Changing minds in neoliberal times: the global politics of mental health awareness and anti-stigma campaigns

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Abstract

This thesis explores the global politics of mental health through an analysis of the discourse in mental health awareness and anti-stigma campaigns. The purpose of my research is to understand and expose the types of knowledge about stigma and mental illness that are promoted as 'scientific truths' in these programmes. To this end, I conduct a genealogy of anti-stigma campaigning in the United Kingdom and employ a Foucauldian framework of power/knowledge and governmentality to trace the process of neoliberal subjectification in the discourse of different anti-stigma campaigns. My findings from archival research at the Royal College of Psychiatrists in London suggest that previous anti-stigma campaigns produced a medicalised understanding of mental distress and mental health stigma which intensified the pharmaceuticalisation and neoliberalisation of mental health.

In my analysis of the contemporary anti-stigma campaign *Time to Change* (2007-2021) I further expose the scientific discourse as promoting a narrative of self-management, resilience, and surveillance. I problematise this discourse by demonstrating that the concepts of stigma and mental health are approached uncritically and without attention to their history. What is more, the globalisation efforts of *Time to Change* indicate that the experience of mental illness is viewed as universal, despite evidence that mental distress is a complex phenomenon at the intersection of race, gender, and class.

I argue that awareness campaigns promote the performance of mental health anti-stigma activities while drawing attention away from the harmful neoliberal structures that are implicated in the emergence of mental distress. At the same time, these programmes follow a bio-medical understanding of mental health that reduces mental distress to an individual pathology. Psychiatric and neoliberal knowledges are upheld as 'scientific' in anti-stigma campaigns which I thus expose as technologies of governance that legitimise the commodification of mental distress. My research makes an empirical contribution to the study of mental wellbeing in the discipline of International Relations, particularly to the literature of global health politics, through a critical engagement with the sociology of knowledge of anti-stigma campaigns and highlights the need for further research into the global politics of mental health within IR.

List of Abbreviations

CM	Changing Minds
CTO	Community Treatment Order
DD	Defeat Depression
DHSC	Department of Health and Social Care
FSS	Foucauldian Security Studies
FYFV	Five Year Forward View
GASA	Global Anti-Stigma Alliance
GMH	Global Mental Health
GMHWG	Global Mental Health Working Group
GP	General practitioner
IAPT	Improving Access to Psychological Therapies
IPE	International Political Economy
IR	International Relations
MACA	Mental After Care Association
MC	Management Committee
MGMH	Movement for Global Mental Health
NAMH	National Association for Mental Health
NGO	Non-Governmental Organisation
NHS	National Health Service
NHS LTP	National Health Service Long-Term Plan
NICE	National Institute for Health and Care Excellence
PM	Prime Minister

RCPsych	Royal College of Psychiatrists
SC	Steering Committee
SMG	Strategic Management Group
TTC	Time to Change
TTCG	Time to Change Global
TTTD	Time to Talk Day
WBG	World Bank Group
WEF	World Economic Forum
WHO	World Health Organisation
UN	United Nations

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1. Introduction

‘If we change our attitude to mental health — we change the world.’

(António Guterres, General-Secretary of the United Nations, in his statement on World Mental Health Day, October 10th, 2018)

This thesis addresses the global rise in mental health awareness and anti-stigma campaigns. I provide a genealogy of anti-stigma thinking and campaigning in the United Kingdom through a critical reading of the discourse deployed in public (mental) health programmes. My analysis demonstrates that biological – and seemingly ‘objective’ – knowledge about mental illness and mental health stigma is promoted as part of these campaigns which silence alternative understandings of the causes and nature of mental distress. I trace the production of neoliberal subjects within the context of a global mental health assemblage, comprised of a variety of Western-led anti-stigma and mental health awareness programmes that are designed to intervene on a population-wide level. In doing so, I make sense of this discourse as a technology of governance that upholds and legitimises harmful neoliberal structures in our societies. This introduction serves to contextualise my research by offering an overview of the rationale, methodology, and overall argument of this thesis. I also clarify the terminology used in this text and state the original contribution my research makes to the literature. To close the chapter, I provide an overview and summary of the individual chapters of this thesis.

1.1. Mental illness – the global burden of our times?

The WHO website (n.d.) states that ‘two of the most common mental health conditions, depression and anxiety, cost the global economy US$ 1 trillion each year’. In 2011, the World Economic Forum (WEF) produced a report that estimated the ‘economic burden’ of mental health conditions worldwide to be around $2.5 trillion in 2010, with the cost projected to surge to $6 trillion by 2030 (Bloom et al 2011). A few years later, in her first speech as Prime Minister, Theresa May chose to focus on the need to tackle growing mental health inequality while highlighting that ‘the economic and social cost of mental illness is £105 billion – roughly the same as we spend on the NHS in its entirety’ (2017a). In the news media, the topic of mental health has gained significant traction over the last decade with mental illness having been branded an ‘epidemic’ and ‘crisis’ (Campbell 2018; Moran 2019; Sarner 2018; Weale 2019). Most poignantly, UN Secretary-General António Guterres said in a 2018 statement that the promotion of mental health needs to begin at the level of adolescents because this would benefit not only the adolescents themselves ‘but also economics and society as a whole, with healthy young adults able to make greater contributions to the workforce, their families and communities’ (UN 2018). In brief, the rise in diagnosable mental illnesses and the potential economic consequences of this development have been brought to the attention of global institutions, inter-governmental organisations and governments alike. It appears that these different actors are united in calling for further attention to the issue of mental wellbeing and its seeming decline among the world population. Even the World Bank Group (WBG) (2020) assures us on their website that ‘mental health, as with physical health, contributes to human capital accumulation and consequently to the wealth of nations’. In other words, there is a widespread consensus amongst international stakeholders that mental wellbeing is not only intrinsically linked to economic prosperity but that we have reached a point at which it requires serious globalised intervention.

Among the academic global public mental health community, these concerns have manifested in a movement that is known as the Movement for Global Mental Health (MGMH). Proponents of this movement began to lay out its purpose with a seminal paper published in *The Lancet* in which a Global Mental Health Working Group (GMHWG) – including over 40 academic signatories – urged governments and global institutions to ‘scale up’ efforts in the provision of mental health services (Lancet Global Mental Health Group 2007: 1241). Additionally, the paper called for an expansion of the ‘public-health training infrastructure’ where mental health courses are to be integrated into public health training, covering topics like ‘the epidemiology of mental disorders and their risk factors’ (Lancet Global Mental Health Group 2007: 1250). In a series of articles published in *The Lancet* from 2007-2011, a general idea of what Global Mental Health (GMH) should look like and who would be involved in its implementation emerged. GMH was supposed to ring in a ‘new paradigm of public mental health’ where targeted funding and ‘local capacity building’ would form the foundation on which measurable progress of mental health programmes could rest (Eaton et al 2011: 1601).

However, GMH and its supporters have attracted a substantial amount of critique over the last decade following this intervention. In the first instance, scholars and activists from the Global South have criticised GMH for putting an undue focus on the brain in its understanding of mental distress and for neglecting alternative and indigenous approaches to mental health (Davar 2014; Shukla et al 2012). There is also an increasing awareness of the economic conditions that drive the discourse of mental illness and the marketisation of treatment and mental health service provisions are called into question (Esposito and Perez 2014; Mills 2014). Finally, the colonial history (Cohen 2014) and continued deployment of psychiatric knowledge to uphold racist structures in non-Western countries through the project of GMH have been problematised by scholars and mental health practitioners alike (Fernando 2010; Hailemariam and Pathare 2020; Ibrahim 2014; Mills 2014). Crucially, the politics of knowledge and knowledge-production in the context of developing a global framework of mental health are now viewed with increased scrutiny. The question arises as to how a universal approach to mental wellbeing implicates the silencing or omission of those voices which are critical of psychiatry as a guiding framework, especially because of its embeddedness within a global neoliberal hegemony.

I position my research at the intersection of critical approaches to knowledge-production in global mental health politics and the growing dissatisfaction with neoliberalism embedded as the guiding principle of the global economy. While it comes easy to champion the idea that mental health should be of political concern given that reported cases of mental illness globally are rising, it is equally important to observe how mental illness and its consequences are framed in public discourse. All too often we witness the 'seduction of quantification' at work in shaping public debate on mental health. This means that a phenomenon is elevated to public consciousness using substantial numbers to show that it is significant (Merry 2016). Defining a problem in a certain way also determines the solutions available to address it. Thus, a methodology based on measurements and statistics affects the scope of governance and policy decision-making for an issue. For mental health, this means that much of its impact has been framed as burdensome to the economy, neatly packaged in an extortionate price tag that is considered comprehensible to the general public. This is not to say that human suffering is not understood to be a part of mental distress but ultimately, economic interests are positioned at the forefront of contemporary discourse.

And this is precisely the point in the story where we can witness the surfacing of debates around mental health stigma and discrimination. Although the history and politics of the emergence of stigma in the context of mental distress are contested (Costa et al 2012; Long 2014; Tyler 2020), 'stigma' has become a buzzword in recent years and is uttered in the same breath as almost every major announcement on mental health. Eradicating mental health stigma is viewed as an essential step in the fight to control the mental health 'epidemic' of our times and negative attitudes are the numeric markers to overcome. The WHO (2017) claims that the principal benefit of de-stigmatisation efforts is their potential to ease access to treatment because people feel confident to speak about their feelings. In addition, the WBG (2016) has started their own awareness programme *Out of the Shadows* whose promotional video asserts that over 600 million people around the world are left without treatment due to three principal obstacles: stigma, inadequate funding, and poor healthcare systems.

In this thesis I dissect the discourse of (anti-)stigma in the context of mental health awareness campaigning in order to understand how a particular version of stigma knowledge is deployed for the purpose of public health promotion. I start by arguing that — bearing in mind the extensive framing of mental illness within the context of the global economy — we must challenge a narrative that positions individuals with mental distress as a burden to the economy. Instead, we must equally consider that it is the economic structures we live under that can be understood as the 'true burden' of our times. For example, because 'under capitalism, great efforts are made to ensure human energy is channelled into labour, even though it is often miserable and tedious', the human need for creativity is repressed and idleness is pathologised (Matthews 2019: 54). This line of argument comes from critiques of neoliberalism inspired by Marxist thought which emphasise that widespread dissatisfaction with work and the precarity of working conditions offer little opportunity for personal fulfilment (Ferguson 2017; Matthews 2019). Others (Fleming 2017) have stressed that neoliberalism's ability to calculate every aspect of our existence on a cost/benefit basis is the underlying reason for the mental burnout that follows a never-ending pursuit of growth. Moreover, the demands of capitalist modes of being, including the basing of an economic system on the creation of individual debt, has also prompted inquiry into suicides as a consequence of economic structures (Grzanka and Mann 2014). These examples show that it is possible to think differently from the propagated status quo with regards to mental health and its relation to the economy. If we can imagine the economy as causing mental distress, it is also possible to think differently about the causes and manifestations of mental health stigma.

My inquiry into the politics of mental health and anti-stigma campaigning is guided by concerns around the knowledge about mental illness and stigma that is presented as 'scientific' in these campaigns. The stories, the discourses, that are disseminated through anti-stigma public health interventions are subject to the conflicting interests of the pharmaceutical industry, governments, and the medical profession. Often, the individual person experiencing mental distress is the focus of anti-stigma interventions, but people with 'lived experience' are still marginalised in conversations about meaningful political transformation (Russo and Beresford 2015; Voronka 2016a; Wallcraft et al 2003). Thus, my initial curiosity is to reveal the processes of knowledge about mental illness and stigma that are produced in and through the discourse of mental health awareness and anti-stigma campaigns. Anti-stigma campaigns are an increasingly common global phenomenon, although programmes are largely managed in and by Western states and organisations. For example, in the United Kingdom there are the Scottish *See Me* campaign, the *Change Your Mind* campaign in Northern Ireland, and the *Time to Change* (TTC) programme, which is promoted in Wales, England and – digitally – in the entire country. On a more global scale, we find campaigns in the United States (*Bring Change to Mind*), Australia (*Beyond Blue*), Germany (*BASTA*), the Netherlands (*Samen Sterk Sonder Stigma*) and Canada (*Opening Minds*). This list is not exhaustive, but the anti-stigma campaign *Time to Change* stands out as a programme that has expanded its operations beyond the UK to non-Western countries. Thus, I have chosen to focus on TTC as my principal case study, interrogating its discourse to make sense of the role of anti-stigma campaigning in the global politics of mental health.

1.2. Case study: The *Time to Change* campaign

My analysis commences with an examination of anti-stigma campaigns and mental health awareness programmes in the United Kingdom. I went on two research visits to the archives of the Royal College of Psychiatrists (RCPsych) in London to sketch a genealogy of anti-stigma thinking and campaigning while also drawing on contemporary sources from social media platforms and campaign websites. In doing so, I first analysed archival material from the *Defeat Depression* (1992-1997) and *Changing Minds* (1998-2003) campaigns. Then, I traced anti-stigma knowledge-making in the *Time to Change* campaign and its extension, *Time to Change Global* (TTCG). Running from 2007-2021 (expected), TTC is the UK's leading anti-stigma public health campaign with funding from both the British Lottery Fund and the UK government. At the time of writing, the leadership announced that campaign funding from the government would stop and that the initiative will come to an end in 2021 (TTC n.d.-j). What programme the campaign will be replaced with – as it is my prediction that a new mental health awareness project is going to appear in its stead – has not yet been revealed. However, the foundation that TTC and TTCG have laid for a global conceptualisation of anti-stigma interventions is central to an understanding of the global politics of mental health, as I demonstrate through my analysis in the following chapters.

Time to Change was launched in 2007 and it is jointly managed by the charities *Mind* and *Rethink Mental Illness*, both of which have received funding from the UK government for the running of the campaign. In 2018, *Mind* alone received £1.9 million from the government for the organisation of TTC. In 2012, the programme was extended through the foundation of the Global Anti-Stigma Alliance (GASA), which included the inception of TTCG. Combining the public health efforts of seventeen countries, GASA's purpose is to facilitate the sharing of 'learning, methodologies, best practice, materials, and the latest evidence to achieve better outcomes for people facing stigma and discrimination related to mental health issues' (TTC n.d.-c). TTC and TTCG rely on social media platforms for the majority of their promotion. My analysis of the discourse in this thesis thus encompasses the interrogation of website content, tweets, videos, and the policy documents available through website archives.

Although TTC is the primary case study for my interrogation of anti-stigma politics, this thesis also encompasses the findings of my research on two previous anti-stigma campaigns that were run in the United Kingdom prior to the inception of TTC. Hence, I conduct a historical exploration of TTC showing how the campaign's discourse is firmly embedded within the legacy of psychiatric anti-stigma thinking of the twentieth century and the advent of the psycho-pharmaceuticals. My analysis of this case study reveals the potted history of mental health anti-stigma thinking in the United Kingdom and its relevance to the study of International Relations (IR) becomes even clearer when it is put into conversation with the study of neoliberal governmentality and the emergence of the modern neoliberal subject.

1.3. Knowing (about) mental health stigma

The theoretical framework of my research is inspired by a Foucauldian understanding of the relationships between medicine, knowledge, and governance. This means that I draw on the idea of governmentality as a guiding concept to understand how meanings and subjects are produced in and throughout anti-stigma discourse. I take as my theoretical foundation Foucault's (2004b: 39) insistence that it is precisely the 'knowledge that has been rendered neutral because its scientificity has become sacred' that matters in the context of the politics of mental wellbeing. It is the space where the discipline of everyday behaviour meets the production of knowledge by sovereign actors that has been of interest in my exploration of anti-stigma campaigns. In applying this framework, I have made use of a variety of concepts from the 'toolbox' of post-structural scholarship in International Relations.

Firstly, my analysis of anti-stigma campaigns in this thesis constitutes a genealogical reading, a critical historical enquiry into the campaigns' inception, which interrogates past narratives of mental health stigma drawing on the promotional materials collected in archival research. I follow a Foucauldian understanding of the significance of genealogy for the purpose of studying relationships of power, knowledge, and discourse. Foucault (2004b: 8) has argued that genealogies are a 'coupling together of scholarly erudition and local memories, which allows us to constitute a historical knowledge of struggles'. Moreover, an approach to genealogy as a problematisation of societal norms has been shown to highlight the different ways in which knowledge about our bodies and minds can be taken for granted through its normalisation (Allen 2016; Koopman 2013). Thus, I decided to begin my research at the archives of the Royal College of Psychiatrists (RCPsych) in London where I studied the materials of two mental health awareness campaigns, *Defeat Depression* (DD), 1992-97 and *Changing Minds* (CM), 1998-2003. The campaigns are an example of past 'local memories' that are equally shaped by the 'scholarly erudition' of psychiatry. I conduct a genealogical reading of the concept of anti-stigma as a knowable entity bearing in mind Foucault's assertion that 'the sciences […] are the effect of a series of procedures' (2006: 56).

Secondly, my approach to the study of mental health is guided by the Foucauldian attention to the importance of disciplinary power in the context of psychiatry. I understand disciplinary power as a force that 'fabricates subjected bodies' because it establishes norms 'as the principle of division and normalization, as the universal prescription' for individuals (Foucault 2006: 55). Disciplinary power thus stands in direct relation to the normalising power of knowledge. Science disciplines the individual and creates a body of knowledge that acts on the individual in the everyday. Implicated in the process of normalisation and discipline is the discourse, the 'regime of truth', through which subjects are constituted. Consequently, I interrogate the vocabulary that is posited as 'scientific' in the context of mental health and stigma, approaching the study of anti-stigma campaigns with an attentiveness to the psychiatric discourse that is promoted as the primary way to de-stigmatise mental illness.

Thirdly, my methodology is concerned with the process of neoliberalism and the neoliberal subject. Neoliberalism is understood in relation to capitalist power as a concept concerned with 'the patterns of capitalism since the 1980s, with particular reference to commodification tendencies […] and wider socio-economic inequalities' (Eagleton-Pierce 2019: 119). Thus, while subjected to much critical debate (Peck 2010; Venugopal 2015; Wacquant 2012), neoliberalism denotes an intellectual phenomenon of capitalism that extends beyond the economic sphere into the realm of the personal psyche (Thomas 2016). The analysis in this thesis relates neoliberalism also to the austerity-driven policies in the wake of the 2007-08 global financial crisis (Cummins 2018a) as well as the earlier healthcare reforms of the British National Health Service (NHS) in the 1980s and 1990s (Rizq 2012). Crucially, neoliberalism is understood to influence the experience and definition of mental health in relation to the expectations of labour productivity and personal success set in contemporary societies (Esposito and Perez 2014; Grzanka and Mann 2015). Centring the study of mental health anti-stigma campaigns on processes of neoliberalisation is thus 'helpful in terms of understanding the economies of influence […] that sustain our bio-medical model of distress/depression' (Cosgrove and Karter 2018: 670). For example, bio-medical explanations of distress are linked to an understanding of individual pathology, in this case the human brain, as the site for intervention (Rose and Abi-Rached 2014). Consequently, pharmacological solutions have become popularised as enabling 'people to regain their social positioning as healthy citizens' (Tseris 2018: 173) despite concerns about the efficacy of antidepressants and other psychoactive drugs (Moncrieff 2009). What is more, the pharmaceuticalisation of mental distress can be traced in the promotional materials and funding structures of early anti-stigma campaigns and will be discussed in more detail in Chapters 2 and 3 of this thesis.

While neoliberalism is a core concept in my work, I understand the neoliberal subject to be an individual that performs self-discipline. My definition is inspired by critical scholarship on neoliberalism, some explicitly in the context of mental health and wellbeing (Brijnath and Antoniades 2016; Trivelli 2014), and some guided by the idea of neoliberalism as governmentality (Davies and Chisholm 2018; Eagleton-Pierce 2016). It is the productive power of governmentality that constitutes the subject into being as a technology of – and a mode for – governance. Hence, the final aspect of my theoretical framework is reliant on the conceptual tools of surveillance and performativity in order to make sense of the process of neoliberal subject-making in mental health anti-stigma discourse.

In sum, I employ a Foucauldian methodology to analyse the production of knowledge and subjectivities in the discourse of the *Time to Change* campaign and its predecessors while referring to the scholarship of International Political Economy (IPE) to contextualise this analysis in broader critiques of neoliberal governmentality. The particularities of my theoretical framework and methodology are further explored in Chapter 2, where I also engage with the limitations of a Foucauldian framework. For now, I contend that an analysis of the global politics of mental health can always benefit from a beginning where the conceptual history of the knowledge we wish to dissect is considered and I continue by introducing a genealogical reading of the emergence of anti-stigma thinking in the decades before my own research begins.

1.4. Histories of anti-stigma

Before leaping into an analysis of my findings in the RCPsych archives I begin by providing the reader with a historical contextualisation of (psychiatric) anti-stigma thinking and campaigning in the United Kingdom. The earliest campaign materials that I was able to see and work with in the RCPych dates from the early 1990s. No other material or information on previous campaigns was available, nor did I find reference to the history of anti-stigma campaigns in the materials that I encountered. However, the history of anti-stigma campaigns is intrinsically linked with the history of psychiatry. While I engage more directly with the discipline of psychiatry in the following chapter, I now introduce the historical context to the narrative of mental health stigma and anti-stigma. In particular, I refer to Long's (2014) extensive research on the history of anti-stigma campaigns in the United Kingdom, dating from 1870-1970. Crucially, Long's work also intersects with that of scholars who have pointed to the extensive history of psychiatry as implicated in the establishment of colonial relations where the subject is psychiatrised for political ends (Fanon 2008; Mahone and Vaughn 2007; Micale and Lerner 2001). In her work, Long (2014: 218) seeks to denaturalise the 'stigma of mental illness narrative' by showing 'that the records of mental health groups researched for this book rarely defined what they meant by public opinion or stigma'. This means that stigma, in the first instance, is an ambiguous concept to be explored through genealogical inquiry.

The story of anti-stigma begins with the desire of psychiatrists and mental health professionals to achieve a more professional status through an integration into the field of medicine. This desire has always contradicted the provision of care in the discipline because psychiatry remains perpetually caught between its own duty to care and the duty to be useful to the state, a theme that we also see emerge in the advent of anti-stigma thinking (Bashford and Strange 2007). In her monograph, Long (2014) begins the analysis of anti-stigma campaigns with an exposition of the complex relationship between psychiatric doctors and their patients and demonstrates how the category of stigma is unstable in its meaning because it emerged representing only the perceptions of stigma from the viewpoint of healthcare professionals. This points to the beginning of a dichotomy between discrimination as interpreted by psychiatric professionals and the discrimination which is experienced by those who are affected by mental distress – one which persists to the present day. In other words, Long's critical engagement with the history of anti-stigma campaigns from the nineteenth and twentieth centuries builds a solid conceptual foundation for my own critical engagement with the RCPsych campaigns (1992-2003) and the contemporary *Time to Change* programme. We now follow Long's anti-stigma journey as she shows, (a) why psychiatry first started to think of anti-stigma programmes as necessary; (b) how the mental hygiene movement from the early twentieth century shaped the stigma narrative; and (c) how these discourses impinge on contemporary anti-stigma thinking.

1.4.1. Professional aspirations in the early twentieth century

Anti-stigma campaigns developed out of a desire by healthcare professionals to educate the public who were perceived to be ignorant about 'the true nature' of mental illness, and the need for a more professional standing of the discipline at the beginning of the twentieth century. Leaving unacknowledged their own complicity in the stigmatisation of patients, healthcare professionals instead slipped seamlessly into the role of the expert educator whose aim became to de-stigmatise mental illness by de-stigmatising the profession of psychiatry. Practices of confinement against a patient's wishes in an asylum were a common occurrence at the time, as were disagreements between patients, families, and doctors regarding given diagnoses of psychiatric disorders and subsequent treatment. Hence, from the beginning we are confronted with a complex relationship between 'experts' and those deemed mentally ill.

Although psychiatrists in the late nineteenth and early twentieth century did not experience the same degree of discrimination as their patients, the low status of the psychiatric profession was constantly reproduced within the medical profession and the public sphere. For example, media reports about psychiatrists frequently 'veered paradoxically between attacking psychiatrists for failing to lock up dangerous lunatics and recounting how unscrupulous psychiatrists colluded with relatives so to wrongfully confine sane citizens for monetary gain' (Long 2014: 28). Moreover, the low status of psychiatry as a sub-discipline of medicine often led to it being called a 'Cinderella' speciality. Psychiatrists and patients in asylums were both affected by the low standing of the profession and the subsequent stigma attached to institutional care, but the two parties rarely worked together. Quite the contrary, as Porter's (1999: 3) investigations into patient narratives of the time show, asylum dwellers thought of psychiatrists as equally mad and psychiatry 'itself mad, rendering others the victims of its own delusions' rather than constituting an evidence-based scientific branch of medicine. Thus, the circumstances were unfavourable for psychiatrists who were perceived as dichotomous by the public, pitiful by the medical profession, and intellectually misled, including by their own patients. It is thus no wonder, as Long (2014) shows, that the psychiatric health care profession at the time felt a strong need to detach common 'misconceptions' about mental illness from their livelihoods.

The primary way by which the psychiatric profession sought to establish itself as more legitimate was through academic research that was presented as scientific evidence. As 'psychiatrists recognised that their professional status was inexorably entwined with public perceptions of mental illness' they began writing books and newspaper articles for a much more popular and broader audience than before (Long 2014: 35). These were the early blueprints of anti-stigma campaigns where psychiatrists published work with the intention of de-mystifying psychiatric knowledge and labour. This presumed the existence of stigma, but there was no clear consensus on the definition of it. At the one end, there were those psychiatrists with a desire to make mental health services more accessible, and at the other end were those more interested in elevating the status of the psychiatric profession. Most crucially though, anti-stigma programmes did not emerge entirely in the patients' interests alone. If they had, perhaps patients would have been involved in their creation, yet the power imbalance between psychiatrists and patients did not allow for this type of conjuncture, thus merely reproducing existing hierarchies in the process.

Finally, through the integration of psychiatric services within the NHS in 1954, the psychiatric profession had found the best possible way to tackle the stigma of their profession (Long 2014). Through the affirmation of the medical aspect of mental health, ‘madness’ was firmly integrated into a framework of mental illness, the consequences of which persist to the present day. As the genealogy of its emergence shows, stigma of mental illness is an ambiguous concept. Indeed, the category of mental health stigma can be filled with meaning depending on who determines the conceptual boundaries of mental illness, the particularities of which I dissect in this thesis. What counts for stigma also counts for narratives of anti-stigma. In other words, the contested categories of mental health stigma and anti-stigma are related to psychiatric knowledge and power at their very origin. This raises very important questions about the politics of (anti-)stigma in the discourse of contemporary campaigns.

1.4.2. The movement for mental hygiene

The inception of public mental health campaigns was underpinned by the movement for mental hygiene which also formalised the role of the government in setting the health agenda for the population. First mentions of mental hygiene are recorded in the nineteenth century, but the concept did not fully develop into a crucial aspect of public mental health until the early twentieth century. In part, the call for mental hygiene in the United Kingdom emerged out of the growing unpopularity of asylums at the beginning of the twentieth century as recovery rates from mental illness in institutional settings remained low and stagnant. Admissions were increasingly avoided by both the public and mental health care professionals, prompting the leading psychiatrist at the Royal Edinburgh Asylum, Thomas Clouston, to address the public decline of the psychiatric profession with his publication *The Hygiene of Mind* (1906). In this monograph, Clouston advocates for the implementation of an adequate ‘diet, education and lifestyle’ as preventative measure against the development of mental disorders (Long 2014: 101). The following ‘mental hygiene movement’ presented a first attempt in the United Kingdom to extend psychiatric practice beyond asylums and hospitals into the everyday life and management of the population. It is also the first time where lifestyle was explicitly posited as one of the determinant factors of mental health.

Outside the United Kingdom, predominantly in European colonies around the world, (psychiatric) medicine has a much longer history of promoting public health interventions among non-Western populations. Bashford (2017) points us to the concept of 'imperial hygiene' and suggests that colonialism and public health have an intricate history. Occupying forces had become concerned with the health of native populations who were primarily viewed as a potential labour force, citizenry, and reproductive entity. What is more, there was concern about overseas colonial settlers who were at risk of falling victim to tropical diseases (Packard 2016). What began as a concern for the spread of communicable diseases, ended up extending to matters of the mind, most blatantly visible in the early twentieth century (Fanon 2008).

In an impactful reading on the history of public health, Bashford and Strange (2007) link the emergence of health governance with that of hyper-nationalism. They argue that 'it is no coincidence that this early-20th-century moment was also the era in which national public health departments and bureaucracies first emerged' (Bashford and Strange 2007: 91). What the authors refer to are the attempts by Western governments to merge the structural implementation of basic hygienic standards – such as handwashing and 'no spitting' on the everyday level – with the idea that these will set Western nations apart from non-Western nations both in terms of intellectual development and on the battlefield. In other words, the historical linkage between imperial hygiene and mental hygiene can be complemented also with 'political hygiene' – the explicit notion of a relationship between health and citizenship.

The political consequences of the mental hygiene movement in the UK included the establishment of the International Committee for Mental Hygiene, the birth of social work as a psychiatric profession, and the passing of the 1913 Mental Deficiency and 1930 Mental Treatment Acts. The latter not only provided the foundation for voluntary and out-patient treatment, but it rebranded the by-now-unpopular asylums as mental hospitals. Particularly, introducing the option of voluntary treatment presented a cornerstone of mental hygiene as individual practice. This meant that the realisation by an individual that she might need psychiatric care was key to promoting and maintaining mental hygiene in the population.

At the same time, the changing of psychiatric institutions from asylums to mental hospitals constituted an explicit attempt to de-stigmatise admissions into healthcare facilities. It was hoped that the change in name would lead to a better public standing because hospitals were perceived as places for recovery whereas asylums were assumed to involve long or indefinite stays (Long 2014). The public imagination and opinions were thus a concern for mental health legislators when making policy decisions about the governance mental illness. The formalisation of legislation was considered to be a crucial point of intervention for implementing anti-stigma programmes. In the Mental Health Deficiency Act of 1913, the responsibility for surveillance of those considered to be at the borderline of a pathological mental health condition and an ‘acceptable’ amount of mental distress was shifted to communities. This meant that voluntary community agencies like the Mental Health After Care Association (MACA) and the National Association for Mental Health (NAMH, later known as Mind) were expected to provide advanced care services, including housing and community treatments. There was still a large demand for asylums, but as Wright et al (2008) show, the principle of community and voluntary care in the United Kingdom is intrinsically linked to the laws that define the scope of funding and responsibility the state is willing to invest. Concisely, the stigma that can be attached to institutionalised or community care is also dependent on the scope of financial and legislative commitment by the state.

What can now be identified as (neo)liberal technologies of healthcare appear to have been the cornerstone of mental health services from the beginning of the twentieth century, where the state outsources the care for mental distress to the community to some degree. This raises questions about the predisposition of psychiatry to an embeddedness within neoliberal modes of governance and statecraft, and whether a desire to govern the mind is inherently linked to psychiatry. Furthermore, it is important to flag the link between the emergence of mental hygiene to the eugenic history of Europe whose states readily employed psychiatric knowledge for the purpose of eugenic and racist politics (Kühl 2013). To be sure, the adoption of neoliberal values into psychiatric care was a process that did not require much external pressure because core features of neoliberalism had already been built into mental health governance for many decades, including the desire to measure and classify mental capacity. Thus, engaging with the history of mental hygiene at the beginning of the twentieth century allows me to illuminate the intellectual roots of modern-day anti-stigma discourse. Collective action in the name of mental hygiene was instrumental to the establishment of institutions and laws which, while they have evolved in their scope and definition, are the precursors for the contemporary neoliberal logics and institutions responsible for the promotion of mental health.

1.4.3. Mental health awareness today

Long (2014) concludes her analysis with a much broader reflection on the development of anti-stigma campaigns after 1970. Although these programmes were not the subject of her research, Long offers important insights into how the anti-stigma narrative is being taken forward in contemporary public health interventions. Her reflection (2014: 51) builds on the observation that,

> 'psychiatrists rarely argued that it was necessary to destigmatise mental illness before the prestige of psychiatry could be enhanced. Thus even when they did seek to address the public, psychiatrists often sought to create more positive representations of psychiatry rather than of their patients.'

This allowed psychiatrists to maintain an illusion of superiority in knowledge which ultimately rested on their claim to scientific evidence. If patients continue to be perceived as 'crazed beasts beyond reason', as victims, or generally as 'incapable of speaking for themselves' then psychiatry can re-affirm its own position as a medical authority (Long 2014: 51). Considering these observations, it is interesting to contextualise Long's (2014) critique within contemporary campaigns such as *Time to Change*. After all, patient and service-user involvement and stories are a common aspect in the promotion of mental health awareness. It is reasonable to wonder whom the inclusion of service-user stories serves bearing in mind the fraught history of anti-stigma campaigning. Long offers her own brief reflections on the *Time to Change* campaign. Drawing on a conversation with a person who worked for TTC in 2009, Long (2014: 218) recalls the bottom-line of what she was told and summarises it as such:

> 'The discrimination experienced by people suffering from mental distress stemmed not from public ignorance, but from public knowledge that mental health problems could inflict profound distress on sufferers, whose difficulties were further compounded by structural discrimination.'

In other words, the conception of stigma that *Time to Change* draws on does not consider the impact of structural discrimination, whereas public perception often does. The focus of TTC remains stuck on a perception of the public as uneducated and the source of stigma thus echoing the concerns of psychiatrists in the early twentieth century. Moreover, Long (2014) bemoans the little critical attention that *Time to Change* has received in the wider academic community. Although accounts of service-users and psychiatrists who view the campaign as very problematic are increasingly common, Long (2014: 223) argues that profound critique is difficult because 'its objectives are self evidently desirable and unquestionable'. The normalisation of this discourse points us to the contemporary 'regime of truth' with regards to mental health where anti-stigma campaigning is presented as an essential intervention. It is therefore more important than ever to put under scrutiny the discourses running through the campaign, an endeavour which I embark on in this thesis.

The work by Long (2014) and Bashford (2007) poignantly captures the emergence of the mental health anti-stigma narrative in 'the long twentieth century' and shows that it rests on the psychiatric gaze that views the public as 'uneducated'. This is further compounded by a profound desire to raise the professional status of the psychiatric discipline through embedding it within other medical specialties. This not only leads to the subjugation of alternate knowledges about mental illness, but it reasserts unequal relations of power between the psychiatric profession and its patients. This is in addition to the history of the relationship between the coloniser and the psychiatrised colonial subject, leading us to understand hierarchies and disciplinary power to be a core feature of psychiatric knowledge (Mahone and Vaughn 2007; Micale and Lerner 2001). Today, we continue to witness the popularity of mental health awareness campaigns as our calendars fill with anti-stigma events and mental health webinars. However, although modern campaigns do work more closely with mental health service-users and survivors, their function as an extension of psychiatric knowledge remains unchanged. On the contrary, the influence of neoliberal modes of thinking, which comprehend individuals as a means of and for economic productivity, have been instrumental in reproducing psychiatric notions about the role of the 'mentally ill' patient as in-need of intervention and medical treatment. While neoliberal logics of personhood are supported by the bio-medical framework of psychiatry, the neoliberalisation of mental distress sustains psychopharmaceutical interventions, giving rise to a co-constitutive relationship between psychiatry and neoliberalism in modernity.

1.5. Terminology matters

This thesis is attentive to the particularities of discourse. The precise vocabulary and its meanings in anti-stigma campaigning are examined very closely over the following pages and therefore I also pay attention to my own use of words and potential 'labelling' in this thesis. I start by thinking about the terms we use to describe and talk about mental health, because they have a long and contested history. Am I writing about 'madness' or 'mental illness'? It may be that these terms are used interchangeably at times, even if their (legal) history indicates that they are quite different (Craig 2014; Mylonopoulos 2014). Crucially, there is a politics of language at work that determines the consequences of using one term over another. I have engaged with the process of 'naming' over the course of my research, as I was often confronted with different usages of the terms that are so important in this text: mental disorder, mental distress, mental illness, service-user, survivor, patient, stigma, and discrimination. Anti-stigma campaigns, policy documents, and academic papers do not employ a unified mental health vocabulary. Therefore, I now provide an overview of my usage of these terms in this project while highlighting possible points of contestation in their application (Beresford 2005; Costa et al 2019; Wallcraft et al 2003). This is by no means to suggest, that my employment of these terms is inherently 'correct' or 'better' but rather that I want to draw attention to the disciplinary power of words from the very beginning. Thus, in my analysis of anti-stigma campaigns, it is much easier for me to highlight why the discourse is problematic.

In the first instance, there is a distinction to be drawn between the terms of 'mental illness', 'mental disorder', and 'mental distress'. The latter is an all-encompassing term that I use to describe a broad spectrum of emotions that are often experienced as negative and fall under the, equally broad, umbrella of mental health problems. 'Mental illness' is the term used for mental distress after it has been classified by the medico-psychiatric diagnostic framework as a pathology. The language of 'mental disorder' is more precise in that it often refers to specific mental illnesses, such as personality disorders or substance abuse disorders. When analysing the available materials, especially those from my archival research, I use the language of mental illness/mental disorder whenever this is the dominant vocabulary used in official sources, even if it is outdated or could be replaced with the less biased language of mental distress. To be clear, mental distress is my preferred term, but the psychiatrisation of it requires me to talk about mental illness and mental disorders as well.

The language of 'madness' sometimes appears alongside the contemporary lexicon of mental health. There is some indication that madness emerged as a social and legal functionality, whereas 'mental illness' stems from a more modern medical framework (Craig

2014). Thinking of mental health problems as madness is largely viewed as an outdated conceptualisation, at least by healthcare professionals. It is precisely this fact, which has given the terms ‘mad’ and ‘madness’ new vitality as terms of resistance where ‘being mad’ is a label endorsed by mental health activists and Mad Studies as an emergent field of scholarship (Beresford et al 2021 [forthcoming]; LeFrançois et al 2013). Consequently, the language of madness features in this thesis only in the context of engaging with Foucault’s *History of Madness* (2009) and *Madness and Civilization* (2001) and in my reflections on the possible avenues forward for anti-stigma activism and user/survivor-led research in the conclusion.

Secondly, there is disagreement about how to talk and write about people with/experiencing mental distress (Beresford 2005; Costa et al 2019; Wallcraft et al 2003). Already, my choosing of the terminology ‘with/experiencing mental distress’ is important. Rather than ‘the mentally ill’ I prefer a descriptive language that does not attach an essentialising label. In this thesis I employ the language of ‘people experiencing mental distress’, ‘people with mental distress’, and ‘people diagnosed with a mental illness’, depending on the context. In doing so, I refuse to follow the psychiatric tendency to label someone as ‘mentally ill’. It is crucial to acknowledge that people might have different preferences as to how they are labelled. For example, Costa et al (2019: 4) found that most people receiving healthcare, especially those with cancer, preferred the term ‘patient’ over other alternatives. Particularly unpopular, despite shifting paradigms in the economy of public health, were the terms ‘consumer’ or ‘client’, which were almost entirely rejected over a variety of studies that Costa et al (2019) examined. The terminology of ‘patient’ was most popular for people in in-clinical settings whereas ‘survivor’ was preferred by those whose cancer was in remission. This thesis does not feature the language of ‘consumer’ or ‘client’ because I am critical of healthcare as a consumer good and I soundly reject any attempt to advance the commodification of mental health.

In the context of resistance, there is little agreement about the use of language among groups that have organised to improve (and resist) contemporary standards social, healthcare, and welfare provision. Crucially, these groups are often understood to be ‘service-users’ which has led to this terminology to be employed even by those who reject it. Beresford (2005: 473) summarises the shortcomings of this term and argues that it ‘presents people as if their main and perhaps sole identity is through their consumption of public services’ even if the ‘use’ of these services is rejected or involuntary. This is also true for those who do not use mental health services, even if they would like to, and thus the term of 'service-user' is often applied indiscriminately to a variety of people that appear to be 'in need' of mental health services. The terminology is highly political in that it reduces people to 'users' of welfare, connoting it an extractive or burdening way of being. And yet, the term is often used by service-users themselves because it allows for the inclusion of a 'wide range of people who use health and welfare services', thereby offering avenues for a larger movement for service-user rights (Beresford 2005: 473). I employ the terminology of service-user to speak about people that do, or sometimes do, use welfare services. On the one hand, this acknowledges that the state and the welfare system continue to employ the discourse of 'users', despite its shortcomings. On the other hand, using this term re-articulates the need for the transformation of service provisions and modes of care.

The language of 'survivors' also features dominantly in service-user/survivor literature. This, contrary to cancer survivorship, often denotes a person's surviving the system of psychiatry, rather than the overcoming of a 'mental illness', although it could refer to both (NSUN 2020). It is a language more closely linked to a critique of the status quo of mental health, where the overcoming of a traumatic experience has committed the person to campaigning for change (Wallcraft et al 2003). Most often, I employ the term of 'service-user/survivor' in this thesis to stress that there is no common terminology agreed upon but that this group encompasses a variety people with lived experience of mental distress. Additionally, my thesis (see Chapter 6) makes reference to the politics and limitations of 'lived experience' in the context of mental health service-user and survivor stories, bearing in mind that any understanding of user-narratives as 'pure' has to be contextualised within the socio-economic circumstances under which these experiences emerge (Voronka 2006a, 2006b, 2019).

Thirdly, because this thesis is concerned with the politics of anti-stigma campaigns, I provide a critical reading of the terminology of stigma that is promoted by public health interventions. 'Stigma' is not the same as 'discrimination', although these two terms are often used interchangeably, even by the mental health awareness programmes that I dissect in this project. For example, the *Time to Change* campaign is an anti-stigma campaign but its stated goal is the 'end of mental health discrimination'. This is why the language of 'discrimination' can be found alongside the terms of 'stigma' and 'anti-stigma' throughout this thesis. The crucial distinction between the terms lies in that 'stigma' has a richly debated sociological history, whereas ‘discrimination’ lacks a theoretical foundation as such (Parker and Aggleton 2003). In reviewing the conceptual frameworks of HIV and AIDS-related stigma and discrimination, Parker and Aggleton (2003) have found that stigma is largely understood as a general disposition to an issue while discrimination refers to the active processes and laws that create spaces of exclusion and harm for others. Stuber et al (2008) have come to a similar conclusion and argue that research traditions of stigma are opposed to those concerned with prejudice and discrimination, not because they employ different conceptual frameworks per se, but because of a difference in research topics. In this thesis, I am concerned with mental health ‘stigma’ specifically because it is the guiding framework for anti-stigma campaigning which identifies negative attitudes in the public as a problem. Therefore, it is important to highlight that the language of ‘discrimination’ remains unexplored in a lot of anti-stigma work, with there being very little literature on the different genealogies of these concepts, despite concerns that laws and medical practice can be discriminatory against people with mental distress.

Finally, this being a work situated in International Relations scholarship, I am also attentive to the politics of talking about the world and its relationality. For the purpose of this thesis, I use the language of ‘Western countries’ to talk about nations in Europe and North America. In the context of mental health, ‘Western’ refers to the psychiatric regimes of European origin that have also found their way into North American culture and health systems and are increasingly promoted on a global scale. To be clear, ‘non-Western’ approaches to mental distress are incredibly diverse and are to be understood within the context of global cultural and societal multitudes, not as one homogenous alternate framework (Kirmayer et al 2011; McKeown and Wainwright 2020; Skultans 2007).

Consequently, this project engages with the category of mental health very critically. This is perhaps unsurprising given my theoretical dispositions, which reject a conceptualisation of ‘scientific’ knowledge as universal but are attuned to the ways in which knowledge is produced and upheld as legitimate. I am concerned with problematising the popular narrative of anti-stigma and this thesis should be understood within this context, not as a work of anti-psychiatry. One can embrace the goals of psychiatric interventions and anti-stigma campaigns — such as relief from mental distress and confidence in speaking freely about one’s experience — while also rejecting the harmful aspects of psychiatric knowledge and neoliberal governmentality.

1.6. Mental illness and the politics of global health

Although the COVID-19 pandemic has increased the need for critical inquiry into systems of global public health and the knowledge hierarchies that sustain them, the relevance of studying global health alongside other areas of research in international politics was apparent before the pandemic. The potential threat that international public health emergencies can pose for populations, governments, and economies prompted efforts to strengthen global health systems within a conceptual framework of security, a topic that has been taken up and inspired critical inquiry by many global health scholars in IR (e.g. Elbe 2009, 2010; Elbe, Roemer-Mahler and Long 2014; Harman 2016; Roberts and Elbe 2016; Youde 2016, 2018). One of the major lines of critique to the current standard of global health governance is concerned with the securitisation of health as an obstacle to international cooperation where scientific knowledge has increasingly become a bargaining chip in the relationships between governments (Elbe 2010).

Other critiques highlight the need for changing the gendered lens with which global policymakers have approached the role of women as carers and upholders of many primary care systems around the world. For example, Harman (2016) argues that, without recognising how male bias in global health governance renders women invisible, they will continue to carry the burdens of the social and health care following health crises. Finally, there is a reckoning in the global health security literature that 'health security is currently being used to describe a plethora of different health issues, from infectious diseases outbreaks to chronic lifestyle diseases', which has led to some ambiguity regarding the referent objects in the quest 'to secure' global health systems (Davies and Kamradt-Scott 2018: 492). This is also an interesting point at which to begin thinking about the role that policy and public discourse can play in framing mental health problems as either a 'lifestyle choice' or a burdensome illness which must be managed.

Throughout the available body of literature on the global politics of health and security, two aspects are noteworthy. On the one hand, interdisciplinary thinking and research underpins much of the fascinating work that academics have been able to do. For example, Eckmanns et al (2019) have shown that findings from social sciences and public health praxis can be put into conversation to examine the shift from 'expert' knowledge to algorithmic knowledge in the new era of infectious disease surveillance and control. Chattu (2017) has argued that the budding field of Global Health Diplomacy has the potential to be a truly interdisciplinary project between International Relations and Global Public Health, creating space for methodological innovations and debate. This inclination towards interdisciplinary thinking is echoed in the work of this thesis. While I position my research alongside other scholars in International Relations, particularly those that have used Foucauldian concepts of governmentality and disciplinary power to make sense of mental health politics, I also draw on scholarship from other areas of research in the social sciences, such as geography, history and sociology (Long 2014; Mills 2014; Pupavac 2004a; Timimi 2014; Tyler 2020; Voronka 2016a).

On the other hand, there is an empirical gap within the literature of global health regarding the study of mental illness. Particularly, research engaged in the dimension of human security in global health politics is predominantly concerned with the politics of infectious diseases and how these have become a divisive policy issue. This has meant that studies on non-communicable diseases and mental distress have emerged in other corners of IR. For example, there is a sizeable body of literature on trauma and emotions in IR (Edkins 2003; Resende and Budryte 2014; Zehfuss 2007) whose contributing authors have been instrumental in highlighting the psychological impact from 'world history's most horrific and politically potent events, including wars, famines, genocides, and colonial oppression' (Lerner 2019: 549).

However, I argue that mental health should be shifted more firmly into the field of vision of global health scholars because of the increase in attempts to govern mental health across and within borders. As shown at the beginning of this introduction, governments are increasingly concerned with the risks and potential burden of mental illness on their populations, especially if this can be shown to impact on the global economy. Therefore, it is important that the academy follows this trend by conducting more nuanced research on mental health and the production of knowledge in global governance. Crucially, the study of global health politics has already identified a variety of themes which are also important for the study of global mental health, thus building a solid foundation for the intersection of these two empirical sites.

Firstly, the history of colonial medicine is deeply related to the emergence of international health organisations, constituting an entanglement of colonial rule and the governance of population health. As Packard (2016: 22) shows, public health 'campaigns were imposed from above, with little concern for the ideas or the cooperation of local residents' and the compliance of the colonised population was often achieved through coercion. The sanitation efforts of imperial health systems were designed to maintain the health of European settlers unless there was also a need to maintain the labour force of local people. Colonial health services and public health interventions are firmly endowed with a history of colonialism and imperialism, and closely interlinked with the pathologisation of non-Western 'others', often through a regime of psychiatrisation (Fanon 2008). Hence, there is a strong link between the emergence of global health alongside global psychiatry, where both disciplines were used to control and subjugate colonised populations. Although the global health literature is increasingly concerned with the critical examination of the role of racism, Whiteness, and coloniality in shaping global health politics today (e.g. Burgess 2016; Kienzler 2012, 2020), the continued psychiatrisation of non-Western populations rarely features as a crucial element of this scholarship.

Still, voices calling for the integration of mental health within the existing global health paradigm (e.g. Patel et al 2008; Prince et al 2007) dominate debates about Global Mental Health, with little consideration of the potentially harmful consequences of such an approach. This is not to say that the inclusion of mental health in global health is undesirable, but rather that we must be wary of any policies that exclude the voices of those who are deemed in-need-of intervention. There are points of convergence that can be explored where the coloniality of global health intersects with the vied-for history of psychiatry and mental health. Through an analysis of mental health service-user and survivor narratives as 'curated stories' in anti-stigma campaigning, I begin to draw such parallels and show that public mental health campaigns today are equally imposed from above, with little consideration for alternate voices, despite claiming otherwise.

Secondly, Roberts and Elbe's (2016: 53) and Keller et al's (2009) work on global health security demonstrates that there is an increase in the demand for 'next-generation syndromic surveillance systems' for the mapping of health emergencies. A variety of different surveillance systems and methods are now used by governments to produce big sets of data from the electronic health records of different countries, responding to algorithms that are designed to 'detect' unusual occurrences of disease symptoms. These public health interventions are digital, they are responsive to both official and unofficial sources of data (eyewitness reports, online news aggregators, etc.), and they serve to collect and store data to create 'maps' of potential outbreaks and risk zones (Roberts and Elbe 2016: 53). In other words, they constitute a form of health surveillance that attempts to make visible and knowable the extent to which illness occurs in a given population. This is an important convergence with the way in which mental health is increasingly becoming trackable and diagnosable through the advent of mood-tracking apps and social media algorithms (Gruebner et al 2016). Mills and Hilberg (2018: 49) draw attention to the deliberate framing of technological access as a problem of mental health services provision and argue that biometric technologies in the form of mobile phone apps are an increasingly common practice that can both 'discipline and liberate' users. The discourse in anti-stigma campaigns, as I show in this thesis, similarly relies on the collection of data about public attitudes and the instilment of systems of (self-)surveillance among the population to detect and mitigate the effects of mental health problems.

Thirdly, global health is embedded within the global political economy as a multibillion-dollar enterprise, attracting large sums of money for the strengthening of local healthcare systems and the development of vital vaccines (Packard 2016). The financial beneficiaries of this industry are pharmaceutical companies, chemical corporations, and development contractors, all of which work within a nexus of economic interests. On the one hand, the supply of medication and the development of healthcare infrastructures are the cornerstone of global health interventions. On the other hand, the history of these efforts shows that the improvement of people's wellbeing is not always at the core of the agenda (Bashford 2006, 2017; Mahone and Vaughn 2007; Packard 2016). In addition to the colonial entanglements of early health governance and security, the rise of medical interventions driven by business interests and corporate expansionism shows that the field of health politics is strongly influenced by the global political economy. This echoes concerns about the medicalisation of mental distress and the constitutive nature of poverty and mental illness. The pharmaceuticalisation of development programmes for mental health has long been criticised as a dangerous by-product of the pathologisation of poverty in non-Western countries (Jain and Jadhav 2009; Mills 2016). Thus, the importance of the economy in securing population health is a key focus for the study of global health politics. I argue that the literature in this field would benefit from a more critical engagement with 'mental wellbeing' as a criterion for security and economic governance as well. As this thesis exemplifies, the vested interests and the effects of the global neoliberal hegemony are equally as traceable in the field of mental health as they are in health more broadly.

There are important points of convergence between the existing literature on global health (security) and the study of mental health, although the latter is not often represented as a crucial site of exploration in the study of global health politics. Thus, I situate my work alongside global health scholars that use similar theoretical frameworks of governmentality and surveillance (e.g. Elbe 2010; Kenny 2015; Roberts and Elbe 2016) and who display a genuine criticality towards the study of global health (Stoeva 2016). To echo Howell (2011: 147), the 'psy disciplines are positioned as a resource in the production of peace, order and security' meaning that they serve as a technology of governance that is deployed for the maintenance of the international political order. For an analysis of anti-stigma and mental health awareness campaigning this means taking seriously how these programmes are shaped by the desires of neoliberal states and the politics of knowledge in the production of 'facts' about mental health. Through my examination of the powerful and disciplinary discourse in anti-stigma campaigns, I expand on this existing scholarship. In doing so, I make an empirical contribution to the global (mental) health literature and advance the range of analyses that expose the normalisation of mental distress under neoliberal structures. This thesis also contributes to our understanding of mental wellbeing through an interrogation of the representation of mental illness and stigma in the discourse of anti-stigma campaigns, revealing the processes by which psychiatric hegemony is upheld and neoliberal subjects are produced. Thus, my research follows in the footsteps of critical scholars in IR that are concerned with the intersections between the global political economy, human health, and mental wellbeing.

1.7. Chapter outline

This thesis is divided into seven chapters which, taken as a whole, read as a critical inquiry into the history and contemporary deployment of anti-stigma discourse in the context of global mental health politics and policymaking. I argue that contemporary anti-stigma discourse is a political tool that normalises the experience of mental distress under neoliberal capitalism. The discourse is deliberately deployed as a form of disciplinary power that is productive of both knowledge and subjectivities. Through my empirical inquiry into the mental health awareness campaign *Time to Change* and its predecessors *Defeat Depression* and *Changing Minds* I trace the historical process of this knowledge production and identify the neoliberal roots of subject production. The global rollout of anti-stigma interventions presupposes not only the universal nature of mental health, but it exports Western knowledge of mental health. I thereby problematise the ease with which psychiatric knowledge can be co-opted to perpetuate a neoliberal mental health governmentality.

Following the Introduction, I present my theoretical framework and provide an overview of the methodology of this thesis. I begin Chapter 2 by drawing attention to the theoretical assumptions that underpin my treatment of the relationships between mental health and neoliberalism. The chapter is then divided into three further sections. In section one I show how a genealogical reading of anti-stigma campaigns can reveal the processes involved in the production of knowledge about mental health (Collin 2015). I also outline my approach to conducting research in archives emphasising the embeddedness that the researcher experiences through the materiality of her surroundings. In the second section, I engage critically with the disciplinary power of psychiatry and International Relations. In doing so, I demonstrate that emphasising the 'discipline of disciplines' is an important aspect in beginning my analysis of power and its normative function in mental health discourse. In the final section, I lay down the foundations for my analysis of discourse and neoliberal governmentality in this thesis. This includes a discussion and periodisation of neoliberalism in the UK in order to contextualise the emergence of anti-stigma campaigning within the neoliberal reforms of the NHS of the 1980s and 1990s (Cummins 2018a; Rizq 2012) as well as the austerity policies in the wake of the 2007-08 global financial crisis (Cosgrove and Karter 2018; Mills 2018). Through an introduction of my understanding of the neoliberal subject I emphasise the key features of neoliberalism that I trace in my analysis. I show that the production of neoliberal subjectivity must be understood within the context of a Foucauldian conceptualisation of the disciplinary and normalising power of discourse. Finally, I turn my attention to a discussion of literature in which Foucault has been criticised as an outright supporter of neoliberalism (Becker et al 2012; Mirowski 2013; Zamora and Behrent 2014).

In Chapter 3, I conduct a critical reading of two previous mental health awareness and anti-stigma campaigns in the United Kingdom. Through my analysis of the *Defeat Depression* (1992-1997) (referred to below as DD) and the *Changing Minds* (1998-2003) (referred to below as CM) campaigns I sketch the genealogy of contemporary anti-stigma campaigning. I put this into conversation with the historic research on anti-stigma by Long (2014) and work from other scholars (Bashford 2007; Moncrieff 2009; Teghtsoonian 2009; Timimi 2011; Packard 2016) who have already stressed that the rise of pharmaceutical interventions has been a worrying trend alongside the raising of awareness about mental health problems. I demonstrate through an interrogation of opinion polls, the minutes of steering group meetings, and promotional materials from both RCPsych campaigns, that several contemporary discourses of mental health stigma emerged in the 1990s. For one, my examination of DD shows that mental distress as an individual and biological pathology is a building block for the justification of psycho-pharmaceutical interventions. Both DD and CM highlight the need for awareness of mental illness within the context of the workplace and the risks to 'employee productivity' which foreshadows the econo-centric narrative of mental health that we witness today. While the role of the state in the organisation and funding of these early anti-stigma programmes was relatively small, its significance in determining the course of mental health awareness was to rise considerably with the launch of the new anti-stigma *Time to Change* programme for England and Wales in 2007. In this chapter I demonstrate that the anti-stigma discourse has been deployed deliberately from the beginning of public mental health awareness campaigns and that it has been important in producing knowledge about mental distress that is rooted in serving the interests of the global economy.

In Chapter 4, I continue my genealogical inquiry into anti-stigma campaigns through a first critical glance and exploration of the foundations of the *Time to Change* campaign. I take on the campaign's guiding concepts of 'stigma' and 'mental illness' to demonstrate that these notions are essentially contested at their core. In doing so, I reveal that the 'efficiency' of the campaign in reducing stigma is overstated in TTC's annual reports and that the statistical evidence is tainted by an enthusiasm for attempts to 'measure' stigma that is not based on research on stigma. The discourse of mental illness in TTC is reliant on a psychiatric framework of bio-medical readings of the body which I show to be essentialising and problematic in its understanding of how mental distress emerges. In sum, the *Time to Change* campaign presents both stigma and mental illness as known (or knowable) entities which can thus be intervened upon 'scientifically'. I argue that this not only produces a one-sided discourse around mental health stigma but also limits any understandings of *anti*-stigma to the realm of individual action and the supposed 'defects' of personal biology. Thus, this chapter ends with the conclusion that *Time to Change*, paradoxically, reproduces stigma of mental illness at the same time as being premised on a neoliberal understanding of the mind in its relation to the body and the economy.

After unsettling the core assumptions that underpin the TTC campaign, I build on my analysis in Chapter 5 by tracing the process of neoliberal subject-making within the campaign discourse. In three sections I demonstrate that a neoliberal subjectivity is produced, which promotes a story about mental health stigma that allows for only a very limited scope of intervention. Firstly, I examine the narratives of self-management, resilience, and self-care that are communicated through the campaign's representation of mental wellbeing. It is the requirement of practicing self-care and the observation of others that acts as a disciplinary form of power and surveillance where individuals are tasked to intervene upon their own mental distress without expecting welfare provisions from the state. Secondly, I show that the discourse of anti-stigma is performative in the sense that TTC calls on the public to celebrate and display mental health awareness on specific days. I critically discuss the increase in these mental health awareness days and conduct a reading of the Time to Talk Day kit that is supplied by TTC. I argue that mental health awareness, as promoted by the campaign, is more concerned with the raising of awareness about the awareness day rather than mental distress and thus constitutes a form of disciplinary power through performative action. I close this chapter with a section in which I contextualise my analysis of TTC discourse in current policy papers by the UK government. I show that the available government guidance is strongly influenced by a need to address mental health only insofar as it can be shown to have an impact on the economy, meaning that the promoted solutions are designed to make the labour force more resilient to austere conditions. In this way, I expose the ulterior function of anti-stigma campaigns: to de-stigmatise an insistence on labour productivity, the going to work even while unwell, and to evade an analysis of the workplace as a site productive of mental distress.

In Chapter 6, I draw on the analysis in the previous chapters to make sense of the use of stories and service-user narratives in the *Time to Change Global* campaign. This programme is a part of TTC, but it is partnered with other campaigns on a global level of public health interventionism. I argue that the curation of narratives about the stigma of mental illness in the context of a campaign that is aimed at non-Western nations reinforces previously levelled critiques about the coloniality of mental health interventions. I problematise the universalising and normalising power of mental health anti-stigma discourse as an export of

Western knowledge through TTCG. This chapter brings my analysis of mental health awareness and anti-stigma campaigns to a close. By analysing TTCG and the discourse of story-telling that runs through its promotion, I provide a better understanding of how anti-stigma knowledge travels across nations and institutions. In doing so, I demonstrate that this has a significant impact on the types of policies that are devised in the name of global mental health as well as our understanding of what counts as 'lived experience' in the context of mental distress.

Chapter 7 is the final chapter of this thesis and constitutes the conclusion to my work. I begin by drawing together the findings and arguments from the previous chapters into a summary that links the different aspects of my research. I restate the argument that I have developed in this thesis and highlight the implications of my findings for research on the global politics of mental health. I also outline the original contribution of my work to knowledge about the global governance of mental health and to the global health literature. I then provide insights on the use of a Foucauldian framework for the study of mental health in international politics before sketching the different ways forward for those seeking an alternative approach to the contemporary mental health paradigm. I emphasise that it is possible to work with(in) the current system while also resisting it in different ways to create positive change. I conclude this thesis by suggesting how to approach future research, particularly in the light of COVID-19 and its impact on public discourse about mental health.

2. Theoretical framework and methodology

2.1. Introduction

My theoretical approach to the study of anti-stigma and mental health politics in this thesis has its foundation in the conceptual advancements of Michel Foucault (e.g. Foucault 1980, 1991a, 2003, 2004a, 2006) as well as the work by scholars (e.g. Fullagar 2018; Howell 2011, 2014; Long 2014; Orr 2006; Thomas 2016; Yoo 2016) who have used his analytical tools to make sense of the relationship between mental health and international politics. Working within such a framework is relevant for my research because Foucault's thought is strongly associated with the tracing of the 'history of madness' in Western societies (2009 [1961]) and the critique of the category of the 'normal' which has influenced scholars from across the social sciences. Foucault's poignant analysis of psychiatry allows me to contextualise the histories of anti-stigma campaigning within a broader account of how psychiatry, in its relation to modern economics and modes of governance, impacts on the knowledges and discourses about mental health. Moreover, I follow a Foucauldian understanding of power as productive of subjectivities, which is why I begin my analysis with a critical disposition towards the disciplinary and surveillance discourse in contemporary anti-stigma programmes. In this way I trace the normalisation of scientific knowledge within mental health awareness discourse and expose the practices through which the neoliberal subject is constituted.

Howell (2011: 46-8) emphasises the relevance of drawing on this type of conceptual tradition in the study of mental health politics by arguing that Foucault's achievement in tracing 'the ascendency of psychiatry as a technology for the defence of society' makes it possible to better understand 'the role of the psy disciplines in global security and ordering practices'. My treatment of psychiatric knowledge of mental health stigma as an empirical site of analysis in this thesis, is thus grounded in a Foucauldian attention to the regimes of truth that 'rely on and reproduce the pathologization of racialized populations, the feminine, the queer, and purportedly unsound minds and bodies' (Howell 2011: 17). My theoretical framework is based on a close tracing of how the stigma of disordered minds — and its consequences — are represented in awareness and anti-stigma discourse alongside the behaviours which are promoted as desirable and orderly in the context of countering mental health stigma.

However, despite its popularity among critical International Relations Theory scholars, the Foucauldian framework has also attracted criticisms that are important to acknowledge. For example, Weheliye (2014: 38) shows that Foucault's theory is impoverished in its ability to conceptualise race and racism because his history of 'the Western conception of Man' is 'entrapped within the historiographical cum philosophical precincts of fortress Europe'. This means that Foucault's historicisation of subject-becoming occurs without a contemplation about the impact of colonialism and racialisation, leading to a story of the modern subject that is suspiciously silent about the effects of coloniality. In their recently published critique of Foucauldian Security Studies (FSS), Howell and Richter-Montpetit (2019a: 3, see also Bhambra 2017) have also argued that the contemporary use of the concepts of biopower and biopolitics to understand the violence of liberal peace-making perpetuates 'the undertheorization of racism' and coloniality in Foucault's own work as well as the 'methodological Whiteness' of security studies as a whole. Echoing Weheliye (2014) and Howell and Richter-Montpetit (2019a, 2019b), there are many voices that call for a more serious engagement with the constitutive role of racism and modernity in the study of International Relations (e.g. Bhambra 2017; Henderson 2013; Rutazibwa 2017, 2018; Shilliam 2010) and the legacies of colonialism on global public health (e.g. Bashford 2004, 2017; Blacker 2014; García and Sharif 2015). Ultimately, Foucauldian tools are limited in their usefulness for theorising race and need to be considered part of the mainstream canon of International Relations which rightfully attracts critique regarding its (mis)treatment of race and colonialism.

However, a Foucauldian framework remains vital through its ability to expose knowledge hierarchies and normalising techniques where a 'regime of truth' is created to legitimise political practice. Despite the limitations of his theory, Foucault's work continues to inform contemporary debates about mental health and has allowed for psychiatric concepts to become thinkable as historically produced. In this chapter I introduce the reader to the key methodological, conceptual, and theoretical tools which I use to analyse anti-stigma campaigns in this thesis. I begin by drawing attention to the theoretical points of departure in the fields of mental health and neoliberalism that underpin my research and by providing a brief overview of the Foucauldian texts which constitute the foundation for my methodology in this thesis.

The remaining content of this chapter is divided into three sections which cover the following methodological tools: a) genealogy as problematisation; b) disciplinary power and knowledge; c) discourse as method and object of inquiry for the study of neoliberalism. While the first section outlines the usefulness of employing a genealogical approach to begin an analysis of anti-stigma campaigns, the second section discusses the productive nature of power and knowledge in the form of disciplinary power. I explore the disciplinary power of both psychiatry and the field of International Relations to further contextualise my interrogation of global mental health politics in existing hierarchies of knowledge. The third section of this chapter outlines how constructs of power and knowledge are transmitted through and within discourse, with a particular attention to neoliberalism and the neoliberal subject. In doing so, I draw on literature from International Political Economy (e.g. Ball 2012; Davies and Chisholm 2018; Eagleton-Pierce 2016) to introduce the characteristics of the modern neoliberal subject as an individual performing self-discipline. Neoliberalism is periodised through a discussion of austerity-driven policies in the United Kingdom after the 2007-08 global financial crisis (Cummins 2018a; Eagleton-Pierce 2019; Mills 2018) and the neoliberal reforms of the 1980s and 1990s preceding contemporary neoliberal governmentality (Rizq 2012). Closely related to critiques of capitalism, neoliberalism is understood as a collection of economic and social policies that prioritise the individualisation and commodification of welfare (Esposito and Perez 2014).

2.1.1. Where this analysis begins: psychiatric medicine and neoliberal violence

My exploration of the politics of mental health starts by considering the relationship between power and (psychiatric) knowledge in order to better illustrate how matters of mental wellbeing remain firmly situated within a medical framework of supposed scientific objectivity. Therefore, this thesis starts from the assumption that medical science, as a field of knowledge, is constructed as much as the categories of nature and physicality on which it imposes its limitations. To understand how the notions of mental health and mental illness are embedded within our time and history, I argue that it is imperative to begin with a theoretical framework which allows me to make visible and describe the technologies of structural power – the governmentality – made possible through modern medicine. It will become clear throughout this thesis (see Chapter 4) that concepts like 'stigma' and 'mental health' are powerful markers which determine the direction that public discourse about mental wellbeing takes in shaping our understanding of the causes and nature of mental distress. Medicine, as a field of assembled knowledges, gives way to an understanding of mental distress that is rooted within a desire to provide a diagnosis in order to treat a 'physical' condition. The discipline of psychiatry, which has always been concerned with manifesting its claim to medical specialisation, is thus implicated in producing and promoting that very same diagnostic framework. I contend that psychiatric 'expertise' about mental health needs to be treated with suspicion and as the consequence of a complex process of knowledge production that is embedded within the hegemony of bio-medicalism.

In addition, my analysis begins with the assumption that neoliberalism is harmful as an ordering system of our society. I have already described some of the ways in which neoliberal capitalism has had a negative impact upon the mental wellbeing of individuals (see Introduction). To reiterate, there are several approaches to constructing arguments about the harmful nature of neoliberal capitalism. At the core are the inherent relationship between consumption, competitive capitalism, and the role of humans as both consumers and competitors. For example, Matthews (2019: 54) has shown that a Marxist reading of global capitalism reveals that neoliberal structures can never offer conditions conducive to good mental health because 'labor under capitalism […] is an alienating experience that estranges individuals from its process'. Others have stressed the tendency of neoliberalism to individualise the causes and consequences of 'otherness' in relation to the status quo, leading to increased stress and anxiety among queer youths (Grzanka and Mann 2014). The disciplinary and structural exertion of power on our minds in the continuous thirst for growth and productivity required by capitalist logics can even be said to bring forth resistance in unusual ways. As Davies (2016: 106) shows, 'resistance to work no longer manifests itself in organized violence or outright refusal, but in diffuse forms of apathy and chronic health problems'. This generous reading of mental (un)wellbeing – where it has become a form of resistance – highlights the complexity of the issue at hand. When neoliberal structures are normalised, the mind is an object of subjugation and governance so that economic growth can be maintained.

To be clear, my critical reading of neoliberalism sits alongside the Foucauldian critique of modern psychiatry, despite criticisms that the late Foucault was sympathetic to, or even a supporter of, neoliberalism as a way to counter the disciplinary power of the state (Becker et al 2012; Behrent 2009; Mirowski 2013; Zamora and Behrent 2014). As an example, Mirowski (2013: 80) argues that Foucault supported neoliberalism on the grounds that the market 'is the sole legitimate site for the production of indubitable knowledge of the whole' and thus viewing neoliberal ideas as both liberating and potential sites of resistance. The criticism is such that Foucault aligned himself with proponents of neoliberalism like Hayek or Friedman by stressing the importance of economic liberalism in contesting state power. However, I contend that a Foucauldian analysis of neoliberal subjectification is a valuable endeavor and I position myself alongside scholars who have successfully drawn on Foucauldian methodology to make sense of both neoliberalism (Dean 2012; Joseph 2013; Mavelli 2020) and neoliberal mental health politics (e.g. Howell 2011; Grzanka and Mann 2015; Roberts 2005; Thomas 2016). Countering the aforementioned critics and echoing Gane (2014), Newheiser (2016: 5) reminds us that,

> 'Foucault's circumspect account of neoliberal economic theory exemplifies philosophical critique as he understands it: it traces the contingency of neoliberal biopolitics in order to open a space for concrete acts of resistance'.

In other words, while there is scholarly agreement that Foucault's accounts of neoliberalism in *The Birth of Biopolitics* (2004a) were incomplete and somewhat limited, it does not follow that his methodology is lacking in utility for the provision of a critical history of the present 'between the fracture lines of libertarian and neoliberal approaches' (Gane 2014: 23). Precisely because states have evolved alongside of neoliberalism into neoliberal states over the decades since Foucault's lectures at the Collège de France, the main task of sovereign institutions has shifted to the governance of neoliberal life and the maintenance of the 'rationalities of care' that sustain such life (Mavelli 2017: 509). The Foucauldian attention to exposing regimes of truth as ordering and normalising systems of our societies can thus be successfully extended to an analysis of neoliberal subjectivity, a point to which I return at a later point in this chapter. Foucault's attention to neoliberalism in his later years can consequently be understood as a continuation of his interest in the contingencies of systems of power (Newheiser 2016). Therefore, when I argue that anti-stigma campaigns are productive of neoliberal subjects, my argument is already situated within and building on a body of knowledge that has identified neoliberal structures as harmful to our mental health, exposing the complex relationship between medical knowledge and neoliberal modes of governance (Davies 2016; Grzanka and Mann 2014; Matthews 2019).

2.1.2. Foucauldian texts and conceptualisations of power

The key Foucauldian texts building the theoretical foundation for my analysis in this thesis are *Madness and Civilization* (2001), *Discipline and Punish* (1991a), *Abnormal* (2003), *The Birth of Biopolitics* (2004a), and *Psychiatric Power* (2006). The first two are well-known monographs, while the other texts are posthumously published collections of lectures that Foucault gave during his time as Chair in History of Systems of Thought at the Collège de France. *Madness and Civilization* is a key work of his as it provides a historicising account of madness in modernity and the lecture collection in *Psychiatric Power* complements this reading through a critical engagement with the advent of psychiatry as a legitimate medical field. *Discipline and Punish* is another seminal work in introducing to scholars of the social sciences the ideas of disciplinary power, subjectification, and the normalisation of discourse in producing regimes of truth in a given society. As the editors (2003: xix) point out in the introduction of *Abnormal*, the lecture series overlaps with the publication of *Discipline and Punish* and 'allows us to see dimensions of Foucault's work whose full force might otherwise have escaped our notice'.

What becomes evident from reading Foucault's lectures (e.g. 2003: 292) is that the most telling examples of power were those which can be considered banal or mundane. What is more, Foucault is able to show that psychiatrisation is not a process imposed from above, but rather, an internalised system (or structure) of power which often remains hidden in routinised processes. Hence, this thesis is also concerned with a 'banal' occurrence like anti-stigma campaigns, seeking to understand how these become productive of particular subjects. However, the banality of their occurrence can be questioned when we appreciate that anti-stigma campaigns are simultaneously service-user/survivor driven and top-down governmental interventions. As I show throughout this thesis, there is a tension between these two approaches where public health campaigns are a field of contradiction and ambiguity as to whose interests are satisfied by their promotion.

To be clear, this thesis argues that anti-stigma campaigns are far from banal in their impact. Rather, everyday public health interventions are highly significant in producing a discourse about mental wellbeing that obscures and legitimises the detrimental impact of neoliberal modes of governance on modern societies. This is done by producing subjects who have come to internalise a neoliberal understanding of mental health and illness and this thesis seeks to make visible the discourse with which this knowledge is communicated to the public. Thus, the psychiatric discourse in anti-stigma campaigns acts on subjects in everyday situations while constituting a firm part of the neoliberal mental health governmentality that has emerged in Western societies.

2.2. Genealogy as method

Genealogy constitutes an approach to the study of history that accounts for the processes producing knowledges and discourses, which are embedded within society as common sense, as 'regimes of truth'. To be sure, there are different types of genealogical inquiry that have emerged over the last century, some with higher normative ambitions than others (Koopman 2013). Foucault's genealogy of madness has been shown to promote critique without necessarily becoming 'a tool of normative assessment' (Koopman 2013: 64). Therefore, the use of genealogy as 'problematization' in Foucault's thought, although far from being value-free, offers a way to amplify the dangers of the present histories that he studies. Precisely, problematisation allows for a reflexive critique of 'social institutions and practices' and 'the patterns of cultural meaning and subject formation' in our lives (Allen 2016: 197; see also Koopman 2013). This attention to the specific dangers and difficulties of modernity, that may otherwise go unnoticed, is part of a critical ethos that seeks to carve room for meaningful resistance as well. This is where critics (Zamora and Behrent 2014, see above) of Foucault's move to discuss neoliberalism more closely in his later years fall short of understanding the scope of opportunity that a problematisation of modernity creates. In this thesis, I follow an understanding of genealogy as a method for the problematisation of the emergence and manifestation of mental health anti-stigma discourse in an attempt to make sense of the political implications for the global governance of mental health.

Thus, a genealogical analysis paves the intellectual path to asking how discourses of mental health, mental illness, and stigma are maintained and reproduced. I argue that the most intriguing discourses to study are those which require a lot of effort to maintain while posing as common sense. If a notion necessitates continuous re-articulation to remain legitimate, the question arises for what purposes a status quo is upheld? This is why the study of mental health stigma campaigns is particularly interesting for genealogical inquiry. My historicisation of anti-stigma campaigning reveals that it is a project borne of neoliberal and economic interests with a long history while rooted in the disciplinary power structures of capitalism and psychiatry.

To begin with, we can understand genealogy as tracing the history of 'continuity' rather than change, 'in order to underline the partial arbitrariness of what might otherwise appear true, just of simply natural, such as our contemporary view on sound medicine and adequate therapeutics' (Collin 2015: 247). The continuity of psychiatric knowledge has resulted in a universalism, empiricism, and the normalisation of mental distress as pathology, a trend that continues to this day. Adopting a critical perspective to the emergence of a narrative, such as mental illness, thus allows us to appreciate the mechanisms by which it has become normalised. For the study of anti-stigma campaigning, the same remains true, as I have shown already through an engagement with Long's (2014) genealogy (Introduction, pp. 18-24). Because the status of psychiatry was contested in the medical field, the discipline sought to aggressively promote the deployment of diagnostic frameworks for mentally distressed patients. The tension that lies between psychiatric knowledge, publicly communicated knowledge about mental health, and the emergent narrative of anti-stigma can thus only be assessed through an engagement with the historical and contemporary processes that produce these discourses.

However, employing a genealogical reading of the discourses in global politics does not reject traditional historical methodologies which trace ideas back to the point in time of their inception and to show how these developed in a linear fashion. Rather, genealogy rejects only the notion that there is an essence or origin to a discourse by examining the different constellations of power and knowledge which constitute and continue to make up a concept over time. Hence, Foucault's 'anti-method' of genealogy exists also to demonstrate that an apolitical method and reading of history is not possible (Shiner 1982). Foucault stresses that we can merely observe and examine the regimes of truth upheld by the nexus of power and knowledge within specific contexts.

For example, the emergence of modern psychiatry has been the subject of genealogical inquiry by Foucault (2001, 2009) who provides a historical analysis of madness which considers it to be a cultural, legal, political, and medical construction. In Foucault's *History of Madness* (2009: xiv), the unabridged version of *Madness and Civilization* (2001), he shows, 'how a non-teleological approach to historical phenomena can denaturalise what is to us most familiar' by studying the content of archives which reveal reality to be 'removed from what has was to become the dominant narrative'. Through his inquiry Foucault, has challenged the official narrative of psychiatry as a medical discipline and instead shows how a shift in conceptions around knowledge and expertise were instrumental in the creation of modern psychiatry. In *Discipline and Punish* (1991a), Foucault conducts another important genealogical reading. Through a historical tracing of the Western penal system, he identifies a shift in the aftermath of the French Revolution to a form of sovereign punishment that is less designed to punish the criminal but aimed at reforming individuals. Exercises of sovereign power, for example the use of torture and public executions, gave way to disciplinary power, which in turn, led to a modification of institutions that focus on disciplining its subjects based on examination. Not only were novel forms of punishment largely hidden from the public eye, but they relied on the accumulation of records about a person, making possible measurement and specified treatment.

At this point, Foucault (1991a) also links to the emergence of the social sciences, showing that they are intrinsically linked to an attempt at disciplining and shaping behaviours in society, partly because of their attempts to classify and quantify the social sphere of humanity. Hence, *Discipline and Punish* serves as an important blueprint for how a genealogical engagement with psychiatry can illuminate the changing and political nature of the discipline. Foucault's efforts have crafted the foundations for a critical engagement with mental health which considers how matters of mental illness intersect with issues of power, knowledge, and representation. Shiner (1982: 388) provides us with a concise summary of the ethos of this methodology, arguing that 'a genealogy will not take its events as they are conventionally given to it but will constitute its own events'. Thus, a genealogy traces the anonymous rules responsible for shifts in discursive practice and exposes the network of power relations from which these rules emerge. For the study of mental health politics today, with a focus on anti-stigma campaigns, a genealogy requires an attentiveness to the language and representation in these campaigns to understand the extent to which psychiatric discourse and neoliberal logics continue to govern an emergent narrative of anti-stigma.

In the discipline of International Relations, it is not difficult to encounter genealogy as a methodological framework. A considerable amount of research uses Foucauldian inspired concepts, including governmentality, discourse, and biopower. The influence of genealogy is particularly pertinent as a mode to uncover the intellectual processes that make up the world of international politics. As Borg (2018: 42) writes,

> 'genealogy has not only been understood as a method for conducting historically oriented investigations of central concepts in IR but also as a generalized critical disposition to global politics.'

In this manner, researchers of global politics have sought to expose the anonymous rules responsible for shifts in discursive practice and to reveal the network of power relations from which these rules emerge. The interpretation of history has thus become a matter of political interest where de-naturalisation of taken for granted knowledge is the aim of inquiry. This requires challenging dominant narratives in world politics, such as the ubiquity of the nation-state and the unequivocal endorsement of liberal democracies as beacons of development.

Among the scholarship that is concerned with the global politics of mental health, several authors stand out in having employed a genealogical approach to their work. The most influential author in the field of International Relations who has conducted genealogical research on mental health as a form of governmentality is Howell (2011), whose research on 'madness' in IR has also been influential in championing a governmentality approach to the study of global mental health. The core message of Howell's work is that the discourse of mental health finds global expression through the psy disciplines (psychology and psychiatry) which operate in a variety of spaces in international affairs. Howell (2011: 17) highlights Foucault's approach to genealogy as a method that 'should be centrally concerned with struggle, and the relationalities according to which such struggle occurs' thereby underpinning my use of genealogy as a type of problematisation (Allen 2016; Koopman 2013). Through a critical engagement with different empirical sites, Howell successfully traces the process of psychiatrisation in the realm of development and global governance. My framework is thus situated in an existing body of literature that has employed a Foucauldian methodology to ultimately reveal crucial aspects of the global medicalisation of mental distress.

Further noteworthy examples of research employing genealogy as method for the study of mental health are Long's *Destigmatising Mental Illness? Professional Politics and Public Education in Britain, 1870-1970* (2014) and Orr's *Panic Diaries: A Genealogy of Disorder* (2006). Both works, while not directly conducted in a setting of international politics, speak to the politics of mental health through discussions around knowledge, power, and history in very important ways. Long (2014: 2) is successful in highlighting how,

> 'healthcare workers, voluntary bodies and government officials frequently conjured a selective history of mental healthcare as a means of justifying their vision of reforming healthcare'.

Her insights help foreground that public awareness campaigns have been proven to serve and legitimise the agendas of those who are already in charge of regulating the discourse of psychiatry. The purpose and effectiveness of campaigns are contested, and a genealogical tracing allows for an interrogation of this contestation as well as any sudden shifts in discourse or narrative. Lastly, Orr's genealogy of panic disorders provides an insightful voyage into the historical constitution of 'panic' as a knowable entity and pathology. In a powerful monograph, Orr (2006: 278) concludes that one is left with entangled-ness, a feeling of despair almost, attempting to 'reconstruct the fantastic, storied origins of psychic disorder that, they told me is caused by a few faulty circuits inside'. The politics of the psyche and psychiatric diagnosis are revealed to be a part of an 'emerging network of globalizing controls' where the social is 'indebted to the expertise of the scientific' (Orr 2006: 278). Thus, it is possible to illuminate the historical construction of various meanings and discourses of mental illness and public perceptions through methodologies inspired by a Foucauldian attention to shifting discourses of mental health. It is also the normalising powers of this discourse that are revealed through genealogical methods, an analytical ethos which I follow in my dissection of neoliberal subject-making in anti-stigma campaigns.

It follows that a genealogical reading allows me to make intelligible a contemporary problem which, through its immediacy, would be otherwise difficult to make sense of (Collin 2015). As such, a genealogy of anti-stigma campaigns requires an examination of the (psychiatric) discourse employed by the campaigns through a historicising assessment of the tensions between knowledge, neoliberal governance, and service-user/survivor involvement, all of which point to the emergence of a new mental health governmentality. To this end, I conducted archival research at the Royal College of Psychiatrists (RCPsych) in London which granted me access to the materials of two mental health anti-stigma campaigns from the 1990s and early 2000s, the findings of which I discuss in Chapter 3.

Conducting research in the RCPsych archives was the first step towards a genealogy of anti-stigma campaigning which led me to interrogate more closely the discourses and economic entanglements of mental health awareness-raising. I followed my archival research with a tracing of anti-stigma discourse to the present day through an examination of the contemporary *Time to Change* campaign, the analysis of which can be found in Chapters 4, 5, and 6. My choice to focus on discourse in this way, and not to pursue interviews with people involved in earlier campaigns, was informed by the ambiguity as to who was responsible for the organisational leadership in those campaigns and by my commitments to the analysis of discourse in promotional material. The ethical commitments of archival research also demand that certain voices are not elevated over others (McKee and Porter 2012), whereas interviews with official campaign stakeholders would have almost certainly excluded service-user and survivors, much like the campaigns themselves. While interviews could have provided a deeper insight into the meaning of meeting minutes or policy decisions, there is a problem with assuming that this would somehow provide a 'truer' representation of the campaign's overall discourse and politics. What is more, the available promotional material offered sufficient insights into how knowledge about mental health is represented to the general public, both visually and via 'stories', often by selected service-users and survivors. There is also an anonymity to discourses in that they cannot necessarily be attributed to one person or group of people, but it is rather that they are continuously reproduced and themselves reproduce regimes of truth and knowledge. In my research I was motivated to uncover how the representation of mental health and stigma produces a certain anti-stigma discourse, an exercise which drew me to the examination of campaign material. Thus, by putting my analysis of anti-stigma knowledge in the present into conversation with insights from archival sources and previous scholarship, I show that a defining feature of anti-stigma campaigns is a reluctance to locate themselves in this longer and contested history of anti-stigma thinking.

In sum, the merits of a genealogical approach to the study of mental health stigma lie in its potential to scrutinise and unsettle the dominance with which psychiatric discourse has been prominent in shaping the discourse of anti-stigma campaigns. Through a close analysis of the recent history and rise in popularity of programmes aimed at tackling mental health discrimination, I problematise the processes through which narratives of mental health and illness are produced in these campaigns.

2.3. Discipline(s) and power

Interrogating the relationship between power and knowledge is an important Foucauldian contribution to the study of global mental health politics. My theoretical approach is inspired by Foucault's exposure of the mutually constitutive relation of power and knowledge and the productive nature of their symbiosis. The disciplinary power that is exhibited by (scholastic) disciplines themselves is a crucial aspect in my understanding of both the empirical context and original contribution of this thesis. In this section I foreground the importance of understanding the inter-relation between power and knowledge through the disciplinary power of psychiatry and IR. I begin by letting Foucault's own words underpin the significance of undertaking an analysis into the relations of power and 'madness':

> 'Perhaps, […], we should abandon a whole tradition that allows us to imagine that knowledge can exist only where the power relations are suspended and that knowledge can develop outside its injunctions, its demands and its interests. Perhaps we should abandon the belief that power makes mad and that, by the same token, the renunciation of power is one of the conditions of knowledge' (Foucault 1991a: 27).

This poignant quote from *Discipline and Punish* is followed by an exploration of power as a relational force that is productive of knowledge, whether it does so intentionally or not, and that both power and knowledge imply the existence of the other. In particular, the knowledge about who or what is considered to be deviant in a given society is an important contribution of Foucault's work. For the study of the politics of mental health this means that the field of knowledge about mental illness is constituted through a variety of power relations that create a 'regime of truth' about the behaviours that make up a mental disorder. It also means that subjectivities are produced through the disciplinary effect of this power.

In *The History of Sexuality* (1990, 1992, 1998) Foucault goes further in his exploration of the power-knowledge nexus through a discussion of resistance. His words, 'where there is power, there is resistance' (1998: 95), certainly ring true also for the study of the global politics of mental health. Foucault's later thought implies that he intended to address the rise of neoliberalism through an understanding of the subject as subjected to the self rather than the sovereign. He attempted to carve out possible ways to imagine resistance to neoliberal governmentalities, even if the concrete significance of neoliberalism may have eluded him. This is a particularly pertinent observation when we consider that many public health campaigns are largely aimed at generating behavioural change in the population that is centred around self-care and lifestyle choices. Therefore, the rise of neoliberal modes of governance is one of the cornerstones in my subsequent analysis of mental health campaigns where I demonstrate how the promotion of a scientific discourse shapes the behaviour of subjects. I contend that Foucault's philosophy on power and knowledge, and indeed resistance, remains as relevant for the study of mental health today as when it was first written. That said, the interplay between power and knowledge as a focal point for analysis is not new to the discipline of International Relations. For example, Shiner (1982: 384) follows Foucault in defining power-knowledge as manifested in regimes of truth. He writes:

> 'Every society, Foucault claims, has a kind of political economy of truth which says what kinds of discourse are true, what mechanisms and sanctions are for distinguishing true from false, the techniques for acquiring truth and the status of those who are empowered to say what is true.'

Shiner (1982) further elaborates that subjected and excluded knowledges within institutions are occupied by those with the lowest hierarchical status, for example prisoners, patients, laborers, or students. The discourses of these groups are continuously deemed invalid by the institutions in which they exist and are confined to the specific vocabularies of the dominant economic and political apparatuses. It is in the interest of these apparatuses to enshrine regimes of truth into the structures that make up our society which will then make them much more difficult to shift. This means that discourses are constructed, but they are also continually reproduced, and that we must understand discourses as embedded within established relationships of power and knowledge that inform the structures of our societies.

Contemporary mental health anti-stigma campaigns provide an interesting empirical example precisely because they appear to be working *for* excluded groups, meaning those affected by mental distress and supposedly at the receiving end of stigma and discrimination. Curiously, mental health service-users and survivors are often quoted directly and asked to provide testimony of the campaigns' successes which thus appear to be led by people with mental distress, at least at first glance. If this were true, it would present a contradiction with a Foucauldian mode of analysis which assumes the subordination of service-user and survivor knowledge. However, I argue that the promotion of mental health service-user and survivor stories is little more than the curation of a narrative that ultimately reproduces neoliberal understandings of mental distress.

Following Voronka's (2016a, 2016b, 2017) interventions, it is crucial to understand that 'lived experience' as a category is too often used to universalise the experiences and voice of mental health service-users and survivors. Although mental distress is experienced and understood in a variety of ways, how one makes 'meaning of such experiences is organized through governing formations', including in the context of anti-stigma campaigning (Voronka 2016a: 193). Moreover, there is evidence that representation and stories of 'lived experience' in the context of mental health are complicated by the power relationships between those stories that are deemed appropriate and those voices that are 'tarnished, precisely because we suddenly have access to voice and (precarious) power' (Voronka 2016b: 213, see also Martin 2007). With an attention to these subtleties of service-user and survivor involvement in mental health awareness, I show that the project of global anti-stigma campaigning is particularly invested in promoting only select stories of people with mental distress, namely those that choose to actively engage with the programme and excludes those that are critical of mental health awareness campaigns (Costa et al 2012).

Thus, in an analysis of discourse we can witness the reproduction of power and knowledge within an already established order. The Foucauldian inclination to interrogate discourse within a genealogy can reveal the complex ways in which power and knowledge intersect on the level of mental health politics. In the following paragraphs I discuss in some more detail the disciplinary power of both psychiatry and International Relations to show that my research is embedded within disciplines that can be historically traced and are reproductive in themselves.

2.3.1. Psychiatry's quest for discipline

Through the historicisation of the emergence of psychiatry Foucault (2001, 2009) exposed the conflation of madness and criminality in the seventeenth and eighteenth centuries. In doing so, Foucault has laid the theoretical foundation for a critical understanding of the disciplinary power of psychiatry today and inspired various authors to explore the history of psychiatric knowledge (Bergey 2018; Long 2014; Rose 2006). Essential to a genealogy of mental health is the medicalisation of psychiatry in the twentieth century which lends the discipline its powerful ability to determine the fates of those who come in touch with its diagnostic regimes. The key to making possible the medicalisation of psychiatry is the medicalisation of its knowledge, a process borne out of efforts by asylum doctors to professionalise the status of the discipline. As Long (2014: 27) has concluded:

> 'For most of the period under study, psychiatry spoke on behalf of patients, adopting a bio-medical approach in which patients' speech could be usefully interpreted only as a symptom of an underlying disorder'.

This observation corresponds with psychiatrists' efforts to raise the status of their own profession which had come under criticism for both failing to lock up 'dangerous' lunatics and falsely admitting sane individuals. The move towards professionalisation also led to the medicalisation of mental health in two important ways.

Firstly, the category of 'the public' has been constructed as a binary opposite to the expertise and knowledgeable category of the psychiatrist or mental healthcare worker. According to Long (2014), in many early writings on de-stigmatisation efforts, the public was constructed as a homogenous (irrational and uneducated) mass and very little was written about the public's actual views on mental illness. Long's (2014) research into psychiatric literature of the twentieth century has revealed those texts as reflecting the discipline's own anxieties about the legitimacy of its profession in relation to other medical specialities (see Introduction, pp. 18-24). Psychiatry required an opposing and uneducated public in order to manifest its status as a legitimate medical field of expertise. Hence, the artificial construction of the public versus expert knowledge held by psychiatrists made a significant contribution to the medicalisation of psychiatry. Secondly, mental healthcare workers viewed public perceptions of mental illness as dominated by fear which supposedly led to the public avoiding psychiatric treatment for fear of stigma (Long 2014). Consequently, mental health professionals sought to emphasise the ability of psychiatry to not only diagnose but cure mental illness. This positioning of psychiatric knowledge on par with that of other medical specialities eventually led to the full integration of psychiatry into the medical profession, the consequences of which we can still witness today in that mental distress continues to be approached through the lens of a diagnostic framework that seeks to identify and label mental distress as a medical condition.

Secondly, linked to the professionalisation of psychiatry is the medicalisation of human behaviour. This process leads to the psychiatric diagnosis of normal reactions to the stresses of modern life. More precisely, it ‘refers to a process by which previously non-medical problems become defined or treated as medical conditions’ (Bergey 2018: 153). This is an important aspect of psychiatry’s influence because it practically determines the point at which medical attention is deemed to be necessary. For example, previous research has shown that the reactions of teenagers and young adults to Brexit have come to be labelled as mental health problems, offering little scope to understand aversive behaviour as a form of resistance (Degerman 2018; McCrae 2018). In 2016, the Office for National Statistics on Psychiatric Morbidity published its latest survey aimed at determining the prevalence of mental disorders in the public. Around 17%, or 1 in 6, reported symptoms that would classify for a psychiatric diagnosis (NHS Digital 2016). Although this number is lower than that which is often used in anti-stigma campaigns (‘1 in 4’) it still presents a significant increase in diagnosable mental disorders. We might wonder whether modern life is more stressful and demanding than it used to be or if psychiatry refined its diagnostic abilities, so that it is much better able to identify a mental illness. However, according to Bergey (2018) and Rose (2006), the most plausible explanation is the growing influence of psychiatry in the latter half of the twentieth century as a professionalised branch of medicine.

Crucially, there is sufficient evidence that the medicalisation of everyday life is taking place and one of the driving factors of this is the influence of the pharmaceutical industry, which has given rise to concerns about the ‘pharmaceuticalisation’ of medicine (Braslow and Marder 2019; Davies 2017; Moncrieff 2009). Large investments by pharmaceutical companies into extending the global reach of psychotropic medications prompts questions about the impact of psychiatric knowledge, which is largely guided by Western conceptualisations of mental distress, on the medicalisation of mental health. This suggests that the disciplinary power of psychiatry interlinks with the governance of mental health at the levels of global politics and the international political economy. It is important to draw attention to processes of medicalisation when beginning the study of anti-stigma campaigns because the concept of medicalisation problematises the conditions in which stigmatisation is assumed to occur. By employing a Foucauldian analysis of the history of psychiatry and its construction of the categories of mental health and mental illness, we can begin to trace a genealogy of medicalisation. In the context of anti-stigma narratives, this means asking: What exactly are we supposed to become aware of? Who benefits from stigmatisation and de-stigmatisation?

Another aspect to the disciplinary power of psychiatry is that, despite significant tensions within the profession, 'the discipline presents itself as scientifically legitimate over time' which is problematic because this representation is rarely perceived as such by outsiders (Collin 2015: 247). For example, after a genealogy of therapeutic reasoning in nineteenth century medicine and modern psychiatry, Collin (2015) concluded that prescriptions of antidepressants in the UK today are still on the rise despite evidence that there is only little difference in efficacy compared with placebos. Collin's (2015: 258) research further highlights that there is a stark divide between GP practice in prescribing psychotropic medication and evidence-based recommendations by psychiatrists who are increasingly worried about so-called 'concomitant prescribing practices'. This shows that there are hierarchies of knowledge within the mental health care profession, where day-to-day practices do not necessarily align with, and sometimes even contradict, the most recent developments in psychiatry. However, the discipline presents itself as both 'scientific' and coherent which helps it appear a legitimate body of knowledge that can be trusted in its ability to care for the mental wellbeing of populations.

When conducting research into the disciplinary power of psychiatry then, it is important to consider how the field presents itself to the general public. For the study of mental health campaigns this means that the messages and 'facts' about mental illness articulated through them must be closely scrutinised. To this end, this thesis also aims to de-stabilise anti-stigma campaigns' problematic assumptions about the ignorance of the public which — if it were only educated properly — would no longer hold stigmatising views. However, as Long (2014) has shown in her research, practitioners of campaigns have rarely taken the time to define what they mean by stigma and discrimination. Instead, the assumed expertise of psychiatry continues to be reproduced through public health campaigns.

As Collin (2015), Long (2014), and Foucault (1991a) have demonstrated, drawing up a genealogy of psychiatry reveals the disciplinary power of psychiatry, which is complex in its expression. The discipline is sustained through a continuous (re)production of the discourse of its knowledge. Mental health awareness and anti-stigma campaigns are one of the sites where psychiatric knowledge, driven by neoliberal logics, is expressed and maintained. In the following chapters I build on this work and conduct my own genealogical reading of anti-stigma within the context of psychiatry as a form of disciplinary power.

2.3.2. The relationship between psychiatry and anti-stigma discourse

Psychiatric knowledge needs to be put into a relationship with the concept of (anti-)stigma because they constitute core components of my analysis in this thesis. Psychiatry, as a field of knowledge, is implicated in the emergence of anti-stigma efforts. Yet, the relationship between psychiatric knowledge and the constitution of stigma is far from neatly defined. On the one hand, it may appear that psychiatric ambitions alone are responsible for the production of mental health anti-stigma lobbying attempts, particularly when bearing in mind the long and established history of anti-stigma thinking in mental health professional services. On the other hand, it has also been recognised that psychiatric labelling via medical diagnoses can be a driver of mental health stigma itself (Timimi 2014). This means that the relationship between the discipline of psychiatry and the emergence of a pertinent anti-stigma and mental health awareness discourse is complex and merits analytical attention.

I suggest that the key to understanding the extent to which psychiatry influences anti-stigma campaigns is to observe the organisational shift of anti-stigma campaigns in the recent two decades. Whereas previous campaigns were largely funded and run by the Royal College of Psychiatrists (see Chapter 3), the contemporary anti-stigma programme *Time to Change* receives the majority of its funding from the British government. What is more, UK mental health policy is principally based on the assumption that eradicating stigma is the most important step in improving mental wellbeing (Department of Health and Social Care 2018).

This move away from the RCPsych as a central actor and proponent in running anti-stigma campaigns may appear like a departure from the psychiatric knowledge base as well, particularly when psychiatrists themselves have been vocal in criticising TTC in recent years (e.g. Pilgrim and Rogers 2005; BMJ 2017). However, this change only shows that the government has now taken an increased interest in mental distress thus further blurring the boundary between psychiatry and the state. This is problematic because the state is instrumental in allocating resources to research, service-provision, and the drafting of mental health legislation. There is a link to be explored here, between the emergence and decline of the welfare state and the funding decisions that are made about social and (mental) health care provision. The current institutions responsible for the care of those with mental distress have developed alongside neoliberal states and they are,

> 'increasingly subject to prove their effectiveness through efficiency models that require community agencies to meet targets, ensure flow-through, and collect evidence-based data on their effectiveness' (Howell and Voronka 2012: 1).

In other words, the relationship between mental health service provision and national anti-stigma campaigns can be yet better understood in the context of neoliberal state-making and significant economic phenomena, like austerity politics. Psychiatry as a discipline, in its relation to awareness and anti-stigma, cannot be treated separately from the socioeconomic structures that sustain its legitimacy. Because the state is also responsible for the (de-)regulation of the influence of industry in the realm of public health, there is still a firm hegemony of the bio-medical framework in understanding mental illness (see Chapter 4).

Even some critics (Henderson and Gronholm 2018; Pilgrim and Rogers 2005) of anti-stigma campaigns tend to only scratch the surface whereby they respond to their effectiveness or utility in combatting stigma, but without developing substantial critiques of psychiatry itself. Consequently, the departure of anti-stigma programmes from the coordination by the official body for psychiatry, the Royal College of Psychiatrists, into the hands of the government should instill us with grave concern. It does not follow that anti-stigma campaigning is now out of the grasp of psychiatric disciplinary power. The shift to the state, further explored in Chapters 4 and 5, only signifies a harmful adoption of psychiatric knowledge for other political motives. In sum, the relationship between psychiatry and anti-stigma thinking and campaigning is complex, but its changes are historically traceable and contemporary research on this matter must now take into consideration the state as a third actor.

2.3.3. IR: Because what counts as politics is political

Disciplinary power not only works through medicalisation and the normalisation of psychiatric paradigms, but the effects of disciplinary power can be found in the production of knowledge in the discipline of International Relations itself. I start by asking: 'what comes into sight, what topics and problems are raised?' (Kessler and Guillaume 2012: 110). This questioning allows me to put under scrutiny the sites of inquiry which have become legitimate objects of interest for the discipline. In other words, ontological and epistemological concerns are raised when one begins to examine the disciplinary power of the field of IR.

Academic disciplines become vessels of disciplinary power through the normalisation of routinised organisational processes which hide inequalities and hegemonies while self-producing and creating new identities. An academic field such as International Relations is established through the creation of boundaries which then require definition and maintenance. As Kessler and Guillaume (2012: 111) highlight in their analysis of everyday practices in IR, the ontology of the discipline can be understood through an examination of 'what IR is, where it is to be found, what the disciplinary boundaries are up to, or which literature is to be read and mastered' which 'is today utterly dependent on what one thinks the 'international' actually *is*'(emphasis in original). In other words, definitions and boundaries matter, especially since they become enshrined in institutional practices at universities and colleges over time.

The setting of disciplinary boundaries manifests most strongly in the type of research that receives funding, but it also extends to the realm of pedagogy where much of the accepted knowledge about international politics is reproduced. This is a particularly relevant intervention for this thesis because mental health and mental illness have traditionally not received a lot of scholarly attention within the context of the study of global politics. Stoeva (2016) has pointed out that a lot of the engagement with 'health' in the discipline is severely limited by an underpinning assumption that health research is evidence-based and driven by 'scientific' medical knowledge that needs to be transformed into usable policies. However, this largely applies to research on communicable diseases. In contrast, Howell (2011) and Pupavac (e.g. 2004a, 2004b) have led the field by taking on the task of starting a more serious discussion about mental health and its impact on international politics. Foregrounded in their work is the exploration of mental health in the broader contexts of security, trauma, and (post-)conflict.

Still, I argue that this constitutes a fetishisation of the study of war and military conflict in the discipline and thus (re)produces the contemporary research hegemony in IR which largely fails to recognise the importance of studying everyday practices of power and knowledge in the context of mental health. Hence, this thesis presents an empirical intervention through my study of anti-stigma discourse. Within the discipline of IR it has long been noted that what counts as 'politics' is subjected to a political process itself which 'has to do with the establishment of that very social order which sets out a particular, historically specific account of what counts as politics and defines other areas of social life as *not* politics' (Edkins 1999: 2, emphasis in original). It is thus a key element of the original contribution of this thesis to foreground the significance of studying mental health politics within the context of everyday public health interventions.

What is more, the standing of an academic discipline is also upheld through the creation of an organisational routine which stabilises disciplinary boundaries and creates internal formal (and informal) rules. These institutionalised academic disciplines exhibit power because they determine the legitimacy of knowledge within their boundaries:

> '[…] it is the internal rules, structures, and procedures of academic organisations or organisations linked to the financing, management, and exploitation of knowledge, that define: which grants and proposals scholars can apply for and how they should do it, the necessity of a report, the ways to submit a research proposal, the expectations behind a job application, the value of a letter of recommendation or of an evaluation, the requirement to attend committees and so on' (Kessler and Guillaume 2012: 114).

As the above quote demonstrates, the normalisation of certain processes within disciplines leads to the exclusion or preferential treatment of certain groups of people, thus exercising disciplinary power. This particular concern has already been raised by feminist scholars who have long engaged in critiques of the discipline of IR which has often turned a blind eye to issues of gender, presumably because these 'have nothing to do' with international politics (Tickner 1997). However, just as feminist scholars have had to pursue methodologies and work outside conventional IR, this thesis is engaged in 'pioneering the effort to look beyond conventional training and to investigate the relevance of other disciplines and literatures' (Tickner 1997: 630) by studying the global politics of mental health. In International Relations research agendas, mental health is still a topic at the margins. Stoeva (2016: 101) suggests that, although health issues are of great importance to people around the globe, 'discussions of the global politics of health governance have not engaged with and informed the broader field of International Relations Theory more extensively'. Instead, one can observe significant gaps and shortcomings in the literature that engages with global health politics regardless of its impact on development, security, poverty alleviation and debates about human rights. Stoeva (2016) furthermore points to the fact that those who do study health in the context of international politics tend to prefer constructivism as a theoretical framework and rely on the use of securitisation theory.

This leads to an ‘impoverishment’ of any inquiry into the relationship between international relations and health because it assumes a supposedly recent securitisation of health (Howell 2014). However, the interdependence of the development between modern warfare and modern medicine can be historically traceable from the nineteenth century onwards. Howell (2014) further argues that medicine and warfare are mutually constitutive, much like power and knowledge are for Foucault. While securitisation theory (e.g. Youde 2018) traces the processes by which security threats are constructed, this not only contributes to the medicalisation of security (Elbe 2010, 2011) but it often over-emphasises the importance of ‘elite speech acts in converting a political issue into an exceptional issue’ (Howell 2014: 966). This risks the erasure of mundane or routinised practices of health (in)security. It also misses the critical intervention which would show that health is – like many other concerns of politics – indeed constantly productive of relations of power. Howell (2014: 972) contends that medicine and security ‘have come into being through each other’ and together present an effort to optimise the population since at least the nineteenth century. Hence, securitisation theory fails to account for a mutual, habitual and routinised constitution of health and security.

This thesis echoes Stoeva’s (2016: 102) call for postmodernist analyses of global health politics as these allow for an engagement with power relations and authority ‘which influence and shape international agendas, policy priorities, funding, etc. and power differentials which impact weaker states and actors in many ways’. I aim to demonstrate that a post-structural attention to the interplay of power and knowledge in discourse is essential in revealing the complex interests at play in producing contemporary politics and economy of mental health. Taking a Foucauldian approach means displaying a willingness to challenge the traditional sites of interest and ontological assumptions of the social sciences. In this thesis I take on the discipline of International Relations for its bias in the study of mental health — if it indeed pays any attention to it all — in the context of (post-)conflict or (human) security. By writing a thesis on anti-stigma and awareness campaigns, I attempt to draw IR's attention to a site that seems banal or even benevolent at first sight. The study of ‘mental health’ must be an integral aspect of International Relations for the reason alone that its parameters determine the acceptable standards for normal and abnormal behaviour in our societies.

2.4. Discourse and subjects in the making

The concept of discourse is an essential component of a Foucauldian framework because it constitutes a lens with which we can assess and trace the meanings of different vocabularies in the normalisation of knowledge. To be sure, discourse analysis encompasses a wide field of research in the social sciences. Thus, in this section I outline how discourses are understood to operate in mental health politics specifically, namely as 'regimes of truth', while introducing the reader to the concept of neoliberalism which is essential to the maintenance of this discourse. Neoliberal logics both drive and constitute the purpose of the targeted production of discourses on mental health, and thus I introduce them as interlinked entities.

The link between discourse and neoliberal governance can be best made visible through an attention to the concept of governmentality. Foucault (1991b) defines governmentality as 'the art of government', an emerging form of governance which fused with traditional forms of sovereignty. Governmentality constitutes a set of technologies, including the use of disciplinary power, which shift the focus of governance to the population at large. Rather than merely replacing sovereign power, Foucault argues that we can witness an assemblage of sovereignty-discipline-government, which has as its primary target the population and is an essential mechanism of the state security apparatus. When talking about the population as target, Foucault (1991b: 100) refers to

> 'the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health, etc.; […] it is the population itself on which the government will act either directly through large-scale campaigns, or indirectly through techniques that will make possible, a full awareness of the people, the stimulation of birth rates, the directing of the flow of the population into certain regions or activities, etc.'

What is more, in the same lecture, Foucault establishes a strong connection between the advent of governmentality and the rise of modern capitalism showing the synergy between disciplinary power and attempts to maximise wealth-generating productivity in subjects. There is thus a very clear relationship between a shifting mode of punishment, from individual sovereign power to population-wide discipline and surveillance, and the emergence of capitalism as the dominating economic system of Western societies.

However, as mentioned in the introduction of this chapter, Foucault's views on neoliberalism have come under scrutiny over the last decade, giving rise to an animated debate about whether he was supportive of neoliberalism, consequently impoverishing his theory as a tool for critique of neoliberal governments (e.g. Mirowski 2013; Sawyer and Steinmetz-Jenkins 2019; Zamora and Behrent 2014). The criticisms of his treatment of neoliberalism in *The Birth of Biopolitics* range from arguing that 'his reading of neoliberal theories passes over many crucial aspects' (Audier and Behrent 2015: 417) to claiming that 'Foucault was just dead wrong about neoliberalism' (Mirowski 2013: 82). On the other side of the spectrum lies scholarship that responds to these critics with a different reading of Foucault's treatment of neoliberalism which he shows to be 'both more dangerous and susceptible to change than it might seem' thereby carving room for fundamental critique of neoliberal resilience (Newheiser 2016: 13, see also Mavelli 2017; Thomas 2016).

Foucault's apparent failure to condemn neoliberalism does not mean he endorsed neoliberalism. This is because Foucault's understanding of critique did not 'consist in condemnation' nor was it designed to attach clear labels of 'good' or 'bad' to the objects of his analysis (Newheiser 2016: 15). What is more, when Foucault's lectures on neoliberalism are read in isolation, as many critics have done by focusing almost exclusively on *The Birth of Biopolitics*, it is much easier to label him a neoliberal because of his non-judgmental commentary at the time. However, when contextualised with his other critiques, particularly his treatment of sovereign power in *Discipline and Punish*, the richness of his inquiries becomes apparent, and his lectures a sharp observance of how the influence of government 'presents itself as a recurring question in liberal modes of governmentality' (Flew 2012: 59).

Thus, while it is difficult to hold Foucault to account for not condemning neoliberalism when his methodology is so finely attuned to tracing the resilience of neoliberal power, it is vital to point to his failure to condemn neoliberalism as racist. A methodological commitment to Foucauldian theory is incomplete without a recognition of the limitations that his framework presents in tracing the coloniality of mental health politics. As such, my analysis is based on a critical Foucauldian approach to neoliberal modes of mental health governance while emphasising the need to increase scholarly attention to the normalisation of Western psychiatric paradigms in determining the global politics of mental health awareness. I argue that the tracing of the production of neoliberal subjects in anti-stigma discourse within a Foucauldian framework is not at odds with a critique of neoliberalism because I reveal that conceptualisations of self-care and productivity in anti-stigma lobbying have become a firm aspect of neoliberal governmentality, thus exposing it as a ‘site of the formation of truth’ in economic rationality (Foucault 2004a: 13).

Studying subject-making in global mental health discourse is about understanding how the individual experiences the experience of herself (and her mental distress), and this study forms a key aspect of revealing the particularities of mental health governmentality. I contend that anti-stigma and mental health awareness campaigns are instrumental in attempting to shape the behaviour and attitudes of those who encounter or experience mental distress. These, as Foucault (2010) terms them, ‘technologies of the self’ are also important in facilitating a person’s behavioural change by acting on herself in accordance with certain standards: ‘Care of self allows one to achieve a mastery of the self that enables one to care for others in the community’ (Skinner 2012: 908). Consequently, this research is concerned also with understanding the care standards that are set in the discourse of anti-stigma campaigns. Finally, people are not simply mere passive subjects on which subjectivities are imposed. On the contrary, subjects are continually in a process of becoming, identities evolving with no fixed endpoint. Subjects are hence understood as responding to the discourse which is suggested. What is more, modern anti-stigma campaigns tend to embrace and encourage the participation of their audience in disseminating their message. Therefore, the final sub-section of this chapter introduces the reader to the neoliberal subject before I embark on a tracing of her production through the discourse in anti-stigma campaigns.

2.4.1. Regimes of truth and ‘the gaze’

Discourse, like neoliberalism, is a contested concept and mode of analysis. Some (Swanton 1985) have argued that discourse is an ‘essentially contested concept’ whose analytical utility becomes questionable by virtue of its broad definitional scope. However, the analysis of discourses has proven to be one of the most versatile and commonly employed modes of conducting research in the field of International Relations (Epstein 2010; Holzscheiter 2014; Springer 2012). In this thesis I take discourse to refer to the texts and systems of meaning that constitute the social world around us. I argue that an analysis of these logics reveals the structures and ‘the way we make sense of the world, the way that we interact with broader social processes and the way we provide a sense of meaning to social actors’ (Tatum 2018: 346; see also Milliken 1999). Thus, the study of discourse is an important step in exploring how knowledge in and about the world is produced and normalised. In the following paragraphs, I (a) provide an overview of the influence of Foucauldian theory in shaping contemporary analyses of discourse; (b) reflect on the use of discourse in the study of international politics more generally; and (c) show how an analysis of discourse is relevant in demonstrating how anti-stigma campaigns are productive of neoliberal subjectivities.

Foucault is perhaps one of the most prominent post-structural scholars associated with the methodological move towards centering discourse as a site for critical inquiry in international politics. Foucault (1980: 197) refers to texts of culture, politics, and conflict as 'epistemes', or 'the apparatus which makes possible the separation […] of what may form what may not be characterised as scientific'. In other words, texts are specific artefacts of writing, images, or other representations which, in their constellation, constitute a discourse that becomes the object of scholastic inquiry. This is because the constellation is productive in determining the ('scientific') validity of certain knowledges which make up a given society's regime of truth. What is more, discourse presents one of the many techniques of power which are 'invented to meet the demands of production' (Foucault 1980: 161). To clarify, 'demands of production' refers to the relevant logics which determine what might be conceived of as productive in a given time and space. For example, productivity might refer to the accumulation of capital and economic growth, as we see in the logic of capitalism. Moreover, it refers to the constant need for subjectivities to be produced by and through techniques of power in a routinised and disciplinary array of micro-practices.

What can be further extrapolated from Foucault's reflections on discourse is that techniques of power are productive for the purpose of production itself which functions discursively in and through the texts which we encounter in our everyday lives. For example, one of the most common places where we are confronted with and consume discourse, are (social) media. Foucault, when prompted in a discussion on discourse, makes explicit reference to the advent of the ubiquitous gaze of the media. He comments on the naivety of the population in believing in the idea of 'freely available opinion' as serving 'democratic surveillance' and argues that, 'basically it was journalism, that capital invention of the nineteenth century, which made evident all the utopian character of this politics of the gaze' (1980: p. 162). Here, Foucault draws a direct link between the media and the disciplinary power of the gaze. The notion of the gaze further invokes questions of visibility and representations: what knowledges or experiences become or are made visible in the media?

And more importantly: Which ones are excluded from visibility? While one might dispute that media discourse is consumed so naively by people and 'digital natives' of the twenty-first century, the recent advent of 'fake news' as a strategy of governance and manipulation of public opinion reminds us of Foucault's cautionary tale about the power of the media forty years ago. The potential of discourse as a site of inquiry for scholars of global politics (and mental health) has consequently led to countless publications about language, representation, and the communication of knowledge.

In the study of international politics, discourse is considered to be a powerful methodological tool and site of inquiry because it can make visible the underpinning logics of cultural and scientific texts (Epstein 2008). It constitutes one of the many ways in which critical scholars of IR have been able to effectively counter the theoretical and methodological hegemony of positivist approaches to the study of global politics. Positing a challenge to limiting liberal/realist debates about the nature of global politics, proponents of critical engagements with discourse instead claim that 'all knowledge is interpretative, and interpretation (of acts, language, and objects) is the only method appropriate to the human, social, world when the research question concerns matters of human being' (Yanow 2006: 23). Consequently, there have been a variety of approaches taken to the study of discourse in international politics, some pointing towards the emancipatory potential of discourse (Koopman 2010, 2013) while others have stressed the importance of taking a reflective approach to the study of human life more generally (e.g. Flyvbjerg 2001). They all share a commitment to making visible different regimes of truth that emerge, or are disrupted, by and within discourse.

In the study of mental health discourse, several examples illustrate how a universalising paradigm of mental illness has become dominant in Western countries because psychiatric vocabulary is increasingly embedded within laws, modes of governance, and cultural artefacts (Glick and Applbaum 2010; Jhangiani and Vadeboncoeur 2010). For example, Jhangiani and Vadeboncoeur (2010: 181) argue that 'mental health discourse is based primarily on culturally situated assumptions that universalise and individualise experience, assumptions that do not ground the experiences of people across cultural groups'. In their study of the integration of positive psychology into the Canadian Mental Health Association's information text aimed at immigrants, the authors found that the text is based on assumptions about the universal experience of mental illness of people living in Canada. Moreover, the authors concluded that the second-person language used in the text mirrored self-help books rooted in positive psychology and which 'tend to emphasize emotional or bodily control, the individual as the locus of control, as well as the abnormal nature of the problem itself' (Jhangiani and Vadeboncoeur: 180). This frames Western knowledge as the 'only true' knowledge and ignores alternate descriptions and interpretations of the same experience, thus supporting the familiar critiques of Ibrahim (2014), Summerfield (2013), and Timimi (2011).

In a further example, Glick and Applbaum (2010) provide a close reading of the discourse in a CNN special about the spread of mental illness in the United States. They conclude that the special was strategic in creating a narrative about 'how things are and ought to be' in depicting those with mental distress as victims of a 'poor system' where 'compliance to pharmacological prescription in particular is the implicit solution to the dangerousness of mentally ill individuals' (2010: 242). The pharmaceutical solution is presented as more cost-effective than other therapies and thus highlighted as the best possible path to alleviating the increased economic cost of mental illness. Particularly interesting is also Glick and Applbaum's (2010) observation that the different case studies featured in the programme all include people who have committed acts of violence, meaning that mental distress is put into direct relation with deviance. There is an emphasis on personal culpability in the programme which is called 'Criminally insane', perhaps an unsurprising title considering its content. The authors argue that the programme reproduces a stereotypical depiction of mental illness as the biological cause of violent behaviour and constitutes 'an awful contribution to the stigmatization of the mentally ill' (Glick and Applbaum 2010: 243). The stigmatisation of mental illness can be traced throughout the programme, even when it is not directly addressed. Glick and Applbaum (2010) show that psychiatric knowledge, presented in a 'special news' format, can be instrumental in reinforcing existing sociocultural models of mental distress as a biological disease and henceforth legitimise pharmaceutical interventions over other approaches to therapy. Conducting a critical analysis of media texts and other cultural artefacts is thus powerful in revealing the underpinning logics of mental health discourse. What is presented as objective knowledge can be shown to be deployed almost carelessly, and at worst, with ulterior motivations.

In this thesis, the conceptual landscape of discourse takes on a central position as it forms the basis for the analysis of anti-stigma campaign *Time to Change* in Chapters 4 and 5 and the genealogical reading of previous mental health awareness campaigns in the next chapter.

Consequently, I critically engage with anti-stigma discourse, as articulated through public health intervention programmes, and I attempt to make visible the regimes of knowledge and 'truth' underpinning the logic of these campaigns.

2.4.2. Towards a working definition of neoliberalism

This section serves to introduce the reader to neoliberalism as concept and the figure of the neoliberal subject, both crucial components of the argument that I develop in this thesis. It is therefore relevant to outline what a neoliberal subject looks like and how subjectivity as a process of disciplinary power manifests. Drawing on literature from the field of Global Political Economy (Davies and Chisholm 2018; Eagleton-Pierce 2016) and the works of Foucault (1980; 2004), I understand the neoliberal subject as *an individual performing self-discipline*. In the following, I discuss the particularities of how a neoliberal subject may emerge and reflect on why Foucauldian theory is an asset in identifying and making visible the neoliberal subject. I begin by showing that neoliberalism is a contested concept that evolves in its definitional scope. It is a versatile notion and a precise definition, unanimously agreed upon, does not exist. However, it is possible to start thinking about neoliberalism with a workable definition that considers its role in the creation of wellbeing:

> 'Neoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can be best advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices.' (Harvey 2005: 3-4)

A key emphasis in the above quote lies on the notion of freedom, meaning that individuals may participate in economic competition as a regulatory factor for societal wellbeing. Rather than the state being the principal actor in providing care for the purpose of human wellbeing, its role is diminished to the maintenance of a system in which free markets and free trade can flourish. In a neoliberal society, the state's task is to *not* intervene in the operation of the liberal market. As will become more apparent later, state-led interventions in the form of anti-stigma programmes can be implicated in upholding the labour-market driven status quo through a promotion of commodified lifestyle choices. In other words, even those interventions that are led by the state, can serve to normalise the ubiquity of neoliberal policies which are explicitly designed to operate outside of state jurisdiction.

Noteworthy is also the explicit role that the concept of 'well-being' plays in Harvey's (2005) definition of neoliberalism. The requirement of upholding human health appears to be built into the foundation of neoliberalism's intent. Indeed, its entire purpose can be said to be based on the maintenance and optimisation of human health which is required for the continued function of liberal markets. One important consequence of this is that neoliberalism, in the pursuit of human wellbeing, needs to be concerned with health interventions at the everyday level. For example, mental distress can be an obstacle for human productivity, but it can also be harnessed as a potential source of capital accumulation. This is where we can witness the emergence of a mental health governmentality, an 'art of governing' and process of governing that expresses certain logics while relying on processes of 'micro-power' in shaping subjectivities (Foucault 2004a: 275). These micro-techniques are designed for 'teaching the body efficient and correct behaviour through carefully supervised training and carefully designed surroundings' while seeking 'to increase the economic utility of the body while decreasing its political danger' (Shiner 1982: 393). It is my task in this thesis to show how anti-stigma interventions constitute an important aspect of neoliberal power in shaping subjects to be self-managing. What is more, neoliberalism is reliant on the production of subjects who exhibit the least amount of resistance to this endeavour meaning that there is need for policing and surveillance. Creating an understanding of surveillance in anti-stigma campaigns is where Foucault's (1991a: 187) conceptualisation of 'visibility' to maintain the 'disciplined individual in his subjection' becomes a useful tool for analysis.

Finally, following from my above reference to neoliberalism as a contested concept, this now invites the question whether this also applies to the neoliberal subject. I contend that a universal definition of the neoliberal subject would be difficult to justify, but that it is possible to trace the outlines of neoliberal subject formation through an engagement with relevant scholarship and with reference to available knowledge of neoliberalism (Oksala 2011). It is important to bear in mind that no description of the neoliberal subject is ever complete. However, we can reveal particular characteristics of neoliberal subjects through a genealogy because these characteristics constitute the behaviours most desirable within the contemporary logic of neoliberal governance.

2.4.3. Contextualising neoliberalism

Neoliberalism, in this thesis, is understood in relation to capitalism as an economic ordering system of society. In the first instance, neoliberalism is connected to the 'the culture of post-industrial capitalism' which relies on the emotional labour of workers who are increasingly disengaged because societies 'with strongly materialist, competitive values' are difficult to sustain over time (Davies 2016: 9). Post-industrial capitalism has seen a shift from prices and value largely being determined by factory labour to a conceptualisation of commodities concerned with consumer desires and satisfaction (Davies 2016). In this vein, neoliberalism constitutes 'a system of enhanced capitalist power in which marketisation is stressed' (Eagleton-Pierce 2019: 119). The terminology of neoliberalism thus builds on existing Marxist vocabularies of capitalism, but ultimately allows for a conceptualisation of human relations beyond economic systems and more attuned to an appreciation of how power relations shift over time (Eagleton-Pierce 2019). Therefore, the tracing of neoliberal definitions in the context of mental health governance and anti-stigma campaigning is situated within a specific socio-historical context of neoliberalisation in the two decades before and just after the 2007-08 global financial crisis.

Neoliberalism has been described as a 'wave of market deregulation, privatization, and welfare-state withdrawal' in the 1980s that ultimately expanded to 'a broader political, ideological, cultural, spatial phenomenon' (Venugopal 2015, p. 168). There is an ample body of literature debating the historical origins of neoliberalism (Eagleton-Pierce 2016, 2019; Jessop 2013; Read 2009; Wacquant 2012), but for an analysis of contemporary mental health governmentality, it is important to note that 'the highpoint' of modern neoliberalisation was in the 1990s (Jessop 2013: 72). Even with the 2007-08 global financial crisis briefly calling into question the success of neoliberalism, 'the project still dominates world society thanks to the path-dependent effect of policies, strategies and structural shifts that were implemented during that highpoint' (Jessop 2013: 72). Crucially, an understanding that neoliberal reforms have extended to the realm of the socio-political allows for a broader conceptualisation of how economic principles become part of our very definitions of personhood and achievement (Brooks and Wee 2016; Davies 2016). Neoliberalism is not a monolithic system, but an ever-changing set of reforms and adaptations which encompass the economic as well as the socio-political and personal spheres (Peck 2010). Therefore, this thesis approaches neoliberalism as a zeitgeist that influences the economic realities with which we are confronted as well as the vocabulary with which we come to explain our responses to distress. In an era of austerity this means taking seriously the ease with which a rise in emotional distress among the population has come to be explained through psychiatric diagnoses (Esposito and Perez 2014; Mills 2018).

Austerity policies in the United Kingdom have been marked by the rollback of welfare spending, limits on increases for Jobseeker's Allowance, Housing and Child Benefit, and the introduction of higher tuition fees at universities (Cummins 2018a). What may have begun as an emergency measure has since been critiqued as an 'ideological attack' on the post-war era of welfare spending, particularly in the context of the NHS (Cummins 2018a: 22). Austerity has also been criticised as an attempt to shift blame for the financial crisis away from bankers and bank bailouts, and onto irresponsible public welfare spending (Kotz 2014). This re-articulates the situatedness and purpose of austerity within neoliberalism in the context of a crisis. Hence, the analysis in this thesis is embedded within the socio-historical contexts of austerity in the United Kingdom. The implementation of the Time to Change campaign in 2007 coincides with the global financial crisis and the inclusion of anti-stigma interventions in contemporary government policy (see Chapter 5) thus hints at the interwoven relationship between mental health, neoliberalisation, and austerity. The genealogy of anti-stigma campaigns in this thesis demonstrates that formal mental health awareness programmes emerged at the same time as the neoliberalisation efforts of the 1980s and 90s in the NHS (Rizq 2012) and gained renewed traction at the same time as austerity measures took hold in Britain after 2007 (Cummins 2018a; Mills 2018).

Therefore, a large part of the analysis in this thesis (Chapters 4, 5, and 6) is concerned with an interrogation of neoliberal subject-making within this post-2007 era of austerity, marked by individual responsibilisation regarding mental healthcare (Cosgrove and Karter 2018). Additionally, my archival research (Chapter 3) demonstrates that neoliberal governance of mental healthcare precedes austerity and that the anti-stigma approach of the 1990s was marked by the influence of the pharmaceutical industry and the advent of contemporary thinking about mental health in relation to labour productivity (Davies 2016; Esposito and Perez 2014). In other words, the empirical analysis of this thesis covers two distinct periods of neoliberal governance. Firstly, the mid-1990s–mid-2000s, which were characterised by a stark increase in privatisation in mostly Western democracies signalling an era of state withdrawal from welfare (Eagleton-Pierce 2019). This also saw the advent of a sharp rise in pharmaceutical interventions in the field of mental health, resulting in a shift to antidepressants as a primary healthcare intervention (Braslow and Marder 2019; Healy 2004; Tseris 2018). Secondly, the period from the 2007-08 global financial crisis not only emphasised the need to comprehend neoliberalism as a phenomenon beyond economic structures but as incredibly sustainable in its ability to define the parameters of success and achievement in contemporary societies (Cummins 2018a).

To be clear, the economic reforms and policies that are traditionally associated with neoliberalism – and which we continue to witness as neoliberal state-making evolves – are but one aspect of neoliberalisation. This is to say that ‘market reforms are not the end game, but the means to an end’ (Venugopal 2015: 174). The sphere of the socio-political is neither independent from nor entirely dependent on economic policy. Rather, there is a deep synergy between these two spheres, where the end is the constitution of an ever-adapting neoliberal subject. The liberalisation of markets may be what we have witnessed as a core principle of neoliberalism because it has played into the hands of economic elites (Peck 2010; Venugopal 2015), but that may not always be the case. Even an economic system that returns some responsibility for welfare to the state, can be deeply neoliberal, precisely because neoliberalism extends to the realm of the individual subject and her understanding of what it means to exist in this world. As I explore throughout the remainder of this thesis, the knowledge, or the ‘regimes of truth’ (Foucault 1991a), that we come to accept as facts about mental health determine the boundaries of acceptable discourse with which we comprehend the very definition of personhood. Fundamentally, what is at stake in raising awareness about mental health, is the definition of what is understood as normal and what is understood as abnormal behaviours and feelings in society. Thus, my study of anti-stigma campaigns seeks to reveal how the neoliberal subject comes to be imagined and constituted within the outlined contemporary context of capitalism, austerity, and neoliberal governmentality.

2.4.4. Meeting the neoliberal subject

To begin with, the neoliberal subject is (an) *individual*. As apparent as this assertion may appear, individuality is not a given universal conception of personhood. Rather, the person as individual is a concept of modern Western philosophy where the individual is the ontological starting point for analysis (Eagleton-Pierce 2016). Comprehending the subject as an individual has an important consequence for the working of modern Western medicine: psychiatric explanations of mental distress are directed towards examining an individual's biology as the cause and catalyst for mental illness. I expand more on the narrative of individualism in psychiatric knowledge of mental illness in the analysis of anti-stigma discourse in Chapter 4, but for now I want to provide an understanding of how the individual has become the centre for neoliberal personhood in the first place.

Central to any engagement with the neoliberal subject is the very closely related figure of the 'homo economicus' (Foucault 2004a). The homo economicus presents a 'disembodied, abstract, and universalising understanding of subjectivity' (Davies and Chisholm 2018: 274). She is characterised by self-interest and the making of 'rational choices' in order to pursue the best possible outcome for herself. Neoliberal governmentality assumes the existence of the homo economicus as the foundation for personhood and thus strives to (re)produce the subject in the image of the homo economicus. Crucially, neoliberalism relies on this embodied and abstract version as a prototype of the subject which 'precedes actual subjects and is the prescriptive measure and guide for their decisions and actions' (Davies and Chisholm 2018: 286). In other words, neoliberalism simultaneously presumes the condition of human nature and is reliant upon producing this type of subject in order to persist as the structuring principle of society. The persona of the modern homo economicus is a useful figure to understand why a neoliberal subject is defined by her individuality, namely because an individual's value is increasingly measured in terms of economic productivity and efficiency (McClanahan 2019).

However, neoliberal subjects are more than merely individuals in the sense of the homo economicus. In order to discipline populations into entrepreneurs and believers in the free market, it is necessary to foster an incentive for self-interest and competition among people. This includes the creation of an environment where individuals scrutinise the behaviours of others. This is best done by stressing the ability of the individual to realise her desires through discipline and the management of the self. Thus, a neoliberal subject is an individual that *self-disciplines.* Self-discipline, or self-governance, goes together with the already familiar Foucauldian notion of disciplinary techniques of power that carries with it the need for responsible actions (Eagleton-Pierce 2016). Responsibility is associated with the idea that one should fulfil their duty or obligation within society, a behavioural standard which is also manifested in the workings of legal-juridical institutions. However, it is not only the individual who can be considered as having to act responsibly to meet her obligations: state institutions and companies are actors which can also be held accountable for their actions, at least in theory. Yet, political and business elites are much more likely to engage in denial and instead move the burden of responsibility towards the individual. The notion of responsibility has entered Western (policy) discourses as a motivating terminology, the idea being that reward (often in the form of consumption) is directly associated with productivity (Brooks and Wee 2016). Hence, a responsible individual is managing her own life and success. This is also determinant of the 'success' of a neoliberal state where much more influential actors are relieved of responsibility:

> 'For such privileged actors, one of the most efficient strategies for conserving their power or relative autonomy revolves around ignoring or evading questions of responsibility that could enlarge the space for democratic protest. A retreat into technocratic, expert discourses, for example, can be seen in part as a form of betrayal and a turning away from a critical engagement with power and the long and distinguished history of responsibility' (Eagleton-Pierce 2016: 160).

The above quote illustrates the significance of discourse in normalising knowledge produced by the 'expert other' and in hiding the interests of industries driven by capital accumulation. Consequently, expert discourse is not only successful in hiding the need for responsible action from governmental institutions, but it simultaneously shifts responsibility to the individual who is also tasked with abiding by the 'scientific' framework through which these actions are articulated. For example, in the case of mental wellbeing the expectation of self-discipline by the individual is increasingly being extended to the maintenance of good mental health through self-care and the surveillance of others while the state retreats in providing financial resources for treatment of mental disorders. The responsibility for wellbeing and human advancement is shifted towards the individual who is expected to exhibit behaviour to manage herself and those around her.

Finally, a neoliberal subject is an individual that *performs* self-discipline. The concept of 'performance' encompasses two dimensions. The first establishes a direct relation to the control, management, and surveillance of workers, usually through the measurement of performance. What can be witnessed is the 'social construction of performance' which 'entails the employee in defining their own strengths and weaknesses rather than being told what to do' (Eagleton-Pierce 2016: 138). There is a strong emphasis in neoliberal governance and logic to incentivise performance in the pursuit of the accumulation of capital and economic advancement through competition. To this end, workers are ever more confronted with ‘a seemingly endless array of indicators, targets, league tables, projects, benchmarks, and audits’ (Eagleton-Pierce 2016: 139). In other words, performance is being operationalised in order to naturalise market capitalism as the principal site of reference for understandings of value and purpose. The consequence of this is that human wellbeing and self-worth start to become intrinsically linked with expectations around economic performance and productivity.

The second dimension of the notion of performance is linked to its definition in the sense of ‘performativity’. This conceptual tool is regularly invoked by critical scholarship in international politics to describe how people perform their identities in correspondence to the societal regime of truth where performance, including counter-hegemonic acts, is normalised and constructed. For example, in a neoliberal society we are encouraged to make,

> ‘the most of ourselves, making a spectacle of ourselves […] We are burdened with the responsibility to perform, and if we do not, we are in danger of being seen as irresponsible. Performativity is a moral system, that subverts and re-orients us to its ends. It makes us responsible for our performance and the performance of others’ (Ball 2012: 19).

The duality of performance means that performativity is designed to ensure performance, it is a technique of governance for the purpose of production. As can be seen throughout this exploration of the neoliberal subject, the study of neoliberal subjectivity is closely connected to the tools that Foucault has provided us with for the study of subjectification and discourse. Despite critics’ attempts to decry Foucault as getting neoliberalism ‘so wrong’ (Zamora 2019, see above), it is apparent that his conceptualisation of the workings of power and knowledge remain useful in making visible the neoliberal subject, particularly regarding the aspects of performance measurement and self-discipline. His analysis has been instrumental to ‘critiques that explore the political consequences of the disciplinary and governing techniques of neoliberalism’ (Davies and Chisholm 2018: 275). Thus, a critical approach drawing on Foucault engages with the notion of subjectivity as (re)produced, rather than pre-existing, in the analysis of neoliberalism. Moreover, the mechanisms for hiding the lack of responsible governance from state institutions and corporations behind a veil of expert discourse is a feature of neoliberalism that Foucault has already hinted at in his previous work. As already partially explained in the previous section on discourse, self-discipline is performed through the complex duality of the gaze:

> 'You have […] Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorising to the point that he is his own overseer, each individual thus exercising surveillance over, and against, himself. A superb formula: power exercised continuously and for what turns out to be a minimal cost' (Foucault 1980: 155).

In other words, the study of power, knowledge and discourse, in Foucauldian terms, lends itself also to the study of the production of neoliberal subjects in contemporary discourse on mental health in anti-stigma programmes. The neoliberal subject is, of course, a continuously produced entity and not merely a passive figure on which knowledge is imparted without resistance. Instead, the internalisation of discourse is not one which is imposed, but rather discourse is set up in ways which make possible only certain knowledges, which consequently enter society as common sense. Therefore, it is possible to trace and locate the neoliberal subject in the discourse of anti-stigma campaigns through an exploration of the processes of knowledge production on which it is premised.

2.5. Conclusion

The theoretical framework of this thesis is my conceptual toolbox for developing a critical approach to mental health politics in my analysis of anti-stigma campaigns. This chapter started with an exposition of the use of genealogy in this thesis in which I justified my approach to the study of anti-stigma campaigns through a historical reading of previous campaigns. I showed how a readiness to engage with historically emergent notions of stigma and mental health allows me to make visible the multiple ways in which this knowledge has been shaped, deconstructed, and claimed. The politics of mental health stigma are revealed to be historically contested through a genealogical encounter with anti-stigma and mental illness awareness campaigns. In this vein, one might also invoke the idea or image of an 'assemblage' as introduced by Deleuze and Guattari (2004). I do not employ the language of assemblage in this thesis, but the notion of an assemblage is implicit in my approach as it denotes a continuously shifting network of ideas, which are — much like Foucault's notion of the interdependence of power and knowledge — inherently productive. For the study of the global politics of mental health this means finding a way into tracing the global political structures of economy around anti-stigma and mental health awareness campaigns. In doing so, I demonstrate the emergence of anti-stigma campaigns as a technology of governance in ongoing endeavours to maintain capital-labour relations according to the status quo.

I continued with an exploration of Foucauldian thought on the interplay between power and knowledge by sketching both the disciplinary power of psychiatry and of International Relations. This serves to introduce the reader to the relevance of understanding psychiatric power to make sense of anti-stigma campaigns and to contextualise the original contribution this thesis makes to the discipline of IR. I show that psychiatry as discipline has a complex relationship with stigma and anti-stigma thinking meaning that knowledge about mental health stigma must be understood within the context of state-led influence on psychiatry.

In the final section I provided an overview of the significance of studying discourse as a technology of power instrumental in producing subjects in public health interventions. This section outlined how Foucault came to view language and discourse in the media as a way in which the public can be influenced because of the false assumption that media discourse will serve as a form of ‘democratic surveillance’. I then showed how existing scholarship has succeeded in demonstrating that discourse can be powerful in manufacturing consent or legitimising certain types of knowledge as the norm (e.g. Glick and Applbaum 2010). I also introduced the reader to neoliberalism and the figure of the neoliberal subject. Neoliberalism, as an ever-changing phenomenon, was contextualised within distinct periods of economic reform and austerity in the United Kingdom between the 1980s and the decade after the 2007-08 global financial crisis (Eagleton-Pierce 2019; Rizq 2012). Constituting one of the key building blocks of the argument in this thesis I then showed that the neoliberal subject is understood as an individual performing self-discipline. This is important given that my research reveals a strong link between the discourse of anti-stigma campaigns and the production of neoliberal subjects. Through an engagement with the debate about Foucault’s views on neoliberalism (e.g. Zamora and Behrent 2014), I have demonstrated that a Foucauldian critical attention to the uncovering of systems of power ‘that we are tempted to take for granted’ can be extended to the study of neoliberal subject-making today, despite the ambiguous role of neoliberal thought in Foucault’s later lectures (Newheiser 2016: 16).

In sum, taking on a Foucauldian perspective forces us to question, as expressions of disciplinary power, even those practices that appear mundane or benevolent. More than that, a Foucauldian approach to the study of society requires us to work beyond traditional methodologies with what Shiner (1982) calls an ‘anti-method’ of genealogies that both analyses specific structures of power-knowledge and expresses a critique of the ‘regime of truth’ of that structure. The genealogical approach of this thesis is designed to work with constantly shifting concepts, such as stigma and mental health, while also presenting a challenge to traditional scientific approaches in studying anti-stigma campaigns, which tend to prioritise qualitative and quantitative measurements rather than analyses of power structures:

> ‘One must read his [Foucault’s] genealogies of the prison, sex, or the human sciences, therefore, as a political act rather than merely a history of their development or a philosophy of their foundations’ (Shiner 1982: 382)

This thesis is firmly positioned within the same ethos, meaning that by examining the intellectual assumptions and power structures of a mental health anti-stigma campaign, I reveal the political economy of truth underpinning the discourse of anti-stigma campaigns. This thesis therefore utilises Foucauldian thought to provide a new angle of analysis to mental health intervention programmes. Moreover, my curiosity and methodological framework to studying mental health is driven by innovations and ideas incited by works from scholars such as Howell (2011) and Long (2014) who have built the foundations for the critical engagement of this thesis with the global politics of mental health. I seek to question what is assumed or taken for granted when it comes to conversations and policies about stigma and mental illness. I attempt to reveal the complexities in the relation of power-knowledge in the global politics of mental health by critically engaging with anti-stigma programmes. In the next chapter, I am going to illustrate the neoliberal foundations on which contemporary anti-stigma programmes are built by providing a genealogical reading of two previous campaigns run by the Royal College of Psychiatrists in the UK between 1992 and 2003.

3. Defeating depression by changing minds? A Genealogical reading of two anti-stigma campaigns in the United Kingdom

> ‘Effective action in recognising and treating depression in the workplace can only occur after it has been accepted that depressive illness is common and that affects not only the individual employee, but also the organisation as a whole.’ (*Defeat Depression*, RCPsych n.d. A1: 4)

> ‘The College believes that society, if invited to reconsider its attitudes about mental disorders and given more accurate information about them, has the potential to develop a more tolerant and humane attitude to the mentally ill.’ (*Changing Minds*, RCPsych 1998 B1: 12)

3.1. Introduction

This chapter provides a genealogical reading of two mental health awareness and anti-stigma campaigns in the United Kingdom, run in the timespan from 1992-1997 (*Defeat Depression*) and 1998-2003 (*Changing Minds*) by the Royal College of Psychiatrists (RCPsych). The campaigns constitute the two principal public health programmes aimed at raising awareness about mental illnesses before the foundation of *Time to Change* in 2007. In the following, I will provide an analysis of the materials gathered in the archives of the RCPsych in London during two visits in the spring of 2019 and demonstrate how these programmes were essential in building the ideological foundation for TTC. This chapter pays particular attention to a) the campaigns’ discourses about the nature of mental illness; b) the reasons presented for the need to run anti-stigma programmes in the first place; and c) the advocated paths to recovery. I will conclude that the recent history of anti-stigma campaigns leaves us with intriguing questions about the vested interests of the psychiatric profession, the state, and the pharmaceutical industry in the success of anti-stigma programmes, which are of crucial importance for scholars studying the global politics of mental health.

This chapter begins with a section describing my experience of the archival research itself in order to show that the materiality of the archive was influential in shaping my approach to the campaign materials. In providing a discussion of my experience, I not only expose the significance of the researcher’s embeddedness within archival research but show that archives present an abridged version of a story from the very beginning because of how they select which texts to preserve. This is an important first step in understanding how narratives of mental health and anti-stigma are produced and maintained. In this part of the chapter, I also introduce to the reader the different types of texts and materials which I encountered in the archives and which my analysis refers to.

This is followed by a critical reading of the *Defeat Depression* (DD) campaign in which I interrogate both the organisational structure of the campaign as well as the mental health discourse in its promotional materials. My analysis reveals the influence of pharmaceutical companies in driving the campaign's primary message and shows how stigma has become a concept which can be operationalised for the purpose of reducing resistance to the prescription and taking of antidepressants. The utilisation of stigma and anti-stigma discourses for the purpose of behavioural change in the population also re-emerges in my later examination of the *Time to Change* campaign.

The third section in this chapter is an analysis of the *Changing Minds* (CM) campaign. This campaign followed the organisational structure of DD but puts more emphasis on the promotion of mental health awareness within society generally. As I demonstrate through my reading, CM broadened its narrative scope to encompass more mental disorders, to target stigmatising attitudes more directly, and to enlist the (news) media as a medium for communication. I also show that the commonly used statistic of '1 in 4' to promote mental health awareness has an ambiguous beginning in this early anti-stigma work. I conclude the chapter with a summary of my findings and a reflection on the normalisation of psychiatric discourse in both campaigns which emphasise the need for pharmaceutical interventions and individual action to raise awareness of mental disorders. Moreover, I reflect on the decision by the Royal College of Psychiatrists to terminate the organisation of their anti-stigma campaigns with a look towards the TTC (2007-2021) programme which is the object of inquiry for the following two chapters.

3.2. Encountering the archive

My approach to archival research and to the materiality of the archive itself is based on the assumption that archives are not merely passive locations which serve as the background to the collection of artefacts, but that they play an active role in the constitution of the relationship between the researcher and the researched (Anderson et al 2010). I take the archive to be a 'dynamic spatial and discursive milieu' which means that archives are implicated in determining which knowledge is extrapolated from its resources. I want to stress the importance of reading these two aspects of my work alongside each other. The archive, as a space of psychiatric discipline and locus of knowledge, shaped the conditions under which I was able to discover and collect the materials for this analysis. This is the reason why this section both outlines the wealth of campaign materials that I work with and allows the reader to appreciate the circumstances under which the genealogical reading of these two campaigns was conducted. Although much of the analytical labour in examining these texts was done well after the actual visit, the experience of working in the College stays with me and has undoubtedly been instrumental in guiding the decisions which I made in choosing which materials to foreground. To be clear, in this section I do not attempt to resolve the inherently biased positionality of the subject of the researcher in conducting archival research, but rather acknowledge the complexities inherent to archival research while providing a first overview of the materials which form the basis for the analysis in this chapter.

Contrary to popular imaginations about archives, my visit to the RCPsych archives did not present itself in the form of an immersion into 'the dusty world of manuscripts' (Tamboukou 2014: 618). Rather, my archival experience is much better described as having been placed at a small poorly lit table, into the midst of the commotion of 'psychiatric business' at the College. I was confronted with a working environment where a constant stream of people were coming and going, stopping by to chat with someone, waiting for their meetings, coffee in one hand and smartphone in the other. Rather different from what I expected, I even witnessed a professional photoshoot for RCPsych marketing materials at the same time as I sat working, leafing through unorganised boxes of campaign material, in what can only be described as the 'second entrance lobby' of the College. The archives are located behind the reception, which must be crossed in order to enter the College officially but are still situated in an open-plan space where visitors are received. The room, or lobby, has several leather couches and seats, a coffee machine (free to use), a few tables with computers, some bookshelves, and the archival team based in a small glass room near the entrance. The entire layout of the room, the location of the archives at the very entrance, and the business-like atmosphere, is not what I expected from my archival experience. I was not sitting in a dark, quiet library, but I found myself surrounded by the archival team and other College members at all times.

Most surprisingly perhaps, I was regarded and treated as part of the College from the very beginning, with several people stopping by to introduce themselves and to ask questions about my work. My experience of working in the RCPsych was instrumental to the development of my relationship with the institution and the researched material. The tactile experience alone of looking at and reading previous campaign materials was an impactful way for me to encounter data, particularly in contrast to the largely online-based TTC campaign. However, the welcoming atmosphere of the College was unexpected, a complication poignantly captured by Tamboukou (2014: 620):

> 'This brings me to my next question of how the researcher's experience in the archive creates certain conditions of possibility for what will emerge from the archival research: how she will make selections of what to see, note, transcribe or ask to be photocopied'.

Would the analysis in this chapter be different had I sat in an old Victorian building, and not in a modern office-type environment which practically radiated an atmosphere of expense, internationalism, and business? A researcher's embeddedness is always present, and it is expressed in the smallest of acts, with the establishment of a routine. For example, what one reads in the morning leaves a different impression on the researcher than what is read towards the end of the day (Tamboukou 2014). Being allowed to take pictures, not scans though, of documents meant that I was not concerned about this – I would be able to revisit the texts at a later date with a fresh mind. Yet, the impression upon first seeing the archival materials has been shown to still impact my process of analysis and writing. I felt drawn towards the brochures and meeting minutes that I had read during the beginning of my stay. Since the archival boxes had not been organised or ordered in any way, it was almost random as to which brochure or document I looked at first.

However, it is not only the researcher and her limited experience, that impact on the conditions of possibility as 'archives are neither faithful to reality nor totally representative of it; but they play part in this reality, offering differences and alternatives to other possible statements' (Farge 1993: 5). In other words, there is a need to consider which texts were intentionally preserved and which were destroyed before the start of archival research. From my conversations with the College archivist, it became clear that the surviving boxes of anti-stigma campaign materials had been assembled within the last three years. Many documents were not preserved as only five boxes were made available to house the materials and there is no clear trail of what is and is not included in the current boxes. Upon further questioning I was told that the work was done by an intern who no longer works at the College, and that there was no way of knowing exactly what had been discarded. I had to be content with what was preserved, yet I cannot help but still wonder whether the materials that make up this collection present an almost arbitrary picture of reality. As already observed by Derrida (1997), the archive can be mnemonically faulty and is often incomplete, yet this imperfection also allows for a close examination of those materials deemed worthy of preservation. From the very beginning then, the story of anti-stigma campaigns is an abridged version of itself.

Notwithstanding my concerns regarding the historical accuracy of the archival content, the materials which I did encounter were manifold: steering group meeting minutes; information leaflets for both GPs and the public; correspondence letters with funding partners; advice on improving mental health in the workplace for businesses; celebrity endorsements; children's books; teaching materials for schools and GP surgeries; pieces of artwork; and a variety of correspondence regarding the organisation of the campaigns while they were running. The most common type of document that I encountered were brochures and information sheets about mental health which were distributed to either healthcare professionals or the general public. These provide a very good picture of how mental distress was conceptualised, what the public was supposed to be educated about, and what type of behaviour was encouraged or deemed desirable in the face of mental distress. Moreover, the booklets and brochures almost always provide an introduction into the campaign's intended outcomes and a clear guideline on paths to recovery. In addition to these promotional materials, a smaller part of the preserved documents is taken up by the minutes of the College's campaign steering group meetings. Those offer an insight into the rationales of the campaigns and the decisions that were made with regards to the phrasing in the materials intended for public education. These give some insight into the politics of discourse during the beginning of the campaigns.

3.3. 1992-97: Defeat Depression

The *Defeat Depression* campaign was launched by the Royal College of Psychiatrists in 1992 and was rolled out across the United Kingdom for five years until 1997. The campaign programme's stated aim was to 'both increase the knowledge of health care professionals in the recognition and treatment of depressive disorders, and to enhance public awareness of the nature, course and treatment of depressive illness' (RCPsych n.d. A1: 2). The campaign was eventually replaced by the *Changing Minds* campaign in 1998 which took a much broader approach to the issue of mental health awareness and sought to broaden the narrative of DD to mental disorders generally as opposed to focussing on a single mental disorder like depression.

What sets *Defeat Depression* apart from both *Changing Minds* and the current *Time to Change* programme is its focus on one mental disorder and its treatment as opposed to mental health more generally. This is one of the reasons why we can see a much more visible influence of the pharmaceutical industry in the funding and discourse of DD. My analysis in this section shows that the content of the DD campaign material does link depression to anxiety or substance abuse, including some references to bipolar disorder ('manic depression'), but the main emphasis remains on educating the public about depression as a danger to the individual person and the workplace. This, as will be shown below, is strongly linked to the campaign's goal in making antidepressant medication a more accepted form of treatment by both healthcare professionals and the public. One further difference between DD and other campaigns is the notable use of a campaign logo during the programme. While *Changing Minds* and *Time to Change* are recognisable largely because of their font and colour scheme, *Defeat Depression* relied heavily on the use of a logo as a means to boost its message. Materials were often identifiable as belonging to the campaign only because one could see the logo added to it while fonts and formats for content delivery varied greatly.

This observation is important because the logo itself can tell us a lot about the way in which the RCPsych sought to communicate its understanding of depression or, at least, how the campaign's message might appeal to those who come into contact with it. The logo (Figure 1) is an abstract drawing of a face which is split in two. The left and darker side of the face only features a closed eye and a single, large tear. The right side can be seen to be smiling slightly, with an open eye, and is much lighter as well as turned towards the 'sad' side as if it is observing its sadder other half. This imagery invokes a strong binary between 'happy' and 'sad' which produces an imagery of depression as bad (sad) and not-having-depression as good (happy). This visual representation of depression not only ignores the more complex relationships that people have towards mental distress, but also further positions depression as something a person is afflicted by, equating it with other physical illnesses. What is more, the campaign logo captures the emergence of a discourse which continues to run through mental health awareness and anti-stigma campaigns today. That is, the binary nature of mental distress and its expression within individual bodies.

Figure 1. Logo of the Defeat Depression Campaign

In the following I conduct a critical reading of the *Defeat Depression* campaign materials that I had access to as part of my archival visits. Firstly, I go into some detail about the organisational structure of the campaign as far as I can extrapolate from Steering Committee (SC) meetings and funding correspondence. Secondly, I provide an analysis of the discourse in *Defeat Depression* promotional booklets which were targeted specifically at companies, employees, and men. I identify a clear linking of low mood with a lack of productivity at the workplace as well as a move towards medicalising reduced productivity. This is in addition to problematic suggestions about depression in men as originating in their relationships with women as partners or wives. Finally, I conclude this section by sketching the politics of transition between DD and CM and problematise the role of DD in de-stigmatising antidepressants as a widely accepted form of treatment for mental distress.

3.3.1. Funding and the role of the pharmaceutical industry

In the first instance, the *Defeat Depression* campaign was funded by the Royal College of Psychiatrists. At the time, psychiatrists perceived there to be a mistrust regarding the diagnosis of depression amongst the public as well as general practitioners (GPs) and other healthcare professionals. This suspicion extended also to the prescription and use of antidepressants for the treatment of depression. Although antidepressants had been developed in the 1950s, the taking and prescribing of them as a first response to mental illness by GPs was still rather uncommon in the United Kingdom of the early 1990s. This was not only of concern for psychiatrists who sought to further integrate the psychiatric profession into the medical discipline but also for the pharmaceutical industry who struggled to establish a continuous market for its products (Braslow and Marder 2019; Davies 2017; Moncrieff 2009). Thus, it was of little surprise for me to find DD was funded in part by pharmaceutical companies, most notably by Eli Lilly, the makers of Prozac (known as Sertraline in the United Kingdom), a common drug prescribed to treat anxiety and depression (RCPsych 1997 A6, see also Healy 2004; Moncrieff 2009). While official financial records were not made available as part of the archival material, I did see a 'draft' (written on top of the paper in pen) summary of the DD budget towards the end of the campaign (RCPsych 1997 A6: 1). Non-commercial organisations, including the Department of Health and the West London Health Promotion Agency, had donated a total of £119,550 to the campaign. 'Pharmaceutical companies' had funded the campaign with a larger sum of £183,413. Additionally, Eli Lilly is quoted as having taken on the production of the campaign's leaflets on 'Depression', 'Depression in the Elderly' and 'Postnatal Depression', however the 'total amount for this purpose is not known' (RCPsych 1997 A6: 1). What is more, SmithKline Beecham Pharmaceuticals sponsored 'a pharmacy initiative dealing with the management of depression' with an 'educational grant' as part of DD (RCPsych 1994 A7). This involved the dissemination of audio tapes entitled 'Self Care' to pharmacists in the UK to raise awareness of antidepressant medications. An illustration of the importance of self-care in the campaigning of DD is evidenced by the following cover image from a campaign brochure (RCPsych n.d. A8) that promoted self-care:

Figure 2. 'Try Self-Help!' Campaign Brochure

Although 20% of patients presenting to GPs at the time had diagnosable symptoms of clinical depression, half of which were perceived to be in need of urgent treatment, there was still a sizeable amount of resistance in the public imagination to antidepressant drug treatment according to several studies based on population-wide surveys (Paykel and Priest 1992; Priest et al 1996; Vize and Priest 1993). In other words, as much as the *Defeat Depression* campaign can be seen as a mental health awareness and anti-stigma campaign, its strong and direct links to the pharmaceutical industry and robust message in favour of pharmacological drug treatment for depression make the campaign appear a lot more like a campaign raising awareness of antidepressants than of depression. This is perhaps unsurprising considering the longer history of the anti-stigma narrative and its connection to the public image of the psychiatric profession which I have explored earlier on in this thesis. With the advent of drug treatment being readily available to treat common disorders like depression and anxiety, psychiatry was suddenly facing a new set of hurdles in gaining public consent. Because antidepressants were viewed as addictive and linked to – although by then discredited as a useful drug for the treatment of depression – benzodiazepines, advocates struggled to establish antidepressants as a widely accepted form of treatment (Vize and Priest 1993). It is the gap between psychiatric knowledge and public perceptions of antidepressants that DD sought to close at the time of its launch.

Looking at statistics from a decade later, it appears that DD (and CM) was largely successful in dispelling the supposed stigma attached to psychiatric drug treatment. According to the National Institute for Health and Clinical Excellence (NICE 2004), annual prescriptions issued for antidepressants in the UK increased by 235% from 9.9 million to 23.3 million in the time from 1992 to 2002, and these numbers have continued to rise ever since. The most recent figures show that in the time between 2006 and 2016, the number of annual prescriptions rose further from 31 million to 64.7 million, another 108% increase (NHS Digital 2017a).

Thus, while public attitudes to mental health and mental illness continue to be put under scrutiny by anti-stigma campaigns for purportedly being discriminatory towards those suffering from mental distress, statistics show that the uptake in antidepressants has been on the rise. There were almost as many prescriptions of antidepressants annually in 2016 as there were people living in the United Kingdom (NHS Digital 2017a), although it is important to note that this number likely does not reflect the actual number of people treated with antidepressants. We must remain cautious of the power of statistics and quantification

(Merry 2016), as I have clearly stated in the Introduction. For example, one person could receive more than one prescription, often on a monthly basis, while it is also not clear that the prescription of antidepressants necessarily follows a diagnosis with depression. Thus, it is not possible to extrapolate the number of people in treatment from the number of prescriptions issued nor does this provide us with an idea of the rate of medication compliance. However, the increase in prescriptions is indicative of a clear vested economic interest by the pharma industry that prompts me also to critically consider the categories of mental health stigma and anti-stigma in shaping the messages about mental health discrimination that are communicated. The next three sections thus interrogate the discourse around the consequences of mental health stigma that are imagined by the DD campaign.

3.3.2. Depression at the workplace and the 'wastage of trained manpower'

There is a clear emphasis in the discourse of the *Defeat Depression* campaign that there is a need to address the increase in diagnosable depressive disorders affecting workers and the consequences this has on the efficiency of their labour. Accordingly, a large portion of the promotional material distributed during the DD campaign was aimed at promoting awareness and guidance on dealing with 'Depression in the Workplace' for employers and employees (RCPsych n.d. A1, A2). While both those groups were targeted as part of the initiative, the guidance and advice they received was very different. Whereas employers received more detailed information about how to implement 'an effective and workable mental health policy' within their organisation, employees were handed booklets with 'facts' about depression, accompanied by cartoons (RCPsych n.d. A1: 1, A2).

For example, the 'Depression in the Workplace' information pack that was distributed to large organisations as part of the campaign begins by outlining the rationale for crafting and implementing a mental health policy in a company. In doing so, the guidance emphasised the economic burden which is supposedly put on society by mental health problems from the very outset. The introductory text in the information booklet reads:

> 'The amount of time lost from work through mental health problems is enormous - in England and Wales it amounts to approximately 80 million working days a year, an annual cost of around £4-5 billion. This figure is some 30 times the number of days that are lost through industrial disputes.' (RCPsych n.d. A1: 2)

The paragraph continues to highlight how depression is an illness which has been identified as being responsible for the loss of many workdays annually and that – if left untreated – depressive disorder will result in a worker's 'general reduction in productivity and efficiency at work'. After reading the opening paragraph, it is clear to any employer that the economic cost attached to undiagnosed and untreated depressive illness amongst employees is not only of grave importance but that it can be avoided through the implementation of appropriate management policies. However, left unacknowledged in the guidance document is the potential personal suffering that those affected by depression might experience, as are structural socio-economic factors that contribute to the emergence and perpetuation of depressive moods (Fleming 2017; Matthews 2019). On the contrary, the guidance outlines the reasons for the development of a depressive disorder as the following:

> 'Depression may arise from the combination of an individual predisposition or vulnerability with stressful events, adverse life experiences or life difficulties' (RCPsych n.d. A1: 4).

In other words, the locus of depression is considered to be the genetic makeup of an individual employee, a 'predisposition' towards developing depression. This is a claim contrary to studies which suggest that there is not sufficient or conclusive evidence for genetic predisposition in causing depression (Dunn et al 2015; Moncrieff 2009). Rather, this framing is in line with the desires of the psychiatric profession to medicalise and establish itself as a dominant medical discipline for which it is necessary to be able to intervene upon the human body. Moreover, the organisational guidance booklet provides a definition of depression that is so broad that any situation where the worker is not performing in a motivated or efficient manner could be interpreted as an occurrence of depression:

> 'The term depression is used to describe a spectrum of low mood, ranging from normal unhappiness to a severe mental disorder' (RCPsych n.d. A1: 3)

In contrast to the guidance on depression provided for management, the brochures intended for employees put a different emphasis in their communication about depression. Rather than highlighting the economic cost of depression, although the brochure does name 'not performing as well as usual' and 'arguments with colleagues' (RCPsych n.d. A2: 3) as first symptoms of depression, the common nature of mental illness is the primary narrative running through the information booklet. It appears paramount to stress not only that depression is a common illness that can affect anybody, but that it is easily diagnosable and treatable when one only asks for help.

Now that depression has been framed as a significant problem for both employers and employees, the guidance documents seek to outline the possible solutions to the detrimental effects of depression. First and foremost, employers are urged to implement mental health policies at their workplace while employees are urged to seek medical advice as soon as they notice signs of depression. It is interesting to note that this narrative continues to run through the contemporary *Time to Change* campaign, yet it is now supplemented with advice that one should not only monitor the self, but also the people around the self, for symptoms of mental distress. The *Defeat Depression* guidance for employers goes on to outline the purpose of a comprehensive mental health policy: (a) to regularly screen for depression amongst the workforce; (b) to support employees through a journey of recovery; and (c) to educate employees and management about depression and mental illness (RCPsych n.d. A1). The potential benefits of a successful implementation of such a policy are reduced to three very succinct bullet points: 'Reduction in the wastage of trained manpower'; 'improved efficiency and effectiveness of the workforce'; and 'an enhanced company image' (RCPsych n.d. A1: 9).

Finally, the booklet provides suggestions for organisations on how to 'spot' depression amongst the workforce. It is argued that access to adequate treatment can only be made possible if there is a system in place to check for the occurrence of depression in the first place. To this end, the information materials suggest two things: to be aware of the symptoms of depression and to regularly administer surveys in the workforce to 'test' for depression. The brochure introduces four potential 'pen and paper' tests that can be used in order for organisations to check whether employees exhibit symptoms of a depressive disorder (RCPsych n.d. A1: 12). There is also a strong emphasis on the role of antidepressant medication in helping workers recover from depression. Indeed, antidepressant medication is advocated as a coping mechanism also 'in the presence of life stress' and that it should 'not be withheld simply because a patient's depression appears "understandable"' (RCPsych n.d. A1: 5).

In other words, the medicalisation of reactions to adverse life experiences is an integral part of the campaign's message about pharmaceutical intervention. The guidance brochure even provides a section which outlines the potential effects of antidepressant drugs on the work of the employee, noting side effects such as drowsiness or tremors when operating machinery (RCPsych n.d. A1: 8). There is no mention of potential side-effects for the person taking the medication, despite overwhelming medical concerns that antidepressant medication can sometimes make depressive symptoms worse and that side-effects are commonly reported among antidepressant users (Moncrieff 2009; Raj Marasine et al 2020; Wang et al 2018). Non-productivity at the workplace is thus framed as both a potential symptom of depression *and* a side-effect of psycho-pharmaceutical interventions, highlighting the embeddedness of economic productivity as a core concept within the discourse of depression in anti-stigma campaigns.

The discourse underpinning this guidance so far is troubling for a variety of reasons. Firstly, the emphasis put on identifying depression constitutes a form of workplace surveillance, that potentially extends beyond the context of labour. The suggestion that pen and paper tests should be used to screen regularly for depression is a problematic intervention in the personal life of the individual employee. Secondly, recovery is advocated strictly in form of taking pharmaceutical medication. This means that an individual's brain chemistry is often made responsible for depression and that it becomes the target of pharmacological alteration so that the individual can return to work, even if the causes of mental distress are 'understandable'. It follows that the body of the worker is reduced to the function it can fulfil for the organisation, where wellbeing is only important when it can be measured as economic productivity. Thirdly, the role of the organisation as employer is particularly problematic in the discourse of *Defeat Depression*. As the provider of employment and working conditions they are largely left without responsibility towards the worker unless productivity at work is affected. The brochure for employees explicitly states that 'there is little evidence that poor working conditions can directly cause depressive illness' although 'undue pressure and stress at work can combine with other problems' (RCPsych n.d. A2: 6).

Thus, DD's guidance for employers on depression in the workplace not only prompts organisations to implement regular screening procedures for depressive disorders among their workforce but frames the importance of doing so in the context of the potential loss of economic productivity. In addition, employees are encouraged to monitor their own behaviour for signs of unproductivity or lack of motivation and to report to healthcare providers if depressive feelings continue for a prolonged time. The campaign is firmly positioning the issue of mental wellbeing in a context of labour and economic productivity, it emphasises the role of the individual as the bearer and locus of mental illness, and it prioritises psychiatric knowledge in the form of pharmaceutical intervention as the primary solution to quick recovery and reintegration into the labour force.

3.3.3. On the nature of men(tal health)

In addition to a focus on depression at the workplace, DD brochures were also particularly concerned in providing information about the occurrence of depression in men. The promotional material developed to address depression in men is a brochure called 'Men Behaving Sadly' (RCPsych n.d. A3) which was aimed at educating the general public about depressive episodes in men and a patient information sheet about depression in men (RCPsych n.d. A5). The issue of mental health is approached a lot more cautiously here than in brochures about depression at the workplace and emphasises the common occurrence of depression. According to the brochure, although men are diagnosed less frequently with a depressive disorder, this is not due to depression affecting men less than women, but rather due to men being less likely to ask for help because of the 'way men think about themselves' (RCPsych n.d. A3: 3):

Figure 3. Illustration in the 'Men Behaving Sadly' brochure

The brochure elaborates on this further and claims that men tend to be far more concerned with being competitive, powerful and successful, compared to women. The brochure suggests that the cause for depressive disorders in men are to be found within their relationships with other people. The suggestion found in workplace guidance about ‘vulnerability’ and ‘predisposition’ with regard to depression, is thus *not* reiterated here. Rather the emergence of depression in men appears to be understood as more circumstantial, at the inter-relational level:

> ‘For married men, research has shown that trouble in a marriage is the most common single problem connected with depression. Men can’t cope with disagreements as well as women. Arguments actually make men feel very physically uncomfortable.’ (RCPsych n.d. A3: 4)

> ‘… the process of separation and divorce is most often started by women. Of all men, those who are divorced are most likely to kill themselves.’ (RCPsych n.d. A3: 5)

Indeed, after examining the discourse on the nature of mental illness in the brochure, it appears that it is not genetic predisposition or a person’s inherent vulnerability – assumptions about the nature of mental illness that are very problematic regardless – but that the cause of depression in men actually lies in their relationships with women as partners or wives. Whether busy ‘nagging’ (RCPsych n.d. A3: 5) their husbands to discuss marital problems or leaving a marriage completely, women are posited as the main actor in causing depressive episodes in men. The booklet also includes a section dedicated to pregnancy and children in which it claims that ‘new mothers tend to be less interested in sex for a number of months’ which leads to the man feeling rejected (RCPsych n.d. A3: 7). Again, women appear at the centre of the cause of depressive episodes in men who are presented as unable to cope with complex emotions in a relationship. The only other cause – not related to women per se – for men’s mental distress that is mentioned in the brochure is the loss of employment, either involuntarily or through retirement. However, this is framed as secondary factors only causing depression in ‘one out of seven men’ (RCPsych n.d. A3: 9).

Curiously, the notion that men may not be in a relationship with a female partner is hardly recognised in the brochure. In a short section titled ‘Gay men and depression’ (RCPsych n.d. A3: 8) two sentences are dedicated to the exploration of this possibility as the text acknowledges that gay men may have additional pressures on them due to the stress of coming out. It appears that, if men’s experiences of mental distress are not entwined with their relationships with women as partners, their experience of depression is unlikely to deserve much attention. The brochure also takes particular concern with establishing the need for antidepressant treatment for men:

> ‘It can help to be reminded that depression is a result of chemical changes in the brain. It has nothing to do with being weak or unmanly, and it can easily be helped.’ (RCPsych n.d. A3: 11)
>
> ‘Another problem may be that some anti-depressant drugs will also reduce sex-drive in a small number of men who take them. HOWEVER, the good news is that, as the depression improves, so will your sexual desire, performance and satisfaction.’ (caps/emphasis in original) (RCPsych n.d. A3: 6)

Put simply, there is a strong emphasis in DD that men should try to circumvent the stigma which prevents them from seeking professional help for mental distress. The campaign’s insistence on promoting depression as having a biological cause is at the same time used to show how depression is not a fault of character nor a fault of men alone. Rather, their relationships with women as partners are emphasised as triggering factors for depression. What is more, the potential side-effects of antidepressant medicine are explored at length, presented in a way that assures men that taking this medication would not impact on their ability to lead a ‘normal’ life. It is possible that DD’s focus on men can be attributed to the low uptake in prescribing antidepressants for men. More recent reports suggest that women are still almost twice as likely to take antidepressants than men (NHS Digital 2017b) and that the prescription of antidepressants becomes more common as the proportion of patients who were aged 65 and over, female, and White increased (QualityWatch 2014). In addition to the very gendered and sexed communication about depression in the brochure, it becomes blatantly clear where DD views stigma as originating from: the individual and, in this case, his relationships with women.

3.3.4. Barriers to treatment and the emergence of stigma narratives

The importance of recognising the prevalence of stigma in the context of raising mental health awareness is a recurring discourse throughout the campaign materials. Although stigma is highlighted as an issue which can be addressed through educational programmes at the workplace, stigma of a mental disorder in itself is not presented as the main obstacle to ‘defeating depression’. Rather, the campaign puts a strong emphasis on de-stigmatising the role of medical diagnosis and psychiatric drug treatment. Indeed, it appears as though the stigma of medical intervention, including the prescription of antidepressants and sedatives, appears to be the main focus of the campaign’s message.

For example, the brochure discussed above ('Men Behaving Sadly') has two entire sections dedicated to explaining the effect of antidepressants, assuring men that taking these is neither 'unmanly' nor would mean that their sex drive will be perpetually damaged (RCPsych n.d. A3: 6). The brochures aimed at employers also dedicate sections exclusively for a description of the effects of antidepressants. However, the information for organisations is more concerned with the adverse effects of antidepressants that might impact on a person's ability to be productive in their labour. For example, in a section titled 'The Effects of Antidepressant Drugs on Work', the employer is cautioned to create a care plan with the worker that fits the tasks she is expected to do, as some antidepressants have been shown to cause blurred vision, tremors, or drowsiness (RCPysch n.d. A1).

Moreover, the campaign materials also include guidance on antidepressant prescriptions for GPs. After an Ipsos Mori poll (RCPsych 1992 A12) showed that surveyed GPs were largely convinced by the utility of antidepressants in treating mental disorders, the question remained why prescription rates continued to be rather low. The same survey showed that GPs were unsatisfied with their working conditions, lamenting an increase in patients but a decrease in time available to see them, thus hindering their ability to assess a patient's mental state. To ease the work of GPs, one of the key outputs from the campaign were flowcharts helping GPs make a quick diagnosis of depression if necessary (RCPsych n.d. A4: 17). An example of one of these flowcharts reveals that the one-page leaflet barely allows for a patient *not* to be classified as either mildly, moderately, or severely depressed. Expressing a low mood and indicating tiredness and a loss of interest in usual activities (including work) is enough to be classified as mildly depressed. Any category above the diagnosis of a mild depression also comes with the recommendation for a prescription of antidepressants. It is hence hardly surprising that prescriptions soared in the decade after the beginning of *Defeat Depression*, to levels which were 235% higher than at the beginning of the campaign (NICE 2004).

As I have sought to highlight, the strong emphasis on de-stigmatising psychiatric diagnosis and treatment happened in accordance with more general moves by pharmaceutical companies and psychiatrists at the time to raise the public profile of pill-taking as a coping mechanism and treatment. One crucial aspect to make this possible is to firmly establish the 'idea of depression as a common, medically treatable condition' in marketing campaigns (Moncrieff 2009: 133). Advertisements for antidepressants had been appearing on the back of the *British Medical Journal* since 1961 but the uptake of these as a common prescription method had been slow, a development which has been rectified since the DD campaign. This medicalisation of mental distress was explicitly linked to the experience of low moods at the workplace, a feature that was identified as in need of intervention through a public health campaign like DD. I thus argue that it is important to question the underlying purpose of DD within the context of the normalisation of mental disorder diagnoses and the interests of the pharmaceutical industry, and to scrutinise de-stigmatisation efforts as increasing access to and compliance with psycho-pharmaceutical medications.

3.3.5. Discursive shifts: from 'defeating depression' to 'changing minds'

In sum, *Defeat Depression* was a five-year campaign of the early nineteen-nineties dedicated to raising awareness of depression but whose purpose and effect lay in the normalisation of antidepressant medication as the first line of treatment of low moods. Since the campaign was in part funded by Eli Lilly, an important pharmaceutical manufacturer of antidepressants, it is important to highlight the potentially conflicting interests of different stakeholders in the discourse of depression that is communicated by the campaign. What is more, I have shown the materials to be consistent in framing depression as a mental disorder that is particularly disruptive to the productivity of employees. *Defeat Depression* was thus instrumental in normalising the prescription and taking of antidepressant medication while drawing attention to the economic cost of an increase in mental disorders amongst the population. Finally, the narrative of mental health stigma emerged as an important tool for the production of knowledge about medication-taking and prescriptions. The campaign equated a reluctance to taking psycho-pharmaceuticals to the stigmatisation of mental illness, hence conflating a variety of issues around mental distress, its treatment, and public perception.

In the months before the *Defeat Depression* programme was due to come to an end, the Steering Committee decided that it would be a waste to let the successes of the campaign and new collaborations to 'wither on the vine' (RCPsych n.d. A9: 1). To be clear the Steering Committee was made up of staff – both professional and administrative – from the Royal College of Psychiatrists. The meeting minutes I consulted do not indicate the input from service-users/survivors or from other people working in mental health care services. In the very first meeting of the SC (RCPsych 1991 A11: 1) there was a brief note that 'some concern was expressed' about the membership in that it did 'not include enough input from other professionals involved in the treatment and recognition of Depression'. Consequently, the Director of *Mind* was invited to join the SC, but no effort was made to include the opinions of other NGOs, service-users, survivors, mental health nurses, or social care workers.

The meeting minutes from a brainstorming session attended by the SC in 1996 show that there was a desire to make a new campaign appear 'bottom up' and that this should be reflected in a change of name (RCPsych 1996 A10: 1). The minutes provide a brief clarification on the bottom-up approach: 'The new campaign should be "user driven". See Point 5 below' (RCPsych 1996 A10: 1). However, Point 5 of the minutes does not cover further detail on how 'users' would be involved, but rather it is emphasised that the new campaign were to focus on 'public education' and 'depression and employment' (RCPsych 1996 A10: 2). The initial planning stage of the new campaign may have raised the issue of mental health awareness campaigns appearing bottom-up, but there were no provisions put in place to achieve this, nor was there any discernible debate about what 'user-driven' means. At the time, there was around £50,000 left in the campaign budget that was now dedicated to the creation of the new campaign. *Defeat Depression* was to be replaced by another five-year campaign in 1998, *Changing Minds*. This campaign, as I show in the following section, addressed mental illness generally – not just depression – and it approached a much wider audience while emphasising the significance of 'stigma' as the root cause for 'misinformed' attitudes to mental illness.

3.4. 1998-2003: Changing Minds – Every Family in the Land

Changing Minds was the subsequent five-year campaign with the stated aim to 'reduce the stigma attached to mental illness, thereby making it easier for people to seek help' (RCPsych 1998 B1: 1). To this end, the campaign intended to increase the public and professional understanding of mental illness, particularly in order to

> 'close the gap between varying perceptions in order to improve the availability, effectiveness and acceptance of a variety of treatments for mental disorders' (RCPsych 1998 B1: 3).

The campaign was an educational public health initiative for the United Kingdom through which professional knowledge about mental illness was to be communicated to the – supposedly uneducated – public in order to dispel 'disinformation and stigma'. The target audience of the campaign included those healthcare professionals that had not yet subscribed to the idea that antidepressants are the most effective way of dealing with mental distress. Moreover, the campaign was designed to help media and news outlets in providing more 'accurate' and 'de-stigmatised' stories about mental illness in their programmes. As the full campaign name suggests (*Changing Minds: Every Family in the Land*), the initiative was premised on the assumption that every family was, at some point, to encounter mental illness.

In addition to providing education and guidance on mental health communication to various public actors, the campaign proposal highlighted the importance of promoting mental health 'by re-affirming the role of diagnosis and treatment' (RCPsych n.d. B2: 1). The CM management team strongly prioritised psychiatric bio-medical understandings of mental distress and saw it imperative to continue the work of DD in advocating the use of antidepressant medication. The belief in the underlying cause of mental illness as being rooted in an individual's biology is further exemplified by the use of the terminology of 'the host' as the carrier of mental illness in campaign brochures, suggesting that having a mental illness is similar to harbouring a virus or other communicable diseases (RCPsych n.d. B3: 5). However, as literature (e.g. Earnshaw and Kalichman 2013; O'Connor and Earnest 2011) on HIV/AIDS has shown, stigma in the context of viruses has largely been attributed to the framing of certain populations as 'at risk' and structural circumstances, including policymaking with regards to finding a cure.

The campaign was created not only to change public and professional attitudes but to make possible legislative change which was to put mental health on a par with the achievements made in addressing discrimination based on race, gender, and sexuality. As can be extrapolated from these opening reflections on the CM campaign proposal, the programme's assumptions about the biological basis of mental disorders follows on from the previous campaign (RCPsych 1998 B1).

Although CM differed from DD in a variety of ways – some of which have been instrumental in shifting the (anti-)stigma discourse and are discussed in more detail below – the organisational structure of the campaign remained largely unchanged. This means that, although CM is centrally organised by the Royal College of Psychiatrists, the funding for the campaign is not entirely internal. Like DD, CM lists as their principal sponsors Bristol-Myers Squibb Pharmaceuticals Ltd (the makers of Aripiprazole used to treat bipolar disorders and schizophrenia), Eli Lilly and Company Ltd (the makers of Prozac/Sertraline), and – curiously – Esso Petroleum Co Ltd (RCPsych 1998 B1: 16). It is notable that both Bristol-Myers Squibb and Eli Lilly settled big lawsuits (paying $515 million and $1.4 billion respectively) about the false advertisement and promotion of their antipsychotic drugs Abilify and Zypexra in the early 2000s following years of complaints about side-effects and questionable prescription recommendations (Braslow and Marder 2019). Consequently, my analysis is framed by the same concerns about campaign ownership and purpose that were articulated in my reading of DD.

This section interrogates the discourse in the *Changing Minds* campaign within the contexts of *Defeat Depression* and the succeeding *Time to Change* campaign. Firstly, I demonstrate how the previous emphasis on mental health as an economic burden to be addressed by corporate management of depression in the workplace was replaced by an increased focus on young persons' and children's mental health. This is also true with the previous campaign's focus on depression in men, an issue which did not warrant any extra attention in the agenda of *Changing Minds*. As will be shown later on in this thesis, it is not until the second decade of the twenty-first century that we see the re-emergence of discourses around mental health in men specifically through, for example TTC's 'Be in your mate's corner' initiative. Secondly, CM focused on mental health much more broadly than its predecessor. In fact, CM aimed to tackle the 'six most common' mental disorders in the UK: anxiety, depression, eating disorders, dementia, substance abuse, and schizophrenia

(RCPsych n.d. B1). This presented a change in campaign discourse which was less likely to emphasise the ready availability of psychiatric treatment and instead was concerned with dispelling harmful attitudes that were assumed to prevent people from seeking a diagnosis. Thirdly, I examine the way in which CM sought to influence media discourse and I show that mental health stories in popular culture continue to be selective in their representation of mental health as a problem of and for the individual. *Changing Minds* broadened the scope of anti-stigma campaigns by engaging with the media, through advocacy for changes in legislation, and with an extension of its fight against stigma to children and young people. In the concluding remarks of this section, I briefly summarise my findings and tease out the most important aspects of this analysis.

3.4.1. Towards a focus on young person and children's mental health

Changing Minds intended to highlight the pressing matter of mental health (stigma) and an increase in diagnoses of mental disorders in children and young people. To this end, the campaign targeted different age groups with a variety of promotional materials. The content of these was discussed in meetings at length and altered depending on what content was deemed to be appropriate. For example, the minutes from one Working Group meeting at the beginning of the campaign (RCPysch 1999 B4: 1) show a discussion about the plot in a book project aimed at infant and junior school children. Alterations to these storylines included changing the person with symptoms of depression from 'mummy gets ill' to 'daddy can't cope'. In general, storylines were viewed to benefit from 'the older sister hearing voices' and putting an emphasis on family disruption rather than mere symptoms. The plots were manufactured in order to show how children can easily slip into the role of a carer for a parent and thus to highlight the complexity of mental distress in the family home. Crucially, the meeting minutes (RCPysch 1997 B4) show that the stories about mental health were curated in a way that suited the campaign's objectives – rather than drawing on the experience or expertise of those with lived experience. The CM Management Committee was made up of different people than the previous campaign, most of who were again psychiatrists and administrative staff affiliated with the College. Although the notes from another Working Group meeting (RCPsych 1997 B7: 2) show that there was a desire to involve a variety of stakeholders, including representatives from independent mental health associations and academia, the following meeting records do not indicate that this was actioned upon. Again, very little – if any – service-user/survivor engagement was involved in determining the content of promotional materials.

In a brochure aimed at children called 'Caring around the Clock' (RCPsych n.d. B5) the issue of children as carers was taken up in more depth in order to provide guidance for children who find themselves in such a position. While the brochure begins by assuring children that they are not alone and that they can rely on social workers and psychiatrists, it also provides a list of symptoms exhibited by their parents which will help children decide when to ask for help. The list (RCPsych n.d. B5: 8) includes:

> 'They [the parents] seem to have no energy or motivation;
>
> Sometimes they sleep a lot to shut out the world or have trouble sleeping;
>
> They feel guilty about things that are not their fault and seem unable to cope with life.'

Using child-friendly language, the brochure supplies children with the means to diagnose their parent with a mental disorder and ask for help. This is a troubling premise which asks the child not only to take on the role of a carer, but it also promotes the surveillance of their own parents and, if needed, provides information on how to report them to healthcare authorities. Finally, the brochure reminds children to not blame themselves because: 'Your parent is ill and needs the help of a doctor just as they would is they had a bad heart or diabetes' (sic, RCPsych n.d. B5: 11). This statement further enshrines the comparison of mental illnesses with physical illnesses. This over-simplification of the cause and nature of mental distress is perfectly in line with psychiatric understandings. However, it might also obscure a child's understanding of the very complex determinants of mental distress when they believe it to be treatable like many communicable diseases. Put simply, the guidance by *Changing Minds* for children was not designed to raise awareness of mental illness in children but it addressed children living with adults who are mentally distressed. Crucially, the brochure appears to provide children with the tools to diagnose their parents and instils the knowledge that mental illness is equitable to physical diseases.

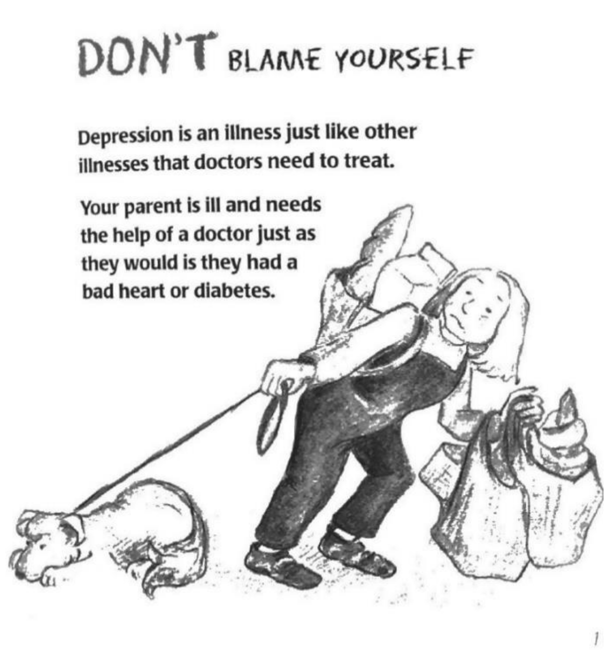


Figure 4. Illustration from 'Caring around the Clock'

In contrast to young children, adolescents and young adults did constitute a much larger target group of the *Changing Minds* campaign. In a separately developed brochure called 'HEADstuff' (RCPsych n.d. B6), young people were encouraged to challenge the myths they held about mental illness and to 'de-stigmatise' their own behaviour. The brochure includes a familiar trope:

> 'Did you know that 1 in 4 people will have some sort of problem with their mental health at some time? Anyone can be affected. They don't usually last forever and make you violent, and they can be treated – just like problems with your physical health' (RCPsych n.d. B6: 9).

There was also a stress on emphasising that footballers and celebrities can be affected by mental illness and that nobody who felt depressed was a 'sad loser'. Foregrounded in the content of 'HEADstuff' was a message about the ubiquity of mental distress. The emphasis was put heavily on communicating that *anyone* can be affected, and that treatment is widely available and successful. Thus, *Changing Minds* set the precedent for intensive public mental health interventions for children and young adults. This focus is still a key theme for contemporary anti-stigma campaigns which are increasingly targeting educational institutions like schools and universities. As Burman (2005, 2011) argues, these institutions are an important aspect of neoliberal subjectification in society and constitute important sites of intervention. It is imperative to acknowledge that this shift corresponds with the rise of

ADHD diagnoses and drug prescriptions in young people (Renoux et al 2016; Timimi and Radcliffe 2005). In addition, children and young adults are supposedly less affected by the 'stresses of life' than adults (RCPsych n.d. B6) which means that a focus on mental illness in young people perpetuates the psychiatric notion that mental distress originates in an individual's biology rather than in structural circumstances.

3.4.2. Public attitudes under question

Changing Minds was concerned with addressing public attitudes about mental health just like *Defeat Depression*, however DD predominantly highlighted the stigma of antidepressants. I argue that the most useful way to understand the logics of the shift to combatting the stigma of mental health more generally is to look at the conceptualisation of mental health stigma in the CM promotional material:

> 'Chances are you know someone who has or has had a mental health problem. […] Despite this, people with these conditions often attract fear, hostility and disapproval rather than compassion, support and understanding. Such reactions not only cause them to feel isolated and unhappy but may also prevent them from obtaining effective help and treatment.' (RCPsych n.d. B3: 3)

This is an excerpt from a CM brochure about mental health stigma that was distributed to GPs, hospitals, and community centres. At first glance, it appears that stigma is ultimately understood to be harming an individual's desire to seek professional help, presenting a continuation of the principal message in DD. However, there is more nuance to the definition of stigma than in the previous campaign. Firstly, the CM campaign has started to invoke the idea that *anyone* can be or knows someone to be affected by mental illness, a trope which continues to the present day, and is explored in some more depth below. Secondly, CM now refers to a definition of what stigma looks and feels like for a person. As can be seen, stigma is considered to be expressed through the treatment of others with fear, hostility, and disapproval. The consequences of this are understood to be the creation of barriers to seeking treatment and feelings of isolation and unhappiness. Crucially, the phrasing of 'attracting fear' continues to locate the problem within the individual.

The reference to 'unhappiness' is particularly interesting considering that a general feeling of unhappiness is considered to be a symptom of most mental disorders the campaign aims to de-stigmatise (RCPsych n.d. B8: 2). It begs the question of who, in the end, is responsible for producing unhappiness in an individual? The above statement provides us with a first glimpse of how negative attitudes between individuals are imagined as intervening in the possibilities of effectively fighting mental illness by preventing those with mental distress from seeking professional help and how this can advance feelings of unhappiness. However, the brochure about mental health stigma, which was handed out in addition to six separate brochures on specific mental disorders, provides a further insight into the origin of stigma, and not only its consequences:

> ‘Stigma can arise in many ways. Mentally ill people may behave differently: a depressed person will appear sad or dull; someone who is in the elated (manic) phase of manic depression may be unnaturally happy or irritable’ (RCPsych n.d. B3: 6)

Immediately, the brochure appears to contradict itself. Although it is stated that stigma can arise in many ways, the material actually suggests that the reason for stigma is in the behaviour of the individual experiencing mental distress. It almost appears as though negative attitudes are presented as understandable given a person’s behaviour. In other words, stigma, in the imagination of *Changing Minds*, becomes a self-perpetuating truism: not only is the behaviour of a mentally distressed person the apparent trigger for stigma but negative attitudes are then also said to prevent the individual from seeking professional help, which means they cannot treat their mental illness. In the end, untreated mental distress again leads to more unwanted behaviours which attract stigmatising attitudes. In order to avoid further stigmatisation, this cycle must be interrupted. Anti-stigma campaigns do this by prompting behavioural change in both those afflicted by mental distress and those who are not. In other words, the onus for behavioural change always lies with individual (communities) and interpersonal relationships – never in the structural inequalities which can lead to mental distress in the first place. As I show in more detail in the next chapter, a critical engagement with stigma as a concept that can reveal how structural stigma is a driving factor in perpetuating mental health inequalities that is frequently dismissed and ignored by public health campaigns because it does not allow for intervention at the individual level.

In an attempt to better explain mental health stigma to the public, the CM campaign team pursued a different angle. In a variety of brochures and in the campaign proposal, mental health stigma is compared to the historical stigmatisation of people with mental distress:

> ‘In ancient times illness in general was seen as the product of demonic possession or as a just punishment for wrongdoing. Such individuals were thus stigmatised.’ (RCPsych 1998 B1: 9)
>
> ‘In Ancient Greece bodily signs or ‘stigmata’ were cut and burnt into people’s bodies to mark them as different. People with mental disorders are no longer physically mutilated, but critical or derogatory attitudes can be just as damaging to them.’ (RCPsych n.d. B3: 6)
>
> ‘Three hundred years ago this woman would have been burnt at the stake.’ (RCPsych n.d. B9: 7)

These are only some of the examples in which the attitudes of society today are compared with the historical treatment of persons suffering from mental distress. The idea appears to be that what was done *physically* to people behaving differently (i.e. exhibiting symptoms of a mental illness) is now done through stigmatising attitudes. This comparison not only dismisses the very real physical harm of antidepressants and many pharmaceutical drugs used to treat mental disorders (Healy 2004; Moncrieff 2009), but it makes it seem as though the physical harm inflicted on psychiatric patients is something which happened far in the past. Psychiatry has very much been guilty of physically harming its patients until at least the closing of the last asylums in the 1960s (Long 2014). Many would argue that physical violence continues to be a feature of psychiatric treatment even today through forced detentions in the community and the continued use of mandatory electroshock therapy.

What is more, these historic comparisons also communicate the notion of societal progress as concurrent or synonymous to scientific advancement of knowledge. This, in its essence, is a liberal notion of a society’s development as linear and tied to progress and growth. This further edifies the psychiatric knowledgebase as ‘advancing’ alongside the rest of society. However, perhaps most importantly, the above narrative lays the foundation for the space that stigma as concept and narrative inhabits in contemporary mental health discourse. Rather than mental distress itself – the stigma of it – is the primary concern for mental health awareness programmes. This is problematic because it makes activism aimed at tackling social inequalities and harmful socioeconomic structures more complicated when they are not understood as the principal problems facing those with mental distress and diagnosed mental illnesses.

3.4.3. ‘1 in 4’ and other ambiguous statistics

Over the last three decades, the narrative that ‘1 in 4’ of us will experience a mental illness at one point in our life has virtually been drilled into our collective minds. However, the origin of this very popular statistic is questionable (Ginn and Horder 2012; Vilhelmsson 2014). Indeed, I argue that ‘1 in 4’ is a narrative that has been one of the political tools in championing and legitimising the anti-stigma discourse in the United Kingdom.

During my research into the materials of *Changing Minds* I was surprised to discover that ‘1 in 4’ was a statistic *chosen* to represent the common nature of mental health problems as an easily digestible figure which satisfied the Management Committee’s view that information should centre around the message that ‘mental illness is extremely common’ (RCPsych 1997 B7: 2). According to the research that the campaign materials quote (Jorm et al 1997), it is 1 in 4 people who come in contact (whether themselves or through relatives and friends) with depression. For anxiety, this number falls to 1 in 10, for schizophrenia 1 in 100 and for eating disorders it is 1 in 50. The number rises to 1 in 3 for alcohol and drug addiction disorders (RCPsych 2003 B10: 1). No conclusive studies or evidence are provided to support the claim that 1 in 4 people in the United Kingdom will be suffering from a diagnosable mental disorder. Clear and simple messaging was viewed as more important than the robustness of the statistics that were used for the promotion of mental health awareness.

The Management Committee meeting minutes from the very beginning of the campaign show that there was a consensus that it was essential to identify a ‘simple’ message to communicate to the public, one which was instantly recognisable and repeatable for anyone who came into contact with the campaign materials (RCPsych 1997 B7: 2). This was also deemed to be important to attract potential sponsors to fund the campaign adequately. Research from Australia (Jorm et al 1997) was quoted to argue that antidepressants and anti-psychotics were not as accepted among the public as among the psychiatric profession. The proposal further states that, ‘although this research was carried out in Australia, the available evidence suggests that similar negative views about the effectiveness of mental health interventions exists in the UK’ (RCPsych 1998 B1: 11). However, ‘available evidence’ was neither quoted directly nor provided in the proposal. In the end, it was decided to promote the campaign under the statistical umbrella of ‘1 in 4’ but the evidence base for this claim remains thin.

In their own research on the ‘1 in 4’ statistic in the *Time to Change* campaign, Ginn and Horder (2012) have also found little scientific evidence that this number accurately represents the incidence of mental illness in the British population. They argue that the popularity of the continued use of this statistic is due to a desire to emphasise the common nature of mental distress as part of public health messaging, similar to the conclusion I have drawn from the CM materials. However, I echo the concern that is expressed in their conclusion. While there might be some benefit in raising awareness of mental distress, Ginn and Horder (2012: 2) argue, ‘it is not clear that championing a poorly supported prevalence figure is the way to achieve this’.

Finally, the statistic of ‘1 in 4’ is further complicated by the politics of diagnosis, meaning that people do not always neatly fall into prescribed diagnostic categories. It is thus not clear at what point a person can be considered to be mentally ill and included in any such statistic. If one of the most recognisable messages of CM, and contemporary anti-stigma programmes like TTC, can be shown to be based on little substantial evidence, this problematises the role of psychiatric knowledge in informing our understanding of mental health and the stigma thereof. Modern anti-stigma campaigns are based on the premise that *anyone* can be affected by mental distress, but the concept of stigma remains ambiguous when we consider the politics of knowledge that underpin the promotion of these campaigns in the first place.

3.4.4. Celebrity endorsements and the role of storytelling

Another key aspect of the discourse in the CM campaign is a novel emphasis on utilising media outlets as a means of communicating with the public. Previously, information had been transmitted through leaflets and brochures which targeted the public in GP surgeries and hospitals, but now the CM programme pioneered a new way of communication: it set up its own website, paid for large advertisements to be displayed in the London Underground, and used television appearances as well as celebrity endorsements to promote its message. In order to find celebrities in support of the campaign, letters were sent to a variety of well-known British celebrities asking them to endorse the campaign. Some of the more notable signatories of CM endorsement letters included Alan Rickman (RCPsych n.d. B11) and Helena Bonham Carter (RCPsych 2001 B12).

The trend of using celebrity endorsements is continued later on in the *Time to Change* programme. For example, a video for the promotion of the global extension of TTC, explored later on in this thesis, features Sadiya Hussein, a British TV chef, and Glenn Close, an American award-winning actress. In addition, Princes Harry and William (The Telegraph 2017) recently attracted media attention by speaking out about their own problems with mental health and their stories have become powerful tools in drawing public attention to mental health awareness campaigns (Tyler and Slater 2018). It is thus important to acknowledge that *stories* play an important role in communicating messages about mental health to the UK public. From the very beginning, the leadership team of CM made it clear that the media's influence on public attitudes was viewed as 'irrefutable' and that 'the campaign therefore needs to influence the media' (RCPsych 1998 B1: 14). Since CM chose young people and children as a demographic to target, it is hardly surprising that the campaign's methods evolved to include the media in its strategy in order to address the perceived lack of mental health literacy in that age group.

Henderson (2018) suggests that popular media formats have increasingly been targeted to promote public health messages to hard-to-access audiences. This includes the use of fictional television programmes which – similar to the news media – still operate under the assumption that media campaigns inform the public about the 'reality of common mental illnesses and reduce the stigma associated with certain conditions' (Henderson 2018: 107). What is more, targeted media coverage is considered to be crucial because it can offset cases of stigmatising media coverage by countering these with empathetic and relatable stories (Hallam 2002). Since 'audiences for TV news are declining, while soap and drama programmes attract ever larger, younger and more diverse audiences', the shift to including messages about mental health within fictionalised lived experiences appears to make a lot of sense (Henderson 2018: 108). All things considered, a move towards communicating with the public in different ways, utilising new media, appears understandable given the campaign's focus on this age group.

However, the mixture of discourse – situated somewhere between communicating 'scientific facts' and the influence of fictionalised accounts of mental illness and recovery – can become problematic when this continues to reiterate weighted messages about the cause and nature of mental illness. For example, Henderson (2018) has found that TV drama programmes continue to address mental distress at an individual level rather than examining structural problems. Henderson (2018: 114) argues that

> ‘organisations and charities have a role in shaping mental illness storylines in popular programmes, but it is important not to assume that these inevitably engage with or challenge social definitions of “what it means to be mentally ill”’.

At the time, CM’s successful engagement with celebrities and the rollout of a children’s fictional book series on mental health laid the foundations for the use of celebrity stories and endorsements as a vital aspect of anti-stigma campaigning. Today, the use of (social) media, celebrities, and popular culture as a means to communicate anti-stigma messages continues to be an important part of anti-stigma programmes, having largely replaced the use of brochures and other physical means of transmitting information. As I show in Chapter 6, the meaning of storytelling in anti-stigma work is contested also at the global level where the curation of narratives about mental health is implicated in reproducing universalising knowledge about mental health stigma.

3.4.5. What remains

Changing Minds was the last anti-stigma campaign that was run and organised by the Royal College of Psychiatrists. In its essence, CM was an extension of DD in that it aimed to de-stigmatise the use of pharmaceutical interventions as an appropriate means to treat mental illnesses and through the targeting of both general practitioners and the public. From the very beginning, the campaign’s Working Group was open about the fact that it would be very difficult to measure any change in public attitudes ‘because of the many uncontrollable compounding variables’ but there was enough internal support and available funding to put forward a strong proposal in favour of running a second anti-stigma campaign (RCPsych 1998 B1: 15). Perhaps surprisingly, the campaign proposal shows that there was an acknowledgement within the leadership team that ‘psychiatry abounds with uncertainties’ and that ‘there are limitations to our knowledge and skill’ while ‘there are considerable complexities and uncertainties surrounding such matters as the chemistry and detailed structure of the brain’ (RCPsych 1998 B1: 4). Yet, the campaign proceeded to produce a rather singular discourse about mental health stigma that is reminiscent of the bio-determinism of *Defeat Depression*. As hinted throughout this section, a variety of aspects of the CM programme set the precedent for the TTC campaign today, which will be examined closely in the following two chapters. In the end, CM was not renewed by RCPsych after 2003, the reasons for which remain ambiguous. In a study on the effectiveness of the *Defeat Depression* campaign (Crisp et al 2000: 7) – funded by Eli Lilly – the authors conclude that 'health education campaigns are slow to produce effects' and that it is not easy to 'modify stigmatising opinions' with awareness campaigning. The study was partly authored by members of the campaign's SC, indicating that the low effectiveness of the College's efforts may have been the reason for abandoning anti-stigma campaigns. Consequently, the organisational structure and funding landscape of *Time to Change* differed considerably from previous campaigns when the programme began in 2007. TTC relies on the management by national charities and funding from the UK government, bringing the interests of the state to the foreground in establishing norms around the governance of mental health.

3.5. Conclusion

In this chapter, I have provided a genealogical reading of two anti-stigma programmes run by the UK Royal College of Psychiatrists and demonstrated that both the *Defeat Depression* (1992-1997) and the *Changing Minds* (1998-2003) campaigns were instrumental in building the basis for the anti-stigma narrative in the contemporary *Time to Change* (2007-2021) programme. We have witnessed a notable shift in discourse from an emphasis to the prevention of mental illness to the prevention of stigma of mental illness, meaning that the principal concern is no longer the experience of mental distress in people, but the maintenance of an economically productive workforce that may experience mental distress.

This chapter thus served to contextualise the critical reading of *Time to Change* in the subsequent chapters through establishing the historical context in which the concepts of stigma and anti-stigma of mental health were developed and are embedded. The underpinning narratives of anti-stigma are connected to neoliberal imaginations of the subject as an individual, self-disciplining person who is imperative for economic growth, where mental health issues are viewed as potential risks. For the study of the global politics of mental health this means taking seriously the complex relations of power articulated through public (mental) health interventions and their consequence for the legitimisation of neoliberal hegemonies.

I began the chapter with a section designed to set the scene for my subsequent analysis. The experience of working in the archives of the Royal College of Psychiatrists had a notable effect on the types of materials which were included in the final analysis of this chapter. The materiality of working in archives is an important determinant of the eventual shape of analysis. Drawing on a variety of work from critical scholars (e.g. Anderson et al 2010; Farge 1993; Tamboukou 2014) on the politics of conducting archival work, I reminded the reader of the complex ways in which knowledge is produced through those who work within archives, the visiting researcher, and the socio-historical context of the research. Before providing my own discourse analysis, which appreciates the constitutive nature of power and knowledge, I thought it imperative to acknowledge the same relations of power which exist in the context of producing research in the first place. As outlined in the previous chapter, academic disciplinary knowledge is subjected to relations of power, and this thesis is no exception. I described my surprise at the way that the RCPsych archives were organised around a modern business model that involved frequent visitors, workshops, and the creation of promotional materials, right where I was asked to sit and study. I was under constant supervision and in the line of sight of the librarian, which I interpret as a nod to the technologies of surveillance that I also seek to tease out in this thesis.

In my analysis of the *Defeat Depression* campaign I focused on three themes: the impact of the pharmaceutical industry in influencing the campaign's message; the discourses of mental health at the workplace and in men; and the conceptualisation of stigma as preventing people from accessing professional treatment. I have shown that pharmaceutical interests in increasing the number of antidepressant prescriptions were principal motivators for the campaign leadership. Moreover, the discourse of mental health stigma in brochures aimed at the workplace showed there to be a tendency to equate mental health with economic productivity. Guidance for depression in men was highly problematic in that it put mental distress in men in direct relation to their relationships with women as partners. Concisely, the purpose of DD can be summarised as de-stigmatising the taking of antidepressants for diagnosed mental disorders, a goal which was achieved. In doing so, DD played an important role in normalising psychiatric notions of mental health and laid the foundation for future anti-stigma campaigns.

My exploration of the *Changing Minds* campaign started with a brief comparison to DD programme. I showed how discourse shifted towards a focus on mental distress in children and young people while the taking of antidepressants continued to play a significant role in shaping the campaign's anti-stigma message. In my analysis I further demonstrated that the campaign broadened its scope by including those working for the media in their target groups.

The often-used statistic of '1 in 4' to highlight the common nature of mental illness amongst the population was shown to originate during the CM Working Group meetings as a means to provide a simple message about mental health. Taken in its entirety, the CM campaign continued the work of DD in that it highlighted the danger of stigma attached to mental illness.

In analysing the archival material, I have come to conclude that *Defeat Depression* and *Changing Minds* were powerful public health interventions in that they normalised the use and prescription of antidepressants, thus furthering the medicalisation of mental distress. These early campaigns also built a strong conceptual foundation for the framing of mental health stigma as a core problem for those suffering from mental illnesses – perhaps rather more important than mental illness itself. This means that both stigma and mental distress are to be located within the individual, leaving the state and structural inequalities off the hook with regards to the taking of responsibility for increased levels of mental distress among the population. The campaigns promoted and reproduced both a psychiatric understanding of mental health as well as a rather ambiguous notion of stigma.

Finally, the above analysis allows us to take a first glimpse at the neoliberal subject which is produced through the campaign discourse. Firstly, the shift of responsibility to the individual (community) rather than structures and institutions is a strong feature of neoliberal governance. The rolling back of the state in favour of privatisation has long been shown to be core feature of neoliberalism (Davies and Chisholm 2018). Secondly, the campaign materials demonstrate a strong influence of vested interests by pharmaceutical companies in the success of the campaign and the de-stigmatisation of psychiatric drugs. This is further underpinned by a clear emphasis of *Defeat Depression* in addressing depression at the workplace and to frame it in terms of economic costs. Thirdly, the mental health guidance for workplace policies reminds us of disciplinary methods which seek to measure the worker's level of depression in order to identify and treat mental health problems. The worker is consequently tasked to monitor also her own behaviour, indicating the advent of widespread self-discipline. Finally, the shaping of media narratives through *Changing Minds* brings in an era of mental health performativity – meaning that lived experiences of dealing with mental illness are becoming important instruments in setting the tone for public consciousness of mental health. In sum, this chapter has provided the genealogical background for the next step in my analysis by exploring the historical roots of the *Time to Change* campaign. In the following two chapters I will critically analyse the discourse of the TTC campaign and demonstrate how it is premised on neoliberal logics of stigma and mental illness and consequently designed to produce subjects according to these principles, thus legitimising mental distress under capitalist structures.

4. Challenging the foundations of anti-stigma in Time to Change

4.1. Introduction

In 2007, the anti-stigma and mental health awareness campaign *Time to Change* (TTC n.d.) was founded in England with its stated aim being to 'end mental health discrimination'. TTC is jointly coordinated by two UK-based charities, *Mind* and *Rethink Mental Illness*, and received an initial four-year funding commitment of £20.5 million from the Big Lottery Fund and Comic Relief (Henderson et al 2012). The two charities nominated the campaign's Global Director, Sue Baker OBE from *Mind*, and Director, Jo Loughran from *Rethink Mental Illness*, as the official leadership team of TTC. Unlike previous campaigns (see Chapter 3), the Strategic Management Group (SMG) is made up of five staff from the leading charities, none of which are psychiatrists, according to the campaign's website. In addition, the SMG hosts three members with 'lived experience', an area which I analyse more closely in Chapter 6. Since 2011, the campaign is partly funded by the Department of Health and Social Care (DHSC) which has supported the programme with £3 million in 2016/17 and £2.5 million in 2018/19 which made up roughly one quarter and one sixth respectively of the available budget for charity expenditures in those years (DHSC 2019a). These are very large sums of investment in comparison to the funding that either *Defeat Depression* or *Changing Minds* had attracted, as far as the available documentation shows. Perhaps this is because *Time to Change* is neither run nor funded by the Royal College of Psychiatrists (RCPsych) unlike any previous anti-stigma and mental health awareness campaigns in the United Kingdom. Instead, TTC is embedded as an arms-length body within the government's mental health policy and long-term strategy for mental health, as noted in the government's *Five-Year Forward View for Mental Health* (NHS Mental Health Taskforce 2016), thus firmly entangling the interests of the state with the psychological lives of its citizens.

I argue that the entanglement between *Time to Change* and the government leads to the reproduction of neoliberal market logics within the discourse of the campaign and that its intended outcomes transcend the slogans with which it appeals to the public. Thus, TTC follows in the footsteps of its predecessors *Defeat Depression* and *Changing Minds*, yet TTC is unique in that it is run separately from the Royal College of Psychiatrists, with increased funding from the government and through its association with public health policy. In the next two chapters I show that the campaign's discourse encourages individualised and disciplined behaviour in the face of mental distress which produces neoliberal subjects who are more tolerant to mental distress and less likely to seek structural change for the benefit of their mental wellbeing. My analysis follows on from the previous genealogical chapter in that it traces the production of knowledge about stigma and mental illness within the discourse of public (mental) health campaigns taking into consideration the relevant socio-economic and historical contexts. While *Time to Change* relies on psychiatric language and understandings of mental illness in a similar manner to previous campaigns, it differs in that the proposed solutions to combatting stigma are more focussed on individual action rather than psychiatric treatment. To be clear, previous campaigns also aimed at intervening on the individual level but there was a very strong focus on psychiatric diagnosis and treatment. TTC, as becomes clear in my analysis, also relies on bio-medical understandings of mental distress but shifts the narrative to foreground the impact of interpersonal relationships and individual lifestyle choices as a means to address mental health stigma.

In this chapter I begin my analysis by dissecting the conceptual foundations on which *Time to Change* is premised and derives its legitimacy. In doing so, I tackle two central concepts from the campaign: stigma and mental illness. In the first section I critically engage with the concept of stigma and the way it is presented in the discourse in TTC. I show that the campaign's conceptualisation of stigma emerges from a particular paradigm of stigma thinking rooted in Ervin Goffman's (1963) work on social and benevolent action, or 'benevolent othering' (Grey 2016), to address discriminatory social attitudes. This means that the narrative in *Time to Change* presents the consequences of behavioural patterns amongst the public as the cause of stigma while obscuring the structural and systematic embeddedness of mental health stigma within a neoliberal society that is premised on the promise of economic growth and the commodification of personal relationships (Eagleton-Pierce 2016). To this end, I firstly discuss the limited scope of quantification in the construction of evidence of stigma, showing that statistics do not constitute an astute indicator of stigma prevalence. Secondly, I show that recent theoretical literature on stigma (e.g. Tyler 2020; Tyler and Slater 2018) demonstrates that a focus on benevolent action at the individual level subverts the gaze away from deliberate action on a structural level to marginalise and stigmatise specific societal groups. Thirdly, I demonstrate that stigma has previously been identified as a political tool that can and has been ‘weaponized’ in order to conflate certain behaviours, such as seeking financial benefits from the state, with deviancy (Scambler 2018).

In the second section of this chapter, I closely examine the presentation of the nature and causes of mental distress in the discourse of TTC. In a similar fashion to the concept of stigma, mental distress is presented as emergent within individuals due to biological pathologies, not as a consequence of structural inequalities or systematic economic and social hardship. It is thus enshrined within the category of mental illness. I show how this has firstly become possible through a medicalised approach of understanding mental distress as a disease located within the human brain. Secondly, I examine the discourse in TTC which calls for mental distress to be treated like a physical illness. I demonstrate that this narrative reaffirms the body as the source of mental illness and obscures both the role of neoliberalism in producing social inequalities and the influence of psychiatry, using the powerful tool of diagnosis, to neatly capture the experience of mental distress in manageable categories. In sum, I identify the *Time to Change* campaign as a political project in which the concepts of stigma and mental illness are used to present the experience of mental distress and its discrimination as a problem of and within individuals, thus shifting responsibility for the increase in mental distress in the population away from the state.

4.2. Producing and promoting (anti-)stigma knowledge

The first step in analysing the *Time to Change* campaign and its discourse is to make sense of the deployment of the concept of ‘stigma’ within the campaign’s structure and the understanding of it that is promoted. This necessitates, (a) an interrogation into the campaign's own understanding of stigma through a tracing of the sources which inform campaign policy; and (b) an analysis of how this knowledge is ultimately communicated to the public. Thus, the politics of knowledge of stigma are under scrutiny in this first section. Its purpose is to provide the reader with an insight into the ways in which stigma and anti-stigma are concepts which are produced by TTC in and throughout the selective reading of sources and statistics.

The premise of an anti-stigma campaign rests on the assumption that mental health stigma exists in a way that can be intervened upon. There would be no need for a coordinated public health intervention if stigma was not deemed to present a significant problem for those experiencing mental distress or diagnosed with a mental illness. But how is stigma defined and how does it manifest? I argue that stigma is a concept which can be filled with a variety of different meanings and that attempts to 'measure' stigma and public attitudes have not accumulated a solid evidence base that would demonstrate the effectiveness of anti-stigma campaigns such as TTC. Indeed, an 'effective' tackling of stigma may not actually be the most significant outcome of TTC because anti-stigma campaigns fulfil a role beyond the eradication of stigmatising attitudes. Anti-stigma discourse is implicated in the production of neoliberal subjects that are taught and incentivised to self-manage their own mental distress. To make this argument comprehensible, I put forward a definitional scope of mental health stigma which understands it as 'embedded within the social relations of capitalism, colonialism and patriarchy' (Tyler 2020: 8), a framework that transcends the definition of TTC which focuses on individual experiences and expressions of stigma. Hence, in this chapter, I seek to open the analysis of *Time to Change* by unsettling the concept of stigma and thereby also the anti-stigma narrative. I contend that the problematisation of stigma is a key step in unlocking the possibilities for meaningful analysis in the remainder of this thesis because it allows for an appreciation of the unstable foundations on which the campaign's premise is built.

I demonstrate the fragility of the (anti-)stigma narrative in three steps, starting with an appraisal of the scientific evidence base regarding the role and effectiveness of anti-stigma programmes as public health interventions. In examining the available literature (Corker et al 2016; Merry 2016), it becomes clear that the quantitative methods used to measure opinions, where negative opinions are equated with stigma, are not only very limited in their scope to assess the prevalence of stigma, but that *Time to Change* overstates its own achievements regarding the change of public opinion. This is followed by a closer look at the theoretical literature on stigma (e.g. Tyler and Slater 2018, *Special Issue*; Tyler 2020), which suggests that instances of structural and institutional stigma (see also Hatzenbuehler and Link 2014, *Special Issue*) are at least as – if not more – relevant than interpersonal stigma, thereby challenging the overarching discourse of the *Time to Change* campaign. The work by Tyler (2020) is particularly pertinent for the analysis of mental health stigma because it traces stigma as a power that is crafted for the purpose of governing populations, thus providing a genealogical reading of stigma that is attentive to the adaptability of neoliberal capitalism. Finally, I conclude with a reflection on the possible 'weaponization' (Scambler 2018) of stigma. Here, weaponisation refers to the idea that stigma can be deployed as a strategy that is both deliberate and discriminatory as well as serving to conceal structural power while constituting a form of power itself.

4.2.1. ‘Measuring’ stigma and the seductions of quantification

One of the first steps to understanding the political meaning of anti-stigma programmes is to assess whether these public health interventions are useful and effective *on their own terms*. I show how *Time to Change* comes to claim that it is effective in changing public attitudes. However, I contend that any attempt to ‘measure’ the effectiveness of stigma would require both a usable definition of stigma and a suitable method to assess the degree of stigma in opinions about mental health, if indeed we assume that public opinions are where stigma is to be found. Neither of these requirements, as I attempt to demonstrate in this section, are fulfilled by the TTC programme. Moreover, I firmly reject an approach that organises public health policy solely around the potential of utility and effectiveness. Instead, I analyse an impact report of TTC (n.d.-k) and assess its validity within the campaign’s own framework of utility and effectiveness. I conclude that, even on its own terms, the campaign fails in combatting the mental health stigma which it seeks to eradicate. Rather, the insistence on measuring attitudes and behavioural change is part of the politics of neoliberal normalisation that I seek to expose.

The quantification of (big) data in the realm of policy and political decision-making has been termed a ‘quantitative enthusiasm’ (Merry 2016: 221) that sacrifices the need for ‘messy’ and long-term qualitative research into complex societal issues for simple and more accessible forms of knowledge. There is a tendency for these statistics to be presented as numerical indicators which both individualise and universalise behaviours and lead to the proposal of actions and interventions aimed at changing these numbers without considering the ideology or manner of their calculation. Although *Time to Change* is clearly invested in personal narratives of mental health stigma through the extensive use of mental health service-user stories (see Chapter 6), there is no evidence that the quantitative data is based on or within the context of these qualitative accounts. While an increasing number of companies signing the TTC employer pledge and schools offering anti-stigma workshops to their students may give the impression that people are invested in behavioural change, numeric indicators like these can only offer a particular type of knowledge, one that still requires interpretation. The interpretation of these figures can be challenged through a reading that is informed by recent and critical sociological scholarship on stigma power (Tyler 2020). Statistical information is often presented as ‘unambiguous knowledge’ and ‘above politics’ (Merry 2016: 4). It seems to offer straightforward solutions to problems without ideological partiality. However, the normalised use of statistical information and numeric indicators to guide the policy and logics regarding the provision of mental health care in the United Kingdom has been shown to be firmly embedded within a neoliberal framework of governance and bureaucracy that is in itself a product of different political processes and philosophies (Rizq 2014).

While researching the *Time to Change* programme, I was interested in examining the official campaign reports that are produced by TTC and which evaluate of the impact of its activities. I pursued this avenue in order to make better sense of the positive impact on mental health stigma which the campaign claims to have had in recent years. I have found that data from TTC is rather difficult to access. Where most official campaign policy documents are available for download from the TTC website, these reports are scattered among many different sub-pages and it takes a lot of time clicking through texts in order to find official documentation and direct reference to academic studies. My experience of gathering data online in this manner mirrors my experience of archival work. The processes of knowledge production and meaning making in anti-stigma campaigns are not easily accessible, there is no ordering system, no clear path to follow when seeking the origins to the concepts that are so readily employed. The politics of knowledge about mental health and stigma are clearly assumed to be universal truths that require very little to no justification by public health programmes. The presumed universality of mental health stigma is an important aspect of the discourse in anti-stigma campaigns, and the ambiguity of its factuality is exemplified by the inaccessibility of important documents and campaign records.

Until 2012, TTC published an annual report which summarised the campaign’s activities, outcomes, and future ambitions. In 2014 this was replaced with an annual report video and this format eventually gave way to the now biannually published ‘impact report’. I have taken the latest report (TTC n.d.-k) as an example for the way in which the effectiveness in the reduction of stigmatising attitudes is reported by the TTC leadership team. The report summarises the campaign’s accumulated achievements from 2007-2016 in a brief text (TTC n.d.-k: 11) that reads,

> ‘between 2008 and 2016, an estimated 4.1 million attitudes changed for the better – that’s a 9.6% improvement […] while in the same period, people with mental health problems were less likely to report having experienced discrimination in the past 12 months because of their mental health.’

While the text takes up only half of the page, the other half of the page is covered in big, colourful speech bubbles with big red numbers that proclaim:

> ‘9,000 Champions Challenging Stigma’
>
> ‘400,000 Facebook Followers. 260,000 Twitter Followers. 100,000 Instagram Followers.’
>
> ‘1,100 Employers Signed the Employer Pledge’

These numbers catch the reader’s eye immediately, yet they tell us very little about how the campaign is effective in combatting stigma. Rather, it appears that the impact of the campaign is measured in how many people the campaign engages. There is a strong emphasis on ‘reaching out’ as a means for and measure of success. No further information is provided on the type of engagement (e.g. is it meaningful?) that increasing numbers of followers on social media produces. For example, as a follower of the TTC Twitter account myself, I have become part of the quantification of the impact that the campaign uses to measure its success. Yet, my following can hardly be said to be meaningful in the sense that the campaign seeks to provoke. Crucially, there appears to be a conflation of ‘impact’ and ‘effectiveness’ in which these two come to signify one another.

As for the other available ‘scientific’ evidence, the study (Corker et al 2016: 11) that is cited in the impact report did indeed report that there was a significant decrease in perceived mental health discrimination, yet the authors of the study also concluded that ‘shifts in scores cannot be directly attributed to the TTC programme’ and ‘the consistently low response rate’ (never higher than 10.3% in any given year of the study) points to the fact that this data is not necessarily representative of actual attitudes within the population. In the final paragraphs, the authors (2016: 12) further caution that it ‘remains to be seen’ whether programmes like *Time to Change* can make an intervention into areas of ‘structural discrimination’ within healthcare settings. In other words, when looking at the available evidence, even those studies directly referenced by the campaign do not explicitly support the (over)stated efforts of the TTC campaign.

At this point, it is worth considering the ontological assumptions that underpin studies which seek to 'measure' public attitudes to determine the level of stigma prevalent within the population. As Tyler and Slater (2018: 731) point out, 'one of the limits of quantitative approaches is that they have a tendency to produce an understanding of stigma as static attitudes', rather than a shifting process. This approach to quantitative methods is driven by social psychology research that is also favoured by the *Time to Change* campaign, as can be seen from the studies which are used to evaluate the campaign's impact (Corker et al 2016; Anderson et al 2018). These studies follow a social cognitive understanding of stigma that is concerned with mental processes which are thus subject to change, for example, through 'increasing people's tolerance for stigmatised conditions' (Parker and Aggleton 2003: 15).

In other words, the studies which are conducted in order to assess the impact of *Time to Change* rely on the presentation of public attitudes as a statistic, while also stressing that these statistics can be altered through specific interventions. For example, anti-stigma campaigns in the UK operate under an assumption that conversations between people can turn into a 'scaled up' and 'national conversation' that ultimately leads to a change in the numeric indicator that was chosen to represent this issue (Tyler and Slater 2018). This is an individualistic approach to anti-stigma campaigning that places the individual person and their 'misconceptions' into the role of the perpetrator and the person responsible for change. Alternative methods of assessing the prevalence of mental health stigma, and thus the impact of an anti-stigma intervention, could lie in, (a) shifting the discourse towards the discussion of systematic inequalities and structural causes of mental distress and discrimination; or (b) qualitative studies and ethnographies that are embedded in an understanding of social situations 'to counter the homogenization […] of the social world inherent in quantification' (Merry 2016: 221).

In the absence of evidence that TTC is 'effective', two principal critiques emerge. On the one hand, the lack of evidence of TTC's utility in achieving its intended aims with regards to stigma reduction leaves one to question the value of this type of public health approach in addressing mental distress in the population. On the other hand, broader criticisms around the use of quantitative methods for the purpose of measuring experiences have shown that 'those who are measured typically lack a voice in the construction of the categories and measurements' and that measurement frameworks tend to become a form of 'settled knowledge' over time (Merry 2016: 25). This risks the reproduction of an assumed objective knowledge or truth about mental health stigma and its fluctuations. Thus, while TTC is not effective in reducing stigma, it is effective in reproducing the harmful norms of neoliberal societies through a deliberate deployment of anti-stigma discourse.

As seen in the previous chapter, while earlier anti-stigma campaigns were shown to be effective in reducing negative attitudes towards antidepressants, it remains disputed whether other public opinions about mental illness and its treatment have undergone similar changes (Paykel and Priest 1992). In the assessment of anti-stigma programmes today, there continues to be a considerable disconnect between what TTC claims it is achieving and the research (Anderson et al 2018; Corker et al 2016) that is cited to support those claims. While the *Time to Change* campaign claims to have made a significant positive impact on public attitudes to mental health, the available data tells a different story – namely that public attitudes to mental illness may have been changing before the start of the campaign and that, due to the low response rate, it is difficult to attribute any change to the campaign at all (Corker et al 2016). Moreover, it remains questionable whether a quantitative measuring of public attitudes is either possible or desirable in the first place.

Anti-stigma programmes increasingly highlight the role of the individual at the receiving end of stigma. It is this individual's job to start meaningful and 'life-changing' conversations about stigma, making the success of the anti-stigma campaign ultimately dependent on their willingness to participate. This is an interesting narrative that shifts the blame to the individual level. All in all, the evidence base for the 'effectiveness' of *Time to Change* is rather unstable. Not only are the quantitative methods which seek to measure public attitudes limited by a very narrow framework of stigma and change, but the campaign's own impact reports are driven by numbers of social media followers rather than evidence of a significant shift in how mental health and illness are perceived by the public.

4.2.2. Obscuring structural stigma

How can we tell if we experience stigma or hold stigmatising attitudes? How does (mental health) stigma manifest in our lives? How do we tackle stigma? These questions are complex and deserve our critical attention at this time as they are intrinsically linked to the purpose, processes, and actions of an anti-stigma campaign like *Time to Change*. Stigma is an 'essentially contested' concept and its versatile use over time in different socio-economic contexts reveals it as a technology of governance (Tyler 2020; Tyler and Slater 2018). This means that stigma can be deployed as a form of (micro-)power by different groups and is thus a politically charged tool with equally political consequences.

I start with a history of the sociology of stigma within the academic literature. Following on from this, I show that the definitional scope of TTC is not only limited but deeply problematic in that it wilfully excludes any reflection on the dimensions of structural and institutional stigma which are shaped by neoliberal and austerity-driven policymaking in the United Kingdom. It is not my intention to suggest that mental health stigma cannot be experienced within interpersonal relationships but to highlight the self-imposed and intentional limits of the TTC discourse which ultimately lead to a one-sided conversation about the causes and solutions to mental health discrimination.

Most conceptual understandings of social stigma can be traced back to North American sociology of the mid-twentieth century and to the sociologist Erving Goffman and his influential monograph *Stigma: Notes on the Management of Spoiled Identity* from 1963. Goffman's research not only brought on a 'new age' of research on stigma as a social determinant (e.g. Hacking 2004; Hannem and Bruckert 2012; McNall and Johnson 1975) but he was influential in setting a new standard of social science research where stigma was said to constitute a set of social norms which can be challenged and dismantled with 'the right tools'. These tools manifest in the form of 'benevolent actions' (Goffman's terminology, 1963) including empathy, understanding, scientific enlightenment (e.g. about the nature of mental illness), and individual practices of self-management within a liberal framework of knowledge production. Thus, more traditional accounts of stigma do acknowledge that it is a socially determined phenomenon and practice, but argue that this can be tackled through, for example, initiatives which dispel and revise 'incorrect' or misleading information about those who are stigmatised. Tyler and Slater (2018: 729) have argued that this approach 'frequently neglects to address structural questions about the social and political function of stigma as a form of power' because it is still attempts to intervene at the individual and interpersonal levels.

Other research (Hannem and Bruckert 2012) from the social interactionist tradition in sociology stresses that stigma is produced in everyday interactions and that this continuous reproduction means that stigmatising attitudes shift across time and space. Foucault (2009: 545-46) has described the same shifting nature of the meaning of mental illness as a 'long occupied and undecided region, which is difficult for us to define' but which is characterised by the stigmatisation and 'prohibition' of actions and languages that appear unintelligible within a giving temporal setting. In other words, mental health stigma is in itself a shifting paradigm that is linked to variable perceptions of the nature and expression of mental illness.

The latest sociological writing on stigma (Bell 2011, 2013; Paton 2018; Tyler 2020; Tyler and Slater 2018) goes yet further in redefining Goffman's original account exploring the relationship between stigma and neoliberal modes of governance through highlighting the need to comprehend stigma as 'a consequential and injurious form of action' that is inflicted from 'the top' (Tyler and Slater 2018: 740). This reading emphasises the impact of stigma as a form of power that can act upon the subject in meaningful, potentially harmful, ways. The exercise by Tyler and Slater (2018) is a necessary conceptual shift in order to counter dominant public health narratives which portray common people as the perpetrators of mental health stigma, and instead point the gaze up to much more debilitating sites of stigma power and production (Paton 2018). Another example of stigma power can be found in anti-smoking legislation. As Bell (2011, 2013) demonstrates, anti-smoking legislation relies on the vilification of the individual smoker as a person unable or unwilling to quit a harmful habit. Bell (2011: 59) critiques the seemingly 'absolute legislation' on smoking, which is upheld despite doubtful scientific evidence that second-hand smoke is particularly harmful. In other words, stigma is exposed as a political tool that is used for the sake of public health campaigning. However, the *Time to Change* campaign's perception of how stigma functions is firmly rooted within a Goffmanian tradition which highlights the need for proper education and 'benevolence' towards those who experience stigmatising attitudes. This means that the TTC programme is ill-equipped to consider the structural manifestations of stigma which are, at times, deliberately activated by governments or corporations to 'nudge people into desired patterns of behaviour' (Tyler and Slater 2018: 732).

As a leading and global(ising) anti-stigma campaign, one might expect that TTC communicates clearly on the different meanings and uses of the concept of stigma and how these impact our understanding of mental health discrimination – yet, an official position on how stigma is defined as part of *Time to Change* does not exist. Rather, the notion of stigma is an assemblage of different fragments of meaning which are dotted throughout the campaign's social media and online presence. It is only through the piecing together of many different tweets, posts, and articles, that I was able to make sense of the campaign's conceptualisation of mental health stigma. Let us look at some of the ways in which stigma is said to occur, according to the TTC campaign:

> 'It is largely the misconceptions that surround mental illness that made my diagnosis so frightening, not just for me but for my family and my friends.' (TTC 2020a)
>
> 'Did you know, 1 in 3 people have never heard of or don't know anything about schizophrenia. Common misconceptions and a lack of knowledge can add to the stigma.' (@TTC 2020a)
>
> 'It can be a small act that makes the person feel more isolated and ashamed, or it can be something that has a monumental negative impact on their life.' (TTC n.d.-d)

As can be seen from the above examples, mental health stigma is presented as being a manifestation of misconceptions about the nature of mental (ill) health. There is a very clear message underlying these examples, namely that 'correct' knowledge about mental illness is the most desirable outcome of the campaign, as this is assumed to counter negative attitudes. However, supposedly 'correct' knowledge about mental health is informed by psychiatric and biological understandings of mental distress which have themselves been contested over many centuries. Likewise, the third quote is particularly interesting in that it vaguely describes the actions which involve stigmatisation according to TTC. These can either be small or 'something monumental' without further elaboration by the campaign on what *exactly* would constitute these actions. Almost any negative experience with mental distress is woven into the narrative of mental health stigma within the selected service-user stories of TTC. Thus, stigma has become a broad signifier for the effect of 'upsetting words' or experiences in the context of mental distress without acknowledging broader structural concerns or historical precedents of stigma power as a political strategy.

Stigma as a form of governmental power and 'political strategy' has been shown to separate the 'deserving' from the 'undeserving' poor, meaning that stigma is not attached to conditions or socio-economic context, but rather to how an individual copes with the 'affliction' of poverty or hardship (Rogers and Pilgrim 2003: 5, see also Tyler 2020). To this end, the state and its institutions and legal framework have produced and perpetuated discriminatory laws and practices that stigmatise those who are deemed unable 'to cope' and thus become subjected to the enforcement of disciplinary action. For example, coercive control (often in the form of involuntary detentions) has been shown to lead to problematic situations where mental distress is directly criminalised. As Rogers and Pilgrim (2003: 160) point out,

> ‘mentally disordered offenders lose their liberty for at least as long as an imprisoned perpetrator of a similar offence [...] and the detention of mentally disordered offenders is open-ended, whereas for those going to a prison, ‘disposal’ sentences are fixed and prescribed.’

In other words, criminal offenders are punished more severely if they appear to be mentally distressed or are diagnosed with a mental disorder. This necessarily blurs the line between punishment and recovery where mental distress is understood to be a form of deviance to be controlled and punished by the state. While the distinctions between mental illness, deviance and criminality have been shown to be blurred since at least the eighteenth century (Foucault 1991a), the stigma that is generated by structural criminalisation and discrimination prevails yet is scarcely thematised by anti-stigma campaigns. These tend to focus on the individual encounter as a space for stigma and fail to conceptualise stigma as an institutionalised form of power.

In sum, in the light of recent research on the sociology of stigma (Paton 2018; Tyler and Slater 2018; Tyler 2020), I argue that the above examples from *Time to Change* fail to acknowledge that stigma is structurally and socially determined. There is no acknowledgement of the embeddedness of stigma within other existing (institutional) inequalities and discriminatory processes, including the dimensions of race, gender, and sexuality. I explore the disciplinary effect of this discourse further in my analysis of mental health surveillance technologies in the following chapter. Now, I turn to an extended reading of stigma as a technology, or weapon, of governance.

4.2.3. Mental health stigma as weapon

For the purpose of this section I am borrowing the language of weaponisation which has made a more frequent appearance in recent academic work on social stigma where it is emphasised that stigma can be co-opted as a technology of governance doing deliberate harm to certain groups of people (e.g. Fouad et al 2017; McCrae 2018; Scambler 2018). What is useful about the terminology of weaponisation is that it allows us to appreciate how a concept like stigma can become a political tool which is filled with alternate meanings and purposes to what is commonly associated with it. In addition, this framework gives a better understanding of stigma as a harmful mode of governance on a large scale. Thus, I conclude this section on the discourse of stigma in *Time to Change* by showing that 'stigma power' (Tyler 2020) has long been revealed to be a strategy by governments and the media to frame specific groups of people as undeserving of help or understanding and guilty for their own afflictions.

For example, McCrae (2018) argues that the 'common sense' of the mental health crisis in younger people in the United Kingdom is a form of weaponisation utilising psychiatric categories which are deployed to pathologise the emotional reaction young people display to an increasingly uncertain and undesirable political and economic future. Drawing on Degerman (2018), McCrae heeds his reader to caution the way in which young people are increasingly diagnosed with mental disorders early on in their lives which means that 'normal' life experiences become to be understood as pathologies. McCrae concludes his commentary by arguing that young people should be left to become more 'resilient' instead. While this point undermines his own argumentation – resilience is a concept which has already been shown to be politically laden, dismissive of dissent, and heavily psychologised (Howell and Voronka 2012; Howell 2012, 2015) – it is nonetheless useful to think of how popular narratives around mental wellbeing are at risk of becoming a technology of governance. What McCrae demonstrates very well, is that common psychiatric diagnoses (e.g. depression and anxiety disorder) have been utilised to explain the behaviour of young people in the UK in a way that depoliticises their concerns. In this manner, a psychiatric diagnosis has become both a marker of stigma and an explanation for undesirable behaviour.

A very similar argument is found in Scambler's (2018) research on the stigma attached to people who are considered 'dis-abled' in a neoliberal market economy. He argues that the rise of 'financial capitalism's (structural) class/command dynamic and its (cultural) sequelae' in the UK has led to the conflation of stigma with deviance meaning that 'the austerity of neoliberalism that seeks to blame and punish vulnerable people like the dis-abled might obtain sufficient purchase to open the door to enhanced capital accumulation' (Scambler 2018: 777). In other words, the relationship between the weaponisation of stigma and neoliberalism is characterised through a deliberate framing of deviant behaviour. It is in the interest of neoliberal market logics that economic unproductivity and debility are viewed as undesirable (or even criminal) conducts, thus leading to the stigmatisation of those who can or will not comply with the expectations of productivity set by a neoliberal society. The purposeful deployment of stigma as a weapon thus underlines the significance of understanding the versatile ways in which stigma has been deployed. Stigma is hence useful as both a mode of governance and a political strategy and manifests as a form of power which can be used to discipline, normalise, and subjugate.

As an integral concept of (anti-)stigma public health campaigns, stigma thus fulfils a function beyond the negative connotation of public attitudes with which it is commonly associated. Indeed, stigma becomes a useful form of governance for the neoliberal state when it is a social phenomenon that is understood to emerge in individuals rather than in structures. In TTC's discourse, structural stigmatisation is made less visible and appears to be less important than personal agency in tackling mental health stigma. While stigma is never perceived as a positive phenomenon per se, it is sometimes operationalised for supposedly positive outcomes, such as anti-smoking campaigns, which rely on the deployment of stigma power (Bell 2011, 2013). Thus, modes of governance can and do benefit from stigma and the attention that is drawn to interpersonal relationships and instances of stigmatising behaviour. That way, the neoliberal structures which continue to erode social security networks and funding for mental health care remain invisible drivers of stigma, at least in the public discourse. Moreover, while attitudes towards mental health among the population have largely remained stable (see above), neoliberalism continues to wreak havoc in the provision of state welfare. Consequently, there is a utility in the continuation of the narrative that interpersonal stigma is the key problem to be tackled as this maintains the perceived necessity of an anti-stigma programme that diverts attention away from structural concerns. In addition to stigma, I argue that an anti-stigma narrative has entered the stage as a new weapon in the scramble for power over the population's mental wellbeing. Emerging through an increase in surveillance technologies, the non-performance of self-care has increasingly become stigmatised. As I will show more closely in the following chapter, non-compliance with (anti-)stigma initiatives has come under increased surveillance, to the extent that it is a target of stigma power itself.

4.2.4. Adaptable concepts

The notion of stigma is unsettling when unsettled. In this section I have, through genealogical inquiry and the reading of different sociologies of stigma within the available academic literature, revealed stigma to be a diverse and fluid concept which makes the casual deployment of it in the discourse of *Time to Change* disconcerting. I follow this analysis with an interrogation of the campaign's conceptualisation of mental illness and demonstrate that the discourse of mental illness in TTC is equally problematic.

From the above discussion and by taking inspiration from previously introduced critical interventions on the genealogy and deployment of mental health (stigma) as a form of governance from Long (2014) and Howell (2011), this chapter proceeds by seeking to understand the discursive work that anti-stigma campaigns do when presenting the public with facts about the nature of both stigma and mental illness. While Long (2014) already demonstrated (see previous chapters) that historical anti-stigma efforts can be revealed to also have been led by a desire of the psychiatric profession to further their position in the medical discipline, Howell (2011) has argued that mental health interventions can constitute a type of governmental technology that upholds existing global hegemonies and power relationships. In other words, there is ample evidence to suggest that (global) mental health interventions in the form of anti-stigma programmes do more political discursive work than appears at first glance.

4.3. The mental illness discourse in TTC

Mental distress manifests within the body in a variety of ways and addressing the social and economic consequences of this experience is one of the raisons d'être of anti-stigma campaigning. The narrative in *Time to Change* asserts that a stigmatisation of mental illness can be avoided if mental distress is conceived of 'correctly' and receives adequate treatment by a medical professional. This narrative likely rings familiar to the reader as it is a continuation of the anti-stigma discourse of the earlier campaigns run by the Royal College of Psychiatrist. In the following paragraphs, I interrogate this discourse further and argue that the TTC campaign operates within a bio-medical framework of mental health that all too easily reduces mental distress to a matter of chemical imbalances within the brain and as an individual pathology.

The analysis in this section proceeds in two steps. Firstly, I conduct an analysis of the discourse around mental illness in TTC bringing it into conversation with existing work on the governance of the human brain (Rose and Abi-Rached 2014). I show that a largely bio-medical framing of mental distress within the campaign's discourse reinforces a narrative of individual responsibility and pathology that corresponds with neoliberal understandings of mental health. Secondly, I interrogate the tendency of TTC and other anti-stigma programmes to call for 'mental illness to be treated just like a physical illness'. The key problem with this discourse is that such a framing assumes that mental disorders can be diagnosed like physical ones which can then be understood and treated within a medical framework. However, the diagnosis of mental illness is both an important factor for the perception of stigma in the first place and remains a contested subject amongst many mental health survivors and activists (e.g. Costa et al 2012; Russo and Beresford 2015), thus throwing into question the purpose of this anti-stigma approach. I argue that there is an obscured agenda behind the move to reach parity between mental and physical health that largely benefits the pharmaceutical industry and the psychiatric profession.

We know that stigma is a social concept with a long history and that a genealogical inquiry can reveal it to be an 'inscriptive form of power' and technology of governance which makes stigmatisation a practice shifting over time (Tyler 2020: 35). In his genealogy of mental illness, Foucault (2009: 251) has similarly argued that 'the discursive knowledge of madness unfolds in the limited space defined by this contradiction' referring to the fallacy of 'positivist psychiatry' and medical frameworks to pin down and discipline the exact nature of mental distress which in itself is characterised by some degree of unintelligibility. In other words, the unpredictable behaviours and experiences that are considered to be diagnosable indicators of a mental illness or a mental disorder are also shifting over time concurrent with the medical status quo. This is an important starting point when beginning an analysis of mental illness discourse because it reminds us to be cautious of those instances when there are attempts to essentialise the cause and definition of mental disorders. Moreover, there are important distinctions to be drawn between the terminology of mental health, mental illness, mental disorder, and mental distress. For example, the *Time to Change* discourse exclusively refers to the terms 'mental illness' and 'mental disorder' to classify and encompass all experiences of mental distress. This assumes that any mental distress is either an illness or a disorder that can be diagnosed and silences those seeking to understand mental distress outside of available psychiatric and diagnostic frameworks. This point has also been made by those who identify as survivors of the mental health system and have called for an increase in research by mad scholars and activists into the politics of mental health diagnoses (Carr 2019; Faulkner 2017; Rose 2017).

The nature of mental illness has been a point of critical debate for a long time (see e.g. Burstow 2019; Moncrieff 2009; Foucault 2009; LeFrançois et al 2013). This means that the causes, manifestations, and the available treatments of mental illness continue to be contested despite psychiatry's attempts at establishing firm scientific classifications for mental illness. To be clear, this section is not designed, and indeed this would go far beyond the scope of this thesis, to provide an in-depth discussion of all the available philosophies regarding the nature of mental illness. I interrogate how the language and available meanings of mental illness are positioned within the discourse of the TTC campaign. While my analysis echoes important critiques of psychiatric knowledge and its deployment, it is not my intention to suggest that psychiatry alone is culpable for the discourse that presents mental illness as a biological condition. Instead, I want to draw attention to the neoliberal framework that has harnessed the potential of psychiatric knowledge to categorise and label people with a psychiatric diagnosis. The sense of security that is offered by a psychiatric diagnosis can be viewed as an attempt to make sense of and directly address the mental distress that is caused by neoliberal modes of governance. But it is not just the power of psychiatric knowledge that intervenes upon societies alone. Anti-stigma campaigns have a much broader role to play in the psychologisation of individual lifestyles, a topic that I return to with more attention in the following chapter. Nevertheless, psychiatry's claim to objectivity with regards to mental illness provides a fertile ground for modes of governance that rely on the pathologisation of individuals to explain and manage certain behaviours.

4.3.1. Brains, drugs, and the governance of individual pathologies

The brain is the principal site of the human body that has been identified within psychiatric knowledge-production as the biological origin of mental disorders. This means that the biology of an individual is positioned as the site at which mental illness emerges and should be treated. Even if social determinants of mental distress are taken into consideration more often today than in the past, the use of drugs as a means of intervention prevails. As a discipline, psychiatry increasingly recognises the importance of social factors in the triggering of mental illness, but its focus on medication as the principal form of intervention prioritises a bio-medical framework as the overarching logic and foundation that underpins much of the discourse around mental health that we encounter in many anti-stigma programmes (Tyler and Slater 2018). I now introduce three examples showing that the *Time to Change* campaign promotes a largely bio-medical understanding of mental illness and that it does so by speaking of mental distress as a diagnosable medical condition. I argue that this is an essentialising discourse which ignores and avoids important longstanding debates and research about the nature of mental illness (e.g. Basaglia 1968; Burstow 2019; Foucault 2009; Laing 1967). Instead, it renders the brain and individual pathology a governable entity without addressing the impact of political decisions and growing socio-economic inequalities as harbingers of mental distress.

> ‘"The brain can get sick just as much as the body, bipolar is not a choice" School pupils respond to Alika's story of stigma #InTheMind’ (@TTC 2016)

> ‘We all have a brain, therefore we all have mental health.’ @chily_g writes about #anxiety and attitudes: http://bit.ly/2jCU2Xk’ (@TTC 2017)

> ‘Anxiety is a normal emotion that we all experience. You might think of anxiety as feeling stressed, tense, worried, uneasy or scared. Most of the time these emotions are not a problem. They are normal reactions to our everyday life and can actually help us to get things done on time or take extra care when we need to. However, if anxiety starts to affect everyday life or prevents a person from doing the things they’d normally do, it might be the sign of a mental health problem.’ (TTC n.d.-e)

The first two examples, tweets taken from the official TTC Twitter (@TTC n.d.) account, illustrate the presumed role of the brain in the development of both mental distress and mental health. The quote, found on the TTC website, provides an important insight into the campaign’s politics of psychiatric diagnosis. The tweets very clearly posit the brain as both the organ which can become sick with a mental illness and as synonymous with being the site in the human body where mental wellbeing is presumed to be located. Mental distress is presented as both emergent and diagnosable within individual bodies and as a biological phenomenon. The second tweet, in particular, epitomises much of the mental health ‘common-sense’ that is promoted by TTC. Through a discourse that places mental health as existing within our brains, it would indeed appear logical to address the causes for it at this site and base a definition of stigma around the notion that stigmatising attitudes arise from incorrect knowledge about our physical bodies. There is thus a symbiotic relationship between the definitions of stigma and mental illness that evolves within the TTC discourse and that presumes the locus of mental health to be within the body.

In the above quote from the TTC webpage, there is an acknowledgement that experiencing anxiety (or panic attacks) is a part of everyday life. However, it is only to be viewed as an everyday occurrence as long as it ‘helps us to get things done’. When anxiety interferes negatively with everyday life, especially if it prevents us from going to work or attending school, it can be diagnosed as a mental health problem. The medicalisation of everyday life experiences begins when mental health problems interfere with our ability to be productive and achieving, a narrative which I also encountered in my analysis of previous anti-stigma campaigns (see Chapter 3). It is also notable that the same TTC webpage cites ‘avoiding certain things, such as social situations, work or new and unfamiliar experiences’ as one of the consequences and symptoms of living with an anxiety disorder. Psychiatric knowledge of wellbeing is thereby framing our understanding of negative emotions and experiences by diagnosing these as a mental disorder. In doing so, the provision of a psychiatric diagnosis is both presented as desirable because it allows for the naming of a complex emotional reaction and because it offers opportunities for the engagement with mental health services and support groups. The desire to know and to manage (i.e. treat) the unpredictability of mental distress underpins the discourse of psychiatric diagnosis in anti-stigma campaigns which are designed to promote bio-medical understandings of mental distress.

We can understand these processes even better by looking at existing research that has traced the historical impacts of rendering the brain ‘governable’ (Rose and Abi-Rached 2014). This starts with a reckoning that the brain is a relatively recent site of biopolitical interest and emerged as a new object of governance in the nineteenth and twentieth century with the advent of modern medicine. This not only led to a variety of attempts to understand how and which diseases can befall the brain but paved a path for the bio-medical intervention by a nascent pharma industry. The aim was to discover bio-chemical solutions to supposedly bio-chemical problems. Particularly in the second half of the twentieth century, the market for psychiatric drugs aimed at the brain had grown significantly also through the advent and prominence of asylums. Indeed, the first drugs aimed at combatting mental health problems were tranquillisers that were used to calm and control growing asylum populations before the intervention of antidepressants in the mid-twentieth century (Rose and Abi-Rached 2014). Although these first psychoactive drugs were neither universally welcomed by patients nor healthcare professionals because they acted on the brain and there were notable effects on the patients' behaviour, novel psychopharmaceuticals continued to be administered to calm asylum patients:

> 'The growing links between pharmaceutical companies, the neurobiological research community and the profession of psychiatry led to many inflated statements about the effects of the compounds being marketed, and the routinization of the belief that psychoactive drugs could manage the travails of everyday life by acting on the brain' (Rose and Abi-Rached 2014: 8).

This meant that everyday understandings of distress were slowly integrated into the discourse on psychopharmaceuticals which seemed to have a variety of adverse effects on those who took them. By the beginning of the twenty-first century, 'for every problem of everyday existence, in almost every region where the management of mental health was a governmental problem, pharmacological intervention was the first resort' (Rose and Abi-Rached 2014: 9) and anti-stigma campaigns have made a significant contribution to easing public and professional resistance to the prescription and taking of antidepressants. This trend continues despite mounting evidence that psychiatric drugs do not always have beneficial effects on the human body. On the one hand, there has been evidence of some pharmaceutical companies themselves taking a stance away from producing psychiatric medication (see e.g. Cressy 2011; van Gerven and Cohen 2011; Whitaker 2010) since the first wave of psychopharmaceuticals like Prozac has dried up and few new drugs have been discovered or patented. On the other hand, academic research by Moncrieff (2009, 2013; see also Davies 2017) into the effects of psychopharmacological treatments has demonstrated that the extreme side-effects of certain drugs and the popularity of alternative treatments are starting to make the pharmaceutical production of these medications less profitable. There is a clear link between the profitability of psychopharmaceuticals and their availability which further highlights the important role that a neoliberal market democracy plays in determining the narrative of mental illness and recovery. Mental health awareness can thus be read as the rising of awareness of the brain as the site of mental illness, 'and the rise of practices and devices of working on the brain in the service of self-improvement thus fit comfortably' within a neoliberal framework of wellbeing as governmentality (Rose and Abi-Rached 2014: 17).

The successful rendering of the brain as a governable entity and the psychopharmaceutical 'revolution' that followed, are important milestones in the Western narrative of mental illness. The pharmaceutical industry has a clear vested interest in the dissemination of drugs for mental disorders and anti-stigma programmes in the past have shown to lower resistance to the taking and prescription of modern antidepressants. The discourse of *Time to Change* that continues to promote bio-medical understandings of mental distress is thus concerning because it allows little to no room for debate about the nature of mental distress and immediately categorises it as a type of corporeal illness. Because the campaign prioritises service-user stories and knowledge which identify mental distress as a (diagnosable) mental illness the advantages of a medical framework are highlighted, and stigma is put in a direct relationship between 'correct' medical and 'incorrect' other knowledge about mental distress. Consequently, the concept of mental illness is presented within a particular framework in which interpersonal stigma is the primary social factor in perpetuating mental distress rather than structural or systematic inequalities.

4.3.2. The consequences of 'treating mental health like physical health'

> 'A priority for the upcoming 10-year plan will be better access to mental health services to help achieve the government's commitment to parity of esteem between mental and physical health.' (DHSC Department Overview 2018: 17)

One long-standing narrative within anti-stigma discourse is the call to treat mental health conditions just like physical ailments. This is exemplified by the above quote from the most recent policy output by the Department of Health and Social Care (DHSC) on mental health as well as social media outputs from TTC. In order for mental health problems to be assessed and viewed like physical health conditions, a psychiatric diagnosis of mental disorders is necessary as this facilitates an incorporation into medical language and treatment. However, I argue that there are two reasons why a general call to treat mental health problems like physical health problems is a misguided strategy for the purpose of anti-stigma campaigning. To begin with, akin to the deployment of stigma as a concept,

> ‘when mental illness is considered to be a medical condition, like any other, it brackets off the peculiar grime of mental health politics. In particular, it obscures psychiatry as a site of epistemological contestation and social control’ (Rogers and Pilgrim 2003: 3).

The call for parity begets an assumption that psychiatry functions like other branches of medicine and that mental health problems are merely in need of integration within the medical framework. As demonstrated by the above quote from Rogers and Pilgrim (2003), the contested nature of psychiatry is thus easily left out of the discourse. I have already provided insight into the politics of psychiatric knowledge earlier in this thesis (see Introduction, pp. 19-26), highlighting psychiatry’s controversial efforts towards an acceptance as a medical speciality. Following on from these insights it is clear that psychiatry, and its treatment of mental illness, are contested, however, the framing of mental distress as a medical issue reproduces notions of scientific objectivity in psychiatry when this is not the case. For example, Rogers and Pilgrim (2003: 71) have shown that

> ‘in psychiatric services, the overrepresentation of people from a lower class and some ethnic minorities in coercive contexts is not about meeting need in the same way that health services respond to physical problems’.

This suggests that psychiatry and psychiatric services serve additional social functions that are meaningful beyond the mere treatment of a disease but are concerned with the control and surveillance of social ills and perceived deviance. And while it is important to note that not all mental health service provision is necessarily coercive, the social inequality of mental health service provision and forced detainments speak for themselves. For example, in 2018-19 the number of Black and Black British people detained under the Mental Health Act in England was four times higher than the number of White people, while community treatment orders (CTOs) were ‘more than eight times’ as likely to be given to Black people leaving hospital (NHS Digital 2019). In other words, the provision of psychiatric services is embedded within the politics of race, but also class, gender (see Chapter 3), and sexuality (e.g. Davy 2015). Despite the clear intersection between race and CTOs, anti-stigma campaigns are silent on matters of racism. A serious reflection on the Whiteness of psychiatric knowledge, neoliberal governance, and stigma (see Tyler 2020, for a detailed discussion on the racist history of stigma power) is missing, the focus instead put on showing how *anyone* can be affected by mental illness. Thus, when calling for mental health to be treated in the same way as physical health problems, this comes with a set of assumptions about the universal nature of mental illness that de-politicise the emergence of mental health problems.

What is more, in her analysis of the UK-based and celebrity-led anti-stigma campaign Heads Together, Tyler (2020: 244) argues that

> ‘the embracing of biogenetic rather than social explanations of mental distress risks amplifying the very stigmatising attitudes and discriminations which these campaigns ostensibly seek to eliminate’.

In other words, presenting mental illness as physical illness can in fact lead to further stigmatisation because it essentialises and enshrines mental illness within individual biologies. Drawing on literature from Critical Disability Studies (e.g. Liasidou 2014; Liddiard 2018; Slater 2015) can illustrate this point further by highlighting the ‘disabling’ of people by society, which understands disability to originate within the individual, rather than the structures around her. In order to mitigate the stigma that continues to be attached to physical disability, the ‘common nature’ of mental illness has been highlighted by *Time to Change* and anti-stigma supporters in the government, such as former Prime Minister Theresa May (2017b):

> ‘These problems affect millions of people – an estimated 1 in 4 of us has a common mental disorder at any one time.’

The statistic of ‘1 in 4’ – whose political implications I discussed in the previous chapter – is promoted as representative of the prevalence of mental health problems within the British population. Emphasising prevalence is supposed to aid in the ‘fight against stigma’ as it stresses that anyone, even celebrities or royals, can be affected by mental illness (Tyler and Slater 2018). However, not only is ‘1 in 4’ a statistic with ambiguous origins but it obscures the politics of mental health because it,

> ‘has entailed a spurious sense of *randomness* about mental health problems. This obscures their social patterning, divorcing mental illness from the social conditions which influence their incidence and prevalence’ (emphasis in original) (Rogers and Pilgrim 2003: 7).

This is to say that 'one in four maybe, but not any one in four' (Rogers and Pilgrim 2003: 8) is affected by mental health problems. Even if taken at face value, the statistic of '1 in 4' does not allow for an appreciation of the unequal distribution of mental health problems among the population. Social determinants (class, age, race, gender, sexuality) play a huge role in the experience and development of mental distress precisely because they interact with other structural inequalities, but they do not form part of the anti-stigma discourse. Once again, this omission diverts the gaze from the responsibilities of the government in providing welfare for everyone and legitimises neoliberal policies such as austerity that disproportionately affect those from already precarious socio-economic backgrounds (Scambler 2018; Thomas 2016). After all, if everyone is affected equally – '1 in 4' – there is little the government can do, other than raising awareness, to address increasing diagnoses of mental illness.

In sum, the call to 'treat mental health like physical health' has significant consequences because it determines the limits of discourse in anti-stigma programmes. The integration of mental health within a medical framework not only obscures structural factors in the emergence of mental distress but reproduces the illusion that mental illness affects everyone equally despite evidence that it is more prevalent in already marginalised groups of society (Williams 2018).

4.3.3. When neoliberalism meets psychiatry

The experience of mental distress is varied, and its nature remains contested. How we think about and understand this experience is vital to recovery and in determining our relationships to others. However, critical debate about mental illness that allows for a multiplicity of voices is not part of mainstream anti-stigma discourse. Instead, mental distress is reduced to an essentialising diagnosis of mental illness (or mental disorder) that promotes the notion of individual pathology. This is why I have stressed the need to interrogate how *Time to Change* discourse promotes a firmly bio-medical understanding of mental illness and thus shapes the scope of anti-stigma work. At the moment, TTC discourse both de-politicises the causes of mental distress and obscures its socially determinant roots because it fails to engage with alternate understandings of mental distress.

Yet, while much of the cited research in this section centres around the politics and fallacies of psychiatry it is important to note that psychiatry is a diverse field and many of those who work in the mental health profession (e.g. the Critical Psychiatry Network) do promote a nuanced understanding of the complexity of mental health problems and their origin. This is evidenced by literature from mental health practitioners like Rizq (2012, 2014) who work within the confines of psychiatric thinking but are challenging its role in relation to neoliberal modes of governance. Still, the psychiatric profession with its contemporary knowledge base does remain dominated by bio-determinism and it is difficult to imagine significant change while psychiatry remains firmly embedded within medical structures. Moreover, as long as anti-stigma lobbying continues to promote bio-medical understandings of mental distress, the politics of neoliberalism and their impact on the mental health of people will remain obscured by mainstream mental health discourse. In doing so, public health initiatives aimed at combatting mental health stigma do little more than legitimise the bio-medical framework of psychiatry which has shown to lead to stigmatisation, too. This creates a situation where stigma is simply a signifier for the reluctance of individuals to surrender to the ubiquity of psychiatric knowledge, who are supposedly unaware that they hold ‘incorrect’ opinions. Thus, there is a mutually beneficial relationship between neoliberal governance and psychiatric knowledge where the need to classify and measure digressive behaviour meets a desire to produce subjects that take responsibility for their mental distress.

4.4. Conclusion

In this chapter I have shown that the premise of the *Time to Change* campaigns rests on unstable conceptual foundations and assumptions about stigma and mental illness. Both concepts have long histories with a variety of meanings and contestations, but the discourse in the TTC programme relies on a simplistic understanding of them. While stigma is reduced to an effect of interpersonal relations between individuals and thus gives way to an equally problematic anti-stigma narrative, mental illness is largely reduced to a conceptualisation of individual pathology which must be included amongst other physical diseases and disabilities. I have argued that this is problematic because it obscures and trivialises the harm that is being done to the wellbeing of populations through the consistent neoliberalisation of our societies and nearly a decade of austerity measures in the United Kingdom.

In tracing the discourse of this chapter, I have engaged with research from across the social sciences (e.g. Paton 2018; Rogers and Pilgrim 2003; Rose and Abi-Rached 2014; Scambler 2018; Tyler 2020; Tyler and Slater 2018) in order to demonstrate that neither stigma nor mental illness are apolitical. Instead, they are projects and processes that can be deployed as tools of governance. Through genealogical research and close readings, it emerges that stigma and mental illness as concepts have historically been utilised to disempower, oppress and govern certain groups of people. It is thus imperative to understand and reveal the (dis)continuities of their power and to critically assess the role of anti-stigma campaigns in the normalisation of this discourse.

In the following chapter, I continue my analysis of TTC by shifting the focus to the emergent neoliberal subject. It is my argument that the campaign is a firm part in the legitimisation of neoliberal statecraft in that it produces subjectivities which are individualised, disciplined, and performative in the context of mental distress. This means that people are expected to ‘develop resilience’ and coping mechanisms in the face of consistent and more stringent austerity measures while enduring the defunding of public health and wellbeing services.

5. ‘If work is the cause, it is also part of the cure’: Neoliberal subject-making in Time to Change

> ‘So it seems incredible that we do so little, as a society, to help companies help their employees: to keep their time off work to a minimum, to prevent them becoming a cost to the NHS, and to help them be as productive as possible.’ (PM Boris Johnson while running for leadership of the Conservative Party in July 2019)

> ‘Too many people with mental health problems are made to feel isolated and ashamed. We want to change the way people think and act about mental health problems.’ (the @TimetoChange Twitter Biography)

5.1. Introduction

This chapter traces the process of neoliberal subject-making within the discourse of the *Time to Change* programme. Following on from my critical analysis of the concepts of stigma and mental illness and the way they are deployed in the TTC discourse I now turn to the figure of the neoliberal subject. In the last chapter I argued that the understanding of mental health stigma that is communicated as scientific knowledge in TTC is underpinned by neoliberal logics of individualisation, commercialisation, and the separation of pathology from social inequalities. In this chapter, I demonstrate that the campaign not only reproduces problematic assumptions about the nature of mental illness and the stigma thereof but that its discourse promotes an equally concerning set of ‘anti-stigma’ behaviours. The individual is encouraged to practice ‘self-care’ and to self-manage her mental distress while the government slowly but steadily defunds the mental health and social care services which are sorely needed in times of financial crises and austerity (Cummins 2018b; Stuckler et al 2017). For example, *The Health Foundation* (2018: 3) published a report in response to the government’s budget plans for 2019/20, which shows that the DHSC’s budget is increased by only 2.7% instead of the average increase of 3.7%. Through the impact of inflation, this means that the DHSC has been allocated less money to run the NHS than in previous years. Moreover, the amount of money that can be used for non-NHS social care services continues to be reduced. As the report shows (2018: 6), non-NHS services have been taking a ‘£1bn hit’ over the last two years. This report is supported by academic research (Cummins 2018b;

Stuckler and Basu 2013; Taylor-Gooby 2012) which has shown that the British government has failed to increase the spending on healthcare concurrent with inflation levels and that it has shied away from meaningful welfare reform.

At the same time, anti-stigma programmes like TTC are designed to facilitate performative actions of 'mental health awareness' that take up a significant part of the annual calendar. The desire to raise awareness of mental health is not met by an equal commitment to the funding of mental health services by the government. I argue that anti-stigma campaigns thus perpetuate an intentional omission of critical debate about the relationship between mental distress and its increasing emergence in societies that are driven by neoliberal market logics of minimal welfare provision by the state. The celebration of mental health awareness and enthusiasm about de-stigmatisation give rise to a performative discourse about mental health that obscures its own complicity in legitimising the neoliberal status-quo of contemporary mental health governmentality. In addition, the process of neoliberal subject-making has become an integral part of the mental health governmentality and anti-stigma discourse in the United Kingdom because it diverts attention away from austerity and the privatisation of healthcare while emphasising the need for the individual to change her attitudes and behaviour.

The analysis in this chapter proceeds in three steps. In the first section, I demonstrate that different modes of (self-)surveillance are promoted as part of the campaign's discourse. My interrogation thus echoes familiar accounts of neoliberal analysis that criticise the dominance of individualisation and surveillance as disciplinary forms of healthcare governance in global politics (Brijnath and Antoniades 2016; Kenny 2015; Teghtsoonian 2009). I show that the anti-stigma narrative in TTC is deployed to promote the self-management of mental distress by individuals who are also encouraged to practice self-care in order to become more 'resilient' and observant of mental distress in others. The consequence of this is a disciplinary system of mental health (self-)surveillance that alleviates the state of responsibility and centres liability for mental illness within individual conduct. Failure to comply with these expectations or to showcase 'sufficient' mental health awareness are increasingly becoming subjects of stigma themselves, creating a loop which can only be disrupted through the adoption of anti-stigma behaviour.

The internalisation of these wellbeing technologies also requires habitual performance. Thus, in the second section of this chapter I show how mental health (anti-)stigma knowledge is performed in the everyday and reveals how this is promoted through the campaign's discourse. I critically reflect on how mental health performance in the form of awareness days, weeks, and months, has entered spaces and institutions, such as schools, universities, and the workplace, as the principal performative action with which issues of mental distress are to be addressed. In doing so, I problematise the ready inclusion of anti-stigma activities as part of public institutions' wellbeing agendas in favour of structural changes to address the conditions (e.g. insecure employment, wage gap, equal access of opportunities) which trigger mental distress in the first place. It is my argument that this compound of features – self-management, surveillance, and performance – acts as a disciplinary form of power that produces neoliberal subjects in the context of contemporary mental health governmentality in the United Kingdom.

Finally, I contextualise my analysis of the discourse in *Time to Change* within the mental health policy objectives of the British government. Through an analysis of the most recent government guidelines and implementation plans, I demonstrate that the need to understand mental health problems and mental health stigma are largely framed as detrimental to the economy, not a person's quality of life, which in itself is already often framed within the context of having a job. This necessitates solutions also to be proposed within a framework of neoliberal governance, with anti-stigma campaigning presented as a way to keep people in work despite experiences of mental distress.

This chapter shows that the neoliberal subject is one of the products of the discursive processes of the *Time to Change* campaign. I have already introduced the scholarship (e.g. Davies and Chisholm 2018; Eagleton-Pierce 2016; Oksala 2011) and the knowledge which underpin my understanding of neoliberal subjectivity in this thesis in the theoretical framework (see Chapter 2). Yet, neoliberal subjectification is only one of the processes made possible through the (anti-)stigma narrative in *Time to Change*. While the neoliberal subject constitutes my primary object of investigation for this chapter, the commodification of mental health by the pharmaceutical industry (Ingleby 2014) and the further legitimisation of oppressive systems and institutions (especially capitalism and psychiatry) are likewise important consequences of anti-stigma discourse.

Concisely, in this chapter I trace and expose the processes of neoliberal subject-making in the (anti-)stigma discourse of the *Time to Change* campaign. The neoliberal subject emerges through a complex set of power relations which are embedded within a broad context of the symbiosis of psychiatric knowledge and the neoliberal desires of the British government. Neoliberalism asks the individual to adapt to the damaging conditions of free-market capitalism. It is thus necessary for a neoliberal hegemony to harness the power of psychiatric knowledge to instil immovable frames of pathology in relation to mental distress. In doing so, it is possible to produce subjectivities that are compliant with the notion that stigma of mental illness is the predominant 'burden' of our times. Moreover, neoliberal capitalism is already (and always has been) a gendered and racialised system meaning that the dimensions of gender, sex, and race intersect on the levels of mental health and (un)wellbeing (Tyler 2015). The process of neoliberal subjectification, as explored in this chapter, is important because it serves to legitimise and sustain capitalist relations of power that implicate the individual in the perpetuation of already existing structural inequalities within a given population.

5.2. Managing the self

This section locates the *Time to Change* campaign within a broader policy-guiding framework of self-management which is implemented through technologies of surveillance. To start with, 'self-management' is a form of neoliberal governance. Self-management healthcare solutions are a chief concern for my analysis because policies and guidelines that advocate for self-management as a healthcare strategy have gained significant traction across Western governments and healthcare systems in recent decades. This type of approach has already been criticised as producing both 'neoliberal patients' (Brijnath and Antoniades 2016) and a 'fetishisation of governance' in mental health care settings (Rizq 2012, 2014). TTC, as a public health intervention, plays a vital part in disseminating and normalising the concepts of 'self-care' and 'resilience' in the United Kingdom. The problem with this governmental approach is that it focuses on managing individual behaviour and attitudes to suffering. Therefore, it normalises mental distress under neoliberal structures by putting the onus for change on the individual who must adapt to these structures or else learn to manage the experience herself. In addition, there are different technologies of surveillance which are communicated as desirable behaviours within the discourse of TTC, and which discipline the subject into following these logics. The campaign both stresses the responsibility of the individual to 'check in' on friends and family and the need for the individual to monitor their own mood. These technologies of surveillance are not only increasingly digital (Bauer et al

2020) but they also firmly shift the responsibility for care on the citizen and away from the state.

My analysis of self-management and surveillance technologies in this section traces an important step in the production of neoliberal subjectivity through the discourse of TTC. The creation of wellbeing indicators and the promotion of self-disciplinary behaviours such as self-care constitute a firm part of neoliberal governmentality in the UK yet are facilitated through well-intentioned mental health campaigning at the community level. As outlined in the previous chapter, the campaign works with ambiguous notions of stigma and mental illness that largely ignore or dismiss competing definitions and understandings. This extends to the encouragement of specific behaviours which are presented as solutions to mental health discrimination. The discourse in *Time to Change* thus deploys and reproduces notions of individual responsibility, surveillance, and performativity which ultimately facilitate the process of neoliberal subject making in the context of mental health politics in the UK.

5.2.1. (Self-)management as healthcare strategy

Self-management, as a primary strategy in healthcare and public health intervention programmes, has been shown to emerge from reforms grounded in neoliberal approaches to health governance (see e.g. Brijnath and Antoniades 2016; Rizq 2011, 2012, 2014). While the term itself refers to a set of behaviours that are designed to manage the patient's emotions and attitudes towards a disease or the treatment of an illness, its contemporary use as a strategy for mental health intervention is problematic because it reproduces neoliberal logics of individual responsibility (Lorig and Holman 2003). Traditionally, practices of self-management are associated with the management of chronic diseases where 'the imagined result is a health literate, empowered patient, one who can reorient her life and monitor her own health to bring about positive change' (Brijnath and Antoniades 2016: 1). In other words, self-management initially emerged as a strategy for those suffering from chronic, often incurable diseases, and the chronic ailments of an ageing population.

Applying the same framework to the management of mental health problems is troublesome because it rests on unfounded assumptions about the cause and nature of mental distress. On the one hand, the link to neoliberalism becomes immediately clear: since neoliberal logics understand social risks and ills as a problem for the individual, in part due to the individual’s failing in maintaining ‘self-care’ (Lemke 2001: 203), the solution has been to promote behaviours which make the individual self-sufficient in dealing with distress, all the while the state retreats from funding vital services in social and health care. On the other hand, framing mental illness as a chronic health problem requiring life-long intervention draws attention away from the potential of changes to societal structures that might alleviate mental distress. The self-management model relies on valuing the improvement of life with an illness (‘coping’) over the finding of a cure just as fighting stigma of mental illness is clearly viewed as more vital than addressing the prevalence of mental distress. For example, in outlining his position on mental health, Prime Minister Boris Johnson (2019) acknowledged that work can be a source of stress and anxiety, but that ‘it is also work that can absorb us and take us out of ourselves until the clouds have gone’. The promotion of a model that relies on resilience and the maintenance of productivity during crisis continues to be a common occurrence in mental health discourse in the UK. This is concurrent with the nation-wide privatisation of healthcare has led to mental health services, although currently still free at the point of access, having long waiting times and scarce resources (The King’s Fund 2018). This prompts an increasing number of people to access mental health care in the private sector, particularly for counselling and other talking therapies (Whyman 2018).

Considering the persistent neoliberalisation of health and social care in advanced market-economy driven states, it is hardly surprising that policies around self-management and self-care have become particularly popular in Western countries such as the UK, the USA, Canada and Australia (Lemke 2001; Teghtsoonian 2009). However, there are two important consequences to this strategy. Firstly, as Brijnath and Antoniades (2016) argue, patients in mental health care settings are turned into neoliberal patients who are responsible for their own care. Secondly, audit cultures and performance indicators shift our understandings of therapeutic success to quantifiable measures of wellbeing, which both patients and professionals are expected to manage (Rizq 2012).

In their 2016 study, Brijnath and Antoniades (2016) sought to understand how self-management solutions in mental health care settings bring about a process of neoliberal subjectification in Australian patients. Their findings show that the study participants ‘became’ neoliberal subjects (‘patients’) through encounters with healthcare services which were so unsatisfactory that patients themselves absolved the government from its responsibilities and ‘neither talked about their right to state services nor about familial, social nor work reforms' and instead 'perceived that change needed to occur only within them for their depression to improve' (2016: 6). Even though all 58 of the interviewees initially sought help for their depression from their GP, a psychiatrist, or social worker, the majority found it too difficult to navigate the health care system. Patients were told that the responsibility for finding adequate care (including the changing of providers) was theirs but there was a consensus among the interviewees that it was nearly impossible to find affordable mental health care, particularly regular access to talking therapy. Consequently, many patients chose to self-medicate and preferred to monitor their own moods without further interaction with a healthcare professional. Brijnath and Antoniades (2016) conclude that the participants were 'trained' in self-management techniques by healthcare professionals which instructed patients to seek their own therapist, make appointments, manage their finances, and follow certain drug regimes. These neoliberal notions of responsibility and risk lead to a subjectification of the individual who, through the passing of responsibility from the provider to patient, undertakes the labour to manage herself and no longer expects the state to perform this task. Consequently, the figure of the neoliberal patient emerges successfully and clearly as an entity which has internalised a responsibility for self-management.

In addition to a neoliberal subjectification of the mental health patient, self-management strategies have also given rise to a new structural paradigm of 'governance fetishisation' in the United Kingdom. Drawing on Rizq's (2011, 2012, 2014) research on the state of therapeutic care in primary mental health services in the last ten years, I outline the challenges brought on by self-management strategies in the context of the United Kingdom. Writing from a practitioner's perspective, and while working as a psychotherapist for the NHS in England, Rizq (2014: 211) has described and criticised the rise of an 'audit culture' for patients and mental health workers alike, that has introduced performance indicators as the primary determining factor in the allocation of funding for NHS trusts. With the implementation of the indicator based IAPT (Improving Access to Psychological Therapies) scheme in 2008 there is now an increased need for 'accurate' psychiatric diagnoses from psychiatrists and psychotherapists in order to secure access to further mental health services for their patients.

The IAPT programme was launched under the 2007-2010 Labour Government headed by Gordon Brown as a response to the Layard Report (Mental Health Policy Group 2006) *The depression report: a new deal for depression and anxiety disorders* which called for comprehensive mental healthcare reform in the UK. With a trial run in 2006-07 and a full implementation in 2008, IAPT was funded with £173 million for the first three years (Rizq 2012), while more recent figures for 2021/22 show an annual budget of around £38 million (DHSC 2021). The purpose of the programme is to ease and streamline access to primary mental healthcare for adults with a focus on talking therapies. To this end, ambitious performance indicators, computerised cognitive-behavioural therapy (CBT) and a 'stepped care' approach were adopted (Rizq 2012: 10). IAPT constitutes a comprehensive upheaval of primary mental healthcare in the United Kingdom that was developed in response to a perceived rise of mental distress among the British population and an increased financial burden to the NHS, as outlined in the Layard Report (Mental Health Policy Group 2006). The programme is aimed at providing 'support for adults with depression and anxiety disorders that can be managed effectively in a uni-professional context' (National Collaborating Centre for Mental Health 2020: 8). Thus, the target audience of IAPT is not only the same as that of *Time to Change*, but its implementation in 2006-08 aligns with the start of the campaign in 2007, demonstrating that the management of mental health problems has become an important health policy focus for the British government.

However, Timimi (2018: 1151) argues that IAPT fosters the individualisation of mental distress and 'serves the functioning of neo-liberal economies' and 'neo-liberal marketization' instead of the building of meaningful relationships with service-users. Again, the power of psychiatric diagnosis can be seen to be co-opted for the purpose of neoliberal governance structures that are based on the demonstration of efficiency. In spite of criticisms about IAPT as a mental health care strategy, the recently published NHS Long Term Plan (2019a: 68) calls IAPT a 'world-leading' initiative and establishes the expansion of IAPT as one of its key pillars in improving psychiatric care with an aim to provide mental health care via IAPT to an additional 380,000 adults in the United Kingdom by 2023/24 (NHS Long Term Plan 2019b).

This, Rizq (2014) argues, is part of ongoing neoliberal reforms within the NHS since the 1980s whose impact undermines, rather than supports, the potential success of mental health care services for a variety of reasons. Firstly, an emphasis on scores and quality assurances has constructed the patient as a 'service user' and customer who can (and should) select her own care. However, this

> ‘shift from patient to purchaser not only means responsibility for care is shifted from the state to the individual, but ensures the treatment of illness and suffering is converted into a satisfying and rewarding customer activity’ (Rizq 2014: 212).

Clearly, the notion of the patient as responsible consumer is concurrent with a neoliberal governmentality which also suggests that wellbeing is an activity which one can choose to participate in and that its success is dependent on individual agency and initiative. What is more, since public service and mental health care provision are driven by private sector and market logics that prioritise ‘customer’ demand, mental health practitioners are now ‘subject to intensified surveillance of their work’ (Rizq 2012: 11). Self-management logics are thus also rolled out to therapeutic and mental health services staff who are held responsible for their ‘performance’ in improving a patient’s wellbeing. It appears that responsibility is shifted to the level of the individual at all stages of care. This also leads to a complication of the therapeutic relationship between patient and psychiatric professional in an already wrought and unbalanced context of power and knowledge. As Rizq (2012) recalls her work of leading a support group for young psychotherapists, she reports the self-evaluation of one of the members. The woman relates an incident at work where she was talking to a suicidal young man on the phone. Following all the protocols while talking to the man, she invited him for a follow-up chat in the next week and later left work to go on a night out. She no longer thought about him that evening or until the next appointment despite his apparent distress during the phone conversation. At first this seemed normal to her but upon reflection she was shocked at her own carelessness:

> ‘[…] she had not worried about her assessment of the situation; she had carefully followed all the protocols and policies and felt she did not need to give her client or her decision a second thought’ (2012: 14).

In the group’s subsequent discussion, it emerged that protocols and procedures ensured peace of mind for the individual responder, but they also undermined the natural instincts and intuitions of those responsible for psychological care. There was a feeling among the group members, that an excess of emotional care was neither possible nor desired while working with the given transcripts and under the pressure to deal with as many clients as possible. Rizq concludes: ‘it seemed to imply that, in an organisation dedicated to psychological care, it was becoming impossible to care' (2012: 14). An emphasis on performance indicators and the pressure of meeting numeric targets can thus hinder the provision of mental health care where the desire to manage and survey is artificially elevated over the need to care.

Concisely, Rizq's research provides us with useful insights into the reforms within the UK National Health Service and demonstrates that self-management and neoliberal structures of governance intersect also with technologies of surveillance. Through audit cultures and the positioning of the patient as customer, scores and performance indicators have replaced and undermined potentially helpful therapeutic relationships. The NHS Long Term Plan from 2019 confirms Rizq's concerns in that it outlines the need for 'clear standards', such as the establishment of specific waiting time targets for emergency mental health appointments and the expansion of the indicator-based IAPT scheme, although the plan fails to establish meaningful policies to improve the quality of care for those with mental health problems. In other words, the trend towards an audit and management based mental health service in the UK that Rizq (2012, 2014) identified in her work, is confirmed by the most recent government guidance. I argue that the *Time to Change* campaign is an example of a public health initiative which promotes and further legitimises this governmental approach to self-management as a primary strategy in mental health care. In its mission to de-stigmatise mental health, the significance of individual responsibility in creating behavioural change, and the need to follow procedures in order to evidence 'efficiency' in numbers are firmly embedded and communicated.

5.2.2. Discourses of self-care and resilience

There is significant evidence to suggest that a self-management approach in healthcare governance is partly used to justify the erosion of public spending on mental health services. By asking patients to take responsibility for their own recovery through self-management, the success or failure of this undertaking is lifted from the shoulders of the state and its institutions. Rather, self-management in the form of self-care has elevated the individual as the bearer of responsibility for her own mental wellbeing. The continuation of socio-economic conditions that cause mental distress, particularly austerity, are thus legitimised and debates about their sustained impact are largely dismissed in the current approach to anti-stigma campaigning.

The concept of resilience plays a similarly important role in upholding the neoliberal status quo and it is a central feature of the neoliberal subject. This is because resilient subjects are less likely to engage with healthcare providers and more likely to seek ways to cope under mental distress themselves. The notion of resilience encompasses the incentive to find one's own coping mechanisms in adverse circumstances. Ahmed, in her work on feminism, offers a concise and relevant summary of how resilience can work as a technology governance:

> 'We can understand too how resilience becomes a deeply conservative technique, one especially well suited to governance: you encourage bodies to strengthen so they will not succumb to pressure; so they can keep taking it; so they can take more of it. Resilience is the requirement to take more pressure; such that the pressure can be gradually increased' (2017: 189).

Ahmed's poignant reflection on the purpose of producing more resilient subjects echoes the observation of others because she shows that resilient subjects are necessary for the perpetuation of oppressive and harmful political systems such as neoliberalism, white supremacy, or the patriarchy (Rose and Lentzos 2017; Walker and Cooper 2011). For Ahmed, one way to break free from resilient subordinance is 'to snap' and to – willingly or unwillingly – refuse to take the pressure of oppression. And yet, 'the moment of not taking it is so often understood as losing it' (Ahmed 2017: 189). This observation is particularly significant in the context of mental health because, if mental distress can be understood as 'losing it', then people with mental distress do not have the option of refusing resilience as this would constitute a 'losing it' twice. In the first instance, through the experience of mental distress, often described or experienced as 'losing it'. Secondly, through the 'snap' that comes with a wilful breach in the performance of resilience. In other words, the resilient mental health subject is so busy concealing her mental distress with layers of self-management and self-care that there is little scope for refusing calls to resilience. In fact, resilience becomes a desirable attribute for the mentally distressed in that it presents a way of coping in an increasingly economically insecure society. This is despite powerful critiques that 'demands for resilience without the collective and infrastructural powers to realize resilience are disingenuous at best, toxic at worst' (Rose and Lentzos 2017: 45). Resilience is thus both a technique of neoliberal governance which has found itself into the realm of healthcare policy as a guiding framework and a notion which can seem imperative for those longing to survive systems of mental health care.

My examination of an anti-stigma workshop by *Time to Change* reveals that both self-care and resilience are presented as meaningful anti-stigma strategies. I take as my case study an 'emotional resilience workshop' (TTC n.d.-l) that is designed to serve as an example session for those who plan to implement an anti-stigma approach at the workplace or in an educational institution for adults. Alongside simply 'talking about mental health', which is also considered an important feature of self-care, TTC invites the public to become more resilient in order to mitigate both the symptoms of mental illness and the experiences of mental health stigma.

Thus, TTC's approach fits very well into the broader anti-stigma strategy of the British government which outlines the need for a 'resilient workforce' and 'resilient communities' in both its five-year mental health strategy (NHS Mental Health Taskforce 2016: 24) and the NHS Long Term Plan (2019b: 2). It is not surprising that anti-stigma programmes that are sponsored by the government also follow the overall guidance by the government in emphasising the need for the population to become more resilient. Accordingly, the description of the emotional resilience workshop (TTC n.d.-l) emphasises the following:

> 'To be emotionally resilient means to be able to spring back emotionally after suffering through difficult and stressful times in one's life.'
>
> 'It isn't to become hard or unfeeling or stop at bad things happening but a way of adapting and working more positively with challenges.'

The workshop description promotes resilience as a skill to be developed. The development of this competency is supposed to help the individual to feel more positive about, and less negatively affected by, stressful and adverse situations. Acquiring crisis-management skills and the adoption of lifestyle behaviours is another feature of neoliberal subject-making that is commonly employed to address public health issues. For example, Mayes (2016) has argued that the approach to tackling an 'obesity pandemic' by Western governments is guided by an emphasis on governing individuals through strengthening neoliberal ideas around individual freedom and healthy lifestyle choices. Likewise, TTC promotes the internalisation of anti-stigma knowledge and encourages individuals to engage in activities (such as workshops) that reinforce set norms around resilience and self-care. In other words, stressful or difficult situations, including austerity, poverty, or racial inequality, are to be experienced as challenges to be overcome through the adoption of certain behaviours. The framing of the negative consequences of neoliberalism and other oppressive economic and social structures as 'challenges' thus delegitimises the continued mental distress that those affected by them might experience. This reinforces a very powerful narrative about self-improvement through resilience in which the individual subject takes on the storybook character of a hero that can persist through any crisis that she encounters. A similar point has been made by Howell (2015: 16) who has argued that 'psychological resilience programming' in the US Army presents an attempt to promote resilience as a 'characteristic of modern warriors' to make warfare more efficient while reducing healthcare costs associated with poor mental health by soldiers and their families. There is a clear link between the push for a more resilient population and austerity politics with the discourse in anti-stigma and awareness campaigns playing an important role in normalising neoliberal harm by promoting resilience as a desirable skill.

Thus, the production of resilient subjects is a willed consequence of neoliberal governance where the individual takes responsibility for her own experience and management of mental distress. Another feature of the resilient subject is her ability to practice self-care in the form of wellbeing activities such as doing sports, following a healthy diet, or practicing mindfulness. In this manner, individual lifestyle choices become 'the cause of potential public health, economic and national security catastrophes, but also the cure' (Mayes 2016: 2). The inclusion of lifestyle choices as anti-stigma actions also corresponds to neoliberal paradigms of commodification. There has been a significant increase in consumer purchasing power which has propelled the wellbeing industry forwards in recent years (Davies 2016). In accordance with the promotion of individual resilience, the TTC website (n.d.-l) offers further video workshops on both mindfulness and the 'Five Ways of Wellbeing' which include advice on how to stay active and be attentive to the mental health of the self and of others.

I argue that discourses of self-care and resilience feed directly into an overall narrative and strategy of self-management which has become the status quo for much (mental) healthcare policy around the world. These narratives are normalised through scientific trends in behavioural research that are embraced by governments because they tend to support neoliberal decision-making. The discourse thus constitutes a form of disciplinary power in that it is aimed at altering the individual everyday behaviours of subjects. In doing so, disciplinary power is not only exerted in and throughout the subject to legitimise a self-management healthcare approach, but it is an instrumental aspect of the production of the neoliberal subject in relation to mental health. At this point it is important to note that the concept of resilience, as critiqued in this section within the context of mental health politics, continues to be much debated in the critical social sciences literature.

For example, there is a growing body of scholarship which decries popular critiques of resilience (e.g. by Evans and Reid 2013, 2015; Joseph 2013; Reid 2012) as 'nihilistic' (see Bourbeau 2018; Evans and Reid 2015) by pointing to recent developments in psychology and social work, which have moved away from an individualised approach to resilience and towards a community-driven resilience response. These are important advances to our knowledge about the uses of resilience because many well-known critiques of resilience as a government strategy (most notably, Walker and Cooper 2011), could therefore rely on a limited definition of the concept. However, I contend that there is still much work to be done in problematising the novel ways in which governments and institutions deploy resilience as a healthcare strategy for individuals. As a technology of wellbeing, understanding and problematising resilience is now more important than ever precisely because governments continue to (mis)use resilience for the legitimisation of neoliberal capitalism despite notable advances that position the concept as a potential driver of structural change (see e.g. Bourbeau and Ryan 2017; Carpenter 2014).

I now turn to an exploration of a further dimension of the self-management discourse, namely that of surveillance. As Rose and Lentzos argue, resilience means to 'rear a person who can not only *take* responsibility but *be held* responsible' (emphasis in original, 2017: 27). Thus, in order for disciplinary power to work consistently as a driver of resilience, various methods of surveillance are deployed and promoted as desirable anti-stigma behaviours by *Time to Change*. Self-management and resilience are underpinned by a discourse which holds subjects accountable for a failure to comply with this status quo through surveillance.

5.2.3. Digital interventions

> 'Sometimes we say we're fine when we're not, so if your mate's acting differently, ask twice.' (Ask Twice campaign slogan by *Time to Change*)

For a self-management strategy to become an internalised aspect of the neoliberal subject, technologies of surveillance are deployed which are designed to monitor the response and uptake of these activities. To be clear, when I refer to surveillance technologies in this section I take them to operate as forms of disciplinary power, which:

> 'is exercised through its invisibility; at the same time it imposes on those whom it subjects a principle of compulsory visibility. In discipline, it is the subjects who have to be seen. Their visibility assures the hold of the power that is exercised over them. It is this fact of being constantly seen, of being able always to be seen, that maintains the disciplined individual in his subjection.' (Foucault 1991a: 187)

Surveillance can operate as a technology of the self, the other, and via different channels, including digital monitoring. What they have in common is that diverse modes of surveillance comprise a disciplinary form of power in that they work on the subject to encourage certain behaviours. In the discourse of *Time to Change*, I have found clear examples of language and policies where the aim is to encourage the public to survey and screen others for potential mental health problems. As the quote at the beginning of this section illustrates, the onus is on the individual person to seek out conversations and to observe her peers for any deviation in behaviour. I argue that this approach leads to further neoliberal subjectification because self-management and healthcare are outsourced to the individual. Therefore, the everyday practices of disciplinary power become particularly visible when we look at how the TTC campaign – operating in a neoliberal society that has harnessed the psychiatric and pharmaceutical language to transform individuals into wellbeing customers (Rizq 2014; Trivelli 2014) – produces subjects within a neoliberal framework that rewards the disciplining of others in addition to the self.

Since the TTC campaign predominantly operates and interacts with the public through social media, it is, almost by default, a public health initiative that intervenes upon the digital level and is designed to be retweeted, tagged, shared, and otherwise disseminated in the sphere of the online. It is thus interesting to see how the influence of the digital makes TTC's message ubiquitous in a different way from the previous non-digital campaigns which I discussed in the third chapter. I argue that the use of digital technologies and social media allows for a new form of surveillance which has been harnessed by TTC in order to connect with its intended audience. This development is reflected in the increase in digital technologies, such as mobile applications, which invite the user to monitor and track their own mental health symptoms and overall mood. The increased interest in this type of technology arises from the hope that mobile applications are a low-cost intervention which will provide the psychiatrist with reliable live data on the user's mental state and personal context, including physical location and sleeping patterns (Bauer et al 2020). However, the accessibility of apps is concurrent with the commercialisation of mental health as it harbours the danger of chatbots providing misleading information and prompts concerns about user privacy. These worries are expressed in customer and app-user surveys on this topic which show that there is still some reluctance in the population to rely on digital healthcare solutions (see e.g. Bauer et al 2020; Valdez and Ziefle 2019). Despite these concerns and the global increase in cyberattacks on the healthcare industry, the market value of personal data is high and continues to drive the fast development of digital applications used for monitoring individual changes in mood and perceived wellbeing. Combined with a strategic move towards self-management policies in the governance of mental health, these applications are increasingly replacing traditional forms of psychiatric care regardless of their limitations.

Digital technologies used for the management of population-wide mental health and wellbeing are also a tool of surveillance that is not merely restricted to the individual user. For example, in the aftermath of the Paris terror attacks in 2015, a team of researchers used 'automated sentiment analysis' of the 'basic emotions' of Twitter users in Paris on the days before, during, and after the attack (Gruebner et al 2016: 2195). The report states that their analysis detected 'clusters of fear' and 'sadness' throughout the area after the attacks. Gruebner et al (2016) suggest that these modes of analysis, 'if refined and prospectively applied in real-time' could provide guidance for the provision of mental health services in post-disaster settings. In other words, the analysis of social media posts is viewed as a useful means to monitor public attitudes and emotions, particularly during real-time events, in order to potentially identify mass trauma in and following a crisis. Although the research by Gruebner et al (2016) appears to promote the provision of emergency mental health services, no reflections are offered on the other political means with which such technology could be appropriated. The researchers also state that this study was partly funded by the Defence Science and Technology Laboratory UK. This prompts important questions about the intersection between security, crime, and mental health surveillance in the United Kingdom, a topic which has already received increased scholarly attention in recent years (see e.g. Heath-Kelly and Strausz 2019).

It is not inconceivable that such technologies can be appropriated for the surveillance of moods and emotions in other settings too, including elections, societal upheaval, and climate emergencies, and that it can be bought as big data. What is more, the historical entanglement between technology, medicine, and military warfare should caution us to be attentive to the origins of technological advancements (Howell 2017). There is a disturbing concurrence between the digital technologies developed for military purposes and their application in the governance of populations as Gruebner et al's (2016) affiliation to the Defence Science and Technology Lab demonstrates. Therefore, we must be cautious about the surveillance of mental health which is increasingly facilitated through advancements in digital technologies that rely on the tracking and measurement of emotions to determine appropriate timeframes for intervention. Especially, the advent of mood tracking apps as lifestyle choices, are implicated in 'normalising rationalities of individual choice' towards 'desirable subjectivities in advanced liberal societies (as autonomous, self-improving and entrepreneurial selves)' in order to minimise the need for welfare provision (Fullagar 2018: 43). In sum, technologies of the self are increasingly deployed in the digital sphere to transform and manage the behaviour of individuals into neoliberal practices of managing mental distress.

5.2.4. Surveillance of the other

Technologies of self-management and self-monitoring are supplemented with the promotion of surveillance of 'the other'. The other, in the case of *Time to Change*, refers to almost anyone: friends, family, or complete strangers. To illustrate, these are two quotes from the campaign's Twitter feed from the current 'Ask Twice' initiative:

> 'Catching up with mates this Christmas? It's easy to get caught up in the festivities, but if you think someone might be acting differently, #AskTwice.' (@TTC 2019b)

> ‘Sometimes we say we’re fine when we’re not. But with one in four of us experiencing a mental health problem each year, if someone says they're fine, they might not be. To really find out, ask twice.’ (@MindCharity 2019)

As can be seen, one of the ways in which TTC imagines that mental health stigma can be tackled, is for the public to seek conversations with those who are perceived to be acting outside normal patterns of behaviour. I argue that this is problematic for two reasons. Firstly, this approach thus defines the boundaries of normal behaviour and asks us to seek out and spot those who deviate. Secondly, the role of the caregiver is once again shifted from the state to the individual. And it is not only the patient herself but everyone around her who is responsible for the identification and treatment of mental distress. An alternative approach would place the responsibility for individual wellbeing into a matrix of stakeholders, including the government and health authorities. Yet, current discourses emphasise that the onus is on the individual to manage her own mental health or to help manage that of others.

What is more, the exact point at which the public is asked to intervene and to start a conversation about mental health with someone else is kept rather ambiguous even if the parameters are drawn ever tighter. On the one hand, the campaign stresses that the signs that someone might benefit from such a conversation are incredibly varied. For example, the section ‘Supporting a friend with a mental health problem’ (TTC n.d.-b) mentions ‘I haven’t heard from them in ages’; ‘they seem distracted or absent’; and ‘they’ve mentioned taking their own life’ as equally important signs to watch out for. On the other hand, much promotional material is focussed on starting conversations more generally and without a clear prompt by suggesting that the public should identify a change of behaviour in the other through observation. For example, the following diagram was posted on the *Time to Change* Twitter account in November 2019 (@TTC 2019a):

Figure 5. Should I check in on my mate?

As can be seen, the discourse in this picture suggests that asking someone about how they are doing is the key to starting a conversation about mental health. However, there is no information provided on what one should do after a conversation was initiated. It appears that a conversation in itself is hailed as a solution that can make all the difference in the fight against mental health stigma. There are additional templates on how to proceed in a conversation and what questions to ask (e.g. 'How's work?'; 'did you watch the game last night?'; or 'are you sure?') on the TTC (2018) website that can be freely accessed. However, beyond the starting of a conversation, the individual is not tasked with other responsibilities, and the anti-stigma work in such a situation is considered complete because the available guidance ends there. This is an approach to managing anti-stigma labour that rings familiar to the above example by Rizq (2012) where a healthcare worker was incentivised to follow protocol over her own instincts.

Still, even if we imagine that someone did feel mentally distressed in a situation such as those described by the above tweets, there is no evidence that 'asking twice' would actually prompt a person to speak about their mental health. This raises the suspicion that this narrative fulfils an ulterior motive. This connects to my earlier reflections on Rizq (2012) who suggests that following protocols is a means of performative action that absolves the individual of the need to care. As such, 'asking twice' constitutes a form of performative action which, if followed, needs no further action because the person has already fulfilled her duty of care. The identification of a subtle change in behaviour requires close attention, it requires surveillance, and it requires this surveillance on an everyday, mundane level. Thus, the public realm outside of institutions, in family homes, among friends, and at the workplace, becomes a site in which surveillance is enforced through the population itself, which is conditioned to monitor for potential mental health problems while ultimately still placing the responsibility for 'speaking up' on the individual experiencing mental distress. The idea that the individual is at the centre of these technologies of surveillance is, as O'Neill and Loftus (2014: 438) argue, not new:

> 'Monitoring and control of the problematic person – rather than problematic populations – remains a cornerstone of British criminal justice, but it is happening with more sophisticated and seemingly innocuous means than has previously been the case'.

O'Neill's and Loftus' (2014) research further confirms my argument in this thesis that 'microscopic systems of control' in the everyday are the preferred methods of surveillance and control of the population in the United Kingdom. While O'Neill and Loftus' (2014) research is concerned with crime and law-breaking in economically poor populations, a Foucauldian understanding of the liminality of crime and madness provides me with the tools to apply frameworks of deviance and surveillance to the context of mental wellbeing. As has been shown in previous chapters, the loss of economic productivity in combination with the non-compliance with psychiatric treatment is viewed as digression, sometimes even symptoms, in those diagnosed with a mental illness. It is thus paramount for a neoliberal mental health strategy to identify and control individuals through surveillance within communities and among friends. Thus, by employing a one-sided definition of mental health stigma, TTC draws attention to the site of interpersonal relationships as a space for intervention.

In sum, the discourse in *Time to Change* promotes behaviour that relies on self-care and self-management as well as surveillance technologies executed by the public in order to manage the increase of mental health problems among the population. Research (e.g. Brijnath and Antoniades 2016; Rose and Lentzos 2017) supports my analysis that self-management as a healthcare strategy and the use of the concepts of self-care and resilience are part of a neoliberal logic which shifts responsibility for mental health care from the state to the individual. Moreover, the campaign's social media posts encourage the public to monitor both the self and others for behavioural changes that might indicate mental distress. In short, the discourse of *Time to Change* facilitates a process of neoliberal subject-making in which individuals are constantly made visible through technologies of surveillance that simultaneously place responsibility of care on individuals and on the community and absolve individuals from responsibilities when they adhere to protocols of intervention. Neither the neoliberal state, nor or the structures of capital and social domination that uphold its legitimacy, are held accountable or responsible for the experience and treatment of mental distress among the population.

5.3. Performing anti-stigma and mental health awareness

The raising of awareness about mental illness is an integral part of anti-stigma programmes. The dominant assumption underpinning this policy approach is that there is a link between gaining awareness of a mental disorder (or mental illnesses more generally) and the reduction of stigmatising attitudes due to an increased 'correct' understanding of the issue. I have already demonstrated in the previous chapter that the discourse of *Time to Change* is underpinned by a bio-medical understanding of mental health which frames knowledge about mental distress as a matter of fact-based science which leaves little room for critical knowledge production about mental health. I now turn to the flagship awareness initiative of TTC, the Time to Talk Day, which – in addition to World Mental Health Day and Mental Health Awareness Week – is a day designed to encourage conversations about mental wellbeing at the workplace and educational institutions.

In this section I argue that it is possible to make sense of the newfound popularity of awareness programmes through the lens of performativity in which the subject is produced through the routinisation of 'celebrating' mental health in the everyday. The mere act of scheduling days in the annual calendar on which mental health is the specific object of attention, facilitates a process of continued subjectification. Mental health awareness is introduced as a habit and as a firm aspect of a nation's annual rhythm. Performing mental health awareness thus constitutes a further aspect of neoliberal subject-making that works constitutively with the previously explored dimensions of self-management, self-care, resilience, and surveillance.

I conduct the analysis of mental health performativity in two steps. Firstly, I set out the premise for my critical appraisal of mental health days through a review of the available literature on mental health awareness events (Dumesnil and Verger 2009; Purtle and Roman 2015). I show that awareness days and weeks have already been critiqued for the undue media coverage they receive and that their promotion is a controversial means to improve public health. Secondly, I make further sense of awareness-raising in the context of mental health by interrogating the types of materials distributed to employers by TTC. To this end, I examine the 2019 Time to Talk Day kit that was made freely available to employers and educational institutions upon request in order to facilitate anti-stigma activities.

Concisely, my analysis in this section shows that the function of awareness days extends beyond the stated goals of mental health awareness and anti-stigma. Indeed, both the insistence on the common nature of mental health problems and the starting of conversations as a means to tackle this problem point towards a legitimisation of the status quo. The erosion of mental health services and detrimental effects of austerity on a person's long-term mental wellbeing are omitted from the public discussion on mental health stigma as it is currently facilitated by TTC. The disciplinary effect of anti-stigma discourse is thus enshrined further through the routinised performance of anti-stigma events which legitimise neoliberal governmentality through the production of neoliberal subjects.

5.3.1. Mental health awareness days – worth the craze?

While mental health anti-stigma programmes have a history reaching to the beginning of the twentieth century, perhaps the most well-known public health intervention intended to raise awareness of a disease in recent decades is advocacy around HIV/AIDS. This has included the establishment of an awareness campaign as well as the inception of an annual World AIDS Day on December 1st, 1988. There are a variety of authors that have critically engaged with approaches to ending the stigma of HIV/AIDS (e.g. Deacon 2006; Jackson-Best and Edwards 2018). However, any advocacy strategy that is extended to the realm of mental health should 'pay attention to the struggles of HIV/AIDS advocacy as well as its successes' and consider the consequences of top-down methods of raising awareness (Howell et al 2017: 7).

Despite cautionary tales about the politics of anti-stigma programmes in HIV/AIDS, mental health conditions have quickly risen to the top of the public health agenda and now make up a considerable portion of the annual awareness calendar. While World Mental Health Day is 'celebrated' on October 10th, an entire World Mental Health Week takes place in May, and there are currently 9 days, 6 weeks, and 2 months in the United Kingdom alone dedicated to raising awareness about mental health, with slightly different observances in other countries (TTC 2020; Rethink Mental Illness 2020). The TTC campaign has added its own day – Time to Talk Day – in 2014, which now takes place every year at the beginning of February and is one of the flagship anti-stigma activities of the campaign. In response to this rise of mental health awareness activities, there is now a growing body of literature available which attends to the question whether this development constitutes an effective or ethical means by which to reduce stigma. The voices most critical of (mental) health awareness campaigning tend to come from healthcare practitioners (BMJ 2017) and those working in the field of public health (Purtle and Roman 2015), including mental health service-users and survivors (Cosgrove et al 2019; Costa et al 2012), some of which I introduce in the following.

In the United States, Purtle and Roman (2015: 10601) decided to investigate the stark rise of public health awareness days and succinctly conclude that 'the health awareness day has not been held to an appropriate level of scrutiny given the scale with which it has been embraced'. In order to come to this conclusion, Purtle and Roman (2015) reviewed the history of academic publications in US-based public health journals and found that health awareness days have neither been critically evaluated by comprehensive studies nor that their advocates provide sufficient evidence of their effectiveness. Instead, data from the internet had been used to assess the prevalence of awareness in a population, for example through tracked webpage visits or through online media coverage. However, this type of data alone cannot justify the enthusiasm about health awareness lobbying that we have witnessed in recent years. In fact, Purtle and Roman (2015: 10601) write:

> 'If left unchecked, health awareness days may do little more than reinforce ideologies of individual responsibility and the false notion that adverse health outcomes are simply the production of misinformed behaviours.'

In order to support their argument, the authors refer to another study (Dumesnil and Verger 2009) which has shown that online awareness campaigning tends to centre around awareness of the day itself rather than the specific public health issue. It is thus not possible to equate awareness with evidence of a meaningful public health policy. On the contrary, short-term awareness of a mental illness could produce adverse effects if too much information about an issue is shared 'to the point where individuals conflate being knowledgeable about a health issue with taking action to address it' (Purtle and Roman 2015: 1063). In other words, the mere creation and celebration of an awareness day is not enough in itself to make a meaningful impact on long-term public wellbeing. On the contrary, an undue focus on behavioural change in anti-stigma work and the promotion of awareness on one specific day are both implicated in valuing the performance of awareness over the tackling of structural problems as drivers of poor public health (Jackson-Best and Edwards 2018).

In the United Kingdom, criticism of mental health awareness days has even come from the former President of the Royal College of Psychiatrists and current President of the Royal Society of Medicine, Sir Simon Wessely. In an interview with Wessely that was published in the British Medical Journal (BMJ 2017: 1) he is quoted as having said: 'Every time we have a mental health awareness week my spirits sink'. Wessely goes on to elaborate on his position, arguing that mental health services are overstretched in their capacity, that the positive impact of IAPT has been overplayed by the government, and that more awareness would risk the over-medicalisation of mental distress. Wessely attributes the awareness agenda to the 'government's need for treatments that show quick results' and laments the lack of integration of mental health services into physical medicine (BMJ 2017: 2). The interview with Wessely thus provides a first glimpse of the difference between the government-sponsored mental health awareness approach and a healthcare professional approach. Psychiatry has already been demonstrated (see Chapter 4) to be a discipline that is liable to the co-option by governments through its power in diagnosing people with a mental disorder. The interview by Sir Simon Wessely (BMJ 2017), put into further context by the critique from Rizq (2012), hence illustrates a rift between what those working within psychiatric services believe is feasible and that which the government presents as desirable outcomes with regards to mental health care. In other words, the available literature does not support the enthusiasm with which mental health awareness has been integrated within our calendars and instead reveals large gaps in both evidence and support from healthcare practitioners.

In addition to Wessely's critique, there is a lack of studies that evaluate the effectiveness of an event such as Time to Talk Day thus mirroring the conclusions of Purtle and Roman (2015) drawn from research in the United States. Together with the observations from scholars critical of stigma and anti-stigma explored in the previous chapter (e.g. Tyler 2020; Tyler and Slater 2018), we are left with an intriguing question about the role which awareness days play in the anti-stigma narrative. All evidence points to the conclusion that performing mental health and anti-stigma discourse disciplines individuals to routinely participate in activities that appear meaningful but do little to prompt the government to improve mental health service provision or to question societal structures. This is not to say that any anti-stigma activity is futile. Indeed, Tyler and Slater (2018) have drawn attention to the fact that mental health campaigning is often well-intentioned and that talking about mental health can have benefits for many. However, in the face of a lack of evidence that awareness-raising brings about significant change in either behaviours of individuals or the provision of mental health services on a structural level, it becomes difficult to enthusiastically endorse such an approach to public health promotion. Consequently, performing mental health in a manner which disciplines individuals to regularly engage with awareness events without actively petitioning the government to improve service provision or to question societal structures, is a tool of governance that legitimises contemporary neoliberal mental health governmentality.

5.3.2. Conversation starters for all

The Time to Talk Day (TTTD), promoted on social media with the #timetotalk hashtag, is a mental health awareness day that was instigated by the TTC campaign. TTTD is 'celebrated' annually in February and it is designed to encourage people to talk about their mental health at the workplace, at schools, and at institutions of higher education as well as on social media. It thus falls into the pattern of new annual awareness activities that have been given a firm place on the mental health event calendar and promoting #timetotalk is one of the primary anti-stigma activities by TTC. Considerable effort goes into promoting the day on social media and developing outreach materials that can be ordered by employers and schools free of charge. The day is often complimented with promotion for other campaigns from TTC like 'Ask Twice' which also emphasises the need to start conversations about mental health in order to tackle mental health stigma. However, a close look at the materials which are distributed to employers as Time to Talk Day 'kits' reveals that awareness activities are largely centred around talking about mental health generally, including the need to tackle stigma. In other words, awareness of how to raise awareness of mental health – akin to the above critique by Dumesnil and Verger (2009) – is the focus of TTTD. This prompts concerns about not only the effectiveness of this initiative, but also the type of information and knowledge that is disseminated during its promotion.

The 2019 Time to Talk Day kit (Appendix C) is made up of six different posters (also available as postcards) that invite the reader to 'make a conversation about mental health, however you do it' (TTTD 2019 C1), a small foldable pamphlet that reads 'Make a Conversation' on the front and 'Make a Difference' on the back, and a 'Conversation Starter' (TTTD 2019 C7) cut-out made of paper that needs to be assembled before it can provide prompts on how to start a conversation about mental health. Finally, a few individual pamphlets are included in the pack which promote commercial interests. For example, sponsored by McVitie's is a coupon for £1 off McVitie's Biscuits to 'get chatting over the nation's favourite biscuit' (TTTD 2019 C8). The same is true for a flyer by PG Tips which encourages chatting with a friend 'over a cuppa' after buying a discounted pack of tea bags (TTTD 2019 C9).

Two themes emerge in my analysis of these materials. First, there is an emphasis on talking about mental health with a friend or colleague at any cost without the materials providing any prompts or suggestions for a follow-up. Second, the framing of mental health problems and awareness through the use of numbers and statistics is a recurrent theme also in the promotion of TTTD. For example, the 'Make a Conversation' pamphlet unfolds to reveal the following call to action:

> '1 in 4 of us experience a mental health problem in any year. However you do it, make a conversation to show someone you're there when they need you.' (TTTD 2019 C7)

In addition to the familiar trope of '1 in 4' (see Chapters 3 and 4) which is used to establish the common nature of mental illness, the pamphlet suggests that,

> 'You don't have to be a mental health expert to help. It's not about 'fixing' things, just to have a chat.' (TTTD 2019 C7)

The management of mental health is thus clearly shifted to the private realm. Without the need for an 'expert' to facilitate conversations, individual responsibility falls on everyone who comes into touch with awareness materials. While this could be interpreted as a measure designed to alleviate under-funded mental health services of additional work, it is still problematic that TTC suggests that individual mental health needs can be met through conversations alone. What is more, it is worrying to find that there is a perceived need to encourage people to have conversations about wellbeing in the first place, perhaps suggesting that they would not be had without the campaign. Mental distress and its consequences are made not only an issue for the individual, but their occurrence is normalised through an emphasis that mental health problems are common and that they can successfully be managed at the workplace. Moreover, the posters which are designed to encourage people to start conversations rely on a very straightforward format that frames these activities in numbers and in a variety of everyday situations (e.g. the gym, outdoors walking the dog, the workplace). Two examples read:

> ‘1 Open-Door Policy. 10 Minutes Checking In. 1 Colleague Supported.’ (TTTD 2019 C1)
>
> ’10 Minutes. 2 Cups of Tea. 3 Biscuits Dunked. 0 Pressure.’ (TTTD 2019 C2)

Both posters highlight the temporal aspect involved in performing anti-stigma. With as little as 10 minutes, the posters proclaim, it is possible to support a colleague or start a conversation. Hence, not only is the individual alleviated of responsibility after a relatively short timeframe, but it is not immediately clear from the writing that this is supposed to be a conversation about mental health. Rather, interactions with others – ‘however you do it’ – are presented as meaningful activities to de-stigmatise mental health. While talking about mental health can have some benefit to people that should not be disregarded (Tyler and Slater 2018) I argue that it is still a cause for concern that a government-funded public mental health campaign like TTC pursues logics that have been shown to neither be effective (see section above) nor are based on the most recent research on stigma and mental health (see Chapter 4).

In conclusion, the material that is distributed as part of Time to Talk Day both confirms my previous analysis on the use of largely unsubstantiated statistics (e.g. ‘1 in 4’) to support the anti-stigma narrative and rearticulates clearly the responsibility of individuals and employers to start or facilitate conversations about mental health. As I have shown above, this is despite a lack of evidence that conversations about mental health are an effective means to combat stigma, also because the concept of stigma continues to be framed exclusively within intrapersonal relationships. What is more, this approach to anti-stigma is problematic because it alleviates the employer of any responsibility towards the mental wellbeing of its workers beyond the putting up of posters and the occasional hosting of tea afternoons. It is important to recall that neoliberal structures in society and the workplace have been identified as causes and drivers of increases in mental distress (Mills 2018; Stuckler et al 2017; Teghtsoonian 2009). Thus, an initiative like the Time to Talk Day rearticulates and promotes a discourse about mental health that does not require critique of structural inequalities because these are neither understood as causes nor as solutions for mental distress. In the end, the harm to those suffering from mental distress under neoliberal economic policies like austerity and welfare cuts is normalised through the performance of anti-stigma knowledge that relies on the very same neoliberal framework (Stewart 2019).

Time is, quite literally, used to change our perception of mental health stigma. Through the increase in days, weeks, and months that are dedicated to the celebration or raising awareness of mental illnesses and mental health stigma, our annual calendars have filled with events that prompt us to think about mental health. The available literature suggests that these days do little more than produce short-term awareness of an issue and are increasingly centred around awareness of the awareness day itself as opposed to the public health concern (Dumesnil and Verger 2009; Purtle and Roman 2015). This has led to increased critique as well as fatigue from those working in (mental) healthcare (BMJ 2017). Considering the lack of evidence that would support ‘the craze’ of mental health awareness days, the fact that *Time to Change* centres its annual calendar around the Time to Talk and Global Mental Health Days is a curious choice. I argue that this should be contextualised within the deliberate deployment of a mental health discourse that centres around individual responsibility and culpability for the management of mental distress and its consequences while creating an expectation to ‘perform’ anti-stigma discourse.

5.4. Neoliberal futures in mental health policymaking

In this final section I am going to directly engage with the most recent mental health policy and guidance documents by the British government. I show that poor mental health is primarily perceived as detrimental for the economy rather than individual wellbeing. Consequently, the framing of mental health as a ‘career option of choice’ for future generations has been proposed as a means to address concerns about an increase in diagnosable mental health conditions in the United Kingdom (NHS Mental Health Taskforce 2016: 20). I argue that this constitutes a further commodification of mental health and wellbeing that aligns with contemporary neoliberal governmentality and thus reproduces the existing hegemony of bio-medical understandings of mental health. Concisely, this section supports my above analysis on the production of neoliberal subjectivities through a closer look at government policy directives on mental health.

In the first instance, a summary of the most relevant mental health policy is available in a briefing document which was last updated in September 2020 by the Commons Library. This brief provides a summary of the available resources which – in their combination – outline the government's position on mental health and future policy directives. Since 2010, the UK has been led by a Conservative majority government, either on their own or in an ill-fated coalition with the Liberal Democrats, and the official mental health guidance published since then has already attracted considerable critique. For example, Stewart (2019: 228) has shown that the austerity policy driven by the Conservatives since 2010 is both responsible for 'preventable harm' through drastic cuts in funding for public welfare and the erosion of public empathy for the chronically ill. In addition, Tomlinson and Kelly (2013: 151) have argued that the Conservative government has set a dangerous precedent by developing a National Well-Being Index that relies on 'measurable happiness' which thus justifies and necessitates further policy driven by behavioural social policy. This focus on statistics, running like a red thread through mental health policymaking in the UK, is a deliberate choice of 'changing behaviours, rather than institutions, distributions and regulation' (Tomlinson and Kelly 2013: 151).

The Commons Library (2020) brief begins with a reference to the *No health without mental health* (2011) policy directive, the first of its kind focussing on mental health alone and which was replaced with the *Five-Year Forward View* (FYFV) plan in February 2016. This guidance is the current blueprint upon which decisions with regards to mental health policy are based with its implication framework designed to end in early 2021. In addition to the FYFV, the NHS Long Term Plan (LTP) was published in January 2019. The NHS LTP is a more specific guidance which outlines policy priorities and goals for the NHS, including the provision of mental health care. I have conducted a critical reading of the FYFV and the NHS LTP in order to understand the underpinning goals of the government and have made the following two observations.

Firstly, it is noticeable that the need for addressing mental health problems at all is justified through their negative effect on the economy – not the wellbeing of a person. For example, in the NHS LTP's (2019: 68) section on adult mental health, the introductory exposé highlights that 'common disorders' like anxiety and depression are not only the leading cause for lost work days, but that ‘the cost of poor mental health to the economy as a whole is estimated to be far in excess of what the country gives the NHS to spend on mental health’. The introductory paragraph (NHS LTP 2019: 68) finishes with a call to reduce the impact of mental health illness to ‘increase the national income and productivity’. In addition, PM Boris Johnson (2019) has written that ‘mental health problems and other stress-related conditions are combining to reduce national productivity by £84 billion a year’. Not only does the Prime Minister appear to acknowledge, perhaps unwittingly, that mental health problems can result from conditions of stress but he also goes on to proclaim that ‘to boost the mental health or performance’ of employees would be a necessary feat in order for Britain to become a more competitive world economy. In this sense, mental health is not only reduced to a resource that can be ‘boosted’ but also understood in direct relation to productivity and performance at the workplace. Although the individual and her lifestyle choices are primarily targeted through public mental health campaigns, the economic costs of mental health problems are thus foregrounded as the most important consequences of mental distress that face the state. This suggests that a neoliberal framework operating through the responsibilisation of the individual in order to support privatisation and the growth of the economy, is used to understand and tackle the rise in diagnoses of mental illnesses in the British population.

Secondly, the *Five-Year Forward View* (NHS Mental Health Taskforce 2016: 4) rearticulates the perceived economic burden of the increase in mental health problems – ‘£105 billion a year, roughly the cost of the entire NHS’ – and it outlines a variety of avenues through which these economic costs could be mitigated. For example, in a section titled *Workforce Strategy* (2016: 46), the advice reads: ‘As public interest and awareness of mental health increases and stigma diminishes, many more people are considering a career in mental health’. Thus, awareness is not only perceived to be benefitting those suffering from poor mental health, but it can be utilised as a technology of governance to promote the advantages of a career in mental health. In the same section, the protection of ‘the mental health of the workforce’ is identified as a key priority with a commitment by the government ‘to help staff make choices to improve their own health, and mental health is a key part of that’ (2016: 47). Once again, we witness the emphasis of the responsibility of the individual to manage her own (mental) health as a crucial step in the promotion of mental health.

We can now see how the TTC campaign is a useful public health intervention in achieving the government’s objectives regarding mental health. The strategy for prevention outlined in the FYFV (2016: 25-28) includes a final policy recommendation to 'continue to support proven behaviour change interventions, such as Time to Change' which perpetuates a mental health politics based upon changing the behaviours of individuals rather than structural conditions. In brief, an analysis of the available government guidance on mental health reveals that policy priorities lie in the calculation and identification of the potential burden of mental health issues on the economy, and to offer solutions based within the same framework of measurable goals and the embedding within marketised structures. Mental health is understood to be an issue for the government primarily because it is viewed to have a negative effect on the economy which requires policies that are designed to make the workforce more productive and resilient. This approach is contrary to the needs expressed by mental health system survivors and service-users who have argued that the current approach to recovery from mental distress fails to 'account for the social determinants of health and the relationship between social inequality and recovery' and that any discussion around recovery or prevention should be informed by the needs of those with mental health problems (O'Keeffe et al 2018: 644). This reading supports my analysis of the *Time to Change* campaign. As an initiative that receives both funding (see Chapter 4) and endorsement from the government, TTC is implicated in the legitimation of an approach to mental health and wellbeing that understands stigma as an obstacle to the maintenance of a healthy workforce. It thus necessitates neoliberal subjectivities to emerge and reproduce in the campaigning and awareness activities that it promotes.

5.5. Conclusion

In this chapter, I have demonstrated how the discourse in the *Time to Change* campaign is deliberately productive of neoliberal subjectivities in order to legitimise a politics of austerity and free-market welfare coupled with a trend towards the defunding of state healthcare provision, including mental health services. I traced the different ways in which neoliberal behaviours are promoted as anti-stigma practices while very little attention is paid to the growing structural inequalities which perpetuate a neoliberal governmentality that offers neoliberal solutions to neoliberal problems. Thus, I have provided a critical reading of the anti-stigma discourse in TTC that builds on my critiques of the uses of the concepts of stigma and mental health in the previous chapter. Taken together, the analysis in these two chapters shows that the TTC campaign is a technology of governance which supports the maintenance of a neoliberal approach to mental health politics through the deliberate deployment of a discourse that disciplines subjects into taking full responsibility for the experience and treatment of mental distress.

In the first section of this chapter I began by showing that the discourse in *Time to Change* encourages the individualisation of mental distress – both through an approach to healthcare that requires self-management and the promotion of self-care and resilience in the anti-stigma narrative. TTC disseminates a discourse of mental health that tasks individuals with surveillance of both the self and the other. I argue that the neoliberal subject emerges through the promotion of routinised behaviours that legitimise existing neoliberal structures of governance. In the second section of this chapter, I showed that the recent rise in mental health awareness activities constitutes a form of mental health performativity that has not been proven to be efficient in bringing forth significant change of behaviours or attitudes. I began by reviewing existing debates and scholarly work (Dumesnil and Verger 2009; Purtle and Roman 2015) on the matter of mental health awareness, all of which showed that raising awareness of an issue does not necessarily constitute a meaningful public health agenda in itself, at least not without the provision of welfare and care for those affected by the illness. I then conducted an analysis of the 2019 Time to Talk Day kit in which I revealed that performing anti-stigma is promoted over a critical engagement with the underlying causes of mental distress. In other words, routinised individual displays of mental health awareness and anti-stigma have become an integral part of the message of TTC while there is no reference to the responsibilities of the employer or the state in contributing to the mental wellbeing of the population. Finally, I contextualised my analysis of the TTC campaign within the available government guidance on mental health. Through an interrogation of the available policy briefs I showed that an anti-stigma programme is situated well within a framework that primarily identifies mental distress as a burden to the economy. This makes possible the proposition of policy solutions that encourage the incorporation of mental wellbeing within increasingly popular marketised approaches to the provision of healthcare.

In sum, I have shown that the individual is foregrounded as the locus of responsibility for both stigma and anti-stigma, with the state largely alleviated of its responsibilities to assure the continued welfare of its citizens. In the end, ‘it is not simply government health campaigns or medical authorities that target the everyday life of the individual’ but rather ‘a network of knowledges, practices, instruments, techniques and expert relationships surrounding the individual, some of which are engaged with voluntarily' (Mayes 2016: 147). This voluntary engagement can be traced back to the promotion of self-discipline in the face of mental distress but can also be found in the ready willingness of people to engage with campaigns like *Time to Change* on social media or in their communities. In the next chapter I am thus going to engage with the (ab)use of personal stories for the purpose of mental health promotion in the *Time to Change Global* campaign.

6. Twisting stories: The use of personal narratives in global anti-stigma campaigns

> 'Do you have lived experience of a mental health condition? Would you like to develop your skills as a blogger, vlogger or online campaigner, and help change attitudes around mental health? Take part in StoryCamp, a new online course where we support you to develop your online storytelling skills and confidence.' (TTC n.d.-i)

> 'Favoured stories feature the uplifting message that with a little hard work and perseverance, you too can be cured.' (Costa et al 2012: 89, *Recovering Our Stories Collective*)

6.1. Introduction

This chapter is concerned with tracing the processes of 'doing' mental health and anti-stigma globally through the interwoven mechanisms of mental health awareness campaigns, their materials, social media promotion, and news coverage. Through an analysis of the global governance of mental health, I establish important connections with national programmes like *Time to Change*. In this chapter, I foreground the use of stories and personal narratives by people diagnosed with mental disorders for the purpose of anti-stigma promotion. I argue that the use of personal narratives constitutes a technology of governance which is employed to both support the public brand of anti-stigma campaigns and to normalise the discourses on which they rest. In doing so, the discourses in anti-stigma campaigns reproduce the existing parameters of psychiatric conceptualisations of mental distress while promoting a universal approach to mental health that rests on neoliberal ideals of wellbeing (Thghtsoonian 2009; Timimi 2011). My principal case study for this chapter is the *Time to Change Global* (TTCG) programme which is situated within the broader *Global Anti-Stigma Alliance* (GASA), a network of various NGOs and public health initiatives that are concerned with the promotion of mental health awareness (TTC n.d.-e). GASA is made up of organisations from seventeen different countries while its secretariat and the organisational centre lie with the leadership of *Time to Change* in England. GASA acts as an umbrella for various national and local anti-stigma initiatives, for example in Denmark (*ONE OF US*), New Zealand (*Like Minds Like Mine*), Scotland (*See Me*), or Andalusia, Spain (*1 de cada 4*). While the core campaigns of GASA are in Western nations, the service-user and survivor stories that are promoted by the

TTCG programme are exclusively from non-Western countries, most commonly from African nations. GASA thus constitutes an organisational umbrella for the management of anti-stigma campaigns, where the leadership of campaigns located in Western countries are put into conversation about strategic decisions. But even though narratives from non-Western countries are featured as success stories of TTCG, organisations from these nations are not named as stakeholders of GASA. This stark divide between those who are considered part of the leadership in global anti-stigma campaigning and those that are rendered sites for intervention, foreshadows my conclusions at the end of this chapter.

The GASA section on the TTC website (n.d.-g) further includes a variety of introductory material into the purpose and aims of the alliance. For example, the informational leaflet about GASA that is supplied by TTC introduces the network by claiming that,

> 'Reducing and ultimately eliminating mental health stigma and discrimination is the work of generation and therefore requires long term and sustained activity and investment; previous evidence has shown that one-off campaigns don't achieve significant and sustainable levels of social change' (sic, TTC n.d.-g: 3).

The introduction to GASA re-affirms the goal of anti-stigma campaigns as producing population and society-wide change in attitudes to mental health. While the leaflet does not provide reference to the quoted evidence that one-off campaigns are not useful in bringing forth change, it suggests that the setting of outcome targets of anti-stigma activities 'is vital to ensure work is effective' in the reduction of stigma (TTC n.d.-g: 4). The setting of specific targets and numeric indicators is thus the premise on which TTCG and GASA are built, the premise with which I begin the analysis in this chapter. In the following, I show that my research is also embedded within the politics of a network of international stakeholders where anti-stigma campaigning presents an attempt to educate non-Western populations about mental health. This is particularly interesting given the contested history of global mental health interventions which have been shown to promote universal and essentialising norms of mental wellbeing while framing non-Western populations as mental health 'illiterate' (Davar 2014; Ingleby 2014; Summerfield 2013; Timimi 2011).

This chapter is divided into two sections. In the first section I critically engage with the move to 'go global' by the *Time to Change* campaign. I show that TTCG, in particular, is embedded within the British desire to become a 'global leader' in mental health (Beresford

2018), thus echoing the interests of the state more than the interests of those with mental distress. I also demonstrate that anti-stigma narratives play an important role in the larger project of GMH, where even global institutions like the WHO have begun to run their own anti-stigma programmes. Crucially, the agenda of the Lancet Global Mental Health Group (2007) to 'scale up' the provision of mental health services in low- and middle-income countries, is in alignment with the narratives of anti-stigma campaigns presenting the public, and non-Western populations, as uneducated and in-need of intervention.

In the second section, I borrow the language of 'curated stories' (Fernandes 2017) to make sense of the ways in which mental health survivor stories about stigma and discrimination are operationalised. I argue that storytelling in anti-stigma campaigns is a technology of governance that legitimises the problematic conceptualisations of stigma and anti-stigma that I explored earlier in this thesis. To this end, I provide an analysis of the discourses in TTCG and TTC. Firstly, I demonstrate that personal narratives in TTCG echo the social media presence of TTC in that they promote a bio-medical understanding of mental distress by highlighting the importance of receiving a psychiatric diagnosis. Secondly, I examine TTC's StoryCamp programme which was advertised as a free online course for volunteers who wish to establish a social media presence in order to share their experience of mental illness. I show that the discourse of StoryCamp gives credence to concerns by service-user and survivor activists who problematise the use of personal narratives as an extractive practice (Costa et al 2012). Thirdly, I show that the quantification of mental distress reinforces contemporary global hierarchies that continue to frame non-Western countries as a sites for intervention. The setting of numeric indicators in the global governance of mental health thus prioritises the desired outcomes of Western nations, while the needs of non-Western states are largely dismissed. Finally, I conclude this thesis with a reflection on the politics of using 'lived experience' for the purpose of mental health care and service promotion. Drawing on Voronka's (2016a, 2016b, 2017, 2019) work on peer support and service-user narratives I emphasise that the concept of lived experience is problematic when it assumes that narratives by service-users and survivors are somehow pure and without bias. It is also possible to scrutinise the rise in peer workers in mental health services as a way for care provision to appear bottom-up while peer workers are increasingly performing affective labour which requires them to continue working within the limits of the given dominant psychiatric framework (Voronka 2017).

6.2. Anti-stigma is 'going global'

This is a chapter about the use of personal narratives in anti-stigma campaigns, but it is also about the story of 'anti-stigma' itself and its relation to the project of Global Mental Health. I argue that the increasingly global fight against mental health stigma constitutes a narrative in itself, featuring a story arc which is constructed deliberately and productively, and which upholds contemporary hierarchies of knowledge production. As such, personal stories are used to legitimise anti-stigma interventions, but the advent of global anti-stigma campaigning must be problematised as a core element of the global governance of mental health.

In the first instance, GMH carved a space for awareness programmes from its very inception, even if anti-stigma programmes were not mentioned explicitly in the opening call to action (Lancet Global Mental Health Group 2007). The 'scaling up' of mental health was designed to promote the inclusion of 'effective public mental health leadership', meaning that mental health professionals should be promoted to government departments and ministries in order to lead the effort on public mental health (Lancet Global Mental Health Group 2007: 1250). This is supposed to mitigate the effects of poor decision-making by officials, especially in low- and middle-income countries, who are viewed as not having the expertise to plan and implement population-wide mental health interventions. The report (Lancet Global Mental Health Group 2007: 1250) identifies the lack of a public mental health training infrastructure as a 'barrier' to the effective management of mental health. In the second *Lancet* rendition of GMH, an article by Sunkel (2011: 202), a service-user/survivor asked to contribute to the series, highlights the need for members of advocacy groups to 'run campaigns to increase awareness' of mental disorders in low- and middle-income countries, to dispel myths about mental illness and to improve 'treatment compliance' and 'employment opportunities' for people with mental illnesses. Proponents of GMH never identified mental health stigma as a core barrier to the 'scaling up' of services, but a comment by Sartorius (2007), which was published alongside the first series, speaks directly to the need to address mental health stigma. Sartorius writes, 'the stigma attached to mental illness is the main obstacle to the provision of care for people with this disorder' (2007: 810). He further argues that stigma can be 'defined as the negative attitude that is triggered by a marker of illness' (2007: 810). Sartorius' description of the manifestation of stigma is aligned with the narratives that we have also seen running through TTC. Since the publication of the 2007 and 2011 special series in the *Lancet*, commonly understood as building the conceptual foundations of GMH, there has been an increase of anti-stigma programmes globally. The 'scaling up' of mental health services thus includes the funding of mental health awareness and anti-stigma campaigns, which have become firm components of international attempts to globalise the governance of mental health.

Secondly, TTC and TTCG are not the only anti-stigma programmes that work on the national or global level. For example, Grey (2016) conducted an analysis of an Australian anti-stigma campaign by examining a variety of posters and advertisements on billboards, that were used for the promotion of the programme. Grey (2016) found that the campaign was funded by the government and primarily encouraged people to donate to the Australian charity *Mind*, a similar organisation to the one in the UK. The posters which were used to advertise the programme, cautioned the reader, to 'show that you care' while depicting people covering their faces with their hands, hunched over, and 'crumpled' on the floor (Grey 2016: 242). Grey (2016) offers a critique of the visual representation of people with mental illnesses in this campaign by showing that 'to be able to position itself as benevolent, Mind requires a needy other, one to whom benevolence can be given – people that Mind can help "recover"' (Grey 2016: 244). Moreover, the images in the campaign itself, were stereotypical and stigmatising representations of people with mental distress. In this way, it is possible to understand how anti-stigma campaigns construct identities, where those diagnosed with a mental illness can be portrayed as helpless and needy while service providers and donors are rendered giving and benevolent. Hence, Grey's (2016) concept of 'benevolent othering' can be a useful tool in approaching a critique of anti-stigma campaigns because it helps conceptualise how those diagnosed with a mental illness and their experiences of distress are framed in particular ways, which then serve to construct a narrative about the nature of mental illness.

A further example of a recent anti-stigma campaign, is the launch of the World Health Organisation's (2017) own anti-stigma campaign, called *Depression: let's talk* which emphasises the need for action on the level of global health governance. While some of the campaign's materials are promotional materials ('factsheets') about depression, it primarily pushes the need to have conversations at the level of governance. The WHO (2017) states, that 'failure to act is costly' and that:

> ‘The losses are incurred by households, employers and governments. Households lose out financially when people cannot work. Employers suffer when employees become less productive and are unable to work. Governments have to pay higher health and welfare expenditures.’

The consequences of *not* talking about mental illness are primarily framed as a problem for the growth of the economy, a concept that I encountered many times in my analysis of anti-stigma discourse. Thus, TTCG is situated within an emerging assemblage of anti-stigma campaigning which is dominated by bio-medical and neoliberal discourses of mental distress. The example by Grey (2016) illustrates that processes of subjectification in campaign discourse are a global phenomenon, while the statement from the WHO (2017) supports my argument that anti-stigma campaigns serve a political purpose beyond the stated aims of improving the lives of people with mental distress.

While we can locate the anti-stigma discourse at the heart of an emerging project of mental health governance, it also reproduces the problematic logics of GMH (Ingleby 2014; Mills and Fernando 2014). As such, anti-stigma programmes should be analysed within the context of existing criticisms of the globalisation of psychiatric knowledge through the project of GMH (Esposito and Perez 2014; Summerfield 2012, 2013; Timimi 2011). In particular, the export of bio-medical understandings of mental health have come under critique. Timimi (2011: 159) argues that the WHO is ‘imposing’ a ‘Western medical model’ of psychiatry on non-Western populations, leading to the undermining of indigenous knowledges about mental health. What is more, Timimi (2011, see also Mills 2014) demonstrates that global institutions often employ emotive images of violent practices, such as people in chains or abandoned, in non-Western countries, thus suggesting that medical care from Western countries is superior and that ‘modern’ psychiatric treatment cannot be understood as violent. I argue that the discourse in anti-stigma campaigns supports this problematic narrative. On the one hand, the personal stories that I dissect in this chapter are reproducing bio-medical conceptualisations of mental distress. On the other hand, anti-stigma programmes are presenting the experience of mental health stigma as universal.

Moreover, the universalisation of mental health knowledge in the WHO’s mental health GAP (mhGAP) programme, which was designed to help detect and diagnose common mental disorders in low- and middle-income countries, has come under scrutiny for the type of knowledge about mental health that it produces (Mills and Hilberg 2019). There is a concern that psychiatric narratives dominate the implementation guidelines which are aimed at non-specialists to aid the reach of the WHO in closing the treatment gap of mental illnesses worldwide by encouraging psychiatric diagnoses. As Mills and Hilberg (2019: 171) conclude in their analysis of the 'social life' of the mhGAP intervention guide, the mhGAP framework is embedded within 'deep historical roots spanning colonial biometrics and censuses of insanity' that 'underlie the conditions of possibility for the expansionary logic of mhGAP and the wider Movement for Global Mental Health'. In other words, Mills and Hilberg (2019) poignantly capture both the historicity of global mental health governance and the coloniality of contemporary intervention programmes. These attempts at universalising the experience of mental distress through quantification, measurements, and target-setting are expressed in the diagnostic algorithm prescribed by the mhGAP intervention guide. Mills and Hilberg's (2019) analysis also speaks to the critique of global public health as a form of population governance by Bashford and Strange (2007), the work by Merry (2016) on the dangers of quantification, and Fernando's (2010) criticism of imperial psychiatry. Concisely, what we witness is an emergent assemblage of attempts at governing populations via the diagnostic frameworks so readily made available by the psy disciplines. Yet, this assemblage comes as no surprise for scholars of the history of global health:

> 'Public health has always been entangled in questions of authority, coercion and freedom, as well as the governance of people, their movement and conduct. There is nothing new about that' (Bashford and Strange 2007: 91).

As Bashford and Strange (2007) remind us, public health in the global sphere is intimately linked with the governance of populations and the expansionary interests of Western nations. The governing of mental distress under global neoliberal structures today is thus underpinned by a legacy of imperial medicine. Moreover,

> 'the fact that psychiatry itself has not been shown to be applicable cross-culturally or to be free of both racial and cultural bias has become obscured by it's over attachment to medicine, the prestige of the latter rubbing off on psychiatry' (Fernando 2010: 112).

In other words, psychiatric knowledge in the form of mental health interventions is exported as a universally applicable framework. As I demonstrate in the remainder of this chapter, this is also true for the global rise in anti-stigma campaigning which uses the narratives of mental health service-users and survivors to legitimise the conceptualisation of mental distress as a medical pathology. However, before I delve into an analysis of the discourse of TTCG, I will emphasise that anti-stigma campaigning has also been harnessed by the UK government as a means to improve its influence in the international governance of mental health.

6.2.1. Ambitions of global influence

The running of mental health anti-stigma campaigns is a part of the UK government's ambition 'to put mental health on an equal footing to physical health across the world' (Gov.uk 2018a). This was reported in a press release just ahead of the first ever Global Ministerial Mental Health Summit, which was hosted in London from the 9th to 10th October 2018. As such, the Summit was designed to align with World Mental Health Day on October 10th. The event was attended by political figures, mental health 'experts', and people with lived experience. It was also attended by the Duke and Duchess of Cambridge in their function as patrons of the *Heads Together* campaign, an initiative that is funded by The Royal Foundation of the Duke and Duchess of Cambridge and that seeks to 'dispel the stigma' of mental health (Tyler and Slater 2018). Crucially, the Summit featured the launch of a short film by *Time to Change*, the content of which I interrogate more closely later on in this chapter. The ambitions for the Summit were big. Matt Hancock, Health and Social Care Secretary, was quoted as saying that 'this summit is a landmark moment in changing the way mental illness is perceived and treated annually' (Gov.uk 2018a). Likewise, Sue Baker, the director of TTC, commented:

> 'We've made major progress on mental health in England, and hope the Summit acts as a springboard for change across all countries and cultures, so that there is no shame attached to mental health anywhere in the world' (Gov.uk 2018a).

The Summit was designed to position the United Kingdom as a global leader in mental health care and in the battle against mental health stigma. In a speech by Matt Hancock at the start of the Summit, he made clear that the British government saw it a priority to dispel the stigma of mental health 'for the sake of future generations' while quoting a statistic that 'one in 10' children are experiencing mental health problems that they will carry into their adult life (Gov.uk 2018b). The official report that was published a year after the Summit goes even further in outlining the British ambition regarding the governance of mental health globally. Firstly, the report highlights the 'legacy of this first summit', arguing that it will pave the way for future global partnerships between countries on the topic of mental health. At the centre of the Summit, was the role of the UK in establishing and hosting this first ever Summit and the urgency with which mental health must be approached. Quoting from the report,

> 'mental health conditions are the leading causes of ill health, disability and lost economic output, making mental health one of the defining global challenges of the 21st century.' (DHSC 2019b: 2)

This framing of mental health as a burden to the economy is by now a familiar trope and should not come as a surprise to the reader. The speeches at the Summit and the subsequent report are all perfectly aligned with the mental health governmentality that I expose in this thesis. What is more, the role of mental health stigma is increasingly foregrounded as an essential obstacle to achieving better mental health care. In the discourse of improving the state of mental health globally then, the UK's government firmly positions the individual and her 'economic output' as a site of future interventions.

Secondly, the report summarises the outcomes and recommendations of the various workstreams of the Summit. Workstream 4, titled 'a just society: supporting societal shifts, tackling stigma and discrimination, creating inclusive societies' was organised by Sue Baker from TTC and Sir Graham Thornicroft, professor at King's College London and long-time publisher of research on mental health care and stigma in the UK (Corker et al 2016; Henderson et al 2012). The recommendations of this working group centre around the need to lead conversations about mental health, spearheaded by 'experts by experience'. While the inclusion of people with lived experience appears commendable, the use of personal narratives is often very divisive, as I aim to show in this chapter. What is more, despite the call for user-led conversations and advocacy, the organisers of this workstream are not service-users/survivors themselves. This prompts questions about the spaces where service-users/survivors *are* allowed to lead the conversation on global mental health. From the available evidence, it is not in the spaces of policymaking and agenda setting at the first ever Global Ministerial Mental Health Summit.

Crucially, the Summit did not proceed without considerable criticism (Beresford 2018; NSUN 2018a, 2018b), although the official report and government website make no reference to this critique. Not only did the Summit attract two open letters by service-users/survivors and academics from the National Survivor User Network (NSUN, see also Cosgrove et al 2019), but Beresford (2018) provided a comment in the British Journal of Mental Health Nursing in which he called out the Summit for presenting itself as involving service-users/survivors while the two open letters clearly show that this was not the case. Poignantly summarised by Beresford, 'consulting service users is one thing, listening to what they say, is quite another' (2018: 199). The two letters (NSUN 2018a, 2018b) are thus important artefacts that testify to the controversy surrounding mental health interventions led by the UK government, despite the insistence from a spokesperson for the UK DHSC that the involvement of people with lived experience was 'ensured'. To be clear, the criticism from the open letters was centred around the failure of the Summit to include critical voices, calling it 'hypocritical that the UK government is taking the lead in creating a global declaration on political leadership in mental health' since its austerity policies have been proven to meet 'the threshold of grave or systematic violations of the rights of persons with disabilities' (NSUN 2018a). Moreover, the open letters call out the consistent discrimination of people from Black and minority ethnic communities in UK mental health services. Mental health service-users and survivors observe with great concern that the UK is attempting to lead the world in mental health care while it continues to employ a policy of 'hostile environment' in its approach to immigration of people from ex-colonial countries, policing and welfare sanctioning.

Over the last two years, the United Kingdom has been an influential actor in driving the agenda in the politics of global mental health. Under the leadership of Matt Hancock, the DHSC has been involved in creating policies and targets for the future international cooperation between countries on matters of mental health. However, this has been met with considerable criticism from service-user/survivor groups. The DHSC claims that it is acting by taking into account lived experience, while activist groups point out that the current actions do not represent the needs and wants of many service-user/survivors (Beresford 2018; Rose 2017). It is thus that we can understand the politics of personal narratives of mental distress and mental health stigma, which can be exposed to be 'curated' for the pursuit of political ambitions. Storytelling is a crucial aspect of the global mental health discourse and it is particularly present in public health programmes and campaigns aimed at de-stigmatisation. The ambitions of the UK government to become a key player in determining the agenda and direction of global mental health governance demonstrates that economic and governmental interests are of vital importance in shaping the discourse of awareness campaigns, particularly if the government sponsors these programmes.

6.3. Curated narratives as a technology of governance

The concept of 'curated stories' is borrowed from Fernandes' (2017) work on the development of storytelling as a method of global advocacy and campaigning. Fernandes argues that the use of personal stories can be problematic because the narratives are twisted in order to drive an NGO's 'social impact through measurable goals such as legislative wins or voter registration' (2017: 3). This means that storytelling is increasingly reliant on a business model that can marketise personal narratives into usable gimmicks that contribute to neoliberalised agendas of social justice. Crucially, this reflects a desire by campaigns to appear bottom-up, such as with the programmes discussed in earlier chapters, whereas I have shown that very little service-user engagement can be traced back to the campaign's management. Fernandes' (2017) research is helpful in making better sense of stories as a core aspect of awareness-raising, particularly in the realm of international governance and diplomacy. Hence, I begin this section on storytelling by interrogating the purpose of personal narratives in the promotion of mental health awareness before showing that these narratives are deliberately employed to re-articulate familiar tropes about the nature of mental illness.

Costa et al (2012) – a collective of authors that identify as service-users and survivors – have argued that, initially, stories were an important aspect of resistance by mental health service-users/survivors in that they served to effectively communicate the lived experience of those who were diagnosed with a mental illness and often found themselves in a psychiatric web of competing diagnoses, changing treatments, and a long journey of recovery. Often, the concept of 'recovery' itself was put under scrutiny in personal narratives. It has been argued that the contemporary recovery-centred paradigm assumes a linear progression of patients' wellbeing, which leads to recovery principles strengthening 'the current neoliberal political agenda, which positions service users as individual consumers', rather than meeting people with mental distress with compassion and kindness (Spandler and Stickley 2011: 561). However, personal narratives are now increasingly used by mental health organisations and campaigns to promote mental health awareness. The harnessing of these personal narratives has several purposes. Firstly,

> ‘these stories function to garner support from authority figures such as politicians and philanthropists, to build the organizational “brand” regardless of program quality, and to raise operating funds during times of economic restraint’ (Costa et al 2012: 86).

In other words, personal narratives can be effective in eliciting essential funding from a variety of stakeholders in the absence of governmental support. It is the content that depicts people struggling to cope with their mental illness, or living just below the poverty line, which is shown to the world in order to garner support. However, this type of messaging is also effective in re-articulating stereotypes about mental illness and poverty, thus reproducing the stigma it claims to reject. Crucially, the selection of stories is a political process that often does not involve the person whose story is used. On the contrary, psychiatric survivors have been shown to be paid to be ‘paraded’ in front of important stakeholders in order to promote recovery journeys that emphasise the crucial role of medication (Costa et al 2012). In this way, personal stories are curated with the specific goal of gaining support from local politicians, lottery funds and donors. However, this is contradictory to the initial reasons why service-users/survivors started telling stories, namely, to provide a critique and provoke radical change in the prevailing governmentality (Costa et al 2012; Voronka 2019).

The second purpose of using personal narratives is to bolster the legitimacy of an anti-stigma programme. The notion informing the storytelling approach is that stigma can be fought effectively through personal narratives because these prompt the public to relate to the stories, and to alter their behaviour, for example by speaking about mental health problems themselves. To this end, the personal stories of celebrities and other well-known figures are featuring dominantly in the discourse of anti-stigma campaigns. For example, in 2018 GASA released a short promotional video titled ‘Time to Change Global: It’s time to talk about mental health’ which features mental health narratives from around the world, including celebrity stories by Nadiya Hussain, a popular British TV chef and presenter, and Glenn Close, an American award-winning actress (TTC 2018). In the video, the negative consequences of mental health stigma are said to create barriers for people in securing employment or accessing medical treatment. Sigma itself is described as ‘knowing no boundaries’ and ‘affecting all ages, all income groups and all cultures’, while the ‘talking’ about mental health is presented as a therapeutic intervention. However, there is no acknowledgement in the video that celebrities in Western nations, often white and wealthy, may not have the same experiences of mental distress as the people that they are addressing (Fey and Mills 2021 [forthcoming]). Another example are the stories of Princes Harry and William, both of whom received extensive media attention when they decided to speak openly about mental health problems after the death of their mother (The Telegraph 2017). In an analysis of this discourse, Tyler and Slater (2018: 723) remark, that

> ‘in terms of potential consequences, there are substantive differences between a Prince or a pop star disclosing their struggles with mental health to the public, a precarious worker disclosing their struggles with mental health to the public, a precarious worker disclosing to an employer, or a mother disclosing to a social worker’.

In other words, there is a disconnect between the shared stories of people who are economically and socially well off and the stories of ‘ordinary’ individuals. Yet, TTC and TTCG draw no distinction between these narratives. On the contrary, allowing these stories to exist in the same space reproduces an essentialising discourse of mental distress that accentuates experiences as universally shared (Voronka 2016a). There is little to no recognition of the intersections between race, gender, and class in the promotional materials of TTCG. The emphasis in the campaign’s discourse is on highlighting the role that stigma plays in preventing people from seeking or receiving adequate treatment for mental disorders. Thus, there are two factors driving the popularity of personal narratives as a core aspect of mental health awareness and anti-stigma campaigns. On the one hand, there is a need to attract funding for the organisation of anti-stigma campaigns which has given rise to the use of personal narratives to raise the profile of the programme and attract donors. On the other hand, the legitimacy of anti-stigma campaigns is strengthened by the use of celebrity stories in its promotional materials. Consequently, we can witness a strong neoliberal agenda underpinning the campaign, where financial concerns encourage the targeted deployment of personal narratives, while these are curated for specific purposes, including the reproduction of anti-stigma knowledge that is rooted in psychiatric understandings of mental distress.

6.3.1. Sustaining bio-medicalisation

An important consequence of the use of personal narratives as technologies of governance in TTCG is that stories are curated to affirm the validity of psychiatric knowledge. In the personal narratives that are shared on the TTCG website (TTC n.d.-c), a strong underpinning theme is the importance of receiving a psychiatric diagnosis. This is presented as leading to feelings of 'salvation' and peace. It is also via a medical diagnosis, that stigma can be supposedly tackled. Quotes from three different stories that are highlighted by TTCG provide further insight into the discourse that is promoted through personal narratives:

> 'The diagnosis of bipolar eight years ago was a huge relief because I finally knew what was wrong with me. I was so relieved because I said – ok, so I am not lazy, I'm not erratic, I'm not unfocused. I'm sick.' (TTC 2019a)
>
> 'My diagnosis has helped me to accept what's going on. All I asked for from my friends was to be treated the same way.' (TTC 2017)
>
> 'If they get a newcomer at their prayer camp, they should diagnose that person. If the person needs injections or tablets, they should give them to the person… while they pray with them.' (TTC 2019b)

In these stories, psychiatric diagnosis is foregrounded as a key to the path of acceptance, recovery, and de-stigmatisation. As the above examples illustrate, the relatively short stories that are highlighted on the TTCG website are uncritical of psychiatric diagnosis. On the contrary, the receiving of a diagnosis is embraced and viewed as a path forward to recovery. It seems that it is only the stigmatising views of the persons' families and communities which continue to be an obstacle. The final narrative is provided by Bernard, a Ghanaian man who talks about his experiences in a prayer camp. He was sent to this camp by his family who hoped it would be a place of healing. Instead, Bernard reported that he was beaten and coerced into praying for hours at length. The story concludes with Bernard saying that there is opportunity for traditional and 'orthodox medicine to work hand in hand' to mitigate the harm of prayer camps. As the above quote illustrates, Bernard's story also legitimises the forced injection or prescription of psychiatric pills at prayer camp. Hence, the story frames the involuntary treatment of individuals at a prayer camp as inhumane while suggesting that, although equally involuntary, psychiatric treatment is a justified means of intervention.

Thus, the narrative in TTCG frames the mental health service-user and survivor movement in non-Western nations as a collective that almost unequivocally embraces the psychiatrisation of their mental distress. Moreover, the cause of stigma is firmly posited within both the interpersonal realm and within the cultural traditions of non-Western countries, thereby framing them as less educated than populations in Western nations. While anti-stigma campaigns in the West are also implying that the public holds ‘incorrect’ assumptions about mental illness, this is not framed as a cultural phenomenon that stems out of a population’s religious and societal dispositions, but as consequence of mere misconceptions about the ‘true’ nature of mental distress. Thus, it is the traditions and culture of non-Western countries that are posited as in-need of intervention through anti-stigma campaigns.

In addition to the apparent universal endorsement of bio-medical approaches to mental distress, the above stories also offer an insight into the hierarchies of knowledge production. Psychiatry and Western medical frameworks are presented as effective solutions to inadequate treatment. However, the long harmful history of psychiatry, particularly through its psychiatrisation of colonised peoples, is disregarded. This reaffirms hierarchies of knowledge production, where Western knowledge about mental health is framed as superior to the knowledge of non-Western populations. As demonstrated by Summerfield (2012: 523), the project of Global Mental Health is already underpinned by ‘the globalisation of Western psychiatric categories’ whose proponents assume that ‘mental disorder can be seen as essentially outside society and culture’. The claim of psychiatry is based on the supposed superiority of the ‘scientific’ methodology that constitutes its knowledge base (Rose and Kalathil 2019). Thereby, indigenous and alternate knowledges are dismissed, or at most considered to be ‘psychiatric diagnostic equivalents’ (Summerfield 2012: 524, see also Fernando 2017; Rose and Kalathil 2019). King (2016: 76) also highlights the Whiteness of psychiatry in this context, where the ‘behavioural conditioning of whiteness’ in psychiatry is reflected back onto non-White bodies as a pathology, a psychosis. The anti-stigma discourse in TTCG, and the voices which are deliberately shared, are thus reminiscent of these critiques, and particularly palpable becomes the omission of any attention to structural inequalities.

Instead, the above narratives highlight the need for non-Western populations to embrace psychiatric knowledge and Western understandings of mental health. What is more, the personal stories that are shared by TTCG all centre in on stigma as being embedded within cultures, not just individuals. This suggests that the politics of anti-stigma intersect with racist structures in the realm of international global governance, where alternate knowledges are routinely dismissed.

Finally, the personal story of Edwin epitomises the process of knowledge production of TTCG perfectly. Speaking of an event where he met with other members of TTCG from Ghana, India, Nigeria, and Uganda, Edwin concludes:

> 'This event in my home city of Nairobi brought together five different cultures and languages, but the most inspiring thing was that we all found a common language, the language of anti-stigma. This language knows no race, religion, gender, creed, or political allegiance. This common drive to end mental health stigma, bound us together as Champions and friends. We are moving forwards together to change the world.' (TTC 2020b)

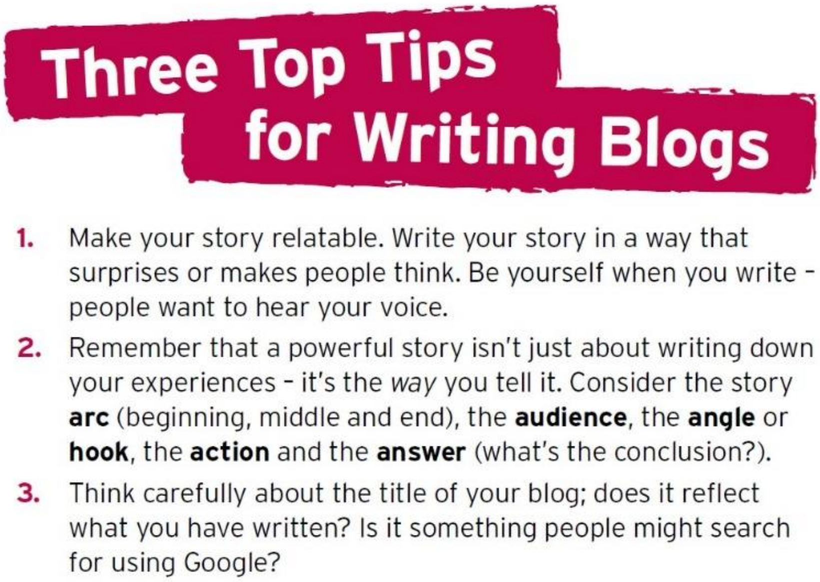
Edwin's words are not only reminiscent of Guterres' (2018) insistence that changing attitudes to mental health 'can change the world', but they demonstrate very clearly that TTCG attempts to promote a universal understanding of mental illness and mental health stigma. It is only through a universalisation of mental distress that psychiatric frameworks can continue to be applied across the globe with little regard for alternate systems of knowledge. What is more, communities and cultures are configured as spaces for interventions in which psychiatric solutions can be 'applied', meaning that populations are framed as 'passive recipients of services' (Bayetti and Jain 2018: 228) or are encouraged, as in Edwin's case, to mobilise using a particular anti-stigma vocabulary. However, the interactions between people receiving psychiatric aid and the processes of medicalisation that they experience are complex. It is in the spaces where psychological explanations fail to capture the mental distress of non-Western populations that meaningful discourse emerges (Orkideh 2016, 2018). The idea that anti-stigma is a 'common language' that unites different cultures only reproduces hierarchies of knowledge and racist assumptions that non-Western populations can be 'bound together' by a 'true' conceptualisation of mental health and stigma.

Consequently, I argue that the personal stories on the social media of TTCG are curated narratives because they are chosen and edited deliberately to uphold a neoliberal understanding of stigma. Moreover, the focus on psychiatric diagnoses legitimises the expansion of psycho-pharmaceutical interventions from Western nations, which have been shown to provide 'modern mental health care on the colonial archetype' where colonial histories have ‘entrenched themselves as medical’ (Davar 2014: 277). Thus, personal stories are not only curated in the name of neoliberalism, but they uphold the problematic hierarchies of knowledge in international politics. The use of personal stories in anti-stigma campaigns relies on the cooperation of service-users and survivors, and volunteers are now increasingly trained to tell their own stories on social media, under the guidance of TTC.

6.3.2. Training for anti-stigma

In 2015, TTC launched its first ever StoryCamp, a free workshop that is designed to give people ‘the tools’ they need to share the story of their lived experience effectively. The workshop has since been run annually, including in 2020, although that year it was facilitated through a virtual seminar series and a moderated Facebook group. StoryCamp is accompanied by *The Little Book of Storytelling* (TTC n.d.-h), a workbook that is made available to the attendees of the course, and which provides insight into the politics of storytelling at StoryCamp.

Firstly, the workbook emphasises the need to tell a story which is relatable to others. Thus, while people are encouraged to ‘be yourself when you write’, they are also asked to ‘write your story in a way that surprises and makes people think’ (TTC n.d.-h: 4). This includes the deliberate choice of the title of a blog, but also the careful curation of a story arc that corresponds with the target audience. The workbook provides information about how to write an interesting story and lists different blog formats that can be followed, with the reader being directed to examples of stories on the TTC website as templates. What is more, pictures to accompany mental health stories can also be taken from a pre-approved TTC image gallery. Thus, it appears that ‘being yourself’ is only encouraged when this leads to the outcome of a powerful story that can eventually be featured on the TTC website.



Three Top Tips for Writing Blogs

1. Make your story relatable. Write your story in a way that surprises or makes people think. Be yourself when you write - people want to hear your voice.
2. Remember that a powerful story isn't just about writing down your experiences - it's the *way* you tell it. Consider the story **arc** (beginning, middle and end), the **audience**, the **angle** or **hook**, the **action** and the **answer** (what's the conclusion?).
3. Think carefully about the title of your blog; does it reflect what you have written? Is it something people might search for using Google?

Figure 6. Excerpt from StoryCamp workbook

Secondly, the workbook highlights the need for narratives to be as concise and as well thought-out as possible. In a page that provides tips for doing media interviews, the following advice is provided:

> 'During the interview, be concise with your answers. Think of all sentences as "sound bites". Breathe and smile – both will instantly make you feel relaxed and slow down your speech.' (TTC n.d.-h: 3).

Additional tips for media interviews include practicing speaking about mental health in front of the mirror and conducting a mock interview with someone from the *Time to Change* media team. I argue that TTC is guilty of pushing for a sanitised version of person's story. The suggestions that smiling helps people feel relaxed is particularly problematic, as it also implies that someone who is sharing a personal story about mental distress should be or feel relaxed in the first place. This is another feature of the aspect of neoliberalisation in anti-stigma campaigns and mental health governmentality that I have already explored in this thesis. Despite feelings of mental distress, people are prompted to behave as though they are feeling well, thereby emphasising the responsibility of the individual person in changing her behaviour and the supposedly cathartic nature of lifestyle choices in determining the level of a person's wellbeing. What is more, the sanitisation of personal narratives in TTC is closely related to the reproduction of sanist practices in public health awareness campaigns, where the media is challenged to ‘correct’ its representation of mental health, despite there being a wide range of experiences of mental distress (McWade 2019). Hence, the use of personal stories can in itself reproduce the stigmatising discourse of psychiatry, while cloaked as ‘true’ stories by service-users/survivors.

TTC is very clear that it should be the individual story that is at the forefront of media stories, not the campaign, as the section of media interviews finishes with the warning that, ‘whenever you speak to the media, you are there to share your story and not act as a “spokesperson” for Time to Change’ (n.d.-h: 3). With this final piece of information, TTC alleviates itself of the responsibility for the stories people share. The personal narratives are presented as authentic (because they are not communicated by an official spokesperson), and service-user/survivor-led, even though the campaign clearly provides instructions on how to tell stories. The skill of ‘storytelling’ finds its place alongside the neoliberal ‘competencies’ that I explored earlier on in this thesis. Resilience, self-care, and self-management are all aspects of the neoliberal toolbox of subject-making that are promoted in the discourse of TTC. Storytelling is another way to perform anti-stigma, but there is an explicit effort to involve people with mental illness. I argue that this is a way to prevent potential criticisms of TTC for not involving service-user/survivors, while my analysis shows that the narratives which are used in the promotion of campaigning sustain the current governmentality.

Consequently, the use of personal stories in TTC is subject to a variety of methods that curate the narratives into tools for the campaign. On the one hand, we already know that stories are only shared by TTC when they re-articulate the campaign’s conceptualisations of stigma, anti-stigma, and mental illness. This became evident when I was not able to find any stories shared by the campaign that contradict the usefulness of a psychiatric diagnosis or that draw attention to the impacts of austerity of governmental policies as a cause for mental distress. On the other hand, the campaign co-opts the lived experience of people with mental distress by offering people training in storytelling. The neoliberal subject, as a continuously produced entity, can thus also be found in the personal narratives about anti-stigma, where people are conditioned to tell their stories in an approved manner.

6.3.3. Stories of demanding numbers

In this thesis I have already explored the ‘seductions of quantification’ that are endemic to the ways in which mental health stigma and the effects of mental illness are ‘measured’ and framed in the public consciousness (Merry 2016). The politics of the narrative of ‘1 in 4’ and the fraught way in which the ‘success’ of TTC have been communicated has exemplified the dangers of attempts to quantify experiences of mental distress and mental health stigma. Further critiques (Maben et al 2009) have drawn attention to the use of numeric indicators in clinical settings. As Maben et al (2009: 10) remind us,

> ‘the target driven atmosphere of contemporary clinical care acts both as an impediment to, and a defence from, proper consideration of the patients experience’.

The voice of those that are working in clinical settings of psychiatric care has been shown to be influenced by the setting of numeric targets. Rizq (2014) compliments Maben et al’s (2009) argument by showing that modern interventions like the Improving Access to Psychological Therapies programme, incentivise mental health staff to prioritise the meeting of targets over their duty of care. The concern about subjugated voices is also a Foucauldian one, who emphasises the need to recognise

> ‘knowledges that have been disqualified as nonconceptual knowledges, as insufficiently elaborated knowledges: naïve knowledges, hierarchically inferior knowledges, knowledges that are below the required level of erudition and scientificity’ (Foucault 2004a: 7).

While Foucault refers explicitly to the knowledges of psychiatric patients in this paragraph, his ideas can be extrapolated to the dismissal of indigenous and local knowledges in the global politics of mental health. As I have demonstrated in this chapter already, critics of GMH (Davar 2014; Summerfield 2012, 2013; Timimi 2011) have also drawn attention to the dismissal of alternate conceptualisations of mental illness in the governance of global mental health.

I argue that the quantification of mental distress at the level of global governance worsens the subjugation of alternate/indigenous knowledges, because quantification adds an additional layer of supposed scientificity, but this time through statistics. By insisting on the use of numeric indicators in the attempts to measure the impact of mental illness and mental health stigma, the knowledge base of Western institutions is prioritised (Bemme 2019).

Western countries often have a greater scope in determining global indicators because these 'tend to build on models that were developed in more affluent and statistically advanced societies where resources are available to gather and analyse data' (Merry 2016: 173). Moreover, global indicators have a tendency to present data in a context where interventions are not necessarily hindered by monetary constraints or political upheaval. In the context of mental health, it is a reduction in the economic cost of the 'burden' of mental illness that is at the centre of global efforts (WBG 2016). Indicators are intrinsically tied to the perceived cost-effectiveness of healthcare services.

Adams (2016: 226) points us to a further complication in the use of metrics in global health, arguing that metrics can be a type of 'violence of erasure', especially 'when the numbers are held hostage, not only to advance political goals, but to obtain funding'. In other words, metrics and numeric indicators do not always present an accurate picture of the state of healthcare because they are subjected to political processes that determine how these numbers are produced. What is more, metrics in the realm of global health politics constitute a form of violence in that the reaching of targets set by non-Western nations is often a pre-requisite for additional financial and humanitarian aid. The role of anti-stigma campaigns in achieving this goal, as I have demonstrated in previous chapters, is primarily to de-stigmatise compliance with psychiatric interventions, be it the taking of pills or the acceptance of a diagnosis. This is viewed as particularly important for non-Western populations, as the personal narratives in TTCG show. Hence, anti-stigma thinking at the global level occurs at the intersection of neoliberal modes of governance with the continued colonisation of knowledge about mental health by Western nations.

To be clear, the goal of global mental health governance is to help reduce the economic costs of mental illness. This aim coexists with a general neoliberal desire to reduce the costs of welfare provisions and to legitimise austere conditions. Anti-stigma campaigns play a very important role in shifting responsibility for mental distress to the individual, a process that allows for the further defunding of mental health services, while at the same time de-stigmatising the occurrence of mental distress under capitalism. In the realm of global health governance, anti-stigma campaigns are additionally important because they re-articulate the neediness of non-Western nations. Thus, the anti-stigma narratives of TTCG echo a Western dream of cost efficiency that does not account for cultural differences or alternate knowledges. Fernandes (2017: 1) emphasises the point by arguing that

> 'nonprofit storytelling and advocacy storytelling are increasingly defined by a business model that emphasizes stories as an investment that can increase competition positioning, to help build the organization's portfolio, and activate target audiences.'

This means that personal narratives constitute little more than a tool to be used in the discourse of anti-stigma campaigns. In the absence of sufficient funding from governments, advocacy groups are also increasingly drawing on stories to attract donors (Costa et al 2012; Merry 2016). Crucially, at the centre of global anti-stigma campaigning lies a concern with the economic benefit of the campaigns, either in running a low-cost public health programme, or in reducing the strain on mental health services and the number of people who are absent from work due to mental distress. With GASA calling for the evaluation of anti-stigma programmes through quantifiable targets, we witness the 'seduction of quantification' at work. Little consideration is given to the idea that it may, indeed, not be possible to measure wellbeing or stigma, let alone measure the change of these phenomena. However, the neoliberalisation of global health governance demands that the healthcare systems of countries can be classified and ranked, including at the level of mental health and mental wellbeing. The global capitalist economy equally requires that human wellbeing is measured in its relation to economic productivity and output. As a consequence, anti-stigma campaigns fulfil an important role in that they help reduce the costs of welfare provisions by de-stigmatising the commodification of mental health, promoting resilience and recovery models, at the same time as 'measuring' public attitudes about mental health.

6.3.4. The limits and politics of lived experience

As the stories of mental health service-users and survivors around the globe are narrated in a way that largely reproduces the current hegemony of marketised care services and psychiatric diagnostic frameworks, there has been a rise in critical voices that highlight the limitations of such an approach (Costa et al 2012; Voronka 2016a, 2016b, 2017). It is not only the curation, or manipulation, of stories that can be scrutinised, but the very concept of 'lived experience' as a pure or apolitical component needs to be interrogated. There is a danger that assuming a lived experience reflects some essential truth because this fails to acknowledge the wider structural factors that make up that experience. It is therefore important to understand that lived experiences are subjective, embedded within subjectivity, and it is not possible to arrive at any essential truth about mental distress. Voronka's (2017) extensive research as a peer worker and service-user points us to a crucial insight, namely that inclusionary practices, whether of people or of their stories, continue to be entangled within a complex web of interests that can ultimately sustain the dominance of psychiatric and neoliberal frameworks.

The involvement of service-users and survivors in mental health advocacy has not only occurred via the promotion of stories and increased representation, but through the emergence of the 'peer worker' as a key stakeholder. Voronka (2017: 334) argues that over the recent decade Western nations have begun to view the incorporation of 'people with lived experience' as a 'best practice' in mental health, social and disability work, thus creating a form of affective labour. Affective labour, although varied in its conceptualisation, is based on interactions between people that are productive of relationships and emotional responses (Oksala 2016). If we understand peer support work as a type of labour that is both precarious and affective, we can come to recognise the importance of peer workers in the context of mental distress where relationships between patients and professionals are paramount. To witness the inclusion of a peer within this system can have important consequences for the experience of mental health care. Voronka (2017: 335) summarises her reflections on peer work in Canada like this:

> 'Through our performance as peers, we realize the goal of neoliberal biopolitical projects by embodying the tenets of normative citizenship: by managing ourselves and others, and most important, by getting back to work'.

As such, even the inclusion of mental health service-users and survivors as peer workers prompts a process of neoliberal subjectification. It seems that a neoliberalisation of the modern mental health subject is inscribed into the narrative of anti-stigma thinking, even if campaigns and services, who are so keen to appear bottom-up, draw on the experiences of service-users and system survivors. Stories and inclusionary practice may not suffice if meaningful change is not brought about on a structural level. As I have highlighted throughout this thesis, structures are far from unchangeable, but they may continue to appear so, if the individual practice and performance of inclusion are perceived as sufficient.

For the labour that is part of anti-stigma work, a similar problematisation is useful. Where and how stigma occurs continues to be a field of contestation (see Chapter 4), despite the insistence in the discourse of TTC and TTCG that it is an individually, or even culturally, determined phenomenon. With stories by service-users and survivors presented as endorsements of the campaign, we come to witness both a curation of their narratives and the co-option of lived experience within the framework of psychiatric meaning-making. Bio-medical explanations rely on the concept of an essential anatomy or scientific truth. This means that the inclusion of lived experience in this framework risks further essentialisation of mental distress. And yet, we can understand that lived experiences as 'discursive processes do not deprive agency' because their exploration opens up room for the interrogation of the structural relations – such as race, class, sexuality, or gender – which are determinants of these experiences (Voronka 2016a: 195).

In sum, one of the key concerns about the inclusion of service-user and survivors is that their apparent inclusion does not guarantee or necessitate the changing of harmful structures. On the contrary, research (Costa et al 2012; Martin 2007; Rose and Kalathil 2019; Voronka 2016a, 2016b, 2017, 2019) has demonstrated that stories and their narrators are almost exclusively allowed to work within the pre-defined boundaries of dominant mental health service provision and knowledge, thus perpetuating the tyranny of neoliberal care. In order to engage meaningful change, it is thus imperative to insist on structural reform, even if the governmentality of neoliberal capitalism continues to be resilient in unexpected ways (Mavelli 2017).

6.4. Conclusion

In this chapter I have analysed the use of personal stories and narratives in the discourse of anti-stigma campaigns, with a particular emphasis on the *Time to Change Global* programme. At the centre of my analysis was an attention to the curation of stories for specific purposes. I argued that personal narratives in TTCG and TTC serve to uphold the ubiquity of psychiatric knowledge of mental health. Moreover, I have shown that efforts to 'de-stigmatise' mental health through storytelling are reminiscent of colonial pasts that elevated Western knowledge over indigenous and local ways of knowing about mental health (Davar 2014; King 2016; Rose and Kalathil 2019; Summerfield 2012, 2013). I argued that storytelling in anti-stigma campaigns is both a technology of governance to legitimise global hegemonies and an important technology by which neoliberal subjectivities are produced.

In the first section of this chapter I provided an introduction to the global politics of mental health awareness and anti-stigma campaigns. I demonstrated that the concept of 'anti-stigma' has become a firmly embedded aspect of the governance of mental health, particularly at the level of global institutions. I also showed that TTCG is an extension of the British desire to become a 'global leader' in mental health. To this end, I introduced the divisive politics of the 2018 Global Mental Health Ministerial Summit. Despite mounting criticisms by service-user/survivor networks (NSUN 2018a, 2018b) in the UK, the Summit served to position the UK as a global leader in the governance of mental health. The fight against mental health stigma and the management of mental distress worldwide are thus exposed as aspect of foreign politics and as embedded within the neoliberalisation of mental distress in the global sphere.

In the second section I interrogated the discourse in TTCG, which is largely communicated via personal narratives. The personal stories that are shared in the TTCG programme are all 'success' stories of individuals from non-Western countries who were diagnosed with a mental illness after experiencing stigma from the local community. I showed that psychiatric diagnosis is thus endorsed as an anti-stigma action, where the relief of a diagnosis supposedly serves to de-stigmatise the mental distress of an individual. Moreover, I demonstrated that TTC's StoryCamps are a means by which personal narratives are shaped to fit the media strategy of the campaign. By 'training' people, mental health storytelling is presented as a skill that can be developed and is thus an essential aspect of the neoliberal subject-making in anti-stigma campaigns. In the following section I traced the relationship between personal stories, anti-stigma lobbying and the global political economy of health. I argued that the quantification of the impact of mental illness and mental health stigma reproduces knowledge hierarchies at the global level because non-Western countries tend to have less influence on the setting of indicators. The setting of numeric targets will always prioritise Western nations, because the indicators represent the desired outcomes for Western nations, which are rooted in psychiatric understandings of mental health (Merry 2016; Davar 2014). I concluded this chapter with a reflection on the limits of using service-user and survivor narratives as lived experience by drawing on work by Voronka (2016a, 2017, 2019) to demonstrate that we must restrain from viewing their narratives as apolitical. While stories may be curated for the purpose of anti-stigma campaigning, their own subjectivity is embedded within discourses that exist prior and in addition to these mental health awareness efforts.

In sum, this chapter concludes my analysis of the *Time to Change* and *Time to Change Global* programmes. I have shown that the global extension of TTC further enshrines the dominance of psychiatric knowledge in the politics of anti-stigma advocacy. In doing so, personal narratives are appropriated for the promotion of essentialising knowledges about the causes of mental distress. This perpetuates the false assumption that stigma is both interpersonal and primarily functions on the level of the individual. It appears to me, that there have been no significant changes in anti-stigma and mental health awareness campaigning since the inception of the *Defeat Depression* campaign in 1992. To this day, the discourse of mental health stigma is largely uncritical of the socio-economic structures that have been shown to cause mental distress. Through its incorporation in the globalising agenda of mental health politics, anti-stigma campaigns perpetuate problematic global hierarchies and hegemonies of knowledge production. The ‘changing of minds’ is at the forefront of anti-stigma interventions, but my analysis has shown that interventions at the individual level are primarily designed to benefit the legitimisation of neoliberal modes of governing mental health.

7. Conclusion

My aim in this thesis has been to make sense of the growing interest in the 'de-stigmatisation' of mental illness and to investigate the role of anti-stigma as a discourse in mental health awareness campaigns. I have used as examples three different anti-stigma mental health campaigns in the United Kingdom and one global campaign in order to provide a genealogy of contemporary anti-stigma knowledge and politics. The driving query of my research was to understand what knowledge about mental illness and stigma is produced in the discourse of these initiatives. What I have found is that the anti-stigma discourse reproduces bio-medical understandings of mental distress and its treatment. What is more, the discourse is productive of neoliberal subjects that are self-disciplined and encouraged to perform anti-stigma through developing resilience and the practice of self-care. This is facilitated through a process of individualisation where the subject's body/mind is the locus of pathology and the individual person is burdened with the responsibility to combat mental health stigma. I have revealed the stigma discourse to be limited to a notion of interpersonal stigma which is supposed to stem from 'incorrect' knowledge about mental illness. The consequence of these processes of subject-making and knowledge production is that the impact of structural inequalities and the organisation of the global political economy are underestimated as drivers and beneficiaries of mental health stigma.

At the beginning of this thesis I quoted the secretary-general of the United Nations, António Guterres (2018), who proclaimed that changing our 'attitudes' to mental health 'can change the world'. The significance of this quote has only revealed itself to me slowly over the course of writing this thesis. Public attitudes are rooted in the knowledge that is normalised as the status-quo in society. Thus, changing attitudes requires a shift in knowledge through the deliberate deployment of discourses over time. This is precisely the aim of global mental health governance, the targeted construction and maintenance of knowledges that produce subjects who are compliant with the status quo. Guterres' speech was intended as a warning, that if we do not start changing our attitudes, mental health problems threaten to overwhelm the progress of our societies. The findings of my research echo the need to pay close attention to the attitude with which we approach the issue of mental health. Only, my warning stands in stark contrast to that of Guterres. I have sought to demonstrate that we must instead be cautious of the normalisation of mental distress under neoliberalism, where de-stigmatisation is a process that encourages us to be more comfortable with the idea that mental illness is just a normal part of life and that we can expect to experience it. While mental distress may be an aspect of the human condition, with all of us set up to experience grief and loss at some point, what role do the socio-economic conditions of our lives play during, and as perpetuators, of the experience of mental distress? To what extent is the capitalist zest for economic growth causing us mental distress, which is then pathologised to make it a legitimate site of medical (and political) intervention? These are some of the more uncomfortable questions that I am left with at the end of this project. My interrogation of anti-stigma campaigns revealed them to be more embedded within neoliberal modes of governance than I had first anticipated, leading me to highlight the symbiotic relationship between psychiatry and neoliberalism in the realm of anti-stigma, where the focus on mental health 'awareness' is successful primarily in shifting awareness *away* from the structural socio-economic inequalities that constitute modernity.

In this conclusion, I now reprise the arguments of my research and reiterate the original contribution of this thesis. Secondly, I reflect on the future usefulness of employing a Foucauldian framework to the study of global mental health politics, highlighting the potential for conceptualising resistance that lies in Foucauldian theory. I also highlight the consequences of my argument for research and activism going forwards, both in terms of resisting the current state of anti-stigma campaigning and in identifying future opportunities for research. Finally, I contextualise this thesis within the emergence of the COVID-19 pandemic, which has brought mental health awareness politics to the foreground, and which emphasises my insistence on problematising the dominant discourse on mental distress.

7.1. The false promise of anti-stigma

My engagement with the global politics of mental health began with the observation that the stigma of mental illness is increasingly framed as an obstacle to the improvement of mental health services around the globe. This has led to a rise in public health interventions concerned with the de-stigmatisation of mental illness, two of which I analysed in Chapter 3. I thus sought to understand better how knowledge about mental illness and stigma is produced through the discourse in mental health awareness and anti-stigma campaigns. In doing so, I have revealed anti-stigma to be a discourse that is both produced and productive of subjectivities. Its contemporary meaning is epistemically determined at the intersection of psychiatric knowledge and the needs of a neoliberal state. In my examination of the *Time to Change* campaign I referred to stigma as a contested concept. To reiterate, its contestation begins with a definition of stigma that reduces the concept to an interpersonal phenomenon. As I have demonstrated in Chapters 4 and 5, TTC is designed to intervene at the level of individual relationships because its conceptualisation of stigma does not extend to an analysis of structures. The omission of structural stigma is an important factor in assessing the politics of mental health awareness because it is indicative of vested interests by those who benefit from the current hegemony. In other words, the individualisation of mental distress and the stigma of mental illness, shift the focus of intervention to the individual level. The consequence of this is that the state is not expected to change the provision of welfare, but it is the citizen who must alter her behaviour for improvement. This logic is deeply neoliberal because it essentialises responsibility in individual persons. Thus, the current mental health governmentality is premised on an individualising discourse which reproduces neoliberal logics and normalises the experience of mental distress as an individual pathology through the deployment of an anti-stigma discourse.

7.1.1. Anti-stigma as technology of (neoliberal) governance

In the first instance, I have revealed the production of knowledge about mental health stigma and anti-stigma to be a technology of governance. The discourses of the analysed campaigns all promote the self-management of mental distress by the individual. This serves to alleviate the state from responsibilities regarding welfare provision and re-articulates psychiatric notions around individual pathology. The confusing set-up of mental health care services is one of the reasons that patients seek to manage their own mental health problems (Brijnath and Antoniades 2016). Ambiguous rules for leaves of absences at work or university and the long waiting times to receive talking therapy treatment are also instrumental in driving the pharmaceuticalisation of mental health. It is easier for patients to adhere to regimes of pill-taking in order to manage the consequences of their distress than to fully engage with the mental health care system. In the long term, this produces patients who no longer expect the state to provide the necessary healthcare and who have learned ‘to cope’.

Thus, we can witness the emergence of the neoliberal subject in the absence of adequately funded welfare provision.

Crucially, anti-stigma campaigns promote this discourse of individualisation and self-management through narratives that emphasise the importance of 'resilience' and 'self-care' for mental health problems. The de-stigmatisation of mental illness is thus implicated in the promotion of neoliberal values which, ultimately, are of benefit to the neoliberal government and the interests of pharmaceutical companies. As a technology of neoliberal governance, discourses of anti-stigma are therefore implicated in the legitimisation of the current capitalist hegemony that demands continuous productivity of the labour force and economic growth. Moreover, I have shown that technologies of surveillance play a crucial role in the production of neoliberal subjectivities. For example, anti-stigma campaigns call on the public to ask their friends and family about mental health by starting conversations. The TTC website has several pages dedicated to providing people with conversation starters. Under the banner of #AskTwice, people are tasked to perform the role of observer for other people's moods. This positions the individual person as a key performer of anti-stigma knowledge.

The performativity of anti-stigma is also articulated through the increase in mental health awareness days in the annual calendar. The flagship initiative of TTC, the Time to Talk Day epitomises this thinking by solely serving to remind people to have conversations about mental health, this being the key aim of the awareness day. Consequently, the awareness of mental health is posited as the main goal of public health campaigns, without offering solutions for improving the care once someone is seeking help (Purtle and Roman 2015). When I speak of anti-stigma as a technology of neoliberal governance, I thus expose the ulterior effect of its deployment in mental health awareness campaigns. It appears not only that awareness itself is valued over the need to interrogate the object of awareness, but that the process of de-stigmatisation is largely productive of subjects who are encouraged to stay in work, albeit while talking about their mental distress.

7.1.2. Anti-stigma as narrative

Personal stories have been an important part of the organisation efforts by mental health service-users/survivors, but they have gained popularity also within the promotional efforts of public health programmes (Costa et al 2012; Voronka 2017a, 2017b). I have thus sought to highlight the ways in which mental health stigma has become a story that is communicated as a 'cautionary tale' to the public. Likewise, stories of successful anti-stigma lobbying contribute to a narrative where the 'correct' engagement with anti-stigma programmes and education about mental health is hailed as an antidote to the burden of mental health stigma. Specifically, stories of anti-stigma have become a technology of governance through their targeted use as promotional tools to elicit a change of public attitudes, rather than being instruments for societal or governmental transformation, as intended by mental health service-users/survivors.

The disciplinary power of storytelling was the focus of my attention in an analysis of personal narratives in Chapter 6. I analysed the personal stories that are promoted by the *Time to Change Global* campaign and have revealed them to be reproductive of essentialising the experience of mental health stigma. It is no co-incidence that storytelling is a common tool in the global campaigning for anti-stigma. In the sphere of the global we can witness the reduction of personal narratives to a set of manipulatable data serving the agenda of hierarchical modes of governing mental health. This reminds us of the colonial past of psychiatry (Fanon 2008; Fernando 2010) and the continuous reproduction of colonial governance in international development programmes today (Davar 2014; Rutazibwa 2018). Crucially, an underpinning current of TTCG is the notion that the experience of mental health is universal and thus universally diagnosable and treatable via psychiatric frameworks.

In the United Kingdom, the *Time to Change* campaign also relies on personal narratives to promote its message. I have drawn on a variety of examples throughout my analysis to show that stories are presented in a way that allows TTC to re-articulate individualising and bio-medical knowledge of mental distress. TTC does not promote narratives that reflect the desire by service-users/survivors to resist the current welfare paradigm, despite abundant evidence of powerful counter-narratives in user and survivor-led movements across the UK (Fleming 2017; Grzanka and Mann 2014; Matthews 2019). I argued that this constitutes a deliberate 'curation' of stories in the discourse of anti-stigma campaigns, where shared narratives unequivocally support the dominant psychiatric framework of mental distress. In doing so, I have demonstrated that understanding anti-stigma as a narrative is possible through an examination of the stories that are told as part of the campaign's social media presence, even more so because these stories are selected for the sole purpose of their promotion.

We can speak of the ‘curation’ of stories because they are narratives that are deliberately deployed to communicate neoliberal values, such as self-management, resilience and the importance of individual lifestyle choices in the causes of mental distress. The recent running of the online workshop StoryCamp (see Chapter 6) further illustrates the importance that TTC attributes to the telling of personal stories. TTC clearly sees a need to instruct people in a workshop on how to ‘improve the impact’ of their stories. These are only some of the tropes situated in the genealogy of anti-stigma discourse, as my historicisation of the concept has shown. Crucially, the significance of this narrative is yet more visible when we come to know the processes of subjectification that occur in its deployment.

7.1.3. Implications for anti-stigma research

My findings in this thesis have important consequences for future academic research into mental health stigma and anti-stigma. Firstly, I have shown that it is imperative to shift away from attempts to ‘measure’ discrimination or stigma. As I have demonstrated throughout this thesis, the quantification of public attitudes has led to the manipulation of meaning by the evaluators of TTC and the overuse of statistical methods sets a problematic precedent for ‘indicator-setting’, where the meeting of numeric targets is valued over the duty of care.

Secondly, research on mental health stigma would benefit from a thorough engagement with the long history of sociological critique on the concept of stigma. My research has shown that such an engagement challenges the very foundations upon which anti-stigma campaigns base their assumptions. Therefore, further research on mental health requires a framework situated within the knowledge gained from the social sciences and the varying debates about the causes and purpose of stigma in society. What is more, since stigma can be shown to be rooted in colonial pasts through the physical labelling of Black ‘others’, there is a very strong need for any future research to address the racialised ways in which knowledge about mental health stigma is produced and communicated (see e.g. Tyler 2020). This is particularly important because stigma is also a crucial determinator in the defamation of welfare and benefit claimants (Scambler 2018). I therefore suggest that future research needs to take a multidisciplinary approach to the study of intersecting inequalities in mental healthcare and to provide a more nuanced understanding of stigma as a type of disciplinary power.

Finally, once the structural causes of stigma have been revealed as important contributors to mental health discrimination, there needs to be a conversation about how to create meaningful change. Even if structures are difficult to transform, much more so than individual behaviours, it needs to be the purpose of future research to offer paths for innovation by allowing subaltern voices to be heard and by providing a way forward for genuine user- and survivor-driven reform.

7.2. Original contribution

The work in this thesis makes three important contributions: to knowledge about the politics of mental health awareness and anti-stigma campaigns; to the global health literature; and to the community of scholars and activists that seek to challenge the current mental health paradigm. Firstly, I make a contribution to knowledge about anti-stigma campaigns by demonstrating that the discourse of these programmes is implicated in producing neoliberal subjects. In doing so, I de-familiarise the assumption that anti-stigma campaigns are solely designed for the benefit of those diagnosed with a mental illness. Rather, I expose the discourse to be deployed deliberately to re-articulate an understanding of mental distress that is rooted in bio-medicalism and to uphold the legitimacy of psychiatric conceptualisations of individual pathologies. I have shown that this leads to the individualisation of both stigma and mental distress, thus prompting public health intervention at the level of individual behaviours. The focus on individual behaviour patterns with regards to lifestyle, consumption and reliance on welfare provisions, stems from a neoliberal mode of thinking of and about mental health. Consequently, I provide important insights into the discourse of mental health awareness and anti-stigma campaigns in relation to neoliberal governmentality, drawing attention to the processes of neoliberal subject-making that underpin these programmes.

Secondly, this thesis makes an important contribution to the global health literature because of its empirical insights into the politics of anti-stigma campaigns. Despite the existence of research on the impact of the psy disciplines in the global governance of mental health (e.g Howell 2011; Mills 2014; Pupavac 2002, 2004a) there are few studies that examine the role that mental health awareness and anti-stigma campaigning plays in the configuration of global mental health politics. Especially in the discipline of International Relations, a serious engagement with mental health and mental health stigma as constructions of modernity is lacking. I contend that future critical engagement with stigma can also be used to make sense of the growing stigmatisation of poverty, welfare claimants, and migrants. My thesis thus addresses a gap in the global health literature by embedding the international politics of anti-stigma campaigns within a wider paradigm of neoliberal mental health governmentality. In doing so, I also expose the tendency of International Relations research to focus on more traditional topics and sites of interest, such as conflict and post-conflict societies as well as security studies, a particularly pertinent theme in global health politics research (Elbe 2009, 2010; Youde 2016, 2018). I add to this literature through a study which employs a similar post-structural framework, but is more attentive to public health campaigns, thus broadening the field of empirical possibilities for future research on mental health in IR.

Thirdly, my project is designed to serve as a tool for the growing body of mental health service-user/survivor research that challenges the dominance of 'scientific' studies in dictating the agenda of mental health governance. I hope that my work can help with efforts to strengthen counter-hegemonic knowledges and voices. Thus, this thesis makes a contribution to the community of scholars and activists that are involved in the critique of emerging paradigms of global mental health governance.

7.3. Using Foucault for the study of (global) mental health politics

In this thesis I have drawn on a Foucauldian methodology and theoretical framework to make sense of the emergent mental health awareness and anti-sigma narrative in public health campaigns. I employed this framework cautiously. In Chapter 2, I highlighted important criticisms of the Foucauldian approach, which have caused heated debate in the discipline of International Relations (e.g. Howell and Richter-Montpetit 2019; Weheliye 2014). In particular, the inability of Foucault's framework to understand coloniality as a determining factor in the production of modernity and the process of subjectification in Western societies, stands out as a clear limitation to his thinking. However, when put into conversation with frameworks that are explicitly designed to explore the dimensions of gender, race, and sexuality, a Foucauldian lens is enriched and can be better equipped to engage with the complexity of global mental health. Going forward, I argue that researchers of the global politics of mental health can still gain a lot of insight from Foucault's work. It is perhaps an uncomfortable reminder that even today, it is still the writings by an author who wrote about madness in the middle of the last century, that allow us to grasp some of the intricate power relations that are inherent to the workings of modern psychiatry. Reflecting on the research conducted in this thesis, I offer two pointers on the use of Foucault in the study of global mental health politics.

Firstly, the Foucauldian framework of genealogy is, from its very inception, designed to bring about transformation. Genealogy has been and remains a useful framework for the study of mental health, not least because Foucault's (2006, 2009) own genealogies of madness and psychiatry provide crucial insights into the emergence of psychiatric knowledge vis-à-vis the politics of deviance and punishment. In Foucault's (2004b: 9) own words, genealogy

> 'is a way of playing local, discontinuous, disqualified, or non-legitimized knowledges off against the unitary theoretical insistence that claims to be able to filter them, organize them into hierarchy, organize them in the name of a true body of knowledge, in the name of the rights of a science that is in the hands of a few'.

Reflecting on the legacy of his own work, Foucault (2004b) came to understand the purpose of genealogies as extensions of archaeologies. Because a genealogy is concerned with the relations of power and knowledge in the history of a concept, genealogies help the researcher detect and expose the instances in which some knowledges are positioned superior to others. Showing the continuity of knowledge production allows for an understanding of the 'regimes of truth' that guide the zeitgeist. At the same time, this offers insight into the knowledges that are discontinuous, or 'non-legitimized', and brings to the fore points of contestation. It follows, that 'genealogy has to fight the power-effects characteristic of any discourse that is regarded as scientific' (Foucault 2004b: 9). Genealogy is a powerful framework for the study of mental health precisely because the contemporary discourse is still concerned with maintaining the idea that mental distress can be made knowable through 'scientific' research. In order to counter these narratives, it is necessary to pay attention to the epistemology of mental health, to identify struggles, processes and points of contestation.

Secondly, Foucauldian frameworks can illuminate the relationship between mental health and neoliberalism, between mental illness and the capitalist construction of our societies, despite criticisms that claim otherwise (Mirowski 2013; Zamora and Behrent 2014; Zamora 2019). Foucault's analytical tools can be employed for an analysis of neoliberal subject-making, as demonstrated within this thesis, without needing his work to have provided comprehensive definitions of neoliberalism. What matters is that a Foucauldian framework can be adapted to make sense of the discursive practices of power in psychiatry in its relation to the commodification of mental health. A Foucauldian attention to the discourses of lifestyle and mental wellbeing reveals processes of surveillance and subjectification that form a crucial aspect of contemporary mental health governmentality, thus demonstrating that his frameworks are compatible with an analysis of neoliberalism in mental health.

Thus, a Foucauldian framework remains useful for the study of mental health in the twenty-first century. However, we must acknowledge that the shortcomings of his theory are rooted in the Whiteness of the Western academy, a process which is engrained also in the discipline of International Relations, the foundations of which are based on a 'premature declaration of the end of scientific/biological racism as a prism through which to understand contemporary knowledge production on the (inter)national' (Rutazibwa 2017: 192). Still, I suggest that reading and referring to Foucault can be a useful exercise even for those who are developing frameworks that are more attuned to the exposure of racism and colonial relations in the global politics of mental health. It is Foucault, after all, who rejects the idea of grand theories to explain the world, who zones in on the everyday, and who insists that genealogies serve to disturb our present-day conceptualisations. It follows, that while our present might demand new genealogies and different problematisation, the criticality necessary for these endeavours is compatible with a post-structural attention to the production of knowledge.

7.4. 'So, what do we do now?'

When presenting or talking about my research – at conferences, in the office, among friends – I am almost always asked whether I have any suggestions on how to improve the current state of mental health politics. Since I am levelling a seemingly damning critique at much of the anti-stigma work we encounter in our everyday lives, this question seems justified. In fact, thinking about the future of anti-stigma work and mental health policymaking deserves significant consideration at this point in time, because we are witnessing an unprecedented interest in the consequences that global events (see the below section on COVID-19) have on people's mental health. My answer in this section is guided by the activism that is organised by various mental health service-user/survivor groups and their recommendations for the future of mental health research efforts (e.g. Carr 2019; Costa et al 2012; Faulkner 2017; Rose 2017).

While campaigns like *Time to Change* have made it a priority to utilise the mental health stories of individuals to promote anti-stigma discourse, strong counter-hegemonic voices have emerged from precisely these groups and in different forms. I argue that there are ways to work with(in) the current system and that it is possible to transform the system at the same time, both approaches which can lead to an improvement of anti-stigma work and mental health care. In addition, I want to introduce two further methods of thinking about resistance to the current psychiatric and neoliberal hegemony. On the one hand, there is the promise that survivor-led research can offer us in terms of changing the tone of scientific evidence. On the other hand, the world of fiction, where it is easier to blur the lines in our imagination through stories, has long been able to transform our understanding of what mental illness *is* in the first place.

7.4.1. Re-thinking stigma

The hegemony of the current mental health governmentality can be resisted by transforming the discourse. Challenging the anti-stigma paradigm needs to start with a re-conceptualisation of 'stigma' as an effect not only of the interpersonal, but of the structures of neoliberal governance. Such a critique of stigma can open spaces for new practices, understandings and ways of doing activism. Importantly though, these spaces are not stable or permanent, but they are continually contested just like the notion of stigma. Although the struggle to change parameters of knowledge is endless because it is continually contested, it is also within that struggle that endless possibilities of positive change are found (Mayes 2016). The re-conceptualisation of stigma necessitates a shift in scholarly treatment of the phenomenon, as described in the section above, but it is also crucial for the many volunteers and activists to provide counter-narratives.

We can start by thinking differently about the 'victims' of stigma. As Grey (2016) argues, awareness campaigns tend to victimise the people that are the target of awareness. This is done by presenting the volunteer as a 'benevolent other' who is made to feel good about participating in an anti-stigma event. In that way, awareness campaigns can easily be reduced to initiatives that serve to make those who already feel well feel better, not to help those with mental distress. However, doing so requires a shift in narrative about what stigma, and therefore anti-stigma, means. This shift can be brought about by centring the research and voices of user/survivor initiatives (e.g. Costa et al 2012; Faulkner 2017). Moreover, these voices need to be allowed a central role in anti-stigma activism in order to bring about changes in mental health policy. It is only through the re-conceptualisation of stigma, by taking into account a socio-political approach, that we can identify and address laws and policies that are stigmatising.

To be sure, any shift in stigma narrative is reliant on individual contestation in concurrence with an 'everyday, restless and communal' form of resistance, where the daily habits and choices become the centre of attention (Mayes 2016: 134). We must ourselves begin to re-think our engagement with stigma and mental health awareness, without falling into the trap of thinking of ourselves as 'heroic' in our resistance (Foucault 2004b). The neoliberal rationality of mental health governmentality is too flexible and mundane to respond to individual acts of dissonance. Thus, disciplinary and relational forms of power can only be resisted through a continuous struggle that has at its core a willingness by individuals to challenge long-held assumptions about mental health and to adjust the habits with which we think about the expression of stigma.

7.4.2. Working the system

In order to work with or within the current system, we must be clear about the systems of knowledge and power that we are faced with. Foucault (2006: 55) reminds us that,

> 'A disciplinary system is made so that it works by itself, and the person who is in charge of it, or is its director, is not so much an individual as a function that is exercised by and that person and that could equally be exercised by someone else, […].'

In other words, the individualisation that is the effect of disciplinary power is eliminated at the top of the hierarchical ladder. Even the supervisor is supervised in the systems of knowledge and domination that we work with. This is of consequence for our imagination of successful resistance. If the broader systems, even if represented by individuals, are not under the control of individual people, we must begin our resistance by affecting the ways in which power is distributed. When talking about 'systems', I refer to the intersection between psychiatry as discipline and the neoliberal governmentality that guides the governance of our societies. Psychiatry itself, can be understood as a 'medical, legal, economic and socio-cultural and political system of understanding and intervening' which works 'on the individual body/brain, through frameworks of diagnostic categories that frame distress or difference as pathology' (Mills 2014: 12). In turn, neoliberalism refers to an ordering system of society that requires the individualisation and commodification of lifestyles in its pursuit of economic growth (Eagleton-Pierce 2016). Throughout this thesis I have shown psychiatry and neoliberalism to be intimately linked to the perpetuity of capitalist modes of governance. In their combination, these systems support each other, they increasingly require the existence of the other to uphold their legitimacy, and they constitute the foundation of contemporary mental health governmentality.

Working within 'the system' starts with targeted efforts to improve the available funding for mental health services and psychiatric care in clinical and hospital settings. While the raising of awareness about mental illness can be said to have led to the overcrowding of mental health services (BMJ 2017), another way to understand this phenomenon is to not blame increased awareness, but the lack of a sustainable mental health service infrastructure in the NHS. Even if we disagree with the bio-medical mental health model propagated by psychiatry, there is nonetheless evidence that psychiatric diagnosis and treatment are of benefit to some patients, and that there is a demand for a provision of these services (Tyler and Slater 2018). The harm caused by psychiatric knowledge is greatly amplified through austerity and lack of government funding because it does not allow for comprehensive care plans and restricts staff hiring. Thus, to properly fund mental health care in the UK would be a step forward to mitigate some of the harm caused by negligence, even if the core of psychiatric knowledge remains contested.

Moreover, there is a need to increase the available funding for research on mental health. Only with sufficient funding is it possible for academics and practitioners to explore the more nuanced and less popular strands of psychiatric knowledge, instead of adjusting their research proposals to fit a narrow set of requirements. Faulkner (2017: 504) notes that,

> 'researchers seeking large-scale funding grants from the National Institute for Health Research have to 'play the game' and construct clinical trials with conventional medical outcome measures, even if they wish to explore such things as recovery and peer support.'

As a consequence, clinical knowledge dominates the mental health discourse in psychiatry, even if researchers with practical experience tend to want to explore more closely the implications of medicalised treatment models. Russo (2012) argues that the landscape of funding allocation in the UK means that very little space is given to approaches and theories that challenge the medical model, supporting the reproduction of existing knowledge hierarchies. Thus, altering the governance of knowledge production in the realm of mental health is a crucial step in bringing forth possibilities for meaningful change.

Finally, there is a window of opportunity that is opening through the de-funding of the *Time to Change* campaign. With the British government having chosen to stop funding TTC, apparently without reason provided to the organisational leadership of the campaign (TTC 2020), there is possibility to involve a wider array of people in the organisation of other public mental health campaigns. In the absence of further centrally organised mental health programmes, communities can work to devolve the governance of mental health and adjust them to specific local contexts. Consequently, to work the system requires us to petition for increased spending on psychiatric services at the same time as attempting to dismantle and challenge the knowledgebase on which it is built. This is only possible through harnessing opportunities to petition for more funding, including for the research of mental health service-users/survivors.

7.4.3. Service-user/survivor-led activism and research

Mental health service-users and survivors of psychiatric systems are not only aware of their own oppression and the harmful effect of neoliberal governance, but they are challenging the current hegemony. Resistance from mental health patients has a long history, beginning with revolts and subverting behaviour in closed asylums. Long (2014) describes the story of the Royal Edinburgh Asylum in 1845, where patients were writing an asylum newsletter, the *Morningside Mirror*. In the newsletter, a popular column was dedicated to the fictionalised account of an alternate asylum where patients' behaviours were attributed rationality while the behaviour of psychiatrists was classified as symptomatic of mental illness. In this way, the column held up a mirror to the asylum, questioning its purpose and reversing the established hierarchies of power (Long 2014). In the final contribution of the well-liked column, the superintendent of the asylum, Dr Clouston was imagined going through an admissions procedure himself. He was given the diagnosis to be suffering from 'delusions of grandeur' where he 'thinks he is a medical superintendent. In fact, he behaves just like a medical superintendent' (Long 2014: 34). Upon insistence that he was, in fact, a medical superintendent, Clouston was admitted to the asylum and locked in a room. The story of this column shows that patients subverted hierarchies of knowledge and disrupted the binary of rational/irrational by imagining a reality in which the marker of madness is attributed differently. The voice of service-users/survivors is thus preceded by the attempts of patients and asylum inhabitants to challenge the ubiquity of psychiatric knowledge.

Today, user/survivor groups are organised networks that facilitate user-led research and they openly address the need for examining intersectional issues, such as racism and sexism, that are endemic in the mental health system. Survivor-led activism insists that,

> 'a radical acceptance of a person's lived experience of madness or distress – however difficult, challenging, or painful – within a hopeful relational environment plays a key role in creating the conditions for more hopeful mental health practices' (Spandler and Stickley 2011: 563).

In other words, the lived experience of mental distress can serve to suggest paths for recovery that are in alignment with the needs of the individual, not the rules that are imposed by psychiatry or dictated for the benefit of the economy. Crucially, it is also the collaborative nature underpinning most service-user/survivor research that is viewed as a possible driver of change. For Faulkner (2017: 509) 'peer support' is the 'bedrock of experiential research', where peer groups take on an important role in helping people navigate through the mental health services and funding landscape. In the United Kingdom, the *Asylum* magazine stands out as a publication that is user- and survivor-led and offers a critical lens on contemporary mental health politics. *Asylum*, which has been published since 1986, is 'a forum for free debate, open to anyone with an interest in psychiatry or mental health' and it is run as a collective, organised by volunteers (*Asylum* 2020). The action group National Survivor User Network (NSUN), whose advocacy work we met in Chapter 6, has called for an approach to mental health that opposes funding cuts under austerity and the dominance of the bio-medical model over social models of conceptualising mental distress (NSUN Manifesto 2019). NSUN has been successful in uniting a large group of mental health service-users, survivors, academics, practitioners and volunteers to publicly resist mental health governance in the United Kingdom. But there are more groups in the UK that have organised to facilitate spaces of resistance, including *Recovery in the Bin*, the *Hearing Voices Network*, and *Kindred Minds*. All of these networks are united in their effort to foreground the voices of mental health service-users and survivors, especially those from Black and minority ethnic communities, in order to challenge the status quo of mental health care provision.

7.4.4. Madness as resistance

> 'Is it possible for the production of the truth of madness to be carried out in forms other than those of the knowledge relation? It will be said that this is a fictitious problem, a question that arises only in utopia.' (Foucault 2006: 346)

One final understanding of mental illness, of madness, is to conceptualise it as a possible form of resistance itself. I alluded to this briefly in the first chapter of this thesis, quoting Davies (2016) who suggests that chronic mental health problems are a manifestation of labour refusal in the absence of possibilities for violent and public revolt. However, the notion that mental distress can be a form of resistance, is also found elsewhere. For example, there is a growing body of literature on the politics of suicide pointing us to the possibility that taking one's life be a deliberate act (of defiance) rather than merely a symptom of a mental disorder (Case and Deaton 2020; Michelsen 2017; Mills 2018). Moreover, Rogers-Vaughn (2014: 519) has argued that depression can be a form of political resistance where mourning and sadness constitute a response to the 'the veiled oppression of today's global hegemony' which at the same time gags 'the voice of despair' to cover its own tracks. The 'gagging' happens through blatant medicalisation, where framing depression a disease obscures its political significance. To be clear, at no point do the texts that I refer to dismiss the distress that is caused by mental ill health. Rather than attempting to minimise the detrimental impact that mental distress can have on a person, these accounts attempt to highlight the histories and social contexts within which our understanding(s) of mental illness have emerged and offer new ways to think about its significance. For the politics of anti-stigma, the conceptualisation of mental distress as a form of resistance can be a powerful tool in de-stigmatising both the symptoms and the consequences – such as missing work or deadlines – of mental distress.

To illuminate better how madness has already been re-conceptualised as resistance, we can also turn our gaze to fictional worlds, where time-travelling can become a way of challenging the temporality of psychiatric diagnosis and confinement, such as in Marge Piercy's *Woman on The Edge of Time* (1976). The purpose of fiction in this instance is to provide a counter-narrative to the narratives which are imposed through psychiatric vocabularies. As demonstrated throughout this thesis, narratives are crucial in determining the boundaries of discourse for mental health and distress. Therefore, we cannot discount the potential that alternative stories, whether fictional or not, can offer as tools of resistance or refusal. Piercy is not alone in offering us different perspectives on madness by creating a world which imagines resistance to the harm of systematic psychiatric violence. Other works of fiction that explore the same theme, often through the lens of feminism, are *The Yellow Wall-Paper* (1892) by Charlotte Perkins Gilman, *Girl, Interrupted* (1993) by Susanna Kaysen and J. D Salinger's *The Catcher in the Rye* (1951). Stories are and continue to be tools of governance as well as doors to the imagination of powerful resistance.

In addition to fiction, auto-ethnography can be a means by which the researcher challenges her embeddedness within the narratives that are constructed through the confines of academic writing (Trivelli 2014). As Inayatullah and Dauphinee (2016: 1) argue, changing the form of prose can allow the reader to 'feel, think, and experience the story'. Writing differently allows for an intimacy between writer and reader that is rarely achieved, but which can bring an otherwise abstract academic discussion closer to the personal. In the context of mental health, there is thus an opportunity to challenge the abstraction with which we come to understand our minds through bio-medical frameworks. For example, Trivelli (2014: 152) demonstrates in a narrative piece that her own research on depression leads to a fragmentation of herself, where 'I warmly nestle in thinking that my distress is discursive and a social construct', obscuring the harm she experiences from psychoactive medication. It is through the letting in and writing out of the pain that Trivelli (2014) comes to analyse her own situatedness within the academy, writing about mental health while self-medicating, but also refusing to distance herself from the pain in her academic work. The declaration, 'where there is power, there is resistance' (Foucault 1998: 95) has never rung truer than in the context of resistance by refusing the call to sanity, where the normalisation by and disciplining power of stories is met with the power of counter-narratives that provide an alternate reading and opportunity of doing research about the human mind.

7.5. COVID-19 and beyond

The conclusion to this thesis would not be complete without acknowledging the global context in which a large part of it was written. The beginning of the COVID-19 pandemic in

March 2020 coincided with the submission of the third chapter of this thesis, meaning that I wrote a large part of my thesis during a global pandemic — not a scenario I had imagined. Spending an increasing amount online, doom-scrolling, and being lured into attending evermore Zoom meetings, it was without any surprise that I witnessed the topic of mental health emerge within the public discourse. (News) media and anti-stigma campaigns reacted in a variety of interesting ways, two of which I would like to highlight at this stage.

Firstly, as an avid follower and subscriber to all *Time to Change* social media accounts and newsletter, I observed closely how the campaign reacted and adjusted its social media output during the unfolding pandemic. In the first instance, TTC changed its message to meet the demands of lockdown, emphasising in a variety of tweets that it is ‘okay to feel anxious’, to be ‘uncertain’, and that it is important to ‘check in’ on others (TTC 2020b). In a tweet from the beginning of June 2020, TTC claimed that, with the easing of lockdown restrictions, it is important to show compassion towards others who might be uncomfortable about this and to offer to talk to them about their concerns. In doing so, TTC addresses people’s concerns about the end of lockdown by attempting to make people feel more at ease about the lessening of restrictions, thus acting as an arms-length body of the British government. Any negative emotions concerning the government’s decision making during the pandemic, including the controversial implementation of different lockdown tiers, is pathologised as a symptom of mental illness, particularly as an anxiety or panic disorder. Friends of concerned individuals should, TTC (2020b) suggests, ‘try not to minimise their concerns and really listen to them’. In a tweet from August 2020, parents who are ‘stressed about their children returning to school’ are advised to go to the TTC website for tips on how to start a conversation about mental health (TTC 2020c). Once again, the stress and anxiety of parents is delegitimised and starved of its political potential because it is pathologised and framed as a mental health problem. The campaign’s social media feeds have clearly communicated that the experience of mental distress during the pandemic is a medical issue, not a social one. Negative feelings and any mental distress related to the pandemic and its handling by the British government are reduced to signs of poor mental health, rather than being viewed as legitimate concerns that could spark political resistance. Therefore, the role of TTC during the pandemic has been to uphold familiar narratives of anti-stigma campaigning by emphasising that mental distress is to be explained through a bio-medical framework.

Secondly, mental health has also become a recurrent theme in COVID-19 news media coverage. Especially worrying is the current trend by news outlets to suggest that mental health will be the ‘next epidemic’ or wave of the pandemic, and to sensationalise psychiatric diagnoses in COVID-19 patients (Grover 2020; Lintern 2020). In an article from *The Guardian*, the headline reads that ‘nearly one in five Covid patients’ are ‘diagnosed with a mental illness after having tested positive’, most commonly with depression and anxiety (Grover 2020). The article suggests that there is a link between a COVID-19 infection and the effects it can have on the brain, while little acknowledgement is given to the emergence of mental distress as a result of being infected during a global pandemic. In other words, collective human trauma, by calling it an ‘epidemic’, is undergoing a process of medicalisation in the media. While it is understandable that the mental distress caused by the last nine months, which will surely affect many of us in the foreseeable future, is a topic that receives attention in the public discourse, there is no justification for the blatant medicalisation of this issue. The idea that psychiatric illness is a consequence of an infection with COVID-19 has neither been scientifically proven nor is there evidence that it is possible to draw a distinction between mental distress caused by the socio-economic effects of the pandemic and the emergence of symptoms that fit a psychiatric diagnosis. In the end, the feeling of despair and anxiety in times of unprecedented hardship is perhaps a sign of normality, of a mind that is ‘well’, even if it is distressed. The power of the (news) media is significant in shaping the direction of public discourse on mental health. We must be alert to the ways in which the relationship between COVID-19 and mental wellbeing is imagined in public discourse – and on what terms it is debated.

Appendices

Appendix A: Defeat Depression

Materials from the archives of the Royal College of Psychiatrists in London.

	Title	**Date**	**Type**	**Location**
A1	“Depression in the Workplace”	n.d.	Implementation Guide	Box 2
A2	“Depression in the Workplace”	n.d.	Brochure	Box 2
A3	“Men Behaving Sadly”	n.d.	Brochure	Box 1
A4	“Depression: Recognition and Management in General Practice”	n.d.	Booklet	Box 3
A5	“Depression in Men”	n.d.	Patient Information Factsheet	Box 1
A6	Funding obtained for the Defeat Depression Campaign”	November 1997	Funding Information	Box 3
A7	Correspondence from the National Pharmaceutical Association to the *Defeat Depression* campaign	May 1994	Letter	Box 3
A8	“Try Self-Help!”	n.d.	Brochure	Box1
A9	“The Future of the Defeat Depression Campaign”	May 1996	Meeting Minutes	Box 3
A10	“The Future of the Defeat Depression Campaign – a brainstorming session”	June 1996	Meeting Minutes	Box 3
A11	“First Meeting of the Depression Campaign Steering Committee”	January 1991	Meeting Minutes	Box 3
A12	“The Treatment of Depression: A Survey of General Practitioners”	December 1992	Ipsos Mori Poll	Box 2

Appendix B: Changing Minds: Every Family in the Land

Materials from the archives of the Royal College of Psychiatrists in London.

	Title	Date	Type	Location
B1	“Changing Minds: Every Family in the Land”	1998	Proposal	Box 4
B2	“Changing Minds: Declaration of Intent”	n.d.	Press Release	Box 4
B3	“Mental Disorders”	n.d.	Booklet	Box 5
B4	“Working Group Meeting”	July 1999	Meeting Minutes	Box 4
B5	“Caring around the Clock”	n.d.	Booklet (for children)	Box 5
B6	“HeadSTUFF”	n.d.	Brochure (for teenagers)	Box 5
B7	“Meeting of the Stigma Campaign Working Group”	April 1997	Meeting Minutes	Box 4
B8	“Depression”	n.d.	Booklet	Box 5
B9	“Anxiety”	n.d.	Booklet	Box 5
B10	“Changing Minds Campaign (1998-2003) Toolkit”	November 2003	Press Release	
B11	“Declaration of Intent”	n.d.	Signed Endorsement Letter by Alan Rickman	Box 4
B12	“Declaration of Intent”	June 2001	Signed Endorsement Letter by Helena Bonham Carter	Box 4

Appendix C: Time to Change

Materials from the Time to Talk Day kit 2019.

	Title	Date	Type
C1	“1 Open-Door Policy 10 Minutes Checking In 1 Colleague Supported”	2019	Poster/Postcard
C2	“10 Minutes 2 Cups of Tea 3 Biscuits Dunked 0 Pressure”	2019	Poster/Postcard
C3	“4 Funny Videos 2 Silly Jokes 1 Friendly Smile 2 Mates Looking out for Each Other”	2019	Poster/Postcard
C4	“3 Weeks of Planning 60 Cupcakes Baked 1 Room Booked 50 Colleagues Talking”	2019	Poster/Postcard
C5	“1 Knock at the Door 4-Legged Companion 4 (Very) Muddy Boots 1 Day Changed”	2019	Poster/Postcard
C6	“1 Trip to the Gym 25 Reps 4 Smelly Socks 1 Myth Challenged”	2019	Poster/Postcard
C7	“Make a Conversation. Make a Difference.”	2019	Booklet
C8	McVitie’s “Get Chatting over the Nation’s Favourite Biscuit”	2019	Promotional Flyer
C9	PG Tips “Invite a Friend for a Cuppa”	2019	Promotional Flyer

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