understandings fit the conceptualisation of recovery as a practice of 're-creating "normality"' and 'resuming the task of living (and not only surviving)' (Das 2001: 3-4). The authors also argue that recovery could ultimately be seen as a process of addressing the future while pointing to the decisive role that time plays in dealing with traumatic experiences more generally. As we shall see in Chapter 6, my research participants in Richmond also talked about wholeness, the 'new' or 'full' life that they achieved through recovery. Meanwhile in Chapter 7 we shall look at recovery through the prism of my research participants' accounts and experiences of social centres and of transformations of services. Accounts from both these chapters lead to a notion of recovery as an environmental and, consequently, an innately social process.

Conclusion

Oral histories showed interpretations and views about experiences of mental health problems that shared in common a more or less consensual perception of the gradual change and improvement in treatment, services and social attitudes towards mental illness. Oral histories were more detailed than, for example, activist-made representations and, as such, they provided a more complete picture of mental health.

This capacity to bring forward the detail of experience is linked to Reflections' focus on documenting a variety of perspectives on mental health rather than addressing wide audiences. However, a range of questions that aimed to accommodate accounts of people from different paths of life both hindered and facilitated the process of the interviewing. For example, employees of charity organisations found the question about stigma irrelevant to their own experiences yet it prompted three of them to talk about stigma as experienced by service users. Meanwhile, questions about living in Richmond were irrelevant to people who did not reside in the area, although questions about favourite places in Richmond were appropriate to all respondents.

These issues were retrospectively discussed during the feedback session with volunteers, which took place several months after the recordings. On this occasion, participants who conducted the interviews agreed that the meaning of the term 'oral history' was not entirely clear from the start and at least two volunteers were convinced that oral histories were supposed to focus only on experiences related to Richmond Borough Mind. At the same time, some of the interviewees thought a whole history of their life would be recorded and not, as was the case, the period of illness and recovery only. This perception indicated something that did not emerge from the accounts, namely, that those respondents who suffered from mental health problems thought of their experiences as part of a broader life trajectory. Consequently, what we do find in oral histories are accounts of only particular periods of respondents' lives, which I discussed above, in order to show the scope of mental health-related experiences, views and ideas in Richmond.

In the evaluation of Reflections compiled by Helen in April 2011, she admitted that the oral history part of the project proved challenging, as some volunteers followed the questionnaire word for word, or found it difficult to elicit further comments on particularly relevant stories and experiences or interpreted the questions differently than intended. For example, the question about stigma was, on a number of occasions, being understood as relevant to the respondent's experience of services at RBM rather than stigma in life more generally. The reason for this appears to be purely practical, as this particular question was preceded by one regarding experiences of the organisation.

If the essence of oral history is in asking specific questions that would elicit accounts not otherwise available in written or material form (Portelli, 1979), such an approach would appear to be suited to a project such as Reflections that aimed at exploring the history of mental health and experiences of problems. However, the social proximity between interviewers and interviewees, their shared past and knowledge of the local context seem to have prevented more detailed questions, since interviewers often already knew what the situation was like and did not feel compelled to investigate further. Meanwhile, it also seemed that interviewees sometimes did not feel obliged to go into detail, assuming that the interviewers already had a considerable knowledge of the circumstances.

The technical execution of the recordings made it impossible to consider the accounts collected as a coherent data set. This is because some of the recordings were partly incomprehensible due to interruption, which occasionally hindered the flow of a respondent's account. The files I received were also unnamed and, therefore, on several occasions I assumed that two recordings were of two different people realising only later that they were accounts of the same person and vice-versa.

These issues, however, do not render these oral histories any less useful than more traditional types of narrative-focused interviews (Czarniawska, 2002; 2004). In fact, thematic sequencing of the questions proved practical in identifying the key themes and domains of illness and health relevant to the people affected or those professionally addressing mental health problems. The oral histories encompassed a wealth of informative personal accounts on experiences and recovery, relationships with particular places, volunteering, social responsibility and senses of community, all of which help in the identification of Richmond as a site of specific forms of mental health activism and of recovery. What is more, the accounts provide us with a sense of change in regard to treatment and social attitudes towards mental health and, thus, are helpful in making sense of the contemporary situation.

Barthes claimed that narrative 'is simply there, like life itself' (1977:79) while Cortazzi suggested that narratives are 'one of the fundamental ways in which humans organise their understanding of the world.' (Cortazzi, 2001: 384). Meanwhile Rapport claimed that 'stories people tell about themselves and their worlds propagate a meaningful sequence across time and space' (Rapport, 2000: 74). It has also been asserted that narrative-making is one of the most opportune tools available for responding to life problems or disruptions (Kleinman 1988; Charmaz, 1991, 1992; Frank, 1995; Skultans, 1998, 2004; Rapport, 2000) and it has been also suggested that narrative-making is in itself a form of recovery (Rosen, 1983; Antze and Lambek, 1996). All this might explain why narratives became one of the central focuses in studies of illness (Stacey, 2002; Potts, 2004).

Ricoeur (1981) believed that narratives could lead to the formation of ‘narrative identity’ whereas Antze, in reference to Ricoeur’s work, argued that ‘our very experience of identity, of being someone in particular has a tactic narrative structure’ (Antze, 1996: 6). A number of other writers also emphasised correlations between individual identities and narratives (Charmaz, 1991, Frank, 1995; Stacey, 2002). What is more, narratives can also be considered as crucial to formulation and maintenance of collective senses of belonging. (Charmaz, 1991; Cruikshank, 1998; Cortazzi, 2001).

More recently, Bloch (2011) argued that anthropological studies of person/individual/self/personhood have failed to account for the multi-layered dimensions of experience that encompasses the social as well as the biological and the cognitive. Bloch replaces all these idioms with a term, blob, and goes on to argue that in the Western context this blob consists of interconnected ‘core’, ‘minimal’ and ‘narrative’ selves. While the ‘core’ relates to the basic awareness of one’s body and actions, the ‘minimal’ indicates perception of change to self over time. The final, narrative layer of the blob is conceived as the level of ‘reflexive interaction with others’ (2011: non-paginated) that, according to Bloch, brings meaning to the individual.

Following Strawson (2005), Bloch concludes that everybody has a capacity for a narrative ‘autobiographical’ process, but that some people may be more aware of having an active role in autobiographical practices. This leads the author to another assertion: that the ability to tell stories about self is distinct from the practice of telling these stories or, to put it another way, the public expression of stories about self, along with the social and cultural context within which this process takes place, render a sense of self different from its narrative manifestation (*ibid.*). In short, Bloch suggests that the experience of being ‘self’ is distinct from the narrative ways of self-presentation.

Anthropologists, argues Bloch, often make the mistake of ‘consider(ing) discourse about the self and others to *be* what it is a representation of’ and, as a consequence, they confuse the ‘core’, ‘minimal’ and ‘narrative’ selves or, in other words, describe people on the basis of what they tell them. These selves, however, are part of a continuum of a blob – they are inseparable from each other. The problem is that ‘narrative selves’ are those selves floating in the realm of the public, while facilitating communication and, therefore, attracting anthropologists’ attention.

All in all, the underlying assumption in analytical approaches to narratives points to their capacity of generating a sense of self. Bloch’s take on the subject is distinctive as it suggests that this sense is not a full but only partial representation of experience. With regard to this, oral histories are in-depth expressions of personal experiences of a highly public character uttered for the specific occasions of the Reflections projects,

telling of meanings of certain key dimensions of protagonists' lives, but not allowing for speculation in regard to health or illness-based identities.

This is, in a sense, self-evident if we remember that the focus on questions regarding health and illness surprised some of the interviewees who thought of their mental health problems only as a part of their larger life narrative. In the context of the UK, however, with highly privileged modes of 'narrating' the self, certain forms of narratives never really provide a full sense of self at all. Instead, we could say that narratives are a form of strategic re-contextualisation of experience. Oral histories, for example, can be seen as attempts at collective understanding of issues of mental health in a particular context. It would not, however, be correct to claim that they misrepresent experience.

We should note that in Bloch's model of blob there is a definite separation between the biological, psychological, cognitive and social spheres of experience. According to Ingold's (2000) argument, however, experience is never only cognitive or biological, but necessarily contextualised by environment and, therefore, all-encompassing. What is more being-in-environment (*ibid.*) renders experience necessarily reflexive through orientation, movement, etc. and, therefore, it could be suggested that narratives accompany rather than represent experience of self-in-environment. We shall see in the following chapter, for example, how landscape 'tells – or rather is a story' (Ingold, 2000:59) where I also suggest that narratives are embedded in experience of environment and, effectively, a form of engagement with it rather than the essence of its experience. In short, narrative practice is, also, a way of ordering experiences-in-environment.

We have seen such contextual systematisation of experience to be the case with accounts of experiences of mental health problems on the TTC Facebook Page, that led to reported senses of wellbeing as well as realisation of a common goal. Oral histories could also be considered as a form of documenting experience in an attempt to make a collective sense of mental health problems. In the case of the TTC Facebook Page, as we have seen, characteristics of communication therein allowed for instant reflexivity with regard to actions of experience-sharing. In the case of oral histories such immediacy was absent, which explains why the consequences of collecting oral histories were not discernible. However, some of the accounts were later used during the exhibition, with some excerpts included on a sound trail and all of the accounts were made available to the public in a local library. In that sense oral histories also contributed to reflexive insight into mental health in Richmond whilst providing future generations with first-hand accounts on matters of mental health in Richmond.

It might appear that the difference between the narrative practices we have discussed is that some concentrate on making sense of experience individually and others collectively. This difference, however, might rather be between narratives that

consider environment as innate to experience and those that consider environment only as a source and not part of experience. Meanwhile, in the following Chapter, I hope to show with the discussion of my research participants' favourite places in Richmond that 1) even most personal health-related practices are also inherently social and 2) how narratives accompany health actions in environment.

Chapter 6

Favourite Places in Richmond

It takes 16 minutes to get to Richmond on the 9.37 a.m. South Western train to Windsor and Eton Riverside from London Waterloo terminal's platforms 17 or 19. Richmond Station fascinates with its early modernist features: tiled staircases, curved brass banisters, geometric glass doors and a wooden waiting room. Once on the high street, I automatically turn right and walk towards Royal Richmond Hospital. However, I could have also gone left towards one of the cafés on the banks of the river where I would meet with Helen or other participants in the project. Alternatively, I could have got off one station earlier in Barnes, or at the next station in Twickenham in order to reach one of the social centres or a particular filming location. The journey to Richmond from south-east London, where I resided during the research, seemed generic up to the point of the arrival in the field.

Meanwhile, over the months of fieldwork, the area of Richmond Borough became a site of the particular and the specific, that encompassed my research participants' experiences and stories as well as individual and collective struggles to save or reactivate the old, or establish new mental health services and groups. These accounts and practices seemed inseparable from the locations in which they took place: either outdoor spaces in Richmond or social centres. I concentrate first on the former places and, specifically, on favourite places in Richmond that I filmed as part of the Reflections project.

As we shall see, favourite places are sites of intricate personal practices of recovery from mental health problems that have an inherently narrative structure. On this basis, I propose that my research participants' practices with their favourite places can be considered as particular forms of landscape of mental health. Landscapes are conceived with reference to Ingold's understanding of the concept as temporal loci of activity *in* and *bounded by* environment²⁷ and this notion leads to my understanding of practices around mental health in Richmond as a form of environmental action.

Reflections project coordinator Helen originally intended to make one document that would focus on the similarities between people's experiences of the area. Provisionally called 'Local Perspectives', the film was supposed to offer a multilateral perspective on how people spent time outdoors in Richmond. In the course of the project, however, we decided to produce individual 'vignettes' that followed the stories of four individuals, including two inhabitants of Richmond and two visitors to the area: Christine, Q, Paul as well as Helen herself who, as the project coordinator, encouraged the other three to participate.

The decision to split films was made so as to retain the depth and candid nature of the accounts collected and, looking retrospectively, it also precluded a rather simplistic suggestion that there is some essential characteristic of Richmond that is good for

27 'Environment' as opposed to 'the environment' connotes its universal and omnipresent character.

mental health. Instead, my intention was to show how individuals become aware of the environment and its qualities and how such realisation of self-in-environment can be fundamental to processes of recovery. At the same time, accounts of favourite places are not indicative of features of one particular place but show, more generally, how people make sense of illness in and through environment.

The four films produced as part of the Reflections project and distributed in the form of a DVD attached as an appendix,²⁸ show what cannot be fully accounted for in language: that is, movement and the active being in one's favourite place, something I conceive here as a form of attunement to the environment. Initially, I focus on the making of the films and consider my research participants' practices in favourite places in more detail including the activities of sitting, walking and narrative reflection.

Christine

On a sweltering June afternoon in the Twickenham Bridge area, people sitting outside a pub speak loudly and empty glasses of beverages. Water in the Thames under a steel suspension bridge looks clean and inviting for a swim. A father accompanied by three sons is angling on one of the riverbanks, whilst another group of men are cleaning a boat. Twickenham seems peaceful and undisturbed by urban bustle. On the other bank there is a quiet, bushy towpath that leads to a congregation of modest-looking houses. Christine, a resident of Richmond, and a service user who agreed to have her story of mental health problems and her favourite place recorded, lives in one of them. Almost immediately after Helen rings a bell, a happy woman opens the door and with a friendly gesture invites us inside. As we sit at a large kitchen table, Christine points at the camera and microphones and with a visible sense of relief says that she expected a full filming crew.

Being in Christine's house, which she shares with her husband, two children, a cat and a couple of dogs, feels like visiting an old friend. Helen and Christine are, in fact, very good friends and it was the former who encouraged the latter to share her account of dealing with mental health problems as part of the project. They have known each other 'for years' as they respond in unison to my question, and tell me that they got to know each other during the organisation of a local independent mental health-focused social meeting group. Just as Helen has done in the past, Christine is now training to be a mental health counsellor, as she hopes to use her experiences of a successful recovery in guiding others. From our conversation it emerges that she sees the film as yet another opportunity to bring about better understanding of mental health problems.

28 The DVD includes one film made by another volunteer and the four films I discuss in this chapter. The films are also available to watch on RBM's webpage and its YouTube channel: <http://www.rbmind.org/reflection> as well as my Vimeo page: <http://vimeo.com/album/1745144>

Q

On another sunny summer day, Helen, Paul, a volunteer on the Reflections project and I wait in front of Pembroke Lodge, a Georgian mansion in the upper part of Richmond Park. The Lodge stands atop a hill surrounded by a sea of greenery with its waves of abundant vegetation reaching all the way down to the horizon. In front of the building a group of schoolchildren form an orderly queue in front of a small ice cream outlet while owners give water to their thirsty dogs. On the other side, across the street, a herd of fallow deer graze, undisturbed by the scarce traffic and the presence of people.

Q finally appears and offsets his lateness with a wide smile. Although he knows both Helen and Paul, he initially comes across as a little reserved. However, he quickly turns out to be a very warm and friendly person. While I fix a lapel microphone to his t-shirt, Q announces that we will follow his usual walk. He needs no encouragement and appears impatient to start. Before I manage to set the camera, Q shoots off through a wide gravelled alley and almost at once we find ourselves a few hundred yards behind him. Thanks to the microphone, however, it is possible to hear Q explaining that Richmond Park is one of his favourite parts of London and that it is ‘really amazing’. Several minutes later we arrive at a glade hidden between trees on one side but with a magnificent view of south-west London and Surrey on the other.

Paul

I met Paul a couple of months into the Reflections project. He was also a volunteer and helped with sound recordings and the organisation of events. We spent many hours together travelling around Richmond, planning, filming and visiting social centres, where we would talk to workers and service users and also with each other. Paul was in his mid-twenties and he previously studied for a degree in humanities, but did not work professionally at the time of this research. In fact, he had plenty of spare time, which he used enjoying himself, meeting people, travelling around or outside London. Paul was particularly fond of walking and horse riding, although music seemed to be the most important element of his life. He is fond of ska and reggae and, consequently, the music scene in Brixton, where he goes out and performs, and where he lives in a flat on his own.

When outdoors, Paul usually carried a cigarette in his hand and always spoke slowly and in an articulate manner. He enjoyed the company of other people and while commuting from one location in Richmond to another we would always stop to chat with one of his colleagues or fellow service users. Despite his undeniable social skills and connections, there was a degree of distance that Paul kept from others. At times, he seemed emotionally disconnected and never mentioned his mental health problems

to me. It was prior to filming along the Thames Riverside, his favourite place in Richmond, that Paul found an opportunity to talk about his experiences for the first time.

Helen

Helen, the Reflections project coordinator, is also passionate about music, although of a different type. She plays the violin and performs in a local choir where the focus is on works by baroque composers. Singing, claimed Helen, helped her to manage her panic attacks, as it helped her to develop the ability to control her breathing. Helen has lived in the Richmond area for most of her life and, currently, she shares a house in Mortlake with her cats. She would always emphasise how lucky the residents of Richmond are to be living in the area and I have never heard her say anything negative about the borough. Even during our trip to Ham, a district consisting predominantly of run-down council estates, Helen highlighted its positive aspects, such as access to parks.

In the mid-1990s, following a series of severe episodes of mental illness, Helen started working for Richmond Borough Mind. Throughout her time with the organisation, she held a number of positions but the one she mentioned most often and the one she seemed to be most proud of was that of manager of a day social centre in Ham. From the end of 2009 until the end of March 2011, Helen was the Reflections Project Coordinator and, effectively, the engine of this enterprise. Helen found the Reflections project very meaningful, as it provided her with an opportunity further to explore her local area, to maintain or renew existing contacts, and to create new relationships.

Helen would always introduce volunteers, service users or workers with their personal story or their contribution to the local community, and her knowledge of Richmond and its people allowed for effective, although not effortless, coordination of the Reflections project across different locations. Meanwhile, social links she had developed over the years were critical to the recruitment of volunteers, to gaining access to resources and to reducing expenses. Given that I spent most of my time in this field with Helen, it was initially through her perspective that I came to know Richmond, its parks, historical sites, social centres and, most importantly, its inhabitants and visitors. As our cooperation progressed, Helen also started to talk in more detail about her own history of health and rehabilitation that, just as the rest of her life, unfolded in the local area. One place in particular - Marble Hill House and, surrounding it, Marble Hill Park – was of great importance to Helen’s recovery.



Fig. 22 On the filming location in Richmond Park; photo credit Helen Robinson



Fig. 23 On the filming location in Richmond Park; photo credit Helen Robinson

Discovering the Favourite Place

In order to get to Christine's favourite place, we leave her house and take a path at its rear. She seems undisturbed by the presence of the camera and with a slightly theatrical tone and dynamic gestures introduces the surrounding area as if we were in a fairy-tale. Upon the first patch of lush greenery, she explains that this is the view from her bedroom window and that looking at it each day makes her very happy. Some ten minutes later we reach the banks of the river. Christine points at the left to a little glade hidden between bushes and trees. I set the camera on a tripod as Christine sits down on a small wooden bench facing the water. She then explains that several

years ago, after viewing her house for the first time, she walked to the river and found this place. Christine also came here on the day she moved into the area. It was during these initial visits to the riverside that she became convinced she would be able to manage her mental health problems.

On the glade in the upper part of the Richmond Park, Q explains that a friend told him about this place several years ago. Q, who does not live in Richmond but has been attending local mental health services in an attempt to recover from his recurring mental health problems, was eager to find out more about it. With a wide smile on his face he recalls that the first time he came here the weather was warm and sunny. However, he immediately clarifies that he enjoys his favourite place regardless of the season or the weather. It was also on that first visit that Q found the wooden log where he always sits before and after a walk across the park.

Paul and I sit in a café hidden underneath Richmond Bridge that conjoins the two banks of the river Thames. Heavy rain continues to hinder our attempts to record Paul's story; on two previous occasions we were also disturbed by the weather. This, however, provides us with plentiful time to chat. As we sit on large sofas and drink coffee, Paul talks about his favourite place in Richmond, The Thames Riverside and Thames Path that follows the river's banks. Paul does not recall the first time he came here but he does remember that, a few years ago, he visited his uncle who lives locally. At that time Paul was experiencing severe mental health problems which culminated in an involuntary five month-long stay in a mental health hospital. Following this period, he started to attend mental health services in Richmond and began to explore the area for himself.

On a Saturday morning the wide lush lawns of Marble Hill Park that surround a Palladian villa (and former residence of King George II's mistress) have invited numerous locals and tourists to relish another day of the beautiful summer. I recognise Helen from a distance and immediately notice that she looks different from usual. Instead of her day-to-day dark utilitarian clothing, she is wearing a white knee-length dress with a large red and magenta floral print, accented by matching lipstick and shoes. Initially, perhaps a little anxious, she sits down on one of the park benches whilst I set up the equipment. She tells me what and whom she saw in the park before my arrival and is visibly happy to see other people enjoying themselves. Once the camcorder is set, Helen accounts for the discovery of her favourite place. Her mental health deteriorated in the late 1980s and, consequently, she became unemployed. During walks from one distant part of the borough, where she lived, to another where she had to sign on at the local job centre, she often made a detour and came to Marble

Hill Park. It was whilst sitting in this particular place that Helen started to reflect on her mental health problems.

While both Q and Christine recalled the exact day on which they found their places in Richmond, Helen and Paul did not specify such precise dates and their discoveries seemed to be more gradual. All four, however, identified the locations in periods during which they were experiencing severe problems and looking to reflect on their condition. Outdoor areas of Richmond provided all four with an opportunity to do so. Regardless of whether the initial visit was planned, as for Q, or coincidental, as for the other three protagonists, the first encounter was conceived as the beginning of a transformation and an indication of a possible recovery.

Attunement and movement as recovery

It is worth noticing that research participants' reflections on favourite places preceded their elaborations of personal experiences. For example, it was only during our visit to the Riverside that Paul talked about his issues for the first time. He started with a detached and observational description of his surroundings and only then told of his experiences of illness and hospitalisation. Although filming situations encouraged the telling of a story, such practices of making sense of experiences characterised my research participants' processes of recovery in the past, according to what they told me.

In each of the accounts, the qualities of favourite places and their features, such as the serenity of a park or the calming properties of passing water, bore strong similarity to the protagonists' desired state of mind. For Paul, the Riverside was 'calm' and 'relaxing' as he would spontaneously announce each time we walked past or across the Thames. Helen and Christine thought of their favourite places as 'peaceful'. During the walk in Richmond Park, Q proclaimed his favourite place to be 'beautiful', and 'relaxed'. These adjectives, however, seemed to serve as more than descriptions of an essential quality of a place but also to indicate research participants' past and future relationship with the environment.

Moreover, these qualities are not exactly embodied, as Ingold has suggested that the term is not useful because it considers the human body and its environment as two separate entities. We could instead emphasise an attunement with these favourite places. In Q's case, for example, the process of becoming in tune with Richmond Park became evident through the blending of his narrative, surroundings and recovery.

After a still moment on the log of wood, Q stands up, walks towards a metal gate and enters the densely forested part of the park. He seems to be ignoring the fact of being filmed and simply shares his thoughts with me as he does with himself during one of

his regular visits to his favourite place. Q describes difficulties he encounters while feeling ill: an inability to fulfil everyday obligations, to engage with other people or even make any physical effort, such as leaving the house. Then he says '*... but I know, I say to myself. You've been here before and you know you got out of it*'. 'Being here' denotes both the recurring perplexing mental state and this presence in Richmond Park.

Q carries on walking fast, even up the steep steps leading to another hill. He then turns towards another part of the park and several hundred yards further we find ourselves in the front of an arched metal structure covered by a trailing plant. Q enters this leafy tunnel and, with a shaky voice, starts describing his experiences:

My energy is lifting. I'm energising and when I reach the end I'm fully charged up... in my mind... and I feel complete.

He stops at the other end of the path for a moment of quiet contemplation. Some half an hour later we are back in the glade where Q gives into another moment of silent reflection.

Q's walks are divided into distinct stages. The period of sitting on the log seems to represent a search for inner peace and a pause for gathering energy. The fast walk through the park seems to match the intensity of Q's thoughts and experiences but could also be interpreted as a dynamic rejection of unwanted feelings that slow down the dynamics of Q's everyday life. The pause at the green tunnel is a moment of cleansing and liberating suspension, whereas the final stage of returning to the log is a kind of equilibrium, where Q finally reaches a sense of sought-for calm and peacefulness.

Q's sequence that includes sitting, walking and crossing the tunnel appears to be of a ritualistic character; a form of separation from everyday life and an intrinsic part of it connected through transition or liminality (Turner, 1987). Q, however, explicitly did not consider his walk in that sense. Instead, Q's interaction with the favourite place is an intricate strategy for recovery based around a deep sense of satisfaction and completeness, derived from movement and stillness in an environment that is at the same time verdurous, yet cultivated. These sensations do not come as a consequence of the Park's qualities (i.e. the greenery does not simply make Q healthier). Instead, I suggest that this practice of recovery is based around Q's attunement to his environment.

Although in *The Perception of the Environment* Ingold (2000) refers to being 'attuned' or 'in tune' on a number of occasions he does not account for it analytically nor does he provide a definition. However, the author tends to use the term in order to denote a subtle process of adjustment to environmental circumstance that involves sentience, intuition and learnt knowledge: a hunter becomes attuned to his hunting

grounds, a walker to her path, a child to its mother and, at a collective level, industrialised societies become attuned to organised time. With reference to the last example Ingold explains that by being attuned to the clock, people do not make their ‘bodies into pieces of clockwork’ (2000:333) indicating that becoming attuned to environment is not a simple mechanical or bodily function. Instead, we could think of attunement as a comprehensive action of becoming aligned with the movement and stillness of the environment.

The notion of attunement stands against an idea of environment that individual agents negotiate their way through by imposing their ideas onto it and benefiting from or taking advantage from its elements or qualities. Instead, in line with ‘dwelling perspective’ (Ingold, 2000; see the Introduction above) attunement suggests that practice such as, for example, recovery is a continuous engagement with the surroundings where it is not possible to separate actions, ideas and emotions from the environment, as the former necessarily occur in this environmental context in the first place. For example, Q’s senses of satisfaction and being at peace with his experiences (which amount to a sense of recovery) are not simply a result of him coming to his favourite place. Instead, recovery entails a process that is *unfolding alongside* but also *is* his movement and stillness in the park. In short, attunement is simultaneously *being* and *becoming* in environment and through learning and repetition it also models a future. Or, in other words, attunement denotes quality of both being and becoming through and with environment and not simply transforming as a consequence of external agent.

I described Q’s strategy of recovery in his favourite place at length because he enacted his engagement with his favourite place in front of the camera lens. The other three research participants presented their favourite places somewhat differently. In the case of Paul and Christine it seemed that the filming situation encouraged them to focus on a narrative account of their practices, while Helen considered her problems to be a matter of the past and, thus, her story was fully retrospective. Nonetheless, all three indicated a form of attunement with the environment in their recovery.

Paul, for example, enjoyed energetic walks and could ‘spend hours’ along the Thames Path ‘regardless of the weather’. He suggested that walking considerable distances was a test of his mental and physical perseverance and strength. He also indicated that walking allowed him to let his emotions flow, just as the water in the Thames does. It is movement in the context of his favourite place that leads Paul to reach an ability to manage his experiences. For both Paul and Q, being active, in movement, encourages a coherent mode of thinking and helps to avoid fixation on particular emotions, thoughts or experiences.

Christine and Helen lived within walking distance of their favourite locations while Q and Paul had to rely on public or private transport in order to reach theirs. It seemed

that this proximity to their favourite places, but also perhaps because of the different set of issues they faced, that led Helen and Christine to focus on a more contemplative ‘being’ in the environment through sitting. Due to emphasis on stillness, their actions might appear to some as more passive but only because we tend to assume sitting to be less dynamic than walking.²⁹ Sitting, however, as I show here, can be equally eventful and meaningful as walking.

While sitting on her favourite bench, Christine had a chance to reflect on her experiences in a quiet location, close to, yet, at the same time, at a distance from her everyday existence. She claimed that being between greenery, a cycling path and the riverside provided her with a sense of peacefulness. Time was crucial to this experience, as Christine noted that only a long period spent on the bench led her to feel a sense of the ‘whole world’. Such wholeness, it seemed, required a continual yet paced engagement through observation *of* and *in* a place and it was her motionlessness that allowed Christine more comprehensive engagement with or attunement to the environment. This is also relevant to another important feature, namely, a concurrent ‘natural’ and ‘urban’ character of Christine’s favourite place that encouraged her to reflect on her mental health problems. The realisation of this particular duality of her favourite place led her to become more accepting of her own emotional highs and lows.

Helen used to have her favourite bench but she did not remember whether the bench she was sitting on the day of filming was the same one she sat on in the past. Sitting, however, led Helen to feel a sense of separation from her mental problems as she claimed that observing the world as it passed by in front of her was in itself ‘therapeutic’. In Helen’s case, as in Christine’s, being still was key to this positive experience. More specifically, motionlessness allowed Helen to observe the movements around her – those of other people, animals and plants in the park but also of planes that were coming down towards the nearby airport with a regularity of three-quarters of a minute. This consistency and the predictability of the environment gave Helen clues to abide her experiences and, over time, she became like her favourite place - alternating between motion and peacefulness in her everyday life.

In these moments of sedentary motionlessness Helen and Christine came to accept their emotions and reached sought-after peacefulness. Sitting, however, was nothing short of dynamism, it is just that, in the activities of walking and sitting, movement was played out in different ways, or, we could say, entailed different kinds of attunement. Ultimately, for Helen and Christine sitting constituted the core of their

29 To me it seems that the key difference between the two is that walking and sitting require distinct intensity of the breath which corresponds to different heartbeat, both of which indicate different types of attunement to the environment.

respective interactions with the favourite place, in the same way that walking was key for both Q and Paul.

One extreme take on walking suggests that ‘only those thoughts that come from walking have any value’ (Nietzsche, 1998:34 [1889]). But sitting, as we have seen above, is just as valuable as walking; it can carry analogous meanings and serve similar purposes. Meanwhile Ingold and Vergunst (2008) argue that narrative process necessarily accompanies the activity of walking. What is more, with reference to Bourdieu’s notion of hexis, the authors go on to explain that walking is a form of thinking and feeling. They then invert this metaphor and suggest that ‘thinking and feeling are also ways of walking’ (2008:2) in line with Johnstone’s argument of ‘thinking in movement’, which conceives of walking not as a cognitive process that takes place between the walker’s mind and the environment but as a movement ‘through the world’ (Ingold and Vergunst, 2008; see also Ingold, 2000), one that is not happening on the interfaces of consciousness and environment but one that is all-encompassing (body, mind and environment) and is therefore holistic but also never finished.

Both walking and sitting appeared as catalysts for what my research participants highlighted as a sense of totality/coherence. For Christine and Helen, as they sat on their respective benches, ‘the whole world’ went by in front of their eyes, Paul inverted this experience of totality as walking along the Riverside helped him to escape from ‘everything’, while Q felt ‘on top of the world’ especially after walking through the green tunnel. Through listening to the birds or water, drinking tea or smelling flowers while walking and sitting, my research participants gained a thorough recognition of their favourite places. Such a sense of wholeness could, in turn, be seen as counterbalancing the sense of fragmentation caused by mental health problems.

Illness, we should recall, was often portrayed by my research participants as providing them with the sense of debilitating stagnation and disruption to everyday existence. In the case of the four research participants in Richmond, their attempts to bring life unsettled by mental health problems back on track, whether by registering with a job centre, enjoying freedom after a discharge from a hospital or finding a peaceful location to live in, or spend free time in, led to a discovery of particular places. Meanwhile, walking and sitting in these locations helped in restoring movement in life: becoming into the flow with the surroundings and bringing this flow back to one’s life while also ensuring continuity in moment-to-the-next experience. These activities and the movement they entailed contributed to the resolution to my research participants’ mental health problems, which leads me to suggest that recovery could also be a kind of movement (or stillness) in an environment or, more specifically, a process of attunement to it –becoming *at one* and *as* the surroundings but not the *same* as the environment.

With regard to my participants' practices, we could further observe that their accounts thereof operated according to the properties of language as discussed by Tambiah in reference to Jakobson (1968, see Chapter 4). For example, in their stories, favourite places came to represent metaphorically, or in line with the principle of similarity, their ideas about how their lives could be like. Given the previous argument regarding being-in-environment and the inseparability of environment from its experience, it could be suggested that these characteristics of language created a difference out of what was not previously separate, in so far as they separated, narratively, their experiences from the environment.

However, if we remember Tambiah's argument regarding the closeness of words and actions, or how words anticipate and determine action, then we could see my participants' practices in their favourite places, or attunement, as functioning according to these same principles. Walking seems to have entailed a metaphorical attunement because the environment and activity within it was conceived in terms of similarity: the intensity of the walk matching the intensity of Q's emotions or Paul's thoughts flowing like water in the River Thames. Sitting appeared to be of a more metonymic character in the sense that it involved attunement based on contemplative perception and understanding that come as a result of close observation, being in close contact with and explanation of the whole through focus on fragments, such as Christine's perception of closeness to nature, despite living close to the centre of London. Also there was Helen's following and enjoyment of the regularity of the planes that were coming down towards the airport near her favourite place. Ultimately, it seems that not only words but also actions could have a metaphoric and metonymic character and particularly when words help in orientation in or attunement to the environment.

Importantly, processes of doing (walking or sitting) were accompanied by processes of saying or, more precisely, recording. This is because, as I pointed out earlier, *being* in environment necessarily requires orientation; a process which, we could say, is of an innately narrative-like structure. Accounts of favourite places did not operate at the level of communication only but were, also, inseparable from the experience of being in a place and we could say that, in the context of my research participants' favourite places there was no priority between doing and saying-recording. This is because these two activities constituted part of the same relationship with the environment and complemented each other: narrative-like orientation organised, informed and anticipated actions, while action, as a source of experience, both required an orientation and also provided detail or fodder for the narrative.

Ingold (2000) argued that walking is not an innate capacity but a skill acquired in the same way as cycling: one that encompasses learning through engagement with the surroundings. Everybody who has tried meditation will admit that sitting is also a

skill. Ingold adds that this process of developmental learning or ‘enskillment’ renders walking an essentially social activity but we are also told that this process has real impact on the anatomic constitution of the human and is, thus, a process of transformation of individual in environment.

In this light I see my research participants’ practices of recovery in favourite places as a form of skill acquired through interaction and practice. More precisely, walking and sitting imply a reskillment or learning how to live life anew, where key ramifications are transformation of thoughts, experiences and feelings.³⁰ With time, walking and sitting become enactment of that skill.

The social dimension of recovery

Recovery, as an acquired skill of living rendered possible by activities of sitting and walking, has yet another dimension. So far I have focused on the individual aspect of my research participants’ practices. However their actions in favourite places were also inconspicuously social. Due to physical proximity, Christine’s bench appears to be an unofficial extension to her house, but Christine would always come to her favourite place on her own. She liked, however, to observe walkers passing by and cyclists and added that she might start a conversation with a dog-owner if she felt a need to talk to someone. Helen would also always sit down by herself, and her favourite place allowed her to enjoy the distant company of fellow park-goers while, concurrently, permitting her to enjoy the area on her own.

The other two protagonists sometimes came to their favourite places with other people. Q, for example, visits Richmond Park with his girlfriend, especially during periods when his mental health problems are ‘severe’ and it is difficult for him to leave the house on his own. However, Q claimed he best enjoys being in the park when there are no other people around him. Paul came to the Richmond Riverside with his friends, to sit down on the grass, look at the river and passers-by, drink and play music. Yet, it was only during solitary walks along the banks of the Thames that he could give in to moments of reflections on his problems.

My research participants did not choose ‘solitary confinement’ as a context for their recovery. Conversely they explained that presence in public outdoor places counteracted their senses of loneliness within the four walls of their houses. They attempted to remake their lives alongside other people and not against them, nor in

30 We could perhaps further differentiate between *the skill of walking* (or sitting for that matter) that indicates a long-term learning process, which entails permanent transformation of the bodily as well as a potential and *practice of walking*, as a temporary application of that skill accompanied by thought processes and orientation and, thus, transient transformation of body and mind (the two simultaneously) in action.

their absence, which, in turn, suggests that they conceived of other people as an intrinsic element of their favourite place. It was in these states of ‘undemanding sociality’ of being present and absent in a particular type of environment where social interaction is possible but, at the same time, not required, that the four participants seem to have found an opportunity to gain a perspective on their respective mental health problems and their relationships with others.

With regard to this and the example of discussions on Facebook, it seems that processes of recovery benefit from and are facilitated by sections of environment (or landscapes) that enable, but do not enforce, social contact. Imposed or unavoidable sociality in asylums and hospitals might thus partly explain why in the oral histories these institutions were seen as preventing, rather than enabling, recovery. This assertion of the importance of social context to recovery is also relevant to the accounts of social centres, which I discuss in the following chapter, but for now it leads us to consideration of some analytic approaches to relationships between recovery and environment.

Health and Environment

Studies conducted within the Western biomedical field make generally straightforward, positive associations between green spaces and health. Räikkönen et al. (2012), for example, pointed to the impact of the experience of the environment at an early age on mental health in later stages of life. In similar vein, Depledge et al. (2011) argued that access to natural places, even through a window in a hospital, can aid in processes of recovery while also concluding that restorative influences of natural environments are be observed in cases of both mental and physical health. Mitchell (2012) argues that experimental evidence indicates physical activity in green spaces to be more beneficial to mental health than recreation in other places and, on this basis, claims that frequent activity in natural environments lowers the risk of mental health problems and that access to such spaces is fundamental to recovery. In a similar vein, Barthon and Pretty (2010) evaluated the ‘dose of nature’, here a period of exercise in natural settings, necessary for the improvement in mental health.

All these medical investigations share a teleological assumption of the positive benefits of natural environments to health generally and to mental health specifically. Consequently, they tell us very little about the mechanism of this process in such relationships. We could observe a similar tendency within the field of human geography.³¹

Korpela and Ylén (2007), for example, suggest that for people who reported health issues, visiting natural ‘favourite places’ brought a greater sense of consolation and

31 And also in the Reflections project, an issue to which I return in the conclusion to Chapter 8.

perceived wellbeing. A Danish study claims to have found a direct correlation between access to green spaces and lower rates of stress and obesity (Nielsen & Hansen, 2007). Meanwhile, an investigation in Sweden (de Jong et al. 2012) indicated that particular qualities of green spaces, rather than simple availability, provide a sense of general well-being. Finally, Roe and Aspinall (2011) suggested that walking in non-urban environments is beneficial to people's health generally and, in particular, for people with poor mental health.

Among human geography's better-known studies on the subject of places and recovery is Gesler's work on 'therapeutic landscapes'. Gesler (1993) once defined therapeutic landscapes as:

those changing places, settings, situations, locales, and milieus that encompass both the physical and psychological environments associated with treatment or healing;
(...) reputed to have an enduring reputation for achieving physical, mental, and spiritual healing (Gesler, 1993: 171).

According to this passage, therapeutic landscapes appear to be sections of environment that through concentration of human activity and shared belief come to hold some kind of special healing properties. It is worth noting, then, that, in another work, Gesler also thought of therapeutic landscapes as a kind of 'geographic metaphor for aiding in the understanding of how the healing process works itself out in places' (Gesler; 1992: 743).

However, we should note that without people's actions therein, landscape would never be therapeutic, in fact, without this action, it would never ever be a landscape. Thus, rather than a sum of mutual influences and impacts we could say that therapy, healing or recovery is, at the most fundamental level, a form of integration of 'human' and environment.

Gesler abandoned the term 'therapeutic landscape' in his later work. This, however, did not prevent the coming of a considerable amount of literature that utilised the notion of therapeutic landscape. Originally conceived of in relation to holy sites and places a religious character such as shrines, pilgrimage sites, graves, etc. (*ibid.*) the term therapeutic landscape came to be applied to non-religious places as well (Williams, 1998; Palka, 1999) and even encompassed health-related media propaganda (Scarpaci, 1999). In these works, landscape continued to be conceived as 'promoting' activities related to wellbeing and health. Recently, Cattell et al. (2008) noticed an important shift of focus from extraordinary to more every-day landscapes. However, the emphasis continued to be put on places' properties, qualities or functions that facilitate processes of healing and recovery (see Milligan et al. 2004).

Some studies concerned with therapeutic landscapes, however, do not rely on the straightforward positive associations between places and health. Milligan and Bingley

(2007), for example, argued that access to nature at an early age can produce both positive and negative associations for mental health later in life. The authors point out that, depending on an individual person, some places might have either a negative or a positive impact on health and their conclusions are more in line with Ingold's notion of environment that prioritises action *in* and *becoming* through environment rather than its impact.

Meanwhile, Pinder et al. (2009) suggest that it is impossible to think of categories of health and environment as singular entities and casually to assume simple causalities between the two. The authors explain that visiting a community forest in east London and Essex helped local residents organise the cosmology of their everyday lives, which as we have seen was also the case in my research participants' favourite places. What the study (*ibid.*) also found was that people's relationships with particular green spaces were fluid, rather than fixed. Consequently, the authors concluded that rather than places having an 'effect' on people, the relationship between environment and human health is best understood through people's practices and the associations they make within particular locations.

We have seen that my research participants' increased senses of wellbeing did not come as a result of some innate characteristic of their favourite places, but through activities and reflections on experiences in these contexts, which involved comprehensive bodily, sensual, narrative, reflexive, emotional and social engagements with the environment. Rather than being therapeutic, favourite places in Richmond are sites for the continuous renegotiation of experiences, of transformation, and the reinvention of everyday existence where movement and temporality are fundamental to the activity.

The Role of Time and Temporality

Time, in my research participants' practices, was a signifier of change in the sense that interactions with the place, the attunement to it and reskillment of living through walking and sitting were not immediate but, instead, unfolded gradually. We could colloquially say that 'it takes time' to recognise and realise the potential of environment in health-related practices. Meanwhile, the temporal dimension of recovery could be said to have necessitated my research participants' narrative organisation of their experience.

In our case, time was also a witness to recovery. For example, the current state of the protagonists' mental health reflects their relationships with their favourite places. Q and Christine continue coming to Richmond Park and the Twickenham Riverside respectively as a part of the ongoing processes of managing their experiences. Q's recurring problems require various periods of recovery, which can take between a couple of days and several months. Mental health issues continue to affect Christine

as well, yet she highlighted that coming back to her favourite place provides her with an immediate opportunity to confront troubling experiences. Paul and Helen located their most serious problems in the past yet they still make regular, but not always intentional, visits to their favourite places. Paul continues to come to the Riverside because he simply ‘loves it’ while Helen walks across Marble Hill Park while working nearby, or visiting a local art gallery.

Favourite places were also sites of continuous exploration. For example, on the last day of filming, Paul showed me a passage under the Richmond Bridge that he discovered some days earlier. He was captivated by the acoustics and decided to play his harmonica there, after which we sat down on a nearby bench. A few minutes later Paul declared that the passage is now the best part of his favourite place in Richmond. Paul’s continuous engagement with his favourite place suggests that recovery is not a goal but rather a continuing process.

Such essentially temporal dimensions to practices in environment speak to Ingold’s theoretical understanding of landscape. Landscapes, we should recall, are never finished, due to ongoing human action therein (Ingold, 1993); they are constantly in the making. This is also the case for favourite places as sites of recovery; as my research participants’ health improves or worsens, their relationships with favourite places alter too. On that account, I suggest that the notion of landscapes of mental health, as opposed to ‘therapeutic landscape’, is more fitting to the analysis of favourite places in Richmond, as it points to the temporality of practices of health- and place-making rather than to places’ intrinsic restorative properties.

With regard to Ingold’s consideration of landscape as ‘the world as it is known to those who dwell therein’ (1993:62), I conceive of landscapes of mental health as strategic practices of involvement (of experiences, body, senses and thoughts) in and through favourite places that amount to the increased sense of wellbeing, which, through their grounding in environment, necessarily require personal reflections on meanings of such actions in processes of making sense of experience.

Filming certainly encouraged public articulation of narratives but was not the reason for my research participants’ reflexive considerations of their actions. Instead, bearing in mind Ingold’s proposition that landscape ‘tells – or rather is a story’ (1993:59), we could suggest that my research participants’ practices of making sense of their experiences in and through their favourite place are a form of re-telling how to live. With specific reference to landscapes of mental health we could, thus, say that the success of health-related actions in a place and over time is rendered possible by reflexive consideration of the meanings of experiences invested and emerging from the action in environment. Social situations, such as filming of favourite places, commenting on the TTC Facebook Page or, as we shall see in the following chapter, meetings in social centres all provide possibilities for a narrative reflection on the meanings of health-related actions in these locations.

Conclusion

I have focused on discussion and analysis of my research participants' practices, hoping this would provide the reader with a more comprehensive sense of favourite places in Richmond and account for the complexity of health-related actions unfolding in these contexts. In the conclusion to this chapter I make some remarks about my filmic encounter.

Like activist representations of mental health, the four films about my research participants' favourite places fits in with the tendency of emphasising processes of recovery rather than suffering and presenting illness as something that can be managed and dealt with. This is partly because I felt obliged to produce constructive representations, but mainly because, in their accounts, my research participants focused on the constructive aspect of their experiences.

What sets the four films apart from other activist-made representations discussed is that they present recovery as a practice grounded in the environment in which it takes place. My protagonists did not operate with the all-encompassing notions such as 'mental health' and the reason for this absence is the respective rationale for representation making. More specifically, the four films did not have an explicit intention of bringing about change to social perceptions of understandings, as was the case for other representations; they concentrated on details of recovery processes instead. Such attention to details of experience rendered the films about favourite places relevant to people who themselves suffered from mental health problems, yet also interesting, I hope, to everybody.

Two of my research participants showed an explicit awareness of the films' potential audiences. Helen's narrative, for example, appeared to be carefully planned as, during filming, she expressed herself succinctly, and it was evident from the way she formulated her experiences that she had taken care in the preparation of her story. On the one hand, as *Reflections*' manager, Helen wanted to make her account universally relevant. On the other, knowing that her co-workers and friends would be watching the film, she made a strategic decision in regard to what other people should know about her problems.

Meanwhile, Christine decided to speak directly to the film audience, as she pointed her gaze at the camera and encouraged a sense of responsibility for mental health problems. In particular, she talked about being 'proactive' in making sense of experiences and how outdoor space provided opportunities for doing so. This emphasis might have originated from Christine's training as a counsellor and her will to encourage people actively to engage with mental health issues. Despite such professional engagements Christine did not use any professional jargon.

Notably, all the accounts were largely devoid of medical terminology. Q once referred to himself as a ‘survivor’, a term characteristic of mental health movements in the 1970s and thereafter (Crossley, 2004) but his use of the word did not entail politicised demands characteristic of survivor movements. In describing his experiences, Paul distanced himself from his diagnosis of psychosis by referring to his ‘mental health issue’. Christine mentioned her ‘bipolar condition’ just once throughout the recording. Helen was the only one to talk about ‘being ill and depressed’. She trained as a medical student and in daily conversation she sometimes deployed medical discourses. The protagonists also explained how they deal with their problems. Q makes his mental health problems ‘part of himself’. Christine ‘rationalise(s)’ and ‘take(s) care’ of her ‘condition’. Paul, who sees his issues to be a matter of the past, talked about detaching himself from unwanted experiences. Helen, who like Paul located her issues in the past, ‘distanced’ herself from her problems.

All in all, my research participants’ accounts of favourite places point to a multiplicity of possibilities in which people conceive of and make sense of their experiences of illness. Rather than prioritising effectiveness or unambiguity of message, the films focus on details of experiences and complexity and diversity of health-related practices. In particular, these accounts indicate that mental health problems are not simply a medical matter but a more comprehensive environmental concern.

Although not intentionally aiming to change social understandings and attitudes, these four accounts have a quite explicit activist dimension. First, the films were made as part of the Reflections project, which by documenting diverse experiences brought a possibility for a more exhaustive understanding of the issues in the particular context of Richmond. Second, in line with Cruikshank’s (1998) observation that public telling of stories renders them socially pertinent, we could say that my research participants’ personal accounts of favourite places may be relevant to inhabitants of and visitors to Richmond. More specifically, their stories contribute to the realisation that people deal with their experiences in all kinds of locations and that recovery is not necessarily a medical process. This is also relevant to the discussion of social centres in Richmond in the next chapter where I pay specific attention to practices around mental health in these locations or the social dimension of landscapes of mental health.

Chapter 7

Social Centres in Richmond and Senses of Community

The Timeline of Places

In RBM's Social Centre in Richmond Royal Hospital, Helen, the Reflections project coordinator, Michael, a service user, and Sasha, a volunteer for the organisation, walk quietly around a work surface devised from several tables arranged together. Every few seconds one of the gathered puts a marker pen to A3-sized sheets of thin chalk paper in order to mark a date or an event on a timeline that spans the period from the 1950s to the present, May 2010. From time to time, they look nervously at one of two camcorders I had set up in the opposite corners of the room. Silence is broken only by monosyllabic expressions of pondering as well as distant sounds of steps in another part of the building.



Fig. 24 Screenshot from the film recording made in the RBM Social Centre

A woman enters the room and curiously asks 'what is going on?' Helen responds that they are creating a 'timeline of mental health in Richmond'. She adds that this graphic will help in facilitating research for the Reflections project and that it will also be used during the exhibition in Marble Hill House. As paper gradually becomes less white and more colourful, it appears that the history of mental health in Richmond is grounded in particular locations: mental health hospitals, asylums, social centres and community meeting points. As the majority of dates marked indicate openings, changes to or closings of these establishments, the timeline shows rather clearly that, for its authors, places have a pivotal role in the provision of mental health services.



Fig. 25 Screenshot from the film recording made in the RBM Social Centre

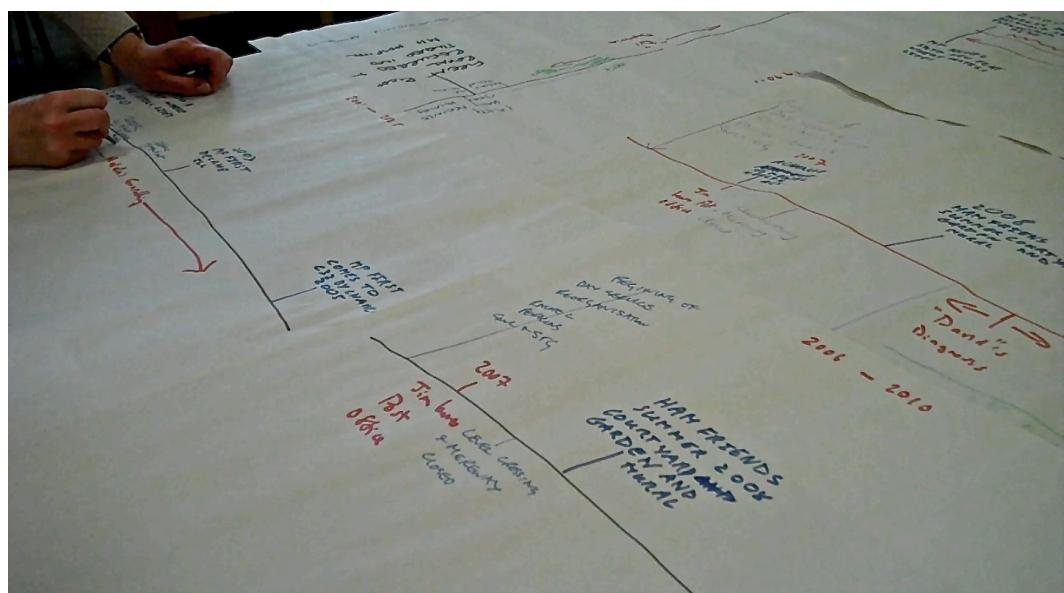


Fig. 26 Screenshot from the film recording made in the RBM Social Centre

A spatialised perception of time and its role in processes of recovery that I discussed in the previous chapter is also relevant to health-related collective practices in the context of social centres, which I focus on in the current section. We have also seen earlier that hospitals and asylums did not elicit positive associations, long-term relationships or senses of community in the ways social centres did and that is why at this point I concentrate only on the latter type of locations as interviewees in oral histories often did not remember or did not want to remember hospitalisation. In short, hospitals and asylums were perceived through the lens of physical confinement as well as limited ability to negotiate one's environment.

Unlike hospitals, social centres emerged in my research participants' accounts as focal points in their lives. These places encourage practices around mental health that are of

a collective kind. In the last chapter I proposed that processes of engagement with favourite places in a drive to recovery could be conceived as personal landscapes of mental health. By focusing on my research participants' accounts as well as ethnographic observations within social centres, this chapter addresses the role of places in dealing with mental health problems collectively.

My focus is on landscapes' collective character and shared experience of mental health problems and recovery, of stigma and discrimination, of using services, their rapid closing and, finally, the ideological and functional changes to the system of services provision in Richmond. As we shall see, the closing of the centres and transformations of services have exposed the sheer importance of attending services to sustaining the continuity in service users' lives. However, termination of old and introduction of new services had also a mobilising effect, as it encouraged new forms of participation grounded in senses of community developed over the years in the context of the centres.

The term community stands for the self-reflexive social senses of belonging articulated by my research participants: service users and RBM employees that I interviewed and/or filmed for the purpose of the documentary as well as those who shared their oral histories. On the basis of these accounts it emerged that the recent transformation of social centres enhanced, or perhaps necessitated, a greater sense of social responsibility, which, in turn, fuelled social action, led to the establishment of new groups both within and outside RBM administration and, ultimately, seems to have strengthened my research participants' senses of community, despite the fact that they did not eagerly embrace these changes.

The first part of the chapter is a journey through four social centres in Richmond Borough that I came to know and filmed while volunteering for the Reflections project. The descriptive character of this section aims to convey the feel for, and the specificity of, particular locations that I hope is helpful for the reader in terms of evoking the environment that mattered to my research participants so greatly. Furthermore, this account is also a form of commemoration of places as the documentary film on the subject was not completed³² and thus similar filmic evidence as presented in the previous chapter cannot be provided. This description is followed by an analysis of interpretations of the social centres and more specifically, I ask why some of my research participants considered socialisation and engagement in prosaic activities in social centres to be fundamental to their recovery, while others, such as some of the RBM workers considered the same activities to be of little benefit. These opposed views seem to have emerged only recently together with financial struggles and resultant withdrawal of services, yet they allow us to understand how places

32 The material for the documentary about social centres was filmed but remained unedited on request of RBM.

where recovery takes place come to be envisaged differently depending on circumstances, position and needs.

Let us start with RB Mind Social Centre in Royal Richmond Hospital, the sole centre that survived the transformations, the only one that functioned throughout the period of the research and the one I visited most often throughout fieldwork.

Social Centre in Royal Richmond Hospital

Located on the ground floor of the Royal Richmond Hospital, Richmond Borough Mind Social Centre³³ encompasses the main social room connected through a window to a spacious industrial-style kitchen as well as several therapy rooms and worker's offices. Although an open space, the social room is divided into designated activity areas. Right by the entrance there are six joined tables covered with neatly organised stacks of magazines, leaflets and newsletters. In these, users can find out about mental health-focused groups, services, campaigns, changes to legislations and a wide range of local issues. For those wishing to spend more time reading there are contemporary paperback novels, old copies of the National Geographic, knitting handbooks, art albums and self-help publications. It was also on these tables that my research participants created timelines of mental health in Richmond. On the right side of the door sits a tired snooker table, an aged but functional piano, computer stations and a sewing machine workshop. At the far end, sofas arranged in a C letter shape face a whiteboard covered in writing and current event dates. Pot plants, a selection of users-made artwork, postcards and knitted hats decorate the room. Large south- and east-facing windows, overlooking a quiet street and an extensive sports playground, let plenty of light in and, if opened, also fresh air.

The Victorian hospital that hosts the Social Centre as well as the Richmond Borough Mind offices functioned as a closed unit until 1997, when a fire damaged the building. Following a successful reconstruction and the addition of an extension, Royal Richmond was reopened as a day-only mental health hospital. Nowadays, it spreads across several older and more contemporary buildings, which create an enclosed but sunny quadrangle. Sections of this courtyard function as a parking lot, while the rest is covered with well-kept greenery that provides a quiet space for workers and visitors to have a coffee and a cigarette. In this area, located near the main entrance, I would often see users converse with each other or, if on their own, relax in silence.

It was also in this garden that my research participants told me of the Social Centre's disadvantaged position within the hospital. On one sunny May day a group of men

³³ I use the capitalised name Social Centre in order to denote *specifically* the RBM Social Centre in Richmond Royal Hospital.

and women explained that they did not want to be labelled mentally ill while walking towards or away from the building. The garden where they were sitting was visible only upon entering the hospital grounds and therefore considered safe to be in. What is more, some of the users who were previously sectioned either here or elsewhere, thought of hospitals as institutionalised environments associated with suffering and illness. Anna, a service user at another RBM centre who refrained from attending the Social Centre for that very reason, also claimed that, unlike other centres, this one lacked a ‘home-like feel’. Her opinion matched those of other users in the garden who described the centre’s ‘clinical’ and ‘sterile’ features, which they connected with the hospital’s intimidating size, and the fact that medical services continued to be provided on site.

Users like Anna tactically avoided the potential stigma originating from being seen in a hospital. Such attitudes towards the hospital point to a seemingly straightforward yet very powerful association between places, health or illness. Places become loaded with characteristics seen as preventing or providing a possibility for recovery. However, just as in the case of favourite places, hospitals or social centres do not have healing qualities in themselves. Instead, people who experience mental health problems in Richmond make informed choices about which places to attend and which ones to avoid. This selection is based upon subjective perceptions, preferences and previous experiences of recovery and environments associated with health and illness (hospitals, social centres, clinics) but, at the same time, practically restricted by the limited number/availability of such places.

Alongside research participants who held unfavourable opinions, there were users who felt extremely positive about the Social Centre. In his oral history, John revealed the significance of visiting the Social Centre to his everyday existence: ‘I had life only when the day centre was running, on other days I was getting completely wasted [drunk]’. Radeem, who initially thought that the Social Centre was ‘dire’, subsequently changed his mind and found it ‘very safe and very comfortable’. He also claimed that the Centre gave him ‘something to look forward to’ and concluded: ‘if it wasn’t for the social centre, chances are I wouldn’t be here’. Like users from all the centres in Richmond and, indeed, service users I met in other fieldsites during research, John and Radeem indicated the possibility for socialising and spending quality time with others as key to their recovery. This leads us to the first characteristic of social centres as places for social contact. Socialising with fellow people suffering from mental health problems was seen by my research participants as necessary for managing their own experiences, and it appears that social centres become associated with recovery through social relationships developed therein.

The Social Centre had also been the headquarters of the Reflections project where volunteers would meet, plan, learn and compromise, so I had the opportunity to observe the changing ambience of this location. At times, the social room would be

filled with laughter and lively conversations. On other occasions, the space would be dominated by close attention, especially during a workshop or creative activities such as art classes. Not once, however, did I encounter any quarrels or arguments between users. This made the Social Centre stand out from other such locations where disputes and disagreements between service users were common. Users at the Vineyard, another RBM centre, explained that the continuous presence of RBM employees might have contributed to a sense that the Social Centre was more controlled and managed than other centres.

All in all, the Social Centre in Royal Richmond might not have suited all the people experiencing mental health problems in the area due to its position within a hospital and the presence of RBM offices. Nonetheless, it constituted a focal meeting point for over 300 users. Just as all other social centres, it was a locus of sociality and, consequently, became associated with a sense of security and stability, considered by my research participants beneficial to recovery. The Social Centre, however, was the only one where such activities continued. All the other centres in Richmond were temporarily or permanently closed. One such place was Ham Friends, a user group that met for the last time in mid-summer 2010.

Ham Friends

On yet another sweltering day of the unexpectedly hot summer, an almost empty local bus finally arrives in Ham, a noticeably less wealthy part of the Borough of Richmond, with extensive council estates, scarce amenities and limited public transport links. People seem to have abandoned the area, as the only motion on the street is that of tree leaves dancing with the wind. From a distance I notice Helen and her fellow RBM employee, Anna, who unloads bags of shopping out of the boot of her car parked in front of a moderately handsome but rundown modernist Baptist church. At the same time, seemingly from nowhere, a group of service users arrive on the site.

As we enter the building that stands solitary on an extensive meadow of concrete, Anna explains that Ham Friends, a mental health-focused group that has been running for over a decade, initially had its own designated premises. Over the last few years, however, users have been meeting in the hall of the church. Its intimidating size and religious décor render it an unlikely venue for a mental health-focused meeting. The users, however, seemingly unbothered by the aesthetics or the original purpose of the place, make themselves comfortable at the far right corner of the hall. They appear accustomed to the space and their casual conversations about everyday issues indicate that they are also familiar with each other. In the adjacent kitchen, Anna prepares Ham Friends' last supper, or given the time of the day, it would be more appropriate to say last lunch: some inexpensive pizzas, crisps, supermarket sandwiches and

snacks. She struggles cutting margarita and pepperoni pizzas into small pieces with a blunt knife, one of the few utensils provided by the congregation.

More people continue to arrive bringing the total number of users present to 12. They are from different backgrounds and of various ethnicities, but, noticeably, all of them are men. The meal is laid on the tables and lunch begins; yet it feels too hot to eat. The situation does not favour filming either, as the camcorder intimidates Anna and several users. Some, on the other hand, are keen to be filmed. Among the enthusiasts is Ron, a cheerful man in his fifties, with salt and pepper-coloured hair that disperses in all directions over his shoulders. Once Helen asks him to sign a film release form, he laughs loudly and announces that he has always wanted to be a model.

Upon my questions regarding the history of the centre, Ron tells me that Ham Friends' former building is located within walking distance from the church. When I ask whether we could visit and film the site, Helen, Ron and another service user, Chris, immediately agree. Within less than five minutes the four of us reach the destination: a tiny one-storey building standing, detached, between run-down council houses. Its windows are concealed behind heavy blinds, and its courtyard surrounded by a tall brick wall and a high metal gate, which boasts an oversized rusty padlock.

Helen explains that the small garden used to be at the heart of the centre, with barbeques, art groups and celebrations. She adds that the garden was once awarded third place in a competition organised by Richmond Borough for the best public green space. A scrappy table, empty plant pots and some rubbish someone must have recklessly thrown over the fence seem indifferent to its former glory.



Fig. 27



Fig. 28



Fig 29

Figs. 27-29 The former garden of the Ham Friends, source: Ham Friend's Archive Folder

Ron recounts that inside the centre there was a computer station, table tennis set and a tiny kitchen where volunteer chef, Peter, used to prepare meals. Chris adds that, on a daily basis, the centre attracted between 15 and 17 users with relaxation sessions being particularly popular. Meanwhile, Helen provides some details on the centre's history. Ham Friends was established by the Borough of Richmond in 1996 as a day centre for local people experiencing mental health problems. At the beginning of the

next decade, RBM took responsibility for provision of services on site. Nine years later the centre was closed due to financial constraints. However, following users' protests, the group was re-established and started meeting in its current location.

A walk around the building reveals its structure to be in seemingly excellent condition and it is surprising to see it not being used. Ron breaks a prolonged period of silence and starts laughing. He recalls that he has lived in the area all his life and, for many years, he had not realised that there was a mental health social centre nearby. He smiles and says how he used to pass the building every day until someone told him about the group.

Suddenly, his mood changes and he remarks on the closing: 'it's sad it had to go [the centre] eventually. It was like a community, you know...'. Helen joins Ron in remembering, and claims that she really enjoyed running the centre: 'it was a very special time for me to be the manager [here]'. In particular, she liked the 'mixture of users, some of them local and others coming to the centre from afar' and the 'variety of experiences people shared with each other'. Following another moment of quiet reflection the three decide to walk back to the church, while I stay around in order to film some cutaways.

Several weeks later I interviewed Katie, a former RBM employee, who used to work across various RBM social centres including Ham Friends. Katie claimed that the centre's compact physical dimensions encouraged a particularly 'friendly atmosphere'. Such positive experiences of proximity to other people contrasts sharply with my research participants' negative memories of spatial confinement in mental health hospitals and indicates that service users were able to enjoy being close to others³⁴ but only in non-limiting and non-controlled spatial settings. Katie also recollected the closing of Ham Friends, and users' attempts to find an alternative meeting place. She expressed awe at 'how people with very difficult experiences (were) so selfless' and, like Ron, she explained people's motivations for their actions: 'they wanted to be a group and look after one another... It was like a family, like a community'.

The notion of community here appears as intrinsically positive and characterised by understanding and vibrancy of engagements and activities, rather like family or, for some users, even substituting for family. This was also the case for another social centre, The Vineyard. Services there were also discontinued by RBM and the centre was closed. However, it was later revived by the church congregation that provided the location, but without the financial support from the organisation.

34 Something they found difficult in the context of institutions.

The Vineyard

With few pedestrians on the streets, early Thursday morning in a residential part of Richmond is considerably quieter than central London or even Richmond Village. Parallel rows of smart residences hidden behind high brick walls allow only for a narrow but convenient shortcut. At the end of this secluded path stand two neighbouring churches, one built in a neo-Gothic and the other in neo-Baroque style. A gathering of approximately 30 people in front of the latter indicates the location of The Vineyard. The group consists of men and women of different ages, and a couple of teenagers too. Many of them are smoking cigarettes; some are finishing cans of beer or cider. One person is leaning against a sign on the wall, which informs that consumption of drugs or alcohol will not be tolerated on the premises.

I squeeze through the crowd and ring the bell, as the centre has not opened yet. Helen lets me into a sizable room with computer stations, tables, lockers, sofas and a pool table. At its far end there is a mural depicting Richmond, its park, bridges, greenery and animals. Unfortunately, because of dim lighting, the artwork is barely visible. Several steps up, there is a bathroom area with showers and washing facilities. In the adjacent café area, food donated by local businesses is ready for sale at a nominal price, £1 for a sandwich, 50 pence for a croissant or a pastry. Another room houses a small, but professional kitchen, where Peter, a volunteer chef, is preparing lunch. Today's main meal, just as usual, will be served upstairs, 'where 'Tony Blair used to play in a band' explains Arthur, The Vineyard's manager.

The door to the centre is opened and service users make themselves comfortable. And comfortable they seem. Some sit by the PCs, others start a game of snooker, one man immediately falls asleep on a sofa. The majority, however, move to a beautifully arranged garden at the back of the building, where they continue smoking cigarettes, laughing and arguing. Although many have been through 'rough times', as one of the employees puts it, the atmosphere is friendly. Not everybody, however, is in a good mood. An older man describes how he has been sleeping rough over the last couple of months, while a younger man is upset because a restraining order prevents him from seeing his two children.

Helen explains that the centre was established in 1977 by the Vineyard Church congregation in cooperation with Richmond and Barnes Mind and dedicated to people experiencing loneliness and, in particular, homelessness. At that time, adds Helen, homelessness was considered a mental illness. However, over the years, the link between the two has weakened as a result of a greater social understanding of both issues and, in consequence, mental health services providers across the country closed many places serving the homeless. This was also the case for RBM, which terminated provision of services at The Vineyard in May 2011, a year after my initial visit.

Despite the distinction between homelessness and mental illness in service provision, the literature points to multiple ways in which these two issues are strongly related. Attempts were made to single out individual risk factors for homelessness among people suffering from mental health problems (Breakey et al., 1989 in Goodman et al., 1991). Goodman et al. (1991) proposed that experiences such as loss of home, conditions in new accommodation or worsening of already existing symptoms amount to trauma. For the authors, who view ‘homelessness as a psychologically traumatic experience’ (1991:1222) and rely on psychological models of mental illness, experience of homelessness trauma is characterised by social disaffiliation and learned helplessness, a point relevant to my discussion below.

In The Vineyard, conversation with services users about homelessness slowly unfolds. Some users seem daunted by their situation, yet, as hours pass, they become more eager to talk about their lives. Instead of focusing on the negative aspects of not having a home, they emphasise the positive experiences of the centre where they are provided with food and the possibility of taking care of their personal hygiene. Their views match those of Debbie, a volunteer at The Vineyard, who claimed during the recording of her oral history that the centre was a ‘safe environment for people to get food, talk, shower’. Yet it appears that the centre is more than just a context for addressing basic everyday needs. Marcus, one of the users, aptly summarises this at the end of our conversation in The Vineyard: ‘it’s like a family here, we’ve known each other for ages, we do stuff together, we argue and this is kinda our home’. Coming to The Vineyard allows users to build this fundamental sense of security and belonging.

During her interview, Katie, a former RBM employee, explained how the spatial arrangement of the centre made such relations possible. In relation to the point she made about Ham Friends’ original location, she claimed ‘size makes a difference’ and went on to explain that the largeness and the multipurpose character of The Vineyard allowed people simultaneously to create their personal places while being able to socialise in the communal spaces. Her explanation reiterated users’ views of the centre as a place aggregating both stability at a personal level and a sense of belonging to a group.

However, The Vineyard’s location within a residential area caused issues. Leo, another user, claimed that some of the local residents, many of them considerably wealthy, were not happy to have The Vineyard as a neighbour. Katie, on the other hand, claimed that ‘social contact can eradicate prejudice’. Although she did not elaborate on the mechanism of this process I understood her assumption to be that the sheer presence of a centre would raise awareness among the neighbouring population. Her view, however, was quite different from that of service users who thought that stigma continues to reside in places, which, as we have seen above, discouraged some of them from attending the Social Centre in Royal Richmond.

More importantly to our account of the centres, social contact was considered to play a major role in the process of addressing and understanding one's mental health problems. Such claims were particularly salient in regard to the last of the RBM social centres - Centre 32.

Centre 32

On a high street of suburban Twickenham, Helen swiftly opens three locks on a door to a two-storey house, number 32. Milkglass windows block the view from the outside to the interior and vice-versa. Sounds of passing cars and of a bus stopping just in front of the building fill up the otherwise completely silent space. A thin layer of dust covers the chaotically arranged chairs and the piles of old magazines that spread across the surface of a low coffee table. The place looks like someone was supposed to come back, but never managed to do so. Helen turns a switch on and the atmosphere brightens up but only for a brief moment, as the light exposes large pieces of plasterwork falling off dusty cream-coloured walls, as well as notices reminding us of activities that used to take place in this now disused social centre. There is a thought-provoking disjunction between its current emptiness and accounts collected during filming and oral histories, in which Centre 32 (C32) was described as a 'positive' and 'spirited' place.

Twickenham Mind started providing services on the site in 1975, in a building leased from the national Mind. Initially, C32 was run by volunteers but increased funding, that followed the statewide introduction of care in the community, allowed for employment of several members of staff. In mid-2009, RBM suddenly closed the centre due to the organisation's difficult financial situation, which caused outrage among users who thought the termination of services was too quick. As service user, Alex, put it in a casual conversation, people felt 'cheated' because they were not consulted about the change. Local newspapers and MPs were involved in order to mediate the escalating conflict, during which it was revealed that C32's building did not belong to RBM but to the national Mind and, therefore, could not be put up for sale as planned.

Consequently, services continued to be provided on a sporadic basis until late February 2010, a couple of weeks before I began volunteering work on the Reflections project. The centre remained closed until June the same year, when peer-led services were introduced. In RBM's attempt to reinvent the place and bring C32 to a symbolic end, the 'Centre 32' sign on the front of the building was painted over. In spite of this, users continued to refer to the centre's original name.

On my second visit the door to the centre was already open, indicating that users of its former services who had agreed to be interviewed for the purpose of the documentary had already arrived. Helen, Paul and three interviewees, Ron, Michelle and Malcolm, sat at the back of the building in what used to be the garden, but has become a storage space. The three users recollected the centre's past: 'All different types of people would come here. With all different types of conditions', explained Ron. Malcolm and Michelle nodded their heads in agreement while Ron continued to say that users could engage in a wide range of activities including art, creative writing, cooking, bingo, karaoke, play and prose readings, monthly quizzes, massages and 'violent Scrabble' - a particularly engaging home-grown version of the popular game. 'Something for everybody', added Michelle, and immediately followed: 'it was a joy to be here!'

While recalling his first visit to the centre, Malcolm said that he felt immediately incorporated into the group: 'it was refreshing to be welcomed somewhere after two years of being at home'. Ron clarified that people who experience mental health problems often feel confined to the 'four walls' of their rooms and houses, or in hospitals. C32 provided an alternative to such domestic or institutional isolation as, accordingly to Malcolm, it was a 'place to go out and not be lonely'. Over time, relationships between users came to be endowed with a 'sense of responsibility' for each other. Ron, who used to keep attendance records and, thus, always knew 'who was having a difficult time' elaborated on this sense:

C32 was our life, really. And we made it a little community – staff and clients together. And we welcomed people with open arms, of any race, religion. We wanted that kind of community. C32 was a community!

Ron's view of C32 duplicated those collected during oral histories where ex-users explained that C32 used to be 'like a small family' or a 'community' which 'people were part of' and that they 'made' over the years of attending the centre.

One person, however, had a diametrically different view on the subject. Juliet, the former manager at C32, and, successively, peer-volunteering officer for RBM, found C32 to be 'unfriendly' and 'not fully open to the community'; although she did acknowledge during her oral history interview that the centre was 'well-established'. One of the issues identified by Juliet was low attendance by female clients, which she tried to address by introducing a women's group. Most problematic, from Juliet's point of view, however, was the apparent lack of purpose of activities happening in the centre. She explained:

Whenever I came here, I was taken aback by this place. Example: you could sit here for five hours, have a cup of tea and chat if you wanted or sit in the corner if you did not want to get involved.

Juliet did not consider chatting, drinking tea or sitting on one's own as productive pursuits. She highlighted the difficulty of assessing the outcomes of such activities and explained that parties supporting RBM financially 'wanted to see some results'. In this situation, Juliet might have had no other choice but to emphasise a necessity for change, and no other way to justify the closing of the centre than by noting an absence of measurable outcomes. Service users, on the other hand, thought that the organisation failed to see the benefits of prosaic activities such as sitting together and drinking tea. For them the closing of C32 disrupted their sense of community and was an abrupt end to an environment that they strongly associated with sociality, safety and certainty.

On Social Centres

Conflicting views about what constitutes a productive or worthwhile activity in social centres point to the divergent ideas about their purpose and, in particular, contrasting expectations about recovery environments that emerged in times of difficulty. Whereas, from the management point of view, activities such as talking and drinking tea might not seem constructive to recovery, as they do not generate enumerable results, from the perspective of users, these activities have very beneficial ramifications. This is because prosaic activities, first, are a basic form of socialisation considered by service users as necessary to processes of recovery and, second, they provide further opportunities for mutual sharing of experiences of mental health problems. To put it another way, regular meetings in a particular location with people who also have experienced mental health problems and engaging in ordinary action was conducive to sharing and discussing illness-narratives and illness-related issues and, consequently, to recovery. This is because externalising and elaborating on the matters of mental illness and health in a social context, just as in the case of the TTC Facebook Page, allowed users to gain a better understanding of their conditions and, as a result, to manage troubling experiences more effectively. Ultimately, my research participants considered socialising and possibilities for sharing experiences vital to their recovery.

As these processes of sharing and discussing experience have unfolded over time, in some cases over several decades, related senses of group belonging have also emerged. These were pronounced by my research participants in Richmond to be communities. In a most basic sense we could view these communities as groups of people affected by mental health problems who engage in a range of health-related practices within specific locations. It is not the experience of mental health problems, however, that serves as the foundation for these senses of belonging, but the ongoing experience of recovery. This is because claims to community were made only once practices of realisation and sharing of experiences took place. These communities are, thus, not communities of the mentally ill but of people who do, or who attempt to,

recover from mental health problems. They are communities of people who, in a collective context, take an active role in remaking their personal mental health and, by doing so, also participate in the improvement of the mental health of others.

Furthermore, it is the continuing process of recuperating from ill health rather than achievement of recovery that sustains such groups, as those who fully recovered would stop attending the centres and sometimes cut ties with the group.³⁵ Membership of these communities is, thus, temporary, strategic and conditional. Temporary, because one enters the group for an unspecified period of time, conditional, as one needs experience of mental health problems in order to join, and strategic, as one comes to a centre with an explicit aim to address one's mental health problems and to recover.

It was, among others, Cohen (1985) who argued that one of the most effective ways of understanding communities is to examine the subjective experience of community membership. The universal feature of that experience, argues the author, is in making and/or sustaining community boundaries. Cohen further explains that such boundaries often have a symbolic character and might exist in sheer differences between particular communities. In our case, the boundaries appear to be quintessentially physical since communities became associated with the social centres and their buildings, and we have seen already that closing the centres, according to users, disrupted their senses of community.

However, since they managed to find other locations for their activities it is clear that senses of belonging to a community are not merely defined by boundaries, but emerge alongside (but not as a result) of processes of boundary-making. Boundaries might temporarily fix senses of communities in particular locations yet, in special circumstances, these senses and boundaries are also transferable. Thus in our case, community boundaries appear to be established and re-created along the lines of community membership, which is a minor yet crucial point for better a understanding of practices that reinterpret Cohen's original argument.

Another point made by Cohen relevant to the discussion is that of communities' self-made exclusivity and, more specifically, that communities define themselves through boundaries and, concurrently, against other communities. In Richmond, the majority of users would attend services only at one centre and, consequently, they would consider themselves as members of a community meeting in that given location. Users might have held negative opinions about other centres, in particular, about the Social Centre in Royal Richmond, because of the association with the hospital and/or

35 In Richmond, former service users who felt that they were 'further down the road to full recovery' organised an independent meeting group outside of the centre. At the same time those who have recovered sometimes came back as volunteers and staff.

the presence of RBM offices, and about The Vineyard, due to prevailing stigma against homelessness. In that sense, for some users, their choice of which centre to attend was based around perceived characteristics of other groups.

At the same time, however, membership was not limited to one group only, as several users would attend services at various centres. Ron, for example, felt part of C32, Ham Friends as well as TAO, a self-organised meeting and support group in Twickenham (see Chapters 2 and 8). Meanwhile Paul, who attended all the centres in Richmond, always highlighted their positive, distinctive features and for him membership in such kinds of communities seemed to be negotiable and fluid.

Although there was a sense of separateness, communities of service users existed parallel to each other and did not define themselves against each other or other groups. Community boundaries were, as we have seen, constructed in relation to the social relations taking place therein but not necessarily in active opposition to the boundaries of other communities or other locations.³⁶ It is not just boundaries that constitute communities but processes of boundary creation and maintenance. Instead, boundaries and communities delineated by them could be seen not only as symbolic, but as homologous forms of experiential-ideological by-products of human activity in particular locations. Communities discussed in this chapter arise when activity acquires greater social relevance/meaning and leads to perceived beneficial results that, consequently, become associated with its locations and fall within the boundaries of its location.

In terms of the composition of the groups, research participants often claimed that their communities included a variety of different people and that diversity of experiences brought to the group contributed to communities' vibrancy and openness. Other research participants, such as Juliet, C32's ex-manager, suggested that men would occasionally constitute the majority or entirety of groups, which, in her eyes, would render groups exclusive. I have indeed encountered men-only meetings in Richmond although during only one of my numerous visits, more specifically, on the closing day of Ham Friends. Still, Juliet might have had a point with regard to the past when more centres were opened and possibilities for men-only or women-only meetings were available.³⁷ What my research participants' accounts do tell us is that, subjectively, service users considered their communities to be open, inclusive, and, generally speaking, cohesive, regardless of gender, ethnicity or social status and in spite of arguments or disagreements that took place in the centres.

36 This could be due to the abovementioned temporal, strategic and conditional character of these communities

37 Due to insufficient data, consideration of such gendered division of groups would be purely speculative and, therefore, is not included in the analysis.

Amit and Rapport (2002) warned of a tendency in social sciences to produce romanticised portrayals of communities that depict people living harmoniously, particularly when it comes to communities situated in singular locations and, consequently, suggested that it is more important to focus on the dynamics of communities rather than on their apparent or perceived unity. The case of social centres might add to the argument made by the authors in the sense that it shows that communities portray themselves as unified in the same way that anthropologists or sociologists might do. Scientists and communities, however, might be doing so for different reasons: the former for analytic coherence and the latter for strategic, political, economic or prestige reasons. In the case of C32, for example, users might have emphasised the positive rather than negative aspects of the group in the hope that their centre would be reopened.

In the same volume, Amit (2002) discussed an example of an Armenian diaspora in London, a community that became integrated not through the experience of closeness but, on the contrary, through the experience of dispersal as well as practices of making a shared history. In the instance discussed by the author, experiences that underlie social relations, which lead to the formation of communities, are, at the same time, diverse and homologous – here not identical but of similar kinds and, thus, leading to similar life-experiences. Users who came to social centres had experienced different illnesses or disorders, yet, at the same time, they all had, to a smaller or greater extent, come up against stigma, discrimination, loneliness and a sense of hopelessness, all of which co-constituted the experience of mental health problems.

These common experiences established grounds for discussion and, I was told, led to understanding and recovery. However, at the same time, dissimilarities in experiences, severity of illness, various expectations of a centre and, more generally, different views and opinions fuelled quarrels and conflicts. In her oral history, Lady, who attended C32 for many years, explained that the centre ‘could be volatile at times’. During the interview in C32’s garden, Malcolm also discussed conflicts as a ‘natural’ element of the everyday functioning in the centre. Both he and Lady agreed that members of the group argued, but it was a group responsibility to maintain lasting order and ‘make sure no one got hurt’.

Discord was characteristic of the mental health social centre in Norfolk, UK discussed in Parr’s (2000) ethnography. In her example from the late 1990s, service users created and executed norms of acceptable behaviour, which excluded a severely ill individual from attending the social centre. One of Parr’s conclusions was that the social centre was ‘not an organic (...) location for the expression of difference, but rather (...) infused with a dynamic collaboration which allows for difference to be expressed’ (Parr, 2000: 231), although only to what users considered to be an appropriate extent. My interpretation of this argument is that it is not any particular

quality of a place but it is rather the people who establish a context in which various experiences can or cannot be formulated and told.

In the case of the RBM social centres I did hear about occasional exclusions from the centres, but these were very infrequent, while decisions to bar a user from attending the centre were always made by the management who might have been obliged to do so by specific regulations and policies. This, I suppose, might have also been the case in the social centre discussed by Parr (2000), although the author's analysis suggests that her research participants excluded a fellow user because his behaviour was too reminiscent of what the rest of the group was trying to avoid. My point, however, goes in a slightly different direction.

As the accounts above have shown, users organised and managed the spatial settings of centres according to their preferences, where arguing and disagreement was just one of the features they thought was acceptable. I mentioned earlier that some people chose not to attend the Social Centre in Royal Richmond due to a perceived aura of control supposedly generated by the presence of RBM offices and numerous employees, and also because there were no arguments or quarrels. I also explained that service users enjoyed personalising particular spaces within social centres and that the ability to modulate a space symbolises a possibility for control over one's mental health problems. Such negotiation of experience through environment was possible in favourite places and in social centres but not available in hospital or people's homes and we should be able to see more clearly by now why some places came to be associated with recovery and others did not. As such we could see arguments and discord as giving users a sense that they were in control of their settings while also giving extra vibrancy to the group.

Given that helplessness is inherent to traumatic experiences (Goodman, 1991) and that falling ill is sometimes conceived as losing control (see Chapter 5) it becomes intelligible why coming to social centres was seen by my research participants as conducive to recuperation of health, especially vis-à-vis other places, such as medical institutions, where the process of recovery was dictated and enforced by medical staff and remained beyond the control of an individual/patient. While the development of senses of belonging was unlikely in the controlled medical settings of a hospital or asylum, communal making of space in social centres led to the establishment of social relations from which reported senses of wellbeing and community have emerged.

As I noted in Chapter 1, deinstitutionalisation created a completely new spatial dimension for mental health care. We have seen that in these new spatial milieus, underpinned by notions of community, responsibility for health and illness has also been transformed. Echoing Kearns (1993) who talked about a 'reformed post-medical geography of health', Parr saw mental health social centres that took the duties from the hospitals as new 'post-medical geographies of care' (1998) highlighting the

inherently spatial character of the transformations such as care in the community. Meanwhile, Williams (2002) considers ‘changing geographies of care’.

The latter author focuses on residential homes as new loci of recovery from mental health problems. More specifically, with reference to deinstitutionalisation in Canada, Williams explained that home was seen by the state as the preferred environment for the provision of care, especially due to the availability of informal carers, here, the family. However, Williams also notes that the changing demographic structure of society enforced a greater need for formal, paid care.

It has been suggested that provision of suitable housing as part of community care programmes in the UK was never accomplished (Bochel et al., 1999) and, consequently, many discharged patients experienced issues with accommodation. A similar point was made in the oral histories collected for Reflections, which revealed that recurring mental health problems were related to uncertainty in regard to housing. Meanwhile, social centres, The Vineyard in particular, provided users of its services with that nominal sense of home where it was possible to take care of basic needs such as food, temporary shelter and hygiene as well as providing a sense of stability. At the same time, my research participants in Richmond also associated their homes with loneliness, immobility and stagnation and talked about an inability to ‘feel at home’ in their private or state accommodation. In contrast, social centres provided a counterbalance to that ‘four-wall’ loneliness.

All of this shows that my research participants made divergent analogies between home and social centres, which also exposed multiple associations made between health and particular places. These were dependent on an individual’s situation, experience and preference. What is more, these various perceptions challenge an underlying assumption made by legislators responsible for the emergence of the post-asylum mental health care as well as in the literature (Goodman et al. 1991) that home, as opposed to a hospital or asylum, is an environment necessarily conducive to recovery.

Williams noted a recent upsurge in recognition of ‘place as a dynamic element in health and healing’ (Williams, A.; 2002: 148) in academia, medical practice and beyond, but indicated that more research is required, in particular into the informal settings of caregiving in the home. In this work it was suggested that the notion of therapeutic landscapes might be useful in this endeavour. Williams claimed to have gone beyond ‘nominal’ and ‘positivist’ approaches and emphasised the fundamental importance of subjective experiences to understanding therapeutic landscapes. However, by proposing the change of focus from treatment (Gesler’s original idea of landscapes as having healing properties) to prevention (landscapes as places promoting and sustaining health), Williams offered only a different re-arrangement of health-place relationships; one that continues to focus on positive, albeit subjective,

experiences within the beneficial influence of a place, and not on active practices of co-constituting health- and place-making.

In line with the argument made in the previous chapter and the evidence present here, I believe the proposal for place-health relationships that limits the emphasis to the impact of places to be unsustainable. This is because such a ‘socio-ecological model of health’ (Williams, A. 1998, 2002) continues to rely on the idea of the health promoting qualities of particular places while leaving little space for what in my research participants’ practices appeared as pivotal to recovery, that is, the ability to engage actively with the environment in which it takes place.

What also emerged from the fieldwork was that, although my research participants do think of their practices around health in spatial terms, they interpreted spaces in which recovery occurs contextually. Divergent analogies made between social centres and home, for example, show the variety of ways in which social centres were thought of by service users depending on their circumstances. Another example that calls into question the essential characteristics of places is the association between social centres and stigma. Users felt stigmatised and labelled while entering the Social Centre in Royal Richmond. Conversely, Katie thought that the presence of a social centre in the neighbourhood would lead to eradication of stigma through its sheer presence. Such divergent associations of particular places with health, illness or stigma suggest that places do not have inherent qualities. However, they do become characterised in line with personal perceptions of their functions and activity taking place therein. What is more, affixing particular characteristics to a place might, for example, perpetuate stigma.

Users became accustomed to the locations in which they attended services. This was partly due to practical reasons, such as a convenient bus route or, for users disliking public transport, the ability to reach a particular centre by foot. Attachment to and familiarity with particular places seemed to be deeply rooted as new groups started to meet either in the same locations (The Vineyard) or in proximity to the initial location (see discussion of Together As One [TAO] in the following chapter). Other characteristics of the places, such as the aesthetics, however, could be compromised with or, as Michael, one of service users, put it with regard to the church where Ham Friends were meeting: ‘better here than nowhere’. What did count, however, was the capacity to make a centre their own as well as the possibility of a variety of activities and different options for socialisation. It appears, then, that this versatility of social centres, as well as an outdoor space such as a garden, were advantageous to social interactions that facilitated senses of health.

Social centres as landscapes of mental health

Interestingly, in their descriptions of the centres, users sometimes employed spatial metaphors to describe their experiences therein. For Jonathan, C32 provided a ‘new positive dimension’ to a lonely life, while Mark claimed that spending time with other users in the centre rendered it ‘a good environment to stimulate recovery’. Such explanations that see recovery practices as actions unfolding in particular locations over a period of time bring us back to the notion of landscapes of mental health. We have seen that the landscapes of social centres are made through a complex web of individual motivations and experiences that inform, inspire or necessitate social actions and relations. With time, these landscapes led to associations of particular places to recovery as well as senses of belonging, here, community. These senses of community, I suggest, manifest the temporal character of these landscapes.

The difference between the two kinds of landscapes of mental health discussed here and in the previous chapters is in the process of their making and, in particular, in the forms of recovery embarked on in their context. Whereas in the case of favourite places, recovery was a form of negotiation and making sense of experience through practices, including sitting, walking and narrative within the realm of the normally solitary experience, sharing of experiences in social centres showed the inherently collective character of recovery processes where experience was the source of understanding between users, but also of arguments and quarrels and other features of social relations.

The key similarity between these collective and individual landscapes of mental health seems to be in the fundamental importance of place to recovery and in the temporality of action. Or in other words, we could suggest that the capacity to recover in the context of a particular location is conditioned on active and sustained engagement with, and embracement of, this place and its characteristics.

However, these landscapes are not relevant to all and, for example, some people did not attend social centres because the felt meeting others in that context would not help them. Others (namely RBM employees), as we shall see in the next chapter, did not see the interactions or conversations between users as facilitating recovery. Thus, in order to consider these collective landscapes of mental health more fully, it is necessary also to investigate new projects that followed the shutting down of social centres. These disruptions, although considered by my research participants as acute to their senses of community, turned out to be temporary because users mobilised in two distinct ways.

First, peer-led or peer-volunteer services were started. The principle of this project was to engage current service users in participating in the provision of new services, as trained volunteers gradually replaced paid staff and took responsibility for running

services. Second, some of the users created their own independent project. Called Together as One, this self-organised group started to meet in a rented hall of a Baptist church located approximately 100 yards away from the closed down Centre 32.

I consider TAO and peer-volunteering in more detail in the following chapter where the descriptive accounts of these two projects leads to discussion of one of the main concerns of both the Reflections project and of the research, that is, the recent transformation of services and, by extension, contemporary forms of participation in mental health-related action in Richmond. We shall see in the accounts of transformations that users and employees saw them differently, with the former emphasising the need for greater informality, and the latter for more structure. What is more, these different understandings of the benefits and drawbacks of new options seem to relate to different notions of recovery.

Chapter 8

The Meaning of Change

In the former garden of Centre 32, Michelle, Ron and Malcolm, who all decided to join the peer-volunteering programme, reflected on their experiences. Ron, in particular, was eager to explain the reasons behind his participation in the project: ‘it makes you responsible for other people and it also improves your confidence’. For him, the situation was clear: peer-volunteering is about two things: taking care of other people and faith in oneself. Given that Ron claimed earlier that recovery is ‘a belief in what you can do’ and that mental illness is often characterised by a sense of helplessness (Goodman et al, 1991) we can see how, in the context of social centres and changes to services, responsibility underpinning action and processes of recovery came to be closely interlinked and, at the level of motivations, somewhat inseparable.

Michelle focused on the practical preparation for peer-volunteering. She claimed that the atmosphere during the training organised by RBM was ‘extremely positive’. Malcolm agreed and added that ‘we got on well’, even though he thought the first days were ‘tense’ and the training room was ‘too small’ to accommodate 14 people. He explained that trainee volunteers were given a chance to talk openly about their problems in the presence of each other. The three volunteers highlighted other ways in which they benefited personally from participating in the project. For example, they appreciated that the training was free of charge and that it included first aid, food handling and hygiene workshops. They saw the additional skills gained as increasing their employability in a period of high unemployment and competition for jobs. Michelle also highlighted that as a result of the training she learnt how to remain more calm and assertive in challenging situations.

However, the three volunteers expressed some criticism. For example, Malcolm was unhappy with the intensity of the training, claiming that ‘learning is not instant’. He argued that the course should have been spread over a longer period of time and that it lacked a practical aspect. Malcolm concluded by claiming that ‘one needs experience in order to run services’, hinting at the difference between the experience of using and the running of mental health services. This difference, however, appeared to be blurred in practice as I had the opportunity to find out several weeks after the interview, while filming one of RBM’s first peer-led groups as part of the Reflections project.

At a peer-led group in the former C32

In the building of former C32, ten members of a recently established art group led by peer volunteer, Martha, sit at a large table covered with books, magazines and art materials. The group consists of both men and women of different ages and next to each person sits a cup of tea or coffee. Users seem to know each other well and the atmosphere appears to be friendly and leisurely. Since there is no particular theme or creative technique, each person creates a very different piece of art. One woman paints the landscape around Richmond Bridge while another glues blue sequins within

an outline of a fish drawn onto a white sheet of paper. As I begin to film, service users continue working and chatting, seemingly undisturbed. They are very supportive of each other's work, exchange some tips about how to use the materials and remarks on the accuracy of their representations.

Encouraged by some of my questions, users gathered in the centre reflect on their participation in the group. Some comments are fairly general, with Jack, for example, claiming that 'art as a medium of communication is important'. Others provide insight into the dynamics of the group. Becky says that she appreciates the informal and relaxed atmosphere while Siobhan is fast to identify the reasons for this atmosphere: 'people are nice to each other and they care'. Becky agrees and adds that the group is non-judgmental. This assertion is echoed in Tom's recognition that he is 'not very good with drawing' but that he enjoys being with others and watching fellow members at work. Debbie agrees, and says that being encouraged to do her best makes her happy. She concludes that the understanding among the members of the group derives from their respective experience of mental health problems which they discuss with each other while working on their art. During the conversation, Joanna makes an interesting link between sharing experiences and the process of recovery: 'the group certainly has a therapeutic aspect to it'. James expands on this association and concludes that 'freedom of expression at an ordinary level' is 'translated' into a 'sense of freedom' from mental health problems.

It could be suggested that groups focused on particular activities, such as painting in this example, provided a possibility for undemanding sociality. This is because users could focus on doing something rather than only on their experiences. The sharing of experiences, however, seemed unavoidable, whilst the benefits of participation in a group were interpreted as benefits to health at an individual level. In short, from the perspective of users, participation in a peer-led group and in casual conversations in social centres was perceived as bringing the same beneficial result. The key difference between former and previous meetings was, thus, in the organisational aspect and, specifically, in the person who oversaw the activity.

I ask Martha, the peer-volunteer, how she prepares for the session and how she feels about managing the group. She is reluctant to answer and, instead, explains she is 'keen about the colours'. Following a long pause, Martha adds that 'all goes well' and explains that while Jo, another service user, and she come up with ideas, the group will be focusing on 'freestyle' drawing. With time, they are planning to specialise in particular techniques. Martha pauses then, suddenly, stands up and disappears to the kitchen. I sense that she might find questions about running the group challenging, as the answers may reveal the unstructured character of the meetings. Martha might have also found the situation of overseeing the group to be stressful, as it was only the second time they had met, and there was a weight of responsibility on her shoulders.

It seemed, however, that volunteers found their new engagements to be rewarding and a positive experience. For example, during her oral history recording, Rhona, another peer-volunteer, explained that peer-volunteering provided her with ‘a sense of wellbeing’ and added: ‘it makes me feel good about myself’. Another peer-volunteer, Radeem, derived satisfaction from ‘a sense of giving something back’. Meanwhile, Ron explained that ‘keeping it [the services] running for other people (...) kept me better than anything else’. Their opinions reiterated that putting a sense of responsibility into action became a way of improving self-perception and, in general, it seemed to have led to an improvement of the volunteers’ mental health. Still, one needed to be healthy enough in the first place in order to participate in the training, while recurring mental health problems might have prevented volunteers from the running of services on a continuous basis. To summarise briefly: users and management shared convergent views regarding individual responsibility, but there was a noticeable distance between their perspectives in relation to the primacy given to the individual versus the collective dimension of action.

Despite the initially optimistic outlook presented by research participants, not everybody was content with the new system. Maria, who used to run art groups at RBM’s social centres as a paid worker, explained during her oral history that services have declined as a result of the introduction of peer-volunteering. She did not explain why she thought so, yet, in her account, she repeatedly emphasised a need for qualifications, indicating that services cannot be sustained without professional knowledge or training. Lady also did not appreciate the new services: ‘It wasn’t the set up it is now! It is almost irrelevant; it wasn’t used in the same way as it is now. I might just skip now’. Lady was among those who did not enjoy structured meetings and preferred more casual and less focused social interactions. Ron provided further insight:

Instead of having a drop-in where people can just go and chill, now you have to go to a centre where you have to do a group. And some people can’t do that! They struggle in that kind of field. They might not be well enough to do something. That’s where it’s changed a hell of a lot.

Ron’s explanation further substantiates the point that illness might prevent you from participating in structured activities, whether as a service user or a peer-volunteer. Meanwhile, recent changes to RBM services focused on giving structure to users’ lives while also putting greater emphasis on individual responsibility for mental health. The questions regarding these transformations were asked during oral histories, but my research participants would often discuss the subject in their conversations with each other or with me. In his oral history, Robert gave the following explanation:

they are moving away from the centres, where people tended to just go, to sit and chat. Now they are trying to get away from that, get people into volunteering, getting people to be more independent.

In his elaboration of these developments Ron returned to the issue of purposeful activities:

it's more focused on recovery-kind of situations, you tryin' keep 'em [service users] making do something, rather than them coming having a cup of tea and have a chat and communicate, you know! (...) The government want [sic!] more recovery programs, rather than go and sit down and have a cup of tea.

Ron concluded that the current situation considerably changed the settings in which people suffering from mental health problems recover, and pointed to the further shift of services' emphasis towards greater structure and measurable outcomes. In her account, Juliet, the peer-volunteering coordinator, praised the very same rationale:

the idea is to go much broader, much wider (...) for old clients to meet new people and the idea is that you can do more than just drink coffee. We are looking at a bigger picture [and] giving people confidence.

This 'bigger picture' was to be drawn through 'recovery support', that is, new forms of services that encompassed individual coaching sessions, assistance in finding employment and help with managing day-to-day issues such as bureaucracy, accommodation or payment of bills. Christine, another RBM employee, described these developments as 'helping people to achieve their aims and aspirations but not doing things for them, just giving them a slight push' and 'getting people into the mainstream'. Her account pointed to the increasing importance of individual responsibility for one's own mental health in the context of both services and everyday life situations. Service users did, indeed, talk about these new ventures, and, particularly, about life coaching sessions as 'helpful', yet it was Christine herself who, as a recovery support worker, pointed to a need for change:

from clients I had one-to-one [sessions] with, they wanted more out of life, they wanted to progress, they wanted to know 'why I cannot do that', or 'what can you help me to progress'. They want something else to be their life.

Recent services developments in Richmond were underpinned by two viewpoints. One of them, maintained by the management, emphasised a need for more structure, purpose and palpable results in services, while the other, that of service users, showed a preference for less formal and organised settings. From the perspective of the management, new services were 'extremely difficult' to implement because of users' reluctance to embrace the new approach. This difficulty, however, was the result of different ideas with regard to recovery, with users emphasising the social goal, and the

management the individual goal. Juliet, former C32 manager, admitted that ‘clients were afraid of change [both to services but also more generally]’ but added that people who resented the transformations most vocally in the first place eventually agreed to take part in the training, and became peer volunteers.

I suggest that this was because people who were willing openly to voice their concerns in the first place were also those most likely to participate in new projects. One thing that the users and the management seemed to agree on was the anxiety regarding recent developments. Michelle, for example, felt ‘nervous about change [of services]’. Questions about transformations of services also inspired consideration of change more generally. Nathan, for example, claimed that ‘change is a difficult thing for people with mental health problems’. Ron, yet again, provided a down-to-earth summary of the issue: ‘you know, with mental health, change is not a good thing but it is inevitable’.

Ultimately, some users’ fear of change was superseded by a willingness to help, as they decided to take responsibility for running services for others. These decisions were grounded in senses of community that had developed in the now closed social centres. However, we should also note that this responsibility was effectively necessitated by the situation in which the choice was either participating, or having to rely on the few services that were left.

The example of a self-organised mental health support group I discuss below shows that some were not ready for such ordered and predetermined solutions and, consequently, chose not to participate. The group’s choice of the site for a meeting was a church in Twickenham Green positioned nearby the former Centre 32. It is worth noting at this point that only users of this centre were able to mobilise and to open a group on their own. Ham Friends had relatively few members and some of them came to C32 anyway, while users at The Vineyard simply did not have access to resources, financial, social or other, that would allow them to open and run a group independently.

Together as One

On a sunny spring day 60 people gather for TAO’s first annual meeting. The church’s hall is the liveliest I have ever seen it. Members of the group face a long table covered with a white piece of fabric behind which sit seven people, including David, TAO’s informal leader, Ron and the Mayor of Richmond. The mayor’s presence in person adds considerable splendour to the event. As the official part of the meeting begins, David opens with an assertion that the continuation and potential expansion of the group is dependent on a new strategy of operation. If TAO is to approach new sources of funding, he explains, it needs to formalise its status and become a charity.

‘Finances are fundamental to the survival of the group’, claims David. Ron, who is the TAO trustee who is responsible for the budget, is not feeling well. As he is half asleep with his head between his arms on the table, David reads out the outgoings and receipts on his behalf. These are equal amounts of just over £10,000. Payments include small-scale expenditures such as £2.99 for a comments book and £11 for a blackboard, as well as major expenses such as the rent for the hall, which is almost £4,500. Meanwhile the income is declared to include a £5,000 grant from Grassroots³⁸ and much smaller, but pivotal to the functioning of the group, as in contributions, donated by a local rotary club, funds collected during food and clothing sales as well as earnings from local fairs and events.

David also breaks the news that three separate organisations recently donated a sum of £6,000 in total. In response, a wave of cheerful appreciation fills the hall. Subsequently, David reads out the Annual Report where it is explained that over the last year, 120 people attended at least one of the two weekly meetings. TAO also developed links with other organisations. A local theatre expressed interest in supporting the group’s next project, while a nearby cinema decided to make free tickets available to the members. TAO also attempted to expand its outreach, as a new group was set up in East Twickenham. However, despite a successful start, the project was abandoned due to gradually decreasing attendance and lack of resources.

The annual report is followed by the Mayor’s speech and a vote on changing the organisation’s constitution that would allow TAO to become a charity. The motion passes with unanimous support, but it seems that there is simply no other choice for the group than further to legalise and professionalise its status. As usual, I leave TAO’s meeting impressed with its members’ determination, commitment and willingness to support each other. Yet I am also concerned about how the bureaucratic reorganisation might affect the group. On the train back home, I study TAO’s annual report in more detail. It contains one sentence that clearly delineates the group’s aim: ‘TAO objectives are to provide a safe place for mental health users (...) and to provide for anyone else in the local community who suffers from social isolation’.

This statement shows very clearly that from the perspective of those affected by mental health problems, a location and social contact are fundamental in their processes of recovery. This is in the sense that a place can constitute a context for meeting with others, for sharing experiences and for counteracting loneliness – all of which, as reported by my research participants, lead to senses of stability, security and structure. In contrast to this, one-to-one sessions and individual recovery-support promoted by Richmond Borough Mind through its new services might have helped users to become better at fulfilling their duties, such as paying bills or finding an employment but, from the perspective of people affected, these new projects did not aim at users’ lives becoming more socially vibrant and less lonely. We could perhaps

38 A charity providing funds to a variety of grassroots projects and enterprises.

note that even part-time employment would also allow for socialisation and meeting with other people, although in a different capacity. However, at that time there were very few employment opportunities, the best example of this being the replacement of paid positions with peer volunteers. What is more, it was suggested in a number of oral histories that stigma towards mental illness in the workplace was widespread and persistent.

Accounting for the transformation of services

The difficult situation of public services across the UK, rooted in the fiscal crisis that started in 2008 and resulting in spending cuts that also affected Richmond necessitated some of the service users to become concerned with bureaucratic, structural and financial dimensions of service provision; this effectively made them partly or fully responsible for the new places for recovery.

My account points to several issues with this novel framework. For example, users might not be well enough to run services continually, as was the case with Ron, who was not able to fulfil his duties as TAO's trustee. Furthermore, efforts in the direction of what organisations saw as more intentional and result-oriented activities are not likely to match with some of the service users' expectations and needs. First, recovery will be difficult to assess because of varying perspectives on what recovery means (i.e. what amounts to 'full recovery'?). Second, recovery might be impossible due to the recurring character of some mental health problems. Finally, the example of the peer-led art class shows that interpretations of the purpose of meeting and, consequently, understandings of recovery might differ. Here too the organisation's outlook on the situation that emphasised the necessity for a particular activity, was at odds with that of users who did not consider art practice to have a therapeutic effect in itself but, instead, highlighted the importance of social contact and mutual understanding.

One of the relevant assertions coming from the field is that we should consider locations where services are provided not as beneficial to health per se (i.e. a social centre as conducive to recovery) but as offering opportunities for people to take an active role in their process of recovery and to counteract experiences that are associated with mental health, such as loneliness. Given the data presented above, it would, thus, be advantageous for service providers to recognise that the dynamics and results of these actions are not universal. Finally, when reorganising services, a fundamental question could be asked: whether and how would the change be embraced by those affected, viz. the service users?

With greater emphasis on service users' proactive role in the management of their mental health problems and everyday life more generally, we could say that the

transformations of services in Richmond offered a model of recovery centred around individual responsibility for mental health and, thus, partly reminiscent of the activist discourses of universal mental health. What seems to be absent from this new modus operandi, vis-à-vis the activist outlook, is the collective dimension of recovery practice. To some extent, these recent changes are a continuation of earlier trends in the modifications of mental health services in the UK. Parr (2000) argued that as a result of deinstitutionalisation and introduction of care in the community, the very basic structure of recovery environment has changed from a highly medicalised to a more informal one. With time, however, social centres became less grassroots and more institutionalised, something Parr, borrowing from Wolch, saw as the spreading of the ‘shadow state apparatus’.

According to Wolch the shadow state carries out welfare state functions, providing essential human services, financial and in-kind benefits and surveillance of clients. In these activities, it is enabled, regulated and subsidised by the state (Wolch, 1990: 41 in Parr, 2000: 228). The situation of mental health services in Richmond could, thus, also be seen as a permeation of the ‘shadow state’: in the case of peer-volunteering we have the formalisation and institutionalisation of users’ senses of community and responsibility, while in the example of TAO, there is the necessity to acquire the status of a charity that could be seen as a partial compromise of its independent status and, consequently, a greater accountability to state regulation. It is thus possible that, in the near future, TAO might find itself in a situation similar to that of RBM, and be required to provide evidence of enumerable outcomes of activities taking place during their meetings, which, in turn, might compromise its emphasis on providing a context for sociality.

Overall, it seems that the key manifestation of the shadow state in the case at hand is in the transfer of responsibility for health. Looking back at the transformation of mental health services in the UK since the 1950s, we observed the state’s continuous attempts to relocate the responsibility for mental health services and, consequently, for mental health to various social actors and institutions: in the first instance to local health authorities, then to communities and families, subsequently to the third sector and, finally to the very people affected by these shifts, achieved initially through policies of involvement of patients (cf. Chapter 1) and, nowadays, to the service users themselves. The danger of the current situation is that there seem to be no social groups or professional establishments left to pass this responsibility onto. What is more, we should recall that my participants also expressed concern about the absence of professional expertise and help while in this chapter we have seen that there are limitations imposed on volunteers and users by their very condition.

Services that are sustained on the basis of users’ sense of responsibility might be the final ones to be controlled by the state. As such, the recent changes in Richmond could serve as the evidence for weakness and withdrawal of the welfare state and might, indeed, be indicating the beginning of an end of the welfare system altogether.

This, on the one hand, might signal the inevitability of a privatisation of health care but, on the other, also indicates the possibility for health-focused projects that are more autonomous and independent from the state and its bureaucratic apparatus. An important question in this matter that remains to be answered in the future regards the effectiveness of mental health services organised around responsibility that is enforced structurally, necessitated by the situation and derived from senses of belonging. This research suggests that, regardless of the motivation behind the various initiatives, the ultimate aim of participation and action remained the same, that is to say, the achievement and promotion of recovery through socialisation in particular locations. The question above is thus concerned as much with responsibility for health as with places in which recovery takes place. Crucial to our summary of the fieldsite, these two matters were among key concerns of the Reflections project and informed the presentation of its outcomes during a public exhibition in Marble Hill House in October 2012.

Exhibition in Marble Hill House

The day of the exhibition's opening is sunny but foggy so, from the distant perspective of the park entrance, the contours of Marble Hill House appear blurred behind the thick mixture of morning mist and penetrating autumn sun. On the ground floor of the villa, a group of volunteers recruited from service users walk urgently, making sure everything is ready for the arrival of the guests. Today is an important occasion, as the results of the over six-months long work on the Reflections project will be shown publicly for the first time. The exhibition is a showcase of findings of volunteer-conducted research and collection of oral histories as well as relevant objects and visual material, including the films about favourite places, and it stands as a proof of hard work and dedication put into the Reflections project. For the occasion, all volunteers have dressed in white and pink t-shirts featuring Time to Change's slogan and logo. Prompted by my question, one of them explains that 'there were many of them lying around in the [RBM] office'. Another one says she heard about the campaign but admits having only a vague idea of its aims besides those indicated by its logo – 'Let's end mental health discrimination'.

The official beginning of the exhibition takes place in the main room on the first floor where a group of approximately eighty people gathered for the occasion: RBM employees, managers and directors, local officials including the Mayor of Richmond as well as dozens of volunteers and service users. Speeches are made by Darren, the RBM project manager, a volunteer, RBM's recently appointed director, and the organisation's CEO. The CEO highlights that the Reflections project was conducted predominantly by the volunteers, not by the management and that, in its duration, people were able to declare 'this is what mental health means to me' and 'this is how other people impacted me'. Then, the new director of RBM says she is thrilled about the exhibition, as it was the users' choice of what to include in it. She also claims that the Reflections project has shown how much has changed over the last 50 years of

mental health services in the borough. She sees the transformations as largely positive, but highlights that mentally ill people continue to be stigmatised, and that is why campaigns such as Time to Change are needed. She ends by saying that RBM does not only play a crucial role in provision of services but also in the struggle against stigma and prejudice.

During her speech, Marble Hill House's manager claims that it is important to consider the history of mental health as part of the wider history of the borough. She explains that, if it were not for the support of the 'local community', Marble Hill House would be demolished and its grounds built on. She adds that providing venue space for the exhibition could, thus, be seen as a form of giving back to the local community. The last person to talk is the Mayor of Richmond who concentrates on the point that mental illness is something that people 'cannot see' - 'it's hidden by the people who suffer'. He then claims that the exhibition is a chance for lay people to see in detail this often concealed part of people's lives.



Fig. 30 One of the photographs displayed during the exhibition showing Long Grove Asylum, source: Surrey History Centre

The exhibition sprawls over both floors of the mansion with a soundtrack played from portable devices leading visitors through the history of mental health in Richmond, from the 1950s to the present. The soundtrail includes recordings from oral histories and interviews collected during the project, as well as clusters of relevant information

read out by a narrator. The trail begins downstairs where one can admire a bronze sculpture of a curled-up girl. Right in front of the artwork is a timeline, a more symmetrical and also slightly more comprehensive version of the one created in Royal Richmond over six months ago (see Chapter 5). Although it now also shows events of national significance that were relevant locally, such as key changes in legislation, the timeline retains a focus on locations where people's recovery takes place, such as hospitals, social centres and meeting groups. At the same time, the timeline indicates that the exhibition is designed to show a chronological account of events and change, thus trying to conceive of change to mental health across time and place.



Fig. 31 One of the photographs displayed during the exhibition showing Long Grove Asylum, source: Surrey History Centre



Fig. 32 The film screening during the exhibition in Marble Hill House

The soundtrail leads through the rooms of the house filled with artwork, pictures, physical objects made by service users as well as and newspaper cut outs. Photographs show some unsettling images of former asylums and hospitals and modest first ‘care in the community’ accommodations. There are also plenty of pictures of social centres - C32, Ham and The Vineyard, and of people – service users in various settings, in groups but also individually in their favourite places in Richmond. One of the exhibition rooms downstairs is devoted solely to screening the films made by Alice, one of the volunteers, and myself. The films’ storylines also focus on places and recovery taking place in their context.

When asked what impressions she took away from the event, my mother, who was visiting London at that time, answered that she was fascinated by the transformation of settings of mental health services and the treatment of people suffering from mental health problems. She also noted the importance of places to recovery and pointed to the dramatic difference in social attitudes towards mental illness between Poland and the UK.³⁹ Having worked in a hospital environment for over 30 years, my mother was bound to make such an observation. At the same time, photographs, testimonials, as well as Alice’s film have all clearly shown a radical shift in the approach to mental health problems in Richmond – and given the broader legal, financial, administrative and bureaucratic framework that fuelled these changes – also in the UK.

I suggested that this shift was, essentially, a change of the spatial conditions of recovery processes, with service and care being brought closer to the usual environments of those suffering from mental health problems – their homes and local communities. As such, these transformations could also be conceived of as a modification of the position of mental illness within both the local community and society. All in all, we could see the change documented by Reflections as a profound transformation of the landscapes of mental health in Richmond, where the shift of the actions-around-health-in-environments saw an emphasis on recovery in various non-medical settings replacing spatially constrained and medically controlled conditions (of madness). The crucial change has been concerned with a process whereby people affected choose or, as we have seen earlier, are required by circumstances to take, an increasingly active role in ‘making’ their mental health, including the creation and maintenance of locations in which recovery takes place.

In his habilitation research, a Polish clinical psychiatrist, Adamowski (2009), investigated non-hospital recovery conditions for patients suffering from schizophrenia in various locations in Western and postsocialist Europe. He noted that in Poland, where the principal setting for recovery was the family home, the social

³⁹ In our conversation I also found translating some of the terms such as ‘care in the community’ or ‘patient involvement’ into my native language almost impossible as no similar transformations have taken place in Poland, where asylum-style hospitals remain as the primary sites for treatment and recovery of mental illness.

lives of Polish patients were largely limited. This was mainly due to the unavailability of contexts that were suitable for social meetings (out-of-hospital settings for recovery were introduced only recently). In the UK, Adamowski notes that schizophrenia sufferers enjoyed greater possibilities for recovery in non-domestic and non-clinical settings provided by the comparatively well-developed voluntary sector. This comparison allows us to appreciate the rather distinct, and somewhat advantageous, situation of people suffering from schizophrenia, and possibly other mental illnesses, in the UK.

We have seen earlier, however, that users' views regarding recent transformations differed markedly from the views of the management, and this dynamic was missing from the exhibition. For example, there was no mention of the new, independent group that arose as a result of the recent closing of services. Consequently, it seemed that the official narrative produced by the organisation managed, at least at the level of the exhibition, to stress change and transformation. However, it also neglected the processes and indeed conflicts through which these changes were produced.

In management speeches we also find assertions of mental health being part of the history and heritage in the borough. Rather than this being an accurate assessment of the situation, we should see these claims as anticipations for a better future. This is because in the course of the project it has been shown that stigma against mental illness prevails and, consequently, that the mission of widening social awareness about mental health has yet to be accomplished. Consequently, we could interpret the decision to situate the exhibition in Marble Hill House, a National Heritage site and a local and touristic landmark, as part of this effort to counteract stigma by giving greater public visibility to mental health. This, along with the aim of promoting greater understanding of mental health problems, points to the activist dimension of the Reflections project.

Reflections on 'Reflections'

Several months after the exhibition in March 2011, an evaluation of the Reflections project took place in the Social Centre in Royal Richmond Hospital. The event was attended by 27 volunteers who took part in the project and Helen and run by Elaine, a worker for an independent assessment organisation. The volunteers, prompted by Elaine, engaged in a conversation regarding the pros and cons of the Reflections project. As was the case with volunteers in peer-led services, participation in the project was felt to bring benefits at the individual level, such as satisfaction and a sense of contribution. As one volunteer researcher commented to the meeting: 'I gained pride from giving something back to others'. Others reported gaining greater insight into mental illness more generally, which, according to the volunteers, made them more 'accepting' of themselves and 'empathetic' towards others.

While still referring to the personal benefits of participating, volunteers raised a number of practical issues they encountered while working on the project. Some of these were seemingly prosaic, such as the complaint that one of the exhibition venues was cold, yet reasonable given the event took place in the winter season. It was also pointed out that the project initially lacked focus and people were not sure what they were supposed to do. Helen rightly pointed out that no one involved had done anything similar before and saw this as a reason why, in its initial stages, Reflections might have seemed disorganised. Her response was met with immediate praise from one of the volunteers who loudly congratulated Helen for ‘pulling it all together really well’.

Volunteers also remarked on the process of collecting oral histories. Although they received a thorough training, some of them found the equipment difficult to operate. The choice of locations for interviews was also criticised, as the rooms in the Social Centre where collection of accounts was taking place guaranteed no peace. Indeed, some of the recordings were frequently interrupted and thus difficult to decipher. In some cases, the recordings had to be stopped altogether and, consequently, some people had to be interviewed twice, which, according to one volunteer, decreased the value of the interview because of ‘invested emotions’ on the first occasion. In addition to this, it was reported that oral histories brought some upsetting emotions and troubling memories for both interviewers and interviewees and that suggestions should have been made as to how to manage such sensitive situations. Helen also admitted that the project was an ‘emotional roller-coaster’, but noted also that although participation ‘had an impact on the psychological wellbeing of the participants’, it ended up being ‘positive’.

As the project coordinator, Helen explained that she had experienced difficulties with recruiting volunteers although, in the end, she succeeded in attracting a sufficient number of contributors and participants. In a report complied several weeks later, Helen saw the engagement of local community members with no previous experience of mental health problems as a considerable success. The report was written in the first person and accompanied by an evaluation table that featured numerical and statistical data, including the number and ethnic origin of participants working on specific parts of the project. In the conclusion to the document, Helen wrote:

The Reflection project gave a great sense of achievement to the services users who took part in the project. It was able to raise awareness of mental health amongst a broader group of people than who had previously been aware.

Helen also explained that personal contributions and palpable results, such as the exhibition and the films, provided volunteers with a sense of pride related to participation in something that created a ‘value’ and which was of relevance to the local community. Helen also mentioned positive ‘learning experiences’ including patience and more effective use of resources. Given that the main purpose of the

document was to inform the project funders about its achievements, it was unsurprising to have Helen ending the report on a positive note and she wrote: ‘amazing things can happen when you ask for the impossible’. In short, the report compiled by Helen indicated that participation in Reflections had a number of positive ramifications, including an increased sense of satisfaction and self-worth for those involved, activation of interest from people previously unconcerned with mental health problems, collection and documentation of accounts of mental health problems as well as the acquisition of new skills. With all this in mind, I would like to consider Reflections in relation to other activist projects as discussed earlier, in Part 1 of the thesis.

Despite issues with the emotional and practical execution of the project, the volunteers I talked to also considered the experience of being part of the project to be, on the whole, positive. While participation was seen as bringing satisfaction at a personal level, the project also encouraged sociality and led to formation of new friendships and relationships between the volunteers and, in particular, those volunteers who were service users. Given this, we could consider Reflections as RBM’s perhaps unintentional effort to patch up some of the damage caused by the closing of social centres, as working on the Reflections gave users a new, albeit only temporary, opportunity to meet, work collectively and to make sense of the current transformation through the reflexive insight into the meanings and history of mental health in Richmond.

Furthermore, Reflections provided users with a possibility to speak about their experiences of mental health problems, and have them heard publicly during the exhibition that, following Marble Hill House, travelled across various locations in south-west London. The personal accounts in the form of oral histories and films were also preserved and made available to future audiences, the former in the archive of a local library and the latter on a DVD distributed around the borough and on the Internet. Concern with personal experience and social contact renders Reflections similar to other nation-wide activist projects.

However, Reflections also appeared to differ markedly from other activist campaigns and undertakings I looked into in the course of the research in several ways. We have seen earlier that the large majority of these projects concentrated on eradication of stigma and prejudice, through improvement of social understandings and attitudes towards mental illness and health, and did so with considerable emphasis on the use of mainstream and social media in the making of positive representations of mental illness and health. Such concern with change of current social attitudes appeared to be secondary in the case of Reflections, which, instead, pursued an in-depth examination of mental health-related transformations with focus on the detail of what it means to live with mental health problems across time and space. To put it another way, Reflections focused not on directly changing the social status quo, like other projects discussed earlier did, but on making sense of mental illness (and, by extension, health)

by looking over the spatial and temporal circumstances in which people experience and recover from it. Consequently, Reflections contributed to the recognition of the many ways in which it is possible to recover, or to address mental health problems, whilst also showing that recovery is defined in various ways and that this difference is reflected in practice.

In an ethnographic study of the English city of ‘Alltown’, Edwards (1998) noted that it was the anxiety about ‘presence’ that made people consider the local heritage and history of their town. More specifically, explains the author, a sense of the glorious past seemed to have helped Alltownians in coping with the contemporary situation that saw the area they lived in falling into economic decline. However, Edwards concludes that such nostalgia ‘reveals only a sanitised version of history’ (1998:143) and, thus, fails to account for the past in its entirety. In the case of the Reflections project, the past has not been idealised in the same way as in Alltown, as the history of mental illness has been one of struggle and suffering. Yet investigation of this history in times of crisis, like in the example discussed by Edwards, might have helped my research participants to understand that practices around mental health are continually changing, giving them a sense that the current, difficult situation would not be permanent.

Meanwhile, Boyarin (1994) argued that memory is ‘neither something pre-existent and dormant in the past nor a projection from the present, but a potential for creative collaboration between present consciousness and the experience or expression of the past’ (1994:22). Remembering and documenting people’s memories of mental illness in Richmond, which provided a sense of a continuous change with regard to mental health, could also be seen as a chance for creative possibilities for such creative engagement with the present. Possibly, then, change, which through Reflections appeared as inherent to practices around and understandings of mental illness, was not something to be afraid of. Boyarin (*ibid.*) also suggested that memory can undergo a process of spatialisation through technology, with the most prominent example given by the author being computer memory.

At the same time technology allows for or necessitates exploration of the spatial character of memory. In the case of Reflections, exploration took place through the documentation of accounts of mental health in Richmond as recordings and films. The project’s emphasis on the environmental circumstances of mental health is perhaps the most fundamental difference between the Reflections and activist-made media representations and it might have been this very concern with a specific location, that is to say Richmond, which allowed for a focus on memory and the past. This assertion is also in line with Ingold’s (1993) understanding of landscape and actions therein as fundamentally temporal (cf. Introduction, & Chapter 6).

Another key difference was that the notion of mental health that came to characterise the national activist scene was absent from the accounts and everyday conversations

in the context of Richmond. Reflections might have initially appeared to its participants as more of a history (or indeed memory) focused project rather than an activist endeavour and, unlike the case of national projects, a single term such as ‘mental health’ might not have been necessary or useful. This is also relevant to the point made earlier that Reflections focused primarily on self-reflexive making sense out of mental health in a specific local context, while other projects concentrated on speaking to audiences and changing of attitudes across various locations.

Nonetheless, in the course of the project, a number of my research participants in Richmond made some interesting general remarks on mental health and illness. These were, in fact, reminiscent of claims made by research participants in other fieldsites. Catherina, for example, highlighted the universal aspects of experiencing mental health problems: ‘When you have mental illness no one can live your life for you and illness can be very debilitating’. Malwia claimed: ‘it’s not anyone’s fault when you fall ill, sick or depressed, it can happen to anyone ‘cuz it happened to me’. Similarly to activists on the national scene, my research participants in Richmond encouraged understanding of mental health problems through elaboration of personal experiences while pointing to the fact that mental health problems are both unpredictable and widespread.

The absence of the notion of ‘mental health’ in the context of Reflections might suggest that the project’s concern with location and temporality of experience of mental health problems eliminated a necessity for use of such a universalising term. The consideration of actions-in-time-and-space necessarily renders experience specific while general or collective notions of experience, such as mental health, might be confusing to or misleading to the public (cf. Chapter 4). Our conclusion could thus be that the contextualisation of experience of mental health problems prevents its generalisation unless, as we have seen with the example of the TTC Facebook Page, generalisations are reflexively recognised as facilitating consensus or collective action.

All in all, we could see the national projects such as TTC and the local ones such as Reflections as complimenting each other in making, documenting and spreading distinct, yet overlapping, ideas about and representations of mental health. With regard to these projects’ envisaged outreach, we could see an interesting similarity. We have seen that users of the TTC Facebook Page and people speaking at mental health-focused conferences saw the whole of society as the audience of their narratives and demands. Meanwhile, in the case of Reflections, it spoke to the ‘local community’, that is, people who have some connection with Richmond either through inhabitation or visit.

It is worth recalling that in their posts and comments, users of the TTC Facebook Page saw themselves as members of the wider society. Analogous claims were made in the context of Reflections as my participants saw the ‘local community’ as

necessarily inclusive of people experiencing mental health problems. Such senses of belonging to these larger social groups among both TTC Page users and participants in Reflections translated into perceptions that they spoke not only to the society or community respectively but also as representative members of these social groups.

The overall difference between the two kinds of project is in the scale of the respective social groups addressed by their actions and the extent to which they focus on the particularities of the local environment. It is thus more appropriate than it might initially appear to the reader to conclude this chapter with reference to my research participants' associations between Richmond and mental health.

In the oral histories, for example, one of the observations was that life in the borough was considerably better than in other parts of London or the country. 'I've got a lot more support here than I would get in the countryside, where I grew up', said Claire. Robert thought he was 'lucky' to be living in Richmond and claimed he rarely left the borough, as he felt a sense of security there. Meanwhile Radeem said that 'Richmond is probably the best place to be if you're suffering from mental health or some other illness'.

Access to mental health services must have been paramount to these opinions, as Richmond is a considerably wealthy council where use of private healthcare is more widespread making public health services not as congested as in other parts of the country. Moreover, fundraising was also considerably easier in Richmond than in other boroughs, claimed John, during our visit to Sheen Home. Others, such as Justine, said they felt 'privileged' to live in the area because of the availability of outdoor spaces which other research participants thought of as contributing to a 'specific feel' of the area and its perceived separateness from other parts of London. Debbie, for example, talked about Richmond as a 'beautiful town' isolating it from the other parts of the capital city. Meanwhile, as we remember, Christine highlighted the benefits of simultaneously 'being close to nature' and to the centre of London.

Living in Richmond was also sometimes associated with freedom. This sense of autonomy was particularly germane in the accounts of people who experienced involuntary confinement in medical institutions or at some point were incapable of leaving their houses due to their mental health problems: in these accounts being free to move in space amounted to a sense of freedom from illness. All these positive perceptions led to the notion that living in Richmond was 'very good for mental health'. On the contrary, some research participants did not see a simple connection between living in a particular place and falling ill: 'I would have had my mental illness wherever I was living', explained Deborah. At the same time, no negative associations were made between illness and place and none of my research participants thought that living in or visiting Richmond caused them to experience mental health problems.

On the basis of these views we could say that neither places nor their characteristics are of direct benefit to health in their own right. Instead my research participants' accounts point to a propensity to attribute particular places with meanings and possibilities for practices therein. Such a tendency suggests that experience is inseparable from environment but that there is a limit to the possibilities for narrative expression of this relationship. This is why we should conceive of the 'specific feel' of Richmond as an articulation of a special relationship with the environment, rather than evidence of its intrinsic quality. As we have seen in the chapters above, such a special relationship with a place was also the case for my research participants' favourite places, social centres and informal groups.

By concentrating on collective and individual practices and accounts of these places, the Reflections project led to a greater understanding of contexts in which people address their mental health problems and, consequently, brought greater appreciation of mental health being an environmental and, therefore, social concern rather than only a medical or individual one. With regard to its capacity for encouraging reflexivity, Reflections bears a similarity to participation on the TTC Facebook Page and, as such, we could conceive of the project as a fundamentally activist endeavour. However, we should also note that such recognition of the environmental dimensions of recovery and health were not matched in RBM's transformations of its services that emphasised individual rather than collective practices for dealing with mental health problems.

Conclusions

In this conclusion, I first reflect on the overall contributions of this research to the understandings of contemporary forms of mental health activism. Secondly, I explore the links between the two parts. This leads to a discussion of my analytical outlook on the data including the environmental dimension of health and interrelated notions of landscapes of mental health, undemanding sociality and attunement. Next, I consider the implications, strengths and weaknesses of my approach. Finally, I outline possible avenues for further research.

Accounting for Mental Health Media

The research presented in this thesis was an exploration of how people affected by and concerned with mental health problems in the United Kingdom use media to publicise, document and discuss illness- and recovery-related accounts and narratives; all these efforts aimed at understanding and transforming the social conditions in which experiences of mental illness and health unfold. Such mediated practices were underpinned by my research participants' anticipations that informing the society about what it means to go through mental health problems, explaining how stigma and discrimination prevent recovery and raising awareness regarding the universal potential of falling ill might change, for the better, social attitudes towards mental illness. By exploring their personal experiences through a range of media-based projects, my research participants attempted to bring a widespread realisation that mental illness is something that can potentially impact anybody, to entail an interrelated sense of social responsibility and to encourage participation in actions that prevent mental illness and/or promote health; they directed our attention to the ways in which we talk about mental health problems determine public comprehension of and social sentiments towards these issues, all of which, in turn, have direct consequences on the lived experience of people suffering from mental health problems.

Coming from Poland, where mental health care continues to take place primarily in closed wards of psychiatric hospitals built well over 100 years ago and where voluntary organisations concerned with issues of mental illness came about only recently, I was struck by the immensely broad scope of health-related services, governmental and voluntary organisations and projects, as well as formal and informal user and patient groups focused on mental health in the UK. Thus, it was vital for the orientation of the research to concentrate on one element that connected these diverse forms of engagements with matters of mental health. Given the recent proliferation of social media and its immediate appropriation by mental health activists on one hand and my background in anthropology and communications studies as well as experience in documentary film production on the other, I decided

to explore media tackling issues surrounding mental health and embarked on the research with the intention of participating in the making of representations alongside my research participants. The Reflections films in particular constituted an integral part of an activist project in Richmond, which allowed me to combine the two roles of ethnographer and voluntary filmmaker rather than just film events unfolding in the context of the field. I thus see the film component of my work more as a participatory than a visual method, and its possible contributions at the intersection of the anthropology of mental health, of media and of social action.

What emerged from the field was that the use of media brought a promise of a social transformation; more crucially, however, participation in mediated practices oriented towards mental health contributed to realisation of common aims, cemented a need for collective effort, brought about or reinvigorated various senses of unity and also was reported to have increased senses of wellbeing. We should remember, however, that because the focus of this research was on how ideas about and experiences of health are exchanged and shaped alongside media- and representation-making and use, my account was necessarily about how mental health is understood and evoked through language, narratives and media.

Early in the thesis (Chapter 1), I explained how contemporary activist practices could be linked to former mental health movements in the UK precisely through their concerns with social conditioning of mental health and illness as well as their intentional applications of language and personal insight used in attempts to transform the situation of those struggling with mental health problems. I have also suggested that the current circumstances including the grave situation of services, requirements to put forward more encompassing funding proposals and the faltering dominance of psychiatry in the management of mental health problems required activists to focus on more general suggestions for transformation of the status quo and, consequently, to address the whole society and not only particular professional groups or fields. With regards to this, we could see media as one of the most auspicious tools allowing for such totalising concern to be expressed and for sustaining the aim of reaching the widest possible audiences. However, it also seems that the turn to media was one of few lifelines available to my research participants and, therefore, as much a matter of convenience as of necessity. In short, given the challenging socio-economic situation, the focus on media might have been opportunistic rather than strategically programmed.

This novel emphasis on media in campaigning, as we have seen throughout the thesis, required a number of concessions such as, for example, the compromise on illness specificity due to the marketing-like style of campaigns; it also generated distinctive views and disagreements with regards to what direction activism should take; finally, in Richmond, media caused some difficulties with the practical execution of the project, which led to eliciting very specific, fragmented accounts. Despite these drawbacks, my research participants' use of media could be considered as innovative, especially when it comes to their engagements in the context of social media, which, I have proposed, cut across the boundaries of marketing and social

action. In this realm, activists also encouraged reflexivity with regards to mental health problems and brought realisation of the common struggles experienced by people affected by mental illness. All this leads me to suggest that the use of media contributed to a new approach to mental health-focused campaigning and activism.

I showed how the focus on media also played its part in encouraging the employment of new ideas with regards to mental health, most prominently, the one that ‘mental health is something we all have’. This notion of what I suggested could be called ‘universal mental health’ delineated the activist emphasis on ubiquitous responsibility for mental health. It could also be read as a call for a comprehensive change to the social attitudes towards this matter. The notion of mental health does not suggest that stigma and discrimination against mental illnesses are simply unjust but that, since mental health problems could potentially affect all of us, we could all fall victim to prejudiced or uninformed attitudes and, therefore, such a situation should be counteracted and avoided. Or in short, stigma should be removed because it can turn on anyone. What is more, by speaking to a fundamental question of how (and not who) am I, the notion of mental health is promoting reflection on changing human condition, while also inviting a re-assessment of what it means to be ill, to be healthy or to experience mental health problems.

Such concern with something essential, characteristic of all members of society, might explain the seriousness of the media campaigns and projects I explored; they were, on the whole, devoid of irony and sense of humour so characteristic of everyday language and media discourses in the UK. This pensiveness or seriousness could, perhaps, be seen as a reflection of the gravity of issues that my research participants placed under the umbrella of mental health; some of them even came to replace names of specific illnesses with the term. This we could see on one hand as an attempt to avoid stigma and on the other as contributing experiences to public debates and knowledge in a way that would not further jeopardise their personal senses of wellbeing. Such unwillingness to speak about suffering and pain in an outright manner could also be considered as a creative way of addressing the reality in which mental illness is not accepted. This is why in my analysis I referred to Tambiah’s notion of the magical power of words as this allowed for understanding the activist notion of mental health and associated with it use of media not as a mere public relations tools or exercises but as attempts to make a collective sense out of diverse experiences and, at the same time, a hope for or expectation of a social transformation and a better future.

In line with Tambiah’s argument we could see the notion of mental health employed by activists in their mediated practices as a linguistic device or utterance that helps in the imagination of a better, more inclusive world, one signalling the kind of change that needs to take place. The notion of universal mental health is, as I have argued, magical in the sense that it is making possible what seems impossible, here, a universal concern with matters of mental health, the absence of stigma and discrimination. The notion of ‘magical’ possibilities also denotes my research participants’ optimistic, hopeful and, perhaps, utopian expectation that mental health

will become a universal concern. Furthermore, I proposed that activism focused on mental health demystifies the subject as it suggests that everyone is in a position to take an active role and to improve mental health. It was the activists' employment of diverse media that allowed for such creative and intentional applications of language in this drive towards universal responsibility for mental health.

At the same time, my research informants' accounts and practices invited me to reflect on a number of concerns that went beyond the original emphasis on media. This included transformations of health services, senses of community and the diverse engagements with and perceptions of environment that they considered to enable or prevent mental health. Among these myriad issues raised through participation in activist media projects, my research participants kept emphasising two interrelated aspects of their involvement. Firstly, we have senses of understanding and unity developed and/or stabilised through engagement in collaborative actions. Secondly there are the diverse approaches to and understandings of recovery from mental health problems that informed discussions, representations and shared narratives.

I see the main ethnographic contribution of this thesis precisely in documenting how the use of media in promoting social change with regards to mental health encouraged development and/or sustenance of senses of sociality and how these senses are related to, but also contribute to, various notions of recovery. It is with references to these two themes, senses of unity and recovery, that I would like to draw together the two parts of the thesis. Accounting for the two-part approach should also help in understanding the variety of views and engagements discussed above as belonging to a distinct moment in mental health action in the UK as well as context-specific differences in the particular emphasis on these various forms of participation in making mental health.

The National and Local Dimensions of Activism

Apart from reflecting on the history of mental health movements, health services and the role of psychiatry in the British context (Chapter 1), in order to indicate the relevance of a wider background to contemporary mental health-focused action, I have avoided considering the two research contexts discussed in Part 1 and Part 2 of the thesis as a 'whole'. This was because, as we have seen, different locations for the research were characterised by distinct foci on mental health. In particular, it quickly became discernible that, from the perspective of those with illness or working in the mental health field, the activist focus on media had its limitations due to generalisations and omissions made in media representations that aimed to address widest possible audiences. Whilst some of the research participants (for example, people involved in the Open-Up grassroots network) subscribed to and/or actively participated in some of the national campaigns, the focus on the development of media campaigns had its limits and did not capture what seemed important at the regional level. I thus adopted media in quite another way to attempt to work with and

to present a diverse range of narratives of mental illness and health in order to show how media could also be used in a local context of Richmond. However, we should note that these accounts collected in form of oral histories and films constituted part of a media activist project and, therefore, were not spontaneous or *de novo*.

All in all, the two-part approach recognised the diversity of my research participants' perspectives and it also reflected the development of the research from the national campaigns and meetings to local contexts and concerns. What is more, as some of the research sites, social media in particular, have received ethnographic attention only recently, I considered it to be of paramount importance to present and discuss forms of participation in mental health-focused action with regard to the settings in which they unfold, while drawing a distinction between what I have suggested could be seen as national (or cross-locational) and local arenas of mental health activism. However, whilst I was following media were they led me I found that, despite divergent perspectives, priorities and concerns, the use of media in all contexts of the research accounted for diverse strategies and techniques for recovery from mental health problems. What is more, the use of media across the fieldsites also led to increased senses of unity between participants in the activist projects.

Part 1 focused on the national realm of activism. There, we have seen how people concerned with issues of mental health from across the UK hope to work collectively towards the destigmatisation of mental illness and making mental health a widespread social concern. In particular, a considerable effort has been put into counteracting negative conceptions and representations of mental health by replacing them with positive ones. While contemporary forms of participation in mental health-action establish continuities with past movements in the UK, I drew attention particularly to the ways in which a non-conflictual approach to campaigning involves a compromise with, or at least a striking lack of attention to, the specificities of mental health problems or illnesses.

This new non-antagonistic outlook is the consequence of a number of factors, including the success of groups working in the mental health field in the past as well as legislative changes, together which altered the formerly dominant role of psychiatry in the management of mental illness and encouraged the emergence and proliferation of new, non-institutionalised settings for recovery. In combination, these developments have led to a change of emphasis: away from the many divisions in and around mental health, and towards the possibility of unified actions. I further noted that all these transformations pointed to a shifting spatial organisation of ideas and practices regarding mental illness and health care, accompanied by continual delegation of responsibility for health to various social groups and peripheries. I showed that these concerns with the position of mental health problems and responsibility for mental health continue until now. Finally, with regard to the current possibilities I suggested that while transformations within the mental health field were alleviating antagonism between various professional and social groups involved in mental health, they are also contributing to the considerable dependency of the voluntary sector on the support of the state.

I outlined a number of issues and tensions arising from this new, general outlook that came into view during activist meetings and discussions and on the Internet. These included an absence of detail about experiences of mental illness in activist representations, disagreement and/or frustration with a marketing style of campaigning, and claims about under- or over-representation of certain social groups. I have suggested that in attempts to overcome these disagreements and divergent points of view and in order to denote autonomy and impartiality, the directors and CEOs of charity organisations and campaigns in the mental health field referred to a ‘movement’. In other words, the notion of a movement highlighted the necessity for unity in their actions.

It is still to be seen whether projects focused on promoting mental health will crystallise as a social movement. Given that previous forms of participation in mental illness-focused politics were also considered movements in both popular discourse and academia this could, indeed, be the form in which we will come to recognise what I have considered under the rubric of activism. However, we should note that the contemporary emphasis on universal social responsibility for mental health, together with the compromise on illness specificity, go beyond the framework of identity politics and contribute to novel senses of social unity or solidarity.

I noted that this drive for collaboration and associated senses of unity that emerged during activist meetings and conferences have proliferated in the context of social media where some issues and disagreements received more thorough consideration. This happened, for example, through discussions in the context of TTC’s Facebook Page and Group that contextualised both mainstream and activist-made media representations of mental health. They did so by giving depth through personal experiences, opinions and accounts and these contributed to the realisation of a common purpose and helped in orienting activist participation, all of which combined led users of the Page to pronounce a sense of unity that was encompassing of both those suffering from mental health problems as well as all of us.

In short, activist practices focused on mental health in the national context led to a crystallisation of unity in action inspired by shared background and aims as realised through reflexive uses of broadcast and social media. Further investigation might reveal how these social links or relationships shall unfold over time and whether the use of media might play any additional role in this process. Conversely, it may be the case that their usefulness is limited to their capacity for spreading knowledge, information and propositions for social change and for encouraging reflexivity.

The cross-locational dimension of activism discussed in Part 1 constitutes only part of the wider picture, as my research participants agreed to emphasise mental health in the public sphere whilst remained preoccupied with detailed, or we could say more local, aspects of mental health problems in other contexts. This is why in Part 2 of this thesis I explored concerns and practices around mental health through the prism of Reflection, a local activist project that served multiple roles.

From the perspective of Richmond Borough Mind, the initiator of the project, Reflections paid homage to the long-term contributions of the organisation that,

according to its users, had recently lost some of its credibility by rapidly closing well-established social centres. From the perspective of participants, the project not only helped in making sense of shared histories of mental health in the area but also provided new possibilities for socialising and working together towards a common goal. With regard to its activist dimension, Reflections contributed to a better understanding of mental health in Richmond and brought a shared realisation of gradual changes in health-related attitudes and practices, and in particular greater recovery possibilities and much better treatment of the mentally ill. What is more, the exhibition showcasing the results of the project contributed to a greater public visibility for these issues. Finally, from the perspective of this research, working alongside Reflections' participants provided me the possibility of investigating mental health-focused practices in a more traditional ethnographic setting.

Given the multipurpose character of Reflections as well as the diversity of accounts collected and issues touched upon in its course, it is challenging to point to a single aspect of this fieldsite. What is more, given my direct engagement, it was often difficult or impossible to distinguish between the project and the research. However, I would say that my research participants in this fieldsite had two interrelated aims: first, to bring about a better understanding of mental health problems in Richmond and, second, to continue creating opportunities for recovery from mental illness while overcoming a set of challenges and obstacles, including quite a radical transformation of services in the area. Needless to say, these two aims were not considered as separate. On the contrary, as in other settings discussed, the possibilities for recovery were seen as dependent on social attitudes, or, in this specific case, those of the local community.

The example of the Reflections project showed a distinctive approach to issues of mental health, as its main focus was not the general society, but was concerned instead with making sense of mental health through documentation of both individual and collective health-related experiences within Richmond. This local focus necessitated a somewhat different emphasis to that in places where the focus of attention and campaigning was on the national environment. The Reflections' concern with multiple voices and diverse accounts rendered generalising notions of mental health unnecessary. Meanwhile, the project's focus on details of experience helped to account for the manifold ways in which people engage in practices of recovery whilst also showing the scope and degree of transformation to understandings of mental health and to services on the local level over the last 50 years, which were portrayed as part of a common heritage. We should note that this notion of heritage is somewhat similar to the conviction in national campaigns that mental health is the concern of everyone.

All in all, Part 1 brought together the ways in which experience-based media representations are currently used to transform public perceptions of mental health. Meanwhile the move to Richmond in Part 2 showed how these concerns with mental health play out in local settings over a period of time, and how they come to life. Importantly, in both contexts media helped in exploring and sharing these diverse

meanings given to health and illness. What is more, in both contexts, there were similar mediated depictions of recovery as dependent on social attitudes on one hand and facilitated by a collective context on the other. Although my research participants across fieldsites operated with various notions of mental health, imagined and represented it in multiple ways, they saw one particular factor as preventing it. Stigma was seen as magnifying experiences of mental health problems and inhibiting recovery. The view that, without stigma, living with mental illness would be more bearable was key to national campaigns and also reflected the opinions and experiences encountered in the local context. In Richmond, for example, a fear of stigma prevented some people from attending certain social centres. Meanwhile, the exhibition organised as part of Reflections, just as activist media campaigns, aimed to counteract stigmatising views of the mentally ill.

However, despite a close association, we should not conflate stigma with mental health problems, as this is not how my research participants conceived of the relationship. They recognised that stigma is just one, albeit a very important one, of many contributing factors to illness that include social and family pressures, stress, and hereditary predispositions. Perhaps, the sheer difficulty of challenging governmental agencies or professional groups led to this focus on addressing stigmatising and discriminating views among general society. Stigma (and social attitudes more generally) became one of the key concerns of activist participation, both in national and local settings, because, from the perspective of activist efficacy, challenging stigma as a method of improving mental health was considered a workable goal. More importantly, however, the prevalence of stigma made it a burning issue to resolve.

In the case of national projects, the amount of activity on social media sites was quite astounding and enabled dialogues between people concerned with local issues and those working on the campaigns. What is more, the TTC Facebook Groups and Page became a domain of people with mental health problems who claimed that discussions in this particular context brought mutual understanding and, often, a sense of relief or alleviation of some of the worries and troubling experience. Notably, exactly the same claim has been made with regard to social centres in Richmond. It seems, then, that both meetings in social centres and activity on Facebook shared a common purpose, which was to talk openly and in multiple voices about mental health. It is not surprising that in both contexts I encountered similar expressions of unity based on that shared experience as well as suggestions that recovery from mental health problems is a social process. I do not argue, of course, that participation on Facebook could replace social centres. Instead, I am pointing out that the sharing of personal experiences accompanied participation in health-related action across all sites of the research. Although the motivations reported for doing so were distinct, the sharing of personal accounts through various mediated practice invariably led to reported senses of unity in all contexts of the research.

While these forms of social unity, the presence of others, sociality and/or social contact were considered to have a positive effect on mental health (through

discussions that enabled realisation of common issues and experiences and resultant mutual understanding), stigma and discrimination, which we could conceive of as a lack of understanding (or as an attempt to maintain social distance), were seen as having the opposite outcome. I am, therefore, inclined to conclude that, in the context of this research, recovery from mental health problems emerged as an innately social process in which narratives and mutual sharing of accounts brought realisation of common experiences which, in turn, was seen as initiating processes of healing and/or getting better. At the same time, negative social forces such as stigma were seen as capable of disabling transformation towards mental health. Notably these understandings of recovery and, by extension, of mental health as socially conditioned processes that unfold in particular places or contexts go beyond biomedical/psychiatric notions of mental illness and this is why I decided to interpret them as essentially environmental concerns, issue to which I come back in the following section.

To briefly summarise, the two distinctive spheres of participation discussed in this thesis both face the challenges emerging from the contemporary socio-economic situation, changing legislative frameworks, concerns with stigma, a focus on media and personal accounts, as well as notions of unity and recovery emerging from the collective actions of sharing these accounts. What is more, in both research contexts, research participants appeared to be working towards a common goal, which was a society or local social reality where mental health problems are accepted and understood (and we could note that the various degrees to which social groups were seen as required to take part reflected the employment of different notions of ‘us’ and ‘we’ in the context of discussions on TTC’s FB Page.) These two spheres of participation complement each other also in the sense that one imagined a better future for mental health and another looked into and documented the change in social attitudes and understandings of mental illness in its recent past, here the last 50 years. However, we should note that despite a common overall aim, shared background and emphasis as well as analogous senses of unity and interrelated notions of recovery there were some gaps in cooperation between the local and national forms of participation.

For example Reflections volunteers were not sure why they were wearing Time to Change T-shirts during the exhibition in Marble Hill House while there was no information about the event in a nearby charity shop run by Mind. At the same time, many service users I met in Richmond, but also in the other research contexts, were unaware of the existence of campaigns such as TTC. All of this indicates that cooperation between two spheres of activism was not fully integrated despite mutual dependency. More coherent information regarding each other’s actions, or, as suggested by John, a centralised database of activity, perhaps also on social media, would benefit everyone involved. However, my intention is not to focus on the shortcomings of collaboration between various activist projects and groups. Instead, I would like to spell out how these modes of actions that emphasised social unity and recovery bear on the theoretical outlook of this thesis.

Mental Health as an Environmental Concern

With regards to the above, the two key interrelated findings of the research are that new strategies for tackling mental health problems have emerged in the contemporary UK where a general emphasis is being put on mental health being a universal social responsibility, while in the local contexts, such as that of Richmond, the focus on mental health is through stress on personal and collective practices of recovery and on (rescuing of) services. The second finding is that, despite differences, these various concerns and actions contribute to or carry a potential of bringing about the social change they envisage by trying to transform the conditions in which health and illness unfold. What is more, these actions contribute to and/or re-establish various senses of social unity, including those of community that are not centred on illness identities but are related to a collective drive to recover and to promote mental health. These observations, in turn, inform the principal theoretical conclusion of this thesis, namely, that, in the context of this research, mental health was conceived of not only as a medical matter but as a fundamentally social concern expressed through mediated, reflexive and often collective engagements with or attunement to the environment and its particular fields, here, landscapes.

In the course of the last decade, particularly within the disciplines of human geography and biomedicine, and increasing attention has been devoted to the effects of the environment on health. This emphasis resonates with the practices of people I worked with during the research and it has also received some international recognition. Most notably the World Health Organisation considers environmental health as '*all the physical, chemical, and biological factors external to a person, and all the related factors impacting behaviours [and it includes] the assessment and control of those environmental factors that can potentially affect health*' (WHO webpage⁴⁰, see also Novice, 1999).

I suggest we need to expand on this definition, which currently sees the environment as external to human beings and therefore capable of promoting or preventing health. My participants' practices showed that the environment has neither a detrimental/harmful effect nor a healing/beneficial impact on health per se. In line with Ingold's writings, it could be suggested that actions and engagements, which entail transformation in and alongside the environment, might enable or prevent health.

The importance of the environment to my research participants' practices of recovery and senses of health first came apparent during filming the favourite places in Richmond as part of the Reflections. Subsequently, I came to recognise the association between mental health and environment in other sites of the research as well. We have seen in the chapters of this thesis how walking, sitting, sharing experiences, realisation of common hardship and struggle or collective participation

⁴⁰ http://www.who.int/topics/environmental_health/en/

contributed and, in some cases, cumulatively amounted to senses of wellbeing and even recovery. We have also seen that such actions were necessarily conditioned through a range of forces including public opinion or subjective perceptions, media representations, political and economic situation as well as organisation, design or geographic and biomaterial characteristics of particular places. Furthermore, such health-oriented actions, through reflexivity, anticipation of a better future and intention for change, carried the capacity for transforming these very same conditions. Taking all of the above into consideration we could say that mental health and recovery function in a sphere of continual dialogue and mutual influences between a sum or material and immaterial, human and non-human, personal and social elements or what, in line with the dwelling perspective, I conceived of here as the environment.

Now, in the largely secular society of the United Kingdom, the so-called natural environment, is often considered in popular representations and discourses as something essential or inherent and, therefore, requiring preservation, conservation and protection (see Forde, *in preparation*). What is more, in this same context, we have the idea of the natural world as juxtaposed to the industrial and to the modern and, also, as the abode of peace, calmness and separation from civilisation. Although some of these broader ideas resonate with certain accounts collected in the course of the research, and I explain below how narrative expression enters this configuration, the notion of environment I worked with afforded no distinction between cultural and natural world. Instead, the environment was conceived here as the totality of both human and non-human elements where its differentiating attribute was that of landscape.

I suggest that Ingold's understanding of landscapes as sections of the environment, temporarily co-constituted by particular activity unfolding therein, allows us to conceive of activist forms of participation and engagements I explored during the fieldwork as landscapes of mental health. I found Ingold's notion of landscape to be a useful analytical category not only because it denotes the subjective perceptions of and meanings given to the world as it is made by people who dwell and function therein but also because it helps in conceiving of their activity as being in a state of continual engagement, change and transformation. In other words, the notion of 'landscapes of mental health' helped to account for the multiple dimensions of my research participants' individual and collective health practices.

Each of the landscapes of mental health discussed in this thesis is characterised and constituted by its niche or point of attention. Social centres and meeting groups, for example, is where people share stories, support each other and experience senses of togetherness. Meanwhile, in outdoor spaces such as parks and the riverside in Richmond, individuals address their mental health problems within the realm of personal experiences through being in what became their favourite place. Social media could also be considered to belong to the same category of landscape because of their focus on changing the circumstances that condition health and in transforming its understandings, including media representations. Finally, conferences and activist meetings are also a form of landscape through their sustained attempts to develop

effective methods and strategies to bring about social change with regards to mental health.

Among the key characteristics of the contemporary landscapes of mental health in the UK we find a non-obligating presence of other people to which I came to refer to as ‘undemanding sociality’. I first found this notion to be useful in understanding the favourite outdoor places in Richmond where the presence of other people not only constituted an important element of background to individual health-oriented activities but it was also incorporated into ideas and perceptions of the world that my research participants engaged with or created in their drive to achieve recovery. Retrospectively, I found the notion of undemanding sociality to be relevant to the analysis of other landscapes. In the context of social media for example, the undemanding presence of other users of the Page seems to have encouraged disclosure and sharing of personal stories. Meanwhile, in social centres, my research participants appreciated the ability to take care of their own interests and needs whilst being in proximity of other service users. In all these contexts, the undemanding presence of other people constituted an important element of health- and/or recovery-oriented practices by encouraging reflexivity, promising acceptance and a possibility for coexistence as well as providing senses of mutual understanding.

It was also this capacity to be alongside but, at the same time, not fully engaged with other people in the context of social centres that caused dissatisfaction with the more organised approach to social contact as those introduced through peer-led services. The new organisation of services could, thus, be seen as limiting the undemanding sociality, and re-introducing an enforced or structured element somewhat reminiscent of pre-community care organisation of healthcare. Undemanding sociality also recognises the fundamentally participatory dimension of health and, thus, confronts the dominant biomedical ideas about mental illness as an essentially individual concern. It also speaks to what I conceive as one of the most promising strategies of contemporary activism, of encouraging the realisation that people and their actions contribute, in both direct and indirect ways, to others’ senses of illness and health.

In my research participants’ relationships with their favourite outdoor places it is clear that the making of a landscape through mental health-oriented practices involves a form of attunement. The use of this term reflected Ingold’s notion of ‘being in tune’ in order to denote habitual and ‘learnt being’ in an environment mediated by former experiences, skills as well as habits acquired over time. I drew on this notion of attunement in an attempt to extend a conceptualisation of the associations between health and environment. I found that it was not easy, or, indeed, feasible to describe or account for this relation within the so-called Western tradition and its building perspective where the environment is seen as external to human beings and, thus, also to their health. Although in my analysis I could have discussed being in favourite places as a form of mindfulness and/or embodiment, I thought that a new term, more compatible with the dwelling perspective I embarked on, would be more suitable.

This also was in line with Ingold's useful suggestion that embodiment implies prior separation of (or distinction between) a human subject and her or his environment.

Attunement, on the other hand, denotes a mode of functioning according to the dwelling perspective, and, thus, an integration of humans and their environment. More specifically, with reference to the example of favourite places in Richmond I saw attunement as a process of health-oriented navigation, active learning and aligning oneself to the environment by becoming similar to or like its characteristics and/or its constituent elements and, with time, transforming both alongside and as part of it. Attunement, however, is not a mere intuition or the ability to comprehend something instinctively. Instead, it is a sentient mode of establishing and maintaining relations both within and as part of the environment.

Attunement also seems relevant to the analysis of other types of landscapes discussed in this thesis. Meeting in a social centre or as part of a self-organised group, a mental-health focused conference or discussion on a TTC Facebook Page, all require engaged social sensitivity as well as a form of collective understanding, which come into being through adjustments, adaptations and/or habituations to the context as well as its characteristics. This includes the size of a meeting room, the former contacts already established in a community centre, the technicality of a social media page and, also, to the undemanding yet intimate presence of others. In all these contexts attunement stands for concurrent sensing, being and transforming alongside the environmental circumstances; adapting to the surroundings that include other people but functioning according to personal expectations and needs.

The idea of attunement also speaks to the linguistic inability to account for human relationships with and experiences in their surroundings in their totality. Arguably, it is this inadequacy that feeds the notions that certain places can be good or bad for mental health, although what they are really doing is simplifying or naturalising the scope of interactions and engagements between the human and his or her environment. The prevalence of this particular perspective in the UK might explain why, in their narratives and accounts, some my research participants conflated their senses of wellbeing or health with being in a particular place or location. However, it should also be noted that my research participants shared such instrumental understanding of the environment only to a certain extent or, more precisely, depending on the context. For example, they did emphasised control of language and the settings in which it is being used (such as for example the TTC Facebook Page or activist conferences) as crucial to social transformation for better mental health yet, in the context of social centres, favourite places in Richmond or Rethink Talk, they considered lack of restraint of the environmental circumstances as conducive to recovery.

It seems, then, that prospects of public scrutiny necessitated a more constraint-oriented approach to environment or, in other words, control of social settings in which health unfolds (that took place through intentional use of language and media) inevitably implied some form of control of the environment. This we could associate with the building perspective. At the same time, it emerged that there were possibilities, predominantly within the realm of the individual or personal experience,

for engaging with the environment beyond the controlling mode and in line with the dwelling perspective, here, as integral part of it.

All in all, I am inclined to suggest that in the context of this research, the capacity to engage in health practices or to transform senses of wellbeing were bounded by the culturally, socially and linguistically established notions and concepts about the world and possible relationships with and understandings of environment they entail. This, in turn, might imply that the process of externalising experiences in form of accounts, narratives and media representations is differentiating something that was not previously separate: here one's relationship, or a sense of unity with the environment. In other words, participation in social relations and, in particular, the necessity to adhere to social norms could be seen as disturbing personal senses of mental health or wellbeing by enforcing particular forms of engagement with and understanding of the environment and, by extension, of self, but that, at the same time, social participation creates opportunities for patching up, at least partially, this damage. In the contexts such as that of this research, where building perspective constitutes the dominant mode of thinking and living, this would seem particularly feasible by rethinking and remodelling of society's relationships and attitudes to the environment. The findings of this research lead me to suggest that media practices are especially useful in this endeavour as they transgress the existing notions of sociality, togetherness and simultaneity whilst also allowing for new imaginations and depictions of both individual and social change over time and space all of which might be helpful in contributing to new ideas and forms of engagement with the environment in drive towards mental health for all.

Theoretical and Methodological Limitations of the Research

These general conclusions lead me to the assessment of the strengths and weaknesses of my approach. I do realise that by choosing the UK as the site of my research, and by focusing on matters related to mental illness and health, I have exposed myself to criticism especially from the perspective of people rooted professionally within the mental health field or those hoping for a contribution to one particular sub-field of the discipline, such as medical anthropology or the anthropology of media. I nonetheless hope that my perspective, as simultaneously an insider and outsider, using a wide range of participatory research methods and with the theoretical outlook I embarked on, might contribute a fresh view on the contemporary situation of those concerned with mental health in Britain and contribute to understanding of how health-related matters transform and transgress in this particular moment in time.

This thesis aimed at ethnographic documentation of the social phenomena on mental health in the context of mediated practices that emerged at the time the research was in developmental/planning stages. Thus, rather than focusing on established or traditional practices, I was interested in whether anthropological methodology and analysis would be of use in these particular, unfamiliar and

continually changing settings. At the same time, in the context of the United Kingdom, I thought it would be both ethnographically feasible and responsible to account for how the intersection of mental health and media connected various groups of people across different locations. As such, this research and the thesis are a homage to my research participants' attempts to transform both the unfavourable social circumstances as well as their personal life issues.

In line with Bloch's argument regarding the extent to which narrative/communication sphere of human being limits anthropological knowing, I decided to discuss my research participants' mediated practices taking into account the specificities of wider and local contexts that shape the possibilities for health-oriented actions. Given their diversity and interconnectedness, each research setting or landscape required slightly different methodological approaches. For example, I did not feel in a position to enter discussions on TTC Facebook Page as there were clear indications that interruption in this particular context would not only be impertinent but also destabilise the order of participation taking shape on the page. In other words, encouraging further reflexivity in the context so heavily embroiled in reflexive discussions and confessions and disclosure of personal problems not only would be unnecessary but also inappropriate.

Since the aim of this project was not to examine the extent of suffering related to mental illness but to focus on how campaigns and participatory projects focused on mental health are produced and executed, I concentrated on how personal dimensions of mental illness are used in the spheres of media and collective action. Consequently, in this thesis I explore how experiences and emotions are evoked rather than fully expressed (especially as my research participants often suggested that the most upsetting feelings, traumatic experiences and the negative sides of mental illness should not be disclosed to the public eye). Although I personally think that a more controversial and experience-near approach could also be incorporated into some media campaigns, it was necessary to account for this non-contentious and non-illness specific outlook that characterised contemporary mental health activism; it connected various, formerly opposed groups and organisation, and invited participation of people regardless of their class, ethnic or social status. Analogically to my research participants' willingness to work together, I focused on what bonded them and on how cooperative participation is possible despite divergent opinions, experiences, views and expectations.

Even though I recognise the contributions to transformations of social realities made by social movements focused on other illnesses or health-related problems, I tried to limit my discussion to former mental health movements, especially given the availability of existing in-depth sociological accounts on the subject. What is more, as I already mentioned, the field of mental health activism was transforming rapidly and I felt a sense of ethnographic responsibility to make sense out of these changes and pinpoint the specificity and novelty of action, in particular the implications of forms of participation on social media. Ultimately, it appeared that in this new context illness-related identity, which characterised a majority of health movements in the

past, was conspicuously absent. Instead, as we have seen, a new way of imagining mental health as a universal feature of all members of society has emerged.

Although hospital experiences were important in the narratives I collected, I was unable to take Reflections into the hospital as well as to the open spaces and social centres described. While an extension of the participatory method would be valuable, it would require a very different kind of approach in collaboration with the National Health Service. What is more, research in institutionalised settings would require an assessment and consideration of biomedical models of illness, and I felt that the academic critique of psychiatry was already well established and, therefore, other ways of constructing meanings of illness and health needed to be explored. Moreover, there was mounting evidence of a gradual decrease in possibilities for institutionalised treatment in the UK, and recently the British media reported that some patients are being refused voluntary treatment due to the lack of hospital places. Finally, a very close and much loved member of my immediate family had fallen ill not long before the start of the research and was subsequently diagnosed with schizophrenia. Seeing how debilitating this illness was not only for the individual concerned but for the whole family, and given my sibling's reluctance towards diagnosis and institutionalised treatment, I was inclined to look into how other people cope with their mental health problems or, indeed, recover outside the scope of the medical interventions.

Acknowledging my research participants' courage in talking about their experiences in the hope of changing social attitudes, I feel moved to add that I have also been experiencing mental health problems for a number of years. As I was struggling with day-to-day situations, I found vehement academic critique of psychiatry and pharmacological treatment unhelpful. Personally, I thought that a diagnosis helped me in making sense of my mood swings while medication allowed me to function better in my everyday life and it also helped me to write this thesis.

Although I did not actively look for such evidence, it emerged quite clearly in the course of this research that my research participants affected by mental health problems considered psychiatric diagnosis and treatment as just one way of understanding their problems while they continued to engage in various other forms of health practice. Consequently, in data collection, I wanted to focus on health-related interactions that could be enabling and were unlikely to be disabling, while in my account I felt compelled to emphasise the importance of less formal health practices, as I thought this approach would be both more fruitful and representative of the people I met than further critique of psychiatry and its models of illness.

As pointed out in the introduction to this thesis, anthropology has offered an invaluable insight into health-related matters including the distinction between illness, disease and sickness, cross-cultural meanings and experiences of suffering and health-related inequalities among others. However, despite differentiation between various dimensions of ill-health, the discipline has told us very little about health in itself. This, I suppose, relates to the commonly observed situation that health, unless lost, is a matter that people themselves rarely consider or talk about. My research

participants' notions of and practices around mental health, however, constitute a notable exception even though, as we have seen, the meaning of mental health was far from straightforward; it often served as a replacement term for mental illness while senses of health were most commonly denoted by recovery.

We should also note that the activist idea of mental health resonates with various notions of mindfulness that have entered both popular and professional health discourses and practices in recent years. In particular, we could note the similarity between forms of participation in mental health-oriented actions I discussed here and mindfulness in their conviction that intentionality of action, alongside with becoming aware of the situation constitute the preamble to the solution of mental health problems. However, the research did not provide evidence with regards to how these two discourses: on mental health and on mindfulness could have influenced each other. This is why I would not want to extend the comparison too far. A different methodological approach and research questions, focused specifically on individual techniques for recovery, would be able to answer whether there is any convergence between ideas around mental health and discourses on mindfulness and whether combination of these approaches to mental health could collectively contribute to some fundamental transformation of the ways in which we think about and engage in mental health

The notion of activism is also problematic, and yet I have used the term throughout the thesis as an umbrella term for mental health-focused forms of participation. Some might find this term unhelpful due to the considerable dependence of the projects and campaigns that I have discussed on state funding. Others might consider it irrelevant given that not all of my research participants used the term themselves. Finally, there might be reservations towards considering certain types of activity, such as walking in the park, engaging in a discussion on social media or meeting in a social centre, as activism. Through my particular use of the term, I have tried to capture the conviction of my research participants that any kind of positive action, whether individual or collective, with regard to mental health brings us one step closer to the transformation of social understandings and attitudes and, ultimately, a potentially better society for all.

If we agree that mental health is, indeed, something we all have and that we all share responsibility for it, then the implication might be that everyone could become an activist or, more precisely, be like people who for the purpose of this thesis I considered activists. Ingold (2000), following Gould and White (1974), argued that through our engagements with the world we are all cartographers. Similarly, my suggestion that we all could be activists speaks to the fundamental need for engaging in matters of health expressed by people working in the mental health field in the contemporary UK.

Interestingly, my participants' claims and practices make their aims all the more plausible as they go beyond the identity politics framework that demanded recognition for difference and, instead, concentrate on something we all have in common. We might not all become medical professionals but we certainly all are in a

position to concern ourselves with mental health. It thus seems that some of us need to become activists in order to encourage others also to become involved in the things that matter and, furthermore, that experiences of distress or suffering might galvanise engagement and further action. Ultimately, my research participants seem to be suggesting that it is better to coexist rather than just to survive.

All new and rapidly changing social phenomena most likely lead social scientists to contradictory or insufficient conclusions, and the Internet and social media in particular serve as one of the best and most recent examples. What is more, these phenomena might actually make sense only from a greater distance as time passes to those actively participating. This need for reflexive and retrospective insight seems to be particularly relevant in the case of social/political movements and change. As Graeber noted in the preface to ‘*Direct Action*’ (2009), participants in political movements are not out there for scholars to theorise on their actions. In the same volume the author suggests that anthropological work, and doctoral work in particular, should not aim to make a coherent theoretical point as it devalues the key strength of ethnography, here, its capacity to capture human life in a particular period of time.

With regard to Graeber’s two assertions (2009), I understand that ethnographic work concerned with participatory forms of non-violent social change aim for involvement or, at least, for better understanding of the cause and associated practices discussed, while ethnographic accounts of these forms of participation aim to be interesting and accessible to all. I therefore hope that this current attempt to make sense of contemporary forms of participation in mental health focused actions, my account of changing notions and practices around mental health in the UK as well as the films contribute to greater understanding of my research participants’ aims and causes. I should perhaps mention that my research was of interest to people active in the mental health field. For example, Abigail, TTC’s social media coordinator, invited me to participate in a group discussion focused on the subject of social media and mental health recorded in March 2011 and later distributed as a podcast available to download on Rethink’s webpage.

I also received positive feedback regarding the films I made as a volunteer on the Reflections project, from RBM workers and from viewers during the exhibition, but most importantly from the people who shared their stories. However, the source of greatest personal satisfaction was to be told by Helen, during the follow-up event of the Reflections project in February 2011, that one of the recent screenings in a social centre in another borough inspired a group of users to embark on regular outdoor activity. What is more, following the Reflections project, RBM was looking for further volunteering help and asked whether I could put them in touch with students from Goldsmiths. One undergraduate continued working on films with the organisation.

The question of mental health, and health in general, is indeed a very important one. However, it seems that it is not at all straightforward to avoid generalisations or

clichés. Talking about mental health thus seems to share an important similarity to painting the evening sky just before sunset. Just as it is impossible to recreate the diversity of shades and saturation with existing colours, it is also not viable to account for the burden of mental illness and associated suffering in words. It is, however, not impossible but, rather, requires particular techniques. My research participants, for example, seem to be suggesting with their mediated practices that certain words, combined in a particular fashion and uttered in an appropriate context and in relations to certain actions, can aid in framing or making sense of health-related experience while also hoping to transform the reality that shapes that experience.

Direction for further research

I hope that this account has shed some light on recently emerging ideas and practices regarding mental health in contemporary Britain and on matters of health more generally. I also hope that this research can contribute to the activist aim of making mental health problems more widely recognised and better understood. Because I have adopted a wide angled lens and a broad sweep, the advantages of documenting the diverse scope of participation or activism also carry disadvantages in a lack of detail on many specific aspects of contemporary actions.

Among issues and questions that appeared during fieldwork but were, inevitably, left unexplored were the activity of groups that continue work initiated by former movements, such as Mad Pride. I have explained earlier that I chose to concentrate on recently emerged forms of participation. I also did not enquire into the public perceptions of activist-made representations of mental health problems. This was because I thought it more important to account for the reception and critique of these media by people directly affected by mental health problems who share their personal accounts in the hope of eradicating stigma and prejudice. Furthermore, I could have inquired into whether users of the TTC Facebook Page participate in other non-social media settings and whether and how their reported senses of wellbeing continue into their every-day lives. My conviction was that this enquiry would undermine the relevance of the vigorous activity already taking place in this context, and would trespass across a division participants in discussions therein did not themselves want to cross.

I do not consider that these and other issues undermine the relevance of the research presented in this thesis. Rather, I see them as providing a sense of the direction for further research. Among the most burning matters, there is a necessity to follow contemporary forms of participation that I have discussed in order to assess their long-term successes and failings, and new research might enable us to see whether the activist focus on universal mental health and social responsibility brings about the envisaged comprehensive social change. Of particular attention should be TTC's Time to Talk campaign that encouraged conversations about mental health problems in everyday situations. Focus on this project might provide a better

understanding of the dynamics of social change initiated by activists in relation to responses from people who have no experience of mental health problems, and it could also help in assessing whether the notion of mental health was understandable and useful.

Particularly interesting and relevant will be additional investigation of the role of the media in shaping public attitudes towards mental health problems, especially as there has been some recent increase in mainstream television channels' airtime devoted specifically to matters of health. For example, in Autumn 2013 the BBC launched a series of programmes focused on mental health problems under the name 'It's a Mad World'. In parallel, Channel 4 featured a series of programs tackling the subject of health more generally. Audience research focused on the reception of programmes broadcast in these series could provide useful data regarding contemporary social understandings of mental health problems in the UK.

I would also emphasise the need for further investigation of the role of social media in both health-related action and processes of recovery. We should recall that users of the TTC Facebook Page claimed that participation in discussions in this medium had a positive effect on their sense of wellbeing. Meanwhile, one recent quantitative study has shown that using Facebook among young adults had a negative effect on their subjective wellbeing in terms of both 'moment to moment' experiences and satisfaction with life more generally (Kross et al., 2013). Research into this area could include interviews with users of social media as well as long term observations of forms of participation, which might provide more convincing evidence regarding the possibilities and limitations of social media in health practices. Needless to say, more ethnographic work is required to understand the still fairly recent and continually changing phenomenon of social media more generally.

There is also the unquestioned importance of research into matters of health. Kleinman (1999) noted some time ago that we live in a period characterised by a profound transformation of medical knowledge and practice and with it of suffering, and argued that questions arising from these changes are of great relevance to the understanding of human morality as well as people's lived experience of their local worlds. In similar vein, Cockerham (1981) suggested that attitudes towards health speak to a fundamental concern with the human condition indicative of shared social and community values. Therefore, as matters of health are relevant to all of us, both personally and socially, there is a continual need for research into the subject. A multidisciplinary approach that could encompass but not be limited to anthropology, population studies, biomedicine, biology and human geography would likely provide a more complete understanding of the various dimensions of health and go beyond deterministic and teleological explanations of the environment's impact on human health.

Finally, with specific regard to mental health, I see a great potential of research into practices that cross the boundaries of established medical and belief systems and new meanings of health and mental health that arise alongside them. It seems vital to concentrate on both individual and collective health behaviours and health-related

activity that challenge, transgress and/or transform discriminating beliefs and unequal socio-economic structures. Given these immense possibilities for further inquiry, I see the work presented in this thesis as a mere preamble for future investigations, which I hope could contribute to a more profound realisation that mental health is, indeed, something we all share in common. This recognition would not only contribute to the eradication of stigma attached to mental illness but it might also help in ensuring better mental health for everybody. Further research might also provide more detail into how different concepts of and approaches to environment might contribute to new models for understanding as well as treatment of mental health problems and the role media might play in these configurations.

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Appendix

Appendix 1:

Reflections, Conserving Richmond Borough Mind, 50 Years of Service, 50 Years of Mental Health heritage: DVD produced by RBM in the course of the Reflections project.

The films can also be watched online: at

<https://vimeo.com/album/1745144>

or

<http://www.rbmind.org/reflection---mental-health-heritage-in-richmond.asp>