In Search of the Missing Discourse: A Critical Discourse Analysis of two campaigns to reduce the stigma of mental illness

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Abstract

Recent scholarship enables the understanding that late-stage capitalism is sustained by its systemic and purposeful creation of stigma. This study explores how *anti-stigma* discourse may serve the same order, by activating public goodwill and altruism to achieve behavioural change. The research analyses the language used in and around *Time to Change* and *Heads Together*, two campaigns which declared their aim to reduce the stigma of mental illness.

Stigma is often studied from a sociological perspective, but this research uses CDA (Critical Discourse Analysis), an approach within linguistics which looks beyond surface meanings in language. By analysing campaign websites, together with focus group data, YouTube comments, and interviews with key actors, the study produced novel insights which challenge the perception of 'anti-stigma' campaigns as wholly beneficial. 'Stigma' is not easy to define, but its damaging effects across social life, including mental illness, are well recognised. Yet in mental illness, even before government polices to shrink the welfare state, difficulty in obtaining appropriate help was arguably a greater problem than stigma. The 2007 launch of *Time to Change,* a major national campaign, was therefore a puzzling prioritisation.

A decade later, the effects of spending cuts were acutely evident, both as a source of mental distress and as the reason for service failure. Despite this, a further initiative, *Heads Together*, echoed the ongoing *Time to Change* rhetoric, promoting stigma-reduction through conversation to encourage help-seeking. Neither campaign acknowledged cuts to services. Central messages of anti-stigma campaign discourse ('AS discourse') are that stigma prevents help-seeking, and is as problematic as the mental illness itself. While some empirical evidence supports both claims, these notions create and perpetuate a myth that reducing stigma removes barriers to *obtaining* help, rather than seeking it.

AS overtly sought attitudinal and behavioural change, but this change covertly included nudging people away from long established frameworks of care, towards self-help or low level 'talking therapies'. *Time to Change* recruited and trained people with experience of mental illness ('Champions') as its vital unpaid workforce, to initiate 'conversations' and act as exemplars of recovery and normalcy, across community, workplace, and online settings. This

was synchronous with a move to normalise low level talking therapies through the IAPT (Increasing Access to Psychological Therapies) programme, launched as a 'zero cost' policy solution to depression and anxiety, which would simultaneously slash treatment costs and increase productivity.

This research found that the AS narrative was similarly directed towards the protection of economic productivity, through its focus on current and future workers. Older, non-working age adults are largely ignored, with implications for the ways they are perceived and provided for across the mental health sector.

Invoking the concept of stigma to effect behavioural change created a diversionary and ironically stigmatising discourse, by simplifying the lived complexity of mental distress. Subtle textual mechanisms, such as the substitution of 'mental illness' with 'mental health', show how personal experiences can be reframed and devalued.

This study proposes that stigma became a less useful concept when the Covid-19 pandemic provided both a new cause of mental ill-health, and a new justification for service overload. AS had by then however appreciably acculturated the public to accept dwindling state mental health services. This contributed to an accelerated pathway for digital and private services, facilitating further reduction in costs and state service provision; both central objectives of the public health policy of neoliberal capitalism.

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‘We’re all each other’s therapists now, and it’s killing us’

(Aspiring ‘service user’)

CHAPTER 1: Introduction

1.1 The Social (Policy) Problem

This thesis is a linguistic exploration of the policy of stigma reduction in relation to mental illness. Stigma is a complex process with social and political dimensions. It is a deliberate and powerful social construct which significantly affects the agency of many social groups, and has a damning potency to permanently reduce life chances. Following Goffman's broad definition of stigma as a disqualification from social acceptance (1963), growing understanding of stigma as a form of social control has most recently been expressed by Tyler (2020) who situates stigma as a product of power relations in capitalist societies. At a time of increasing global inequality, we appear to have reached a binary state, in which populations are divided into the stigmatised and the non-stigmatised.

Among the many stigmatised groups in society are those with mental illness. The World Health Organisation (2017) confirms that widespread stigma surrounding mental illness still frequently results in abuse, rejection, and exclusion. I do not challenge the reality or seriousness of stigma directed towards people with mental illness. However, I propose stigma reduction has become a soft policy 'solution' to the increasing prevalence of mental ill-health in advanced liberal societies.

Early adopters of anti-stigma initiatives (New Zealand's *Like Minds, Like Mine*, 1997-current; Scotland's *See Me*, 2002-current) were soon followed by further campaigns in developed capitalist societies; England's *Time to Change* (2007-2021), Canada's *Opening Minds* (from 2009), and Denmark's *One of Us* (from 2011). In the US, state-specific or regional campaigns appeared from 2006, then in 2014 the National Alliance on Mental Illness (NAMI), roughly the counterpart to Mind, started its *Stigma Free* campaign. Later initiatives include *Heads Together* (2017) in Britain. It is important not to conflate general organisations which provide mental health information with specific anti-stigma initiatives, although the lines and functions are often blurred, as this thesis finds.

Advocates for anti-stigma interventions in relation to mental illness argue for these initiatives either on the basis of the 'human and economic costs' of public and self-stigma (Tippin and Marazan, 2019) or more blatantly on the basis of the economic burden of mental illness stigma, particularly its negative impact on employment and productivity, and contribution to health care costs (Sharac, McCrone, Clement, & Thornicroft, 2010). Evans-Lacko *et al.* (2013) subsequently evaluate *Time to Change* in terms of return on investment and its contribution to relieving the economic burden of mental illness. The economic focus aligns with suggestions by Oute *et al.* (2015) that articulations of mental illness as weakness are associated with dominant discourses of cost-effectiveness across neoliberal, Western societies. To what extent, therefore, is the overarching aim of anti-stigma campaigns the prevention of lost productivity, rather than improvements in the lives of people with mental ill-health?

1.2 The data

My core data sources are UK mental health campaigns expressing their intention to reduce stigma, specifically *Time to Change* (run jointly by Mind and Rethink Mental Illness), and *Heads Together,* part of the Royal Foundation. I refer to the campaigns respectively as TTC and HT, and describe both as anti-stigma (AS) websites. For the purposes of this thesis, 'AS' refers specifically to these two campaigns, and not necessarily to other bodies with stigma-reduction aims; since I do not analyse other campaigns, I am unable to attribute the characteristics I identify to other anti-stigma campaigns, which may have different origins, objectives, and functions. The two contrasting campaigns in this research are subject to unequal research focus, as TTC is the larger campaign and the more informative dataset. However HT provides multiple key points of comparison.

I also used two types of participant research; a focus group with older adults with experience of mental ill-health, and three interviews with senior AS policy implementers. Part of the focus group considers audience response to AS videos, and I compare these to other public responses by analysis of YouTube comments.

1.3 Anti-stigma interventions: justification and formats

Rossler (2016) identifies three main approaches to reducing stigma: (i) information and education, (ii) protest (i.e. a genuine social movement), and (iii) contact, mediated through three channels; mass media, opinion leaders (i.e. celebrities), and persons of trust (Rossler 2016:1253). TTC, and to a lesser extent HT, can be said to have used (i) and (iii) and to have operationalised all three channels of (iii). Rossler has reservations about each of the 'channels' through which contact is typically mediated, proposing 'unspectacular' day to day contact to be the most effective means of stigma reduction. While TTC propagates the trope that 1 in 4 people will experience a mental illness, Rossler claims 50% of people experience some form of mental illness in their lifetime, and mental illness should be 'familiar' to everyone, and regarded as part of everyday life.

Anti-stigma interventions based on contact are however widely regarded as effective (Corrigan, Michaels *et al*., 2015; Corrigan *et al*., 2012). Such approaches, involving direct interactions between people with and people without mental illness, which are the *defacto* basis of TTC's approach, are derived from the intergroup contact hypothesis (Allport, 1954), suggesting contact with a stigmatized group reduces prejudice toward that group. Subsequent research confirms the utility of intergroup contact, including a meta-analysis of 515 studies involving participants from 28 nations (Pettigrew and Tropp, 2006). As is often the case in AS, the theoretical basis of intergroup contact has been transposed optimistically from another context, in this case from an intervention for racial discrimination, although naturally Pettigrew and Tropp (2006; 2008) claim contact interventions have equal utility for other stigmatised groups. Remote modes of intergroup 'contact' for a digital age include video 'confessionals' or use of stories on websites; an individual discusses their story, symptoms, treatment and recovery. In TTC however, treatment is omitted, typically jumping straight to recovery, achieved with the help of the community based conversations which the campaign recommended. A key aspect of contact in TTC is its use of 'Champions'. These are people who have experience of mental illness, who are recruited by TTC ostensibly to have 'conversations' with the (non-mentally ill) public.

1.4 The Missing Discourse

AS is presented as a response to a mental health policy problem. Yet its presence and necessity are not adequately explained. This question of necessity is important when we know personally, anecdotally, or from media coverage, that the greatest problem in mental health is the lack of adequate state provision of care and services. Statistics abound of the failures in mental health services resulting from cuts to its funding, but the rise in the number of detentions under the MHA (Mental Health Act) alone since austerity measures began clearly indicates a fundamental lack of community services for people in crisis (Cummins 2018:8). AS therefore appears a curious policy focus at a time when resources were being limited by austerity, which as Cummins (2018b) asserts, was not solely a matter of economics but a political project to intentionally reduce the role of the social state. I am concerned with uncovering the 'missing discourse' of stigma. By this I mean that, while AS campaigns constitute the overt, publicly presented discourse of stigma, I am as interested in the unspoken and unwritten as in what is present. Through its actions, AS makes some highly contestable arguments; for example (i) that the main problem of mental illness is stigma, and (ii) that workers are vital targets of AS, especially through the Employer Pledge. What is missing from the discourse is the absence of mental health services, and the reasons for the use of stigma in policy. This 'missing' discourse is thus a central aspect of my critique.

Two key assumptions of the stigma of mental illness, as propagated by AS, are that it stops people from seeking help, and is an experience as serious as the mental health problem itself. *Stigma Shout* (Corry, 2008), a survey conducted for Rethink, was designed to provide information to broadly shape the evolving TTC campaign. TTC summarises its 6 key findings about the effects of stigma: listed first is 'prevents people seeking help' and listed sixth; 'stops people getting jobs'. Yet their chart (Fig.1) refers not to 'help-seeking' but to *disclosure*. Disclosure may have very different meanings to different people, and be unrelated to the process of seeking help. Furthermore, the chart shows that only around 8% experienced *actual* stigma or discrimination upon disclosure; it was the anticipation of stigma which was significant. This rather defuses the claim that stigma prevents 'help-seeking'; the text does not clarify that there is high level of *anticipated* stigma about disclosure. For employment however, both anticipated and actual stigma were high, and the latter slightly higher.

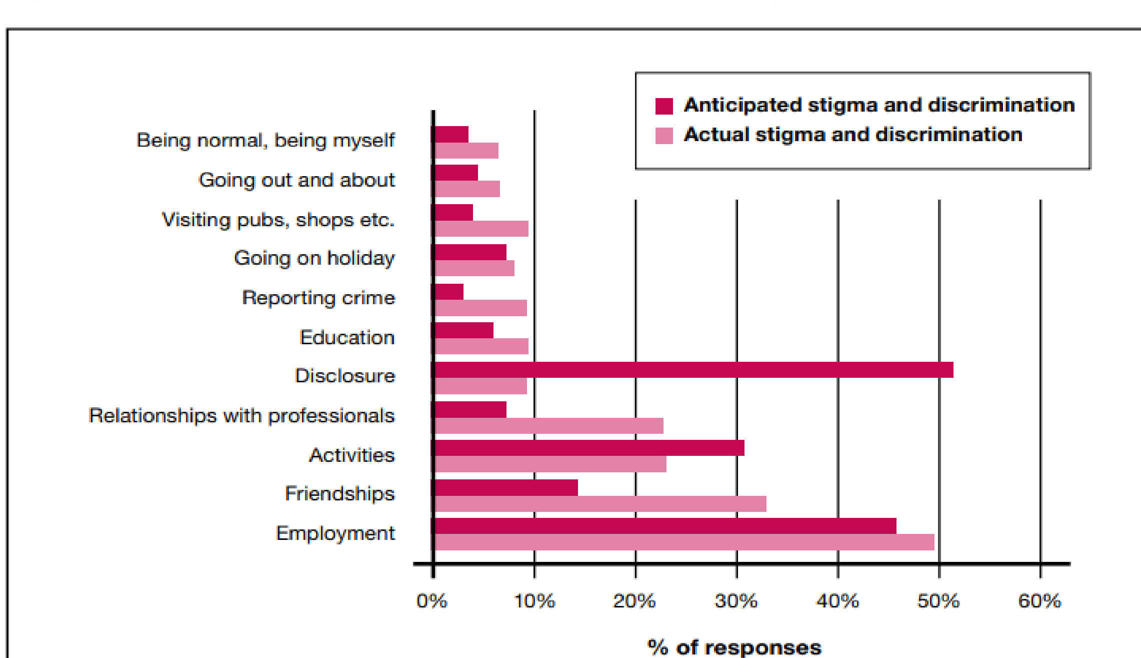


Fig. 1: 'What service users stop or fear doing because of stigma or discrimination'. From Stigma Shout (Corry, 2008).

TTC claim findings from *The impact of stigma* (TTC 2011), resemble those from *Stigma Shout*. The later survey of 2,770 people who were *'in touch with Time to Change'*, does indeed present similar figures. Notably however, the 32% who experienced stigma 'in health services' are not discussed, and importantly, neither survey considered the relative problematicity of stigma compared to other difficulties experienced by people with mental health problems, such as inability to obtain treatment. Rather, the proposition and focus is that stigma is overwhelmingly problematic in mental illness.

I suggest that the findings in relation to both anticipated and actual workplace stigma were sufficiently alarming to compound fears of lost productivity; the economic burden of mental illness had already become a significant concern, as highlighted by Layard (2004). It can be no coincidence that in 2011 government funding of TTC started, the TTC Pledge for business was initiated, ostensibly to combat workplace stigma, and Rusch *et al*. (2011) confirmed that stigma reduction initiatives may improve the extent of help-seeking. This research, from the Institute of Psychiatry, which had a long-term association with TTC, supports the help-seeking narrative, allowing a justification beyond workplace concerns for the continuation of TTC. The

help-seeking trope was later adopted by HT, which played an important role in perpetuating the narrative; its 'about' page still (2022) introduces stigma by stating *'this fear of prejudice and judgement stops people from getting help and can destroy families and end lives'*.

This thesis therefore is very much concerned with highlighting key absences; the explanation for the campaign is largely absent (why stigma, of all the issue which people with mental illness face, merited a campaign); the relative significance of (specifically) mental illness stigma; and what stigma *really* is, not as conceptualised by TTC as public intolerance, but as a broad, systemic process created by economies driven by capital growth, which is dependent on power differentials (Tyler, 2020). AS does not take into account the relationship between systemic stigma and mental illness, nor does it consistently acknowledge the diversity of mental illness and the people who experience it. Older people are not visible, either as the 'lived experience' demographic which TTC uses to disseminate its message, or as a target demographic which needs to be 'reached' by its programme of attitudinal and behavioural change. Therefore, while my text analytical work from the websites aims to reveal the missing discourse, the focus group responds in part to the issue of the 'missing demographic', seeking the voices of this ignored social group. The interviews provide an opportunity probe the motivations for AS (specifically TTC).

1.5 Why should this be a focus of research?

As Fairclough (2013) and Mulderrig (2019) note, it is important to engage critically with the way public health policies are presented to the public, because the representations, discourses, and underlying ideologies which characterise them can help to reveal both the assumptions which inform and drive such policies, and the ways in which the public will interpret them.

Publicly declared initial funding to TTC was £20.5 million for its first four years, from The Big Lottery Fund and Comic Relief. Subsequent funding details are not publicly available, but we know that the DHSC became a funder in 2011 and remained so until its withdrawal of funds forced TTC to close in 2021. This major and long term campaign therefore used public funds, yet its objectives were not an obvious focus of public concern.

As Chapter 4 illustrates, much CDA work has focused on public health campaigns which are patently government-led. In the case of TTC, the funding picture is mixed and opaque as described above, and made more so since annual financial reports of the two bodies which 'led'

TTC (Mind, 2021; Rethink, 2021) show that despite their charitable status, both receive NHS and government funding, indeed Rethink derives its greatest income from local authorities and NHS Commissioners. This raises questions about accountability, and has implications both for the motivations for TTC and the language which it uses.

In previous public health campaigns, slogans have been used to embed a message in the public consciousness, e.g. 'coughs and sneezes spread diseases' (first used in the US during the 1918-20 flu pandemic) or 'Don't Die of Ignorance' (British Government HIV/AIDS campaign, 1986). But Time to Change *is* the slogan. In common with the Change 4 Life (C4L) campaign analysed by Mulderrig (2017; 2018; 2019; 2020), use of 'change' embodies the expectation of behavioural or attitudinal change, reflecting the use of 'nudge' (behavioural economics), whereby changes which sectors of the public are expected to make are subtly inculcated, ostensibly for public benefit, but in fact to align with a neoliberal policy goal. As Mulderrig (2019:16), points out, although policy literature may acknowledge that health inequalities are derived from various power structures, the same literature depoliticizes inequalities, and concentrates instead on nudging the public out of 'deviant' behaviours.

Motivations for this research are thus multifaceted and incorporate both academic enquiry (for example whether this social marketing campaign, like C4L, also uses nudge) and concern for social justice; of all the social issues which beset society in 2007, the introduction of mental illness stigma as a specific policy problem which required a large national multimedia campaign demands investigation.

1.6 The research approach: Critical Discourse Analysis (CDA)

CDA is a research approach which aims to investigate social problems through the lens of discourse. It provides an ideal set of methodological tools through which to develop critical understanding of public health rhetoric, since it is based on rigorous scrutiny of the linguistic and grammatical choices which text producers make, and the effects of these choices. Specifically, the problem of stigma is precisely attuned to an approach which analyses the dialectical relationship between a problem and the discourses which represent it.

I describe CDA in detail in 2.1 and 2.1.3, but introduce its distinct character here. CDA critiques or interprets discourse *'in terms of the contradictions between what is claimed and*

interpreted to be and what actually is' (Fairclough, 2015:9). It seeks to understand how these contradictions are caused by, and are part of, the wider social reality.

Together, the combination of a critique of a discourse with an explanation of how that discourse works within a particular social reality, constitute a basis for action which might lead to change aspects of that reality for the better. A schematic account of the role of CDA in this research is therefore that by critiquing the discourse of AS, and simultaneously explaining how that discourse fits in society and through what forces it has come to exist, it might be possible to provide suggestions not only for a preferable discourse but ultimately a preferable social reality. Fairclough (2015:9) thus describes CDA as part of critical social science. The combination of critique, explanation and action characterises social science more generally, but CDA is distinguished by its focus on the relations between discourse and other social elements such as power, institutions, and ideologies. CDA is not only a critique of discourse, but a critique of a social reality, which starts with a critique of discourse (Fairclough 2009:7).

Understanding relevant aspects of the political economy is central to this research, especially given the relationship between stigma and exclusionary power, and the importance of understanding AS within its social and economic context. CDA works in transdisciplinary dialogue with other academic fields, as seen in Mulderrig's use (2019) of a transdisciplinary model to analyse the role of specific policies in shaping the resilient, self-disciplinary subjectivities which neoliberal governance practices require. Through her analyses she reveals the covert and subtle manner in which behavioural change is operationalized; her approach provides a model and motivation for the linguistic exploration of AS.

I follow an abductive approach typical of CDA research, involving continual movement between theory and method, progressively refining research design as the inquiry deepens. In this iterative process, all the components of the research process, from data selection to research questions and methodology, are adapted over the course of the research; learning from 'first pass' analysis informs and influences subsequent analytical steps. This iterative process is guided by initial research questions.

1.7 Research questions

Research questions in this thesis are both linguistic questions and questions for critical reflection. The earliest, broadest conceptualisation of the enquiry is the 'source' question:

RQ1: What is the language used in anti-stigma policy, as enacted by AS campaigns?

This question and its progeny are addressed through more specific questions reflecting the further strata of enquiry. Exploring these strata entails both more detailed linguistic questions and broader matters of social enquiry for critical reflection. The overall intention of many of the questions is to understand the ideological underpinnings of AS policy discourse, for example why the concept of stigma was afforded such importance, and how the discourse is sustained by the campaigns' respective evaluation strategies. It is equally necessary to ask how this discourse conveys the campaign premise, to whom, for what purpose, and with what effect. By understanding the ideological basis of the discourse it then becomes possible to explore the concept of the 'missing discourse' of AS.

I present the questions in full in 2.4, and discuss their relationship to analysis in 5.1.1.

1.8 Structure of the thesis

In Chapter 2 I describe the theoretical linguistic literature which informs the process of this research and provides a framework for the investigation. I give an account of the discourse-dialectical view of CDA, explaining how it focuses on the role of language in reproducing the social problem, and the linguistic barriers to overcoming it. I then discuss critical policy analysis as a specific focus of analysis for this research. I describe the formulation of the research questions, and set out the text analytical frameworks I use to answer them. Finally, I discuss the importance of CDA's transdisciplinary perspective, which becomes immediately relevant in Chapter 3.

Since stigma research originates in the social scientific domain, a transdisciplinary dialogue is essential to fit the linguistic object of enquiry in its political economic context. Following Fairclough's framework (2001; 2013), in Chapter 3 I explore theoretical perspectives to conceptualize the problem in its semiotic and non-semiotic dimensions. This requires exploration of key literature from critical political economy and social science, starting with the Foucauldian concept of biopolitics. Through the work of Rabinow and Rose, Rose, and Jessop, I explore neoliberalism and the emergent themes upon which it depends, such as individualisation, responsibilisation, and commodification. These themes guide my understanding of the role of the political economy in mental health policy and stigma, and inform my interpretation of linguistic findings.

I examine austerity as a key effect and policy strategy of neoliberalism, and introduce stigma by viewing the consequences of austerity on mental health funding. In considering models and theories of stigma, I contrast recent writers such as Tyler (2018; 2020) with the traditional view espoused by Goffman. I review some key models of mental health stigma specifically and discuss emergent themes; this is important, since anti-stigma initiatives may only be understood in the context of the ontological and epistemological positions which may have inspired them. By briefly charting the trajectory of mental health policy, it can be seen that the growth of neoliberalism enabled an era in which mental health has become especially related to productivity, culminating in AS.

In Chapter 4 I review previous work in CDA which relates to public health or mental health, identifying a lack of CDA in public mental health policy. I attempt to explore some reasons for this, with respect to the pre-existing relationship between psychology/mental health and different types of discourse analysis. This review helps to situate my thesis, verifies the absence of similar works, and confirms my inclusion of participant research as a novel approach within mainstream, discourse-dialectical CDA.

In Chapter 5 I describe the research methodology, explaining its rationale, core data and characteristics, and introducing the main text-analytical methods subsequently selected to analyse the data. I position the key research questions in relation to analytical methods, then explore in detail the nature of the data selected to help answer these questions, including relevant contextual information concerning the TTC and HT websites, the focus group, interviews, and YouTube comments. I also explain my use of corpus linguistics as a complementary analytical method which facilitates analysis of the large quantities of textual data.

Chapters 6 and 7 provide the central textual analysis of the websites, and seek to discover how the AS mental health policy solution is configured as a social practice. Both chapters therefore are significantly concerned with uncovering the ‘missing’ discourse. Chapter 6 addresses issues of identity, genre, and the way in which social actors are represented by TTC. Stigma concerns inclusion and exclusion, and importantly, TTC overtly operationalises the frequently abstract concepts of un-likeness and distance; the target demographics of the campaign are identified by their relative lack of proximity to people with mental illness. This makes the concept of deixis, as operationalised through the pronoun ‘we’, a particularly relevant focus of analysis. I

explain the principles of this analysis in 2.5.2 and 5.9.2, operationalise it in 6.2, and it continues to have utility across Chapters 6 and 7. In Chapter 7 I consider aspects of lexical use, especially the terms used to describe mental illness, finding ‘mental illness’ to be a rare term. I then analyse the strategies through which TTC especially legitimates its existence and social practices, identifying the importance of research and metrics. I draw the textual analysis to a close by reviewing the unfolding narrative themes derived from Chapters 6 and 7.

In Chapter 8 I present the findings from a focus group of older adults with experience of mental health problems. People with experience of mental illness offer a vital perspective on anti-stigma initiatives, and in choosing a group which, as I demonstrate, has been ignored by AS, I give voice to a sample of a marginalised demographic, and in turn their views provide valuable breadth to the research. In this chapter I also present responses to AS videos, both by the focus group, and by public commenters on YouTube.

I carried out interviews with three key implementers of the AS policy response; two from TTC and one from Mind. Informed both by textual analyses and by my findings from the focus group, I use the opportunity to probe contradictory or problematic areas of AS, continuing to address my concern for the ‘missing discourse’, such as the motivation for establishing TTC, the exclusion of older people, and how AS can succeed without addressing more fundamental inequalities. The findings from these interviews are presented in Chapter 9. Together the contrasting participant perspectives contribute vital triangulation of the data.

Following the main analytical chapters, I carry out an observational review of the responses to the impact of COVID-19 on mental illness and associated stigma. This chapter is not linguistic analysis, but an exploration of how institutional responses to the mental health consequences of the pandemic, by TTC, Mind, and the government, reflect the patterns and themes uncovered by the analyses. The chapter also identifies some evolution in public mental health policy.

I conclude this thesis, suggesting a neoliberal path-dependency when it comes to UK public policy responses to mental illness. I discuss how my analyses have responded to the aims of the research questions, and how this CDA research not only identifies elements of the ‘missing discourse’ of AS, but finds the reasons for their absence arise within a neoliberal public health agenda.

CHAPTER 2: CDA and the Theoretical Framework

2.0 Introduction

In this chapter I describe the theoretical linguistic literature which informs the process of this research and provides a framework for the investigation. I give an account of Critical Discourse Analysis (CDA), and introduce its theoretical basis and objectives, with a focus on the work of Norman Fairclough. I also review and respond to criticisms of CDA, then turn to discuss critical policy analysis, the specific focus of analysis for this research. I then expand on the research questions, and set out the text analytical frameworks I use to answer them. Finally, I explain the importance of CDA's transdisciplinary perspective, setting the scene for Chapter 3, in which I review key literature from critical political economy and social science.

2.1 What is CDA?

In this section I describe CDA, and its aims and objectives. I start with a general introduction, then summarise the discourse-dialectical approach, before discussing what constitutes discourse. Returning to CDA, I focus in more depth on 'Faircloughian' discourse-dialectical CDA, its social motivations, and the stages involved in this critical approach.

The CDA approach has its origins in linguistics, and accordingly incorporates a theory of discourse with a detailed framework for textual analysis (Mulderrig, 2016). It is problem-oriented research which aims to understand the means by which language may produce or reproduce social practices, and how it may privilege particular actions, thoughts, or ways of being (Fairclough, 2003). The range of models and possible research agendas in CDA are typically concerned with power or injustice in their semiotic dimensions, and in the potential for social change. CDA combines a theory of discourse with various text analytical methods, and by drawing on the social or political theories most pertinent to the object of research, findings can be appropriately contextualised and interpreted (Mulderrig 2015).

CDA's key approaches are associated with its 'founders' and early exponents, most notably Norman Fairclough, Teun van Dijk, Ruth Wodak, and Theo van Leeuwen. Wodak for example has led development of the Discourse Historical approach, which was developed to analyse

anti-Semitic discourse (Reisigl and Wodak, 2001) and maintains a focus on right wing and discriminatory discourse (Wodak, 2015). Elements of Van Leeuwen's socio-semantic approach (1995; 1996; 2008) have been widely adopted within CDA, notably his system of descriptive categories for the ways in which social actors are represented. Norman Fairclough (1989; 1992; 1995; 2003; 2005; 2015), perhaps the most influential voice in CDA, has focused significantly on how language maintains and influences power. Such 'Faircloughian' CDA has in turn influenced the work of Mulderrig (2012; 2016; 2019).

The range of theoretical and analytical models applied within CDA depends on the focus of research, and therefore each CDA study develops individually in response to specific objectives. Such theoretical and methodological variability is afforded by the key ontological assumptions which underpin CDA (Mulderrig, 2015). For example, the key assumption that within any object of social research, a dynamic, '*mutually constitutive relationship*' (Mulderrig 2105:445) exists between the discursive and non-discursive elements, results in the dialectical approach whereby CDA engages with social scientific theory. Textual analyses can thereby be made sense of through a perspective on social practice as something actively produced through shared behavioural norms, and which is partly constituted in language.

When CDA is discussed in this research, it is this 'discourse-dialectical' approach which is implied. Its name can be understood by the centrality of the dialectical-relational theory of discourse (Harvey, 1996). According to this theory, discourse internalises other elements of social practice: objects, actions, relations, social subjects, and their values and beliefs.

2.1.2 Discourse: definitions and affordances

Discourse has been defined and understood differently both inside and outside CDA. It is important therefore to briefly explore these differences, since only by understanding discourse can we claim to understand how its features present opportunities for analysis.

Definitions range from the straightforward: a 'system of statements which constructs an object' (Parker 1992:5), and Blommaert's (2005:2) concise 'language-in-action,' to the more detailed: 'a set of meanings, metaphors, representations, images, stories, statements… that in some way together produce a particular version of events' (Burr 1995:48). Mulderrig, Montesano Montessori, and Farrelly (2019) define discourse as a process of social signification, which uses a variety of semiotic modes (language, image, sound), and occurs in a particular sociocultural context. They reiterate the ontological perspective above; that in CDA, discourse

is one element of social life and has a dialectical relationship with non-discourse elements. As operationalized in analysis, because discourse emerges from habitual use of language in social practices, it mirrors and influences social practice. These descriptions explain why definitions of discourse inevitably differ, depending on whether the defining perspective relates to, for example, ontology or analysis.

For Foucault (1972:49), discourse means 'practices which systematically form the objects of which they speak'. Following Fairclough (1989/2015) Baker reminds us that Foucault's notion of practices has rendered discourses a countable, not an abstract, noun. Consequently, any idea or concept can be constructed in multiple ways, reflecting different perceptions, and 'discourses' accommodate inconsistencies and contradictions; Potter and Wetherell (1987) observe that the concept of competing discourses arises because discourses on the same subject incorporate changes in position, or contrasting views. Baker therefore suggests that discourses do not describe beliefs or opinions, and nor do they reflect aspects of identity, but rather are *'connected to practices and structures that are lived out in society from day to day'* (2006:4). Discourses are therefore dynamic, as they interact or merge with other discourses. To this one could add that they may also decline. Therefore, defining and naming discourses becomes a matter of personal interpretation (Baker 2006:4). As Foucault (1972:146) states, *'It is not possible for us to describe our own archive, since it is from within these rules that we speak'*.

Returning to CDA, while discourse is 'language', it could more accurately be described as 'semiosis' (Fairclough, Jessop & Sayer 2004), defined as 'meaning-making' in its broader sense. Although Fairclough (2015:8) reminds us that both historical manuscripts and daily conversations combine language with other semiotic forms, technology facilitates production of complex multi-semiotic texts. The websites which are the main focus of this research exemplify this, and it is important to acknowledge the contribution of these different modalities and to AS discourse, for example with respect to branding. For Fairclough, language itself remains the most important semiotic form, although he acknowledges the value of 'multimodal' CDA, guided for example by Kress & van Leeuwen (1996) and Kress (2010).

When social practices are connected to each other in a particular way, they can be said to constitute a social order, the discourse/semiotic aspect of which is an 'order of discourse', a term which Fairclough (1989; 2015) adapted from Foucault as a means of capturing the distinctive power of discourse, which is both socially constitutive and regulatory. Put another

way, each social practice has both a discursive dimension and a set of distinctive discourse practices; together these form the order of discourse of a particular social field or institution (Mulderrig 2015:447). It is helpful to conceptualise this by starting from the understanding that discourse practices can be analysed with respect to three main features: genres (ways of acting and interacting), discourses (ways of talking about or conceptualising the world), and styles (ways self-identifying or being), and that the distinctive configurations of these three dimensions are what together characterise different/particular orders of discourse.

The distinctive configuration described above as helping to structure or 'order' a social practice, does so through links which can be viewed through the lens of interdiscursivity. Interdiscursive links between social practices are an essential social characteristic and play a vital role in generating social change (Mulderrig, Montesano Montessori, and Farrelly, 2019). The 'interdiscursivity' of discourse is one of the features which provides opportunities for analysis, and can be seen as a porosity through which 'slippage of values, norms, practices and power relations between different domains of social practice' can occur (Mulderrig 2015:446); for example in the current study, from marketing to public health, or government to campaigning. This concept of interdiscursivity allows us to capture elements which are incorporated from the wider social context of a discourse. This makes it possible to investigate discursive change, and its role in driving social change (Fairclough, 2003; 2005), such as the increasing influence of market-oriented managerial practices in public health.

Interdiscursivity is inherent to all discourse; the concept of 'dialogicality' (Bakhtin, 1981) regards all texts as containing traces of other texts. Values and ideologies from other social fields may therefore be discursively imported into a text, and may become routine, and accepted as common sense (Mulderrig 2015). Interdiscursive analysis renders the textual processes of 'normalisation' visible, allowing the pathways of ideas and values which move through discourse practices to be identified.

The role of social change in relation to discourse is especially pertinent, as the campaigns analysed in this research seek to realise attitudinal and behavioural change. Discourse can be seen as part of social change in three ways (Fairclough 2015:37) (i) Social change partly constitutes change in discourse. For example, marketisation of mental health is creating changes in genres which are influenced by business models. (ii) Changes in social reality often originate as, and are in turn 'driven' by, changes in discourse (Fairclough 2003). For example, Improving Access to Psychological Therapies (IAPT) services have been part of the

marketisation of mental health, in which private companies sell low-level 'talking therapy' services to the NHS. These services were driven by an earlier discourse in which use of IAPT was presented as an economically advantageous 'imaginary', describing its possible procedure and apparatus. (iii) Social change is represented in the way it is described or explained, and in the arguments, social struggle or debate with which it is associated. In this third aspect one could include, from different perspectives, both the AS websites and this research.

2.1.3 Discourse-dialectical CDA: description and objectives

To further explore the theoretical perspectives, aims, and objectives of the discourse-dialectical approach requires that it is situated within the context of its social motivations and objectives. The contribution which Fairclough makes through his proposal for CDA is to draw together critical theory and analysis to focus on the dynamics of capitalism. Fairclough (2015:5) calls for profound change regarding our understanding of the existing social reality with respect to neoliberalism, the brand of capitalism under which we have witnessed a widening in the wealth gap, tactical unemployment, and systematic reduction in welfare provision, while politics and business in tandem advance the position of those holding economic power (2015:4). Harvey (2010:10) describes neoliberalism as '*a class project ... to restore and consolidate capitalist class power'*, and Fairclough considers austerity, which strategically burdens the poor with economic crises, to be a continuation of that project.

Fairclough's ideological position concerns the way the drive for capital growth has been rendered a common-sense imperative, and the pre-eminent social goal (2015:47). While acknowledging the limitations to critique's transformative potential, he emphasises that the existing socioeconomic order only survives because of the misunderstanding that capital growth is beneficial to all (2015:48).

For Fairclough, CDA aims not only to critique discourse, but to explain the relationship between that discourse and other aspects of the existing reality. Therefore for CDA to effect positive social change, it must understand both the role of discourse within society, and society itself. The unique contribution of CDA is therefore the way it explores the relationships between discourse and other 'social elements' (power relations, ideologies, social institutions). Any social reality consists of 'social objects' (including people, physical objects, environments, institutions, and social events), about which beliefs and ideas are evident in discourse (Bhaskar 1989). It is in the context of, and in response to, a particular social reality

that Fairclough positions the need for critical theory and analysis which presents discourse as a site of struggle, emphasising the role of CDA in revealing the power *behind* discourse (2015:02); how discourse and the social order is shaped by people in power.

Power is not solely economic, but should be considered in analysing discourse in institutional contexts, since people who hold economic power determine opinions, actions, and attitudes in social life, through a multitude of means; pertinently, these include funding research (Fairclough 2015:28). In my analysis of legitimation strategies (7.2) I find significant funding was allocated to academic research to evaluate TTC. The positive evaluation of the campaign made by that research was in turn used to further shape public opinion.

As Mulderrig (2016) points out, discourse most effectively reproduces relations of power when discursive features are so naturalised they are invisible. Through critical exploration of the assumptions, values, and vested interests which sustain relations of power, CDA 'denaturalizes it' (Mulderrig 2016: 486), revealing how discourse is ideologically shaped.

Turning to consider the actual process of critique, CDA could be summarised as a process of seeking explanations about why a discourse is a certain way, then asking what could be done differently. Fairclough (2015:47) describes a process of three interconnected stages: (i) Features of discourse are identified by normative critique, leading to (ii) explanatory critique of an aspect of the existing social reality, with respect to dialectical relations between discourse and other social elements. This provides a basis for (iii) transformative action (praxis) to change the existing reality. The inclusion of explanation and explanatory critique as a basis for social transformation distinguishes this CDA framework from other types of CDA and critical analysis (Fairclough 2015:47; Mulderrig, Montesano Montessori, and Farrelly (2019). Further, the connection which explanatory critique demonstrates between normative critique of discourse and praxis, reveals 'normatively flawed discourse' to be an aspect of the existing reality which is also flawed, and which therefore needs to be changed. This follows Bhaskar's account (1989:101) of the connection between explanation and action and more widely his notion of dialectical reasoning or 'argumentation' (Bhaskar 1989; 1993). While Fairclough would prefer to change all aspects of the social reality within which a discourse is situated, his more realistic aim is that through critique of discourse, CDA makes possible critique of the existing social reality, providing *reasons* for actions which will lead to social change (2015:16).

Returning to the second stage, explanatory critique, this entails asking what wider conditions allowed the situation under investigation to happen. In practice this means considering both

discursive and material dimensions, and how they coalesce. For example, with respect to the stigma of mental illness, one thing which allowed TTC to seize upon stigma as a piece of theatre was a growing understanding of the role of stigma in society and its vast and deleterious effects, as charted by Tyler (2013; 2015; 2018; 2020).

Following explanatory critique, the final stage of CDA is praxis, (transformative) human action. There is no direct connection between CDA and transformative action or social change, but CDA can be a form of argumentation, advocating action through its critique. The gap between advocacy and action means that dialogue with social actors who are well situated to undertake (remedial) action is all the more vital, given Fairclough's emphasis (2015:47) that solutions will only result from tackling the ideological assumptions concerning capital growth.

Mulderrig (2015) agrees CDA has an explicitly emancipatory agenda, but rather than viewing interpretation as a discrete stage of CDA research, emphasises interpretation as integral to its typically multi-layered and iterative methodology, in which stages could be described as follows; formulation of the research 'problem', data selection, identification of germane analytical tools, and evaluation of the meaning and consequences of findings (Mulderrig, 2015).

2.2 Criticisms of CDA

Examining the criticisms levelled at CDA, along with possible responses, contributes to further understanding the approach. According to Breeze (2011:494), a 'barrage of informed criticism' has identified some inconsistencies. Criticisms are levelled at either the approach itself, or its leading exponents, notably Fairclough.

Criticisms include the focus of research, ideological bias, absence of participant dialogue, linguistic bias, and over-reliance on a single linguistic framework. More surprisingly, they even include what could be termed a meta-criticism; that the term 'critical' signifies a 'rhetoric of self-praise' (Billig 2002: 37) which implicitly reduces the value of forms of discourse analysis which do not use the 'reified' name or 'branded' initials.

Luke (2004) and Martin (2004) both find CDA overemphasises the discursive construction of oppression, focusing insufficiently on topics of liberation and freedom. This is puzzling, since CDA researchers are motivated from a starting position which identifies a social problem, and will, at least using the discourse-dialectical approach, have in mind some form of emancipatory

consequence. Yet some scholars have called for greater focus on productive uses of power, including Luke (2004) who proposes a 'reconstructive' discourse analysis, focusing on the construction of community, solidarity and liberation. Martin (2004:183) has labelled this approach 'positive discourse analysis', an approach which, he claims, may involve redistribution of power without necessarily involving struggle.

Breeze (2011:513) observes a tendency for CDA to presuppose a theory of social relations informed exclusively by a focus on the discourse practices of powerful actors, rather than conducting a more rounded study of the way in which language works in a particular setting. This reflects a criticism voiced by several researchers, including Rogers *et al*. (2005), who call for increased incorporation of participatory research in CDA, to increase its potential for emancipatory action. Similarly, Slembrouck (2001) criticises CDA for its tendency to exclude the 'voices' of discourse participants as part of the process of critique. As Wodak's Discourse Historical Approach (Reisigl and Wodak, 2001) illustrates, it can be illuminating and useful to include more ethnographic insights and participant perspectives as part of CDA's framework. In the current research I obtain insights from two participant groups and from online commenters, thereby addressing this major criticism. Fairclough's view, that participant dialogue helps to make sense of practices within organisations (2005:11), resonates with my reasons for conducting interviews (Chapter 9), through which I seek to understand the relationship between campaign texts and other social (institutional) elements, including power. Critical discourse analysts may inadequately address a text's immediate context, leading to interpretations of insufficient relevance to participants (Breeze, 2011:521). This criticism too may be addressed through cohesive and triangulated research. When drawing texts from participant sources I seek not only to ensure they are adequately contextualised, but rather, that their context is a central part of their analysis.

Criticisms from the field of educational research about the substantive focus of CDA include a lack of focus on non-linguistic aspects of interaction, such as emotion and activity (Rogers 2004; 2011). Taking emotion first, one need only consider a few titles of recent CDA research to see that her criticism is unfounded: *Peddling a Semiotics of Fear* (Brookes and Harvey, 2014) critically examines scare tactics in health promotion, Mulderrig (2018) explores *Multimodal Strategies of Emotional Governance* with respect to the government's Change4Life social marketing campaign, and *Fear and Responsibility* (Brookes and Baker, 2021) analyses media discourses of obesity and risk. While these overtly address emotion in their titles, to accuse CDA more widely of ignoring emotion is unfair when emotion is so often

the lived accompaniment to oppression, and indeed it is emotion itself which may motivate research.

It has been suggested that analysts working in CDA use it to further an overt pre-existing political or social agenda, perhaps through selectively extracting isolated quotes to reinforce an ideological point (Rogers, 2012). Such 'impressionistic' linguistic sampling may be partially mitigated by the use of corpus linguistics, which allows a representative view of textual patterns over a large sample of data. I explain and describe my use of corpus linguistics in this research in 5.8. Rogers' concern can be related to suggestions that political ideologies may be being superimposed onto data in CDA, rather than revealed through it. This resembles Widdowson's suggestion (1998) that the macro context may be mapped or applied too readily to micro interactions. Similarly, Verschuren (2001) claims CDA's focus on power in society may mean analysts isolate those aspects of a text which reflect their beliefs, and by using these as the basis of their interpretation, create circular arguments, lacking textual or contextual analysis. In this thesis, my textual analysis of the core (website) data extends to two chapters, while I also dedicate significant consideration to the context of all the data, and in Chapter 3, to its broader social context. Such criticisms might more generally be addressed by a researcher's explicit ideological positionality, openness to challenge, and use of a replicable methodology, offering as evidence representative discursive patterns rather than isolated examples. However, to exclude an especially informative solitary piece of text for fear of accusations of 'cherry-picking' would be negligent.

Rogers (2012) also claims CDA too infrequently extends the boundaries of existing theoretical frameworks. This is manifestly not the case with Fairclough's discourse-dialectical approach which, driven by ontological principles, takes a transdisciplinary approach which involves not only 'borrowing' concepts from other disciplines, but working with their logics and operationalising them within CDA, resulting in transformative theoretical practice. Fairclough (2005) exemplified the way in which transdisciplinary CDA is informed through the disciplines and theories it is in dialogue with, through his own work in which his research topics, the information society and knowledge-based economy, are viewed as elements of transition in Romania. Mulderrig (2019) meanwhile demonstrated use of transdisciplinary dialogue to illustrate how the Change4Life social marketing campaign was used as a technique of governmentality.

With respect to linguistic analytical frameworks, all forms of CDA routinely adopt an abductive approach, continually refining and adapting the methods, and adjusting frameworks to fit the object of research, as illustrated by Wodak and Meyer (2001: 63-93) and Reisigl and Wodak (2001). In the current research I adopt the same approach, incorporating and adapting a number of established text analytical frameworks. For example in my application of van Leeuwen's framework for the representation of social actors, I apply categories to various named social groups, in a way which reveals more interesting findings about the relationships between the social actors. Similarly, in analysis of the pronoun 'we' in TTC, I first used the concept of website 'voices' in the corpora to accurately reflect the different deictic centre implied by the organisation and website user respectively. In these ways I extended the use of theoretical frameworks in response to the data.

While CDA, in common with any research approach, has limitations, as a textually based approach to the investigation of a social problem, it is both robust and flexible.

2.3 The theoretical focus of analysis

In this section I situate my research as a piece of critical policy research which uses CDA. I first discuss why, or to what extent, this might constitute policy research, and why CDA is an appropriate approach for this subject. I then explain the nature of Critical Policy Studies (CPS) and its increasing alignment with CDA, such that Mulderrig, Montesano Montessori, and Farrelly (2019) propose an integrated approach, Critical Policy Discourse Analysis (CPDA). I position my approach as reflecting the commonalities between CPS and CDA, and discuss both the emancipatory objectives of the research, and the dilemmas posed by the reflexive process.

CDA is among several approaches which critically investigate politics and public policy through a focus on discursive practice (Mulderrig, 2016), but because CDA investigates the role of language in the constitution, contestation, and transformation of social problems, it is especially useful in the investigation of social change (Mulderrig, Montesano Montessori, and Farrelly, 2019). I noted in 2.1 that different 'schools' of CDA have emerged through research into specialised linguistic problems. These varieties of CDA are not *'mutually exclusive territories'* (Fairclough 2013:227), and my research is informed by elements from a number of these, with overall conceptual framing influenced by Fairclough's discourse-dialectical, critical realist approach (1989; 2003; 2015) and subsequent work by Chouliaraki and Fairclough

(1999). It is also notably filtered through the lens of Mulderrig (2011; 2016; 2017; 2018; 2019) whose work on biopedagogy, nudge, and innovative combination of CDA with corpus linguistics, and with critical policy studies, informs and guides my approach.

Using the concept of 'social practices' in CDA is vital in moving between, respectively, social structure and social agency and action. Using Fairclough's (2003:205) definition, a social marketing campaign such as TTC can be viewed as a social practice; it is 'stable' in the sense that it is a repeated practice, across contemporary capitalist society, driven by government requirements, with policy justifications, and with declared objectives of changing an aspect of social life and behaviour.

To define this research as policy analysis means first being sure what type of discourse AS is. It has some similarities with political discourse, if this is defined as a form of action, within which the representations made are part of producing an argument (Fairclough and Fairclough, 2012). We can identify two clear arguments in AS; that stigma (not access to treatment) is the key problem in mental illness, and that the policy solutions are to be found in self-directed community actions (not in state provision). Yet if the defining nature of *political* discourse is its argumentative *nature* (Fairclough and Fairclough, 2012), anti-stigma is not political discourse *per se*.

Policy-making however is distinguished by its problem-solution 'nature' (Fairclough and Fairclough, 2012), which can be linked to Foucault's (1984) notion of 'problematisation', the idea that problems addressed by policy are socially constructed, rather than having an objective reality. A situation may be 'problematised' in a variety of ways, with some solutions favoured (and textually foregrounded) while others are precluded or backgrounded, and there may be little clarity concerning the relationship between problem and solution (Fairclough and Fairclough, 2012). AS is thus recognisable as policy discourse, since the reasons for the campaign's institution remain opaque, and consequently textual analysis of the problem-solving nature of the underlying policy could allow alternative solutions to be identified. Thus, although AS is not overtly policy discourse, it is the expression and enactment of policy.

Policy documents are associated with networks of social practices (Fairclough 2003:141), and they function specifically to regulate and control ('govern') other networks of social practices. Significantly, TTC is to a large extent specialised for regulating and controlling both its network of 'Champions' (the unpaid workers of TTC), and the people with mental illness who tell their 'stories' through on-site blogs. TTC represents a particularly complex network of

social practices, influenced by the fundamental contradiction that although their declared target demographic is people who stigmatise and are not mentally ill, if their public interface did not significantly attract people with mental illness, the site would have no ‘stories’ to tell, and few Champions either.

The language of policy requires critical scrutiny because policy influences the way subjectivities and practices are constructed in the wider socio-economic order. Here I briefly explore Critical Policy Studies (CPS), an established approach to policy research, to enable me to position it in relation to CDA. CPS originated as a post-war endeavour to develop a critical, democratic policy science, and has more recently established a clear link with discourse approaches through an analytical focus on meaning-making practices. Its recent recognition of the limitations in positivist analyses, and interest in democratic goals, is perceived by Mulderrig, Montessori, and Farrelly (2019) as part of the ‘cultural’ or ‘ideational’ turn in political science, which recognises the significance of social semiosis (Fairclough, Jessop and Sayer, 2004). In the context of policy this means embracing the analysis of social semiosis in interpreting how policy is developed, implemented, and understood.

The departure from positivism is also reflected in its recognition of the importance of ethnographic approaches to understand the meanings which actions have for social actors (Mulderrig, Montesano Montessori, and Farrelly, 2019). The influence of Foucault’s views on the role of discourse in forming social practices, regimes of power, and individual subjectivities, further drove the move away from positivism, and has been reinforced by the field of cultural political economy, for example Jessop (2004) and Sum and Jessop (2015).

CPS has however been criticised for ignoring fine details of text, lacking a systematic mode of enquiry, and for dependence on a narrow field of scholars for its methodological and interpretive approach (Mulderrig, Montesano Montessori, and Farrelly, 2019). Since it has also been criticised for failing to look beyond policy texts themselves, it is important that in CDA’s ‘treatment’ of policy analysis, it fully contextualises its analyses, for example through triangulation by ethnographic approaches such as participant work.

Therefore both in response to the ‘readiness’ of CPS, and to the above criticisms, Mulderrig, Montesano Montessori, and Farrelly (2019) propose an integration of CDA and CPS, named CPDA; essentially a policy-specific type of CDA, incorporating explicit methodology, fine textual analysis, and emancipatory objectives. The argument for this integration is strengthened when considering that CDA and CPS share several assumptions about the object of research,

along with epistemological and ontological principles; for example both view policy as dependent on political 'imaginaries'. This follows Fraser (1992), for whom political imaginaries can be understood as taken for granted assumptions and beliefs about problems in society, including how, and by whom, they should be addressed. The use of such imaginaries discursively simplifies the reality of political action, and assumptions concerning government intervention (Mulderrig, Montesano Montessori, and Farrelly, 2019). Imaginaries construct a particular version of a policy problem, which is legitimated through expert evidence; the latter is a significant feature of legitimation in TTC (7.2.2). It is with awareness of the role of imaginaries that CPS and CDA are able to understand the extent to which policy language influences the conceptualisation of the policy problem (in this study, the stigma of mental illness) and subsequently legitimates the solution or solutions which it proposes (Fairclough, 2013; Fairclough and Wodak, 1997; Fischer, 2003). The concept of imaginaries is explored further in 3.3.

CDA and CPS are thus complementary, and CPDA might be viewed as accepting and extending Fairclough's challenge to contribute to strategies of resistance through theoretically informed explanatory critique. CPDA is able to show both how and why neoliberal language and logic dominates and colonizes (Mulderrig, Montesano Montessori, and Farrelly, 2019).

My approach reflects the commonalities between CPS, described above, and CDA. I adopt a critical and socially grounded approach which analyses not policy itself but the consequences (or products) of the enaction of policy decisions (Fairclough, 2003; 2015). A theoretically informed account of both the data and the social and political economic conditions of its production allows me to understand why the texts took their specific form (and consequently, through what manner of intervention to the social reality they might differ). This methodology therefore incorporates a movement from normative critique of discourse to explanatory critique of discourse (Fairclough, 2005; 2015).

My methodology is both reflexive and abductive, requiring continuing movement between theory, method and data in order to achieve 'explanatory adequacy' of the research process (Mulderrig, 2015). This multi-layered process aims to find the links between the 'macro' social processes and the 'micro' discursive events (texts or conversations), and requires systematic understanding of the social context of texts. Mulderrig, Montesano Montessori, and Farrelly (2019) note that research may start with a partially conceptualised problem. In my research, an evolving conceptualisation of the problem, and the questions which it generates, was integral

to this reflexive, abductive methodology. It is the abductive nature of the approach, whereby data is analysed at each stage and the findings reinform the research design, which led me to carry out participant research.

My emancipatory agenda consists of several related stages. I aim to highlight the ideological underpinnings of the practice of AS in relation to mental illness. My research does not seek to make explicit an unequal distribution of a 'common good', such as inequalities in mental health, which are already well documented, yet it does constitute a form of praxis (Fairclough 2015:14) in seeking to reveal hidden interests. First, I seek to reveal the way in which the concept and reality of stigma has been cynically adopted to publicise and help enact a set of policy goals which serve neoliberal, rather than public, interests. Second, having shown how neoliberalist governmentality underpins the policy creation of the TTC 'theatre', as an expensive piece of social propaganda, I aim to consider what form a purely (i.e. genuinely) anti stigma intervention might take, were it not constrained by neoliberalism and the privileging of forces. Given the social reality, I also hope to conceptualise a better set of possibilities *within* the existing social context; my critique seeks to emerge with suggestions for a better form of stigma intervention with respect to mental illness.

Mulderrig, Montesano Montessori, and Farrelly (2019) highlight two possible outcomes of the analysis of policy initiatives, both of which are relevant to my own research. First, by exposing the vested interests behind policy initiatives, analysis can challenge the neutrality and inevitability of a policy. Second, by uncovering the contradictions inherent in policy, the weaknesses of hegemonic dominance may be exposed.

As is common in qualitative research, the researcher should reflect on their involvement. Rogers (2012) distinguishes between reflection and reflexivity, the latter defined by Bucholtz (2001:166) as a process in which the analyst's choices are visible at each step, such that they become part of the analysis itself. Chouliaraki & Fairclough (1999) concur, regarding the researcher as *part* of the discursive practices they study. Yet reflecting on the *nature* of the critique may be overlooked. There is a distinction to be made between the explicit normative critique of discourse (which is expected) and the accompanying critique of social institutions and structures which, within Faircloughian CDA is a legitimate and in fact necessary focus of critique. But where, within the spirit of practitioner reflexivity, does this leave us when wanting to critique individuals? Ethical questions remain for the researcher who believes they have dispassionate and evidential reasons to critique an individual on the basis of research.

2.4 The formulation of research questions

Here I explore the research question(s) through which I explore the social (policy) problem of this research. In 1.7 I introduced the 'source' linguistic question, *RQ1: What is the language used in anti-stigma policy, as enacted by AS campaigns?*

The research questions evolved, in response both to the data and the need to be realistic with respect to the text-analytical methods and the scope of the research. Below are RQs 2-10, which emerged, in no specific order, as the most useful in this dynamic process.

RQ2: What does the language around the campaigns reveal about the (explicit or more opaque) function of AS campaigns?

RQ3: Why is the concept of stigma afforded such importance as part of mental health policy?

RQ4: What is the ideational and ideological content of AS discourse?

RQ5: How is the practice of anti-stigma self-evaluated and legitimated as a policy response by its architects (or its enactors)?

RQ6: How does this discourse of stigma define the nature of the policy problem?

RQ7: To what extent is the discourse of AS inflected and constrained by discourses which serve neoliberal objectives?

RQ8: How is the campaign premise conveyed to the public, and what is asked of the public?

RQ9: Who did the campaign target, and how were they represented linguistically?

RQ10: To what extent do official AS discourses represent the lived experiences and needs of those experiencing mental illness?

Areas for critical reflection (CR) were also continually modified, in response to findings at both macro- and micro-level:

- *CR 1: To what extent is the overarching aim of AS a response to productivity concerns, rather than the wish to improve the lives of people with mental illness?*
- *CR2: What are the consequences of AS - for people with mental illness, for the 'public', and for government?*
- *CR3: How might anti-stigma efforts be improved, in light of the findings?*

- *CR4: What did a further campaign (HT) contribute, and how was it different to TTC?*

Explicit reflection on the evolution of research questions is part of positively engaging with an abductive process and demonstrates the nuanced fluidity of researcher positionality. My growing understanding of the data led to modification both of my perception of the social problem, and of the RQs, as I became more focused on the mechanisms by which neoliberalism benefits from AS initiatives. *RQs 2, 3, 4, 6,* and *7* are especially relevant to this exploration. Together these questions represent the need to understand power and economic considerations as motivations for the use of AS in policy, and ultimately, what vested interests underpin the order of discourse of mental health anti-stigma campaigns. In each case, the objective is to demonstrate how these power relationships, motivations, and interests, are realised linguistically. These questions are investigated by asking smaller scale, often very specific, questions of the language encountered in particular texts during analysis.

2.5 Linguistic description in CDA

In this section I introduce the basis of the core method of linguistic description used in CDA, as a basis for the subsequent description of the specific text analytical frameworks which I make use of to help answer the research questions explored above.

As described earlier, one of the key assumptions of CDA is the assumption of the relationship between language and the social world. Since exploration of this relationship relies on a trans-disciplinary perspective to achieve explanatory adequacy, the frameworks I use are drawn not only from linguistics, but also from the social scientific realm, reflecting the different types of data I use (web texts, focus group data, interview data, and YouTube comments).

The core analytical framework follows Fairclough's proposal (2003; 2005: 2015) that language is to be treated as a social semiotic. This itself owes much to the foundational work of Halliday (1978;1994), whose conceptual framework, Systemic Functional Linguistics (SFL) describes language as a system of meanings whose configurations reflect its wider social functions. SFL offers a core method of linguistic description through which to underpin analysis in CDA Unlike Chomskyan linguistics, SFL focuses on the relationship between language and other aspects of social life (Fairclough 2003:5) and is concerned with the social character of texts. It allows analysis of the linguistic resources in terms of processes, participants (actors), and circumstances.

This alignment of SFL with the Faircloughian conceptual framework means it is ideally suited to CDA. SFL and CDA have different aims however (Fairclough, 2003), which Chouliaraki and Fairclough (1999) have attempted to critically synthesise. Despite the utility of SFL, Fairclough still emphasises the need for transdisciplinary dialogue in CDA, which he regards as a long-term process of engagement with different types of linguistic and non-linguistic analyses.

Functional views of language tend to highlight their multifunctionality (Fairclough 2003:26); in SFL, texts concurrently have 'ideational', 'interpersonal' and 'textual' functions. What is meant by this is that texts are representative of features of the physical, social and mental world, and simultaneously '*enact social relationships between participants in social events',* along with their attitudinal positions, to '*coherently and cohesively connect parts of texts together* (Fairclough 2003:26-27). Texts are also connected with their (situational) context (Halliday 1978; 1994).

Fairclough also views texts as multi-functional, but does so differently, in accordance with the distinction between genres, discourses and styles, which as noted in 2.1.3 are the three main ways in which discourse contributes to social practice. Fairclough (2003:27) prefers to consider the meaning of texts, rather than their functions, and assigns three principal types of text meaning; Representation, Action, and Identification, which are at work simultaneously within whole texts or parts of them. Textual analysis which considers the way these meanings work together constitutes the basis of the analysis of the social world through texts; but typically this is articulated by respectively describing Action as genres, Representation as discourses, and Identification as styles. When these elements are considered at the level of social practices, then as described earlier, they are identified as elements of 'orders of discourse' (Fairclough 2003:28).

SFL is not a static field; significant contributions to CDA have been derived from SFL, most notably the work of Hodge and Kress on social semiotics (1988) and language as ideology (1993), Kress (1985) on the relationships between linguistic processes and sociocultural practice, Lemke (1995) on textual politics, and van Leeuwen (2008) who provides influential frameworks for the analysis of social actors, social actions, and legitimation.

2.6 Text analytical methods in this research

Below I set out each type of textual analysis which contributes to answering the research questions. I selected each analysis to reflect both the data and the information I sought from them, yet there are not necessarily neat links between analytical categories and answers to research questions. The analysis provides the evidence, allowing structured and reliable insights to be derived from the data. This then contributes in piecemeal fashion to a more fundamental understanding of the data, and the nature of the social action it represents, in turn allowing the research questions to be addressed. More detailed description of text analytical methods is provided in Chapter 5.

For analysis of both of the main websites, TTC and HT, I make significant use of the analysis of the pronoun 'we', using the principle of deixis, following work by Mulderrig (2012). This framework had a broader utility than anticipated in this research. Deictic choices demarcate the boundaries of participation in discourse, and in the case of websites, this reveals writers' and readers' positions in relation to events, and the way they are involved in them. Chilton (2004) and Van Dijk (2002) have both noted the contribution of the deictic system to the negotiation of roles and responsibilities. Pennycook (1994:178) emphasises that all pronouns are inherently political. However, because 'we' plays an important role in including or excluding participants from the deictic centre, Pennycook (1994:175) describes it as the '*pronoun of solidarity and of rejection, of inclusion and exclusion*'. 'We' therefore has great value in revealing the discursive construction of discrimination.

I use Van Leeuwen's (2008) framework for the analysis of the representation of social actors to understand how individuals and groups are represented specifically by the TTC campaign, again aided by its corpus. These linguistic choices help to reveal the way a text portrays or describes a particular aspect of the social world, in this case, mental health 'activism', and how that portrayal is textured by issues of identity, power, values, and assumptions in relation to people involved.

AS can be viewed as an ideological struggle, with shifting symbolic territorial boundaries which need to be continually sustained by striving for legitimacy, which is revealed through textual patterns. Van Leeuwen's sociosemantic approach to CDA offers not only frameworks analysing the representation of social actors and social actions, but also the legitimation of

social actions (2008). I accommodate some of his categories of legitimation strategies to explore how the social actors associated with operationalising AS justify courses of action, and ultimately, how they justify AS as a social practice. My greatest focus however is on the interdisciplinary framework developed by Reyes (2011), which is anchored theoretically in CDA, and uses analytical tools from SFL. Reyes takes into account previous studies on legitimization in CDA, including van Leeuwen (1996; 2007; 2008). My focus is on the application of these frameworks to the TTC corpus.

I also analyse the websites' genre, aware that the power dynamics of the social groups who use them are embedded in genres. Tardy and Swales observe the potential for genres to result in exclusion of users who are not familiar with the practices associated with them, 'or who do not bring 'the preferred forms of capital to the communicative context' (2014:167). This is especially relevant to AS, since these websites seek specific forms of interaction and activity from people with a preferred attitudinal alignment. Despite the relationship between genre and power, genre analysis has been most widely used outside of critical work, but critical perspectives within CDA have included Flowerdew (2004), who analysed the discursive construction of Hong Kong as a 'World Class' city, analysing genres used in public consultation to demonstrate how 'consultation' in fact adopted an authoritative voice which imposed the government's goals. Bhatia's (2008) framework for critical genre analysis integrated 'text-internal' and 'text external' factors. Through this combination he scrutinised text and genre while examining professional culture and practice. His research on the texts and practices of corporate disclosure thus combined an internal focus (on lexicogrammatical features and rhetorical moves) with analysis of institutional discourses and actions. With respect to more specifically social issues, Huckin (2002) analysed genre within a CDA study of news texts, identifying textual 'silences'; the absence of particular details (about, for example, homelessness). By creating a corpus of texts in the target genre, he analysed the presence of absence of a list of topics and subtopics which might feature in it. Tardy (2009) meanwhile traced intertextual use of ideological expressions across linked texts over time. These examples serve to demonstrate that when critically investigating genre, researchers tailor their approaches according to the data they are researching. Genre analysis, and especially critical genre analysis, is not a specific procedure, but calls for different approaches which focus on individual features and patterns.

With this is mind, I adopt a partially traditional approach drawing on analytical frameworks proposed by Swales (1990) and Bhatia (2008), but then diverge to better acknowledge the

online medium of the campaign texts, by using Askehave and Nielsen's (2004; 2005) approach which employs the concept of reading and navigational modes in web-mediated genres, and emphasises the importance of hyperlinks. Adopting this framework exemplifies the utility of considering analytical ideas originating outside linguistics; in this case, from communication studies. I consider the genre of both TTC and HT, using corpus and non-corpus data, with a particular focus on their 'homepages'.

In all the analyses above I am aided by corpus linguistics (5.8), drawing on the corpus findings to inform consideration of both narratives and lexical patterns which emerge from the web texts. In CDA, identifying lexical choices may be a means of understanding the institutional choices and vested interests which motivate them, thereby allowing us to challenge the ideological naturalisation of discursively expressed meanings or values. In 7.1.1, I analyse the website corpora with a specific focus on the lexis used to describe mental illness, mindful that the meanings of words are potential, not fixed; they are generated by both their co-textual environment and the schema (a concept from cognitive linguistics referring to background knowledge and values) which they trigger. Therefore it is important to distinguish, as Semino (1997) points out, between the meaning projected by a text and its final constructed meaning.

When examining matters relating to social exclusion it is necessary to consider language which is expressed imprecisely, since this imprecision may be intentional. Van Dijk, distinguishing between surface and implicit meaning in lexis, describes implicit meanings as those which are not *'openly, directly, completely or precisely asserted'* (2001:104). In 7.1.2, I consider the use of vague lexis and whether it is used strategically.

Van Dijk (1984; 1998), who often uses a socio-cognitive approach in CDA, discusses the linguistic mechanisms of discrimination, and refers to the linguistic creation of difference as a process of 'ideological squaring', in which lexical patterns are used to create *'opposing classes of concepts around different social actors',* which involves exaggerating 'our' sameness and positive self-representation and 'their' difference and negative representation. I apply Van Dijk's concept of ideological squaring during my critical commentary of the focus group data, in 8.5.

The recurrent use of words from the same semantic field, repetitions, and use of quasi-synonymous terms, is a concept which Fairclough (2003) terms 'overwording', which he suggests may indicate a focus of ideological struggle. The use of such repetition can be observed in TTC, and explains its repetition of messages, in different ways to different

audiences. Through such patterns of repetition, an ideological perspective becomes embedded and normalised in society. The discourse process through which meanings or values are naturalised as 'common sense' is the linguistic aspect of hegemony. The use of the corpora to understand word or phrase frequencies, to confirm apparent repetition, is therefore something I return to frequently during analysis.

The websites' textual materials constitute the core data. Wider data includes three 'policy-implementer' interviews, a focus group discussion which included a screening of campaign videos, and comments from YouTube videos. At this juncture I summarise key theoretical or contextual information about all three methods of triangulation.

Focus groups are a key method of qualitative exploration used to prompt discussions on a certain topic within a specific social group. Since Kress (1985:19) asserts that from an SFL perspective, most situations which are bound by rules and conventions produce generic texts, a focus group text can be regarded as generic; it is one among many semi-public genres. Focus groups aid understanding both of how the public sphere influences individuals' political and social understanding, and how the social or individual level may in turn potentially influence policy. Having become popular as an investigative tool in the exploration of the 'commonality of individual experiences' (Kryzyanowski 2008:163), focus groups are used for a variety of types of research into diverse areas of social life, including socio-political macro concepts and abstract issues such as national identity (Wodak *et al*. 1999; Benke 2003; Kovács and Wodak 2003).

Focus groups can facilitate understanding of the relationships between discourses and society, or the discursive practices by which an ideological status quo is created or sustained (Fairclough and Wodak 1997:258). The 'voices' from focus groups also complement primary analyses, in helping to reveal discursively shaped inequalities (Kryzyanowski 2008:178). Since focus groups may contribute to understanding the discursive construction of a social outgroup (Reisigl and Wodak 2001), they are a particularly appropriate means by which to explore, as I do, older people's views on stigma and AS. Unlike interviews, focus groups involve the 'explicit use of group interaction to generate data' (Barbour and Kitzinger 1999:4), while the moderator determines the macro topics and may intervene or influence turn-taking (Myers 2004). The focus group is literally 'focused' on a collective activity (Kitzinger, 1994:103), in which discussion is facilitated by group tasks. While focus groups are 'naturalistic rather than natural', their naturalism must be 'carefully contrived' by the researcher (Bloor *et al.* 2011:19).

Comment analysis from YouTube videos complements the video response element of the focus group, broadening understanding of audience perception of these videos. YouTube, founded in 2005, has become the largest online video sharing platform (Gill *et al*. 2007). Most UK YouTube users (44%) are aged 25-44, 57% of whom are male (Statista.com 2021), making it an ideal channel for TTC, which latterly had a particular interest in influencing young males. Multiple direct and indirect economic implications exist for many posters of videos, including health campaigns.

YouTube is also part of the political sphere in some countries, such as the USA, and political (and other) campaigns may analyse YouTube comments to understand which aspects of a message provoke greatest response (Thelwall 2014). For advertisers and social marketers, posting campaigns on YouTube provides the posting organisation with demographic information on viewers via the YouTube API (Application Programming Interface). YouTube also extends the 'media life' of videos first broadcast on television, as were some TTC videos. It provides alternative means by which 'visual and verbal artifacts', as ideas, images and talk, remain in - or first enter - the lives of the public (Jones and Shiefflin, 2009). In short, the established relationship between YouTube and marketing renders it an ideal platform to extend the coverage of public health campaigns involving social marketing.

Comment facilities are part of a generalised shift towards user participation in websites (Madden *et al*. 2013) and perhaps also a societal shift in which rating and evaluating social activities has become widespread. Jones and Shiefflin (2009) consider evaluative affordances a reflection of YouTube's inherent dialogicality. Television commercials arise from 'monologic mainstream media', but when transplanted to YouTube they invite dialogic discussions. To understand the written reactions of the online audience, I use qualitative content analysis informed by Madden *et al*. (2013), in which I assigned categories (as codes) to comments, then tested them against further data to verify the utility of categories.

When discussing the interviews (Chapter 9), I also examine how the speakers talk about things their organisations might do. I consider the concept of irrealis statements, a term first coined in linguistics by Iedema (1998) and subsequently explored by Graham (2001) who notes that policy language can be problematic in analysis, as it often operates in the future tense. Policy persuades people to do things by the creation of a perceived value, applicable to a future time and space; this can be seen to have relevance to a social marketing campaign message or commitment. Voltaire (*Idées républicaines*, 1765) discussed the concept of utopian future

spaces, but for Graham, who considers the concept of irrealis in relation to a future time and (utopian) space, utopias of any age are ‘powerful illusions’, notably including the online variant which he terms ‘techno-utopias’ (2001:766). In my own examination of irrealis, I consider how the interviewees orient their, or their organisations’, actions towards irrealis (potentiality) rather than realis (actuality) (Iedema 1998:484), not with respect to a utopian future but, conversely, as a way of hedging commitment to action.

The analytical choices described above were all made on the basis of salient textual characteristics; yet the multifunctionality of discourse, described earlier, inevitably means that the analytical categories assigned are, in a sense, artificial abstractions. Any of the texts might be analysed from multiple perspectives, but since this is not feasible, it is salience which largely both determines, and allows the use of, a relatively narrow perspective. Exploiting the interrelated nature of the elements which together constitute this data is what allows a fluid exploration of the purpose, functions and utility of AS, and ultimately an adequate response to the research questions. This view aligns with Fairclough and Fairclough (2012:2), who assert that rather than examining discrete elements - genre, representation, and identities – a focus on the inter-relationships between these elements is more likely to clarify the ways in which texts provide a reason for a particular action, or serve particular power interests.

2.7 Interdisciplinarity

I have noted that in drawing on accounts from other theoretical fields in order to generate a critical narrative, CDA is not only interdisciplinary, but transdisciplinary. Engagement with other disciplines allows the use of their logic and categories in the development of a theoretical and methodological framework. Here I explore the reasons for transdisciplinarity in CDA.

Discourse-dialectical CDA has an inherent relationship with several areas of critical theory; starting with the influence of critical realist ontology, notably from Bhaskar (1986) on its analytical categories and research goals. It also has close associations with Marxism, Hallidayan systemic functional linguistics, and with critical political economy. These fields all require a collaborative understanding of their relationship with CDA. In addition, CDA also requires a relationship with subject-specific disciplines, according to the object of enquiry. For

this reason I review both relevant scholarship from the field of CPE (Chapter 3) and a selection of CDA work in public and mental health (Chapter 4).

Because understanding the social context of the data is vital to its interpretation, CDA routinely works in dialogue with Foucauldian analysis, which ideally equips CDA in analysis which involves addressing problems of the state, or of governmentality. For example, Mulderrig (2017), noting the increasing prominence of techniques of self-regulation in political power, draws on the Foucauldian concept of biopower and combines it with the text analytical methods of CDA. Mulderrig (2015) explains how interdisciplinarity can be understood through the work of Harvey (1996), who distinguishes between the discursive and non-discursive, and the relationship between them, through his proposed framework of six 'moments' or social processes, introduced in 2.1. The term 'moment' reflects the transient nature of social processes. Harvey's conceptualisation of social processes can be regarded as the root of interdisciplinarity in CDA. These moments can be described as (i) beliefs/values/desires (our epistemology, ontology and sense of self); (ii) institutions; (iii) material practices (the physical and built environment); (iv) social relations; (v) power (which is a function of all the others); and (vi) discourse (Mulderrig, 2015). Since each moment has distinct properties, each is associated with distinctive academic disciplines. Therefore to understand the relationship between discourse and other dimensions of social life, other academic disciplines need to be involved. Because these elements or 'moments' are dialectically related, in addition to retaining their distinctive properties, each element 'internalises' the others (Fairclough (2003). Thus, an adequate explanatory critique of the discourse 'moment' (the key objective of CDA) necessitates transdisciplinary engagement with theoretical frameworks developed in other disciplines, in order to account for those other moments. The discourse 'moment' is a potent means of sociocultural reproduction, particularly when it has become naturalised and invisible. Critical analysis of discourse allows characteristics which sustain relations of power, such as values, beliefs, assumptions and vested interests, to be revealed (Mulderrig 2015).

2.8 Chapter Conclusion

I started this chapter by introducing CDA, before briefly considering the nature of discourse itself. I then situated Faircloughian discourse-dialectical CDA within the social context which drives its description, objectives, and operationalisation. I discussed criticisms of CDA, before presenting critical policy analysis, describing its appropriacy within CDA as an approach for

the current research, acknowledging its potential shortcomings, and how CDA is able to address them. I discussed the research questions, then described the text analytical frameworks which I use within CDA, and introduced my means of triangulation. Closing with an explanation of the transdisciplinary nature of CDA serves as a prelude to Chapter 3, in which I review literature which helps to conceptualise and contextualise the current research.

CHAPTER 3: Anti-stigma and its Cultural Political Economic context

3.0 Introduction

In this chapter I explore literature which contextualises and conceptualises this investigation, thereby describing what has influenced my position on the use of language in anti-stigma initiatives in mental health.

I start by describing the Foucauldian ideas of biopower/biopolitics and governmentality respectively, as important concepts within which to frame and understand other ideas. I then move on to neoliberalism, describing this as an expression of governmentality. These are distinct concepts but I aim to demonstrate how they form an integrated system, and to situate them in relation to mental health.

I then consider transdisciplinary theories of what policy is and what it is for, including a return to the concept of imaginaries, introduced in 2.1.3. I continue by explaining how within neoliberalism, certain policy mechanisms and actions have been identified which support its aims, and can broadly be understood in terms of Foucauldian biopolitics. These include responsibilisation, commodification, and the use of data, including 'stories', which I consider through the lens of mental health policy specifically.

I move on to examine austerity as a key effect and policy strategy of neoliberalism, and introduce stigma by viewing its consequences on mental health funding. I subsequently consider models and theories of stigma, positively contrasting more recent writers with traditional views, especially as espoused by Goffman, and then review psychosocial and anthropological models of mental health stigma specifically, examining some of the most relevant key themes which arise from the literature.

The final section entails a shift of mode, away from the empirical, to briefly sketch the public and mental health policy trajectory, showing how neoliberalism created a situation in which social relations are inflected with neoliberal assumptions, such that health services have an extrinsic value, and mental health in particular is related to productivity, culminating in an 'era' enabling anti-stigma.

3.1 Foucauldian biopolitics and governmentality

When Foucault (1976; 1984) challenged the classificatory divisions between the 'norm' and the 'perverse', and described sexuality as a social construct of modernity which created a new category of knowledge, this had implications for other types of categorisation, including mental illness. Such observations were foundational to Foucault's views about the nature of power, which is *'bent on generating forces, making them grow, and ordering them'* (1976:136). Of the fundamental role of power in society, he asserts: *'Ours is a society in which political power has assigned itself the task of administering life'* (1976:139). Foucault thus coins the term 'biopolitics', a form of organisation which wields 'biopower' and which regulates and organises society according to healthcare management, and discourses about population or gender. The concept of biopower encapsulates Foucault's (1978) subsequent argument that power is situated and exercised at the level of life.

Because the terms 'biopower' and 'biopolitics' have come to be associated with environmental issues, Rabinow and Rose (2006) reassert their meanings as Foucauldian concepts and clarify their components. The first two components are, respectively, forms of expert knowledge, and strategies of intervention. The third component is especially transferrable to the practice of AS campaigns:

> *Modes of subjectification, through which individuals are brought to work on themselves, under certain forms of authority, in relation to truth discourses, by means of practices of the self, in the name of their own life or health, that of their family or some other collectivity, or indeed in the name of the life or health of the population as a whole* (Rabinow and Rose 2006:197).

Biopower is a disciplinary power which is focused on harnessing the body in the service of the economy, and presents new characteristics, being simultaneously individualising and 'totalizing', entailing 'calibration' to optimise the individual. Rabinow and Rose (2006:196) describe Foucault's bipolar conceptualisation of power over life, in which one pole of biopower concerns the politics of the human body itself, whereby the forces of the body are maximised and integrated into efficient systems. The second pole is a population-based biopolitics, concerned with regulatory controls on the 'species body' (Foucault 1978). This bipolar technology arose in the 17th century *'to invest life through and through'* (Foucault, 1978: 139), and by the 19th century these two poles were bound and consolidated by the *'great technologies of power'*. Consequently new types of political struggle emerged, in relation to *'life as a*

political object' (Rabinow and Rose 2006:196). Rabinow and Rose observe that 'individualizing and collectivizing subjectifications' have become mobile and international, citing the global reinterpretation of models of patient activism. Pertinently, they also ask *'who could have imagined depressed people as a global category, not only as targets but also as active subjects in a new biopolitics of mental health?'* (Rabinow and Rose 2006:216).

Foucault (1988) describes governmentality as *'the dualistic process of reinforcing the social whole (the hegemonic model) through the individualisation of people'*. This relies on the use of 'technologies of power' and 'techniques of the self', both of which are exercised on the body (and implicitly, the mind), which thereby becomes the locus of individualisation (Foucault 1988;1994). Through this concept, a range of individual and collective conduct is problematized and acted upon *'in the name of certain objectives which do not have the State as their origin or point of reference'* (Rabinow and Rose 2006:200).

Foucault's process of 'governmentality' has been described as when the subject is *'governed by others and at the same time [is the] governor of him/herself '* (Ball and Olmedo, 2013:87). Individuals and populations become governed through subtle practices which direct us towards a desired behaviour. These practices of governance also act on our most personal human qualities; our motivations, beliefs, aspirations and attitudes. Despite being directly governed, we also govern our own conduct, such that it conforms to the dominant regime (Dahlberg and Moss, 2005:19).

Discourses of governmentality are pervasive across a variety of spheres (Rose 2007). Their contemporary operationalisation is typically motivated by cost 'efficiencies', although such measures may be met by 'enclosures of expertise' which represent an autonomous form of resistance to governmentality by professionals of sufficient stature to retain their own disciplinary standards (Rose 1999). 'Technologies of performance' meanwhile are the tools employed to breach these enclosures of expertise, to bring about maximum productivity and minimum waste, forcing professionals to become financial managers of their activity. In this way, despite the appearance of conferring devolved power, such activities are rendered more governable (Rose 1999:153).

Within the optimum performance required by governmentality, the constant definition and self-surveillance of healthy behaviours means that biopower, as power operating on the body, is integral to governmentality. Two key elements within this framework are the construction of

risk and the care of the self as part of the pursuance of optimum performance, with healthy behaviour regarded as virtuous. It follows that mental illness may be construed as unhealthy behaviour, and may therefore constitute wilful deviance (Filc 2005).

3.2 Neoliberalism

I introduced neoliberalism in 2.1.3, when describing the specific social reality which is central to Fairclough's CDA, and I expand on it here.

Jessop defines neoliberalism as a *'political project that is justified on philosophical grounds and seeks to extend competitive market forces, consolidate a market-friendly constitution and promote individual freedom'* (2013:70). The proportions of these components are variable in different places and times, and the socio-cultural significance of neoliberalism as a political project also varies according to its context.

This neoliberal regime shift, which in the West emerged following post-World War II models of capitalist development, saw the introduction of policy designed to radically change the balance of market forces in favour of capital, by a 'newly empowered elite alliance' (Jessop 2013:71). In the public sector, these changes included deregulation, privatisation, and the creation of market proxies, as witnessed under Thatcherism and Reaganism. Successful 'rebalancing' in favour of capital resulted in stagnant wages, welfare cuts, and increases in personal debt in relation to housing, health, or other living costs. Simultaneously an increasing proportion of wealth became concentrated in the top 10% and particularly the top 1% (Jessop 2013:71).

Having reached a peak in the 1990s, the regime shifts of neoliberalism were supplemented with 'Third Way' policies and public–private partnerships (2013:72), and the determination to maintain neoliberalism's momentum necessitated further 'flanking and supporting' mechanisms. Massive state intervention in response to the global financial crisis of 2007-8 supported the return of neoliberalism to 'normal' operation. This intervention, together with the *'path-dependent effects of policies, strategies and structural shifts'* instituted at its peak, means that the global domination of neoliberalism continues (Jessop 2013:72).

Through the economic lens of neoliberalism, all aspects of life are 'economised' to the extent that human beings are wholly market actors, all fields of activity are markets, and all entities, whether public, private, person, or state, are governed as a firm. People are human capital, and

must continually address their current or future value (Brown, 2015). Neoliberalism *'is a form of political reason and governing that reaches from the state to the soul'* (Brown, 2015). To achieve this relies on neoliberalism's dominance as a regime of truth, and the insistence that any other image is aberrant (Robert-Holmes and Moss, 2021:90).

With the public sphere dominated by the free market, all citizens become both consumers and entrepreneurs, if only of their own skills and time. The notion of the ideal neoliberal subject as entrepreneur of the self is especially relevant when precarious forms of employment reinforce the need for such entrepreneurialism (Robert-Holmes and Moss, 2021: 95). The result is an unhealthy state of permanent competition between workers, with inevitable consequences for emotional health, as it drives frustration, depression and aggression (Cromby and Willis, 2013).

Neoliberalism, as a way of *'reconfiguring selves and the social order in accord with the demands of market economies'* is therefore a type of governmentality, and is strongly associated with austerity (Cromby and Willis, 2013:241). Neoliberalism remorselessly converts the normative 'you should be' into the actual 'this is who I am', whereby people have willingly internalised neoliberalism's images as natural and desirable (Robert-Holmes and Moss 2021:92); from this perspective too, neoliberalism *as* governmentality is clear.

Robert-Holmes and Moss regard the 'particular modes of subjectivity' which neoliberalism demands as neoliberalism's 'imaginary'; the set of images about how subjects should be under neoliberalism are social constructions, constituted by the dominant discourse of neoliberalism, and inscribed with its conceptions and visions (Robert-Holmes and Moss, 2021:90).These images are normative, representing the identity or subjectivity that neoliberal beliefs ascribe both to people and to institutions. But they are also productive, seeking to produce or create people and institutions in neoliberalism's own image; in Foucauldian terms, this is what constitutes subjectification, through power relations, dominant discourses and regimes of truth (Robert-Holmes and Moss, 2021:90).

Foucault's concept of biopower was not related to a specific set of dominant interests, but is now broadly interpreted in terms of neoliberalism (Rabinow and Rose 2006:199), and his situation of biopower within the proliferation of regulations at a 'sub-State' level during the nineteenth century, including the fields of medicine and welfare (Foucault 2002: 250), makes for a logical transposition, especially when we construe neoliberalism as a form of governmentality. Isin (2004) positions biopolitics as part of a neoliberal concept of a perfect 'bionic' citizen able to calculate risk, and describes how the subsequently prevalent 'neurotic

citizen' signals the rise of new characteristics of government which he terms 'neuropolitics' (rather than biopolitics) and 'neuropower'. While neoliberalism centres around the rational and calculating subject, neuroliberalism concerns the 'anxious and affective' subject (2004: 232), and so is especially relevant to mental health. The concept of neuroliberalism has subsequently been adopted by others, such as Whitehead *et al*. (2018).

3.3 Transdisciplinary concepts of policy: imaginaries and fantasies

Jessop (2009) regards semiosis as a key mechanism whereby complexity is reduced. He considers policies, along with their attendant decision-making, instruments and evaluation, as important 'technologies' (in Foucault's sense of the mechanisms which are involved in governing conduct) which contribute to the way policy discourses are selected or retained. These technologies are important in the selection and retention of 'imaginaries', and are therefore instruments of meaning making, within a pathway towards social construction, and ultimately, social life.

Jessop describes 'imaginaries' as semiotic systems which frame the complex lived experiences of individual subjects, and/or *'inform collective calculation about that world'* (Jessop 2009: 344). This is an important alignment with CDA; Fairclough (2003) regards imaginaries as constituting the *semiotic* moment of a network of social practices in a particular social field. Jessop (2009:344) distinguishes between the 'imaginary' as a general description of semiotic systems which shape our experience of a complex world, and the 'institution', through which mechanisms such as policies are embedded in lived experience.

Through policy, economic activities may be transformed into objects of governance. Various strategies, concepts and projects are oriented to economic imaginaries, at both micro and macro levels, and seek to redefine specific activities. The forces involved in these efforts include not only political parties and financial institutions, but also, importantly, social movements and the mass media (Jessop 2009:346).

For an imaginary to be successfully institutionalised, it uses various *'behavioural or operational dispositions, specific technologies that sustain and confirm these imaginaries'* (2009:346). Simultaneously, the forces which set in place the imaginary prevent antagonistic imaginaries being pursued. Jessop uses the concept of 'sedimentation' to describe the

routinisation through which the contested origins of discourses, practices, or structures become forgotten, so that they become objective facts of social life.

Fotaki (2010) acknowledges the concept of policy and political imaginaries, but proposes instead that the role of fantasy is an important stimulant of social and political initiatives, which has been overlooked in critical social theory and public policy analyses (Fotaki 2010:704). She draws on psychoanalytic perspectives such as that of Lacan (2006) to conceptualise the idea of the '*fantasmatic (sic) construction of social reality*' (Fotaki 2010:707).

From a political economic perspective, the concept of patient choice is key to the neoliberal political project, since it is seen to be a fundamental mechanism undermining market freedom. As Rose (1999:141-142) suggests, *'All aspects of social behaviour are now reconceptualized along economic lines – as calculative actions undertaken through the universal human faculty of choice ...'.* Market discourse influences mental health care as much as physical health care, in what Nordgren (2010) refers to as a homogenous system of ideas, in which words such as 'market', 'freedom', and 'choice' are organised into strategic statements.

But as Mol (2008:79) highlights, importing the concept of choice within a framework of economic thought, into health discourses using words like 'care' or 'diagnosis' is problematic; the discourses clash when they meet, creating contradictions and tensions which become apparent through scrutiny of texts. In many contexts choice is also illusory for all but an ever-diminishing minority who hold the necessary economic and social power. The policy of patient 'choice' derives from an 'idealizing function' intrinsic to the policy process. In particular, 'freedom of choice' is an illusory concept, although it appeals to policy makers as it requires little of them to offer it (Fotaki, 2010:709). The term 'choice' lacks conceptual clarity, and policy rhetoric disregards the complexities entailed in rendering the policy workable, but the underlying fantasy sustains the concept and its popularity (Fotaki 2010:710). The assertion that policy makers have been permitted to generate policies which are aspirational, rather than realistic, resonates in mental health care in Britain, in which policies are frequently '*formulated in denial of their contextual reality'* (Fotaki 2010:711).

Fotaki's central claim concerns the failure of the imaginary construction of policy-making. The use of abstract economic models unrealistically simplifies human decisions and ignores 'real life messiness' (Fotaki 2010:712). The policy making process fails to acknowledge the conflict between fantasy and reality, and the subsequent likelihood of failure, which results in the apportioning of blame as a defensive mechanism (Fotaki 2010:712).

At a more concrete level, policies change what we do, which has implications for equity and social justice, and what we are, which has implications for subjectivity (Ball 2015:306). Discourse, and concomitantly power relations, are manifest in policy objects, subjectivities and practices. These are the 'instruments and effects' of discourse (Ball, 2015:307). Policy discourses provide ways of discussing our institutional selves, forming 'a regime of truth' that 'offers the terms that make self-recognition possible' (Butler, 2005:22).

The policy researcher therefore hopes to learn how people are 'envisaged' by the social practices involved in a policy. Policies as discursive strategies, consisting of texts, events, and practices, speak to wider social processes (Ball, 2015:308). This thesis does not examine a specific set of government policies, but rather examines the consequences of a translation and enactment of policy which is situated within the infinitely tentacled dominance of neoliberalism. Ball (2015:309) has suggested, albeit with respect to education, that there is a danger policy can conjure up a world in which we consist entirely of techniques of correct training, methods of categorisation and forms of exclusion. This danger appears all too transferable across spheres.

3.4 Policy mechanisms which support neoliberalism

3.4.1 Responsibilisation

With neoliberal doctrine accepted as virtuous, across multiple spheres, governments have been encouraged to advance economic prosperity by financial deregulation and the concomitant dismantling of institutions such as the welfare state (De Vogli 2011:314). It is consequently the individual who is held to account for health and welfare, including mental health. Thomas Lemke (2001:201) describes how responsibilisation strategies dispose of responsibility for social risks, including illness, rendering the problem as one of 'self-care'.

For Rose and Miller (1992:175), emphasis on the individual and on private services are two core features of neoliberalism as a political rationality. As advanced government technologies construe the social in economic terms, under discourses of responsibilisation, the individual makes active choices to further their own interests (Rose 1999:142); the 'enterprising self' invests in, and works on themselves.

Under neoliberalism then, 'efficiencies', privatisation, and choice are emphasised, along with self-care and personal responsibility. We have learned to regard ourselves as creatures

responsible for our self-mastery, making our lives the object of 'practices of self-shaping' (Rose, 1999:96). Rose's *'strategies for the conduct of conduct'* (1999:88) [1] in terms of logical choices, are a close approximation to the concept of choice architecture operationalised as 'nudge', promoted by Thaler and Sunstein (2008). Rose notes the tendency to diagnose one's *'pleasures and misfortunes in psy[2] terms…seeking to rectify or improve… by intervening upon an 'inner world'* (1998:192). The parallel between Foucauldian concepts of self-mastery and nudge is explored by Mulderrig (2017; 2019) who critiques behavioural economics in terms of neoliberal governmentality in her CDA research of the UK government's Change4Life social marketing campaign. Her key premise (2019:48) is that behavioural economics should be understood in relation to the practices of neoliberal governance to which it is connected, and she makes a powerful argument, through her transdisciplinary dialogue between CDA and governmentality, for the way in which, through analysis of the 'conduct of conduct', the policy nudge of C4L can be viewed as a technique of neoliberal governmentality.

Problematic and heterogeneous minorities outside the 'regime of civility' (Rose 1999:88), are codified as an underclass, an *'amalgam of cultural pathology and personal weakness which is racialized…spatialized…moralized…and criminalized'*. Such groups, including people with mental illness, are, significantly, allocated to 'paragovernmental agencies' (1999:88) including charities and grant-supported voluntary organisations, with for-profit sectors operating in tandem. Together these agencies guide their 'clients' towards a capacity for normalisation.

Psychological practice revolves around techniques to create 'autonomous selfhood' (Rose, 1990:90), often through the 'psychotherapies of normality', i.e. self-help. Such technologies of responsibilisation also depend on the employment of experts from a variety of fields. According to Canguilhem (1961), the spread of the concept of 'normality' in the mid-18th century led to the birth of the field of social statistics, whereby human traits and characteristics including intelligence and 'moral worth' became subject to comparison. Rose refers to a consequent *'government through the calculated administration of shame'* (1999:73), in which shame entails anxiety over how one is perceived, according to public perceptions of moral or civil worth.

The existence of 'policies of conduct' (Rose, 1999: 268) results in the reformulation of problematic or marginal people as a moral or ethical problem, through technologies of activity.

[1] Drawing on Foucault's (2007) concept of the 'conduct of conduct'.
[2] An established abbreviation expressing association with the domains of psychology, psychiatry, etc.

Rose notes the utility, within this system, of re-naming marginalised states, whereby, for example, an unemployed person becomes a ‘jobseeker’. The terms, appellation and institutional euphemisms employed in describing mentally ill people constitute an especially large semantic group. The imperative of engaging in activity to become (re) educated in corrective personal skills, and the underlying assumption of choice, can be seen to extend to mental health/anti-stigma campaigns, for example as incitement to become a responsible ‘sharing’ member of a mental illness community.

Fotaki (2010) considers further how ‘patient choice’, which supposedly empowers service users, is part of responsibilisation (2010:712); the ‘idealised’ patient engages in the choice architecture system, while those who fail to accept responsibility for their health choices are categorised as ‘undeserving’. While theoretically encouraged to act freely and rationally, the governed must in fact conduct themselves in accordance with an approved mode of action (Scourfield, 2007). Such responsibilisation ignores ‘non-uniform’ patients, rendering them ‘fragmented subjects’ (Fotaki 2010:712).

Teghtsoonian (2009) sought to understand two simultaneous developments; the increasing prevalence of depression, for which the governmental focus was the effects of depression on the labour force, and an intensifying neoliberal economic framework. Her paper refers to British Columbia, Canada, but is relevant to the UK, since the governments of both regions have sought ‘efficiencies’ in mental health spending, and have operationalised agendas to reduce workplace mental illness. Teghtsoonian analysed two public information documents, referred to as *Depression Strategy* and *Mental Health Literacy*, which intended to minimise the costs of mental health provision by diverting people from state help and towards either the cheapest options, or a private one. Families, presented as an ideal source of support, are encouraged to develop ‘problem solving’ skills in support of their relatives’ treatment. Indeed, mental health ‘literacy’ largely consists of adopting the functions of mental health services (2009:32). Such reliance on family did not acknowledge the role of women in carrying out the envisioned support; reliance on family is therefore both misogynistic and ignores the likelihood that the relied-upon women will consequently be more likely to experience mental ill-health themselves (Teghtsoonian 2009:32).

Teghtsoonian’s work is significant for demonstrating that mental health ‘literacy’ materials, which share similarities with those propagated by AS campaigns, were used to replace, and divert from, timely access to mental health services. Within neoliberal agendas, such materials

represent exceptional cost reductions compared to medication or therapy. Care and interventions in mental health may be long term, and cost reduction is minimised by constructing the 'good citizen' as one who takes responsibility, by making choices incurring the least cost to government (Teghtsoonian 2009). Responsibilisation, in mental health especially, where diagnoses and aetiologies may be imprecise, and solutions may feel remote, almost constitutes a scolding, and therefore can itself be regarded as a form of stigma.

3.4.2 Commodification, data, and 'stories'

Lupton (2014a, 2014b) describes the existence of a 'digital patient economy' within online health platforms. The characteristics of such an economy include 'prosumption', the simultaneous production and consumption of content. Prosumption is characteristic of 'Web 2.0'; internet use, distinguished by dynamic/user-generated content, expansion of social media, valorising of big data, discoursal encouragement of sharing, and the commercialisation of affective labour. So significant has been the shift towards data as a source of health knowledge that the technologies involved have accordingly been termed 'Health 2.0'. From Lupton's material-semiotic theoretical perspective, the platforms, hardware and coding may all be seen as social actors (2014a:866). Two key aspects are seen in the digitally-engaged patient, both of which, while ostensibly part of 'patient empowerment', have significant cost benefits under austerity (De Vogli 2011). First, the 'ideal patient-citizen' is encouraged to maintain responsibility for their own health, and second, patients use technology to learn about their conditions and convey information to other individuals (Lupton 2014a:857).

Enhanced technology and the growth of social media have resulted in significant proliferation of both mental and physical health websites, increasing the potential for data aggregation. Sites variously constitute online support, information provision, evaluation of care, or areas roughly (and in the case of TTC, erroneously) construed as activism. A broadly positive reception of such activities constitutes a 'data utopian viewpoint'. Site discourses focus on the concept that positive change is possible through collaboration and 'sharing', which is presented as an altruistic gesture of participation by a good citizen (Lupton 2014a).

Lupton's 'digital patient experience economy' (2014), in which opinions and experience have both commercial and informational value, is flourishing. Data become the digital intellectual property of the platform, which may benefit not only from the knowledge itself but from its

manipulation or sale. For business, common commodification types include eliciting donations, clinical trial recruitment, and advertising sales. User-generated content, a digital record, trace, or by-product of a user's engagement with websites, all contribute to 'big data', constituting vast amounts of qualitative and quantitative data. In mental health particularly, such content may be deeply personal. Aspects of individuals and groups become visible through manipulation of big data to create algorithmic identities; people can be 'rendered' into multiple aggregations, subsequently becoming identifiable to 'nudge' and vulnerable to its machinations (Lupton 2014a:859). Through an interactive loop, digital behavioural and attitudinal data constitute intelligence for use by government and business, to both shape the nature of behaviour and inform healthcare policy (Lupton 2014a:859).

The digital patient experience supports a whole data economy, yet despite possibly gaining a sense of engagement or community, the patient receives no financial compensation, even if their 'work' is monetised (Lupton 2014a:862). Power relations are also relevant, since the websites which propose or confirm a hegemonic stance have greater visibility, through technological or commercial strength, so the user is less likely to engage with alternative positions. In this novel form of exploitation, the individual is powerless with respect to the analysis and use of their 'affective and altruistic labour' (Lupton 2014a:866).

Tyler (2020) also expresses concern about the 'sharing' of personal stories solicited via mental health campaigns, asking whether it could expose people to discrimination, and pointing out that its negative impact will be determined by an individual's social position. Campaigns encourage their followers to copy the disclosures of celebrities, but the consequences for a worker in precarious circumstances are entirely different (Tyler and Slater 2018; Tyler 2020:244).

Sharing stories has been central to mental health activism, playing an important role in challenges to psychiatric authority and as a mechanism of change. But this activity has been 'co-opted' both by third sector organisations and by governments. Once stories become commodified as Lupton (2014a, 2014b) describes, under corporate control they may contribute to an organisation's brand and fundraising. Thus, removed from the tradition of survivor storytelling, stories become modified, sanitised and no longer challenge hegemonic portrayals of mental illness (Tyler 2020:245).

3.5 Austerity and its consequences

Austerity as a fiscal discipline (of neoliberalism) has been ideologically constructed in part by the concept of 'togetherness' (Cooper and Whyte 2017:5). Governments created the myth of public responsibility for the financial crash, and that recipients of welfare benefits in particular contributed to the budget deficit (2017:8). Austerity involved an attempt to *'permanently dissemble* [*sic*] *the protection state'* (Cooper and Whyte 2017:1), leaving people subject to the cuts of austerity humiliated, and experiencing both physical and mental ill-health. Austerity enacts profound violence through mundane events, and has deeply traumatising and damaging effects (Cooper and Whyte 2017).

Jensen and Tyler (2015) find neoliberal strategies of state-sanctioned stigma production, amplified by the media, have largely legitimated the cuts. The process of justifying austerity has necessitated intensive production of stigma, propagating an image of a feckless, dependant, and undeserving poor, who contrast with valorised 'hardworking families'. Stigmatisation and neoliberal governance are intimately connected, through attempts to deliberately manage behaviour through *stigma strategies* which instil shame and humiliation (Jensen and Tyler, 2015).

Shifts in power relations have accompanied neoliberalism's shrinkage of the welfare state. These re-shaped power dynamics specifically disadvantage employees, borrowers, and tenants. (Sayer 2018:22). Sayer (2018), considering neoliberalism through the lens of 'moral economy', highlights how the growth of unearned income, derived from control of assets, has had major implications for welfare. The extent of wealth redistribution is such that the combined wealth of the richest 1000 UK citizens grew from £98 billion to £658 billion from 1997 to 2017, at which point such funds could have entirely sustained the NHS for 4.7 years (Sayer 2018:21).

In tandem with the move from social democracy to neoliberal regimes, the meaning of the term 'welfare' has changed. Social democratic policies in Western Europe formerly associated 'welfare' with the welfare state, which consisted of the policies and institutions that essentially protected society from some of the detrimental effects of capitalism. Neoliberalism has redefined welfare as a *'parasitic form of 'dependency' of an undeserving minority on the majority'* (Sayer 2018:22). Similarly, Tyler (2020:191) describes hardening public attitudes towards welfare claimants, the deliberate contraction of governments' meaning of 'welfare', and the reframing of the welfare state as an unaffordable provision for 'economically inactive' people, such that *defacto* 'anti-welfare' is promulgated as economic rationality. The change in

public opinion has been constructed by the *'stimulation of stigma'* (Tyler 2020:192), through policy which influences the perception of self and others; for the political economy of stigma to work, a 'moral economy' which propagated the notion of undeservedness was driven by stigma power:

> *The welfare stigma machine churned through wider society, settling in institutional forms, embedding in the design of social policies, and infecting the culture, practices and attitudes of welfare workers* (Tyler 2020:196).

Mental health services in the UK were already under-resourced before the effects of austerity resulted in increased levels of depression and anxiety (Tyler, 2020:248). An increased number of suicides (O'Hara 2017) is testament to the fatally detrimental consequences of the welfare 'stigma machine' on mental health (Tyler 2020:199), and Mills (2018:304), who explores austerity suicide through the framework of a 'psychopolitical autopsy', finds suicide has been normalised in the welfare system.

Cuts to mental health services occurred at precisely the time of increased need which resulted from austerity measures. Schrecker and Bambra (2015) describe 'neoliberal epidemics' of mental ill-health, resulting from the production of chronic stress derived from reductions in welfare and workers' rights, and reduced job security and pay. In 2017, probably as a result of the absence of earlier interventional help, mental health crisis teams faced a 60% increase in referrals, where 'crisis' meant a likelihood of self-harm, or harm to others, at a level where life is endangered (Tyler 2020:246).

Ideologies driven by the stigma machine, for example that people in poverty make poor choices, become an organic part of social life, acquiring 'psychological validity' (Tyler 2020:197); these ideologies are therefore more effectively positioned to wreak havoc on mental health, compounding the damage. The level of deprivation produced by the austerity programme equates to that seen after natural disasters (Tyler 2020:166), and the state's refusal to meet even basic needs with respect to multiple vulnerabilities, including mental health, weakens the relationship between people and state and represents a failure of democracy (Tyler 2020:203).

3.6 Stigma: from Goffman to a new perspective

3.6.1 Goffman

Goffman's key work *Stigma: Notes on the Management of Spoiled Identity* (1963) has widely informed conceptualisations of discriminatory practices. His classic definition of stigma, as an '*attribute that is deeply discrediting*' (1963:3) refers both to easily discernible attributes, and those which are hidden but still discrediting if revealed, including 'blemishes of character', such as mental illness. Goffman (1963) characterised stigma as 'undesired difference' in an outgroup; as Corrigan (2018:48) notes, 'difference' in a social exchange is almost always negative.

Tyler and Slater (2018) observe that Goffman's conceptual framework ignored questions of how and why stigma is produced, and who it benefits. Despite Goffman's supposed interest in the 'structural preconditions' of stigma, by so completely ignoring the *stigmatiser,* Goffman conceals the idea of stigma as a relation of power, producing a 'toothless' conceptualisation of stigma (Tyler 2020:100). Tyler and Slater (2018:728) regard Goffman's ideas as 'apolitical and ahistorical', and examining Goffman's work in the light of contemporaneous civil rights and black power movements in the US, Tyler (2020) is incredulous of his ability to ignore the historical context in which he wrote, and to thereby ignore power.

Goffman viewed stigma as a generalised social process, and proposed that all stigmatized individuals encounter similar constraints in the way they 'manage' social interactions. Goffman observed these interactions extensively in micro-level domestic or workplace situations. Because Goffman (1963:42) regarded understanding what constitutes 'normality' to be part of socialisation, he expected someone with a stigmatising condition to inherently understand how they would be perceived, and how they were 'deficient'. Tyler (2020:111) emphasises a disquieting attitude in Goffman's assertions that it is the stigmatised individual who is responsible for the reactions of wider society, and they, not 'normal' people, must make the adaptations. There is therefore no challenge to the social 'norms' which perpetuate relations of power. Significantly, TTC recruited people with experience of mental illness and made them responsible for effecting 'anti-stigma' change, albeit in the 'normal' population rather than in themselves.

Hinshaw (2010:25), considering whether stigma exists '*in the eyes of the perceiver, or the response of the 'deviant''*, agrees with Goffman (1963), that it is the person with the devalued attribute(s) who solidifies and internalises the perception. Such blame of the stigmatised person

for their own stigma, making them responsible for the repair of stigma through managing their interactions with a 'normative' society, raises the question of whether Goffman unintentionally legitimised the further use and misuse of stigma. Certainly, *Notes on the Management of Spoiled Identity* (1963) is correctly titled, but beyond this, Goffman's assertion that stigma is a problem to be challenged by *'benevolent social action'* (1963:5) may have contemporary resonance.

3.6.2 New perspectives on stigma

Following Goffman's exposition on stigma, the concept significantly remained in the domain of psychological and social psychological research, and was explored at the micro-level, to explore specific social phenomena.

Work in evolutionary psychology typically examines exclusionary behaviours as forms of adaptation. The fullest account, from Kurzban and Leary (2001), explores concepts such as dyadic cooperation, in which it is posited that humans develop complex cognitive processes for evaluating the value of another human in terms of their reciprocal social value. Kurzban and Leary also describe coalitional exploitation, in which humans shun 'tribes' with unfamiliar characteristics; this category is most interesting for suggesting that outgroup members are dominated and exploited.

Stigma research has undergone a radical theoretical shift towards a broad consensus that forming social comparisons, and categorisations, is a universal tendency embedded in social processes such as ingroup and outgroup identification, but that structural variables such as unequal power are also important (Hinshaw 2010:29). Work within this century expands and reorients the theoretical lens of stigma, placing greater emphasis on meso and macro socio-cultural structures, power, the role of institutional practices, and the population-level consequences. Among this work, Link and Phelan (2001) emphasise the power differential between the stigmatiser and the stigmatised; stigmatisation occurs most often across a gradient from high to low status, is used to exploit, control, and exclude, and is 'deployed' in ways which increase existing inequalities. They describe stigma as consisting of four sequential processes: the labelling of human differences, the stereotyping of such differences, the separation of those labelled from 'us', and finally the loss of status in, and discrimination against, those who are labelled (Link and Phelan, 2001).

Later, Phelan, Link, and Dovidio (2008), in addition to a focus on stigmas related to 'character', also explored the more 'bounded' social categories of race and ethnicity, in which stigmatisation stems more from processes of exploitation and domination than the supposed violation of social norms. Drawing on this work, Link and Phelan (2014) defined their concept of 'stigma power' as being driven by the motivation to *'keep people down'*, with respect to status, *'keep people in'* as applied to violation of norms, or *'keep people away'* (2014:26), drawing on Kurzban and Leary's ideas (2001) of the evolutionary advantage of distance from an anomalous individual. These motivations are achieved in taken for granted cultural processes which allow stigmatisation to succeed. Link and Phelan's social scientific study empirically applies their concept of stigma power to mental illness; they describe how the aims of stigmatisers are covertly achieved through various social psychological processes affecting the stigmatised individual (2014:26). Their theory is aided by concepts from Bourdieu (1987; 1990), such as symbolic violence, in understanding how the interests of stigmatisers may be hidden within seemingly unrelated processes (2014:30).

The authors admit their research cannot confirm the broad utility of the stigma-power concept. Importantly, their study involved people at an early stage of inpatient treatment for psychosis, so is not generalisable to all mental illness. Link and Phelan claim to consider the implications of the concept of stigma power for 'structural stigma', the *'macro-level factors that drive stigma processes'* (2014:30), but regard stigma power as culturally derived, resulting from cognitive or evaluative beliefs which trigger a 'cascade of responses' on behalf of people with mental illnesses. The resulting patterns of social relationships facilitate social structures in which people with a mental illness may be set apart and 'pushed down'. Stigma power thus belongs within the cultural system in which social structures are created, and stigma is cyclically reinforced when the public discern that a group has been pushed down or excluded. Therefore, despite invoking the concept of power, Link and Phelan describe socio-cultural issues, and view structural stigma not as systemic, top-down, and intentional, in the manner described by Tyler and Slater (2018) and Tyler (2020), but as something originating from, and situated in, the public realm.

Tyler's approach over the past decade has firmly attributed stigma to neoliberal governmentality. To illustrate her new perception of stigma, Tyler (2013) invoked Naomi Klein's views on disaster capitalism, which describes how the exploitation of natural or

political crises enabled neoliberal policy through a policy ‘trinity’; elimination of the public sphere, corporate freedom, and drastic social spending cuts (Klein 2007:17). Within this climate, antipathy is *‘channelled towards those groups who are…imagined to be a parasitical drain upon scarce resources’* (Tyler 2013:211) and *‘the daily, pervasive production and mediation of stigma’* (2013:10) is a key mechanism through which neoliberal modes of government operate. Importantly, rather than being a simple consequence of neoliberalism, Tyler positions stigma as a ‘core organ’ of neoliberal governmentality (2013:212).

Tyler and Slater (2018) and Tyler (2018) further confirm stigma as a set of social processes which relate to power. They also support assertions that the relative failure of anti-stigma campaigns results from theoretical and methodological limitations (Pescosolido and Martin, 2015). Illustrating the need for a different approach to stigma, Tyler and Slater (2018) question the logic of the objective of *Heads Together* to erase stigma by talking in order to supposedly enable access to mental health services, given the low level of availability of such services. Responding to an apparent stagnation in stigma research, Tyler and Slater aim to promulgate the understanding that stigma is itself a political apparatus, and that stigma power is no less than the *‘productive and constitutive force’* through which power is able to function (2018:732).

A key point in this new sociological approach to stigma is a major work by Tyler (2020) which extends the ‘emergent cross-disciplinary social scientific consensus’ (2020:17) situating stigma in relation to power. Tyler acknowledges the significance of Link and Phelan’s work on stigma power, but her own repeated emphasis is on the need to position stigma as power within its historical and political context, and to understand how it has been enabled by capitalist social structures, colonialism and patriarchy. Tyler’s focus on race as a vital lens through which to examine stigma power helpfully informs the stigma of mental illness, as this stigma too is a form of *‘dehumanisation…also grounded in eugenicist and/or essentialist ideologies of human difference’* (2020:118).

Our aim should be not merely to seek to reduce the effects of stigma, but to investigate the *‘social causes and political function of particular modalities of stigma production, to ascertain not only where and by whom stigma is crafted, but who profits from stigma power’* (Tyler 2020:249). Use of the term ‘crafted’ unambiguously implies intentionality, and accordingly, Tyler’s work represents a call not only to understand stigma as a governmental technology, but

to acknowledge the extent of state-cultivated stigma, and to see it clearly as a form of political capital and power.

Capitalistic exploitation depends on various forms of inequality, and the policies which create inequality demand *'diverse, state-sanctioned stigma strategies that often involve the reactivation of stigma along historical lines'* (Tyler 2020:20). Tyler uses the notion of the genealogies of stigma, by which we can better understand the *'increased velocity of stigma as a modality of governance (under) neoliberal capitalism'* (Tyler 2020:21). The notion of reactivation aligns with my belief that the concept of mental illness stigma has been strategically re-activated through the discourse of AS.

Beyond the punitive use of stigma within capitalist 'statecraft', Tyler (2020:25) is concerned that stigma fuels the nationalist politics of the far right, contributing to an increase in authoritarian propaganda. As part of the 'machine politics' which characterises authoritarian neoliberalism, the stigma 'machine' is a vital technology of control (Tyler 2020:268). Digital, for-profit technologies enable populist political shifts, and a concomitant 'digital stigma power' is represented by a variety of threats to freedom, including digital surveillance technologies and algorithmic paths to social control, representing incremental consent for authoritarianism. Although, as Tyler points out, each age is accompanied by its own new technology and attendant novel mechanisms of stigmatisation, the processes through which people are devalued or excluded are consistent historical traits.

3.7 The stigma of mental illness: models, causes and types

In this section I discuss the key models of mental illness stigma, and summarise the types of stigma, in order to subsequently contextualise several themes which repeatedly arise in this literature, and which are relevant to this research.

Hinshaw (2010:8) deems it necessary to understand the models of mental illness in order to understand society's various responses to it, including stigmatisation. To explore these models is beyond the scope of this study however, except to note that the medical model, which sees primarily biological causes, predominates in the West. This model is supported by brain imaging in a few instances, and neurochemical research in others; yet full application, in the manner of a physical illness, remains impossible. Among all the complex attributions made for 'aberrant' behaviour, from the bizarre (demonic possession) to the positivist (genetic

causes), and despite many prosaic and detailed explanations, no single model of mental illness is adequate. The brain, and importantly, its environment, interact in non-linear ways which are not fully understood (Hinshaw 2010:54).

3.7.1 Mental illness stigma: explanatory models

Social science has used the concept of entitativity, the extent to which any group sees another social group as a distinct or meaningful entity, to determine which conditions are stigmatised and which are not. If a group has easily recognisable negative characteristics, stigma may result. Mental illness is a social entity that generates stigmatising reactions, as it has defined boundaries, distinct characteristics, and is associated with core stigmatising beliefs concerning unpredictability and dangerousness (Rusch, Corrigan, Wassel *et al*. 2009). The 'normal', stigmatising majority is objectively neither normal nor superior, but is *'the obverse of the stigmatised construction'* (Corrigan 2018:44), and mental illness stigma is typically described as a negative cognitive, behavioural, or emotional reaction, evoked by the 'signs' of mental illness (Corrigan, 2000, 2002; Link & Phelan, 2001). While psychiatry regards mental illness as a problem of the individual, stigma, as a social construct, is in the domain of the community (Corrigan 2018:41).

Models used to explain the stigma of mental illness often constitute an extension of those developed to understand stigmatisation of ethnicity or sexual orientation. Among more specific hypotheses, the 'kernel of truth' theory (Allport, 1954; 1979) proposed stigma to be a rational reaction, by a normal majority, to bizarre behaviour. This accorded with contemporaneous thought; in 1980 the US National Institute of Mental Health (NIMH) rejected use of the term stigma, which it regarded as a natural response (Corrigan 2018:58). The NIMH still appears to prefer to discuss the *effects* of (general) stigma on mental health, rather than to consider the stigma of mental illness itself (NIMH 2022). Allport's notion of 'bizarre behaviour' is challenged by Link *et al*. (1987), who found that people with mental illness experience discrimination irrespective of their behaviour, and that discrimination activated by a label is as severe as that enacted on the basis of behaviour. The concept of rational stereotyping is generally unsupported by objective social scientific assessments of group characteristics (Corrigan 2018:60).

A further group of theories suggest discrimination evolves to psychologically protect people and their groups, by justifying a status quo in which disparities exist between groups, at three possible levels; the ego, the group, and the system. There is little widespread support for the claims of psychoanalysts such as Bettelheim and Janowitz (1964) that the self (ego) is protected by projecting internal conflicts onto stigmatised groups, nor for the notion of group justification, for example using stereotypes of a minority outgroup to positively frame the in-group, as suggested by Abrams and Hogg (1988). More interestingly, Jost *et al*. (1999) suggest stereotypes or discrimination develop to confirm or support a system. Having become established, a set of social relations then becomes justified, and evolves as a result of social, historic, or economic forces. Corrigan (2018: 61), perhaps simplistically, offers slavery as an example of system justification; the historical existence of slavery evolved into *post-hoc* racism. Exploring how system justification might account for mental illness stigma requires both some historical perspective on mental illness, of the type chronicled by Foucault in his first major work, *Folie et déraison* (1961)[3], and clarity concerning the stereotypes involved.

In mental illness, three main stereotypes prevail: dangerousness, responsibility (for their condition), and (social) incompetence (Corrigan 2018:49). The concept of mentally ill people's fundamental responsibility for the existence of their own mental states is interesting, connecting stigma in a different way to the neoliberal agenda. There is ample historical evidence from the 18th century of the construction of mentally ill people as dangerous, culpable, and incompetent; Foucault (1972a) chronicles the historical experiences of people with mental illness, demonstrating how mental illness as a social category was gradually created out of a *'mythical unity between the judicially incompetent subject and the person recognised as perturbing the group'* (1972a:18). One might add that the use of psychotropics in early 20th century institutions would only enhance perceptions of incompetence. Since deinstitutionalisation, growing numbers of people with mental illness are again housed in prisons; 45% of adults in prison in England have anxiety or depression, 8% have a diagnosis of psychosis, and an extraordinary 60% have experienced a traumatic brain injury (Durcan 2021). Yet public system justification does not depend on the public holding historical knowledge; a contemporary understanding of the existence of institutions which control mentally ill people, combined with news media and entertainment, mean this theory is still plausible (Corrigan 2018:62).

[3] Later revised as *Histoire de la Folie a l'age Classique* (1972a).

3.7.2 Types of stigma

In any discussion of stigma, the *type* of stigma should be defined. Public stigma is the most commonly conceptualised form, understood as the prejudice and discrimination which society directs toward a 'labelled group' (Corrigan and Lee, 2013; Link and Phelan, 2001). The 'normal' public majority first avoid and withdraw from the mentally ill (and do not wish to live in proximity). The second stage is segregation and coercion. The first element concerns housing, which, post-asylum, tends to be in poor areas, creating a ghetto effect. Coercion refers to commitment to treatment, or in the US, to attendance at 'mental health court' (Corrigan 2018:49). Such descriptions illustrate how canonical understandings of mental illness stigma and its consequences concern severe mental illness; Corrigan's descriptions of segregation are shaped by ideas of how, or if, psychiatric patients could be accepted by the rest of society following deinstitutionalisation. Such research informed the CAMI (Community Attitudes to Mental Illness) survey, used in the evaluation of TTC, despite the fact that TTC does not address serious mental illness.

With respect to the mechanisms of public stigma, the public infer mental illness on the basis of psychiatric symptoms, deficits in social skills or physical appearance (being 'unkempt'), and labels (Corrigan 2018:54). Yet these may all be misattributed, or conversely, 'false negatives' may occur. Since it is only when someone is seriously mentally ill ('floridly psychotic') that their condition is 'obvious', the label of mental illness is primarily responsible for much mental illness stigma, whether diagnostic labelling, self-labelling or 'labelling by association'; via contextual social information (Corrigan 2018:55).

The second type of mental illness stigma, self-stigma (or internalised stigma) is said to occur when a person with mental illness incorporates negative stereotypes or societal attitudes into their own identity or conception of self (Vogel *et al.*, 2013), potentially resulting in reduced self-esteem. Both public and self-stigma reportedly lead to a reduced likelihood of seeking treatment (Evans-Lacko *et al.*, 2012), and public stigma is associated with impaired social relationships, and difficulties in obtaining employment or housing (Corrigan, 2000; 2004; Corrigan, Druss, and Perlick, 2014). Thornicroft (2006) regards the stigma of mental illness as partially the responsibility of 'service users'. He identifies two issues; first that stigma is not merely something which is 'done to' them (i.e. they also self-stigmatise), and second, that service users' passive acceptance of the role of victim is a potential barrier to progress.

Finally, structural stigma, much less prevalent in mainstream literature, occurs when mental health services are unavailable, either through intentional restriction, or possibly through policies with unintended consequences (Corrigan 2018:55). Here Corrigan is influenced by the ideas of Pincus (1996; 1999) on structural discrimination in the context of race. Pincus also distinguished between institutional and structural discrimination, suggestion that tackling the former was fairly ineffective, while the latter involves confronting the fundamental principles of social organisation (Pincus 1996:192). This is a hugely overlooked aspect of stigma. I noted earlier the importance of defining the type of stigma being discussed; the mainstream conception of stigma, used by AS and conveyed by government, is of stigma enacted primarily by the general public. This obfuscates understandings of the concept of structural stigma, or government's role in its creation. Considering structural mental health stigma is the closest we get to a domain-specific equivalent to Tyler's view of stigma, discussed earlier and below.

3.8 Key issues in the stigma of mental illness

Three issues which arise thematically in the literature of the stigma of mental illness concern: (i) treatment avoidance, which I explore because it is cited as a key consequence of mental health stigma, and therefore an important justification of TTC is that mental illness stigma prevents people from seeking help. (ii) Dangerousness is one of the most significant, best documented, stigma-producing stereotypes of mental illness, but is especially relevant to stigma associated with schizophrenia, which the AS campaigns in this study do not seek to address. (iii) I consider the issues of diagnosis, medicalisation, and the question of parity between mental and physical illness; these are not discrete, circumscribed entities, but interconnected and interdependent. I also address the expansion of diagnostic criteria which extensive medicalisation has enabled, and which pharmaceutical companies both exploit and influence in order to achieve capital growth.

3.8.1 'Failure' to seek help

Goffman (1963) distinguishes 'label avoidance' as a subtype of stigma. In mental illness, the characteristic resulting in stigma is far more likely to be hidden, and therefore the 'mark' is in truth a label (Corrigan 2018:52). Therefore avoidance of mental health services may be seen as a way to avoid being stigmatised, across the severity spectrum of mental illness (Mojtabai *et al*. 2011).

Among the negative outcomes of public stigma, Tippin and Marazan (2019) afford prominence to treatment avoidance, aligning with the view promoted by TTC and HT that it is primarily stigma which prevents people from seeking help. Several studies (Corrigan, Druss *et al.*, 2014; Schomerus and Angermeyer, 2008; Thornicroft, 2008) agree that stigma results in avoidance of, or lack of compliance with treatment. Yet when there is also evidence that the behaviour of medical or mental health practitioners may be stigmatising (Atzema, Schull, and Tu, 2011; Loch *et al.*, 2013), and possibly more so than the general population (Rossler 2016:1252), work to distinguish the impact of stigma from the impact of a stigmatising practitioner, with respect to factors which supposedly dissuade people from seeking help, would be valuable.

Corrigan claims that in the US, 30-40% of people for whom treatment could be beneficial, do not seek it (2018:28), prompting a movement towards patient engagement and compliance which is echoed in the UK's drive to raise awareness to encourage people to seek 'help'. The concept of non-adherence in mental illness is problematic however, since it is historically construed as 'non-compliance' or 'resistance'. Non-engagement may even be regarded as evidence of further pathology, and opting out of treatment may be stigmatised (Corrigan 2018:30). Claims by anti-stigma campaigns, not only in mental health, that they will overcome barriers to seeking help, fail to acknowledge the deliberate inclusion of stigma in the design of social provisions, such that seeking help is difficult at best (Tyler 2020:17); many stigmatised people understand that purposely engineered 'stigma machines' are integral to organisational systems. In the US, the reasons for not seeking or complying with treatment may be financial, but in the UK, they may be because help is non-existent; therefore the geographical context of studies on treatment avoidance is important, and their findings should not be transferred in support of policies in different social contexts.

3.8.2 Dangerousness

People with schizophrenia are most affected by the stereotypes of mental illness, namely dangerousness, unpredictability and unreliability (Rossler 2016:1250), among which dangerousness is a core public concern (Corrigan 2018:52). In a 27-country study, Thornicroft *et al.* (2009) confirmed the ubiquity of stigma towards people with schizophrenia, and proposed that interventions to improve self-esteem and discrimination laws were both necessary responses. Perceptions of dangerousness, particularly with respect to people with schizophrenia, appear to have doubled from 1956 and 1996 (Phelan *et al.*, 2000). Pescosolido

et al. (2010) confirmed these findings in the US, estimating that 40% of the US population believe mentally ill people are dangerous. A meta-analysis by Schomerus *et al*. (2012) extends these findings globally, finding the wish for social avoidance of schizophrenia is greater than for other mental illness types, and that this likely originates in perceptions of risk which followed deinstitutionalisation. Foucault (1990:128) regarded psychiatry, psychiatrists, and the notion of 'danger' as responsible for what he terms the 'psychiatrization of criminal danger'. He remarks that the collective fear of crime, and an obsession with the associated danger, is an intrinsic part of society, and therefore 'inscribed in our consciousness' as presenting risks which are to be systematically reduced. But as he points out, no modern society can be without risk (1990:147).

To understand the concept of dangerousness in mental illness requires some historical contextualisation. In Foucault's chronicling of the experience of madness, it is possible to see the contemporary fear of dangerousness as derived from the historical fear of 'unreason', a pervasive equivalent which Foucault reports first in the Renaissance, and again in the 17th, 18th and 19th centuries. First, as the benign influences of late medieval medical humanism waned, the 'madman' became homogenised and was *'dissolved in a general fear of unreason'* (Foucault 1972a:9). By the 17th century in Europe, the mentally ill were incarcerated in specifically corrective institutions, in a deliberate shift to a disciplinary focus which served to *'subsume the mad within a moral experience of unreason'* (Foucault 1972a:11), and made no distinction between insanity and criminality.

Committal to asylums in the 19th century was intended either to 'cure' people or to remove them from society for disciplinary correction (1972:6). Foucault describes how among those incarcerated, 'the furious' mingled with the destitute and received the same treatment. Although madness was increasingly perceived as an illness, it was paradoxically met with confinement and punishment (Foucault 1972a), which, given the clear historical associations between madness, violence, and criminality, has implications for the roots of contemporary discrimination. The social context too has some parallels; the 19th century was no neoliberal state, but the combination of extreme wealth and grinding, insoluble poverty, make it unsurprising that a sector of society was 'furious', and removed from society for being so.

In England during the 1800s, solid 'medical' categories of mental illness became a 'lexicon of deviance' (Foucault 1972a:7). Among the categories of mental illness, schizophrenia was the domain of the *'inspired and visionary'*, while delirium *'always inhabited the discourse of*

unreason'. Naturally the state wished to remove from society those whose deviance entailed unreasonable or visionary discourse. Foucault's account of the incarceration of the visionary reminds us of the breadth of the concept of 'danger', which may include danger to a hegemonic order. Drawing on references to historical confinement of such 'threatening' individuals, one could conceptualise the stigmatisation of their contemporary counterparts as a metaphorical confinement.

Pinel (1745-1826), considered the founder of psychiatry, devoted much of his career to the promotion of more humane treatment. However he also formally initiated the highly consequential choice of 'inoffensive or dangerous', with respect to the imperative to confine. This binary, dependent upon the concept of normality, which as Foucault (1972a:19) points out, is the *'a priori of all our psychopathology's claims to scientific status'*, may truly be the root of the contemporary dichotomous perspective concerning dangerousness.

Hinshaw, describing contemporary mental illness, states that its symptoms *'…are often irrational …and in many instances, cause threat to other people, who may fear for their own tenuous hold on stability and control'* (2010:34). Here then is a micro-level version of the more systemic threat described by Foucault.

The solid association between schizophrenia and danger raises questions about the way people with mental illness are homogenised. Rossler (2016) condemns use of homogenising terms such as 'the mentally ill'. Hinshaw goes further, arguing that it necessary both to specify what type of mental illness is being discussed, and what type is attracting stigma; referring only to 'mental illness' or 'mental illness stigma' sustains the stereotype that all mental illness is alike (2010:20). He explains the problem of homogenisation when applied to perceptions of dangerousness through the 'outgroup homogeneity effect' whereby, in contrast, ingroup members are perceived as heterogenous and individual. This amplifies the perceived normality of the ingroup, and the perceived violence and dangerousness of the outgroup, which compounds stereotyping (Hinshaw 2010:42).

Corrigan acknowledges stigma associated with dangerousness as a 'virulent force' in society (2018:62), as confirmed by American literature. For example, The Treatment Advocacy Centre claimed around 1000 murders per year were committed by mentally ill people (2002), and Satel (1998), on behalf of the American Enterprise Institute, a 'neoconservative' policy research body, suggested inpatients at California's State (Psychiatric) Hospital had committed crimes at a rate ten times that of the general population. Such findings have been criticised for suggesting

that anyone with a mental illness is potentially dangerous, and for combining samples of acutely ill people, and police statistics, to make simplistic generalisations about the entire mentally ill population (Corrigan 2018:63). Teplin (1984) pointed out the 'double bind' that perpetrators of violent crimes are more likely to be construed as mentally ill because of the psychiatrization of criminality, and that an individual with a mental illness is more likely to be arrested for an offending behaviour than an individual without one.

In response to undeniable perceptions of danger, the MacArthur Research Network on Mental Health and the Law sought a politically and socially contextualised consensus statement over the true relationship between mental illness and crime. The resulting meta-analysis concluded: (i) a weak association exists between mental illness and violence; (ii) the public perceives a strong association, and this results in stigmatisation; (iii) it is necessary both to eliminate stigma and to offer adequate treatment to mentally ill people (Monahan and Arnold 1996).

Despite such assessments, high levels of representation in news media of mentally ill people who commit crimes demonstrates the media's (re)production of a societal fascination with crime, contributing to stereotyping through sensationalisation (Wahl, 1995; Rossler 2016:1253). Further, the concept of the dangerous mentally ill has been grasped by apologists for gun ownership, including Donald Trump: *'This isn't about guns, this is about, really, mental illness'* (ABC News October 2015), and Republican congressman Tim McMurphy who, following the 2012 mass shooting at Sandy Hook Elementary School, did much to solidify the public perception of violence, specifically gun violence, with mental illness. In 2022 mental illness, not gun ownership, is still blamed for mass shootings.

With the premise of actual dangerousness to the public demonstrably weak, perhaps we need to return to the broader concept of danger; the (potentially hegemonic) threat posed by Foucault's concept of fear of 'unreason' among people who are mentally ill. Such fears among policymakers and government may have generated policy influenced by evaluation of risk. Filc notes how the 'discursive deployment of risk' (2005:191) pushes the individual towards diagnosis, medication, or other interventions. Rose (1999:235) considers psychiatric interventions as large-scale administrative actions rather than therapeutic, individual actions; interventions target populations at risk, or presenting risk, rather than people in need of help, through an anticipatory 'actuarial analysis' entailing collation and interpretation of large amounts of data. With classifications of risk centring on the identification of those whom it is not possible to manage in open society, *'the logic of prediction comes to replace the logic of*

diagnosis' (Rose, 1999:261). Consequently, psychiatric institutions become locations for the containment of risk rather than sites of care, with motives for containment resembling some of those described by Foucault (1972a) in the 18th century, and mental health workers being conferred the responsibility to administer *'a new territory of exclusion'* (Rose 1999:262), which feeds cyclically into stigmatisation.

More broadly, governmental projects may be based on fears and anxieties to such an extent that they are 'governing through neurosis'. Governments, organisations and professionals, including medical professionals, exploit and generate a culture of fear (Isin 2004:219).

Governing through risk means… inviting (subjects) to speak truths about themselves, their conditions, and the assessments by which they conduct their selves…. Subjects are encouraged to conduct themselves in the most beneficial ways to their health, wealth and happiness in ways that are rational, self-interested and calculating (Isin 2004:220).

3.8.3 Parity, medicalisation, and diagnosis

Diagnosis of mental illness emerged as a means of social control, allowing the public to be reassured by the removal of 'troubling people', with *'peace of mind…purchased very cheaply'* even if such diagnoses were *'pronounced by a medical philosophy as yet unable to formulate its own principles'* (Foucault 1972a:7).

As noted earlier, the outcome of a diagnostic process may be labelling. Diagnoses of mental illnesses across the Western world are made according to the definitive taxonomy provided by the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association since 1952. But diagnosis has conceptual limitations; the diagnoser may search for pathognomonic symptoms (the group of characteristics associated with a particular disorder), as sought in physical medicine. Although lists of defining symptoms in mental illness should not be regarded as absolutes, an enduring reification of diagnostic nomenclature, and of diagnosis itself, confers on diagnoses an existence beyond conceptual domains (Corrigan 2018:9).

The realm of what merits inclusion in the DSM has expanded drastically since its inception to its current iteration, DSM-V (2013), as the boundaries of what is deemed psychopathological have shifted. This has significant implications, since the potential for mental illness to be 'applicable' to a greater proportion of the population may have created greater stigma for more

people, because mental illness itself has become concurrently denigrated and devalued by its conceptual expansion (Hinshaw 2010:20). With an increasing amount of what was formerly considered within the normal range of experience now deemed pathological, 'real' mental illness becomes trivialised. The expansion of what constitutes mental illness may be seen both to reflect an increased medicalisation of everyday life, and an explicit drive to expand the market for psychotropic medications. Corrigan criticises the relentless pursuit by the pharmaceutical industry of innovative and costly drugs which, despite the context of supposedly evidence-based medicine, lack proven efficacy. He suggests the 'authoritarian power of science' allows obscure and complex methods to be respected (2018:27).

Moynihan and Cassels (2005) explore such behaviour in their US-based study which exposes the extensive influence of pharmaceutical companies in 'selling sickness'. They find that the pharmaceutical industry is involved in the definition and design of disorders and dysfunctions to create or expand their markets (2005:vii), and that the number of medical conditions has been routinely extended in order to increase the number of possible candidates for prescription medications. Revised definitions of what constitutes clinical depression for example means far more people 'qualify' for medication.

The broadening of markets and expansion of (mental and physical) illness categories is achieved in part by corporate payments to 'thought-leaders' from academia and research (2005:6), and transactional and pressurised relationships between pharmaceutical representatives and clinicians. Moynihan and Cassels describe an immensely calculated process whereby the pharmaceutical industry distributes its 'largesse' to *'those considered to be most commercially helpful'* (2005:171). Extraordinarily, the authors found the Federal Drug Administration (FDA) receive significant funding from the very drug companies who they are tasked to regulate.

Thus in two ways, neoliberalism can be seen to *sustain* mental illness stigma within a supposedly rational society. First, through medicalisation, the explanation of 'normal' fields of the human experience are subsumed into defined categories and sets of practices (Filc, 2005). Medicalisation is entwined with the growth and dissemination of the concept of parity between mental and physical health, and can also be linked to responsibilisation. Secondly, the calculated construction of an expanded diagnostic field, to service market growth in psychotropics, is a form of biopower, which exposes more people to being stigmatised within the devalued field of mental illness.

Striving for parity between mental and physical illness has superficial appeal, semantically connoting egalitarian values. However, because it entails embracing more closely a medical model of mental illness, then as the previous paragraph demonstrates, it serves neoliberalism, especially when medicalisation benefits capital growth from several directions. In tandem, the social and cultural context of mental illness is ignored (Hinshaw 2010:14). The desire for social distancing is increased in people who ascribe to a biological view of mental illness, and therefore offering a biological explanation is detrimental (Rossler, 2016:1253). Tyler (2020) agrees, and referring to HT's espousal of the parity model, suggests using biogenetic rather than social models of mental illness can increase stigmatising attitudes.

3.9 The policy trajectory leading to anti-stigma

I briefly examine key aspects of the mental and physical health policy trajectory which, in combination with market-based cultural turns, set the scene for the initiation of, and maintenance of, the use of the stigma of mental illness as a policy initiative.

I present illustrative aspects of policy from the latter Thatcher years to the Cameron government, although many policy trends are not reflective of individual governments, but rather of cross-party, incremental themes, in which creeping privatisation, cuts, policy failures, and denial of the socioeconomic causes of physical and mental ill-health, converge to provide fertile territory for the utility of stigma as a concept. A unifying theme through these years is the striking difference between policy and its realisation, and the lack of consequences when a policy or target is not achieved. Hunter (2003) observes the enduring presupposition that unproblematic relationships exist between public health policy making and implementation.

First however I provide the historical context of mental health policy of the asylum system and subsequent deinstitutionalisation, which led to the policy of 'care in the community' during the Thatcher years. 'Care in the community', which could be regarded as a policy solution to the social stigma of insane asylums, had been reflected in a somewhat diffuse British policy of deinstitutionalisation since the 1960s, but it was only in 1983, under Thatcher, that the policy became more concrete, following the Audit Commission's report, 'Making a Reality of Community Care' and the respective green and white papers which made care in the community, or at least closure of asylums, a reality.

While France witnessed a 'great confinement' in state asylums under Louis XIV's absolutist reign[4], in Britain prior to the 19th century, the confinement of 'lunatics' was an area of market growth, populated by privately-run, unregulated madhouses with varying tariffs, managed through regimes of strict secrecy, leading Defoe to remark on the ease with which they facilitated the removal of problematic wives or daughters (Porter, 1987:168). This echoes Foucault's reference (3.82) to individuals' removal and confinement for public convenience or perceived social threat. In tandem, pauper asylums dependent on parishes or charities seem tantamount to workhouses. Thus, although we most often associate asylums with Victorian Britain, which certainly witnessed huge expansion in the numbers incarcerated, it was preceded by an even darker system which Porter (1987:167) describes as a 'trade in lunacy'. [5]

The proliferation of Victorian asylums, whereby the patchwork of private and charity concerns became a matter primarily for the state, was the result of the County Asylum / Lunacy Act (1845), which resulted in the building of over 100 asylums, housing approximately 150,000 patients in England and Wales. Deinstitutionalisation was an incremental process involving a movement of around 100,000 people, from the 1960s.

Deinstitutionalisation entailed three elements: diversion from hospital admission, movement of individual from hospitals to the community, and the creation of community mental health services (King's Fund, 2022). The forces driving deinstitutionalisation were a combination of human rights concerns, anti-psychiatry sentiment, reports of mistreatment, and a vocal 'service user' movement, together constructing a primarily moral agenda, implicitly intended to improve the experience of patients. This was supported by clinical proposals that severe mental illness was not only treatable, but that it was treatable in an outpatient context.

Such notions of welfare could be framed as a watery anti-stigma initiative, since there appear to be few concrete proposals of patient benefits. Yet according to The King's Fund (2022), where community services were 'available and comprehensive', patients benefited from deinstitutionalisation. However, primary care services were largely excluded from this extraordinarily ambitious transformation, based on the assumption that GPs wanted no part in community management of people with mental illness. This shameful failure of

[4] 1643-1715.

[5] John Perceval, one of the best known voices of 'lived experience' from the early, less regulated Victorian asylum system, formed the 'Alleged Lunatics' Friend Society', perhaps one of the earliest known mental illness 'service user' social movements. In aiming to protect the interests of people 'improperly confined', it might also be deemed an AS initiative.

communication and planning, perhaps based on horrifically stigmatised attitudes, disastrously impacted outcomes.

Economic motivations for deinstitutionalisation should not be overlooked; some institutions may have been financially unviable, but as estates their value was immense. Additionally, through voluntary redundancies and re-grading of nurses, local health authorities were able to reduce their staff budgets by 20% during the first year. Yet relocating 'care' to the community has not generated longer term cost reductions; the King's Fund (2022) claims community care is of higher quality, and has been more costly. The release of estate capital was also slow, and some institutions remain unsold.

Notwithstanding the 'trade in lunacy' described by Porter (1987), from the above discussion a broader trajectory can be seen from a philanthropically-financed policy of social containment during the asylum era to a policy of care in the community, seemingly driven by a small-state neoliberal ideology of dispersing the 'problem', framed and legitimated in a discourse of empowerment and enablement which evokes the concept of the autonomous self, discussed by Rose (1990:90).

Returning to the Conservative landscape, the two Conservative governments of Thatcher (1979-1990) and Major (1990-1997) heralded a new era of market incentives. It was towards the end of the Thatcher government (1979-1990) that the white paper *Working for Patients* (1989) formally introduced market forces to health. Evans *et al*. (1995:4) note the increase in health inequalities under Thatcher. The NHS had previously been a 'data-free environment' (Cairns and Donaldson 1993:3) with little means of tracking outcomes and little motivation to cut costs. Now however, concern with 'inefficiency' culminated in the view that NHS efficiency could most effectively be promoted through increased competition.

The subsequent Major government was equally disinclined to accept economic deprivation as a cause of ill health. Both governments depoliticised health, depicting it as an individual's personal responsibility, and often the result of behavioural choices (Scambler and Goraya 1994). This represents a scene-setting for the austerity and responsibilisation seen post-2008. During this government the discourse of 'choice' came to prominence (Mulderrig, 2008). Choice was also an element of the first Patient's Charter (1991), a commercially-modelled instrument of neoliberal ideology which enshrined new tenets such as patient participation. In this supposed rebuffal of paternalism, the notion of 'empowerment' was embodied, making the

Charter a further precursor to responsibilisation. In 1992**,** the Private Finance Planning (PFI) initiative, in which private 'partners' designed and maintained NHS services and facilities, drew in private capital to create health 'efficiencies', through private sector practices, compelling trusts to behave as commercial enterprises. Yet unforeseen increases in capital costs resulted in significant cuts to services; the notion that 'operational efficiencies' would result from capital investment and private sector practices was always flawed (Price and Green 2010:79).

During this period, studies of the costs of mental illness emerged, using information on prevalence, service data and 'unit costs' (Smith and Wright, 1996:61). These served to influence and justify policy which emphasised 'cost containment'. In addition to being used to set priorities, such cost analyses appear to herald the start of the concept of the 'burden' of mental illness, and its metricisation.

Mental health became a significant policy focus under Blair's New Labour government (1997-2007), which adopted the standard political stance of blaming the preceding Conservative government for its deficiencies (Hannigan and Coffey 2011:223). The problem was framed as a systems and services issue, and *Modernising Mental Health Services* (DoH 1998) blamed failings in community care for systemic problems. Compliance with community mental health 'treatments' became legally enforceable, and a novel category of mental illness, *'dangerous and severe personality disorder'* was instituted. Powell (1998:168) criticises Labour's 'new' NHS policy documentation for its repetitive array of soundbites and acronyms, especially since its plans were built on existing Conservative policy, not on implementing the spending which Labour had itself called for in opposition. The 'new' NHS increasingly consisted of diverse local services rather than a true, unified national service, and budgetary constraints saw waiting lists reach new highs (Powell, 1998).

The NHS Plan (DoH 2000) set out diverse and ambitious proposals for implementation over 10 years, and committed to national targets for health inequalities, which appeared to follow the recommendations of the Acheson report (Department of Health, 1998). Tellingly however, Hunter (2001) notes an overemphasis on the influence of individual lifestyles, and little acknowledgement of the socioeconomic determinants of health.

The turn to individualism has been influential in the concept of wellbeing across public and political domains. For governments, promotion of 'wellbeing' does not incur serious costs, and its 'roll-out' can be enacted in high-profile ways which lead the public to believe their health

is being provided for. Carlisle and Hanlon (2007) question the sustainability of alignment by public health bodies to a paradigm which fails to tackle health inequality, and they note that the ‘science’ of wellbeing has emerged from psychologists, who inevitably focus on the individual.

The commercial adoption of wellbeing has been part of the broader commodification of health, such that the consumption of wellbeing products, and engagement in wellbeing practices, is integral to a ‘good’ life within capitalist societies, and is a social indicator of a certain level of income and education (Carlisle and Hanlon, 2007:267). As a regular focus of media content, ‘wellbeing’ allows diversion of policy attention from health, and even economic, inequalities (2007:266).

Use of the wellbeing concept in public health is an understandable response to the failures of neoliberal economic order (Crawshaw 2008:259). It is a construct which has emerged from the failure of neoliberalism to create happiness (thereby potentially explaining the ‘need’ for a ‘Happiness Czar’). The vagueness of the term allows it to include or exclude specific characteristics and experiences, according to the user; in reality its meaning amalgamates the social, the biological, and the economic, representing complexity in a simplistic form (Crawshaw, 2008:260).

Because ‘wellbeing’ is not tied inextricably to biomedical outcomes, it is exploited by non-medical specialists, but also by those from disciplines such as marketing. I would include the marketing of ideas. Crawshaw suggests the ‘science’ of happiness, espoused by Layard (2005), risks essentialising a category which may not in fact be reducible (2008:260). Yet ‘wellbeing’ provided a convenient cultural milieu for the acceptability of Layard’s ideas, especially in combination with the subsequent economic climate.

Layard, afforded the appellation *‘The Happiness Czar’* following publication of *Happiness: A New Science* (2005), was a staunch Blairite and influential figure in mental health policy under the Blair leadership; the years in which AS emerged. Layard’s enduring position is succinctly demonstrated by his opening statement at a lecture: *‘This lecture argues that mental health is a major factor of production’* (Layard 2013, LSE). Layard, nominally a ‘Labour’ peer, has been influential in keeping mental health discourses firmly away from considerations of equality. He has been concerned with the effects on productivity, considers absenteeism from many mental illnesses ‘needless’, and is convinced that depression can be inexpensively addressed. He argues that mental illness leads to physical illness, and therefore policies

targeting mental health will save the nation's health budget. *The Depression Report* (Layard/LSE, 2006) was a call to government to implement what was to become Increasing Access to Psychological Therapies (IAPT), setting out the economic cost of depression, and the solution. Co-signatories included Graham Thornicroft.

A combination of 'altruistic concern and moral panic' ensued from the zealous policy activity in mental health during New Labour. Amid administrative upheaval, and short implementation times between policy directives, conflicting power interests were apparent, particularly in emerging concerns about stigma and discrimination (Hannigan and Coffey, 2011:225).

Under Gordon Brown's premiership (2007-2010) the debt crises resulting from the global economic crash ultimately led to the creation of austerity agendas, including a drive to reduce the costs of healthcare. Although the number of people deemed vulnerable increases with economic downturns, cuts to health budgets were rigidly enforced; the 2008 economic crisis resulted in huge cost containment, and policies restricting access to services significantly increased social inequality (Wenzl *et al*., 2017:947).

Layard was ready with a solution for mental health, and spearheaded the drive for IAPT, which the NHS instituted from 2008 following his recommendations via the LSE's Centre for Economic Performance (CEP) Mental Health Policy Group, of which Layard was chair. The programme instituted new NICE therapy guidelines developed by psychologist David Clark, with whom Layard later collaborated in a celebration of psychological therapies[6]. Layard claims IAPT achieved recovery rates 'approaching 50%', although he does not describe by what criteria someone is deemed 'recovered'. Layard recommends mental illness should be 'caught' early, since onset of mental health problems often starts at around 15yrs. He manages to construct children with mental health problems as having a 'conduct disorder' (2013:9).

Think tanks, which aim to influence government through supposedly neutral and independent expertise, in a range of spheres including health care, may be seen as an aspect of Americanisation in policymaking. The US RAND Corporation, formed in 1948, was prototypical. Shaw *et al*. (2015) challenge the 'independence' and performance of such bodies, considering them to be means of *'gathering and assembling forms of authority'* (2015:5) with respect to health policy. Think tanks variously describe themselves as charitable or policy research organisations, and claim to be free from bias or vested interests. The Centre for

[6] Clark , D. and Layard, R. (2015) 'Thrive: the power of evidence-based psychological therapies'.

Economic Performance (CEP) from which Layard 'launched' IAPT, is a policy research organisation.

The Thatcher government had provided a comfortable backdrop for the proliferation of think tanks, which also went unchallenged under New Labour (Shaw *et al*., 2015: 60). Many, such as The Institute for Economic Affairs (IEA), founded in 1955 and wielding significant current influence, deny being right wing, claiming they have only 'free market' objectives. Empirical research (Shaw *et al*., 2015) highlights think tanks' use of rhetorical strategies to influence NHS reforms, and finds they intentionally convey a 'view from nowhere', supposedly lacking ideologies. However, far from offering neutrality, Shaw *et al*. (2015:73) found ideas from think tanks lent credibility to proposals to extend market principles in health policy. Lack of resistance to think tanks can be explained by the UK Government's limited ability to design its own solutions; it is eager therefore to offload policy research to politically aligned bodies, at no time or financial cost to itself. Within this scenario, it is easy to see how Layard was able to exert such influence from the CEP.

Thus we see, over the nearly three decades between Thatcher and the institution of TTC, within an overarching political-economic framework dominated by neoliberalism, policy frameworks have been representative of the denial of economic causes of mental ill-health, concern with burden of mental illness, austerity and the retreat of the state, and have collided with the 'wellbeing' marketplace, and literal selling of the happiness concept, at a time when the concept of stigma was re-emerging.

Anti-stigma campaigns rose to prominence following the financial crisis, and can be seen within that political-economic context to constitute an evolution of mental health policy. In tandem with the creep of for profit health provision, state health and social sectors are increasingly reliant on charities in a manner reminiscent of early 20th century philanthropy (Tyler 2020:204). This parallels my belief of a reinvigoration of a public schema within which, with both philanthropy and charity a familiar part of the social landscape, the concept of stigma was not alien but rather, came to be a concept in alignment with the reality of austerity, in which charity was expected to take a greater role.

Reliance on charity in many areas of social life includes mental health, although as Tyler notes (2020:204) the charitable offer is frequently associated with corporations whose 'predatory capitalism' played a role in the crisis in the first place; HT's partnerships with Blackrock, Virgin, Unilever and Carphone Warehouse, mean that HT is *'bankrolled by some of the very*

corporate and financial organisations that are the beneficiaries of neoliberal economic policies…that are eroding state welfare and social care…' (Tyler 2020:250).

While a set of policy circumstances can be seen to have created the terrain for the inception of AS, equally significant are those which may help explain its longevity. For example, David Cameron's concept of Big Society (2010) blended communitarianism, a philosophy emphasising the connection between the individual and the community, with Thaler and Sunstein's (2003) concept of libertarian paternalism, which proposed that institutional policies may legitimately steer people towards rationally making choices which they might not otherwise make ('nudge'). In the Big Society, community-based activities were valorised, and volunteering and charity work encouraged, in line with the ethos of TTC. AS initiatives appeal to public decency and goodwill, and doubtless to latent feelings of resistance, through TTC's deceptive self-definition as a 'growing social movement'; this was part of the cultural 'zeitgeist' which David Cameron's 'we're all in it together' speech at the Conservative Party Conference (2009) both reflected and enhanced.

Orsini and Smith (2010), exploring the role of social movements in the policy process, find citizens construed as an undifferentiated problem to be solved. Their observation of 'overlapping networks of public, para-public and private actors' in the policy process (2010:38) resonates with the anti-stigma 'movement', in which the blurring of boundaries between society and state may be exploited, when state-derived anti-stigma campaigns employ established and trusted institutions as their vehicles.

Socially-based health movements may have true agency, shaping policy by drawing focus away from hegemonic constructions of what counts as knowledge or expertise (Orsini and Smith 2010:39), thereby challenging power and authority. AS campaigns are constructed without this ability, and the ideology guiding their behaviour and output is inextricably constrained by their sources of funding, and is consequently non-disruptive in nature, and only superficially empowering. In TTC, the emphasis on grassroots, community based initiatives could be construed as an attempt to replicate 'genuine' social movements, by repeatedly self-identifying as a 'growing social movement'.

Mental health charities have existed in Britain since 1946, when Mind was created. In many charities a broad functional shift can be observed whereby organisations which previously identified wholly as charities, and whose founding objectives were to provide education and advocacy, are now significantly engaged with anti-stigma efforts, with their educational

component subject to an apparent conceptual re-branding, representing instead the 'awareness-raising' component of AS.

Often then, anti-stigma operates within an existing mental illness charity, or is part of a shift in organisational focus. TTC is different; it derives credibility from its parent charities, Rethink Mental Illness, and Mind, but was founded in 2007 as a specific and distinct anti-stigma body, in common with national campaigns in other developed countries in the same decade. In 2012, TTC was instrumental in the foundation of the Global Anti-Stigma Alliance (GASA), representing 14 Western, neoliberal countries. When HT entered the fray in 2017, it joined an already crowded arena.

TTC launched its first phase of operation from 2007-2011, launching its social marketing campaign in 2009, the second phase from 2011-2015, followed by a third phase which ended in March 2021, marking the closure of the programme. That its lifespan accompanied some of the most egregious cuts in public spending appears to be more than a spurious correlation.

It may seem puzzling that the DHSC should choose to fund, throughout the years of austerity, a lavish multifaceted campaign purporting to address the stigma of mental illness. This ostensibly beneficent social objective, to counter stigma by encouraging talking, so that people seek help, is superficially counterintuitive in the context of mental health service provision already struggling, and facing incremental cuts. On closer examination, the campaign activities can be seen to constitute a multi-level cost-cutting exercise, as I will explore this later in this thesis, and in the concluding chapter. At this point however, I wish to highlight the use of the concept of stigma as a tool through which to enact a policy initiative. Stigma is undoubtedly a destructive and pervasive social phenomenon, as described by Tyler. The stigma of mental illness is all too real, but as this chapter has shown, it is most strongly associated with serious forms of mental illness. However, AS campaigns foreground the notion that it is stigma which is the greatest problem for people with mental illness, not the lack of mental health services. The public and mentally ill people alike are recruited in support of the diversionary discourse which draws public attention away from the increasing erosion of mental health services.

AS campaigns may be regarded as a cynical placatory measure of social control, obviating other more costly measures, sited within a receptive policy environment forged over the preceding decades. Second, as the brief sketch of the preceding policy and cultural trajectory has shown, Layard's IAPT, from 2008, is the 'help' which is available when stigma is challenged. It is a form of help which was motivated from the perspective of labour economics,

to increase productivity, and for which, through his application of labour economics, Layard calculated *'the net cost to the Exchequer is zero'* (2013:7). While IAPT services are provided 'by' the NHS, they are purchased from a vast range of private suppliers, who have proliferated, and profited, since the inception of the scheme. This helps explain why the logic of TTC found ready acceptance, since it is inflected with a range of assumptions normalised by a series of neoliberal policy and cultural turns.

3.10 Closing comments

The aim of this chapter has been to offer a genuinely transdisciplinary conceptualisation of the problem of the stigma of mental illness, and its use as a policy response. This broad ranging chapter has therefore utilised literature from across the social sciences, from critical political economy, philosophy, psychology and social psychology, in order to contextualise this thesis from socio-cultural, historical, political and policy perspectives. It is intended that consequently, the objectives and character of this work are made clear, and that the subsequent chapters may be understood in the light of these perspectives and explanations.

CHAPTER 4: Linguistic (CDA) Literature in Public and Mental Health

4.0 Introduction

The contextualisation provided in Chapter 3 demonstrated the breadth of literature relevant to this research. In this chapter I review studies which have used CDA in the fields of public and mental health, or which consider the stigma of mental illness. I first introduce, then describe, core work using CDA/multimodal CDA, with a public health subject focus. I then describe relevant linguistic work relating to mental health or stigma; first, studies by key linguists who use corpus studies, then selected studies which serve to illustrate the nature of the available scholarship, and its absences. I then review the state of work in linguistics which concerns mental health, to identify how my research addresses some current omissions, and can be positioned within this emerging field.

4.1 Introducing the work of key linguists

In the literature we see a body of 'true' (Faircloughian) CDA in public health; key critical studies by Mulderrig (2017; 2017b; 2018; 2018b; 2019) demonstrate use of nudge tactics in the *Change4Life* (C4L) anti-obesity campaign, Brookes and Harvey (2014) examine the rhetoric in a diabetes awareness campaign, Brookes (2021) analyses the *Tackling Obesity* policy during the pandemic, and Brookes and Baker (2021) explore responsibilising discourses of obesity and risk in the UK press. Work on dementia (Harvey and Brookes 2019; Brookes *et al.*, 2018) is perhaps the intersection between the focuses on policy or texts relating to physical illness, and the small amount of work concerning mental illness. Dementia is itself a contested area with respect to its funding, public perceptions, and inclusion or exclusion in both mental health policy and campaigns. Brookes & Harvey (2016), Harvey (2012) and Harvey and Brown (2012) approach subjective experiences of mental illness from a corpus-linguistics perspective.

From the outset it is apparent that while a range of CDA studies critically examine public health policies and their enactment, the same is not true of mental health policy.

The studies described above focus on campaigns, policy papers or initiatives, social marketing campaigns, or media responses. They are unified in their critical analytical approach and interpretive position, and frequently demonstrate how, in response to changing modes of communication, researchers often use multimodal CDA (MCDA), analysing all possible semiotic modes in their data.

Such critical studies have in common their identification of a neoliberal perspective on public health, which involves linguistic mechanisms of individualisation and responsibilising rhetoric. This neoliberal mode of political economic practice seeks to advance mechanisms of individual entrepreneurial freedom within a free market institutional framework. As Mulderrig (2017b) points out, the state both creates and maintains the institutional framework which enables support of neoliberal practices, and neoliberal modes of governance have been permitted in the UK by 'cross-party consensus' since the 1980s.

Although little CDA focuses on mental health issues, many public health CDA analyses highlight the mental health consequences of public health policies, for example invoking fear (Brookes and Harvey 2014; Brookes and Baker 2021). Similarly Mulderrig invokes the concepts of 'emotional governance' (2018) and 'psychological governance' (2019). Broader observations of the mentally deleterious consequences of neoliberal policies, including their stigmatising effects, align with the assertion from Lupton (1993:431) that health education campaigns psychologically manipulate people's fears, anxieties and feelings of guilt when persuading them to adopt certain behaviours.

4.2 CDA Studies: diabetes, obesity, and dementia

4.2.1 Diabetes and obesity

Brookes and Harvey (2014) critically analysed a major campaign partnership between the charity Diabetes UK, and the supermarket chain, Tesco. This 2013 campaign was designed to raise public awareness of Type 2 diabetes. The authors use critical multimodal discourse analysis, underpinned by a social semiotic theory of multimodal communication, in which

meaning is derived from the interplay between various semiotic modes (Machin and van Leeuwen 2007).

The photographic images from the Diabetes UK campaign strengthened the neoliberal ideal of responsibilisation by suggesting diabetes is faced entirely at home, not in a medical setting. The textual resources also construct diabetes as a potentially fatal threat. Readers are urged to urgently assume personal responsibility and evaluate their risk of diabetes "Before it hits you and your family". This metaphoric conceptualisation is likely to instil fear (Brookes and Harvey 2014:68), and such 'synthetically personalised' messages might lead any reader to feel they were being personally addressed (2014:71). The implication that anyone is at risk of diabetes ignores environmental factors in its aetiology.

Three discursive techniques were identified (i) the depiction of grief and danger, (ii) the promotion of diabetes risk (and individuals' responsibility to address it), and (iii) the commercial branding of the Diabetes UK/Tesco partnership, which included the promotion of products and services to prevent and manage diabetes. Together these techniques provide an integrated solution to the problem, but without offering practical health advice.

The semiotically-realised *'fear-inducing, stigmatising and commercial strategies'* (Brookes and Harvey 2014:57) obscure the reality that diabetes is largely manageable; an approach the authors find morally questionable, especially combined with the commercial partnership between a charity and a supermarket which encourages consumer dependence on processed foods.

This study is among several illustrating the increasing frequency of partnerships between publicly funded health promotion bodies or charities and businesses. When commercial discourse merges with purportedly non-commercial public health or charity campaigns, features of commercial communication, including logos, slogans, and synthetic personalisation, are incorporated in those campaigns (Brookes and Harvey 2014:74).

Mulderrig (2017) investigated the origins and enactment of the long-running 'Change4Life' (C4L) anti-obesity social marketing campaign. Launched in 2009 and targeting children and their parents, this commercially-sponsored campaign represents the UK government's principal obesity-policy intervention. Social marketing combines the social practices of government and commerce, from which values and assumptions may clash. This exemplifies the merging of communicative techniques noted above. Mulderrig views C4L as part of a political climate whereby governments ostensibly meet their social welfare responsibilities, but

do so through cost-effective policy interventions which do not constrain the market requirements of advanced capitalism.

In this political setting, 'nudge' has become established as a policy approach which claims to *'help the less sophisticated people in society while imposing the smallest possible costs on the most sophisticated'* (Thaler and Sunstein 2009:252). Mulderrig systematically analyses the application of nudge to C4L, using CDA to examine the social practices that constitute nudge as a policy instrument, and finding C4L to be part of a trend towards the use of behavioural psychology in public policy.

The first stage of the campaign aimed to reframe the problem of obesity, by avoiding the term 'obesity' itself, which was deemed alienating (Mulderrig 2017:473). Instead the campaign used simplified descriptions such as 'dangerous amounts of fat in the body' (2017:470). Mulderrig demonstrated however that the claims produced by simplifying biomedical research were factually questionable, and potentially heighten anxieties about body weight.

By analysing patterns of intertextuality, legitimation, and representation in the TV advert which was used to launch C4L, Mulderrig investigated how the advert recontextualizes and simplifies understandings of obesity. The advert's cartoon-like genre simplified scientific research on obesity, and by recontextualising knowledge across policy chains, it obscures the reality of the complex causes of obesity, including environmental and political-economic factors particularly associated with social inequality (Mulderrig 2017:472).

Mulderrig identified semantically ambiguous pronouns (where 'we' slipped from being inclusive to ambiguous, potentially including the government). This subtle linguistic mechanism revealed a contradiction of this policy; it partly frames obesity as a systemic problem, but presents an individualised solution. The campaign's reliance on brand power, realised partly through its corporate partners, endorses the consumer culture which contributes to our 'obesogenic environment'. It also challenged the idea that eating healthily is expensive, and that rather *'You just need to be clever about it'* (Change4Life 2016). Thus the campaign persists with an individualised solution, even when implicitly correlating obesity with social deprivation (Mulderrig 2017:472).

Mulderrig's second analysis of C4L (2017b) further emphasises the campaign's application of 'nudge' tactics, revealing how the spoken narrative of the campaign's cartoon style TV adverts draws individuals into the 'active citizenship' required of them. Mulderrig found the target group of C4L were working class people with northern regional accents, whose behaviours

were pathologized by narratives of dietary excess and ignorance. The scripting of the adverts presupposed the decision-making of this demographic was governed by habit, short-term gratification, inertia, and lack of knowledge; characteristics which Thaler and Sunstein (2009) present as typical of those in need of behavioural modification. Through such analysis, Mulderrig relates her findings to Foucauldian explanations of domination and hegemony; techniques of biopolitical surveillance identify those 'at risk' and the 'less sophisticated' are represented as irrational. Nudge therefore provides *'a legitimatory discourse and policy apparatus'* (Mulderrig 2017:17) through which are reproduced *'relations of domination and effects of hegemony'* (Foucault 1978:141).

Mulderrig's analysis demonstrates the use of nudge as a technique of biopedagogy, with biomedical discourse recontextualised to render it comprehensible to children. More broadly, the campaign uses children to model the unhealthy lifestyles, invoke expert knowledge, and present the marketized behaviour change solutions, which Mulderrig (2017:17) identifies as a hegemonic strategy allowing the government to conceal its power.

Focusing on the political power of affect, Mulderrig (2018) demonstrates how both children and their parents are emotionally manipulated by the campaign's multimodal strategies, to persuade them to adopt healthier lifestyles. The semiotic resources in C4L all represent choices made by the campaign creators with respect to policy aims (2018:48), and by bringing this multimodal model into dialogue with the concepts of biopolitics and governmentality, Mulderrig investigated how the various semiotic resources persuaded the 'at risk' citizen to actively regulate their health. She consequently identified, respectively, discourses of risk and threat, and of 'smarter' consumerism. Children are presented as 'out of control' (Mulderrig 2018:63), and parenting is pathologised by representations of ineptitude. Nudge, applied as a technique of governmentality, instrumentalises guilt and fear, and reinforces individual blame for health inequalities. The process of configuring a more consumerist relationship between citizen and state is aided in C4L by use of slogans and consumer technologies, such as its Smart Swap app.

Reflecting on the campaign as a whole, Mulderrig (2019) presents three main insights: first, the discursive representation of the family's 'dysfunctional' behaviours constitutes an important tool for governing the population's health; second, by using children as agents of behaviour change the policy inverts traditional parent-child power relations in order to invoke self-disciplinary behaviours (2019:14); third, a discourse of consumer 'smartness' is used to

instil more resilient, risk-prepared subjectivities, illustrating the importance of the responsible consumer-citizen under neoliberalism.

Mulderrig's series of studies on C4L combine CDA text analytical methods with the Foucauldian concept of governmentality, situating both the use of behavioural economics, and the policy problem which the intervention aims to address, within practices of neoliberal governance. She identifies nudge as integral to the neoliberal regime by reinforcing narratives of individual irrationality as a cause of social problems. Through nudge, C4L frames the social inequalities which result in worse health outcomes to demographic 'risk factors', which are thereby depoliticized, and removed from the state's realm of competence (Mulderrig 2019:16).

Mulderrig's identification of the representation of working class lifestyles as delinquent (2018) is corroborated by her subsequent analysis of the policy documents and commissioned market research which underpin the C4L campaign (Mulderrig 2020). Through this she proposes a typology of families, according to socioeconomic and racial variables, with the working classes and ethnic minorities located at the 'riskiest' end of the spectrum. This study also identifies that UK obesity policy has historically blamed and stigmatised individual fecklessness.

Brookes and Baker (2021) used a corpus-based approach to examine references to obesity risk in British print media representations of obesity between 2008 and 2017. 67% of the articles were published after 2013, demonstrating a recent increase in focus on obesity risk. Informed by Foucauldian theorisations of risk, Brookes and Baker sought to identify the discourses used by the press to activate notions of obesity-related risk, and how subsequently 'truths' about risk become established, forming the basis of actions related to obesity. The authors conceptualise obesity within a 'chain' of risk; both as the consequence of 'risky' (food consumption) behaviours, and as a 'risky' condition, associated with the development of health problems such as diabetes (2021:2). Findings confirmed the concept of a 'chain' of risk, which was expressed differently in different groups of newspapers, with broadsheets tending to focus on risk factors which contributed to obesity, while tabloids more often presented obesity as a predisposing factor in heightening the risk of other health problems.

Among findings from left-leaning broadsheets, pre-modification by terms denoting high economic status ('rich', 'developed') established a connection between capitalism and obesity risk (2021:8). Among the right-leaning broadsheets meanwhile, the expression of risks through quantification reflects the neoliberal fondness for metrics. Use of the modal verb 'could' illustrates how reported health risks were often worst-case scenarios (2021:11), and is related

to a need to invoke expert authority (van Leeuwen 2008:107), which requires legitimation to boost its credibility (Brookes and Baker 2021:11).

Only the left-leaning broadsheets identified socio-political risk factors. The other newspapers reflect a discourse of individual obesity risk responsibility, which the authors link to Foucault's (1997) notion of governmentality. From this perspective, the reader, as a rational decision-maker, is responsibilised; they must manage their own risk of developing either obesity or associated health problems (Brookes and Baker 2021:13). This conforms with the tendency for the right-leaning press to favour reduced levels of state intervention, in accordance with economic liberalism.

An increasing prevalence in the discursive framing of obesity risk can be seen to parallel increasing neoliberalism in Britain. Individuals are urged to keep themselves healthy, productive, and to avoid placing financial burden on the state, and this is reflected in an intensified focus on individual risk reduction in news reporting (Brookes and Baker 2021).

During the Covid-19 pandemic, a new policy response was launched by the UK government, to address the heightened risk posed by Covid-19 to people who are obese: *Tackling Obesity: Empowering Adults and Children to Live Healthier Lives*. Associated policy measures included a new PHE online campaign, *Better Health—Let's Do This!* Brookes (2021), who analysed the *Tackling Obesity* policy paper, suggests the pandemic presented a 'teachable moment' for behaviour change (2021:2214).

The paper conceptualises obesity through familiar representations; as a threat to life and life expectancy. Health risks linked to obesity are presented as noun phrases, not as processes; rather than using the process 'dying,' obesity is framed as being *'associated with reduced life expectancy'* (Brookes 2021:2216). These vague linguistic choices obfuscate the connections between obesity and health problems, and subsequently the identity of the individuals concerned also becomes unclear, and obesity is represented as a shared, generalised threat.

Brookes notes the metaphorical sense of a battle, present even in the name of the paper, further construes obesity as a violent threat. Obesity is also presented as avoidable through individual effort, here minimised by 'just': *'If all people who are overweight … lost <u>just</u> 2.5 kg… it could save the NHS £105 million over the next 5 years'* (2021:2217). By representing people who are obese as a burden on the NHS, *Tackling Obesity* obscured other threats to the NHS, namely chronic underfunding.

Individuals were sometimes explicitly 'functionalized' as 'customers', and the concept of transaction is reinforced by offering them a metaphorical 'fair deal'. Together with assurances that *'we want to ensure everyone has the right information'*, citizens are constructed as self-determining consumers (Brookes 2021:2218).

Brookes found that the referents of 'we' and 'our' switched between the (collective) nation and the government, and recalls Mulderrig's analysis (2017:471) of C4L, in which the semantic vagueness of referential slippage in use of 'we' suggested the government simultaneously assumes responsibility for the nation's health, while also imparting responsibility onto the public. In *Tackling Obesity* the threat of obesity, and thus the individual responsibility to change lifestyle and consumer choices, is rendered more urgent by Covid and the rhetoric of saving the NHS. This requires citizen-consumers to be educated sufficiently to resist 'temptation'; for Brookes, this represents a discourse of the government as a benevolent body; helping manage individuals' actions, and furnishing them with the necessary information to make 'healthier' choices.

Brookes also proposes that *Tackling Obesity* represents 'lifestyle drift'; the text initially acknowledges obesity is not solved merely by individual effort, but then reverts to the customary discourses of self-governance. 'Lifestyle drift', following Popay *et al*. (2010:148), occurs when policies initially acknowledge that action is needed from 'upstream social determinants' of health inequalities, but then 'drift downstream', returning to dwell on individual lifestyle factors (Brookes 2021:2224).

In identifying that the discourses in *Tackling Obesity* are based on a neoliberal framework of public health policy, Brookes (2021:2224) recognises similarities with findings identified by Mulderrig (2017; 2107b, 2018, 2019) in C4L.

4.2.2 Dementia

Brookes *et al*. (2018) explored newspapers' use of linguistic and visual semiotic tropes in coverage of dementia, responding to a (2016) ONS report which described dementia as 'the leading cause of death' in England and Wales. The report was covered in 10 national newspapers, and was re-formulated in a headline describing dementia as the nation's '*biggest killer*'.

Dementia was constructed as an aggressive, catastrophic phenomenon, and the overall representation is sensationalist; by portraying dementia as an active, agentive 'killer', those who experience it are 'victims' (Brookes *et al*. 2018:371). The authors found militaristic metaphors, as are common in public health discourse, but also the representation of dementia as a competitor, that actively 'overtake[s]' and 'surpasse[s]' heart disease, the previous leading cause of death, and 'knock[s] it off' the 'top spot' to become 'the biggest killer' (Brookes *et al*. 2018:379). Semiotic analysis demonstrated that people with dementia were consistently depicted using images which represented them in reductive and objectifying terms, and which typically portrayed only the later stages of dementia. Brookes *et al*. (2018:389) suggest that since dementia can neither be simply explained or cured, this construction *'confers a measure of symbolic order on the syndrome'*, allowing the public a (false) semblance of understanding.

In a further study of the representation of dementia, which unusually undertakes multimodal CDA through analysis of images alone, Harvey and Brookes (2019) analysed commercial stock images depicting dementia and aging. The 100 most used stock images identified via the query term 'dementia' were extracted from the Getty image bank (Harvey and Brookes 2019:991). Photographs were subject to several analytical criteria, first identifying the participants and their settings, then analysing gaze, angle of interaction, and colour choices.

This analysis found the images matched prevailing narratives of dementia, representing cognitive decline and a loss of personhood. By foregrounding biomedical and pathological aspects of aging, images predominantly objectified and de-humanised their subjects, emphasising their vulnerability, and promoting a 'deficit' model of dementia (Harvey and Brookes 2019:998).

This presentation of dementia as a clinical, rather than a socio-cultural phenomenon, denies the possibility of a measure of health or autonomy in dementia. Negativity is newsworthy, and stock image providers respond to commercial demand, but the perpetuation of negative perceptions renders less credible the concept that a reasonable quality of life is possible with dementia, and this will heighten both fear and stigma associated with dementia (Harvey and Brookes 2019:998).

4.2.3 (Corpus) Studies in Mental Health

Brookes and Harvey (2016) reflect on two corpus-based studies of online mental health communication from a non-commercial health website, Teenage Health Freak (THF), created in 2000 by two doctors. They propose that examining individuals' communications about depression and self-harm allows greater understanding of the way adolescents perceive their identities in relation to their illness, and the illness itself. (2016:214). The interactive website received over 50,000 visits daily, and featured a virtual surgery, where users receive guidance from 'Dr Ann' the online persona of co-founder Dr Anne McPherson. Responses were publicly visible, and therefore reached a wide audience.

Both studies used a corpus of unedited but anonymised emails seeking advice from the THF site during 2004-2005. Harvey (2012) examined the ways young people formulated their concerns about depression, finding that keywords relating to depression suggested that biomedical terms ('depressed' and 'depression') were more salient than 'everyday' vocabulary ('sad', 'unhappy'). Collocational analysis then showed that the formulae *'I am depressed'* or *'I have depression'* construct depression as something one can 'be' or 'have'.

Concordance analysis showed the term 'depressed' was frequently used as a way of encoding adverse personal or social situations (Harvey 2012): (*'I'm really depressed about splitting up with my boyfriend'*). Such messages focused as much on problems of daily life as on depression itself, and involved seeking practical social advice, not medical advice. Brookes and Harvey (2016:223) claim that in attributing depression to circumstances over which they had little control, the adolescents situated themselves within a 'victim discourse'. They then claim that uses of the keyword 'depression' (*'i have severe clinical depression'*) indicate the adolescents viewed their condition from a medical perspective, portraying a continuing experience which indicated they were presenting symptoms in a 'psychologising style' (2016:224).

Harvey (2012) thus identified two communicative tendencies; adolescents either psychologize their experiences by employing medical terms, or they frame daily life experiences as depressive. Brookes and Harvey (2016:224) suggest that 'psychologized' presentation of symptoms may result in collusion between young people and practitioners, whereby normal human experiences are medicalised, and therefore their findings have implications for mental health practitioners.

Harvey and Brown (2012) used the same corpus to explore the way research self-harm is formulated linguistically, in a study identifying the most frequent collocates of the keywords ‘cut’ and ‘self-harm’. They found the linguistic choices of contributors who self-harmed evoked the language of addiction, with individuals constructing themselves as addicted to their self-harm behaviours, which were portrayed as ‘non-volitional’. The authors find this paradoxical, since self harm has been regarded as a means of obtaining control over feelings (Brookes and Harvey 2016:227).

Harvey (2012) and Harvey and Brown (2012) both used wholly corpus methods to explore subjective experiences of mental illness in messages seeking advice online. These analyses can be seen to diverge from core CDA studies of health policy or policy consequences. They offer linguistic exploration, but do not explore political economic context, nor do they enter into dialogue with other theories which seek to understand the reasons for mental distress. Brookes and Harvey (2016) emphasise the use of frequency, keyword and collocation as tools which are precursors for more refined, qualitative (concordance) analysis providing contextual depth; however such context is intra-textual.

This type of contextualisation cannot consider, for example, how the age of the online participants might affect their communicative style; teenagers may naturally frame their feelings of depression through their day to day lives. The authors also omit to mention the lack of availability of ‘real’ mental health care. It is disappointing that these scholars so readily invoke ‘victim discourse’, and to label the advice-seekers’ conceptualisation of their experience as ‘medicalised’ or ‘psychologised’ on the basis of keywords alone feels unjustified, especially within the context of addressing a clinician. These points highlight some fundamental differences in approach between wholly corpus studies, and a CDA approach which is aided by corpus work.

4.3 More varied linguistic work: mental health policy and stigma

The selected works below reflect the paucity of CDA (mental) health policy studies, the methodological diversity in analysing language use, and a need for greater understanding of the methods and affordances of CDA. To ignore this varied body of work would be to disregard valid, language-focused scholarship on mental health and stigma. In each case I make clear

their diverse methodologies; of the studies below, three claim to use CDA, 'features of CDA', or 'discourse analysis', one of which combines CDA with computational linguistics.

Jhangiani & Vadeboncoeur (2010) observe a shift to a 'positive psychological' approach in mental (public) health discourses which appears to be intended to reduce mental health stigma and to encourage self-monitoring of mental health. They examine this shift by analysing the discourse of the Canadian Mental Health Association's *Mental Health Online*, using 'features of CDA', referencing Fairclough (2001; 2003).

They observe use of metaphors, finding a central, 'orientational' metaphor reflecting 'positive psychology' is demonstrated by use of 'good' as (emotionally) 'up', and 'bad' as 'down' (2010:178). A further 'mind as body' metaphor was identified in exhortations to test mental 'strengths' and improve 'mental fitness' (2010:179). The authors identify the way readers are encouraged to undertake individual physical activity, and they stylistically compare the website's second person perspective with a self-help manual which attributes agency to the reader, who is identified as essentially well, and able to evaluate and manage their own mental health (Jhangiani & Vadeboncoeur 2010:177).

For these researchers, the 'universal psychology of individual mental health' in the online discourses is unacceptable from a sociocultural and postcolonial perspective; they criticise the ethnocentricity of the tenets of positive psychology, which have limited applicability to immigrants to Canada, specifically South Asian women (Jhangiani & Vadeboncoeur 2010:182). The focus on ethnocentricity, combined with the authors' use of *features* of CDA, means that they do not connect attribution of individual agency and the exhortation to engage in individual pursuits with responsibilisation, nor recognise that this is an integral feature of neoliberal public health texts.

Sukhera *et al*. (2022) seek to understand the stigma of mental illness during training in medicine, a field in which they suggest psychological wellbeing initiatives are under-used, as students do not seek help 'due to stigma against help seeking' (2022:1); the authors' acceptance of this trope as fact suggests a lack of criticality. Their approach involved CDA 'informed by' Foucault', and data drawn from Twitter, digital news media, and semi-structured qualitative interviews (2022:1). Their Foucauldian principles centre on the idea of the emergence, alignment, co-existence, and competition of discourses. From this perspective, discourses that emerge as dominant become the 'natural' and unchallenged way of understanding a phenomenon. Their understanding of dominant discourses as a reflection of power conditions

and social and political context is informed by Fairclough and Wodak (1997), and within an apparently related analytical framework, the authors aimed to explore the language used to discuss stigma, disclosure, and seeking help, both in real-world and online contexts. Their methodology however is unfamiliar to mainstream CDA; Twitter data were ‘mined and scraped’, and tweets were identified using a custom algorithm. This study is therefore a methodological hybrid, using computational linguistics to realise objectives within a CDA approach.

Their findings return to a CDA perspective, describing two conflicting discourses; an emancipatory discourse in which encouragement to disclose normalises help-seeking, and a discourse of performance driven by a perfectionist medical culture. Disclosure of mental health problems was perceived as disruptive to maintenance of the system's hegemony, and the authors therefore locate stigma both in the structural power inherent in the system of medical education, and in wider society (Sukhera *et al*. 2022).

Boyd and Kerr (2016) report using CDA to critically examine the Vancouver Police Department (VPD) policy reports on ‘Vancouver’s mental health crisis’ (2008: 13). The authors start from the critical perspective that ‘claims makers’, by defining the problem and proposing solutions, are in part responsible for the social construction of such crises. Solutions fit the institutional priorities of claims makers, thereby reinforcing technologies of social control (Boyd and Kerr 2016: 420). They observe that expansion of criminal justice systems in Western nations, accompanied by increased interaction between the police and people with mental illness, have been simultaneous with neoliberal policies which impact health, housing and welfare (Boyd and Kerr, 2016:418).

Having described their analytical approach as CDA however, Boyd and Kerr follow a methodological framework suggested by Bacchi (2009). Bacchi’s WPR framework, from *What’s the Problem Represented to be?* (2009), is not CDA. Indeed Bacchi (2018) distances herself from Faircloughian CDA, which she has described as focusing primarily on the content and linguistic construction of text (Bacchi 2005). WPR does not understand discourse as language or language use, but refers to a Foucauldian concept of ‘knowledges’, as ‘unexamined ways of thinking’, which underpin political practices (2009:35).

Boyd and Kerr used Bacchi’s framework to conclude that the reports of the VPD reproduce negative discourses on mental illness, may heighten stigmatisation and associations between mental illness and dangerousness, and could contribute to policy debates about re-

institutionalisation. This study therefore examined texts, and framed its critical enquiry through considerations of structural discrimination, inequality and forms of social control, but was not CDA. However, I include this research to illustrate the confusion concerning what constitutes CDA, particularly in fields relating to mental health and mental health policy.

Linguistic studies of online mental health communications lend themselves to wholly computational methodologies. For example Pavlova and Berkers (2020) examine mental health discourse on Twitter using a ten year (2007-2017) dataset. In common with CDA, their study is concerned with mapping both discourse and power within a transdisciplinary framework. This study used Linguistic Inquiry and Word Count (LIWC) software (Pennebaker *et al*., 2015) to assign sentiment characteristics, and to quantify collections of lexis relating to stigma. The authors also used topic modelling and statistical data regression analyses. Such methodology is anomalous to CDA, but the study merits mention, for finding an increase in 'mental health discourse' in relation to total Twitter discourse (Pavlova and Berkers 2020:11), and for revealing a trend towards increasing references to awareness-raising and mental health 'conversations'. However, in suggesting their findings could be used by mental health advocacy organizations to improve outreach, by promoting active use of discourse which aimed to reduce mental health stigma, the researchers seem unaware of the prolific social media activity of AS initiatives, especially during the period 2007-2017. This illustrates the potential for computational linguistic research to lack wider social context.

Makita *et al*. (2021) also researched digitally mediated mental health communications, analysing mental health discourse on Twitter during Mental Health Awareness Week, 2017. This annual event, managed by the Mental Health Foundation, is an element of the mental health awareness-raising 'calendar', and one with which the TTC 'own brand' Time to Talk Day competed for attention. The authors used *'Content Analysis (CA) within a Discourse Analysis (DA) approach'* (Makita *et al*. 2021:439). The researcher's description of their approach, especially their emphasis on social context, on which they cite Wodak and Meyer (2015), and their application of multimodal analysis to accommodate the various semiotic modes which are embedded in tweets, reflect their use of concepts aligned with CDA.

By analysing tweets which included the terms 'mental health', 'mental illness', 'mental disorders' and '#MHAW'[7], the group identified three central discourses; 'awareness and advocacy', 'stigmatisation' (including a positive subdivision, 'fighting stigma'), and 'personal

[7] Mental Health at Work – one of the initiatives of HT.

experience of mental health/illness'. The less dominant anti-stigma discourse, associated with a narrative of awareness and advocacy, entailed protest against negative perceptions of mental illness, or urged the public to challenge stigmatizing attitudes (2021:443).

The keywords 'mental illness' and 'mental disorders' identified stigmatising comments which were typically discrediting, and either trivialised mental illness, or associated it with crime (Makita *et al*. 2021:442). Yet the focus of these stigmatising tweets was political figures, political parties, or religions. Stigmatising views of mental illness were thus 'ideologically charged', or in relation to specific situations, were typically used as a perfunctory means of rejecting a contradictory opinion (2021:443).

Only depression and anxiety were salient disorders, and content rarely mentioned sources of help, treatment, or the causes of mental illness. These characteristics, and the identification of a 'fighting stigma' discourse, is pertinent since in 2017, when Makita *et al*. collected their data, TTC had been active for a decade, and HT had recently launched, so the discourse of AS, and its promotion of 'conversation' is likely to have influenced Twitter content.

4.4 Linguistic research related to mental illness: an evolving landscape

Research into mental health has historically been dominated not by critical linguistic studies of policy but by biomedical research which focuses on epidemiology, diagnosis and treatment. More recent analyses of subjective accounts of mental illness (Stoppard 2000; Galasiński 2008) may have informed the focus of corpus linguistic studies by Harvey (2012) and Harvey and Brown (2012).

I have described representative examples of studies which use variable types of CDA or discourse analysis. The work of researchers from disparate fields reflects a heartening interest in critically understanding the use of language. However, citing the work of Fairclough may function more to signal ideological positionality than to denote the application of a relevant framework of linguistic analysis. Clearly, while dialectical relational CDA is well established in critical work on public health, in matters of stigma or mental illness, the terrain is more uneven. I believe this subject-specific problem is derived from pre-existing trends in psychology, and highlights the need for more CDA in policy issues relating to mental illness.

Georgaca (2014) describes what is understood by 'discourse analysis' in work relating to mental illness. Social constructionism, an 'epistemological approach that conceives of social

and psychological phenomena as constituted through interpersonal and wider social processes' (Georgaca, 2014:55), was accompanied by two attendant versions of discourse analysis in and around psychology, which appear to remain influential. First, 'Foucauldian' discourse analysis is perceived as a post-structuralist endeavour that focuses on 'socially available' discursive resources, which may be drawn upon to help people present their experiences. Second, 'discursive psychology' (DP) involves the strategies people use, often in naturally occurring talk, to present themselves. From an analytical perspective, DP focuses on the effects of the use of available discursive resources (Willig, 2001:97).

Because discourse analytic studies of mental illness emphasise the way in which professional knowledge and practice is both historically contingent and socially constructed (Georgaca 2014), research has focused on psychopathological categories as constructs, and the consequences for diagnoses, treatment, and interactions. CDA approaches are distinct from 'traditional' discourse analysis because of their focus on the discursive dimensions of power and social justice, and their explicitly problem-oriented and emancipatory agenda. Yet I believe that in critical discourse approaches to subjects relating to mental illness, the lines between 'traditional' discourse analysis and CDA have been blurred by the pre-existing emphasis on how power and knowledge impact the experiences of people with mental illness. This tradition of criticality can in part be attributed to the transdisciplinary nature of Foucault's writing on both discourse and mental illness. Foucault (1961;1964) was significantly instrumental in the movement highlighting the socially constructed nature of mental illness, one legacy of which appears to be the tendency for the theoretical and methodological assemblages seen in 4.3, when studies concern both language and mental illness.

4.5 Conclusion: identifying the 'gap'

I suggest above that the traditional associations between psychology and other discourse analytical traditions may have confounded the trajectory of research, so that while a relationship between CDA and public health policy has evolved organically, subject-specific constraints have hindered a parallel evolution in public (mental) health, contributing to the 'gap' which this chapter illustrates.

I have described a body of Faircloughian CDA work on public health initiatives, which models the approach I seek to take with my own research. The paucity of CDA in mental health policy and stigma is clearly reflected in the contrast between the CDA research which centres on public health concerns, and the more methodologically variable studies concerning stigma or mental health. I have described corpus linguistics studies of mental health discourses in online help-seeking contexts, and critical studies of mental health policy or policy initiatives which use variants of CDA or other linguistic analyses. A large body of non-linguistic scholarship on stigma exists, as Chapter 2 identified, and similarly, multiple works evaluate AS, most pertinently those which officially evaluate TTC (e.g. Henderson *et al*. 2013; 2016). However, these works are not linguistic studies, and are not comparable to my research, which does not evaluate the *efficacy* of AS, but seeks to understand the language which two campaigns use, to what effect, and with what possible motivations.

I have not identified studies which use a CDA approach to examine the policy initiative of AS, or to analyse a major public health campaign relating to the stigma of mental illness. Nor have I identified CDA studies in relation to mental health which triangulate the data by moving outside the core text. This chapter has also demonstrated that where multiple semiotic modes exist in the data, CDA studies of public health policy often embrace multimodal analysis. I enrich my data and findings through engagement with human participants, rather than through a major focus on different semiotic modes, thereby seeking a relatively novel route to analytical breadth. The current research therefore represents an unexplored subject area within CDA, which incorporates participant voices to create triangulation, and contributes to redressing the absence of CDA research relating to mental health policy.

CHAPTER 5: Research Methodology

5.0 Introduction

In this chapter I first make some important points about the research questions, then describe the data selected to help answer these questions, and the text-analytical methods which were used to explore these data. Discussions of data may also include practical or contextual issues relating to that data, especially when I describe participant elements of the research.

5.1 The relationship between research questions and analytical procedures

I provided an account of research questions in 2.4. These questions evolved significantly during the research, as is appropriate with an abductive approach. I noted this 'evolutionary' process in 2.4 and highlighted that an important aim of analysis is to understand the way in which the policy problem of stigma is framed, and thereby to reveal the 'missing' discourse of stigma. Some RQs may be 'mapped' directly onto what was asked of specific core data through particular types of textual analysis. For example *RQ5:How is the practice of anti-stigma self-evaluated and legitimated as a policy response by its architects or its enactors?* is addressed primarily by analysis of legitimation strategies (7.2) and through the interview data in Chapter 9. Meanwhile *RQ9: Who did the campaign target, and how were they represented linguistically?* is chiefly answered by analysis of the representation of social actors (6.3). Yet the process of responding to *RQ9* commenced with exploration of the website data as seen throughout 5.3, prior to analysis itself. Indeed no *RQ* is reliant upon a single type of analysis. It would be misleading therefore to solely associate each question with a specific analytical procedure. Most textual analyses represent an iterative 'unpacking' of a particular linguistic question, such as *RQ8:How is the campaign premise conveyed to the public, and what is asked of the public?* Similarly, some smaller linguistic questions are necessarily an *ad hoc* response to texts as they present during analysis, as described in 2.4. Finally, many questions, such as *RQ3: Why is the concept of stigma afforded such importance as part of mental health policy?* may be especially relevant to specific data, in this case the interview data, but have summative answers which can realistically be provided only at completion of analysis, in common with

the questions for critical reflection. Nevertheless, from Chapter 6, I precede each area of analysis with the most relevant specific RQ/s, distinguished by green type.

5.2 Summary of data

The data were derived from several different sources. The core primary data were drawn from the websites of TTC and HT. The research questions prompted by these data broadly relate to the purpose and utility of a policy intervention which focused on the stigma of mental health conditions. These questions are especially pertinent in view of the timing of TTC; during the years immediately preceding the campaign's launch in 2007, people with mental health problems were most likely to state that access to treatment was their greatest priority (Mental Health Foundation/Rankin, 2005), and lack of such treatments was their biggest complaint (Layard 2004). Yet waiting times for psychological therapies could extend to two years, and no target existed to address this problem (Rankin, 2005). The most impoverished quintile were twice as likely to experience a mental health problem as people on average incomes (Meltzer *et al*., 2002), and prevalence of psychiatric problems increased in proportion with decreased household income (Department of Health, 2004:10). The social context of the data therefore informed the initial questions asked of them in 2.4.

The two primary datasets constitute an appropriate entry point through which to approach the research questions, but since they are the products of AS policy, textual analysis of the websites alone can neither fully answer the research questions, nor allow the websites, particularly TTC, to be positioned within their wider social context. To do this it is necessary to leave the online context and seek data from social contexts. I therefore sought participant perspectives, which I describe in chapters 8 and 9 and introduce in 5.4 and 5.6. Use of participant research is not typical in CDA, although as Mulderrig *et al*. (2019) point out, the Discourse Historical Approach (DHA) to CDA (Reisigl and Wodak, 2001) is known for its incorporation of ethnographic methods, as seen in analysis of political discourse by Wodak (2009). Nevertheless, use of participant work distinguishes this study as genuinely occupying the multidisciplinary space which CDA so often claims for itself.

Preliminary analysis of the campaign data led me to understand that not all social groups were represented or targeted equally, and that people of working age, or indeed the next generation

of working age people, were of disproportionate interest to AS compared to older adults. For this reason I sought the opinions and views of a group of older adults, through a focus group. I screened a selection of anti-stigma videos during this event, and a necessarily restricted but complementary analysis of public comments on YouTube in response to these videos constitutes a further dataset. In order to fully triangulate the data, I also conducted three interviews with senior policy ‘implementers’; key stakeholders involved in the running of TTC. Each data type is considered in turn.

5.3 The website data

TTC (2007-March 2021) and HT (2016-current) are significantly different national AS campaigns. Their very existence contributed to motivating this research. Textual data from these sites were primarily drawn from, but not restricted to, public-facing output, reports, media guides and published activities. Two important characteristics of TTC were materials concerning the training and engagement of ‘Champions’ (volunteers with lived experience of mental illness, who undertook the campaign’s community-based work), and the recruitment of businesses and institutions as signatories to the TTC Pledge, a commitment to change workplace attitudes, partially enacted by specific workplace Champions. A further key component is the ‘stories’ which people with experience of mental illness were encouraged to submit to the site, as ‘blogs’. Other less obviously public-facing materials, which were nonetheless in the public domain, included assessments, reports, and descriptions of behaviour change models.

The appearance and composition of the two websites is described below, and compared in Tables 1 and 2. Detailed description of TTC is especially important since the site is no longer operational.

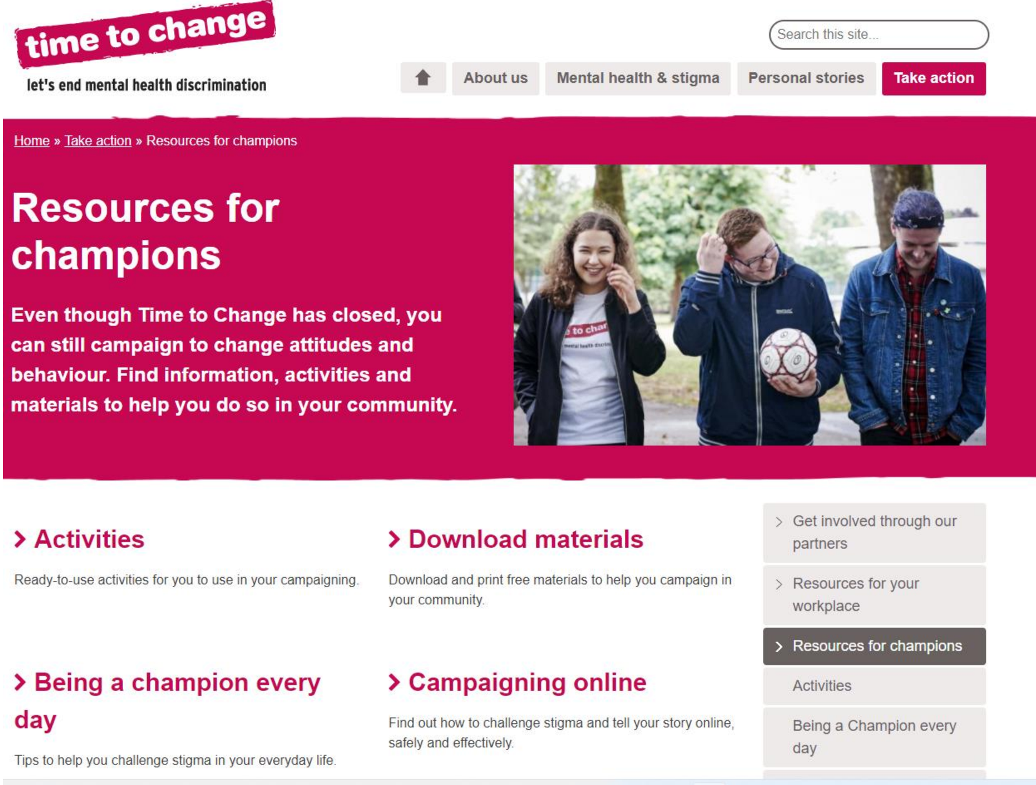
5.3.1 Time to Change: appearance, composition and content

TTC was a major campaign with a declared aim to address the stigma associated with mental illness. Despite having a distinct identity, it was run jointly by Mind and Rethink Mental Illness, and funded by a combination of sources, including the Department of Health and Social Care from 2011.

Information is conveyed through sentences which use simple language. Combined with use of bullet points or text boxes, wide margins, and spaces between text sections, its message is

rendered accessible. Denser text is constrained within PDFs or other linked documents, such as reports. Typical page features are described below, and illustrated in Fig. 2.

Fig. 2: Typical TTC page appearance, showing (post-operational) resources for Champions



a. TTC logo positioned top left, with a concise main menu to its right (*About Us, Mental Health and Stigma, Personal Stories*, and *Take Action*). To the far right, an in-site search tool.

b. In addition to the unchanging main top menu, a more dynamic side menu, centre right of page, provides 4-10 links prompting more exploration related to page content.

c. A cerise (brand colour) banner or text block contains the page topic in white type.

d. Typical format then includes one or more of the following: a photograph, graphic, embedded video, or pertinent quotation/s from an individual, divided into 'digestible' sections (as in Fig. 3). The format often includes questions – *What? Why? Where?* especially when discussing having 'conversations'.

e. At the foot of each page, a standard cluster of logos and social media links is accompanied by links to resources, accessibility, and privacy policy; this section alone contains 12 links (see Table 1).

Fig. 3: Example of TTC text box with quotations from a Champion

I previously worked for an organisation where my mental health issues were dismissed. It was very hard to function at work and I had to conceal just how bad my mental health was. It deeply affected me to a point where I began harming myself with the intention of ending my life.

I was so pleased when I found out my new employer, Kirklees Council, had signed the Time to Change pledge as I knew that they would be more open to mental health problems, and this made a huge difference to my work life.

However, I noticed that the staff weren't aware of the support on offer or about the importance of talking about mental health. That's why I worked with my fellow Employee Champions to run a mental health event.

Being a champion has given me a real purpose and shown me that I am not alone in my experience of anxiety and depression. We used storyboards to show that it is ok to talk about mental health in the workplace, and included some of the experiences of our senior managers and directors.

I can't walk down the corridor now without bumping in to somebody I know, and that has made my job much more enjoyable. I have event management and marketing experience from my previous job and it was great to be able to use these skills again to organise our event.

So far we have made a real difference and I feel so proud of what we have achieved.

The proportion of text to image was greater for TTC (estimate: 60:40) than HT (estimate: 40:60), even before considering the large number of downloads in the form of functionally diverse, branded resources in PDF, Word, or PowerPoint format, some of which are still, post-closure, available online. The framing of content as 'resources' merits consideration; this lexical choice suggests the audience is being freely endowed with an asset which has intrinsic value, and which enactors of the campaign's objectives need in order to carry out their functions. This conforms to a market-based exchange-value logic of supply and demand. Resources are directed at workplace and community Champions, schools, businesses, and local 'hubs'. Depending on their intended social context, resources variously publicise the campaign,

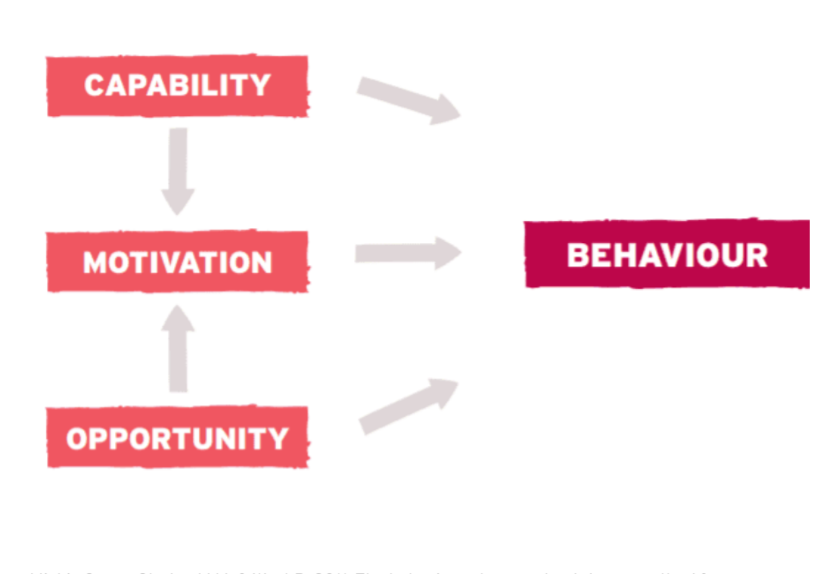
‘raise awareness’, or constitute training materials, posters, school assembly or lesson formats, activity sheets, guidelines, role descriptions, and self-help materials. Resources range in size from a single page proposing a small community activity, to detailed planning documents guiding large businesses to prepare an ‘Action Plan’ in association with the TTC Pledge. Indeed the majority of materials directed at businesses concern recruitment to and operation of the Pledge, which TTC launched in 2011. Pledge signatories engaged in a year-long Employer Action Plan, devised in collaboration with TTC, and latterly according to the principles of the Thriving at Work Report (Stevenson/Farmer Review of Mental Health and Employers, 2017).

Resources also include reports, for example the ‘Impact Series’ using Turtl, a visually rich format which uses psychological design principles *‘…to lock down the attention of skim readers’* (Turtl, 2021). These online brochures prompt topic exploration by use of large photographs.

Fig. 4: Opening page of an Impact Series text

The Impact Series makes clear that the website represents a major element of the campaign's aim to change behaviour through communications. It also describes the social scientific basis of the campaign's approach to attitudinal and behavioural change, notably COM-B; the notion that capability, motivation and opportunity together influence behaviour (Michie, van Stralen, and West, 2011).[8]

Fig. 5: Graphic of COM-B behaviour change model (Time to Change, 2020).



TTC complements COM-B with the Stages of Change model (Proschaska, DiClemente, and Norcross, 1992) to tailor marketing. This second model (see Fig 6) has been used in health interventions (smoking cessation, substance abuse, and obesity management) but its application to reduce stigma appears novel. While these models appear in the Impact Reports, only the contact model of stigma reduction (1.3) can be readily discerned across the website more generally.

[8] Marks (2020) suggests the model lacks empirical support, and regards the COM-B model of behaviour change as unfit for purpose because the theory ignores the core motivational process of 'wanting', resulting in a gap between intention and behaviour.

Fig. 6: Stages of Change model (Time to Change, 2020).

Stages of Change model

The Transtheoretical, or Stages of Change, model enables us to consider change over time and assess an individual's readiness for change.

By understanding the varied stages our different audiences are at, we are able to tailor our marketing and communications accordingly.

While the COM-B model provides a snapshot of barriers and drivers to behaviour, the Stages of Change (or Transtheoretical model) is a health behaviour model to assess an individual's readiness for change. Stages are defined by the likelihood, or occurrence, of the desired positive behaviour within the next 0-6 months. Relapse is possible at any time leading to an individual moving back multiple stages.

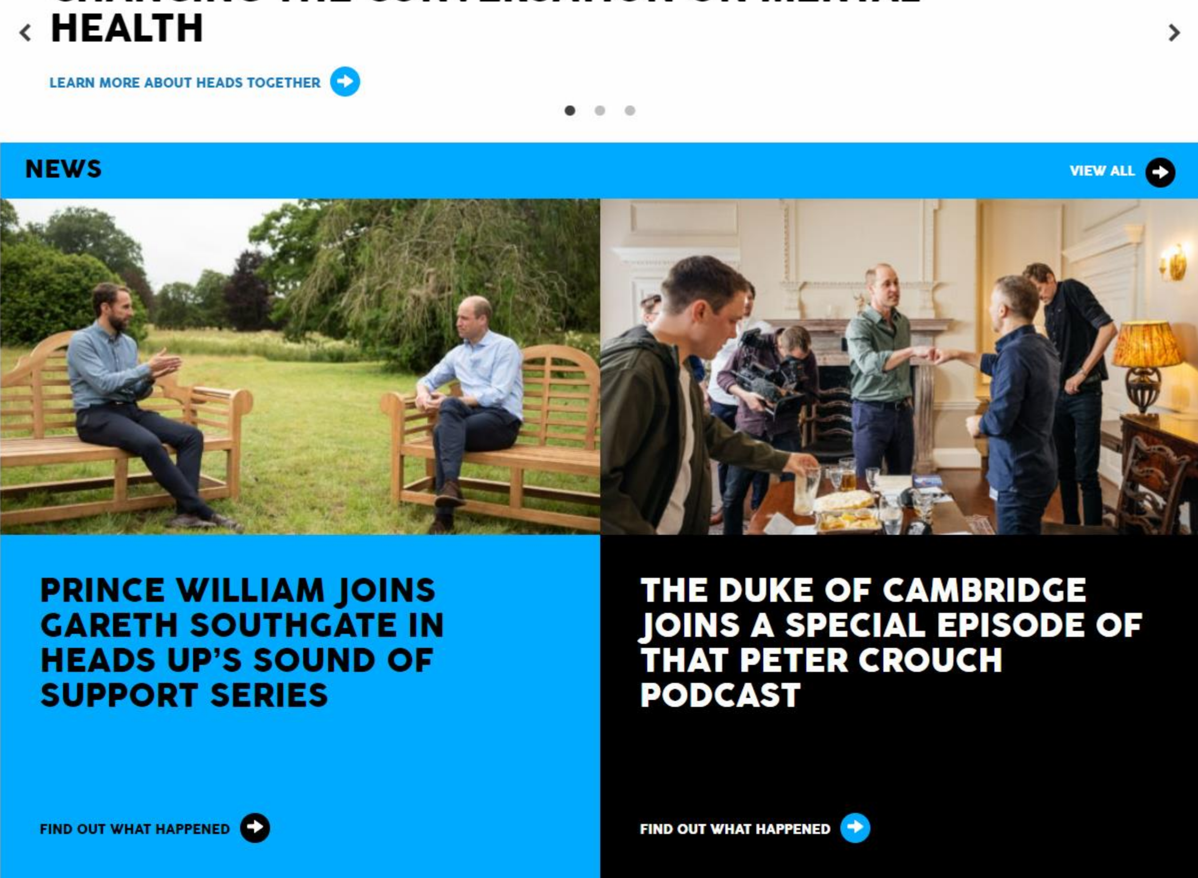
Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. 1992. In search of how people change: Applications to the addictive behaviors. American Psychologist, 47, 1102-1114.

Abundant positive evaluation of TTCs work is often emphasised by bulleted points and quantified, typically with an associated link to further information. Changes in levels of discrimination are also reported, along with more nebulous markers of success, such as Champions' 'confidence' to address stigma.

The diversity of resources reflects the breadth of one aspect of TTC's intended audience; the public, people with mental illness, businesses, Champions, parents and teachers – yet there is little for the 'stigmatisers'. Rather, materials represent a network of actions to be undertaken by others, under the direction of the campaign, and in the 'service' of attitudinal change.

5.3.2 *Heads Together* (HT): appearance, composition and content

Fig 7: Heads Together 'homepage' (Middle section; central photographs)

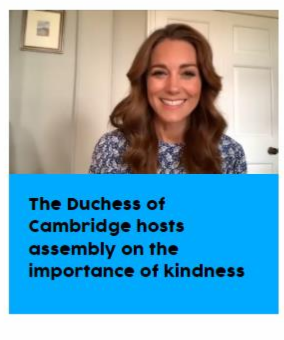


The purpose of this campaign has been more fluid; its original ambitious aim, to *'end stigma around mental health'* (Heads Together 2017) has subsequently become less defined, and, perhaps more realistically, more concerned with mental 'wellbeing'. The website is much smaller and more limited than TTC, and this is reflected in its functionality. It is best described as a hub, providing access to the external websites in which its associated activities are located; *Mental Health at Work* (MHAW), *Mentally Healthy Schools*, *Shout* (a text-based support service) and *Heads Up* (a collaboration with the Football Association/FA, encouraging 'Mentally Health Football'). From the main HT website, after following the first link to an introductory page describing each 'legacy programme', a further link navigates to these

external sites. Thus, after entering the site, only two 'clicks' are needed to travel through and away from it.

Typical page composition includes the logo positioned top left, then the static horizontal menu (*About, Stories, Get involved, Get support, FAQs, Heads Up,* and in black, *Get Urgent Help*). HT also uses large banner headings, typically containing white type within blue colour blocks. Use of bold, upper-case type to create titles or to signal a link, attracts attention and creates emphasis on headline pages (see Fig. 8), reflecting usage noted in other health campaigns by Brookes and Harvey (2015). A proportional reduction in text compared to TTC reflects the lack of structured purpose and activities, and accordingly a greater amount of each page consists of non-text modalities; the 'landing page' contains three large, four medium, and four smaller photos, and two embedded videos towards the foot of the page. All but one of the images portray the Duke or Duchess of York, accompanied by text which names them. On 'non-headline' pages, for example those describing core activities, approximately 50% of the screen width is blank, and text is generally denser, and of smaller type. At the foot of the page, large blue and black bands respectively offer options to 'join' HT, 'Get help', and provide standard links to social media.

Fig. 8: Photographs representative of HT



Contrasting significantly with TTC, the only internal resources, excluding videos, are publicly-authored blogs, predominantly written by marathon runners, and a short FAQ section, in which only two questions, *'What is the Heads Together Campaign?'* and *'Where can I find mental health support?'* concern mental health, and only the former uses the word 'stigma'. Other questions focus on use of money, donations, merchandise, the Virgin London Marathon, how to contact 'Their Royal Highnesses', and requests for resources, the absence of which may confuse anti-stigma website devotees accustomed to the informational breadth of TTC. Site users seeking information or help are directed to Mind, or to one of HT's seven other 'charity partners', of which six are for young people or children, perhaps reflecting the current life-focus of the Duchess.

5.3.3 Multimodality in the website data

In common with most websites, the AS sites contain a variety of semiotic modalities, notably use of colour, text graphics, photography, and video. Acknowledging this breadth of semiotic modes accords with the principles of systemic functional grammar, which regards language as a social semiotic. Analysis of written and spoken language dominates this research, but all the texts analysed involve, or can be contextually related to, some aspect of multimodality. Multiple semiotic modes combine to construct the texts' message, and this inevitably informs my responses to the materials and my analysis. Therefore the multimodality of the data,

although considered lightly, is not ignored. Consideration of the videos screened to the focus group, or of the way different semiotic modes contribute to the construction of campaign brands, are both examples of the way in which, even without multimodal analysis, these different modalities remain vital to situating the data within social practices and structures. The modalities encountered in the websites are summarised below:

Table 1: Multimodal elements in TTC and HT

Type	*Time to Change*	*Heads Together*
Photos	Various sizes, representing 'the public'. Only rarely represent key staff.	Larger, frequently represent Duke and Duchess of Cambridge. Latter focus on footballers.
Colour	Brand colour (as per logo) dominates and is used regularly for titles/heading text, especially when text contains a link. Text and titles often contained in colour blocks or banners.	Block of colour in banner form to contain text, titles, and links. Text black (or white within blue or black boxes/frames).
Videos	Embedded, with link. #InYourCorner (9) #Ask Twice (3) Mental Health in the Workplace (57) Multiple user vlogs (25+), often themed. Functionally diverse: used for campaign message but also for (Champions') training modules and (business) 'masterclasses'.	On most pages. Embedded, with link. Divided into series: HT launch (5), #Heads Up (4), #Heads Up Sound of Support (6), #Okay to Say (12), #Mentally Healthy Schools (12), Team Heads Together (marathon) (6), #There for Me (7), Together in Action (12) and Sports Stars Talk to Prince Harry (5)
Drawn images	Speech bubbles containing text. Occur within PDF formats and main site. Image of cups represent the 'cuppa' over which conversations are held:	No, but characteristic in the associated MHAW site.
Graphic images	'Infographics' summarising statistical data	No.
Text type	Standardised font, standard use of cases.	Bold type and upper case prevalent.
Frames	Text often contained within frames or colour blocks.	Frames and heavy colour blocks are a core element of page design.
Use of brand	Very strong brand identity. Brand control described within the site.	Characteristics of brand (colour, font, logo), but less pervasive.
Icons and logos	Own brand logo, top left of page:	Own brand logo, top left of page:

	Partner logos in two categories: ‘led by’ (Mind and Rethink Mental Illness) and ‘funded by’ (Dept. of Health and Social Care, Comic Relief, Big Lottery Community Fund.	Partners’ logos: categorised as charity partners (mental health), founding partners (business) and BlackRock (uncategorised).
Social media icons	Instagram, Twitter, YouTube, Facebook, at foot of pages. Each icon forms a link.	Facebook, Twitter, Instagram, YouTube, Linked In. Icons form links at both head and foot of pages.
Links	Indicated/activated by arrows, buttons, bold text or icons.	Indicated/activated by arrows, buttons, bold text in narrow coloured banners.

5.3.4 Contrasts between TTC and HT

The campaigns provide useful contrast for analytical comparison, but their differences, summarised below, mean they do not merit equal analytical focus. Greater focus is afforded to TTC, on account of its size, organisational origins and influences, core activities, and the longevity and consistency of its objectives.

Table 2: Significant differences between Time to Change and Heads Together

Characteristic	*Time to Change*	*Heads Together*
Size	Corpus 2,210,357 words. Very frequent PDF links	Corpus 109,836 words Few PDF links
Longevity	2007-2021	'2017'-current. (2016 launch date revised retrospectively)
Curating/authorial bodies	Mind Rethink Mental Illness	8 charity partners including Mind and Anna Freud Centre.
Funding	Department of Health and Social Care, Big Lottery Fund. Comic Relief.	The Royal Foundation. 'Enabled' by Rausing Trust. Founding business partners: Virgin Money, Unilever, Carphone Warehouse. General partner: Blackrock.
Declared objectives	Reducing mental health-related stigma and discrimination (TTC 2021)	*'to end the stigma around mental health'* (HT 2016). Later significantly attenuated: *'to help people feel much more comfortable with their everyday mental wellbeing and have the practical tools to support their friends and family'* (HT 2021).
Non-corpus text materials	PDFs, including training and publicity materials and some reports.	Use of PDFs minimal. Reporting and rationale absent.
Multimodal materials[9]		
Resources	Multiple resources: a defining campaign feature.	No in-site resources.
Demographic target/s	Workers, children and young people, men. Defined as those most distant from experiences of mental illness.	Broad, but focus on workers, men, young people. No clear focus on social distance from mental illness.
Key initiatives	Workplace and community 'Champions'. Employer Pledge	'Legacy programmes': Mental Health at Work, Mentally Healthy Schools, Heads Up (2019) to '*harness the power of football'* and Shout 85258, a volunteer-led '*de-escalation'* text support service.
Use of personal 'stories'	Yes, a major aspect of the campaign. Content controlled.	Limited. Use apparently 'by invitation'.
Summary characteristics	Ambitious, broad scope. High degree of control. Repeated objectives to effect behavioural and attitudinal change.	A PR website acting as a resource hub. No clear behaviour change message.

[9] See Table 1.

5.4 Focus Group Data

Below I provide a 'natural history' of the focus group in this research, describing its rationale, objectives, ethical and practical considerations, recruitment process, and format. In planning and running the event, I drew on Bloor *et al.*'s (2011) practical focus group components, and Kryzyanowski's (2008) more concise core elements; the role of the moderator, the selection and role of participants, and the roles of the topics discussed and of the event's communicative dynamic.

5.4.1 Focus group rationale, framing and design, and research questions

Adequate response to the research questions demanded an understanding of the opinions of people with experience of mental health problems, and of stigma in particular. Because opinions available via TTC are highly mediated, I required a different means to gather perceptions of mental illness stigma, AS campaigns, and some of the campaign materials, specifically videos.

Preliminary research findings indicated that older people are, at best, poorly represented in AS, possibly as a consequence of mental health policy whose primary focus is people of working age. I therefore selected this missing demographic; older people who are no longer working and who have, or have had, mental health problems. Perspectives from this demographic would contribute either to validating, or to expose to challenge, some of my preliminary findings and assumptions on the utility and character of AS campaigns. Restrictions of scale mean the focus group findings are not generalisable, but community participant voices are a valuable contribution to this research, especially combined with analysis of online responses to videos on YouTube.

When a focus group constitutes part of a multi-method research design, the other elements of the research become *defacto* pilot materials (Bloor *et al*. 2011:16), so no pilot group was needed. The timing of the focus group was important, as these data were to partially inform the content of questions used during the interviews with AS policy facilitators.

'Framing' the focus group depends on asking the 'right' questions, in accordance with research objectives (Kryzyanowski, 2008). In this case, I sought to understand the group's views with respect to their:

- Knowledge of or exposure to AS

- Conceptualisation of stigma as it relates to mental illness

Then from the responses to AS videos:

- Do participants like or approve of the videos? Do they find them relevant?
- How well do they understand or accept the videos' anti-stigma message?
- How might video content be different/improved?

My objective was a group event with sufficient structure to provide rich data, and in which through a position of neutral social enquiry I avoided imposition of bias. The format evolved through an iterative process of reflection on what each discussion point and activity might realistically reveal. Following a short pre-group questionnaire exploring awareness of AS organisations (Appendix 1.3), audio recording commenced, with informed consent, allowing accurate transcription. Since the objective was to stimulate group interaction, 'questions' were focusing exercises intended to concentrate interaction on specific topics.

Part 1 of the event involved discussion guided by activities, several of which explored issues through use of cards on which various options were printed (Appendix 1.5), to promote discussion and focus, and act as an *aide-memoire*. Card activities involved 'ranking' possible options; such ranking exercises are a common type of focusing activity, as discussion about rankings illustrates the tacit understandings of group members, revealing background assumptions (Bloor *et al.* 2011:7). I used ranking exercises to elicit views about the most stigmatising social states, the most stigmatising mental illnesses, and the most important concerns for a person experiencing mental illness. By encouraging participants to contribute their own suggestions to rank, on blank cards, I ensured expression was not restricted to prescribed responses. Part 2 involved response to a range of videos produced and disseminated as part of anti-stigma initiatives, following which the event drew to a close.[10] A detailed running order is provided in Appendix 1.4, and findings are presented in Chapter 8. I use the same approach to analysis for both the focus groups and the interviews, and I describe this approach in 5.9.6.

[10] Bloor *et al.* (2011) advocate running times under 90 mins. Paradoxically, most members would have gladly extended beyond the 150 min discussion, yet the difficulty some participants experienced in retaining focus challenged the event timing. Bloor *et al.* (2011) also emphasise the importance of debriefing, even if, as in this case, it constitutes a small personal exchange.

In designing and conducting the group I was aware that the moderator must avoid being the centre of the groups' interaction (Bloor *et al*. 2011:12), and that the participants are the key actors in the communicative dynamic. Kitzinger (1994) agrees that ideally the 'lead' presents topics, guides discussion, and only minimally intervenes. In reality, the necessity of interventions is acknowledged, for example to encourage people to challenge their 'taken for granted reality' (Kryzyanowski 2008:164).

5.4.2 Focus group ethics, recruitment, and practical issues

Ethical approval was granted separately for both elements of participant work. The focus group required careful ethical consideration since the UOS's Research Ethics Policy Note 6, which defines vulnerability and the measures expected of researchers, deems this group doubly vulnerable in view of both their age and the nature of the discussion. I consulted and implemented the Specialist Research Ethics Guidance Paper (SREGP), *Ethical considerations in research involving older people*.

Recruiting participants for research relating to mental health was challenging, primarily because of the perceptions of those who facilitate access to participants. Yet speaking, albeit protectively, on behalf of service users, denies them a voice. My approach to U3A (University of the Third Age) however was met with positivity. U3A is a national body formed of local groups, which offers social and learning opportunities to older people who are no longer in employment. I negotiated two recruitment opportunities at U3A's monthly drop-in meetings; these gatherings have no formal agenda, and therefore presented an ideal opportunity to introduce my research, and the focus group and its purpose.

U3A membership is diverse, encompassing a wide range of professional and educational backgrounds, and so all spoken and written language was graded to ensure comprehensibility, because it was vital to ensure potential group members genuinely understood the nature and purpose of the group. Counterintuitively, I prevented attendees from signing consent immediately, instead guiding people to listen, to read and understand the materials provided, and ask questions, either in person or privately by phone or email. Only in this way could it be ensured that consent was genuinely informed; a key tenet of ethical participant research.

Patently seeking participants with 'lived experience of mental illness' became a philosophical point of discussion at both meetings. It was agreed that this experience could also mean

experiencing mental illness in someone close, or caring for that person. I did not seek personal disclosures, and respected individuals' right to self-identify as having/had a mental illness.

I achieved my aim of recruiting eight participants, although two withdrew at a late stage for personal reasons. Outside commercial contexts, six to ten is often regarded as an optimum participant number (MacIntosh 1993), although the literature reports between four (Kitzinger, 1995) and fifteen (Goss & Leinbach 1996). Similarly the number of meetings varies, but within a broader study, a single focus group provides adequate complementary insight.

Since participation represented a significant voluntary time commitment, participants' welfare was an important consideration. As a safeguarding measure, I recruited a volunteer with counselling qualifications to provide support or appropriate signposting in the event of a participant becoming distressed. To accommodate this, a 'staffed' breakout room was available until all participants had left. Such provision constitutes an essential part of responsible contingency planning when discussing mental illness, and on a practical level meant that I was able to focus on moderating the event. The volunteer was familiarised with the event's structure and content as an objective non-participant.

The location at the UOS was chosen for its technical affordance (screening of videos) and accessibility.[11] The group met on 10-02-20, when although the UK had recently seen its first cases of Covid-19, no preventative public health measures were in place, there was no evolved threat of infection, and no known risk to participants. Primary research support costs were met by the WRoCAH Large Award funding scheme, including tokens of thanks, which both demonstrated appreciation of participants' involvement, and contributed to maintaining the positive relationship between the University and the community.

5.5 Video data: focus group and comment analysis

AS and other mental health campaigns are prolific producers of video materials, which through dissemination on their own websites, and via YouTube, are exposed to diverse audiences. Although a meta-analysis (Corrigan *et al.*, 2012) found anti-stigma interventions consisting of live contact more effective than videos, the production and dissemination of various mental health literacy video interventions has proliferated alongside anti-stigma campaigns, according

[11] This location contained a long rectangular table, which Bloor *et al.* (2011) suggests encourages direction of responses to the researcher rather than to other group members. To this it could be added that attending a university department at all may activate 'teacher' and 'learner' roles.

to Ito-Yaeger *et al.* (2021), whose own meta-analysis confirmed the utility of such videos for young people, with 'photovoice' videos[12] in particular resulting in positive assessed outcomes. Tippin and Marazan (2019) concur that video interventions are superior to 'live' contact, given their 'assured' content, easy dissemination, and cost-effectiveness.

I was interested in how audiences respond to these videos, specifically how older adults, as a group primarily 'excluded' from mainstream AS efforts, engaged with them and perceived them. The selected videos include two made by organisations (Rethink and the WHO) outside the core data. Of these, one is a first person testimonial from an older adult, and the other, an animation for a global audience, represents non-white ethnicities. Video data are summarised in Table 3, in chronological order by year of upload. The number of YouTube views per video is considered an important data characteristic, and is shown in Table 3 below the video title, in each case referring to views on or before 4-12-19. The number of public comments the video attracted, excluding deletions, appears in parentheses below these viewing figures. Further descriptions, and a screenshot from each video, are provided in 8.2.3 and 8.6.1.

5.5.1 Video selection and transcription

I took into account a video's 'iconicness' or status within a campaign, but did not select videos on the basis of the number of views or comments they had received. Breadth of institutional origin (respectively TTC, HT, Rethink, WHO), a range of relevance to older adults[13], diversity of form, and potential to provoke discussion were important. Transcription of both videos and comments became the first stage of identifying potential categories for YouTube comment analysis, and simultaneously created a distinct dataset for each video.

Table 3: Videos for focus group ('FG') audience response and YouTube comment analysis ('CA')

Title of AV material and URL	*Origin*	*Length and year*	*Content type*	*Media*	*Older person seen or heard?*	*FG, CA or both.*
Time to Change 60 Second ad. 80, 529	TTC	60" 2011	Creative narrative.	TV	No	Both

[12] Videos in which people with a mental illness (or members of other marginalised groups) directly convey or document their experience (Tippin and Maranzan 2019).

[13] Given the dual purpose of these videos, for comment analysis and focus group response.

(11) https://youtu.be/hdPZ7rw0wMc	Stitch Editing		Humour	YouTube video		
The Stand-up Kid 1,402,199 (468) https://www.youtube.com/watch?v=SE5Ip60_HJk&t=1s As at 29-10-21 the TTC URL is unavailable, but the video is accessible via Comic Relief: https://www.youtube.com/watch?v=SE5Ip60_HJk&t=1s	TTC	3'07" 2012	Creative narrative. Humour. Pathos	TV Included Comic Relief YouTube video	No	Both
Andrew's Story 2649 (1) https://youtu.be/XNM2UyYb8lw	Rethink Mental Illness	1'11" 2015	Awareness raising	YouTube video	Yes	Both
Be in Your Mate's Corner 46,895 (28) https://youtu.be/3l8LpDitZvY	TTC	1'0" 2017	Creative narrative. Boxing metaphor	TV YouTube video Website platform.	No	CA
World Mental Health Day 2017 1,576 (2, before comments blocked) https://www.youtube.com/watch?v=heoxc6yjAWw	HT	2'10" 2017		YouTube video	No	Both
Let's talk about depression – focus on older people 88,815 (5) https://www.youtube.com/watch?v=DXZZcdFXTtY	WHO	30" 2017	Awareness raising Animation	YouTube video	Yes	Both
Mental Health Minute 2018 16,111 (8) https://youtu.be/vCLoVYK77MM	HT	1'06" 2018	Awareness-raising	Radio YouTube video	Yes – through actor voice	CA

This small sample showed remarkable congruence with Thelwall and Sud's (2102) assertion that the average number of comments is 76.2 (the average from this dataset is 74.7). For perspective when viewing Table 3, music videos accrue over 5.3 million views and 12.5k

comments over a few weeks (Veletsianos *et al*., 2018), whereas even the most widely watched AS video, *The Stand-up Kid*, attracted 1.4 million views and 486 comments over seven years.

The analysis of YouTube comments offers a further element of triangulation, contrasts with the focus group's responses to videos, and provides unexpected insights into opinions on age. However, when I undertook comment analysis, the scope of my other participant work was not yet clear, and since in this thesis, presenting data from live participants takes precedence over anonymous YouTube data, I present in 8.6 a summarised version of my comment analysis findings, and a case study (8.6.4) which focuses on the YouTube comments made on *The Stand Up Kid*[14]. Additionally however, where YouTube comments, from any of the videos, are critical or political, such that they suggest commenters 'see through' AS, or where comments constitute an informative response from the posting organisation, they are included, since they contribute to answering the questions asked of this data.

5.5.2 YouTube Comments: the nature of the data

YouTube comments are anonymous, asynchronous, remote, permanent, and public. The distance between commenters can result in significant cultural heterogeneity (Thelwall and Sud 2012); this is illustrated by AS video comments which include US cultural referents such as dollars or PSAs (Public Service Announcements). Cultural differences, compounded by differences in age and standards of acceptable behaviour, may lead to antagonistic commenting. Commenters' anonymity liberates them from the constraints of socially normative behaviour, and because comments are subsumed as newer comments take their place, commenters likely exercise less self-restraint (Thelwall and Sud 2012). Comments are mainly unregulated, although the uploader of the video may delete inappropriate comments, and users may flag contributions for moderation.

Ernst *et al*. (2017) suggest user comments influence perception of the quality or reliability of the related (video) content. Lee and Jang (2010) go further, claiming attitudes change more in response to comments than they do in response to the video. If the efficacy of a message really

[14] Therefore I provide a transcription of this video (Appendix 3.1).

depends on user comments, this has major implications for use of YouTube as a campaigning medium, reinforcing the importance of researching comments and their effects.

Comments may be very short, and are often fragments or single words (Madden *et al*. 2013). Exclamation marks, paralinguistic features (emojis), and interjections ('Wow!') are common, imitating features of spoken language. Slang and sarcasm are frequent, and may be problematic semantically; for example 'great' may be sarcastic. Comments may also be relatively content-free, based on the type of communication which Malinowski (1923) described as 'phatic'. YouTube comments have been condemned for their typically casual, youth-oriented language, but Jones and Shiefflin (2009) more poetically regard them as evoking Bakhtin's concept (1984:10) of the carnivalesque, for their *'temporary suspension…of hierarchical rank …a special type of communication impossible in everyday life ... [liberated] from norms of etiquette and decency imposed at other times'*.

5.5.3 YouTube comments research: a brief overview

Investigating YouTube comments offers several methodological affordances: it allows rapid and valuable insights into public opinion, data are already in the public domain, and their collection is non-obtrusive. Irrespective of the research objective, comment analysis is typically situated within an *initial* framework of qualitative content analysis, such as that of Mayring (2000), for whom a central procedural tenet is that categories allocated to content should evolve, but should be identifiable by rules and prototypical examples. Given the scale of the medium however, the approach in many YouTube studies is not merely quantitative, but highly automated, and latterly dominated by fields such as statistical cybermetrics. The scale of large analyses, such that of Siersdorfer *et al*. (2010) who analysed 6.1 million comments, facilitates generalisations which inform smaller qualitative studies.

I noted in 2.5.2 that my comment analysis was informed by the work of Madden *et al*. (2013), whose major content analysis sought to produce a coding schema which would be applicable across video genres. The qualitative element of their approach resembled mine, with initial identification of possible categories followed by iterative testing. 'Deviant case analysis' was employed in developing categories; data which did not align with the existing schema were re-

evaluated, and categories were accordingly adjusted, or new ones created until 'theoretical saturation' (Bell, 2005: 20) was reached[15].

Three other sets of authors have provided relevant findings: Thelwall and Sud (2012), who sought to provide 'benchmarks' for future work; Ernst *et al*. (2017), whose qualitative methods also followed Madden *et al*. (2013) and Mayring (2010); and Veletsianos *et al*. (2018), who conducted sentiment analysis on comments in response to TED talks on YouTube. In place of a dedicated literature review, I reference these authors where relevant when discussing the findings (8.6.0).

5.6 Interviews: the data, question design, transcription and corpora

I conducted three interviews with senior implementers of AS policy, all of whom were associated with TTC. Each were valuable contributors, and within a research project of this scale, seeking further interviewees from HT was neither necessary nor realistic. The interview findings are presented in Chapter 9.

Questions (presented within the transcription Appendices 2.3, 2.4, and 2.5) were carefully planned to maximise the opportunity of speaking with each interviewee. The objective in each case was to allow sufficient fluidity to facilitate broad discussion in which productive conversations addressed key questions. This requires considerable balance; Abell and Myers (2008) observe the utility of sociability, but caution against intentional creation of solidarity.

Asking identical questions of each interviewee would have resulted in straightforward analysis but impoverished data. There were several questions in common, but each interview had a different emphasis reflecting the interviewee's institutional role, expertise, or influence (e.g. co-authorship of influential mental health strategy publications), and their positionality where known.

The interviews resulted in transcribed conversation of just under 28,000 words. Transcription is not an analytical stage, but undertaking it familiarised me with interviewees' respective speech characteristics, enabling initial observations of emerging themes, points of convergence (a shared tendency to repeat 'facts') and divergence. Each transcription, cleaned and

[15] The point at which sufficient categories exist to accommodate all comment types, and new data confirm existing understandings rather than revealing new insights.

anonymised, was compiled into individual corpora (T(transcript)1, T2 and T3 respectively), allowing accurate identification of individuals' positions. In contrast, I do not use CL for the focus group, but in other respects both types of participant data are subject to a shared broad approach to analysis, which I describe in 5.9.6.

5.7 Overall methodological rationale and approach

The research questions are addressed by adopting the transdisciplinary, CDA approach described in 2.1.3, in which I established that since CDA concerns the analysis of the dialectical relationship between language and the social world (Fairclough, 2013), it is an especially appropriate approach to inform this research, which as the above sections illustrate, is characterized by the need to understand several discrete types of data. CDA aims to shape an analytical framework which both fits the linguistic object of enquiry and situates it within its wider political economic context; in this case, the responsibilisation of mental health. Understandings of responsibilisation largely derive from the writing of Foucault, as described in 3.4.1.

In Chapter 2 I described literature relating to both linguistic analysis and critical policy analysis. Additional comments from Fairclough and Fairclough (2015), considering policy and political texts, are also useful in explaining my approach. Fairclough and Fairclough emphasise the way that the multifunctionality of texts happens at various levels, such that an 'argumentative' text may simultaneously be analysed from logical, dialectical and rhetorical perspectives. These terms are relevant to AS; a 'dialectical' text advances a particular viewpoint (against a contrasting one), while the rhetorical element relates to a text's function in convincing people to accept or reject a viewpoint. Thus AS is undeniably both dialectical and rhetorical.

Text multifunctionality suggests that textual analysis should be concerned less with discrete elements (genre, or social actor representations) and more with the relationships between these elements (Fairclough and Fairclough, 2015). So while TTC represents a form of action, it simultaneously represents people and events in certain ways, and it also constructs and reflects (organisational, group, and individual) identities. The aim of my analysis is therefore to understand the relationships between, for example, representation and identity, and to

understand what these relationships mean in the texts' social and political context. However, while analytical categories may be 'artificial', they are constructs necessary to make sense of and categorise the data.

The principles described in Chapter 2 provided an abstracted, theoretical framework for CDA analysis. Here I describe how my research design seeks to apply this framework to the research questions, tailoring analytical options which meet the needs of specific data. Much of the analysis in chapters 6 and 7 responds to the research questions by discovering the ideational and ideological content of stigma discourse, learning how the practice of anti-stigma is evaluated and legitimated as a policy response, and identifying the 'missing' discourse of AS. In keeping with the abductive approach I adopt (1.6 and 2.3), just as the iterative research process involved a systematic convergence on its aims, the research questions too evolved in response to findings (see 2.4).

As described in 2.5.1, the Faircloughian view (2005) of language as a social semiotic is guided by the conceptual framework of Halliday (1974) whose systemic functional grammar describes linguistic resources in terms of processes, participants (actors) and circumstances. The core textual characteristics I analyse in the website data, through specific frameworks, are the representation of social actors, deixis (notably through the pronoun 'we'), genre, and legitimation. I explain the methods for each in the current chapter, then in chapters 6 and 7, I present my findings and consider how they inform the overall narrative of AS. Since my methodology can be characterised as corpus-aided textual analysis, I start by describing corpus linguistics and its use in this study.

5.8 Corpora and corpus linguistics

A corpus is a large amount of naturally occurring language data, which is stored electronically. Computational corpus 'processes' allow linguistic patterns to be revealed across large amounts of text. A study corpus generally constitutes a sample of a specific type of language, and therefore reference corpora, such as the British National Corpus (BNC), provide useful comparative data, for example to determine how unusual (or 'key') linguistic phenomena are within the study corpus.

McEnery and Wilson (1996:1) define corpus linguistics (CL) as a way of studying language 'based on examples of real life language use'. Its applications range from determining a simple frequency of a linguistic phenomenon to large scale grammatical analyses. CL entails a

quantitative element as it concerns analysis of electronically encoded text, although since it is always dependent upon an interpretative stage to derive meaning from it, CL will always be partially qualitative (Biber 1988:4). The incorporation of CL into CDA has been relatively recent, and following Mautner (2005; 2015) has been driven significantly by work by Mulderrig (2008; 2011; 2012; 2015) on political discourses relating to education. Blending CL and CDA has a transformative effect on the size of texts which critical discourse analysts can aspire to work on. Baker (2012) explicitly considers the methodological synergy of this dual approach, while emphasising that since corpus linguistics alone does not eliminate bias, researcher reflexivity remains crucial. A meta-analysis by Nartey and Mwinlaaru (2019), drawing on a database of 121 studies, observes an increase in the incorporation of CL methods into CDA research since 2009, and confirms the value of combining CDA and CL (2019: 203).

5.8.1 Why and how: use of corpora in this study

Compiling corpora from the web texts supported analysis of the websites as whole texts, which was invaluable when investigating linguistic patterns. CL was integral to several analytical methods, providing a secondary, non-intuitive method of exploring and analysing the ideas derived from non-corpus analyses. When a linguistic category (for example when analysing representation of social actors, or legitimation) is known to be characterised grammatically in a particular way, a corpus search allowed identification of these characteristics in the data. The context of the phenomenon of interest (such as the pronoun ‘we’) is observed through the lines of a corpus; in these ‘concordance’ lines, the lexical item of interest is placed centrally, and context, to left or right, can be referred to accordingly, and extensively if needed. I provide a sample page of concordance lines in 5.9.1. Demonstrating linguistic patterns in this way helps to reveal how the discourse of AS is constructed, and by extension, the version of reality or truth which this discourse presents.

Using corpora also serves to reduce bias, helping to counter the accusations of a lack of objectivity which CDA has faced (2.2). CL in this research at times uncovered unexpected and even counterintuitive findings. Its scope in this study should be defined; following the distinction between corpus-based and corpus-driven studies (Tognini-Bonelli, 2001), my use of corpora to explore theories and hypotheses largely derived from distinct, previously undertaken analyses means this study would be deemed corpus-based, yet because I do not use CL in every aspect of each analysis, this study is corpus-aided.

5.8.2 The corpus tool, and core research and reference corpora

Sketch Engine, a tool for corpus management and analysis developed by Kilgarrif (2003) was selected for its position, at the *'intersection of corpus and computational linguistics'* (Sketch Engine 2021). The platform is able to compile and process very large text corpora, and its integrated reference corpora facilitated comparison with the study corpora.

For this research however, the most important function of Sketch Engine was the non-standard ability to create a corpus from a URL. While this 'vacuum' approach is not without consequences, I rejected alternative techniques, such as data web-mining, which occupy an ethically dubious area and are far less functional. One disadvantage of creating corpora by the URL approach however is that this technology is not consistently able to incorporate linked PDF documents within the corpus. I therefore compiled and compared several corpora from the same URL to verify consistency, and was satisfied that the result was valid and representative; indeed, probably a truer and more balanced view of users' experience of the sites than could be obtained manually. To counter the absence of PDFs from the corpus however, I also examined the majority of PDFs 'manually', to fully understand the campaign output, resulting in a combined (corpus and manual) approach. This has value since it is important to note that corpora are blind to the diversity of semiotic modality, and therefore, unlike a purely corpus approach, such a combined approach has the advantage of allowing greater consideration of important multimodal elements and their relationships to the text.

The research corpora, their sizes, and dates of compilation are listed below. Compilation dates are significant, given the dynamic nature of website content.

(i) Time to Change: 2,210,357 (23-03-19 technical recompilation 08-01-22)
(ii) Heads Together: 109,836 (02-04-19, technical recompilation 08-01-22)
(iii) Interview transcription [16] 1: 6,234 (16-09-20)
(iv) Interview transcription 2: 6,551 (16-09-20)
(v) Interview transcription 3: 6,956 (17-09-20)

The following reference corpora were used for comparative purposes, for example allowing an understanding of keyness of a linguistic characteristic. A reference corpus of web language,

[16] Interview data were anonymised; all content which indicated individual identities, or which could be used to construe identities, was removed before compilation.

ukWaC, allowed comparison between AS web content and general web content, rather than with non-web texts.

(i) British National Corpus (BNC) (1994): 96,134, 547. Written (90%) and spoken language.
(ii) BNC Spoken (2014): 10,495,185.
(iii) British Web (ukWaC) (2007) 1,313,058,436
(iv) English Web (2020): 38,149,437,411

5.8.3 Characteristics of the TTC corpus

The TTC corpus is not simply a series of texts, informed by policy, which exhort the public to engage in certain actions or behaviours in order to reduce stigma relating to mental illness. The central campaign materials may have several (un-named) authors, but the 'voices' which constitute the texts are numerous. The corpus includes the quoted words of a range of social actors; Champions, in-site 'bloggers', and various supporters and businesses. All of this textual material intentionally constitutes the message of a campaign which defines itself as a *'growing social movement'*. However, although the campaign exerted control over content, and therefore the attitudinal range found in the corpus would not be expected to diverge significantly, it remained important to be able to confidently attribute an utterance to a specific type of social actor.

It might appear that an obvious response to this, to obtain 'cleaner' datasets, would be to create numerous sub-corpora, of texts which were either named, had a specific character, or presented certainty over authorship. It is true that some texts contained a greater proportion of organisational 'voice'. However, even within such texts, the organisational voice was still textured heavily with various types of audience voice. This texturing can be seen to reflect TTC's declared determination to be 'led by' lived experience. The consistent use of the quoted words of supporters, Champions, or people from the business community, mean that although the corpus as a whole reflects the character of TTC, the extraction of the organisational voice through subdivision into smaller corpora is not feasible.

Such intra-text texturing in the TTC corpus led me to consider context more extensively throughout the corpus-aided analysis. The multiplicity of voices is a complicating factor and constrains, or rather influences, analytical scope. For example, when analysing types of 'we', my first move was not on the basis of linguistic characteristics, but concerned exploring beyond

the sentence context to determine the ‘voice’ (6.2.2). The texturing of different voices occurs to a much lesser extent in HT, which as a smaller, simpler website, presents less ambiguity.

5.9 Text analytical methods

I describe four methods of textual analysis, explaining why they are important and how I applied them to the data. These are the analysis of genre, legitimation, the pronoun ‘we’, and the representation of social actors. Each method requires some explanatory focus, to clarify and contextualise its purpose and subsequent use in Chapters 6 and 7.

5.9.1 Deixis, analysis of ‘we’, and aspects of coding

A focus on personal pronouns in this data, in particular ‘we’, provides a means of understanding not only their use in constructing interpersonal roles, but crucially, in accountability and in/out groups.

Deictic choices are a way of demarcating the boundaries of participation in the ‘discourse world’ which a text creates. Mulderrig (2012) argues that through use of the pronoun ‘we’, deixis is used to change the relationship between those who govern and those who are governed; by including the latter in the ‘discourse world’ of policy propositions, the public who are affected by policies implicitly share the perspectives of policymakers. In the context of AS, ‘we’ can be a way of including the reader within the attitudinal position of the organisation, automatically rendering the public part of the policy process.

Pronouns are deictic expressions; they relate to a speaker or writer’s specific situation, place or time, and so they lack an intrinsic meaning and depend on context to determine their referential meaning (Levinson 1983; Mulderrig 2012). CL allows fluid examination of either close, or more extended context; the demands of analysis are thus ideally met by the main tool used to support it.

Analysis has traditionally distinguished between two types of ‘we’: inclusive ‘we’ includes the addressees, so that they are anchored to the deictic centre along with the speaker(s), thereby creating a clear 'in-group' by establishing solidarity (Mulderrig, 2012). Exclusive ‘we’ meanwhile excludes addressees from the deictic centre. But this understanding has limitations, including difficulty in determining which form of ‘we’ is intended. While analysing New Labour policy discourse, Mulderrig (2012:709) identified the potential for rhetorically

significant 'strategic vagueness', and proposed that an extra category, 'ambivalent' or 'ambiguous' we, is needed when the referent is unclear. Mulderrig (2012) observes that this type is frequently used to construct imperative speech acts about something we 'must' do, such as a policy action, which is justified in a vague and abstract manner. Ambivalent/ambiguous 'we', by presenting a policy decision as inevitable, allows a speaker or writer to avoid accountability for that decision.

For each corpus, I first identified the frequency of 'we'. Its high frequency in TTC necessitated sampling[17]; I therefore first created a random sample of 200 to understand the associated linguistic patterns, then extracted a larger random sample of 1,000, drawn from across the corpus. While sampling provides statistics which demonstrate emerging linguistic patterns, I also quote further examples, from outside the sample, to fully characterise the data. In this way I provide both a securely quantified result and broader illustrative evidence.

I have described how the organisational voice in the TTC corpus is textured with the 'user' voice. Context is already considered an important factor in analysis of 'we' (Mulderrig 2012:709), and the textured, multi-sourced nature of TTC adds another dimension to its analysis, requiring a significant amount of context to be used to determine 'voice' in each instance, before analysing the type of 'we'. In what could be termed a hybrid, truly corpus-'aided' method, I analysed the context of each of the 1000 uses of 'we' to identify the organisational ('org') voice, i.e. words authored by the campaign, which were my primary focus of interest. Accordingly, 'user' voices (the general public who engage with the website or actively support its aims, such that their words appear on it), constituted the other part of the sample. For both 'org' and 'user', I coded each type of 'we' (inc., exc., and amb.), thereby creating a total of 6 possible categories.

I attributed coding of 'we' as much by semantic context as by a set of qualifying linguistic characteristics. Below I provide a sample page of concordance lines, individual examples of each 'we' type as concordance lines, and in each case the full sentence context. [18]

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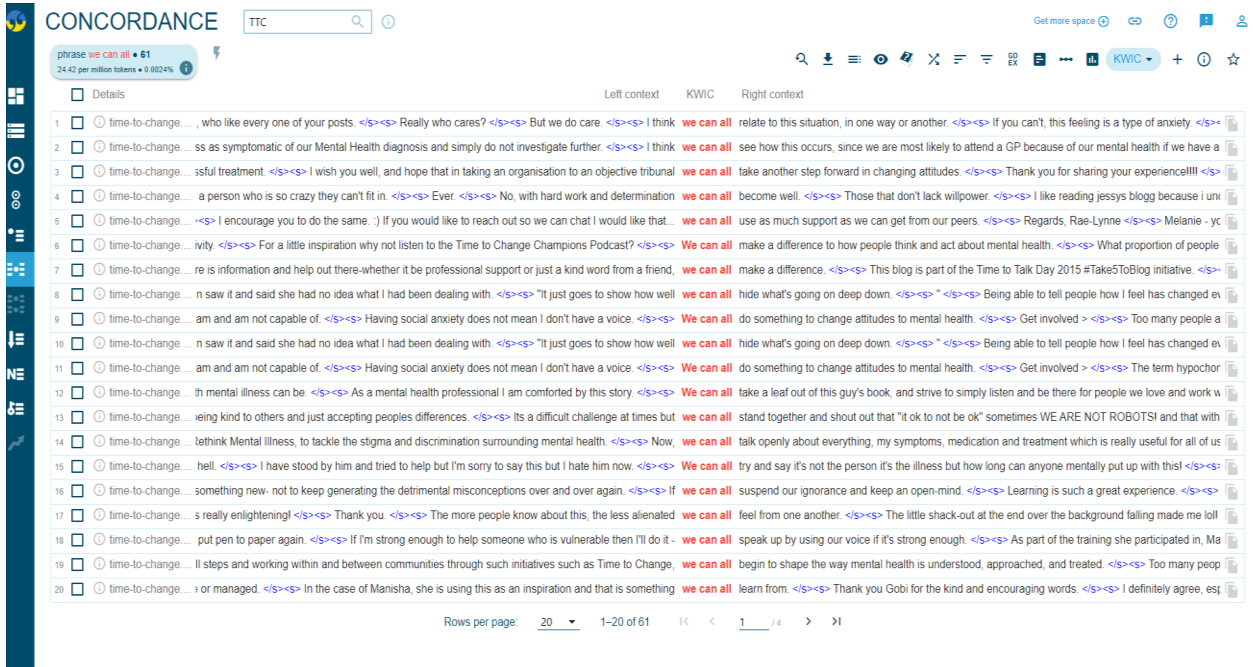
[17] Sampling in corpora is a standard technique (Baker 2006).

[18] KWIC is the acronym for 'Key Word in Context': this refers to the red text highlighted in a concordance, which matches specific search criteria.

Fig. 9: Sample page of concordance lines from Sketch Engine



(i) Features of inclusive (inc.) 'we': the speaker includes the addressee/s. May be identified by contextual anchors 'all' and 'together' (and in user voice, contracted 'we're all'), and in wider context, by semantic characteristics suggestive of imagined community or shared identity.

Anxiety is a normal emotion that <u>we all</u> experience but becomes a mental health problem when someone finds they are feeling this way all or most of the time.

(ii) Features of exclusive (exc.) 'we': the speaker excludes the addressee/s. In the 'org.' group, exc. 'we' typically concerned verbs relating to organisational knowledge or identity: 'we are', 'we know', 'we learnt', 'we provide'.

31 time-to-change.... rtnership with people who have lived experience, as well as experts, NGOs, policy makers and funders, we 're helping to change the way communities in low and middle income countries think and act about ment

By working in partnership with people who have lived experience, as well as experts, NGOs, policy makers and funders, <u>we're</u> helping to change the way communities in low and middle income countries think and act about mental health problems.

26 time-to-change.... health problems say discrimination from friends, family and neighbours has the biggest impact. </s><s> We support hundreds of Champions to reach people and change attitudes where they live and oversee a net

'<u>We</u> support hundreds of Champions to reach people and change attitudes where they live and oversee a network of more than 30 Time to Change Hubs'.

Both the above examples describe (exclusively) the campaign's actions. In systemic functional linguistics, these are material processes.

(iii) Features of ambiguous (amb.) 'we': following Mulderrig (2012:711), all uses of 'we' for which it was *'not possible to unequivocally determine referents'* are coded amb.

89 time-to-change.... e as a result. </s><s> Time to Change Time to Change is a growing movement of people changing how we all think and act about mental health problems. </s><s> Our voice is stronger and louder thanks to fundi

'Time to Change is a growing movement of people changing how <u>we all</u> think and act about mental health problems'.

This is ambiguous because the campaign itself does not need to change, and uses 'inclusive' we strategically. (See 6.2.5).

11 time-to-change.... <s> Looking after ourselves is key to maintaining our long term well being and extending our lives and we should n't become complacent. </s><s> So here's to Mental and Physical Wealth! </s><s> We deserve it! </s>

'Looking after ourselves is key to maintaining our long term well being and extending our lives and we shouldn't become complacent. So here's to Mental and Physical Wealth!' [19]

The modalised exhortation can similarly be seen as strategic.

5.9.2 Legitimation

In discourse, legitimation concerns the ways in which a social behaviour is justified by linguistic means. While the legitimation of HT is rather patently derived from its royal associations, TTC repeatedly signals a need to justify its existence, rectitude, and success, and therefore the strategies it uses require exploration.

[19] The use of 'wealth' is interesting here, but it does not relate to wider context, and may be an error.

For this analysis, I was guided by the frameworks of Reyes (2011) and van Leeuwen (2008) as noted in 2.5.2. I briefly explain the analytical framework below. Frequently the categories required refer to particular semantic or grammatical characteristics which were identifiable from corpus searches. I also had pre-existing reference points through my knowledge of the texts; in particular, this analysis was unexpectedly complemented by the analysis of 'we'.

Analysis of legitimation involved drawing together diverse textual elements. I first considered legitimation through emotion, in which 'we' analysis was relevant in terms of the 'constructive strategies' (Van Leeuwen and Wodak 1999:92) which position people as belonging or not belonging to a social group. I then considered legitimation through a hypothetical future, and considered van Leeuwen's (2008) notion of a timeline construing the present as a time requiring important actions, related to a (past) cause and possible future consequences. Using the corpora, I then examined how modalised statements, or those which refer to the future ('will'), are used to talk about aspects of campaign efficacy. I sought the frequency of a variety of lemmas (listen, consult) and other verbs denoting mental or verbal processes, to investigate the existence of organisational legitimation from the 'rational' process of consulting different sources. As part of van Leeuwen's (2008) category of instrumental rationalisation, which discusses how purposes are used to explain the reason for a social practice, I examined the way TTC signals its successes and actively manages its failures.

At each stage, I support my arguments using the frequencies of semantic features found in the corpus, again frequently using collocates of 'we'. For example, 'we know' statements helped illustrated legitimation through the campaign's use of expert voices, authority figures, and the knowledge derived from them. I also considered how assertions of organisational knowledge led to the use of research and metrics as argumentation strategies. Finally I considered authority from role models and people with experience of mental illness.

5.9.3 Genre analysis: what is genre? Its analysis in this research

AS is a type of social practice. Genres constitute one dimension of the discourse practices which contribute to social practices and the ways they are enacted. They can be defined as a distinctive, patterned way of enacting a social action in a particular context, and therefore the linguistic features they contain both reflect and illustrate a genre's social purpose(s). These features may not be patent, so analysing genre is part of explaining how a text 'works' in

society. Genres are dynamic rather than static, so an innovative genre can be regarded as a re/source from which social change may emerge. Since AS websites are intended to inculcate behavioural and attitudinal change, consideration of their genre is necessary.

Some theoretical models of genre are mentioned in 2.5.2. While, as Bhatia (1996) notes, the 'common ground' in genre analysis concerns understanding communicative purpose(s), 'moves', and rhetorical strategies, there is no single analytic method. I embrace this lack of constraint, and while still examining 'traditional' features; author and audience, communicative purpose, and setting, form, and medium, I do so in terms of their relationship with the distinctive structure of online texts. Digital texts do not entirely fracture conventions of routinised sequential structure; for example, TTC 'blogs' have a conventional structure: date, title, photo, introduction, main body, response from TTC ('*what did you think of…*'), and link to other blogs. However, despite many such micro-structures, the dynamic and recursive formats of websites, driven by hyperlinks, mean that it is appropriate to focus significantly on the *medium* of the campaign texts.

I therefore examine the interconnected elements of the websites' authorship and audience, and explore their communicative purpose, then when considering medium, I diverge from traditional models of genre analysis, and acknowledge work by Askehave and Nielsen (2004), whose model accommodates the way that online texts are actually used; by a combination of reading and navigation. I use both websites' 'homepages' as definitive texts, and for each, I analyse the purpose, moves and rhetorical strategies, first following a 'traditional' model, and then considering 'navigating mode'; the use and consequences of hypertext links.

5.9.4 Representation of Social Actors

Exploring the way social actors are represented helps to reveal how an aspect of the social world (in this case, a specific area of mental health 'activism') is portrayed, and how this portrayal is textured, by issues of identity, power, and assumptions. Social actors (hereafter, SAs) may not be represented in a neutral manner, but in ways which but create rhetorical or ideological effects, serving the agenda of text producers. These representations can reveal and reproduce patterns of discrimination and social inequality, and so they are a relevant analytical focus for data in which inclusion and exclusion are central concerns.

The sociosemantic inventory devised by van Leeuwen (2008) to describe how SAs can be represented in English has become a standard tool for analysts exploring how a text represents participants. It is a linguistically comprehensive network, involving more categories than I invoke for the purposes of this study. Quantification of the sociosemantic categories would have limited value with such an interpretive analytical method; rather, I aimed to characterise the text, identifying categories of representation either through the corpora (by seeking grammatical forms characteristic to each category), or by re-visiting patterns observed during 'we' analysis, which proved so informative across the textual analyses. Below I introduce this analysis, and describe relevant categories, using illustrative examples from the TTC corpus.

(a) Exclusion: suppression and backgrounding

Texts may include or exclude an actor. Exclusion is of interest in CDA, since it can relate to assumed knowledge, and can also be strategic. Exclusion can occur in two ways. In 'suppression', the SA does not appear anywhere in the text. Characteristic grammatical forms include passive agent deletion (van Leeuwen 2008:29); a passive form is used, and we are not told who the agent is:

'A review of impact on Black and Minority Ethnic communities was commissioned in 2011 and recommendations <u>are being taken forward</u>.'

Alternatively, in 'backgrounding', the excluded SA might not be mentioned in relation to a particular action, but their identity can be inferred:

'try to resist the urge to offer quick fixes to what they're going through.' (contextually, 'they' are people with mental illness).

Beneficiaries (SAs who 'benefit' from an action grammatically or socially) are easily suppressed or excluded: *'we help shape <u>a future</u>'*

(b) Role Allocation: activation and passivation

Interest in the roles allocated to SAs mostly concerns whether a representation assigns an actor an active or passive role. 'Passivated' actors are represented as undergoing or 'receiving' the activity: *'Champions were bought a hot drink'.*

Passivated actors may be either 'subjected' (treated like an object) or 'beneficialised' (they benefit, positively or negatively, from the action).

Actors are not necessarily grammatical participants; they may be activated by various means; for example, 'circumstantialised' by prepositions such as 'from', as in *'staff needed support from colleagues',* ('staff' are the actors), or they may be activated by pre-or postmodifiers, e.g. premodification by public in '*public support*' creates activation. Possessivisation (use of a possessive pronoun) also activates a SA ('*our Champions*').

(c) Individualisation and assimilisation

These categories are important when considering power relations; unless a social actor is referred to as an individual ('individualized'), they are 'assimilated' into a group or class, either by collectivisation ('*young people*'), or aggregation, in which they are quantified, or presented as statistics, using percentages or other numerical markers: *'1 in 4 people will experience a mental health problem in any given year'*. Assimilisation through aggregation can be anticipated in a campaign seeking in part to create consensus opinion through survey findings and other statistical displays of what constitutes legitimate practice. In TTC, assimilisation is frequently realised by mass nouns, or nouns denoting social groups (*'Champions'*).

(d) Determination and indetermination

Determination means that an actor's identity is specified in some way, while in indetermination, SAs are unspecified, 'anonymous' individuals or groups. This anonymisation, which may suggest the writer considers the actor's identity is unimportant, is usually realised by indefinite pronouns in a nominal function, here in an aggregated form: *'some people find it helpful to see their experience as an illness'*. Anonymisation can be realised by an exophoric reference (Van Leeuwen 2008:40) i.e. coming from outside the text, and the unseen referent may feel threatening: *'they tell you that you're just making a fuss'*.

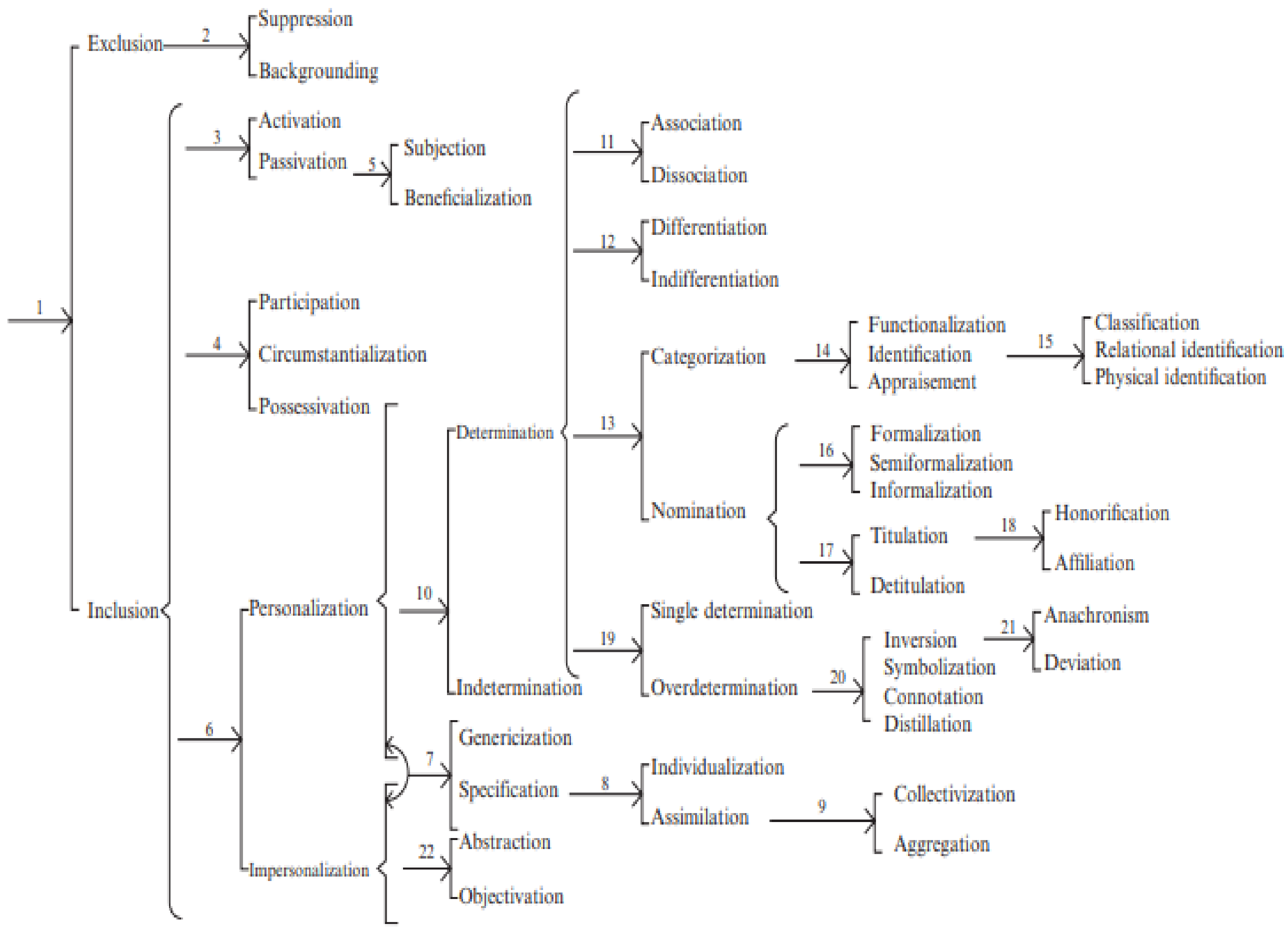
(e) Categorisation and Nominisation

Categorisation represents an actor in terms of shared identities, while nomination considers their unique identity, which may be formal *('Sue Baker, OBE'*), semiformal, or informal (*'Sue'*). As van Leeuwen (2008) remarks, irrespective of medium, a nameless character is typically inconsequential.

Categorisation may result from 'functionalisation', in which SAs are referred to in terms of a specific role or occupation (e.g. *'Workplace Champions'*), or 'identification', which defines them in terms of what they 'are'. Nomination combined with categorisation is uncommon (van Leeuwen 2008: 41) yet occurs in TTC, for example with *'Champion Adam'*.

Impersonalisation is a characteristic of bureaucratic language, and is realised by 'objectivation' or 'abstraction'. Objectivation occurs when SAs are represented by a reference to an action, thing, or place (i.e. by a metonymical reference, such as *'Time to Change believes'*). Abstraction meanwhile occurs when a SA is represented by a quality assigned to them; if mentally ill people (or those deemed to stigmatise them) are referred to using the term *'problems'*, they are then problematised, and thereby evaluated.

Fig. 10: Van Leeuwen's Social Actor network (reproduced from Van Leeuwen 2008:52) [20].



[20] Square brackets indicate 'either/or' choices, while curly brackets indicate multiple options.

I use a more simplified, linear version than the complex socio-semantic web illustrated above, but together with the description and examples I provide, the graphic is useful in relation to 6.3.

Analysis of SA representation is ultimately a matter of interpretation. Accordingly, my analysis uses three role categories which I assign to SAs in TTC (target, operator, and beneficiary)[21] which, as I argue in Chapter 6, reflect the overt and covert nature of the website narratives.

5.9.5 Analysis of lexis

In addition to the specific analytical frameworks described above in 5.9.1-4, I also analyse lexis. Lexical analysis, which facilitates identification and challenge of hidden meanings, values and beliefs, is important is CDA, as I note in 2.5.2. Isolated utterances tell us relatively little; it is the salience of a lexical feature which renders it important. I identify salience by determining corpora frequencies; as described in 5.8, the use of CL allows non-corpus findings to be verified and explored.

Since word meanings are relational (2.5.2), I also investigate the collocates of words; those words which constitute the closest part of its co-textual environment. Collocation concerns the tendency for words to be biased towards particular lexical partnerships, facilitating exploration of a word's range of meanings, and its positive or negative semantic properties or evaluative load.

I focus on lexis in several specific areas of analysis. In 7.1.1, I analyse and interpret frequencies of lexical choices concerning the way in which mental illness is referred to. This is important, as TTC constructs a complex relationship with people who experience mental illness; it presents as wishing to help them, but simultaneously recruits them as Champions and storytellers. I examine the frequencies of descriptive terms used for mental illness, and investigate use of diagnosis-specificity in campaign language. I also investigate some instances of lexical vagueness and reflect on their consequences. Later, when discussing the lexis used in the focus group (8.5) I apply Van Dijk's (1998:275) concept of the ideological square (introduced in 2.5.2), which entails a framework which reveals four key means by which the

[21] While these terms *resemble* usage from Systemic Functional Linguistics, in this case their meaning is subtly different, as explained in Chapter 6.

'us' and 'them' dichotomy can be discursively expressed. In accordance with this framework, I identify lexical choices which:

Express or emphasise positive information about Us;
Express or emphasise negative information about Them;
Suppress or de-emphasise positive information about Them;
Suppress or de-emphasise negative information about Us.

I further explore lexis in Chapter 9, discussing interview findings. Yet lexis is in fact integral to all areas of analysis, particularly legitimation. I consider narrative meanwhile as a summative product of the different types of text analysis, which allows the processed text to be positioned more appropriately within its social context.

5.9.6 Analysis of participant data: a shared core framework with tailored additions

A typical approach to the analysis of research interviews is to categorise content and use illustrative quotes to summarise themes which emerge from transcripts (Abell and Myers 2008:145). More quantitative work may use coding (Bauer 2000), although to code consistently across different interviews would assume each interview's context is also consistent.

Abell and Myers (2008) however favour an approach which considers how research interviews can be treated as a hybrid of everyday conversation and the interview genre. Their proposal for research interviews, guided by the desire for validity exemplified in the sociolinguistic work of Labov (1972), consists of four elements (2008:151), following the four key levels of analysis that underpin Wodak's Discourse Historical Approach (Reisigl and Wodak 2001, 2009; Reisigl 2018). One element may dominate, but some aspect of linking these levels is deemed essential (Abell and Myers 2008:158).

1. Relating utterances to what precede or follow them by exploring the immediate co-text.
2. Taking into account links between the interview talk and other texts; considering interdiscursive or intertextual relationships between spoken utterances and other texts, genres, or discourses.

3 Examining extralinguistic social variables and the institutional relevance of a particular ‘context of situation’.

4 Broader historical and socio-political contexts (Wodak 2001:67), including pre-supposed power and knowledge relationships, and even those which allow the interview to take place.

For the three interviews, I summarise content categories and provide illustrative quotes, and at the same time draw on Wodak’s four-level framework for situated critical discourse analysis, as outlined above.

Abell and Myers (2008) consider that intertextuality in interviews concerns not only direct quotation but also the way interviewees may employ commonly used arguments (or topoi). Such observations, of ‘compressed arguments’ or generalisations, following Reisigl and Wodak (2001) are an inherent part of reaching an evolved understanding of interview content, and are therefore integral to the process of critically interpreting my findings.

Meanwhile ‘context of situation’, which is a key element in my approach, refers to all the conditions immediately surrounding an act of speech, and is defined by Halliday (1978:10) as ‘*a construct for explaining how a text relates to the social processes within which it is located*’. For Abell and Myers (2008:154) it may include discussion of the way interviewees were contacted, or how interviews were scheduled.

Thus by combining a thematic, content-analytical approach with situated critical discourse-analysis, I create the potential for analysis which offers greater explanatory value. Additionally, the findings are enriched by selective analyses using the interview corpora. The resultant presentation of findings challenges Abel and Myers’ perception of primarily thematic analysis as inadequate or denuded.

The manner of analysis of focus group data depends on its objectives (Kryzyanowski 2008:167), and in social sciences and health research, may legitimately remain at the level of providing information which supports other types of analysis. However, I use the same analytical approach for the focus group data as for the interviews,[22] and explain the reasons for this choice below.

Conversation analysis has frequently been used with focus group data (Macnaghten and Myers, 2004) looking not at ‘what was said’ but ‘how it was said’, for example by analysis of particular

[22] Except that I do not create a corpus from the focus group data.

linguistic categories. From the outset of recruitment for this focus group however, I made it clear my interest was not in *how* people expressed their views, but *what* their views were. This reassured participants, and enabled recruitment. My objective was to obtain a broad understanding of the group narrative, rather than detailed linguistic information.

Work with focus groups has often ignored contextualised argumentation patterns, or group dynamics. However, a shift towards understanding that linguistic approaches consist not only of sentence-level grammar means that in analysing focus group data it is valid, and indeed necessary, to consider a range of contexts of language use, including the situational, social, cognitive, and cultural (Wodak 2008). This reflects van Dijk's (1990:164) definition of discourse as text in context. Thus, focus may legitimately be placed on the semantic level of analysis, with syntax only minimally involved.

In the context of discourse-historical CDA (Wodak 2001; Reisigl and Wodak 2001; Wodak and Kryzyanowski 2008), focus group data may be used to uncover thematic structures in focus group discourse (Kryzyanowski, 2008:169). This approach first examines the thematic level of textual representation, and may then identify a second level which considers aspects such as argumentation patterns. For the current small scale study, I restricted my analysis to the 'first' level, because my analysis is based on Wodak's (2008) four-level framework, and has significant contextual focus. Wodak's framework captures the same elements of analysis that many different kinds of thorough discourse analysis would include. This framework explicitly allows me to incorporate, in CDA terms, all the relevant forms of data and analysis which are necessary to allow me to fully describe, critique and explain the social problem I am investigating, in both its semiotic and non-semiotic dimensions. While the two types of data are very different, the framework is a suitable approach for both the interviews and the focus group. In addition, for each data type I use further analytical steps reflecting the specific needs of the data.

(i) Focus group: additional text analytical techniques

Since the focus group is a single event involving multiple individuals, there is greater contextual information to consider with respect to 'context of situation'. In addition, as noted in 5.9.5, I apply Van Dijk's (1998:275) concept of the ideological square as a means of understanding how the group position themselves. This constitutes an appropriate substitute, given the specific nature of the data, for the identification of secondary 'discourse topics'; the key ideas which summarise the meaning of focus group discussions, as noted by Kryzyanowski

(2008:169) and van Dijk (1984:56). Kryzyanowski (2008:174) then distinguishes further between primary topics, 'given' to the group in order to frame the discussion, and secondary topics which the participants develop as a 'product' of discussion, which can reveal a group's true views or concerns. I selected the 'ideological square' to perform this function instead.

(ii) Interviews: additional text analytical techniques

In addition to the analytical framework described (above), from 9.2.6 to 9.3.3 use of the corpora supports my investigation of the interviewees' positions in relation to other members of their organisation, other organisations in the sector, people with mental illness, the general public, target audience demographics, older people, and the government; these investigations all facilitate the explorations of identity. I also consider how interviewees spoke about organisations' activities, through analysis of the material processes used, and I then examine how this organisational work is to be done, by considering identifying irrealis statements and modality.

5.9.7 YouTube comment analysis

The questions I asked of the YouTube comments data were as follows:

- Do comments suggest that the message of the video was understood?
- Is the video and/or its message received positively or negatively?
- What more nuanced responses, including attitudinal positions, can be construed from the comments?

These questions resemble those I sought to answer through the focus group response to videos (5.4.1). To answer them, I generated categories to establish an initial coding framework which could subsequently be expanded, modified, or discarded, informed by Madden *et al*. (2013). Table 4 compares the two methods, and Table 13 (8.6.2) describes my codes.

Table 4: Comparison of YT analysis methodology with Madden et al. (2013)

Methodological step or element	*Current study*	*Madden et al. (2013)*
Study aim	Through content analysis, to understand audience reception	Content analysis to produce a generalisable coding schema of

	(comprehension and approval) of video message.	comment categories, applicable across YT video genres.
Use of corpora/other technological affordances	No, manual analysis	Yes
Representative of all YT videos	No: sample from within a specific genre: AS campaign videos, selected specifically to understand viewers' reception.	Sample included a wide range of YT video genres.
Numbers in video sample	7 (5 for focus group)	78
Number of comments	512 (before deletions by posters)	66,637
Number of categories assigned	22 specific categories.	10 broad categories, 58 subcategories.
Comments removed if controversial, offensive, abusive	No	No
Selected on a single date, and stored in case of deletion (a temporal 'snapshot')	Yes	Yes
Categories created *ab initio*	Yes	No. Initial categories derived from Jansen *et al.* (2009) and Park *et al.* (2008)
Evolving categories tested iteratively	Yes	Yes
Categories tested against individual comments	Yes	No: categories tested against the corpus; assigning a category to individual comments deemed 'impractical'.
Categories combined or rejected during the process	Yes	Yes
Comment categories created with reference to video content	Yes	Only a minority of comments required consideration of video content
Comment analysis on a per video basis	Yes	No: comment analysis according to comment purpose
Comments analysed according to semantic purpose/function	Yes	Yes
Some comments deemed unclassifiable?	No: commonalities allowed aggregation into one of the 22 categories, although the 'U' category (see Table 13) allowed assimilation of 'awkward' comment types.	Yes: around 2%
Independent reliability checks of coding?	No, but a second, later, repeat coding, leading to refinement	Yes, two testers. Where conflict arose, changes were

	of categories and their allocations.	made to classificatory descriptions.
Statistical tests of reliability?	No	Yes: ‘The Kappa Statistic’ (presumably Cohen's kappa coefficient, used to measure inter-rater reliability in qualitative studies)

5.10 Chapter conclusion

In this chapter I first discussed the relationship between the research questions and analysis, then described the website data, and the ways the websites differ, including their different semiotic modes. I also described the focus group, video and interview data. I outlined the approach to my analytical method, and introduced corpus linguistics, before explaining and describing the text-analytical methods I applied to investigate the research questions. The methods selected are those suited to the data within a CDA approach, and were chosen in an inductive manner as the characteristics of the data emerged. In following two chapters, I present the findings of textual analyses of website data.

CHAPTER 6: Textual analysis: Representation, Identity, and Genre

6.0 Introduction

Textual analysis is presented in two chapters, to enable sufficient use of illustrative quotations. I start by introducing the textual patterns seen in TTC and HT (6.1), then in 6.2 analyse the types of the pronoun 'we' found in the corpora. In 6.3, I examine representation and identity by analysing how different groups of social actors are represented by TTC, then in 6.4, I discuss the genre features whereby the websites engage with different intended audiences.

RQ1: What is the language used in anti-stigma policy, as enacted by AS campaigns?

This key question is broken down into sub-questions for some textual analyses, and for others, an additional RQ is also relevant. At the start of each section of analysis, I provide the question I aim to answer through that analysis. All are positioned within the overarching objective of revealing the missing discourse of AS.

6.1 Introduction to textual patterns in TTC and HT

As described in 5.3.1 and 5.3.2, TTC was a social marketing campaign, primarily enacted through its heavily branded website, while HT is a smaller initiative, which functions as a hub.

My preliminary investigation of the sites was aided by corpus tools, enabling me to identify salient linguistic features. I combined this with a qualitative and multi-modal 'first pass' analysis of the data. Together, these methods enabled me to identify the websites' distinctive textual features which in turn suggested suitable text analytical frameworks through which to conduct deeper analyses. Below I describe how some of these features suggest specific areas for analytical focus.

TTC described itself as a *'growing social movement working to change the way we all think and act about mental health problems'*. As the underlined sections illustrate, the campaign identified itself in inclusive terms, inviting the wider public into its semantic sphere of self-

reference, and simultaneously activating ideas of both fellowship and collective resistance. Audience-oriented inclusive language could be anticipated in this website, which shares many features with those produced by commercial organisations. Yet it quickly emerges that the inclusivity is selective, creating in- and outgroups. A key ingroup are 'Champions', the volunteers with experience of mental illness, who on behalf of TTC have 'conversations' in communities and workplaces, primarily with people without experience of mental illness. The directive is ambiguous however, since targets of conversation can include people experiencing mental distress. It is therefore important to explore how TTC represents Champions and other social actors. In addition, understanding broader issues of both campaign and audience identity can be achieved by analysing the way in which the campaign speaks both about itself, and to its audience. This can be understood in part through analysis of pronoun use, especially the deictically flexible pronoun, 'we'.

Repetition of key messages or campaign slogans across the website is a consistent pattern, especially in TTC. I have noted (2.5.2) Fairclough's (2003) recognition of 'overwording' as a mechanism by which an ideological perspective may become normalised and embedded in society. In the user-authored elements of website content, there is some evidence that this strategy of repetition succeeds in embedding messages; for example, sub-campaign titles, such as *Ask Twice* and *In Your Corner*, are re-used in user 'stories'; *'make sure you really do ask twice'*, or *'My wife was in my corner all that time'*. Message repetition in TTC signifies the way website content, and the activities and interactions undertaken on behalf of the campaign, are both controlled. These features may be explored by discovering how TTC identifies itself, and how it represents others. Both the analysis of social actor representation, and again, analysis of the pronoun 'we', respond to this need.

TTC represented a significant investment of public and other funds, and demonstrates its need to legitimise its actions and existence by broadcasting its success. Accordingly, a variety of formal and informal positive evaluations of the campaign are distributed across the website, often substantiated by metrics signalling the high numbers of people which the campaign 'reached'. The campaign's portrayal as successful is functionally important in attracting businesses to sign the TTC Pledge, a commitment to 'support' workplace mental health through alliance with the TTC brand. TTC's concern with self-evaluation guides me to analyse its legitimation strategies. Further, while some consideration of lexical strategies inevitably underpins all the analyses, in relation to legitimation and success, the data prompts investigation of possibly strategic use of vague lexis, such as 'support' or 'reach'.

During preliminary textual analysis, differences between the two campaigns became apparent (5.3.4). For example, HT does not evaluate itself or report its results, prompting a different focus, and extent, of the analysis of legitimation strategies. In HT the promotional work of the site relates to the royal brand, and the campaign's authority is primarily derived from the social capital associated with its royal founders ('Our Principals'). Instead of evaluating itself through managerial mechanisms such as performance metrics, its dependence on external agencies as sources of knowledge suggests less explicit, intertextual strategies of legitimation.

A key element of TTC's online campaign involves the recruitment and use of 'Champions', as part of its emphasis on 'lived experience leadership' and the value of sharing individual mental health 'stories'. People with experience of mental illness are therefore a key part of the campaign's intended audience. Yet the target demographic for the campaign's behaviour change message are people who are remote from mental illness. The different audiences are addressed in distinct ways, and campaign goals and objectives are construed differently in versions directed at different audiences. This audience ambiguity is problematic, raising questions about the socio-political motivation for the enaction of this policy initiative. Social marketing draws interdiscursively on corporate genres and applies them to purposes concerning the 'public good', and therefore corporate genres could be expected in the websites. Yet in TTC, ostensibly internal corporate texts are in close proximity to public facing content; detailed rules pertaining to use of brand and images point to a complex admixture of genres. The interdiscursive hybridity inherent in social marketing genres of this kind, alongside the diversity of audience with which TTC attempts to engage, confirms the importance of examining its genre features.

HT adopts a more selective approach over what it invites to be shared, which together with a relative stylistic formality, creates an impression of distance between itself and the public. Moreover, its use of vague, euphemistic language when referring to mental illness is reflected in confusion over campaign message. HT imprecisely defines itself as *'A series of programmes to support conversations about mental health',* retreating significantly from its initial commitment to 'end' the stigma of mental illness. The way mental illness is described is important; people who experience it are the purported beneficiaries in AS, and therefore clarity of required of text producers if they intend to influence perceptions. Both HT and TTC used a range of terms of describe mental illness, some of which may be strategic, and exploration of these terms is accordingly a key focus of my analysis of lexis.

6.1.2 The analytical concepts

The observations above demonstrate how preliminary characterisation of the data determined parameters for deeper textual analysis. Below I briefly reiterate the analytical frameworks described in Chapter 5.

The interdiscursive hybridity noted above suggests analysis of interdiscursivity and intertextuality would be beneficial. Constraints of scale dictate selectivity, so hybridity is considered within the analysis of genre, guided by the approaches of Fairclough (2003), Bhatia (1997; 2016), Swales (1990) and the more medium-specific lens of Askehave and Nielsen (2004). The representation of social actors follows van Leeuwen (2008), and my examination of deixis through analysis of the personal pronoun 'we' is informed by the work of Mulderrig (2011; 2012). The legitimation strategies which underpin TTC's prominent self-evaluation are explored primarily through the frameworks of Reyes (2011) and van Leeuwen (2008). Analysis of lexical choices focus on how mental illness is described, and on the use of strategic vagueness.

These analyses together inform a deeper understanding of the website's narrative. HT is not subject to the same focus, or the same categories of analysis as TTC, but comparative analyses demonstrate that despite the campaigns' differences, the messages they convey align significantly, particularly in terms of the privileging of community- or family-based conversation, which as discussed in Chapter 3, derives from the neoliberal concern with the promotion of individual responsibility for mental health.

6.2 Deixis: analysis of 'we'

This analysis asks: ***Does AS implicitly construct a normal 'us' and a mentally weak 'them'?*** This is a sub-question of ***RQ1: What is the language used in anti-stigma policy, as enacted by AS campaigns?***

The significance of 'we' was introduced in 2.5.2 and discussed further in 5.9.1; I have discussed how the pronoun's deictic flexibility allows its meaning to shift depending on the perspective of the speaker or writer. This semantic complexity provides a range of rhetorical insights, such as demonstrating an ideological position, acceptance of or distance from an idea, and may also position social actors as allies or foes.

As noted in 5.9.1, Mulderrig (2012:709) explains that inclusive 'we' establishes solidarity and creates an 'in group', exclusive 'we' excludes addressees, while a third, ambiguous category captures the pronoun's semantic vagueness.

I created a simple concordance of 'we' in each corpus and examined concordance lines to identify respective types, as described in 5.9.1. My initial findings highlighted the importance of context; for example, website user text (e.g. stories) may be interspersed with reported speech such as phone conversations, overheard utterances, and medical instructions, requiring use of extended context to assign a category. The context of organisational text could also be complex: in *'so we know they helped inform the decisions we made with you'*, only extended context reveals this is an interview between TTC and a media producer, in which 'they' are people with lived experience, 'we' (exc) are the media company, and 'you' is TTC.

Initial categorisation of 'we' demonstrated that collocations of exclusive 'we' significantly revealed ideational themes in the website content. The information drawn from this categorisation, and the resultant dataset, proved to be a vital lens through which to identify both salient social actors and organisational identities and activities.

6.2.1 How salient is 'we' in the corpora?

In both TTC and HT, the pronoun occupying the highest percentage of the corpus is 'I', which is significantly key compared to the reference corpus. Tables 5 and 6, demonstrating pronoun frequencies (p.143 and 144) show that 'I' occurred in 87.20% of TTC texts and 96.15% of HT texts, reflecting the amount of self-reference from personal accounts or opinions. Personal 'stories' were a significant feature, and function, of TTC, and in HT, transcribed speeches and quotes from the royal principals, using first-person opinions and exhortations *('I believe passionately in working together')* contribute towards its frequency.

'Me' is more prevalent in TTC than in either HT or the reference corpus, and in both it demonstrates significant keyness. For TTC especially, this too is likely to result from 'stories' (*'when times are bad for me, 'it made me feel much better'*).

Use of 'we' in both TTC and HT are fairly key in relation to the reference corpus, but, unexpectedly, to a greater extent in HT. This demonstrates the importance of calculating percentage differences when comparing corpora of difference sizes.

‘They’ is more prevalent in TTC than in the reference corpus, but in HT it is less common than in the reference, supporting my observation that HT infrequently refers to its supposed beneficiaries, and that the campaign is more ‘about itself’ than about a solid social objective which relates to an external group.

‘You’ is most prevalent in HT, in which although a public ‘you’ is addressed, the frequency is boosted by statements addressing potential or actual marathon runners: *‘set up a Virgin Money giving page, ensuring* <u>*you*</u> *select London Marathon’ and ‘once* <u>*you*</u> *have created your fundraising page…’* Such usage incidentally highlights the website’s (x45) references to corporate sponsor Virgin.

Frequency however does not always equate to significance, and the first-person plural pronoun, ‘we’, as a result of its specific deictic qualities, remains of greatest analytical interest, to help explore the ways in which the organisations construe and identify themselves.

Table 5: Pronoun frequencies in the TTC corpus [23]

Table 5 shows the higher prominence of 'me' in TTC, reflecting use of 'stories':

	Lemma	Frequency	Freq/mill	DOCF	Rel. DOCF	ARF
1	i	77,903	31,181.03	1,744	87.20 %	40,668.44
2	it	30,590	12,243.79	1,896	94.80 %	17,691.52
3	my	28,781	11,519.73	1,670	83.50 %	14,297.33
4	you	25,284	10,120.04	1,715	85.75 %	10,912.00
5	me	16,997	6,803.13	1,584	79.20 %	8,451.61
6	they	10,798	4,321.95	1,618	80.90 %	5,455.83
7	we	11,330	4,534.88	1,641	82.05 %	5,189.88
8	your	9,429	3,774.00	1,431	71.55 %	4,304.74
9	their	5,889	2,357.10	1,391	69.55 %	2,906.11
10	them	5,179	2,072.92	1,289	64.45 %	2,660.47
11	us	3,229	1,292.42	1,308	65.40 %	1,730.50
12	our	4,627	1,851.98	1,228	61.40 %	1,884.87
13	myself	3,270	1,308.83	1,046	52.30 %	1,635.81
14	he	3,725	1,490.95	666	33.30 %	1,095.65
15	she	3,472	1,389.68	711	35.55 %	1,075.91
16	her	2,858	1,143.93	695	34.75 %	957.11
17	its	1,147	459.09	490	24.50 %	581.45
18	his	1,545	618.39	485	24.25 %	557.96
19	yourself	884	353.83	471	23.55 %	435.23
20	him	1,448	579.57	394	19.70 %	463.30

[23] In tables 5 and 6, document frequency (DOCF) is the number of different documents in the corpus which contain the item, and relative DOCF is the *percentage* of different documents in the corpus which contain the item. Average Reduced Frequency (ARF) is a modified frequency calculation which safeguards against the influence of a high frequency occurring in a small area of the corpus; with an absolutely even distribution, ARF and absolute frequency are of near-identical value. Here the relative DOCF suggests a valid, broad distribution.

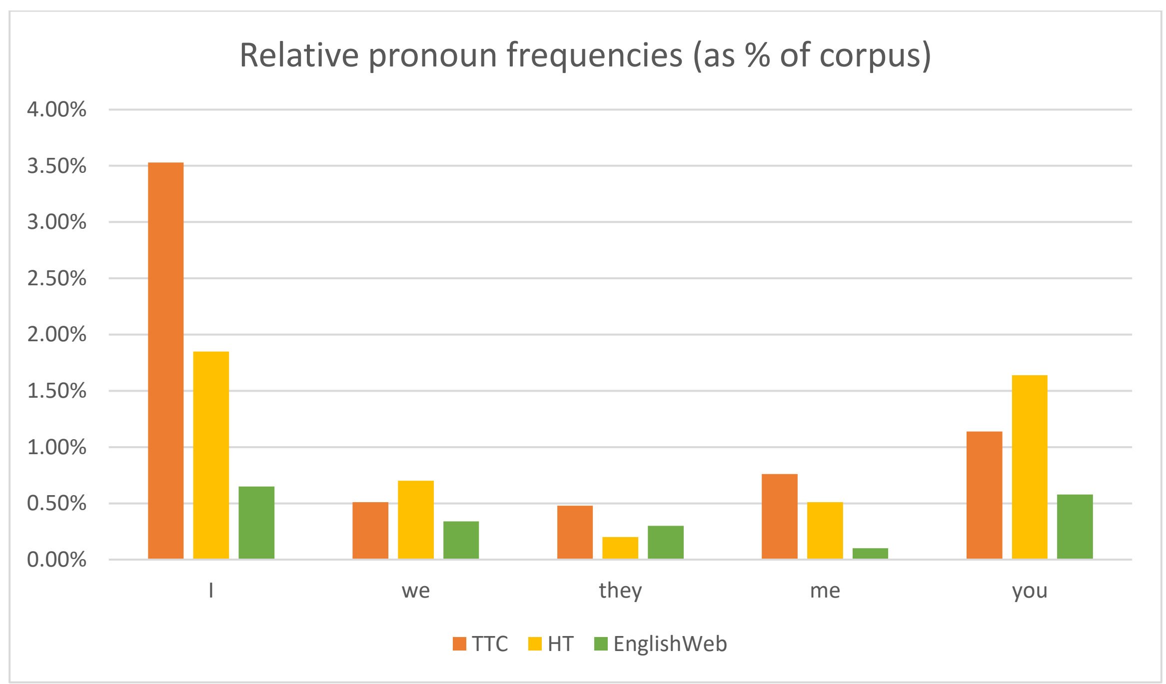
Table 6: Pronoun frequencies in the HT corpus

Table 6 shows the prominence of 'you' and 'I' in HT, and relatively low prominence of 'they', reflecting lack of campaign function:

	Lemma	Frequency	Freq/mill	DOCF	Rel. DOCF	ARF
1	i	2,037	16,397.01	150	96.15 %	833.88
2	you	1,809	14,561.70	156	100.00 %	831.66
3	it	1,076	8,661.35	132	84.62 %	572.12
4	my	907	7,300.97	146	93.59 %	400.37
5	we	774	6,230.38	121	77.56 %	337.04
6	your	774	6,230.38	92	58.97 %	304.44
7	me	568	4,572.16	146	93.59 %	281.77
8	their	521	4,193.83	152	97.44 %	294.38
9	our	435	3,501.57	95	60.90 %	188.78
10	they	427	3,437.17	112	71.79 %	200.23
11	us	358	2,881.75	150	96.15 %	207.07
12	them	270	2,173.39	94	60.26 %	130.25
13	yourself	215	1,730.66	151	96.79 %	141.62
14	her	180	1,448.93	57	36.54 %	63.77
15	she	153	1,231.59	40	25.64 %	44.71
16	he	141	1,134.99	39	25.00 %	41.91
17	his	133	1,070.59	43	27.56 %	45.79
18	myself	103	829.11	33	21.15 %	36.55
19	him	43	346.13	24	15.38 %	18.65
20	its	37	297.83	21	13.46 %	18.16

Fig. 11: Relative pronoun frequencies compared to reference corpus

Fig. 11 considers relative frequencies of the most semantically important pronouns for this data, in terms of the percentage of the corpus they occupy. Frequencies are compared with the reference corpus EnglishWeb (2020), to establish 'keyness' (whether it occurs at a higher level than can be attributed to 'chance').



In each case the lemma was analysed, because searching lemma forms, in the case of pronouns, includes forms such as 'we're', 'I'm' or ' you've'.

6.2.2 Characteristics of TTC texts which influence 'we' analysis

As described in 5.8.3, the highly textured TTC website consists not only of materials authored or spoken by the organisation, but those which could be termed organisation-*generated*. These data represent a curated perspective, derived from diverse sources, including selected news items, quotes from 'aligned' institutions, businesses or individuals. They have in common their support for the campaign message with respect to the privileging of conversation to remedy stigma and often, by extension or conflation, to remedy mental illness itself. I adopted the concept of 'organisational' ('org') voice for these data, and include Champions as creators of 'org' data because, as a trained force charged with enacting many campaign functions, their

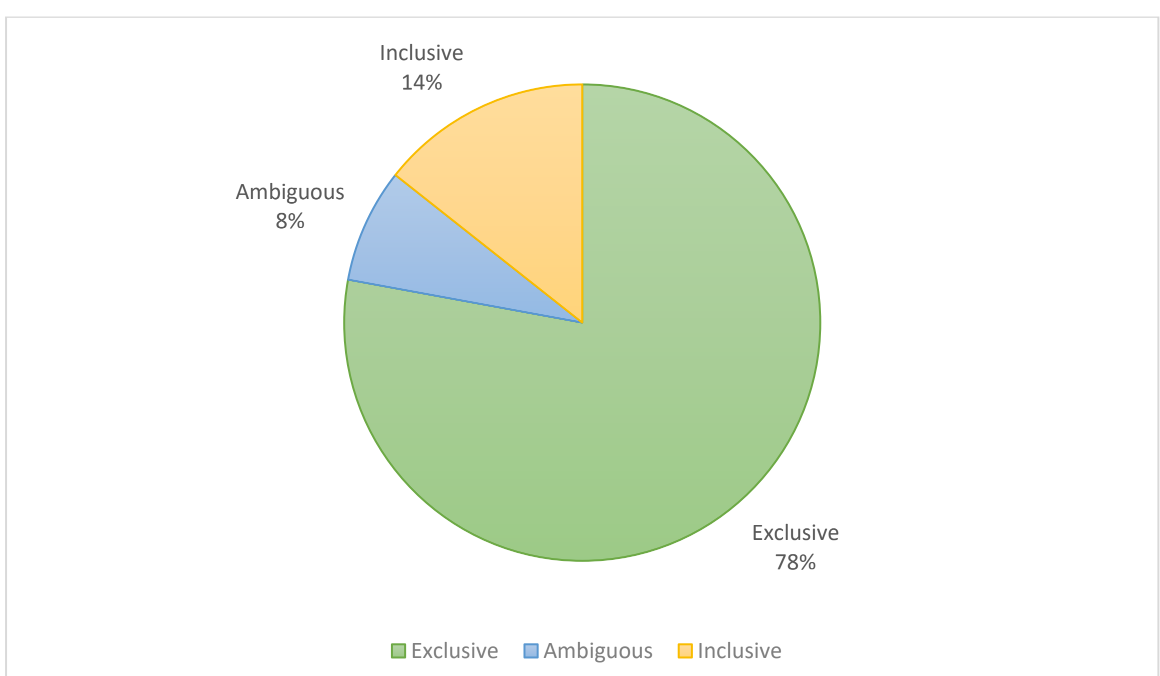
output is sometimes indistinguishable from organisational content; it is indeed their purpose to carry the campaign message and to strongly identify themselves with the campaign and its objectives; Champions' 'we' is the TTC 'we'. The blending of the voices of Champions, expressing sentiments barely distinguishable from those of TTC, has a powerful rhetorical effect which strengthens the campaign message. This linguistic and attitudinal merger however renders analysis more complex.

The TTC website is further textured with (website and campaign) 'user' voices, through quotes dispersed among the majority of its texts, which derive from individuals and non-institutional groups who use or are involved with the website. The largest single body of user voices is the 'stories/blogs' which people with experience of mental illness were encouraged to contribute. I define all language which is not 'org' as 'user' content. To fail to identify the non-organisational content would both create a highly misleading representation of the website text, and would deny the voices of other (non-Champion) people experiencing mental illness, whose words appear, by various means, on the website.

It was important to make this distinction in analysis, rather than to treat all language as institutional. Taking into account the two different types of website 'voice' in TTC - organisation-generated (org) and user-generated (user) – enabled me to more accurately understand the respective referents of 'we'. Had I coded 'we' as a single 'voice', I would also have been oblivious to much of the semantic richness of the data. Specifically, through this division of the data I was able to observe and contrast the controlled organisational message with stories which portrayed lives of chaos and deprivation. The 'user' voice belongs to the supposed beneficiaries of the campaign, and it is important to understand and represent them.

6.2.3 ‘We’ in TTC

Fig. 12: Relative proportions of ‘we’ types in ‘organisation-generated’ content (TTC)



I explore below the three types of ‘we’ in the TTC data, starting with the categories allocated to ‘org’ text. I described the coding of ‘we’ in 5.9.1; for example, ‘we’ was coded as exclusive when there was *‘no obvious textual invitation to partake in the reference’* Mulderrig (2012:711). I follow the presentation of categories with critical interpretation concerning the website’s ‘stories’, and use of what I term ‘scripting’, before a briefer analysis of ‘we’ in HT.

6.2.3 (a) We in TTC ‘org’ text

(i) Exclusive ‘we’ (78%)

Exclusive, organisational ‘we’ is significantly used to construct the campaign’s values and identity. The use of ‘we’ in seemingly disparate assertions, statements and claims together characterise the campaign through diverse descriptions of its actions (*‘we support’*, *‘we provide’*, *‘we engaged’*), achievements (*‘we have built’*, *‘we achieved’*), and organisational experience and knowledge (*‘we know’*, *‘we learnt’*). The use of organisational language can be revealing: *‘creative testing took place…to ensure we had an empowering and not alienating*

message'; here the passive *'took place'* suggests an external agency carried out the work, and this is confirmed by broader context.

Construction of identity also takes place through explicit definitions: *'We work <u>alongside</u> those with lived experience to get our messages out there'*. Here 'alongside' distinguishes, and thereby separates, TTC from people with mental illness. Yet elsewhere we are told: *'We do not want to create distinctions between people with and without mental health problems'*. This statement conflicts with TTC's absolute reliance on, and therefore distinction of, people with experience of mental illness, in order to change the behaviour of people who do not.

When Champions describe their activities, their use of exclusive 'we' exemplifies a linguistic convergence with TTC, reflecting a transition in values and identity towards the organisational in-group. The statement, *'what we are here to do is to improve the way the public actually treat those of us affected by any mental health problem,'* simultaneously describes a core campaign objective and distinguishes between those actively creating the improvement, and the public.

Several examples describe the campaign's evaluation results; in the following, the illocutionary force of the exc. 'we' is strengthened by 'our', through which TTC takes ownership of the success, and lists its elements:

Our evaluation results confirm that we have improved young people's attitudes towards mental health problems, reduced mental health discrimination, increased empowerment in young people with lived experience and increased the likelihood young people would talk about mental health.

Yet admissions (TTC, 2016) of the uncertain value of both the website and Pledge illustrate the differences in language used to report success and failure respectively, as I will explore in 7.2.2(v). The following describe lack of 'evidence' or 'understanding', not failure: *'we had <u>limited understanding</u> of the long-term impact of this work* (the Pledge)*'*.

'We have <u>little evidence</u> of the impact of our online activity… on public attitudes …and/or <u>confidence levels</u> of those with experience of mental health problems'. Yet increased *'confidence levels'* were never a campaign objective.

In addition to the repetition and reformulation of key messages, control of activities may be achieved by *'we recommend'* or *'we suggest'*. Together with *'we want'* and *'we believe'*, these are strongly associated with campaign values; the frequencies (as % of whole corpus) of *'we*

know, 'we believe, and 'we want', are provided in the graph below. In each case, the lemma frequency was much higher, but restricting analysis to respective phrase forms ('we know' etc.) allow specific focus on 'org' use.

Fig. 13: Frequency and keyness of 'we want, 'we know', and 'we believe' in TTC and HT [24]

'We know'

'We know' conveys organisational knowledge (and therefore authority), empathy, or both. It is further explored in the discussion of legitimation strategies (7.2), but an example is provided below:

'We know that sometimes people are afraid to talk about mental health because they feel they don't know what to say or how to help'.

[24] When considering the y-axis, it is important to recall the size of the TTC corpus is over 2.2 million words.

Knowledge is also conveyed by other verbs which express experience, observation, or accumulated knowledge:

'We saw a 2.4% improvement in public attitudes at a national level over the first four years of activity'

'We learnt the value and importance of piloting concepts with target audiences'

'We want'

This is the most frequent value-carrying 'we' phrase. Together with '*we believe*', it allows expression of a campaign value without commitment. Most uses express a variety of goals (*we want to draw your attention to…*), and function simultaneously as a soft mode of command:

'We want those organisations to show a commitment to ending stigma…'

'We believe'

Beliefs express a modalized value position without, necessarily, commitment to an action:

'We believe that people with lived experience of mental health problems should lead this change at all levels…'

The following first modalises, then commits, but most tellingly represents website users as 'customers': *'we believe everyone should be able to access our website and we are taking continual steps to improve our service for customers with disabilities'.*

Many statements of belief have the semantic effect of suggesting the belief is novel, cumulatively constructing an impression of virtuous innovation: *'we believe that working collectively and sharing skills can help maximise and sustain the impact of local activity'.* They may also carry the implicit message 'we believe this… and you should too'. Fairclough (1990), observing the frequency of 'belief' in Blair's 'conviction politics', suggested it indicated the use of sincerity as a legitimation strategy, strengthening the illocutionary force of the speech act which it prefaces.

(ii) Inclusive we (14%)

Inclusive 'we' often accompanies simple messages; in *'the more we talk about mental health, the more we can break down the taboos',* the reader is included because it is contextually implicit that the reader is asked to talk about mental health. Some coding require explanation

however; in a text describing an activity for Champions to undertake in workplaces, 'we' is inclusive because it includes its workplace audience. The activity text asks, *'How can we reduce stigma about talking about mental health?'* then *'What are the barriers to seeking help?'* This is also one of many instances in which stigma is semantically framed as the barrier to help-seeking, thereby backgrounding difficulties in accessing help.

In some examples, 'we all' is the postmodifying element rendering 'we' inclusive, including the formula *'Anxiety is a normal emotion that we all experience but becomes a mental health problem when someone finds they are feeling this way all or most of the time'*. This occurs (x291) after blogs or other references to anxiety. Other semantic anchors of inclusivity include *'we as'* (*'we as a society'*), *'we join'* (*'we join our voices'*), *'together'*, or *'ourselves'* and '*of us*', which invites identification and shared agency, magnifying an impression of organisational empathy and diminishing the sense of TTC as an authoritarian voice: *'Over half (51%) <u>of us</u> say we do not need to talk to friends 'in real life''*. In *'<u>those of us</u> with mental health problems can feel disempowered and excluded from our society'*, *'those of us'* includes the reader, while typically indicating that the author (i.e. a TTC staff member) has disclosed their own mental illness. More atypical uses of anchoring include 'as a nation'*: 'Our research shows that, <u>as a nation</u>, we find it hard to answer honestly'*. This anchor renders the 'fault' more universal, and prevents the inclusivity from damaging the organisation.

The assumption of a shared goal is common: *'We 're one step closer to ending the shame and isolation felt by people with mental health problems'*. Inclusive 'we' is frequently used when encouraging people to act together: *'We can all make a difference to how people think and act about mental health.'* In describing a negative societal position, the organisation can represent itself as affected by, but remote from, errant public actions: *'We feel afraid either to talk about our own mental health problems (for fear of how people will react), or to talk to someone we know has been affected'*. The semantic creation of distance, a 'safe' inclusivity, can also be achieved by '*we see*' (*'Very often, we see an image of a person holding their head in their hands'*); by observing a behaviour the organisation does not risk participation in it.

(iii) Ambiguous 'we' (8%)

Mulderrig (2012) found ambiguous uses of 'we' revealed instances of strategic vagueness. Modalized examples were seen in this data; *'we shouldn't become complacent'* or *'we need to start talking more openly* (about) *this subject'*. In the TTC data I found ambiguous 'we' was a disingenuous aspect of campaign identity, as I explain below.

The repeated (34x) statement of campaign identity, *'Time to Change is a growing movement of people changing how we all think and act about mental health problems'* uses the contextual anchor *'we all'*, and might therefore be read as inclusive 'we'. However, considering the implicit moralisation (the unwritten 'should'), 'we' is not truly ambiguous here; the organisation itself does not 'need' to change. This ambiguity is not, as in Mulderrig's work (2012), about hedging accountability, but instead concerns subtly moralizing the imperative. By including itself as part of fallible humanity, TTC counters that part of its identity which is necessarily both knowledgeable and authoritative in order to achieve campaign objectives. This is comparable to the times when a show of sympathy or empathy (*'So glad you're feeling better, your story shows we can fight mental illness as a community'*) (amb) provides counterbalance to the numerous times when TTC informs people that they do not offer help. In this way a benevolent identity is preserved.

The frequency of the *'growing movement'* identity statement renders it a slogan, and therefore its lack of grammaticality is puzzling (*'how we all think about'* is grammatical, but *'how we all act about'* is not). The slogan has numerous subtly different and sometimes torturously constructed variations:

> *As a social movement we want to be able tell our supporters, like you, about the amazing difference you're making and how your support is helping to change the way we all think and act about mental health.*

The slogan even prefaces admissions of the institution's inability to provide help, ordering the sentence information so that a 'positive' is given before the bleak reality:

> *Time to Change is focusing on changing how we all think and act about mental health [We're not able to provide individual or emergency support for people in crisis, but there are lots of people who can]*

When discussing various initiatives, such as Hubs[25], the Pledge, or engagement with young people, ambiguous 'we' is used to describe activities in a formulaic manner, either by using the original *'to change the way we think and act about mental health problems'* or variations (*'…mental health locally'*, for Hubs, or *'mental health in the workplace'* for the Pledge). Young people meanwhile are *'<u>inspired</u> to change the way we think and act about mental health problems'*. The determination to make a single ungrammatical slogan fit so many different

[25] Local Champion-led 'partnerships' initially funded by TTC

activities and social groups is bewildering. Inclusive ‘we’ occurs in a further, and similarly inelegant and misleading slogan; *‘we all have mental health, just like we all have physical health’*. Lack of grammaticality can be a pervasive feature of corporate slogans, and questioning why such phrases are spawned leads us to assume they are related to the pursuit of ‘democratising’ language.

Employing campaign staff with experience of mental illness appears rational and constructive, and lends credibility. Yet use of ‘we all’ as a deictic anchoring device primarily relates not to mental illness but rather to a sense of public-ness, superficially conveying friendly inclusivity. But in terms of categorisation of ‘we’, it is ambiguous, because the campaign’s inclusion of ‘itself’ is disingenuous, and ultimately, patronising: *‘As a result of the stigma, we might shy away from supporting a friend, family member or colleague’*.

I therefore maintain that contextual anchors do not, in these cases, render ‘we’ inclusive, and that the referents of ‘we’ are still unclear: certainly they may include the public, but there is no meaningful justification for including the campaign, and in doing so, TTC renders itself less, not more, authentic.

In addition to ambiguous ‘we’, an interesting group involved mid-sentence shifts in ‘we’ type, which create proximity: *‘With your help we surpassed the target achieving an incredible 1,066,506 conversations!...together we really got England talking’*. In the first ‘we’, exclusive meaning is retained by ‘with your help’, but acknowledgement of the contribution is strengthened by the second, inclusive ‘we’ which, aided by ‘together’ creates proximity with helpers. A shift from an abstract statement to inclusive ‘we’ similarly enhances proximity here: *‘The pressure to spend money, socialise and 'have fun' can leave people feeling more isolated than ever, especially if we feel there's no-one to turn to’*.

6.2.3 (b) ‘We’ in TTC ‘user’ text

Fig. 14: Types of ‘we’ in user content in TTC

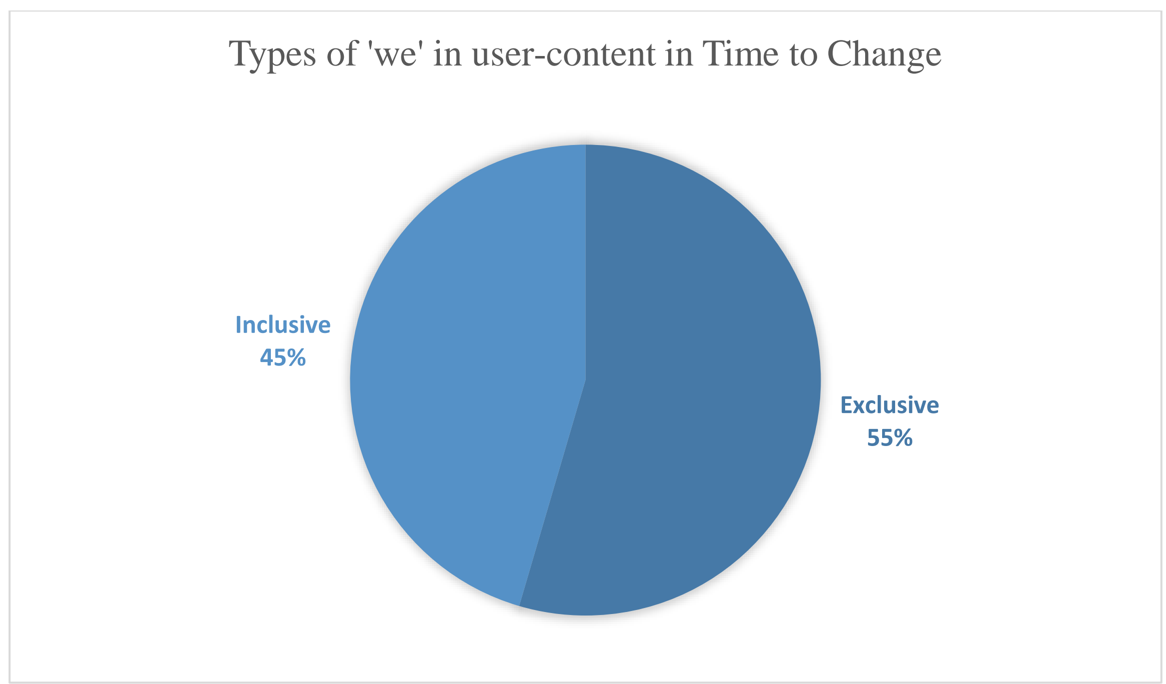


Fig. 14 demonstrates a closer balance between inclusive and exclusive ‘we’ in user, compared to organisational, content, and the notable absence of ambiguous ‘we’.

(i) Exclusive ‘we’ (55%)

Exclusion of the audience in ‘user’ text expresses specific and often personal situations, as a function of the referents’ identity as friends (*‘we spoke every other day…’*) or family members (*‘we’ve had our share of trips to emergency…’*).

In some uses the referent belonged to a specific community, notably patient communities in which referents of ‘we’ shared specific diagnoses: *‘I hope we all can beat this horrible phobia one day’*. Despite containing the contextual anchor ‘we all’, more usually associated with inclusive ‘we’, here the referents of ‘we’ are exclusively people who experience emetophobia. This illustrates how bloggers may perceive a specific, micro audience, and also prompts further discussion of ‘blogs’ (6.2.3 c).

(ii) Inclusive we (45%)

Because users are distinct from the organisation, they speak from a different deictic centre. In user voice, contextually this 'we' type inferred society in general, or people, who through their interest in mental health, could be construed as an authentic audience:

'When we read excerpts on here about people's experiences, we hear how they deal with life and stigma, but very rarely hear what it actually feels like to suffer'.

6.2.2 (c) Critical observations: scripting and blogs

(i) The scripted organisational voice

An unexpected category of texts can be described as scripts or templates. These pre-fabricated messages, designed for use by Champions or other supporters, occurred across multiple areas of the website and fell into two initial categories, based on the interpersonal function they perform:

(a) 'Initiator Scripts' contain templates for Champions to use when making contact and initiating conversations with people (supposedly *without* mental illness) in their workplace or community.

> *"We want to use this as an effective way of breaking down stigma and promoting an inclusive community.' [NB - your own quote can be added here, this quote is just for guidance.]'*

(b) 'Topic Scripts' offer ideas about potential conversation topics for Champions:

> *'…we've given some suggestions of things you might want to think about.'*
>
> *'We've put together some suggested activities to kick-start your thinking…'*

Scripting also includes detailed pro-forma examples of written communications, between Champions and either their 'targets', other volunteers, or TTC itself, for example in applying for event funding:

'We are promoting the event through our local football club… Men are generally less likely to talk about mental health so we think this will make sure lots of people who don't have experience of mental health problems attend'.

This behaviour extends to prepared communications for community settings, especially schools, and between schools, parents, and pupils, as in the example below, which is modalized by 'should' and uses amb. 'we'.

'[Name of spokesperson, position at school] said: (suggested quote) "We are taking part in Time to Talk Day because mental health is a topic that we should all feel able to talk about."'

This scripting, a further opportunity to embed the brand message, illustrates the extent to which TTC pursued standardised use of language, and above also presupposes school staff are unable to compose an appropriate approach to parents. Pro-forma scripting for use between Champions and TTC itself is also an artful means of combining 'education' and control; through repetition of core messages, Champions become more useful and reliable in their unpaid roles.

A further type of scripting, which I term 'Reader' organisational voice, provides 'we' within a question which TTC suggests a website user or Champion may wish to ask. The format of this softer scripting resembles the familiar concept of FAQs, a linguistic phenomenon which organises interaction between text producer and consumer in a highly directed manner, pre-supposing the questions a reader may have and thereby circumscribing the parameters of the consumer's participation in the interaction, effectively limiting their 'voice'. In this context however, the scripting of the reader voice is more dispersed and more detailed, nudging the reader with pre-assumed deliberations. As with the types of scripting described above, provision of complete textual forms contributes to promoting, embedding and retaining campaign modes of thought and behaviour. Furthermore, use of 'we' in questions implies homogeneity, and may engender a sense of belonging, promoting alignment with the institution:

'How do we find the 'right' volunteers?'

'How should we deal with media enquiries about Time to Change?'

As Foucault (1978) observed, the ultimate form of discursive power is to permit or prohibit speech. Through scripting, TTC effectively specifies, and provides the linguistic means of articulating, sanctioned mental health discourse.

(ii) The function of user blogs

TTC urged people to write stories or 'blogs' in order to educate people without mental illness about its lived reality, to showcase its 'normality' through positive accounts of recovery, preferably aided by community-based conversation. The stories constitute a particular representation of user identity, since they were editorially restricted; contributions were not permitted to situate descriptions of mental illness experience within its socio-political reality by discussing its causes, or the lack of treatment.[26] Entries did however include detailed or blunt descriptions of immensely sad or troubled lives, opinion pieces, complex reflections (*'had we been living in 19th century Florence…'*), and occasionally, a writer's disordered perceptions. Some later entries resemble the 'org.' voice, suggestive of progressive levels of mediation, or that campaign ideas became gradually more embedded, or both. Certainly it is the earlier content which is angrier: *'life is shite'*.

The blog texts significantly highlight their multiple functions; as an escape valve, a therapeutic channel, and a 'forum' for mutual support:

'you are never alone on time to change we (inc) *are always open to peoples stories and stigma please keep talking …all my best wishes'.* This compassionate entry is at odds with the 'official' function of these contributions, and also suggests the writer may not understand stigma.

'I'm so grateful for forums such as this, so that we (exc) *can come together and share in our fears and most importantly to remember that we aren't alone'*. Here 'we' are people with Borderline Personality Disorder, BPD.

Bloggers' varying perceptions of the audience determine the referents in their use of 'we'. Contributions often assume, through contextually anchored inclusivity (*'as we are all aware…'*) that the reader also experiences mental illness. Analysis of 'we' here made it apparent that many contributors neither understood nor intended that their 'stories' would help a knowledge-deficient public. Rather, the evolved function of the blogs suggests that people simply appropriated the medium on their own terms, and for their own needs.

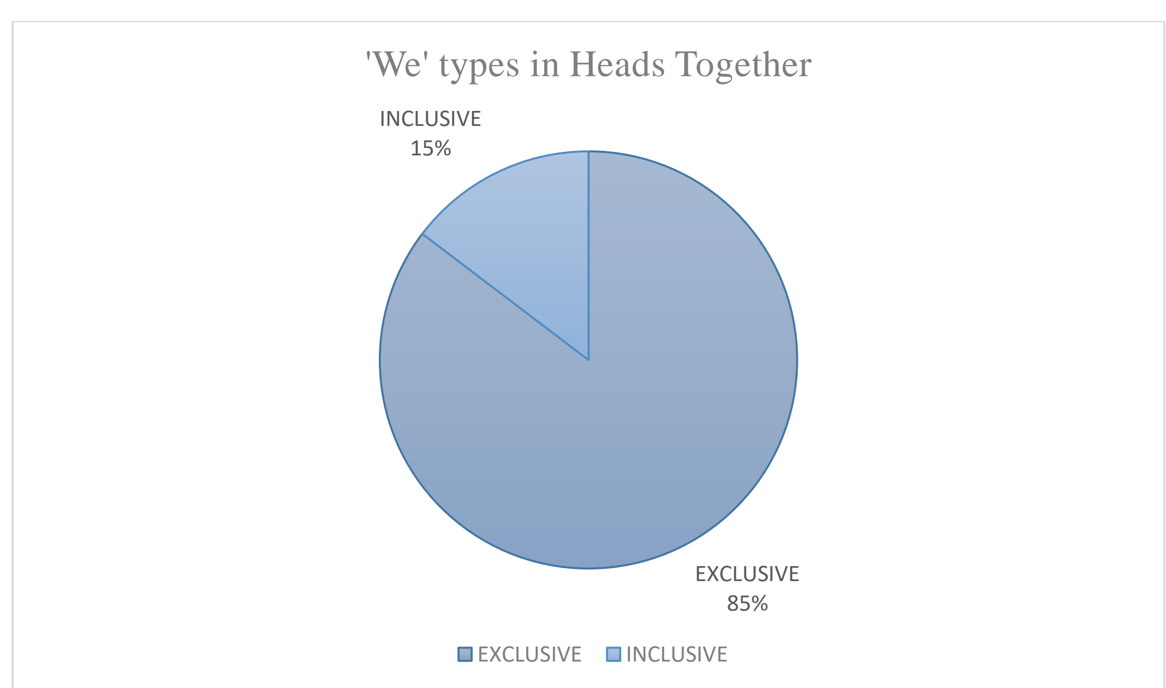
[26] As noted elsewhere, earlier stories were less constrained, but it appears greater restrictions followed commencement of government funding in 2011.

6.2.4 'We' in Heads Together

As Fig. 13 showed, 'we' was slightly more frequent than in TTC (0.62% of the HT corpus, compared to 0.51% in TTC). As with TTC, different 'voices' can be discerned (users, external voices), but are textured and characterised differently, and because the campaign lacks both repeated campaign messages and the 'lived experience leadership' of TTC, the data are not complicated by message repetition or part-repetition by non-institutional actors. Consequently, it was not necessary to divide the data into 'user' or 'org' voice before coding 'we'. In analysis however I still considered extended contexts when necessary, and occasionally distinguish characteristics of 'we' in website users.

When royal speeches are transcribed for the website, the deictic qualities of 'we' become apparent; a 'we' which was inclusive in the context of the original speech (*'We are fortunate to be meeting and celebrating today…'*), in which 'we' referred to 'those of us in the room today', becomes exclusive once removed from its context of delivery. I do not regard such contextual ambiguity as genuinely ambiguous 'we' however; indeed a marked feature of 'we' in HT was the absence of 'amb' types.

Fig. 15: Percentage of 'we' types in HT



(i) Exclusive 'we' (85%)

The formalising influence of royal speeches and statements, and the less systematic inclusion and involvement of site users and adherents contributes to the dominance of exclusive 'we' in HT. Among exc. 'we', 80 uses (10.59% of all HT 'we') concern data use and protection, legal statements such as disclaimers, and even anticipation of complaints. Such elements indicate the organisation's perceived need to protect itself from litigation or reputational damage. Concern for reputation is also implicit in the admonitory statement: *'by volunteering for us, we are counting you as part of the Heads Together team and you will be representing the campaign and everything it stands for'*. HT states that it records personal information from *'any of the other websites we operate or services we provide',* and does so partially to *'measure or understand the effectiveness of advertising we serve to you.'* This echoes the valorisation of business by TTC, and may be related to business 'partners' of HT, such as Virgin. The use of 'we serve' is unpalatable in the context of advertising.

(ii) Inclusive 'we' (15%)

The lower proportion of inclusive 'we' in HT shares some characteristics with usage in TTC, such as co-textual indicators of inclusive 'we' which involve 'we all', 'us' and 'together': '*talking can make us realise we are not alone'*. One example, *'we can all help each other…you don't need any qualifications to help your mate out',* resembles statements in TTC (*'you don't have to be an expert to be in your mate's corner'*), and can be viewed as an example of intertextuality.

Shifts from one type of 'we' to another in the same sentence reflect a shift in responsibility for a problem: *'The conclusion we are coming to, is that the more we all talk about this, the more collectively as a society we can do to support one another'*: after starting with exclusive 'we', the shift to two inclusive uses marked by 'all' and 'as a society' renders 'this' a collective responsibility.

(iii) User referents of 'we' in HT

These included marathon runners, people with mental health problems, and invitees to HT events: *'Then we got down to a sporting challenge joined with Prince Harry, French cricket, I know, what?'*

When 'stories' occur they often relate how life events led to mental health problems; such content links to the Duchess's reference to *'managing the pain at difficult times'*. In terms of

'non-reactive' mental illness, there are accounts of eating disorders, but elsewhere euphemistic statements '(name redacted) *decided we would have a summer of fun to help get me through that 'hiccup',* do little to address stigma.

The breadth of mental illness accounts visible in even the TTC stories/blogs is absent, and while undoubtedly these personal experiences were difficult, and sometimes tragic, there is even less sense of a relationship between these individuals and crushing waiting lists, ingrained poverty, or stigma's multidimensional nature.

(iv) How do institutional uses of 'we' construct campaign values and identity in HT?

In 6.2.3a. I described how construction of identity was an important function of 'we' in TTC, through the expression of knowledge and aims. HT contrasts starkly; as Fig. 13 illustrated, these forms do not perform the same functions as in TTC.

For example, in *'we've put together some simple tips'*, 'tips' are not presented as the product of an informed knowledge base. As shown in Fig. 13, 'know' in HT is proportionally more frequent than in TTC, but the difference in corpus size means we are dealing with a mere eight uses of 'we know', none of which signify organisational knowledge, but highlight the use of the royal principals' personal opinions. Knowledge is therefore not a core part of the campaign identity, yet by virtue of the royal status, having 'seen', requires no substantiation, as in the following two excerpts:

'<u>What we have seen</u> time and time again is that so many of the issues that adolescents and adults are dealing with can be linked to unresolved childhood challenges' (Duke of Cambridge).

This explicit acceptance that people have not received help leaves the reasons for this failure unchallenged.

'Since we launched Heads Together last May, <u>we have seen</u> time and time again that shattering stigma on mental health starts with simple conversations'

Substituting a knowledge base with a combination of status and opinion renders the hub-like structure of HT more comprehensible; the royal identity provides, for some, a basis for authority, while partner organisations responsible for content of 'legacy' activities hold the knowledge. Turning to belief, the excerpt below illustrates how a belief in conversation and talking is familiar from TTC, but is expressed implicitly:

'So the question that William, Harry and I have asked ourselves is how we can get more people to start talking'.

Actual expressions of belief ('we believe'), relate solely to their belief that 2017, the year of HT's launch, would mark a 'tipping point' for mental health.

For the sake of completion, of the 8 uses (0.0064% of this corpus) of 'we want', one strongly resembles the language of TTC, especially in connecting conversation with empowerment to 'get' help: *'We want to be part of the national conversation on mental health; reducing the stigma and empowering people to get the help and support they need'*. Most of the remainder loosely encouraged conversations, contrasting markedly with TTC, which described a range of specific actions it asked of people, in order to facilitate conversations in specific contexts.

However, the Duke of Cambridge not only shares TTC's opinion that stigma prevents help seeking, but regards stigma as synonymous with reluctance to ask for help:

'So, it's time we ended the shame around mental health – the fear of judgment that stops people talking or getting help'.

He later reiterates the importance of seeking help: *'not seeking help at those times …can impact the rest of our lives'*. His further statements promote fundamental misunderstandings, including this memorable assertion: *'unresolved mental health problems lie at the heart of some of our greatest social challenges'*. Such imprecision highlights the lack of campaign expertise, contrasting with TTC's sector-specific curation. Propagation of the notion that mental health problems are responsible for social problems, rather than the converse, is among a number of misleading statements, including the meaningless and ubiquitous sector-wide slogan *'everybody has mental health'*.

A single reference to 'duty' both suggests a motivation for the campaign and also a confirmation of its perception that obtaining 'support' is straightforward: *'William, Harry and I feel it is our duty to do what we can… to shine a spotlight on emotional wellbeing and highlight the support <u>that is out there</u> to prevent or manage the pain at difficult times'*. The absence of a knowledge base in the core HT campaign, rather than in its associated 'charity partners', shows how in a campaign led by people experiencing utmost privilege, genuine good intent may be compromised by ill-informed perspectives.

6.2.4 We: closing discussion

As Figs. 12, 14, and 15 demonstrate, exclusive 'we' dominated both websites. For TTC, this can be construed as an expression of authority, knowledge, and expert status, while for HT, these elements are replaced by social capital, or expert status borrowed from charity partners. Exclusive 'we' statements frequently concern achievements, activities, and work undertaken in TTC, but in HT relate more to aspiration.

I expected inclusive 'we' to be more prevalent in the organisational voice, and attribute its lack of dominance to the fact that to successfully change attitudes and behaviour, authority and knowledge must be presented as central elements of organisational identity. This clashes with the need to constantly include or 'befriend' the audience, but the pre-eminence of authority transcends the efforts to achieve inclusivity. However, ambiguous 'we', in TTC, mimics the proximity created by inclusive 'we', creating a sense of shared community with the audience, while simultaneously contributing to one of its key functions, responsibilising the audience for their mental health, through the modalisation inherent in ambiguous 'we'. Ambiguous 'we' therefore is often suggestive of a conscious determination to write with an apparently inclusive and democratising rhetorical effect.

Genuine inclusive 'we' remained significant however, often demonstrating the assumption that many organisational goals, attitudes and ultimately ideologies are shared by the website user. Fairclough (2003) notes that inclusive 'we' represents attempts to reduce hierarchy and distance, as part of language use which evokes a common experience. These characteristics are especially clear in TTC, in which inclusive 'we' often accompanies hortatory statements. This finding also aligns with the managerialist style identified by Mulderrig (2012) in her work on education, in which inclusion signals compatibility with neoliberal politics.

My choice to work across and between the different 'voices' in TTC both facilitated more nuanced analysis and led me to observe the stark contrast between rigid bureaucratic statements (*'we are not able to offer support'*) and the desperate sadness of a 'blogger': *'we tried so hard to get help for our son'*.

6.3 Analysis of social actor representation

RQ 9: Who did the campaign target, and how were they represented linguistically?

More specifically: ***Who are the people involved by AS in the process of inculcation, and how are they represented?***

6.3.1 Rationale and approach

Understanding the linguistic choices made in the representation of social actors (SAs) may reveal patterns relating to discrimination and power relations, helping to uncover the way a text describes a particular aspect of the social world. Van Leeuwen (2008) defines SAs as the (human) 'participants of social practices', including collective participant groups. His focus of analysis is thus on social, rather than grammatical, participants, and his functional framework offers paradigmatic choices, in which the different options convey different forms of socio-semantic meaning. In 5.9.2 I illustrated this framework, using examples from TTC.

I analyse specifically the way SAs in the campaign audience are represented, rather than organisational actors. The audience is composed of several groups who are vital to the campaign, since they are urged in various ways to operationalise it. From analyses of these groups as SAs, a wealth of information emerges about the campaign; because this analysis reveals how SAs are represented *by* TTC, it tells us how TTC sees these actors.

6.3.2 Who are the social actors (SAs) in TTC?

I trialled two different means of identifying the SAs who constitute the TTC 'audience', before adopting a novel method. I first identified the actors who were most salient in the TTC corpus, and found that semantically vague terms ('people', 'someone') were dominant, children and young people were salient, and older adults were absent. I then identified SAs as the intended recipients of campaign resources; this produced a different range of actors; as recipients of specific TTC documents, the vaguely defined social actors - the referents of 'someone' 'everyone', 'people' – were replaced by an exhaustive list of recipients which was neither feasible nor meaningful to comprehensively analyse. Neither method of identifying SAs represented the groups of interest precisely and concisely. I therefore devised three categories or groups of social actors, each represented by a range of identifying terms. These categories concern the actors:

(i) In whom the campaign is evidently most interested in affecting change: young people, employers and workers (via the Pledge and Workplace Champions), and the core socioeconomic demographic deemed most likely to stigmatise. I refer to this group as **'Targets'**.

(ii). On whom the campaign relies most heavily to do the work of changing attitudes, e.g. Champions. I refer to this group as **'Operators'**.

(iii). Who have current or past experience of mental illness, who may or may not also be Champions. I refer to this group as **'Beneficiaries'**.

The objective of this analysis is to understand how TTC represents each of these three groups and its constituent individuals. I identified terms which were used to describe each group, informed by findings from existing corpus and non-corpus analysis. For example below, to identify and analyse social actors who are the Targets of the campaign, I considered the terms 'public', 'stigmatisers', 'target audience, 'young people', 'colleagues', and 'parents'. In each case I extracted a random sample of 50% of each required word or phrase, to avoid selection bias. I then analysed the way each SA group is represented through the terms which define each group.[27]

6.3.3 Targets

It is important to understand how the target demographic is represented, since through their 'deficient' attitude they may in turn be stigmatised. This group includes the terms 'public', 'stigmatisers', 'target audience', 'young people', 'colleagues', and 'parents'.

(i) Public[28]

Implicitly and explicitly, the public are construed as mentally well: for example, permissible stories were aimed at *'the general public rather than at other people with lived experience'.*

'(Challenging negative stereotypes) *about mental health has proved to be one of the most effective ways to change the way the public thinks and acts about mental health'*. Both quotes demonstrate typical representation of the public; they are Collectivized and Subjected.

[27] Here I use the terms 'targets', 'operators', and 'beneficiaries' with their 'everyday' meanings, not meanings derived from systemic functional linguistics (SFL), which employs similar terms.

[28] (lemma 'public' n = 1,038, 415.46/million tokens, 0.042%).

Primarily through implicature and assumption, the public are represented as ignorant and having the 'wrong' attitude: '(We are here to) *improve the way the public actually treat those of us affected by any mental health problem'*. There is also generalisation; *'the complexity of mental health issues is…not well understood by the broader general public',* and the drive to educate the public is inculcated among volunteers: *'as Champions, our goal is to educate the public on what it feels like to suffer from an illness'.* Yet rare instances of overt Evaluation do not 'unpack' the deficit, merely describing a public *'whose attitudes and behaviours needed to change'.* In stating that media portrayals of mental illness are *'incredibly powerful in educating and influencing the public'*, Evaluation is avoided completely; we are not told that the public are gullible, rather that the media has power.

The public is also construed as hard to access: *'There are many different ways to reach the public* (who) *may not be interested* or may be *reluctant to complete evaluation forms'*. According to a report, one solution would be to *''hijack' the public, for example* (by) *an advertising feature in the Metro'.*

Training instructions for social contact events use marketing lexis, and a power differential is created between volunteers and the public when volunteers are instructed to *'give permission' to the public to ask questions',* and subsequently to shift from conversations to the *'hook'*.

Declared future objectives seek to *'minimise the risk of conflicting messages being delivered to the public'*, who here are Beneficialised.

Although the public are mentioned in statistics, this is not a process of Aggregation, since it is public attitudes which have improved, not the public themselves: *'public attitudes have improved by 9.6%'* (after 10 years of TTC).

To summarise, the public are collectivised, assimilated (usually by subjection), and occasionally beneficialised. They are subject to attitudinal correction by the campaign, with which they may be reluctant to engage. There is a complex power relationship; their lack of understanding construes them as inferior to the campaign and its adherents, and sometimes as the subject of literal pursuit.

(ii) Stigmatisers [29]

TTC defined its key audience as *'subconscious stigmatisers';* people who were unaware that their attitudes and behaviours were harmful. Despite lack of corpus salience (just 3 overt uses

[29] (lemma 'stigmatise', n = 255, 102.06/million tokens, 0.01%)

of ‘stigmatisers’) they are named as the campaign’s key strategic target: *‘There was a clearly defined target audience of 'subconscious stigmatisers' that was the primary audience’.*

In modifying these assimilated ‘stigmatisers’ with ‘subconscious’, the illocutionary force of the evaluative term is weakened, and the criticism veiled. Elsewhere they are positively appraised, as the group *‘whose attitudes and behaviour were most likely to improve’,* or who would be *‘easier to change than active discriminators’.* This is hugely important, as it suggests TTC intentionally avoided targeting ‘active discriminators’ because this would be more challenging.

(iii) ‘Target audience’ [30]

The target audience were typically passivated (subjected), and frequently classified in multiple ways; *‘in terms of age, socio-economic group, experience of mental health problems and attitudes’.* *‘Target audience’* is sometimes synonymous with ‘public’, and shares characteristics in terms of representation; volunteers are instructed that when *‘deciding on a target audience… you'll need to reach out to the public, not people who are already sympathetic to your aims’*; the public is implicitly, by comparison to a suppressed actor group, evaluated as unsympathetic.

Although the *target audience* is always assimilated as a group, TTC claims it *‘wasn't a homogeneous mass’.* Yet, in common with people with mental health problems, who TTC homogenises by avoiding diagnostic definitions, the target audience is homogenised when functionally reduced to ‘the public’. Evaluation occurred not through evaluative adjectives, but through implicature, or misleading sentence structure: *‘The primary target audience for the campaign is people without mental health problems, whose attitudes we aim to change’.*

(iv) Colleagues [31]

Colleagues are usually beneficialised, in phrases such as *‘share…your thoughts about it with a colleague’.* They are implicitly appraised as lacking knowledge or understanding, by suggestions that Champions should *‘get colleagues thinking’* about workplace mental health, or provide them with resources *‘if they're worried about their mental health’.* The latter suggests a possible latent function of Champions; as a community based low-level mental health intervention. Workplace Champions’ official role was to reduce stigma by talking to people without mental illness, yet since TTC equipped Champions to signpost colleagues to

[30] (phrase ‘target audience’ 61, 24.42/ million tokens 0.0024%).
[31] (lemma ‘colleague’ n = 782, 313/million tokens, 0.031%).

'support organisations', and to have supportive conversations involving disclosure, the role boundary is imprecise.

Use of the term 'colleague' is unexpected in the context of 'working class' socioeconomic groups, and could be seen as a form of strategic appraisal, implicitly flattering workers by elevating them. Use of 'co-worker' would have been a classless alternative, without aspirational white-collar connotations.

(v) Young people [32]

'*Young people*' collocates with *'children and'* in 12.5% of uses, so by analysing the former, there is some functional inclusion of children. Young people are below abbreviated as YP.

YP are inherently classified (by specific age, 11-18), and typically subjected or beneficialised, as TTC actors *'work with'* them, or *'work to'* achieve something which relates to them:

'You can send this open letter to parents along with a description of the work you are doing with young people' [to teachers]

'The Children and Young People's Team works to improve the knowledge, attitudes and behaviour of young people around mental health'.

The now familiar presupposition of inadequate knowledge, attitudes and behaviour, constitutes implicit evaluation. The underlined *'around mental health'* does not commit TTC to a specific action or achievement.

The tendency to foreground the achievements of TTC, acting on behalf of YP, is exemplified below:

'we've been piloting a campaign for children and young people in the West Midlands'.

The most prevalent type of representation is passivation, often in combination with another element (here, Categorisation, in its most frequent form for this group): *'The following blog posts are written by young people with personal experience of mental health problems'.*

YP are not always targeted directly; rather, those who can influence them are tasked with affecting attitudinal and behavioural change: [33]

[32] (phrase n =1,357 543.15/million tokens, 0.054%).
[33] The use of young people resonates with Mulderrig's findings (2008) that children were recruited as agents of behaviour change in the C4L campaign (4.2.1).

'With one in ten young people experiencing a mental health problem before the age of 16, mental health problems are likely to affect your child'; the underlined text personalises the mental illness, while the switch from 'young person' to 'child' heightens and renders emotive the implication that the parent has a protective duty. YP are elsewhere implicitly problematised, since accessing them is characterised as challenging: *'Evidence showed that to successfully engage with young people, we needed to use channels beyond schools and parents'*. The actor/s responsible for producing the evidence meanwhile are suppressed.

Despite the strong focus on working with YP and the status afforded to evidence, TTC does not provide evidence of their problematicity; rather, the focus on YP is justified by the fact that they *'respond particularly well'*. This fits with increasing evidence for a 'path of least resistance' campaign model, in which stigmatisers most likely to change, and types of mental illness least likely to provoke stigma, are the campaign's primary focus:

'When running a campaign it's helpful to keep repeating several key messages. We've found, through our research, that young people respond particularly well to these messages.'

Inevitably these targets are assimilated by collectivisation as a group, by the mass noun phrase which describes them. They are commonly passivated, often by beneficialisation. Even when nominated, it is most often with a group name (Young Champions) which simultaneously categorises them; they are functionalised by their social role within the campaign. There are, rarely, examples of individualisation: '(name redacted)*, young champion at Young Minds, who kindly agreed to chat to us'*. Here the nomination and association with a specific institution lends credibility to their opinions, and the actor's behaviour is evaluated by the adverbial *'kindly'*.

(vi) Parents [34]

Approximately 50% of references to parents are found in user content, including comments from what I term 'model users': *'I have often thought that parents could benefit from some kind of training that teaches us about things like your tips and how to implement them in our homes and families'*. Fortunately TTC offers just such tips and instructions.

As social actors, parents were typically passivated and collectivised, but also partially problematised; they *'could be difficult to reach'*. Overcoming these difficulties was important, as TTC perceived parents as *'one of the key groups that need to be targeted'* because of their

[34] (lemma 'parent' n. = 949, 391.45/million tokens, 0.039%).

'important and lasting influence' on their children. Having been targeted, YP and parents then *'co-deliver this education work'*.

6.3.4 Operators

This group of SAs, who 'operate' the campaign's activities, is composed of three sub-groups; Champions, employers, and employees.

(i) Champions (workplace, community and Young Champions)[35]

Champions are construed as having *lived experience* of mental health problems, including experience as carers. They (actively) *'campaign to end mental health discrimination in their communities',* and as such, they are classified, by their experience and their actions.

Champions are represented collectively/generically, and identified primarily in terms of the social function they perform for the campaign (they are functionalised). This genericization has the stylistic effect of, relatively, backgrounding them. However, because the collective representation of Champions and their actions entails forms of positive evaluation, they are counteractively afforded a degree of power: *'effective engagement of Champions and their joint ownership of the local Hubs activity is …seen as vital to both the success and credibility of local Hub partnerships'*. Here it is not the Champions who are passivated, but the actor who regards them as vital.

Activation appends to a range of possibly appealing power or status associations; *'Champions can bid for funding to run stigma busting events and activities'*. Here, 'bidding' and 'running' at least imply autonomy. Compared to other social actors, the normality of activation is refreshing: *'The small team of Champions…now plan to organise more events'*.

Rarely, in addition to being activated, they are individualised, and functionalised as *'individual campaigners'*. Individualisation occasionally extends to nomination, usually by foregrounding the Champion identity and adding a first name; *'Champion Adam'* (who merits nomination by encouraging others to get involved with *'this growing movement'*). Such usage inevitably recalls the monastic 'Brother Adam' or political 'Comrade Adam'.

[35] (Champions n=714, 285.78/ million tokens, 0.029%).

TTC describes Champions as people who are *'passionate'* (about affecting people's understanding) and give *'time and resources to undertake meaningful activities'* (which change the way people think). Here then, Champions are positively appraised in the performance of their 'meaningful' activities. Positive appraisal is a consistent pattern: '*We are privileged to have…young champions…who have kindly agreed to chat to us at today's event'*. Valorisation and respect, conferred through the adverbial 'kindly', as seen with YP, is repeated. However, the lexical choice 'chat' lowers the Champions' status; a higher status guest might 'speak with' or 'address'.

(ii) Employer/s [36]

'Employer' collocated most strongly with 'Pledge' (30.65% of collocates). Before employers have signed the Pledge, they are typically collectivised. Once they have signed however, they become individualised; they are nominated, and often positively appraised.

Lexis relating to commitment is salient: *'new employers commit to open up the conversation about mental health …'* and '(The Pledge) *signals your commitment to changing how we think and act about mental health in the workplace'*. Employees meanwhile are told their employers have signed the pledge *'to demonstrate their commitment'* to creating workplaces free from stigma.

Yet this process does not involve employers talking to their workers, but workers talking to each other: *'employers tell us that getting their employees to share their personal experiences of mental health problems with one another is an incredibly powerful tool'*. Here, 'getting their' implies reluctance.

While it is the employees who must do the 'work' of conversation, under the auspices of the employers and the workplace Champion intermediary, TTC is construed as the expert actor, who variously directs, assists, and provides resources to employers, who are here Beneficialised: (TTC has been) *'supporting employers'* by helping them develop *'workplace interventions and action plans, and providing resources, training and networking events'*.

(iii) Employees [37]

While *staff* (n.1,061) was over 3x more frequent than *employee*, and it too was randomly sampled, it was rarely informative beyond the expected Beneficialisation. Deixis is an

[36] (lemma 'employer' n = 871 348.62/million tokens, 0.035%).
[37] (lemma 'employee' n = 296, 118.48/million tokens, 0.012%).

important consideration in rendering 'employee' the more interesting; use of 'employee' assumes an employer or managerial perspective. Employees are important in this data because they are the subjects of the Employer Pledge; the organisational commitment is to change *'how employees think and act about mental health',* and to ensure that *'employees facing these problems feel supported'.* This speaks to the emerging dual purpose of TTC; the declared purpose is attitudinal and behavioural change, but a less explicit aim of low level mental health intervention is repeatedly revealed. TTC promotes Employers Masterclasses, which instruct employers on how to *'engage and utilise'* their Employee Champions, who therefore in addition to being subjected are represented as a resource.

The employee is typically passivated (beneficialised): *'We want every employer to open up to mental health problems and make sure that employees feel supported to talk about their experiences'.* Looking beyond passivation and beneficialisation, employees, in common with 'colleagues' and others, are represented as reluctant to engage:

'(TTC will) *work with you to… get your employees talking about mental health'.*

Although employees are Beneficiaries both from surface reading of the campaign message, and in accordance with van Leeuwen's framework, the way they are represented demonstrates that in terms of my SA groupings, they are 'Operators', because they undertake an important role for TTC, assigned to them via the TTC pledge.

6.3.5 Beneficiaries: people who experience 'mental illness' or 'mental health problems'

This third SA group was, as expected, primarily beneficialised. The purported beneficiaries of TTC can often be identified through their association with the phrase *'mental health'* (14,450, 0.58% of corpus) which is typically postmodified by '*issues', 'crisis'*, and most frequently, *'problems'* (22.41% of collocates). The associated actors, *'people with mental health problems'* (n. 713), constitute the semantic median with respect to the way mental illness is talked about in TTC (see 7.1.1). Sampling showed that these actors were represented mainly by institutional voices, and were typically passivated; *'we're one step closer to ending the shame and isolation felt by people with mental health problems'.* In *'we aimed for 100,000 people with mental health problems to have increased ability to address discrimination'*, they are subjected. Sometimes in addition to being beneficialised, we see a repeat of the implicit division between

this social group and the public: *'you'd expect to see…an improvement in the public's attitudes and intended behaviour towards people with mental health problems'*. In a further beneficialisation, TTC *'had a target of supporting 100,000 people with mental health problems to gain confidence to challenge stigma and discrimination'* - a relatively low number of people were to be 'supported' to benefit from an intangible concept. Activation is unusual, and may be complex. For example, in the following statement that (working) people with mental health problems *'with the right support* (can) *perform vital roles in workplaces'*, the group is both activated and subtly negatively appraised as only able to work with the 'right' support. Many instances are reliant on interpretation; *'Negative attitudes stop people with mental health problems getting the help and support they need'*. But who holds the negative attitudes? With the actor absent, this could be construed as a negative appraisal of people with mental health problems, if the negative attitude is implicitly self-stigma.

6.3.6 Social Actors: Discussion

After identifying the SAs in TTC by defining social groups who broadly constitute the campaign's audience in various ways, I used van Leeuwen's framework of social actor representation (2008) as a basis for the exploration of the relationships between these key SAs and TTC. The focus of this analysis was actors, not actions, although because I selected social categories which relate to the *functions* of social actors, the analysis revealed details of the overt and covert reality of the relationships between these groups of social actors and TTC, in a manner which leads to a re-positioning of the identity of Beneficiaries and a significant change to the Operator group.

When we consider the social reality of these groups and of TTC, my conceptualisation of the Target group was the people whose behaviour TTC seeks to change. This category is still valid, but because it includes the public, then the target can be expanded in practical terms to 'English society' irrespective of segmentation by the campaign.

The 'Operators' category, consisting of employees, employers, and Champions, is *mostly* valid; these are the actual, social operators, even if TTC might prefer to frame itself as the primary 'operator', having instituted the arrangements which set in motion the work of these groups.

Yet a significant difference which emerges from analysis is that key social beneficiaries of TTC are businesses, who benefit from a resilient workforce and possibly increased

productivity. Additionally, the government will benefit from reduced spending on mental health, since some primary interventions are undertaken by Champions. Champions may in turn benefit from a therapeutic consequence of their own voluntary work. People with new or 'active' mental illness however may only be grammatical, rather than social beneficiaries, and in general people with mental illness ultimately belong to the Operator group, having received the message that they are responsible for their own mental health.

6.4 Genre

This analysis asks: ***How is the 'anti-stigma' mental health policy solution configured as a social practice?*** This can be seen as a sub-question of ***RQ8: How is the campaign premise conveyed to the public, and what is asked of the public?***

Social practices involve, and are given form by, discourse practices. Genres are one dimension of such discourse practices, and constitute a distinctive manner of interacting through language, contributing to enaction of a specific social practice; in this case 'AS'. Genres contain linguistic features which reflect and illustrate their social purpose(s). In 5.9.3 I described my approach to genre analysis, explaining how I consider the websites' authorship, audience, and communicative purpose in a traditional manner, then consider medium using the notion of the 'hypertextual' dimension (Askehave and Nielsen, 2004) which is especially appropriate for online texts. For each element, I discuss in turn TTC then HT.

6.4.1 Authorship, setting and audience

Staff contributing to TTC content are employed by either Mind or Rethink, but precise attribution is problematic. Some texts, such as 'news' items, include the name of the staff member who posted it; but posting texts online is no guarantee of authorship or indeed of ideological alignment with materials being propagated. Therefore lack of patency characterises authorship of core content. In the case of mental health 'stories', authorship is straightforward, albeit often pseudonymous.

Authorship is even more obscure in HT. As the figureheads do not write content, we must attribute authorship to HT staff working within the Royal Foundation, whose names are not provided. Trustees are identified however, and their backgrounds in marketing, public relations, or finance, suggest possible authorship, given the lack of mental health expertise in

HT. For both campaigns therefore, opaque authorship inevitably raises questions about the ideological origins of content, and the potential for more remote influences on it.

The emphasis TTC places on people with experience of mental illness, both as suppliers of 'stories'/'blogs' and as workplace or community 'Champions', make this group a major target audience. Yet the purported campaign objective, to tackle the stigma of mental illness, means the social group construed as 'stigmatisers', whose attitudes and behaviour the campaign seeks to change, is supposedly the primary target audience. TTC is thus contradictory; a mental health campaign which offers no direct help to people in distress, yet significantly requires their involvement. This divided audience is intrinsically linked to the campaign's complex communicative purpose.

The target audience demographic resides in England (rather than the UK), and the website uses the English language, but TTC promoted awareness of its global reach, specifically its activities in African countries and in India. However, the extent of its global influence appears somewhat tokenistic. Taking Ghana as an example, there is evidence of use of the '1 in 4' trope, and the concept of Champions, but the scale of activities and the audience size is unclear.

The core intended HT audience is broader than for TTC, since Royal Foundation initiatives extend across the United Kingdom, and are not solely for an English audience. For HT it is necessary not to overlook an audience unrelated to mental health; crudely, the steadfast royal 'fanbase'. Apart from royalists, the intended audience is diverse, reflecting the campaign's 'legacy' operations; for Mentally Health Schools, the audience is teachers, for Mental Health at Work, it is business owners and employers. Heads Up is for football fans, the entire armed forces community is also explicitly included, and the text support Service 'Shout', targets young people. The operations associated with HT are therefore associated with a more heterogenous target audience than TTC, although the audience of HT itself is likely to be narrower; this is an important distinction; audiences of the operations *associated* with HT may never visit the HT website.

In common with TTC, HT does not target people with mental health problems in order to offer help, instead 'signposting' them to partner charities. What is less clear in HT is the extent to which people with current mental illness are an intended audience at all. The AS objectives of both campaigns mean there is audience divergence from mental health organisations more helpfully connected to the needs of people with mental illness.

Structure, audience and purpose are thus interconnected. It is a feature of online media that while the intended audience may be highly specific, the identity and location of the actual audience is one of the least controllable aspects.

6.4.2 Communicative purpose

We can expect the communicative purpose of AS texts to be inherently strategic in the service of their objectives. However, as Habermas (1984) emphasises, it is important to distinguish between communicative and strategic actions. As is becoming clear, the strategic nature of these websites was not always overt; in TTC especially, a simulation of communicative interaction conceals more strategic, market-driven motivations. Although both communicative and strategic aspects are visible, because of the dominance of the communicative message, and because the very subject of the campaigns is communication itself (as 'conversations'), the viewing participant is rendered less inclined to recognise the more covert strategic intent.

The declared purpose of TTC included the wish to *'end mental health stigma and discrimination'.* The campaign's most commonly reiterated purpose however was combined with its oft-repeated declared identity: (*'a growing social movement…'*). This reminds us of the need to distinguish between the campaign's communicative purpose in its socially-practiced entirety, and that found in the website texts. The website functioned to drive attitudinal and behavioural change, although the social actions and events which it encouraged were not in themselves texts.

Communicative actions in TTC are seen especially when considering 'stories' or accounts of individual actions; but this is absorbed within an overarching strategic action; communicative features are overtly hortatory, while most factual information, for example about mental health conditions, is situated externally, in Mind and other related organisations, accessed by links.

The dilute declared purpose of HT is *'to help people feel much more comfortable with their everyday mental wellbeing and have the practical tools to support their friends and family'.* It later states that it '*combines a campaign to tackle stigma and <u>change the conversation</u> on mental health'* by raising funds for *'innovative new mental health services'.* Yet neither the nature of the current conversation, nor the way in which it needs changing, are explored. These objectives all differ significantly from its original purpose, to *'eliminate'* or *'end'* stigma. The softening of purpose possible through the dynamic affordances of the internet medium is an

interesting sleight of hand whereby no justification was required to drastically modify a core objective.

Since HT functions as a hub, its key communicative action consists of guiding the audience to the legacy activities, for example Mental Health at Work (MHAW). Examining MHAW, we can see that in common with the TTC Employer Pledge, it seeks to limit the threat posed by mental illness to absenteeism and productivity, and is thereby strategic, despite including superficially communicative action. This hybridity is shared with TTC.

Meanwhile the public relations purpose of the site is wholly strategic: HT promotes an image of its royal principals as caring, empathetic, and 'of the people'. Despite stylistic constraints such as the formal use of royal honorifics, the campaign provides an opportunity to parade their humanity, virtue, and even to construct public sympathy through vague disclosure of their own experiences.

6.4.3 Form and medium

Setting, considered earlier in terms of audience, is significantly related to form and medium. In both campaigns, although the core form is (primarily mediated) online media, the enacted campaigns extend beyond the digital, including printed and written texts, especially in TTC, in which provision and promotion of abundant PDF files is a prominent feature. Secondary modalities are also present, especially photographs and videos, the latter either embedded within the websites or available via YouTube.

The online medium is significant because TTC's construal of its discourse community as *'a growing social movement'* explicitly links language to actions. But as Bhatia (1997) notes, although the concept of a discourse community who share genre knowledge creates conditions of homogeneity between the insiders, it simultaneously increases social distance between such a community and those outside it. A consequence of the AS website medium is the practical exclusion of participants from some demographics, notably older adults who engage less with online media (ONS 2021).

It is vital to consider the interplay between medium and genre for these campaigns; their web-mediated genres are not simply traditional genres transposed online. Websites and static texts can not be analysed in the same manner; to do so would ignore the links which provide access within, and out of, the complex internal framework. The position and co-text of links may also significantly 'steer' the reader, whose decisions are guided in a manner unique to internet

communications. Only downloadable PDFs are identical in form and purpose to printed documents.

We are almost too accustomed to the affordances of internet use, so examining websites through the lens of Askehave and Nielsen (2004), drawing on perceptions of a then relatively 'new' phenomenon, provides a paradoxically fresh analytical perspective. For these authors, since the web *medium* is integral to web genres, analysis must include web-specific characteristics. Therefore, having first considered an online text as any traditional text, they then view it as a medium which provides access. From this perspective, they focus on two properties of web texts, 'multi-medianess' and hypertext/hyper-reading.

The first of these concepts, 'multi-medianess', equates to the better understood concept of multimodality. The exploitation of a range of semiotic modes online renders the digitally written word 'hyperactive', with its meaning both implicated in, and reiterated by, accompanying multimedia elements. This promotes a reading process which is non-sequential, interrupted both by graphical frame structures and by the users' shifts between and among the media offered. It also gives texts 'rich polysemous potential' whereby the web user actively participates in assigning meaning (Landow, 1997; Bolter, 2001). Although skimming and scanning also happens in non-digital contexts, the connection of web texts by links means information is transmitted in 'sequentialised linearity'. Production and reception thereby become blurred, and the reader becomes a co-creator of content (Landow 1997; Bolter 2001).

In reading mode, users are guided by a general intention to read sequentially, and therefore traditional genre analysis models apply. In 'navigating mode' however, the reader actively constructs their reading path, possibly across several sites, and so it is necessary to consider how the online medium shapes digital genres. Doing so concerns the second concept from Askehave and Nielsen (2004), who add the hypertextual (navigating) mode to traditional analysis, resulting in a 2 dimensional model, which has the advantage of considering both producer and receiver roles, unlike Swales' and Bhatia's sender-oriented models.

6.4.4 Homepages: reading and navigating modes

The 'homepage', often an 'about us' page, was one of the first internet text types to achieve genre status by being conventionalised in form and content (Askehave and Nielsen, 2004). These 'top level' pages constitute definitive texts, which introduce the site through carefully curated content, and provide a 'gateway', offering navigational tools (links) to other pages, and

in TTC and HT, to other sites. Conceptualising a homepage as a 'front door' acknowledges that people may access the site through 'unofficial' entrances, and may partially explain the repetition of key messages in TTC; irrespective of how the audience enters, they are highly likely to encounter key messages.

The combination of promotional material with content information was a blend historically established in pre-internet promotional and news text types, specifically the *exordium* of classical oratory, and the newspaper front page. Now websites achieve these functions on their homepages, via multiple semiotic modes. The similarity between TTC and HT homepages and newspaper front pages also extends to elements such as layout and content; both include key words (in the non CL sense), attention-seeking headlines, photos, frames, and positioning of elements according to information value. In the large, arguably multi-genre texts of TTC and HT, analysis of the homepage genre, guided by the above perspective, offers useful micro-level characterisation:

Tables summarising analytical steps for reading and navigating modes respectively are presented below, informed by Askehave and Nielsen (2004)

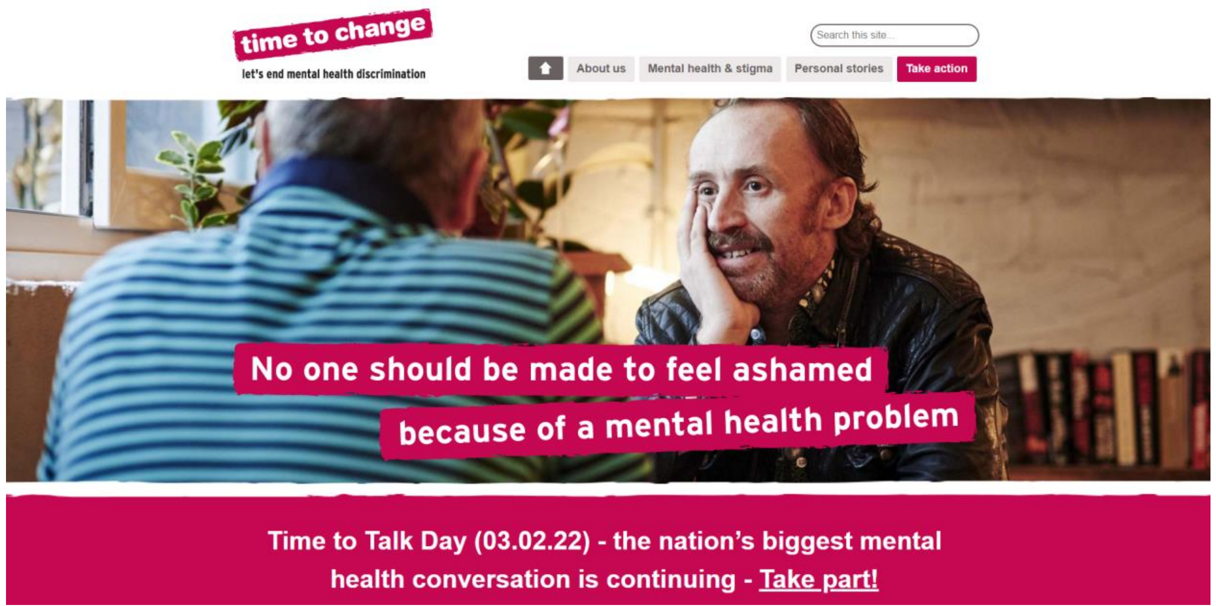
(i) Reading mode

Table 7: Communicative purpose (CP) in reading mode

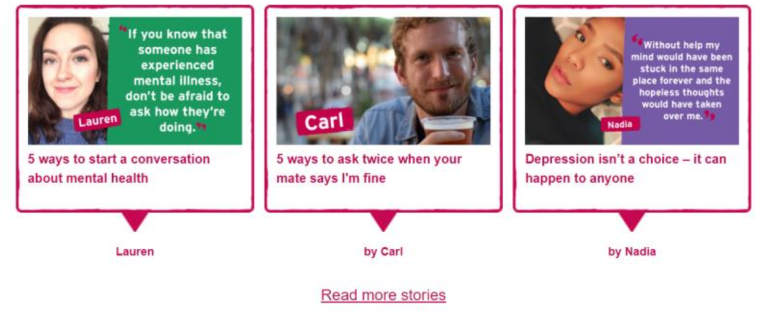
		TTC	*HT*
Primary CP	Introduces the site	✓	✓
Secondary CP	Creates/consolidates sender image.	✓	✓
	Presents news; selected content to 'front page' position, temporarily or permanently.	✓	✓

Typical moves are observed with awareness not only that linearity and sequence may seem suspended, but also that there is blurring between categories. Because both websites are saturated with hyperlinks, reading and navigating modes can also become 'fuzzy', suggesting a need for future modification of this model; websites are not only internally dynamic, but subject to evolving technological change, which, importantly, in turn allows site creators to use websites as vehicles of social change.

Fig 16: TTC home page images showing reading mode moves and rhetorical strategies [38]



Personal stories about why attitudes and behaviours towards mental health problems matter



[38] These images, extracted after the TTC's closure, demonstrate the moves and rhetorical strategies did not change after the campaign closed; all are consistent with analysis in Table 8.

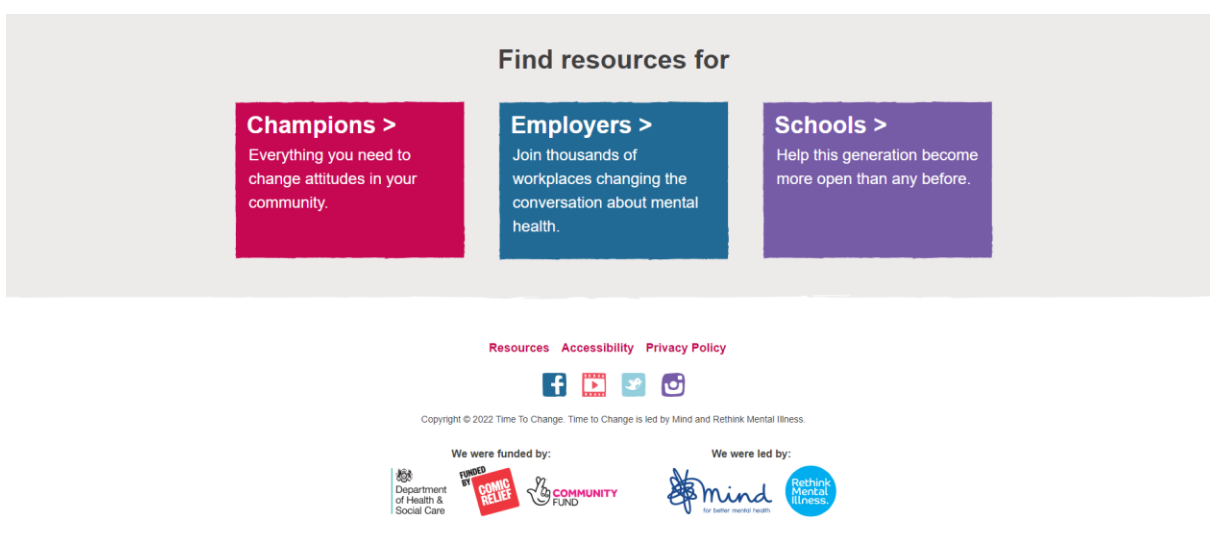
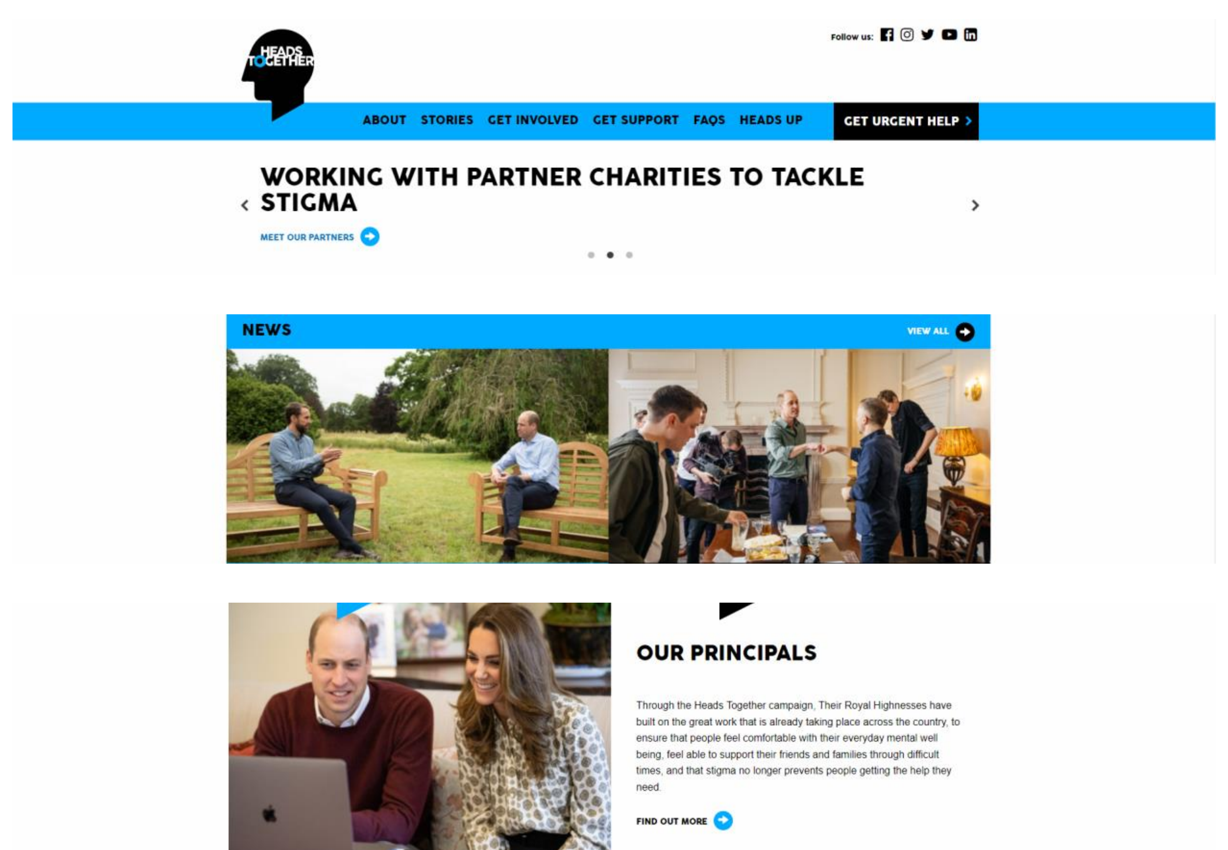
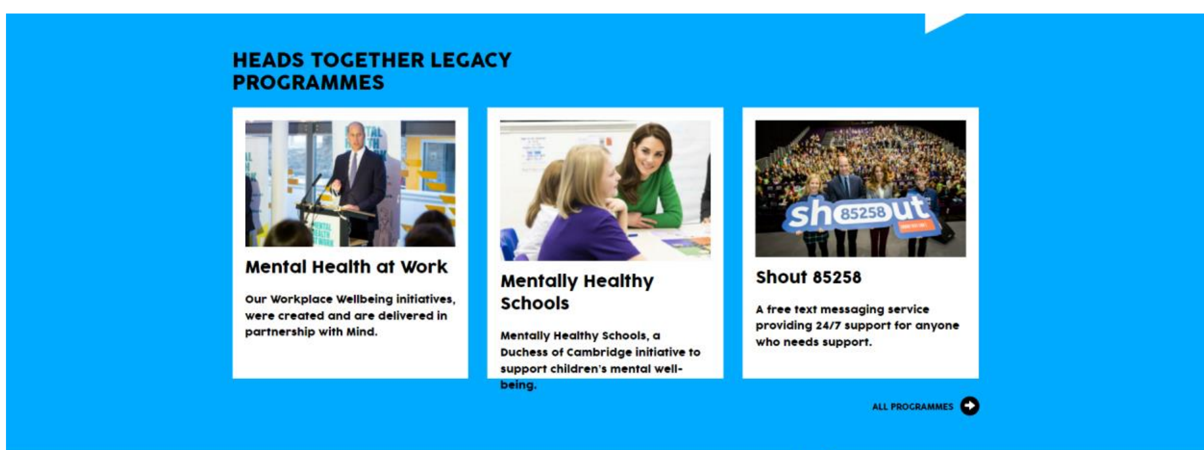
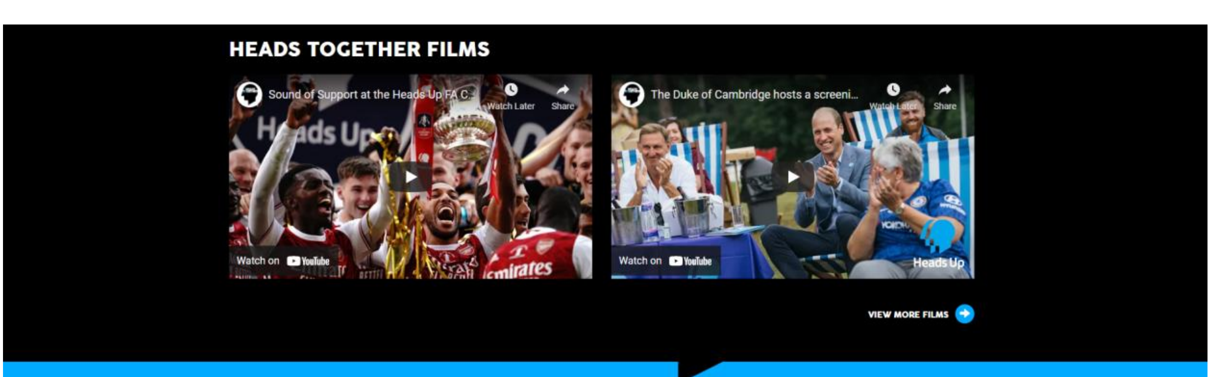


Fig 17: Pastiche of sequential images constituting HT homepage




HEADS TOGETHER LEGACY PROGRAMMES
Mental Health at Work
Our Workplace Wellbeing initiatives, were created and are delivered in partnership with Mind.
Mentally Healthy Schools
Mentally Healthy Schools, a Duchess of Cambridge initiative to support children's mental well-being.
Shout 85258
A free text messaging service providing 24/7 support for anyone who needs support.
ALL PROGRAMMES

JOIN THE CONVERSATION #HEADSTOGETHER
Prince William joins Gareth Southgate in Heads Up's Sound of Support series
The Duke of Cambridge joins a special episode of That Peter Crouch Podcast
The football family unites to sign 'Mentally Healthy Football' declaration
The Duchess of Cambridge hosts assembly on the importance of kindness


HEADS TOGETHER FILMS
Sound of Support at the Heads Up FA C...
The Duke of Cambridge hosts a screeni...
VIEW MORE FILMS

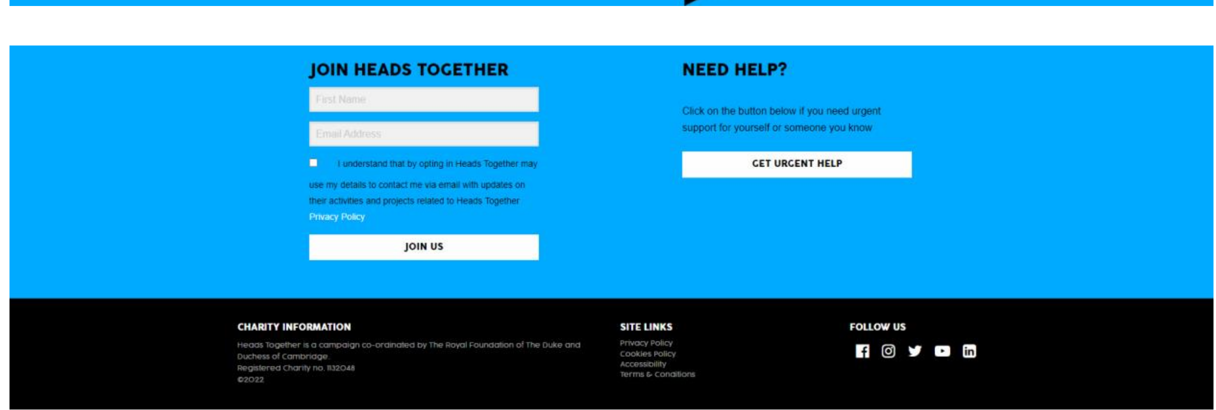

JOIN HEADS TOGETHER
First Name
Email Address
I understand that by opting in Heads Together may use my details to contact me via email with updates on their activities and projects related to Heads Together
Privacy Policy
JOIN US
NEED HELP?
Click on the button below if you need urgent support for yourself or someone you know
GET URGENT HELP
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Table 8: Moves and rhetorical strategies in reading mode

Moves	*TTC*	*HT*	*Comments*
Attracting attention.	✓	✓	
Greeting ('front door' metaphor).	-	-	'Welcome to' etc absent in both.
Identifying 'sender' to orient user	✓	✓	Logos (Integral to organisational image creation strategy).
Indicating content structure: ('main menu').	✓	✓	TTC: includes in-site search feature HT more explicit
Detailing (selected) content. This move also realises the news presenting and image creating function. Self-promotion, information, results.	✓	✓	In HT, balance between self-promotion and campaign relevance is lost.
Establishing credentials/creating a trustworthy image.	✓	✓	TTC achieves through range of logos, HT through trust in royals.
Establishing (means of) contact.	✓	✓	Contact form for HT, but not on this page for TTC,
Establishing a (discourse) community	✓	✓	Loyal/frequent users nudged to establish in-site communities. No login at this point.
Promoting external organisation/s	✓	✓	Occurs more explicitly on linked pages.
Rhetorical strategies			
1. Attracting attention	✓	✓	
Verbally: slogans, lexical items.	✓	✓	HT achieves through news vocabulary.
Visually/audiovisually. Use of colour, text typography and size, highlighting, frames.	✓	✓	Only HT uses video on this page.
2. Establishing credentials.	✓	✓	
Logos, photos, adoption of broader convention of organisational identity.	✓	✓	

The degree to which both websites align with 'standard' homepage features might suggest wider internal homogeneity; however, although Table 8 demonstrates many shared functional and strategic elements, fundamental differences emerge from further analysis using 'navigating mode', which considers the use of links.

(ii) Navigating mode:

Links can be divided into two types; generic links (hereafter and in tables, 'GLs'), which provide a shortcut to a key area, and can be considered empty categories semantically, as they are thematically decontextualised. They may include metadiscoursal text (*'Download the PDF', 'Find out more'*). Specific links ('SLs') are introduced by leads (paratexts), which establish the subject matter and its relevance. They constitute the first, orientational element of a sequence which becomes a narrative chain.

Table 9: TTC navigating mode

Analytical step/Observed feature	*Realised through/example*
Communicative purpose	
Provides access to other areas	Links to: What is Discrimination? Our Campaign's Objectives What we do How we do it Changing attitudes… in the workplace/of children and young people/in communities. Our campaigns Our global work
Move structure	(considering hyperlinks as functional units equivalent to moves)
GLs form top menu: SLs with orientational paratext. Evidence of a link hierarchy. Semantic relationships created: Respective positioning of links: Multimodality	About us, Mental Health and Stigma, Stories, Take Action. Paratext as above. Hierarchy created by selective use of bold and underlined paratext. Relationship between a campaign aim or activity and the actions required of individual site users Either immediately above or below photographs Large colour photos: people in conversation - positive and culturally diverse. Logos: TTC (hierarchically prominent, top left position) Funders: DHSC, Comic Relief, Big Lottery Fund. 'Led by': Mind, Rethink.

	Social media icons and links: Facebook, Instagram, YouTube, Twitter, positioned bottom centre.
Rhetorical strategies	
Explicit (clearly visible) link realisation. Explicit rhetorical strategies: Underlining, colour shift, icons	Entirety of underlined section activates the link. Colour shifts for links, e.g. change of text colour to the brand colour (cerise), and use of cerise text in cream frames. Icons: bullet points and > symbol, representing an arrow/ 'go to' message.

Table 10: HT navigating mode

Analytical step/observed feature	*Realised through/example*
Communicative purpose	
Provides access to all other areas	Whole site accessible, e.g. Legacy programmes: Mental Health at Work Mentally Healthy Schools Shout 85258 (further below, through generic links)
Move Structure	
GLs occur as key menu items SLs with orientational paratext Evidence of a link hierarchy. Semantic relationships created: Respective positioning of links:	Top menu items are generic links with short orientational paratext; *About* *Stories* *Get involved* (with submenus) *Get Support* *FAQ's* *Heads Up* (single link for each) Two 'news' items are presented with SLs which constitute the whole title, e.g. *Prince William joins Gareth Southgate in Heads Up Series.* Links to texts on royalty, 'news' and football are prominent, with capitalised paratext. Primary thematic semantic relationship to football. Dynamic scrolling heading; a single attached link option is visible at any one time. 'Royal-bearing' links are static. On the upper part of the page, only the scrolling banner identifies the nature of the campaign.

Multimodality	Links are adjacent to/above photographs. Of the links to legacy programmes, Mental Health at Work is hierarchically prominent, i.e. on the left. Links to legacy programmes positioned lower down the page, smaller accompanying photographs. Large photographs (royal 'principals') Frames (blocks of blue or black) containing text or photos, form rectangular speech 'bubbles' - a visual metaphor for conversation. HT logo, top right. Social media icons: Facebook, Twitter, Instagram, YouTube, Linked In, positioned both top and bottom right. HT films (football themed), with still images for each and links to YouTube, are embedded in the page.
Rhetorical strategies	
Link realisation is explicit (clearly visible). Explicit rhetorical strategies: Underlining, colour shift, icons etc, meta-text – read more etc.	Use of capitals. Bold type. No apparently strategic use of brand colours (blue and black). Arrows for 'find out more'. Ragged-edged colour frames contribute to 'casual' style.

Links are informative in several ways. In TTC, but less so in HT, the links both provide a practical connection between texts, and build semantic relationships between pages or sections. In TTC, links to information are typically in cerise type, while hortatory links, with paratexts which are commands (*'get involved in your workplace'*) are in black type. Clear relationships are established between (social) problems and actions required of the audience, but there is no equivalent relationship in HT, in which only *Get Involved*, a static, generic, menu bar link, connects semantically with the idea of potential actions. Homepage links in HT create relationships with pages which describe (private, royal) events, football, the legacy programmes, 'charity partners' (who provide expertise) and 'founding partners' (who provide funds), weakening an already imprecise campaign message.

In TTC, contrary to findings by Askehave and Nielsen, many landing page links are SLs, while it is within other sections of the website, once the reader is oriented to them, that GLs, with their metadiscoursal text (*'find out more here'*) are most common. Initial lack of GLs means that the reader has no immediate overview of the website. SLs do create interest however, especially to an impulsive or casual navigator, and their initial prevalence may be an intentional feature. If so, this may be a design feature related to audience; for an expert audience, less

orientation is required, making static GLs appropriate. However, with the TTC audience implicitly and explicitly identified as lacking knowledge, as made manifestly clear in 6.3, an orientation process allows individuals to navigate to a superficially interesting area, from which, if interest is sustained, they may follow GLs to more information-dense materials at various levels, such as reports, training materials, and community resources, which may contain fewer appealing images.

GL's in HT are static, in the sense that they are consistent across pages, remaining accessible as long as the navigator remains within the site; but given HT's hub-like nature, a navigator can easily find themselves 'adrift' in a partner charity's website. GLs are thematically decontextualised, meaning that topic information is not provided beyond a single word or short phrase, even though it is these links which need to create the most meaningful semantic connections between pages.

A non-static banner, which can be scrolled left to right, announces one of three identity statements, each accompanied by a different link:

Fig. 18: HT Homepage banner

CHANGING THE CONVERSATION ON MENTAL HEALTH

WORKING WITH PARTNER CHARITIES TO TACKLE STIGMA

A SERIES OF PROGRAMMES TO SUPPORT CONVERSATIONS ABOUT MENTAL HEALTH

These three descriptions reflect the fractured nature of the campaign identity, while the subsequent links are functional duplicates of those on the top menu. The full duplication of all social media links within the same page aligns with observed use of an online-only community. Such duplication is similar to repetition of linkages throughout TTC.

Below the shifting banner headline/s, prominence is afforded to 'news' items; (*Prince William joins Gareth Southgate…*) and *Our Principals*, all of which also have duplicated GLs with arrows; *'Find out what happened'* or *'Find out more'*, giving two mechanisms to reach the linked page. Content is more semantically sparse but also more richly multimodal than in the TTC page, which does not, for example, offer videos immediately. Despite its 'busy-ness' however, the HT page lacks functional clarity, corresponding with observations of the rest of the site.

6.4.5 Genre: discussion

Fairclough (2003) asks whether a genre is distinct to a particular social practice. Multiple social practices are entailed in both TTC and HT, which are not specific to mental health, but could be considered as situated genres, belonging to the wider, established genre of public health campaigns. This is because the social practices of AS are connected to the broad proposition of a health benefit. A genre which represents anti-stigma may be linked both to related genres but also to other genres in a more closely identifiable 'chain'; in this way, TTC and HT are linked to each other and in turn linked to other public health campaigns. Yet the social practices of AS are arguably more complex and varied than many other public health campaigns, which themselves are more complex than Fairclough's (2003) concept of a 'format'; an emerging genre of expository and instructional websites. However, following Swales' (1990) logic that genres are defined by the purpose of the activity they represent, then since the two websites have multiple purposes, not all of which are explicit, then AS consists of multiple genres. The analysis of homepages, through its emphasis on links, has highlighted the websites' multifunctionality. In combination with the further exploration of the websites' structure and function (see also 5.3), the multi-genre nature of TTC is particularly apparent.

I have demonstrated that there are also multiple ways of achieving the texts' communicative purposes, especially in navigating mode. Although in both websites, communicative purposes are divisible into sub-categories (building organisational credentials, education, recruitment to

a community), in TTC the sub-categories more clearly represent the various strategies which together construct an overarching communicative purpose of attitudinal and behavioural change. These strategies rely on a variety of complementary semiotic modes, utilising the affordances of technological change, especially the normalisation of society's internet and social media use, in order to facilitate social change.

Significant divergence in register can be seen between TTC and HT. While HT is characterised by formality, driven by its royal associations, TTC's (public facing) informality can be viewed through the lens of Misztal's (2000) work on informality, in which 'Informalization' of formal organizations, which results from bureaucratisation (Misztal 2000:88) can be said to facilitate a positive audience perception. Audience perception is threatened at times however. TTC conspicuously signalled the value it attributed to people with mental health problems, and the purported value of supporters was sometimes signalled by semantically warm colloquial statements: *'We 'd love to hear what you're up to'*. Such statements contrast with hard policy language elsewhere on the website, in which the same groups are discussed in an abstract manner in relation to the strategic needs. It is jarring to find the language of social marketing methods dispersed within a public-facing campaign. For example, reference to 'colder audiences', the need to use social media sites to keep supporters *'warm'* between campaign *'bursts'* (of activity), and references to technical aspects of social marketing such as 'mass reach' and 'tiers of activity', could be alienating to website users. The website's structure, with clear paths for an average site user, means that most people will not encounter these materials. It is when viewing the campaign as a corpus however that the coexistence of a discordant variety of registers within the same website becomes strikingly apparent, illustrating a composite genre with the potential to shock or confuse some website users.

HT is less distinct to a specific social practice than TTC, since HT does not define itself as being limited to anti-stigma, and is in turn only one element of the Royal Foundation. TTC in contrast is closely associated with Mind and Rethink, part of a web genre 'familiar' to users, and therefore has socially recognisable purposes by virtue of association with established and credible social structures. For both TTC and HT then, conventionalisation may be exploited to achieve particular intentions (Bhatia 1993:13); the familiar genres of health promotion and charity respectively are employed in the service of a policy objective.

Among the genres in TTC are two which might be termed 'pseudo genres; first, the 'mutated' genre, the 'blogs'/'stories' which became a defacto 'forum'. Second, and quite differently, the

‘social movement’ identity TTC claimed for itself remained a permissible marketing definition because the campaign was a group action to achieve a social goal, but TTC never legitimately belonged to the genre of grassroots social movements.

In TTC the co-existence of corporate disclosure practices, such as reports and evaluation texts, alongside diverse elements from loosely educational genres (toolkits, training modules, information sheets), exemplifies how the genre mix resulted from the appropriation of interdiscursive resources from a variety of professional genres. Individual generic norms are suspended, in an admixture of discourses from commerce, public relations, campaigning and mental health. These genres appear diverse, and in different contexts might function differently, but their specific content, and the manner in which the genres are textured together, mean that they all contribute to the core purpose, behaviour change. Yet ‘behaviour change’ is a broad objective; the campaign is being truthful in stating its intention to change behaviour and attitudes in relation to mental illness; what is made less clear is that only some of this behaviour change relates to stigma. For example, it is reasonable to claim that the end goal of the combined behaviours required of employers, employees, and workplace champions is reduced absenteeism and ‘presenteeism’, and increased productivity.

HT incorporates fewer genres, but includes one which is absent from TTC; fundraising. The discursive practice of fundraising is a further example of the way interdiscursive resources are appropriated across professional cultures, and as Bhatia (2016) has noted, fundraising is significantly informed by marketing practices, even if supposedly philanthropic purposes conflict with the marketing ethos. While philanthropic fundraising entails moral virtue, corporate advertising constitutes a business proposal. In HT these genres are blended, becoming part of shared discursive strategies.

6.5 Chapter Summary

This chapter has explored the way people and organisations are represented and identified, primarily in TTC and secondarily in HT. Analysis of the pronoun ‘we’ was widely instrumental in characterising the campaigns.

The use of my own categories to aid application of van Leeuwen’s framework for the analysis of social actors informed an interpretive discussion of the relationships between social actors and TTC, revealing some differences between overt and covert campaign functions.

With respect to genre, Bhatia (2016:21) suggests there is an inadequate focus on the consequences of the genre-based discursive activities which play a dominant role in the creation of non-discursive organisational activities and practices. Since the discursive hybridity evident in TTC especially is suggestive of the colonisation of the public (mental) health sector by genres which are representative of neoliberal ideologies, the intended outcomes of these genre based activities support neoliberal policy goals, as discussed in the conclusion to this thesis.

In the following chapter, the second which focuses on textual analysis, I first discuss specific aspects of lexical use, and then analyse the strategies of campaign legitimation. Finally I discuss how the data from all core elements of textual analysis contribute to constructing a narrative of AS.

CHAPTER 7: Textual analysis: Lexis, Legitimation, and Narrative

7.0 Introduction

This second chapter of textual analysis of the website data is composed of three sections. I first consider some lexical tendencies and their consequences. Informed both by non-corpora analysis and data from analysis of 'we' and social actor representation, I analyse the lexical terms used to describe mental illness, aided by the corpora. I also consider the strategic use of vague lexis, with a focus on 'support'. Second, I discuss strategies of legitimation, informed by frameworks from Reyes (2011) and van Leeuwen (2008), incorporating and expanding on findings from the analysis of 'we', especially concerning knowledge. Third, I consider how the findings from Chapters 6 and 7 together construct campaign narratives informed by neoliberal principles, introducing ideas to which I return in my concluding chapter.

7.1 Lexis

Fairclough describes his approach to the analysis of texts 'relational' (2003:37), because it concerns the relations between levels of analysis. Analysis of lexical relations is part of considering the 'internal relations' of texts. As described in 2.5.2, analysis of lexis in CDA involves identifying and challenging the hidden meanings, values and beliefs which underpin lexical choices. Because word meaning is relational, investigating a word's collocates – those words which constitute the closest part of its co-textual environment – is a typical approach in CDA, and one through which a word's range of meanings, and its positive or negative semantic properties, may be explored. In this section, I focus on collocation particularly with respect to the phrase 'mental health', and how related patterns of lexical use may influence perceptions, and thereby attitudes. I primarily discuss TTC, but invoke HT where relevant.

7.1.1 Lexis of mental illness

This section primarily asks: ***How do campaigns constitute and define mental illness?*** This is a key sub-question of ***RQ1: What is the language used in anti-stigma policy, as enacted by AS campaigns?***

Since lexis influences perception (Pinker, 2007), perceptions of mental illness are influenced by the terms used to describe it. Therefore, it is necessary to understand the words and phrases used to describe mental illness by campaigns seeking to change behaviour and attitudes towards it. Stigma Shout (Corry, 2008), the pre-operational study used to develop the TTC brand and campaign, found *'mental health problem'* was the most publicly acceptable generic term. TTC adopted this term, along with '*mental illness*' and a limited number of well understood diagnostic terms such as 'depression' and 'bipolar disorder'.

In both corpora I found a nuanced cline of three main terms ('mental illness', 'mental health problems' and 'mental ill-health'), with some further additions. These generic descriptions of mental illness involve gradual semantic dilution. By this I mean that if we regard 'mental illness' as one end of this semantic cline, the meaning is unambiguous, and may even connote a longer term or more serious condition.

The semantic midpoint of the cline can be regarded as 'mental health problem/s', which could problematise the person who experiences the problem/s, and is vague. Because experiences may too easily be rendered pathological, the concept of 'de-medicalisation' has appeal, but can also be used to strategically normalise mental illness; in removing 'illness' from the description, the need for help is also removed. 'Mental health problem' is also a homogenising term, as applicable to mild anxiety as it is to psychopathy. This may be precisely why TTC campaign reports typically use 'mental health problems'. The terms is also used to refer to other Rethink survey work, for example that Rethink's work led to: *'an 8% decrease in agreement that people with mental health problems are often dangerous'* (Pinfold and Borneo, 2007), in which the possibility of association with danger illustrates the term's semantic breadth. In the same research, use of this 'respectful' term was negated by the survey wording, in which options offered on a Likert-like scale include *'The public should be better protected from people with mental health problems'*. This illustrates how, irrespective of the term used to describe mental illness, survey formats may re/activate stigmatising concepts.

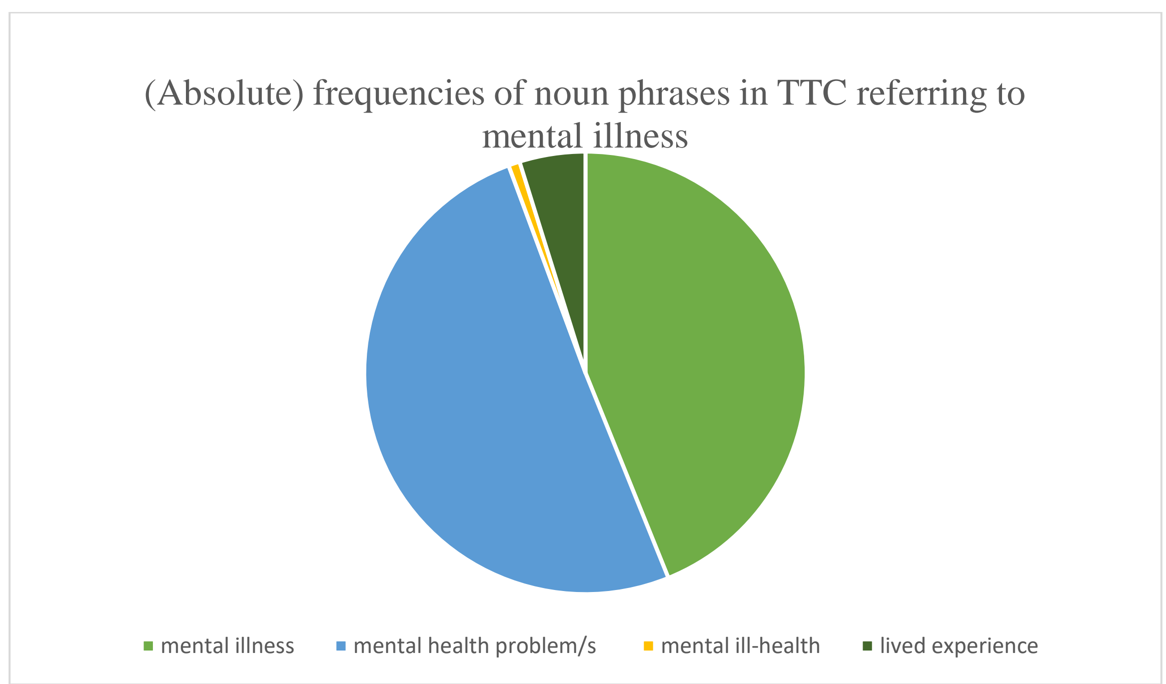
Further down the cline, 'mental ill-health' suggests something less severe; the notion of illness becomes more remote by introducing the word 'health'. A further step along the pathway of semantic dilution, through use of the positive or negative term 'mental wellbeing', mental state is entirely removed from any association with illness. Among descriptions which refer to people having *difficulties* with their 'mental wellbeing' (105 uses, 42.03 per million token, 0.0042% of the corpus), the meaning is vague, and semantically diluted such that it has little meaning and is not included in Figs. 19 and 20. It might signify occasional mild anxiety or needs which require a person to be sectioned under the Mental Health Act (1983 and 2007).[39]

Identifying someone as having 'lived experience of mental illness' meanwhile is often truncated, and attenuated, to 'lived experience', coyly backgrounding what is experienced, even when contextually apparent. The conceptual removal of the substantive experience prevents understanding of mental illness and thereby prevents de-stigmatisation. This 'hovering' term is not part of the cline, but can be appended to any part of it. Similarly unconnected to the cline, 'service user' (43.63 per million tokens, 109 uses in TTC, zero in HT), which prior to austerity appeared prevalent in literature (e.g. Thornicroft 2006) is in contemporary use either delusionary or denialist, in the absence of services to use.

On the following pages, Figs. 19 and 20 demonstrate the frequencies of noun phrases describing mental illness in TTC and HT respectively.

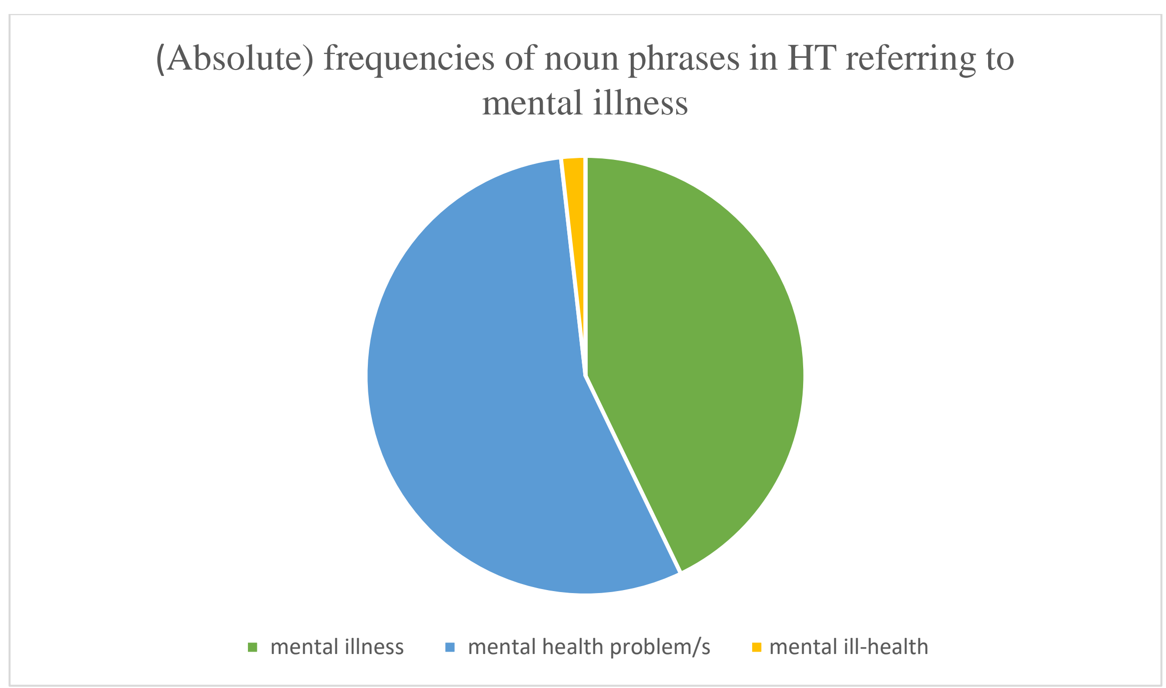
[39] Both superseded the Mental Treatment Act (1930) and the Lunacy Act (1890), demonstrating how lexical trends in legislation too may both reflect and guide standard usage.

Fig.19: Absolute frequencies of noun phrases describing mental illness in TTC[40]



[40] I reduced the area representing 'lived experience' to take into account 25 of the 453 uses (5.51%) which refer to '*Lived experience leadership*' and therefore do not directly describe 'lived experience' as mental illness.

Fig.20: Absolute frequencies of noun phrases describing mental illness in HT



Notably, in HT *'lived experience'* is absent, and the single use of 'mental ill health' originates from *'mental ill-health is estimated to cost UK businesses £35 billion annually'*.

Table 11: Relative salience of 'mental health'

Noun phrase	*Time to Change*	*Heads Together*
mental illness	3897	24
mental health problem/s	4481	41
mental ill health	74	1
lived experience	428*	0
	*after removal of references to 'lived experience leadership'	
mental health	***14,450***	***676***

Table 11 shows the frequencies which created the charts, alongside the absolute frequency of 'mental health', demonstrating that 'mental health' is 3.7x more frequent than 'mental illness' in TTC and over 28x more frequent in HT. As part of this pattern, the adverbial phrase 'mentally ill' has such low frequency (115 in TTC, 46.03 per million tokens, and absent in HT) that any appearance is marked. Within core TTC campaign materials, most examples are from

site users; *'Being mentally ill shouldn't feel like a crime'*, suggesting at least some people prefer a more direct self-identification.

Alternatively, 'mental illness' is simply reframed as 'mental health', whether or not contextually feasible, as in the underlined text: *'someone with lived experience of mental health telling their story is a great way to challenge mental health stigma and end the shame and isolation around mental health'*. I explored 'mental health' further in the TTC corpus, where its frequency (14,450 /0,58% of the corpus) is significant. Of this 14,450, we know from Table 11 that 'mental health problem/s' together account for 4481 (31.01% of the collocates of 'mental health'). I found it is used synonymously with 'mental illness', as in the quoted examples. The plural variant is often used when describing someone with more than one problem, rather than 'mental illnesses'. It is also a generic term for mental illness, applied to large groups, and therefore potentially includes the entire spectrum of possible types of mental illness: *'Time to Change Champions use their experience of mental health problems to change the way people think and act about mental health'*.

To investigate further how 'mental health' is used, I extracted an initial sample of 300 concordance lines, to identify collocates to examine, before obtaining relevant frequencies and uses from the whole corpus. I found that in common with 'problems', 'issues' (802 occurrences, 5% of collocations with 'mental health') is a further means of avoiding 'illness'. Overall, by examining the collocates of 'mental health', I found that at least 36.01% of its uses are synonymous with 'mental illness'.

The two other significant collocates of 'mental health' were, unsurprisingly, 'stigma' with or without 'and discrimination' (543, 3.75% of collates of 'mental health'), and 'discrimination' alone (228, 1.57%). Yet among a range of collocates of less individual statistical significance, it is again used, in various ways, as a substitute for 'mental illness':

'We know talking about mental health is not always easy.'

Both campaigns describe their aim to reduce mental *health* stigma or discrimination. But discrimination against mental *health* is a non-existent problem. The illogicality of this usage is clear:

'It is recognised that someone with lived experience of mental health telling their story is the great way to challenge mental health stigma.'

Some uses of ‘mental health’ are legitimate, for example distinguishing what type of health is meant: *‘It can be really hard to open up about mental health at work’*. Similarly, when people are described as ‘struggling’ with their mental health, or having mental health ‘challenges’, such wording may be euphemistic, but is not inappropriate. However, ‘mental health’ is a phrase which has colonised the surrounding discourse to the extent that it appears to have lost its meaning through mass indiscriminate application. Examining British Web (2007), a major online corpus which I selected for its compilation date, prior to the launch of both websites, ‘mental illness’ occurs 6545 times, (4.23 per million tokens) while ‘mental health’ occurred 61,441 times (39.7 per million tokens). Therefore, even before AS initiatives, ‘mental health’ had already become much more frequent than ‘mental illness’ in online contexts. This lexical reframing therefore differs to Mulderrig’s observation (2017) of the reframing of the term ‘obesity’ by the C4L campaign (4.2.1).

I have suggested that using ‘mental health’ to discuss mental illness is a positive framing mechanism. It is used across multiple organisations, reproduced by site users, and its embedding is facilitated by inclusive and oversimplistic phrases such as *‘we all have mental health’* (used 30x in TTC, and 4x in HT, once by Prince William). These are not high frequencies, but institutional use is influential. The foregrounding of ‘health’ achieved by the simple lexical substitution in place of ‘illness’ has the power to produce an ideational shift which renders real mental illness more remote, and thus ironically more easily stigmatised. The prevalence of ‘mental health’, not only in AS but in wider discourses – such that we in fact describe these as ‘mental health’ discourses – and indeed in legislation, likely originated as a reaction to use of derogatory and discriminatory terms. Recognition of discriminatory impact prompted responses intended to engender respect; use of ‘mental’ as an adjectival slur may have driven well-intended change, but these changes now have utility in policy.

7.1.2 Strategic vagueness: a focus on ‘support’

Mulderrig (2012) described the use of strategic vagueness in the deliberate use of ambiguous forms of ‘we’ in political or policy language. In TTC, when vague language occurs in a context otherwise characterised by precision and quantification, this too can be construed as strategic. I provide an illustrative selection of lexical terms which fall into this category, before examining the lemma ‘support’ in more depth.

'Reach' (frequency 711 in TTC, 284.58/million tokens) is used by TTC in statements and reports which quantify its activities: *'between 2008 and 2010 we held annual Time to Get Moving weeks…reaching 85,405 people over the three years'*. But what constitutes 'reaching'? It might mean targeting, contacting, engaging with, recruiting, attitudinally changing, or a combination of these. When used to report media audience figures; *'The campaign reached over 44 million people through TV, radio, the press, online advertising and PR',* even less can be known of the receivers' perceptions. Using 'reach' enables impressively high figures to be quoted without meaningfully conveying what the figure represents.

In reports of surveys undertaken by TTC, vague descriptive terms contrast with the context of quantification: *'When we asked young people with lived experience whether they felt people were taking mental health problems more seriously, 42% said yes'.* But what does 'taking more seriously' mean? Did survey subjects understand and share a precise meaning? In particular, as a comparative, 'more seriously' than what, or when, is not explained. It becomes almost incidental that the figure achieved, 42% is hardly impressive.

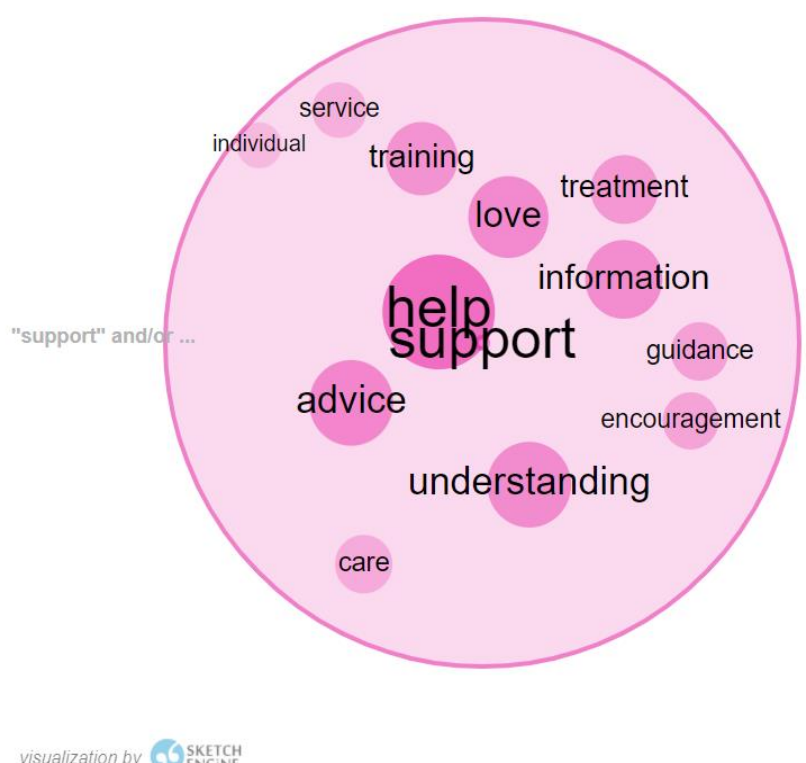
Vague language was also a characteristic of HT. People's episodes of mental illness are referred to as *'crucial times in their lives'*, and parents are urged to encourage teenagers to share their *'worries'*. Elsewhere, in *'we therefore need to look at the prevention of some of these issues, before they take hold and become a problem'*. From context, 'these issues' included poor mental health, but also physical illness, homelessness, addiction, crime, and family conflict. Such lack of specificity represents HT more as a platform for beneficent acknowledgement of social ills than as an anti-stigma campaign.

More significant is the lemma 'support' (5040 in TTC, 2,017.28 per million tokens, 0.2% of the corpus). The meaning of 'support' is not specified: *'When we consider that 75% of all mental health problems are established by the age of 24, it's all the more important that young people feel supported.'* Is 'support' the absence of discrimination, the active involvement of mental health services, or simply having friends? Further, *feeling* supported does not equate to *being* supported. It is however a feeling apparently created by the existence of workplace Champions and Employer Pledges. If a function of TTC is making people feel supported, then when combined with the real-life difficulty in obtaining professional help, 'support' is a mechanism by which the magnitude of problem of mental illness is perceptually diminished. The policy utility of the concept of support is therefore dependent upon its vagueness.

From a sample of 10% of the lemma 'support' in the TTC corpus, a broad range of meanings included financial support both to and by TTC, tips, medical or psychiatric treatment (only in user texts), references to the support available from the Samaritans, family support, and the support offered to Champions and businesses. The latter included *'bespoke support'* available to businesses through 'masterclasses' for intending Pledge signatories. Verb phrases included description of financial support for Champions, and imperatives; *'Support the development of a local Champions Campaign Group'*.

I was more interested in understanding the nature of the support given to people, through the collocates of 'support'. In keeping with the campaign's statements that it did not provide mental health help, the term was not associated with support for individuals with mental illness, except when stating *'we are not able to provide individual advice, help or support'*. Where the collocates of support are *and/or*, the following visualisation 'unpacks' support semantically This visualisation illustrates the textured nature of the corpus and the influence of blogger references to, for example, the *'love and support from my friends'*.

Fig. 21: Visualisation of the collocates of the noun 'support' in TTC



The noun 'support' was synonymous was various forms of information, delivered in person through training, workshops, or documents. This reflects the huge number of resources which TTC contained or was linked to. To capture statements from the campaign, I examined the verb phrase 'we support', and found 75.8% describe the process of education, attitudinal change, and inculcation, while the remaining 24.14% were statements from businesses, website users (*'it's so important we support each other'*), or expressed support for another cause.

In the excerpt below, the context clearly refers to attitudinal change through education, but by emphasising and foregrounding the role of support in doing this, TTC again represents itself as a benevolent identity.

'We support local campaign coordinators and people with lived experience to create training programmes, materials and events (where people tell their stories) to shift attitudes and behaviours within their local communities'

By framing the process as help, via education, the process of 'shifting' attitudes is rendered superficially remote from the principles of 'nudge', the aim of which is to effect behavioural changes in compliance with policy goals. The principles and use of behavioural change through nudge has been described in 4.2.1 through the work of Mulderrig (2018a; 2018b; 2019).

7.2 Legitimation

LQ5: How is the practice of anti-stigma self-evaluated and legitimated as a policy response by its architects (or its enactors)?

7.2.1 Introduction and description of the analytical approach

In discourse, legitimation concerns the ways in which a social behaviour is justified by linguistic means. It is necessary to explore legitimation in the current study because of the extent to which TTC in particular demonstrates its need to justify its existence, funding, or accountability. Legitimation can be observed through a variety of mechanisms and for different audiences. Some examples were introduced in 6.2.3(a), and this section explores legitimation in more depth.

Much of this section concerns TTC, and although the legitimation strategies of HT are discussed where relevant, HT does not publicly practice self-evaluation, or quantify its achievements. Its main form of legitimation is the authority of its principals' royal status and its situation within the Royal Foundation. The two campaigns also have very different relationships with their associated expert bodies. While TTC is governed, and curated, by Mind and Rethink, and has links with academic institutions, HT lacks its own expert knowledge base, instead forging collaborative links with sources of expertise from its array of eight 'charity partners'.

Many of the mechanisms and strategies of legitimation described in the frameworks below were first identified through analysis of political discourse, but with selective application they are readily identifiable with, and transposable to, texts which represent enaction of policy. Reyes (2011:781) presents five types of legitimation strategies used to justify social practices; emotions (especially fear), the concept of a hypothetical future, rationality, expert voices, and altruism. Reye's framework usefully refers to previous work by others, especially van Leeuwen (2008) whose four main categories of legitimation; authorisation, moral evaluation, rationalisation, and mythopoesis, I include in my analysis. I have discussed this framework in 5.9.2, and my particular focus on legitimisation by authorisation/the use of expert voices, and use of research and metrics as forms of argumentation. I give more minor consideration to other categories which are, as van Leeuwen (2008) might say, 'sprinkled' throughout the text.

7.2.2 Analytical categories of legitimation

(i) Legitimation through emotions

Appealing to the emotions of the campaign audience can be seen as an attempt to change their opinions, justifying a call to action. Emotions can condition the audience, preparing them to encounter a proposal for a course of action (van Leeuwen 2008), increasing the likelihood that they will accept the exhortation of the social actor (here, TTC) who activated the emotion.

Key to this is attributing negative qualities (stigmatising attitudes or behaviours) in the construction of a 'them' group (the social group who are stigmatisers), while the campaign and its followers are linguistically constructed as 'us'. Such 'constructive strategies' (van Leeuwen and Wodak (1999:92), noted in 5.9.2, confirm the utility of 'we' analysis to legitimation.

Van Leeuwen (2008:790) highlights fear as especially effective in triggering a response in order to achieve challenging goals, through demonisation of an enemy. The lemma 'fear' occurs 1,297 times (519.13 per million tokens, 0.052% of the corpus) in TTC (*'there are so many people hiding away in fear'*). However 39% of these collocate with 'of', for example '*fear of people's negative reactions'*, or refer to not seeking help *'through fear of shame, rejection and stigma…*'. While neither campaign truly demonises stigmatisers, people who stigmatise are construed, through weaker negative evaluations as, at least, adversaries. Even the term 'stigmatisers' can be deemed a nomination strategy (Wodak, 2001; 2002), defining the 'enemy'.

(ii) Legitimation through a hypothetical future

Van Leeuwen (2008), following Dunmire (2007) suggests presenting an immediate need for action to prevent a future threat can be legitimated using linguistic choices such as conditional sentences; yet in TTC, conditional (modalised) statements are often from users or Champions (*'if we could talk about it without feeling judged or worse…then we could together help people'*). So rather than addressing a future threat, the action proposed simply ameliorates a current state.

However, van Leeuwen's notion of using a timeline, whereby a cause situated in the past is connected to a present during which important actions must be taken, and in turn to a possible future outcome, is more relevant. It exists in the very title of Time to Change, which carries the semantic assumption that the previous state must stop, through current action, to create a better future.

If hypothetical assumptions had been presented as fact or reality, through the absence of modal adjuncts or hedges, the truth claim of messages would be more valid. But this was not seen; while the frequency of 'will' in TTC is high (7389; 2,957.48 per million tokens, 0.3% of the corpus), it does not compare to the combined use of modals such as 'would' (6852; 2,742.54 per million tokens, 0.27%), 'could' (5094; 2,038.9 per million tokens, 0.2%), and most notably 'can' (12,325; 4,933.14 per million tokens, 0.49%); *'can make a huge difference', 'can help'* etc. Statements of fact using 'will' meanwhile concern not a future threat but the prevalence of mental illness; *'1 in 4 of us will fight a mental health problem in any given year/will be affected',* and the efficacy of anti-stigma measures: *'Volunteers who can talk about their MH experiences <u>will</u> be vital'.*

There is no shift to an assertion of fact (claim) that 'we will face more stigma/suffering without TTC', but rather, the certitude that the campaign will have a positive outcome is embedded in the texts. Champions are told the conversations they start *'will change attitudes and behaviour'*, and are therefore instructed to *start talking,* whereupon *'people will not only listen but they will pass it on'*.

(iii) Legitimisation through rationality

Reyes (2011) understands rationalisation as a *modus operandi* which is defined by a particular society. Thus as part of the process of legitimation, it is 'rational' to consult a variety of sources and consider different options. In TTC this is seen in frequent references to the formative Stigma Shout (2008) survey, which sought to shape the way TTC would be enacted. Legitimation through rationality might be articulated by references to 'consultations with…' or through verbs which denote other verbal processes, or mental processes such as 'explore' (Thompson, 2004). Yet although these occur in TTC (*'we sought to explore respondent attitudes to the person returning to work'*), they are not salient. Uses of the lemma 'listen' (924x 369.84/million tokens, 0.037%) meanwhile were typically either imperatives (*'so, if your mate's acting differently, listen, don't judge'*), or were in user voice, rather than institutional *'we listen/ed'*. 'Told' (1562, 625.2 per million tokens, 0.063%) prompts examination of the phrase *'told us'*, which although infrequent (x28), deftly activates and foregrounds the opinions of people with mental illness, using them to legitimate both the existence of TTC and its ongoing actions. This may also suggest an important point of origination for the concept of *'lived experience leadership'*:

> *Time to Change was set up because people with lived experience of mental health problems told us that the effect of stigma and discrimination on a range of life areas was worse than their mental health problem itself.*

However, in foregrounding people with problems who told the campaign something, the means and occasion whereby TTC was told something is obscured. We are not always informed that information was obtained through a survey, or the survey may not be identified. Sometimes it is the research which is given agency: *'the research also told us…'* in which the researcher/s are absent.

(iv) Instrumental rationalisation

Van Leeuwen's 'instrumental rationalisation' (2008) discusses the way that purposes, along with legitimations, are used to explain the reason for a particular social practice. In TTC, in which a key purpose is promotion of contact between mentally ill and mentally well people, semantically strong assertions are common; *'There's a growing body of international evidence that this* (social contact) *is one of the most powerful ways of breaking down the stigma that surrounds mental illness';* there is not one point of evidence but a *'growing body'* of (un-named) sources, and the claim of the utility of social contact is intensified by use of *'most powerful'*. This example also invokes van Leeuwen's notion of the authority of conformity, considered later; if this is the 'international' opinion, then we all should align with it.

Van Leeuwen suggests several types of instrumentality exist, for example goal orientation, realised explicitly by a purpose clause using 'to'. In TTC, with its expressed goal of removing stigma associated with mental illness, purpose clauses include 'in order to' (n=238): *'in order to challenge stigma, social contact conversations must include disclosure of a mental health problem'*. The semantic equivalent, 'so that', was slightly more frequent (n=344); *'so that they don't have to live in shame'*.

Theoretical rationalisation meanwhile (van Leeuwen 2008:116) relates here to the truth propositions about stigma; whether the action proposed is founded on some kind of truth claim. The simple presupposition that mental illness stigma is 'the way things are' is a fundamental aspect of legitimising campaigns which fight against it.

(v) Purpose: signalling success, managing failure

Communicating success in achieving a declared purpose is an important part of legitimation. The ways in which TTC signals its success, and linguistically manages lack of success, relate not only to the value of the campaign's operations but to the legitimacy of its methods. Consistent emphasis on campaign achievements accompanies a culture of detailed reporting. No achievement or activity goes unreported, and opportunities to convey at least the impression of success are embraced. Volume, of people, work, or funding received, is an integral part of this:

'We have over 8,000 Time to Change Champions…'

'We received £16 million from the Big Lottery Fund and £4.5 million from Comic Relief for our first phase of work'

'What we did' is salient too, along with diverse verb phrases which construct a relentless impression of busy-ness. These include 'ran' (*'we also ran the advertorials in Asian specific media'*), 'worked', 'piloted', 'promoted', 'commissioned', 'published', 'monitored', 'set up', 'sought', 'reached', and 'trained'.

In some statements however, verbs are modified, such that claims are weakened: *'we've begun to improve attitudes and behaviour'*, *'we began to see a positive shift in attitudes',* and *'we also helped to empower people with mental health problems'.* This is semantically a transition towards the way that TTC manages declaration of failure. The institutional need to demonstrate success, combined with the obligations of accountability, often conflict. Several strategies can be identified in which the failure to reach a goal is justified linguistically. Such positive framing strategies may be realised by the order in which information is presented, or by abstraction through creation of distance:

(a) Simple positive framing: a small percentage increase is described as important:

'We have seen only a few significant shifts in opinion for the whole data set: 5% increase in reporting of 1 in 4 statistic (which is important as this represents one of the key messages of the campaign featured on all printed materials and the TV ad).'

(b) Order of information, foregrounding success:

'We have seen a bigger reduction in discrimination than an improvement in attitudes'.

The foregrounding still functions even when the concessive 'whilst' is used:

(In young people) *'we have found that whilst awareness of mental health issues is improving, understanding is still poor in the 11-18 age group'.*

In related examples, an achievement is presented, followed by the means by which it was achieved, but the extent of achievement is not specified. Within an institutional text which valorises quantification, absence of quantification becomes marked:

'Since we began in 2007, the success of Time to Change in creating major changes in national attitudes and behaviours ... has been the result of our commitment to our strategy of targeting people through three interrelated activities…'

(c) Abstraction: observing failure from a distance:

This is often associated with *'we learn'*, or *'we found/we have seen'*, the latter allowing the failure to be observed remotely:

'We found… that our messaging around 'talking' did not resonate as well with audiences from Black and Minority Ethnic communities'.

Implicit blame of the BME community removes fault from TTC. A related category entails vague attribution of blame to a target group, from a distance, keeping TTC remote from the failure; below, the age group are framed as creating the problem through their unwillingness

'We learn that (our) *TV advert, whose target age was over 35's did not reach this group well with the message about disclosing mental health problems, as numbers willing to disclose in this age group fell'.*

'our audience did not respond well to the format and fed back that questionnaires were not a cultural norm in the same way as in the western world'.

Above it was *'our audience…'* who failed, by not aligning to Western cultural norms, again distancing TTC from failure. A further strategy is to background a disclosed failure by immediately using the reflective question, *'What do we learn from this information?'* When 'we learn' is a statement however, it is also typically a mechanism of distancing the organisation from the failure, just as *'We also have had some feedback'* suggests 'we hear this from afar'.

(d) Vanishing 'we':

In a report document, the institution as responsible actor may be replaced by the abstract *'the data'* when describing a failure. This demonstrates the value of wider context: *'We list below the key findings…the data shows (sic) that recall of specific mental health problems has not improved'.*

(e) Finally, a failure may simply not be perceived as such: *'We moderate blog and YouTube comments twice a week, removing offensive content and responding to people in crisis'.*

Checking content to identify people in crisis is ostensibly virtuous, but since by definition people in crisis need urgent help, checking twice a week appears negligent.

(vi) Voices of expertise

Authority is commonly used to legitimise actions; authoritative language, associated with credible, expert or high status individuals, is 'more persuasive, more convincing, and more attended to' (Philips, 2004: 475). In TTC, expert voices show website users that the campaign's messages are substantiated by their knowledge. Moreover, the in-campaign institutional speakers are themselves authoritative sources simply by virtue of their organisational position. Below I examine 'expert voices' from two perspectives; authority figures and organisational actors, and second, organisational knowledge, as demonstrated through 'we know' or other expressions of knowledge.

Considering authority figures and organisational actors, key institutional actors, often referred to in the 3rd person through 'news' items, are named and variously identified by role titles or honorifics. This renders them prominent and highly identified, in common with key figures from partner organisations, such as Mind. Such representation both stylistically foregrounds the named individuals as social actors, and confers credibility to their statements and opinions. Typically their names are associated with speech acts (verbal processes) realised through the past tense verbs 'announced', 'said', or of greatest value, 'was quoted'; *'Our Director, Sue Baker, was quoted in several national newspapers…'* Use of individualised senior staff voices lends weight to frequently repeated variants of core messages and embeds the notion of campaign success, for example discussing the *'big shift'* in attitudes and behaviour. Utterances attributed to senior staff are frequently dense in terms of both hortatory 'message' and quantified information: *'When 1 in 4 of us will fight a mental health problem in any given year and suicide is the biggest killer of men aged under the age of 40, it's vital that we come together to end mental health stigma'*.

Turning to consider the demonstration of organisational knowledge through 'we know', the following section builds on themes introduced in 6.2.3, in which 'we know' was seen to convey either knowledge (and therefore authority) and empathy, or both. Some statements are repeated in different forms:

On talking:

'We know talking about mental health is not always easy'.

'We know that sometimes people are afraid to talk about mental health'.

On social contact:

'We know that face-to-face contact with someone who has experienced a mental health problem… is key to transforming our understanding and attitudes'.

'We know that people sharing their experiences of mental health problems is one of the most powerful ways to change attitudes'.

Frequent less explicit statements occur in which knowledge is a prerequisite of the offer or condition: *'we anticipated that', 'we've found that', 'we have a few top tips', 'we have plenty of ideas for actions'.* Tips, ideas, and guidelines link knowledge to 'scripting' (6.2.3.c), and are also related to legitimation by impersonal authority, as discussed in (ix). Above, *'we have'* signals ownership of the knowledge, while demonstrating abundance of resources and expertise. Institutional expertise may also be expressed explicitly: *'we can provide expert spokespeople'*, or *'we also have our own organisational spokespeople to act as experts'* (in which *'act as'* unintentionally infers they are not in fact experts).

Representing campaign staff as expert is part of a pattern of communicating authority, which is also seen in 'we define': *'At Time to Change, <u>we define</u> Social Contact as conversations…between people who have lived experience of mental health problems and those who may not'.* To be able to define, or redefine, social contact assumes both elevated knowledge and social capital. The inherent authority of the campaign's knowledge is also conveyed through references to its current or previous work: *'we have been proud to support campaigns in other countries…by sharing our learning'.* This suggests TTC has superior knowledge, which other countries need. Such a learned state may contrast with website users, who are assumed to have low levels of knowledge: *'We are happy to share the questionnaires with you after we have briefed you on how they can be used.'* This subtle de-legitimisation of others contributes to maintaining power, and can appear patronising, for example when telling users how to have conversations: *'We have lots of advice online… with printable tips cards to keep with you in your purse or wallet'.*

Expert authority within TTC may be referred to vaguely (*'some experts'*), but more often, experts could be termed pseudo-specific, including the *'team of experts at Time to Change'* who, for example, developed the training modules for Champions, or *'are experts in the courses they facilitate'.* Mind and Rethink phoneline staff meanwhile *'have experts on information and support <u>available to you</u>'*, but are not themselves described as experts. It is

emphasised that Champions, and others initiating conversations, are not required to be experts on mental health, even if they are used as such.

(vii) Argumentation: research and metrics

Reyes (2011), framing legitimation as a form of argumentation, recalls the assertion by McCann-Mortimer *et al.* (2004) that scientific evidence (as objective information) can be used to construct truth. In TTC, legitimation through scientific information takes two forms: first, research, undertaken by TTC, King's College London, or the market research sector, and second, use of metrics; the presentation and valorisation of percentages and factual numbers for public consumption, which may or may not have originated from the former research. I consider these two sources of legitimation in turn.

(a) Research

The campaign used positively evaluated references to research to help construct and maintain is authority (*'We know, from our robust research'*). When experts recommend or support a particular course of action, no reasons are necessary, so their input is an especially valuable aspect of argumentation strategies (van Leeuwen 2008). Expertise may be marked explicitly by credentials, or may be taken for granted within the context. The authority of TTC was enhanced and reinforced by external experts; it was 'led by' the frequently named well-established established organisations Mind and Rethink. Professor Sir Graham Thornicroft was highlighted as an individual authority.

References to 'research' in the corpus ranged from the semantically loose; *'I've been doing a lot of reading and research'* to institutional references to research which name, source, and provide a link to a PDF, particularly if the work could be interpreted as demonstrating the campaign's success, such as the Institute of Psychiatry's investigation of 10 year (2003-2013) attitudinal trends before and during TTC (Evans-Lacko *et al.* 2014). TTC cited the term 'step change', the phrase used by Evans Lacko *et al.* (2014: 209), to describe attitudinal improvement in some key areas, which TTC claimed was *'likely to be due to Time to Change'*. Yet TTC did not report that this study found no improvement in intended behaviour, nor that improvements were '*not significant for attitudes related to tolerance and support for community care*' (Evans Lacko *et al*. 2014:209).

I further investigated the lemma ‘research’ (n=592, 236.95 per million tokens, 0.024% of the corpus). Its frequency is not great, but merited exploration of collocates, because a single use of ‘research’ can be associated with a large amount of appended text which uses it as a legitimation strategy. I assumed that *‘our research’* (5.4% of the lemma) would refer to campaign data obtained from surveys carried out in-house: *‘Our research shows that up to 90% people with mental health problems experience some form of stigma…’*

However, examining *‘new research’* (2.5% of the lemma) challenged the notion that TTC undertook its own surveys. Of 15 uses, one referred to research by Ethnos, an international market research company. The remainder initially appeared to describe TTC’s own surveys, with five describing research ‘released by’ TTC, which leads the reader to assume TTC undertook the research. However, wording elsewhere (*‘a survey for’* and *‘commissioned by’* TTC) provides clarity. Highlighting such distinctions may appear pedantic, but cumulatively, such micro-deceptions play a significant role in the way the campaign constructed its image and legitimated its status and message.

The campaign’s commissioned ‘new research’ was announced through press releases, and accordingly the extract below adopts a journalistic style:

‘Ask twice, people urged, as new research shows three quarters of Brits would say they are 'fine' even if struggling with a mental health problem’

The following, from 2018, goes further, creating a tabloid-style headline to attract attention:

‘New research shows Brits happier to discuss sex than mental health at work’

The release announces that a survey for TTC found mental health in the workplace to be the ‘last taboo’, and that of respondents asked to select topics they felt able to discuss with colleagues, 18% said they could talk about sex, but only 13% about mental health. This is suggestive of a survey, or survey question, designed to create media attention.

The identity of some of these research bodies is revealed by the collocate *‘company’*: the ethnographic research agency ESRO undertook research into African and Caribbean men with mental health problems, and the economic research and consulting company Ecorys carried out research to gauge ‘awareness and empathy’ in secondary schools. Other references to research, in a text on media policy, include a range of media analytics companies which analysed TTC’s advertising, and use of the website and the links within it. This speaks both of the technical sophistication of the policy initiative, and the significant cumulative associated costs.

‘Research’ also collocates with ‘market’, identifying other organisations, such as the survey consultants, Censuswide.

The most frequent collocate of ‘research’ which is a nominated institution is the Institute of Psychiatry (IoP), named (66x) using variations of its full title[41] as TTC’s evaluation partner, or as involved in the *‘design of the campaign evaluation’*, perhaps explaining why both the IoP and TTC used the market research group Kantar TNS to obtain and interpret data[42]. A reference to the IoP in the past tense suggested a limited period of involvement: *‘In the first four years the Institute of Psychiatry…was an evaluation partner…’*. Examining the contexts of ‘Institute of Psychiatry’ in the corpus, TTC refers to various positive, or positively framed studies, or elements of studies, undertaken between the launch of TTC and 2012, and published before or during 2013. Professor Thornicroft, a lead figure of the IoP, was simultaneously a strategic advisor to TTC.

The extent of the research involvement of the IoP becomes clear from the pages of its own websites, from which I calculated that over £2.8 million was paid to named IoP researchers to undertake research for, by, or in relation to TTC. The largest single amount, £1,929,010.00 was indeed for Phase 1 of TTC (2007-11), for a project entitled Moving People. However, a study of Phase 3 (2016-2022) was also funded, demonstrating that the IoP’s involvement accompanied the life of the campaign. Professor Thornicroft is not a named author of the Phase 3 study, but was funded by Mind for the ‘BME Public Attitudes Booster’, a survey tool which TTC states that it ‘invested in’.

TTC therefore purchased not only various types of consultancy and studies under the broad umbrella of market research, but also made very significant ‘investments’ in academic research. In the sphere of social marketing, the use of market research techniques to inform and refine campaign methods, or obtain feedback, is entirely expected. However the extent of the funding of academic research, especially within a single ‘stable’ of researchers, is not. It is not possible to know to what extent academic research from a high status institution elevated the campaign’s status and confirmed its utility, both to the public and to its funders. However, significant use was made of primarily positive evaluations, such as the Phase 1 report, to help legitimise the campaign and its work.

[41] The Institute of Psychiatry, Psychology and Neuroscience, King's College London.
[42] Kantar provides ‘evidence and insight’ for public policy for a number of governments including the British Government (kantarpublic.com 2022).

(b) Metrics

Van Dijk (1988:84) describes how the use of numbers, by indicating precision, is a component of a text's authority and credibility. Quantification is a salient feature in TTC, which consistently uses percentages and other figures.

Many aspects of campaign activity were quantified, such as the number of people engaged, reached, or trained. The campaign even found it possible to express level of brand awareness as a percentage. Not only was the amount of media coverage quantified, but texts demonstrate that targets existed for generating such coverage. A picture emerges of ongoing surveys, publicity activity, campaign evaluation, and data creation. Champions were a vital source of data, through both their training and activities.

A typical formula for presenting metrics on the website is as follows: a figure is provided, with a timeframe (*1,861 pieces of media coverage between 1 April 2014 and 31 March 2015*) the percentage increase or decrease (*31% increase… compared to the previous year*) and the relationship between new and previous figures (*…itself a 55% increase of the year before*).

The counting of conversations illustrates the degree to which campaign activities were quantified. Champions were instructed to count their conversations and to report this number to TTC. For Champions' events, the number of conversations held was recorded on tally sheets. TTC stated *'we have found volunteers have around six conversations per hour',* which is suggestive of target-setting. Evaluation of events was justified by the need to *'measure their impact',* to build on successes and *'make improvements for the future'.* Time was invoked elsewhere too, as a unit of measurement of conversation: (on 05.02.15) *'we were aiming to reach 24 hours' worth of conversation. But together we ended up having enough conversations to fill 22 days 1 hour and 5 minutes' worth!'* The content, quality and consequences of the conversations, surely unquantifiable, are ignored.

Metrics are often reduced to formulaic lists of successes; *we did x and x because we know x, we found x and offered tips, we reached x people, we trained x*. The subjects of such lists are primarily Champions, Pledges, and young people. The use of 'reach' is ubiquitous; *'we reached 2.97 million young people'*, but with its definition unclear, as noted earlier, the obsession with metrics obscures underlying meanings or their consequences.

Goals and aims are quantified, e.g. *'to bring about a 5% reduction in discrimination'.* From this tendency we know that the *'ambitious target to have a million conversations about mental*

health' (on the first Time to Talk Day, 06.02.14) is an actual, not a metaphorical goal. Metrics are explicitly valorised and sought, and justified by the need to *'get measurable results so we can learn more about what works to change knowledge, attitudes and behaviour'*.

Quantification is so pervasive that its absence, and replacement with a verb phrase (*'we have reduced'/improved'*) reliably indicates insignificant improvements: *'Our evaluation results confirm that we <u>have improved</u> young people's attitudes towards mental health problems, <u>reduced</u> mental health discrimination, <u>increased</u> empowerment in young people with lived experience and <u>increased</u> the likelihood young people would talk about mental health'*.

Although TTC placed a high value on quantification, it claimed that qualitative insights from focus groups also informed its *'creative approaches'*, and that the campaign was reviewing use of qualitative data collection with audiences *'to capture their experiences and journeys'*. This may reflect recognition that quantified absolutes sit awkwardly in a sphere which ostensibly focuses on experiences and feelings, especially after TTC faced a methodological challenge when use of quantitative evaluative tools was unsuccessful within BME communities, as a result of which, as noted above, it *'invested in a BME booster'*. The function of this survey tool is not explained, but it can be understood from other social scientific work (Jackson 2012), as a type of supplementary focused sampling, specifically designed for BME groups, intended to enhance results.

(viii) Role model authority: celebrities and lived experience

Powerful legitimation is provided when role models adopt or endorse certain types of behaviour or belief. People emulate opinion leaders or role models who either belong to a peer group - 'exemplary noncelebrities' - or are media personalities (van Leeuwen 2008). Both social groups are found in both campaigns, with HT latterly using male footballers. The recognisability of celebrities enables role model authority to be conveyed visually in both campaigns through use of videos, reminding us that legitimation may be multimodal, and that audio-visual semiotic modes maximise the legitimatory potential of role models in both campaigns.

TTC has denied employing celebrities, saying that they 'worked with' several, but had no official celebrity ambassadors. It appears that 'stock' celebrities appear on behalf of multiple mental health organisations. A familiar triad across the sector have been Alastair Campbell,

Stephen Fry (president of Mind since 2011), and Ruby Wax, all of whom have candidly spoken about their experiences of mental illness.

In addition to combining its institutional weight with the voices of subject experts and celebrities, TTC also construes people with experience of mental illness as experts, whose opinions are used to construct validation of TTC through what they 'say':

'People with mental health problems say that *the stigma and discrimination surrounding their mental health problem can be one of the hardest parts of their day to day experience.'*

The unusual absence of quantification and the modalized 'can' contrasts with precise messages elsewhere. Consequently the underlined *'say that'*, although just another variant of the legitimising 'told us', makes the whole sentence feel unreliable. Tusting *et al.* (2002) note that personal experiences can be used to construct a social phenomenon, and thereby to legitimise a cultural generalisation. More specifically, voices which verify experience of a particular truth enable the perpetuation of a social stereotype. Similarly, Hutchby (2001) observes how expressing shared membership with a group participating in an event can be used to legitimise opinions about that event. This is highly pertinent considering the importance to TTC of both events involving, and 'stories' from, people with experience of mental illness. It also fits well with one of van Leeuwen's (2008) legitimation strategies, mythopoesis. Mythopoesis mainly concerns legitimation through a narrative in which an outcome rewards a legitimate action, however van Leeuwen further describes mythopoesis as a legitimation formula in moral tales, whereby someone faces a trauma, successfully negotiates obstacles, overcomes the trauma and experiences some kind of happy ending. These are precisely the type of 'stories' TTC sought; descriptions of experiences of mental illness, often starting from a very negative position, which then relate overcoming mental illness through positive attitudes, and using conversation to break down stigma, leading to a resolution. By prescribing the type of stories which were acceptable to TTC, a truth is constructed in which recovery is an expected outcome, with removal of stigma through social contact integral to the process.

(ix) Impersonal authority

Impersonal authority includes laws, but also extends to guidelines and rules. TTC, and to a lesser extent HT, created numerous 'rules' in the form of 'tips' (x369 in TTC). This

semantically acceptable means of issuing structured guidelines creates a framework through which actions are prescribed.

Van Leeuwen's (2008) conceptualisation of impersonal authority however would not include 'tips'. He regards this kind of legitimation as characterised by nouns such as 'policy' or 'rule', and cognate adjectives ('compulsory' or 'mandatory'). Yet in the context of the campaigns, tips can be regarded as culturally embedded directions rendering acceptable the reasons for doing, or not doing, a certain thing.

(x) Conformity

Conformity bestows authority, such that the message conveyed is, 'everybody else is/most people are doing it, and so should you'. This idea fits van Leeuwen's assertion that the authority of conformity is generally realised by 'high frequency modality'; the use of statements that *the majority*, *many* (are doing this).

The authority of conformity, seen in the way TTC recruits businesses to the Pledge, is strengthened by the valorisation of the status of pledged businesses. During analysis of social actors, 'employer' collocated most strongly with 'Pledge'. In 6.3.4 I noted that pre-Pledge employers are collectivised, but post-Pledge employers become nominated and positively appraised. This appraisal carries with it notions of elevated status, which is then used as a mechanism of persuasion, urging other employers to sign.

Involvement of institutions with existing high status is also highlighted, as in the underlined text below, as TTC boasts of *an England-wide commitment from employers,* including *'corporates'* and government departments. The Pledge is construed as an irresistible force; a movement in which any employer of note will be involved:

'Everyone has a part to play, which is why it is so important that <u>leading employers</u> in the UK follow the <u>Bank of England's</u> example and sign up to the Time to Change pledge…'

(xi) Altruism

Social actors avoid presenting their proposals as driven by personal interests (Reyes, 2011), and in the case of AS, we might extend this avoidance to government or business interests. Rather, the social actors who enact AS are performing a service, legitimising a proposal as a

common good, undertaken to benefit a particular community in need of help. Improving the lives of people experiencing mental illness is a declared campaign objective.

Sharing personal stories online and in conversation is a form of altruistic behaviour required of people with experience of mental illness. Similarly, the collection and processing of data about meetings, from both Champions and attendees, is justified by altruistic means - to '*help inspire others*', and by this means altruism becomes a consistent thread in the public-facing version of the campaign, justifying not only the core purpose, and use of data, but actions required of Champions and bloggers, which are also framed as part of pursuit of a 'greater good', *'to help change public attitudes'*. Framing voluntary activities through altruism is a successful means of obtaining free labour to advance a policy strategy. I noted in 7.2.2 (viii) that TTC construes people with experience of mental illness as a type of valued expert. As if in exchange for this positive recognition however, they are strongly encouraged to supply their expert testimony and work. Altruistic engagement may be 'nudged' by the feeling of being valued, which for some people with mental illness may be a re(new)ed experience. Therefore an emotional transaction may occur, perhaps at a subconscious level for supporters, whereby in exchange for valorisation and status, they give freely of their time and labour. This could be deemed exploitative in view of the social group concerned and their diverse – rather than homogenous – experiences.

7.3 Higher-level narrative: Neoliberalism

This sections starts to draw together responses to ***LQ7: To what extent is the discourse of AS inflected and constrained by discourses which serve neoliberal objectives?***
The emergence of these neoliberal objectives are constituents of the hidden discourse of AS.

Many website users will neither be familiar with the word 'neoliberalism' nor aware of the neoliberal narrative which is demonstrably embedded in AS, particularly in TTC. The social roles constructed by the campaign's communicative exchanges are ultimately market-derived: followers were even on one occasion referred to as 'customers'. Below I consider how a variety of micro-narratives together construct this neoliberal narrative. I first examine the campaign context, and some constraints to its narrative, then consider the drive to evaluate through metrics, the ways businesses benefit from the campaigns, and the ways in which TTC exerted

control, including its use of branding. I then examine some conflicting aspects of the narrative, before briefly comparing the two key campaigns.

7.3.1 Conversations through new technologies

'New capitalism' (i.e. neoliberalism) depends on new technologies, according to Fairclough (2003:77), whose categorisation of communication technologies would define TTC as 1-way mediated communication, because its interactivity is partial and constrained. In noting that social relations can be re-structured though such technologies, Fairclough even specifies that 'conversation' is increasingly shaped by mediated forms of technology (2003:78). Since the very subject matter of both TTC and HT is conversation, one might suggest the technologies were adopted in order to enhance 'the conversation'. Yet this is not a true conversation, but one which is heavily prescribed, and partially proscribed; by effectively censoring voices, only 'conversation' in full alignment with campaign aims was permitted. Concern from TTC that *'as a society we often worry about having that conversation,'* means *'that conversation'* became the primary issue, displacing and backgrounding the reality of the mental illness and the ways in which the state both contributes and responds to it.

7.3.2 Social marketing, funder constraints, and covert agendas

TTC was a social marketing initiative which preferred to identify as a 'social movement'. It was preceded and accompanied by market research outsourced to government-sanctioned agencies, and marketing agencies such as Flotilla, which was employed to *'encourage schools to deliver'* weekly sessions disseminating the campaign message.

Attitudinal shift is certainly at play; the 'Champion' role contributes towards creating a shift away from established reliance on NHS resources and towards self-reliance, thereby reducing the economic functions of the state. This 'shift' is a clear example of nudge, as described by Mulderrig (2018a; 2018b; 2019) (4.2.1). Any market produces something, and in TTC these are behavioural 'products', framed as 'deliverables'. The declared aim of its children and young people's programme is *'<u>delivering</u> discrimination free lives…'*. Similarly, *'resources… will be designed so that frontline youth staff can use them to <u>deliver</u> anti-stigma and discrimination sessions directly'*. The original meaning of 'delivery' is retained, in the sense that the message

is a package, ultimately a product, yet with the term colonised and rendered metaphorical by the commercial realm, its salient meaning is 'producing results', by successfully embedding an ideological message.

Some nudges towards responsibilisation may be small, but have a cumulative effect. For example, TTC stated that, having become such a large movement, it no longer provided volunteers with printed materials to use at events; instead, volunteers had to print their own from the website. This change, framed as a consequence of campaign growth (and therefore, success), fits with the declared aim to become a 'sustainable' campaign; one which continues independently in, and is the responsibility of, 'communities'. The cost to individuals of the printing, and the cost-reduction for TTC, is not mentioned.

On several occasions the campaign admits to functional constraints imposed by its funding sources: *'as we are government funded, we have to route all media buying through the government's media buying agency'.* Such constraints inevitably influence the overall narrative; stories and blogs were a core aspect of content, but their subject matter was restricted; *'we aren't able to publish blogs that are mainly about: Mental health treatment, systems or policy…'.* Dissent or discussion about key aspects of people's experiences was silenced, *'because of the campaign's aims'.* In publishing only blogs *'aimed at changing the way people think and act about mental health'*, and specifically *'aimed at the general public rather than at other people with lived experience',* this use of people with mental illness to change those without it became exploitative, while also ignoring the reality that it was people with mental illness who were more interested in reading them, as noted in 6.2.3 where I describe blogs' evolved, 'reclaimed' function.

TTC repeatedly states that stigma is a serious problem which prevents people from seeking help. The campaign's primary, overt agenda is stigma reduction by attitudinal and behavioural change in people without mental health problems, in order to help people who do have these problems. This narrative value of caring is however a typically neoliberal manner of 'care', in which economic interests are valued most highly, as illustrated by a statement on accountability; *'We are accountable to our funders, volunteers, partners, beneficiaries and ourselves'.* The beneficiaries are not named or described, and receive the penultimate mention, while funders come first. While the declared goals are caring ones, the focus on working or pre-working age people alone allows us to understand the true goals as neoliberal.

A possible second agenda emerges relating to improving the mental health of volunteers (a *defacto* cheap social therapy). TTC's evaluation tools not only measure the impact of social contact on the public, but also on *'volunteers with experience of mental health problems'*. If the volunteer roles have an intentionally therapeutic basis, it is not unreasonable to see the programme as a pilot study for policy shifts towards further responsibilisation. Statements from volunteers, such as *'speaking to the public was very cathartic',* support this proposal.

7.3.3 Quantification and metrics

In 7.2.2.vii. I described how a campaign focus on metrics was balanced by little qualitative reporting. The pursuit of expansion and 'growth', albeit of incremental attitudinal or behavioural change, fits a neoliberal model, which as Monbiot (2016:17) points out *'insists on comparison, evaluation and quantification'*, resulting in a *'stifling regime of assessment and monitoring'*. The TTC statement, *'sometimes there are outcomes that we have agreed to report on, and we need to do this'* falls somewhere between an apology and a justification, but 'sometimes' does not reflect the scale of quantification, which involved all main campaign activities, much in the way neoliberalism commodifies all human behaviour.

This market-derived form of governmentality strongly characterised TTC, and although the HT narrative is not dominated by metrics, quantification sometimes serves to compensate for the campaign's muddled conflation of mental health, mental illness and stigma. For example, the volume of online content for Mentally Healthy Schools (*'600 school assembly plans'*) is telegraphed, but a consistent ideational position which might contribute to concrete social action is absent. In 7.2.2 vii, I described how TTC, or agencies hired by it, used research to construct and validate their message; the metricised reporting of research outcomes perhaps constitute the most important form of campaign legitimation.

Scrutiny of the imperative to survey and quantify reveals that TTC's claimed motivation for its data creation - to inform and guide its work – is flawed. The campaign released results from a *'national survey'* of over 3,000 men, which, they claimed, *'backs up research behind Time to Change's newly launched 'In Your Corner' campaign'*. This major, costly sub-campaign was intended specifically to encourage men to talk with each other about mental health. Yet the survey which justifies the need for the campaign found 86% of the 3,000 men surveyed *'would feel comfortable supporting a friend who has a mental health problem'*. The survey was

nuanced, and did indeed identify some men had difficulties communicating about mental illness. However, the survey showed that the main objective of 'In Your Corner' had in fact been met before the campaign began, rendering it easy to subsequently claim the campaign was a success.

Terms such as 'UK-wide research' or 'a national survey' obscure the campaign's centrality as commissioner, as does locating survey reports in the website's 'news' section, where the abstracted *'research…released by Time to Change'* (7.2.2.vii) is misleadingly suggestive of in-house endeavour. The information 'released' can also be extraordinarily vague: *'There are many different types of mental health problems and disorders and they affect young people differently and last for different lengths of time'.* Such excerpts suggest either that undertaking the studies was more important than their findings, or that reporting was selective.

7.3.4 The Pledge: discourses of persuasion, business benefits, and public relations

The TTC Pledge is presented as an initiative to help create more inclusive and supportive workplaces. But the text also overtly emphasises the financial benefits of signing The Pledge when persuading potential signatories:

> *Many leading employers have found that making a strategic commitment to the mental wellbeing of their workforce not only benefits their staff but also their bottom-line, improving productivity and staff retention.*

Signing the Pledge then is not an altruistic move but, as the underlined text shows, it is what *'leading'* business do, as a *'strategic'* choice to improve their *'bottom line'* and *'productivity'.* Businesses are also told that encouraging employees to discuss their mental health will reduce sickness absence, because employees who are prevented from reaching *'crisis point'* are less likely to be *'signed off sick for longer periods'*. Levels of 'presenteeism' benefit too, and staff will *'feel more loyal and invested in your organisation'.* The link between the Pledge and increased staff retention is rendered more concrete through the tempting statistic that *'FTSE 100 companies that prioritise employee engagement and wellbeing outperform the rest of the FTSE 100 by an average of 10%'.*

Cataloguing the financial cost of mental illness avoids - explicitly - blaming people experiencing it, and the illocutionary force of the statement below is slightly weakened by

'believe'. However, mental illness is undoubtedly presented, to business, as a primarily economic problem:

> *Analysts believe that this sickness absence costs £8.4 billion each year….another £15.1 billion in reduced productivity… A further £2.4 billion is lost replacing staff who leave work because of mental ill-health.*

The total cost *'to UK employers'* is cited as £30 billion per year. The employees who contribute to this cost are charged with some responsibility for persuading their company to sign the Pledge, by informing them of *'our top five statistics'* on the costs to employees of mental health problems per employee, per year. Signing the Pledge brings other benefits; the website's listings and announcements of each Pledged company and their subsequent actions constitute free advertising, promoting their financial growth. Such announcements typically proclaim their plans with respect to the Pledge, and their virtuous corporate attitudes, using formulaic statements concerning '*awareness', 'enabling',* and '*empowerment'*, but are often prefaced by detailed company descriptions, which are irrelevant to mental health:

> *Skymark is the UK's leading independent manufacturer of high quality plain and printed flexible packaging substrates….Skymark Packaging International is committed to raising awareness of workplace Mental Health & Wellbeing in the workplace.*

Signing the Pledge is therefore a powerful public relations and advertising opportunity; while HT provided royal PR, this is business PR. Companies are both promoted and promote themselves and their virtue: The Telegraph boasts of its *'fully integrated approach to health and wellbeing, providing a fantastic suite of services and benefits'*. Similarly, *'we, PepsiCo, continue our journey in challenging the stigma attached to mental health problems…'.* Pearson UK Schools blatantly ask, *'How much could we save?'* They calculate to the pound, based on employee numbers, percentage decreases in mental-health related absenteeism and turnover, and percentage increases in productivity: *'a total saving of £1,039,668 per year'*.

If Pledged companies were financially motivated however, this mentality was constructed by the way TTC 'sold' the Pledge concept to them. TTC comfortably stated that recruitment was facilitated by highlighting financial benefits *'around increased productivity',* and that *'providing an evidence base helped to secure this buy-in'*.

TTC valorises all businesses, but especially large, high status companies, positively evaluating the Pledges of FTSE 100 companies or other 'corporates': *'We 're delighted that The Telegraph*

marks the 1000th employer to take the Time to Change Employers Pledge', and *'We 're proud to be working alongside Ford'.* The latter resembles the familiar 'proudly sponsored by' in television and other advertising.

7.3.5 Conceptual control: embedding and branding

Message control is subtly but diffusely exerted, creating precision over the meanings which the campaign wants to be understood. I have noted that TTC website users are guided to learn *'what we mean by stigma and discrimination',* implying this meaning differs to other possible understandings.

Tips are a semantically 'friendly' ideological steering device, and may be used to correct a user's contribution where it diverges from the required attitudinal position. Similarly, control - in the following example, brand control - may be exerted through a veil of generosity: *'We 've got a series of images for you to use to support your content'* (rather than 'don't use your own images'). Imperatives too are sometimes softened by using expressions such as *'we want to encourage'* or *'we would recommend'*. The degree of control over volunteers may be achieved by implying either the organisation offers them a high level of 'support', or that it lacks confidence in them: if approached by journalists, *'you don't have to remember lots of information about the campaign… we will provide an approved quote'.*

Repetition of messages results in embedding and ultimately inculcation, across different social contexts. This is aided by cyclical linkages, with changes to register which adapt to the perceived needs of different audiences. The campaign even teaches this approach to Champions: *'with different audiences you have to think about what language you use. It's important to do a little bit of research to find out who your audience is, finding out key words to use and repeating them'.* Such statements illustrate that the boundaries between the two identities – truly public facing, and organisational - are sometimes porous.

Brand emerges as a significant mechanism of control for the campaign and its message, as expected in any corporate setting. Despite contradictory views expressed during the interviews (9.2.7.1 and 9.4.), TTC explicitly conveys the high value it places on the campaign brand, both in reports and supporter-facing material: *'We look after the Time to Change brand and manage integrated communications across different teams and organisations'.* Champions and other supporters need to comply with branding, to send *'consistent messages for all events'.* Brand

control functions as a protective strategy to prevent reputational damage; *'We also created a logo for stakeholders that differentiated between work funded by Time to Change and work that supported its aims'*. Statements about brand control can appear, as the underlined text suggests, strangely exasperated: TTC did not

> *support, endorse or promote* (campaigns or projects) *that aren't produced by us or in partnership with us…because we need to ensure everything we promote reflects our values, and* <u>*we simply don't have the time*</u> *to read or watch everything that is sent to us.*

TTC discusses in detail the technical details of branding, across a range of semiotic modes, with constituent elements referred to as a *'suite of assets to use in conjunction with our logo'*. The occasional need to relinquish brand control was obviously difficult, but *'sometimes we needed to let go of our brand'*.

7.3.6 Heads Together and Time to Change: comparisons

The lack of precision in HT's identity, objectives and proposed modes of enaction mean that a consistent narrative is much less evident than in TTC. With any sense of thematic integrity lost by rapid direction of site users to the 'legacy' programmes, the central structure is reliant on recycling core content. The campaign emphasises use of social media to convey its message, but since this message is poorly defined, social media users supporting this campaign will inevitably co-construct this message according to their own interpretation. Thus an already weak narrative is further diluted and generalised by the campaign's close association with organisations whose primary concern is not AS. Meanwhile neither of its distinct features are related to stigma; a concern with 'amplifying mental health' (a brand-specific equivalent to raising awareness) through the London marathon, and an emphasis on links between mental and physical health, confirm the confusion over its purpose.

However, both HT and TTC have shared characteristics. Both want a national conversation, valorise business to varying degrees, have a focus on overcoming problems, celebrate mutual support, and use instructive 'tips'. Although HT has been a less significant and less focused part of the sector, its four core activities neatly encapsulate established narratives in TTC; the high value placed on the mental health of the working population, the drive to improve the mental health of working class men, the determination to inculcate the 'right' messages about

mental health in young people, and the shift towards digital mental health activities, with the tacit concomitant use of data. These narratives share a common focus on responsibilisation, which I discussed in 3.4.1 as a feature of neoliberal governance, and which in this context is a long term objective to reduce public reliance on state provision of mental health services. This can only be accomplished if it is people, not the state, who become accustomed to ‘act’, in a variety of ways.

Accordingly, both TTC and HT demonstrate a narrative focus on ‘taking action’. For both campaigns this may first involve the micro-actions of ‘supporting’ the campaign, via social media, raising awareness, and starting conversations. For TTC, people with experience of mental illness are encouraged to write their story/blog, and employers are asked to sign the Pledge. The calls to action at various levels are reflected in the prevalence of imperatives, to ‘read’, ‘watch’, or ‘talk’.

The most significant actions required of individuals is through volunteer roles, which differ drastically between the campaigns. The TTC Champion role, considered repeatedly in this study, entails a potential personal commitment of scope and magnitude, contrasting significantly with HT volunteering, which consists of being a branded crowd member at marathons, with *‘on the day support through a Cheering Team Leader’.* Branded HT crowd members are told *‘For just a few hours cheering, you'll be helping us to break the stigma attached to mental health’.* The respective roles of Champion and marathon cheerer seem disparate, but have a metaphorical relationship in the etymology of the word ‘champion’ as a vigorous supporter of a cause, literally rallying support. These very different uses of voluntary engagement of people in the two campaigns signal the lack of overt political motivation in HT.

The narrative of both campaigns however drive a shift in public focus, redefining the social habitus away from mental health problems and their management (these concerns are segmented, directed to other sites) and towards a framework of contact and talk. AS can be seen clearly as a diversionary mechanism which functions to allow the framing of this narrative shift. The diverse activities and actions in TTC create distraction from growing public recognition of the social causes of some mental illness, and the lack of help.

The assumption of the problematicity of stigma which was foundational to the campaigns’ existence was reinforced and transformed into the *main* problem in mental illness. This was aided significantly through its strategies of legitimation, including the selective and curated use of linked academic evaluation reports, which can be considered as strategic intertextuality.

Second, it was achieved by repetition and recontextualization of this truth, through linkages across online and offline texts, with changes to register which adapt according to the perceived needs of different audiences, resulting in inculcation of ideas across different social contexts. Having established the magnitude of the problem of stigma in mental illness, and that it was stigma which prevents help-seeking, a public moral imperative to reduce stigma was created, and was simultaneously heeded by William and Catherine.

7.4 Analysis of the website data: closing points

In Chapters 6 and 7 I have presented textual analyses of the website data. In Chapter 6 I examined identity and representation through analysis of the pronoun 'we' and the representation of social actors. I then considered the websites' genre, emphasising their online medium. In this chapter, I have discussed aspects of lexis, then examined in detail the use of legitimation strategies. Informed by all of the analyses, I have reviewed the narratives of the websites.

TTC wanted to foster a sense of inclusivity, but simultaneously created inevitable divisions between mentally-ill and non-mentally ill people, resulting in what could be termed 'selective inclusivity'. A focus on workplaces is functionally extended by directing the campaign towards young people, the workers of the future, helping to embed the campaign's attitudes and behaviours early in life. Older adults - those who are no longer required as part of a productive workforce – are not included, either as stigmatisers, or as the people with mental illness who the campaign seeks to use. For this reason, I wanted to seek their views, and in Chapter 8 I describe the findings of a focus group whose members are older adults.

CHAPTER 8: The Focus Group, and YouTube Comments Analysis

RQ 10: 'To what extent do official AS discourses represent the lived experiences and needs of those suffering from mental ill-health?'

8.0 Introduction

In 5.4 I described the 'natural history' of the focus group, describing its objectives, ethical and practical considerations and recruitment process, and I introduced its design and format. In 5.9.6 I explained the rationale for the analysis of findings. Fully considering the event's context before and during this chapter informs interpretation, and accords with Wodak's (2008) proposal that a context-dependent approach more easily allows perceptions to be identified.

Here I describe the discussion activities in further detail, and present findings, both from the event itself, and from the recruitment phase. For each of the guided discussion activities and video screenings, I then provide short summary commentaries. Thematic findings of the video responses are compared with the YouTube comments. In 8.4 I reflect on contextual implications for the focus group, before a closing critical discussion in 8.5 which draws the findings together and considers them more fully. The 'running order' is provided in Appendix 1.4 and the transcription in Appendix 1.6.

From 8.6, I summarise my findings from analysis of YouTube comments, primarily via a case study of comments on the video 'Stand Up Kid' (TTC, 2012).

8.1 Guided discussion and video response activities

The group discussion was stimulated by five short activities on the subject of stigma and mental illness, commencing with a broad open discussion question:

Discussion activity 1: Discussion question: What does the word 'stigma' mean to you?

This intentionally ambiguous opening allowed individuals to respond to the question either as a semantic issue, or in terms of individual experience.

Discussion activity 2: Objective: to learn the group's views on the importance of stigma in mental illness compared to other conditions or situations.

Participants were introduced to a number of cards upon which a range of human conditions or states were named. The card options were: an invisible disability (e.g. autism, a hearing impairment); experiencing mental illness; a physical disability (e.g. being a wheelchair user); a physical condition such as diabetes; a physical deformity (e.g. a facial disfigurement, a congenital difference); being an ex/offender; poverty; being an older person; homelessness; having a learning disability; + blank cards.

The activity involved two preliminary stages:

i. Sort the cards into two sets; one set for the most stigmatising conditions, and one for the least stigmatising conditions.
ii. Having created two sets, choose one card from each set; one representing most stigmatising state, and one representing the least stigmatising state.

Once complete, the group was invited to discuss their choices.

Discussion activity 3: Objective: to explore opinions on whether different types of mental illness are associated with different levels of stigma.

The group was asked to arrange cards on which names of mental health problems were written in order of most to least likely to result in stigma, to identify the 'number one' stigmatising mental health problem. The cards options were: psychosis; mild depression; anxiety; obsessive-compulsive disorder (OCD); schizophrenia; personality disorders; severe depression (including bipolar disorder), and blank cards.

Discussion activity 4: Objective: to stimulate discussion of the main concerns experienced by someone with mental ill-health.

The card options were: will I get better?; stigma (actual); *fear* of stigma ('what will people think?'); access to timely help; access to the right sort of help.

To elicit individual ideas and experiences, participants were encouraged to provide their own suggestions on blank cards. The group aim was to number the cards (1 = 'greatest concern').

[For activities 3 and 4, the request to number the options was an intentional strategy to encourage participants to express more definitive choices, rather than to reach a group consensus].

Discussion activity 5: Objective: to elicit responses about where stigma 'comes from'.

This activity followed the format of activity 2, using the following card options: self; friends and/or family; colleagues; employers; mental health professionals; other health professionals; the general public; government; the media; other (not an individual, but the social or professional group to which they belong, or an organisation).

The group was asked to create two sets of cards, and to select one card from each set which was respectively most or least 'responsible for' stigma. They then discussed their choices. It was hoped this activity would also reveal whether *self*-stigma was deemed important, how it arose, whether it 'counts' as stigma, or whether stigma is only 'what other people do to us'.

Before the break, the group was introduced to a sheet containing issues to consider when watching the videos, as a prompt and as space to note their impressions. The five videos screened are described in the 8.2.3.

8.2.0 Focus group findings

The focus group itself was not the sole source of data; unstructured, unsolicited contributions constituted an unexpected and valuable source of information. I therefore begin by discussing findings from this recruitment phase of the research, and close by drawing some overall conclusions from this aspect of the participant research.

8.2.1 Findings during recruitment: unsolicited disclosures and help-seeking

From the earliest approaches to U3A, I emphasised that neither this research, nor the focus group, has a therapeutic basis. Yet despite reiteration that I am not a clinician, have no connection with the NHS, and certainly have no leverage with respect to waiting lists, some U3A members still framed me as source of help. During the two recruitment sessions, many interactions with U3A members, the majority of whom did not eventually become part of the group, revealed a raw need for help. Prolonged conversations with several individuals happened because of their wish to talk about their mental health problems, including anxiety, depression, bereavement, dementia, or suicide by a family member. The desire to be better

informed, but above all to access help promptly and at the 'right level' (i.e. by an appropriately qualified professional), was a dominant theme. Many individuals felt they were 'put on hold', directed to self-help activities which they found ineffective or demeaning, and they resented being given self-help worksheets guiding them towards 'strategies' for addressing their mental health issues by themselves. This represents a lived example of responsibilisation in healthcare.

U3A members spoke of their frustration at inappropriate services, and more than one reported knowing someone who had died while waiting for an 'urgent' mental health referral. The need I witnessed with this wider group was therefore not merely for simple human contact, but a need for far more serious and timely help, often as part of a struggle to retain dignity. One individual described both the stoicism which is required of people with mental health problems and the difficulty which the 'outside world' might face in identifying people's problems: *'It's like being Petra* (the Nabatean city in Jordan). *Mostly we're façade. It could be rock behind or… it could be mush.'*

The openness that I witnessed, as a stranger, counters the view that campaigns are required to nudge people towards discussing mental health. Significantly, during the focus group itself, participants observed that they felt potential U3A members attended meetings only because they needed help: *'…at the drop-ins for the U3A sometimes… the people who come in very clearly have come…just to offload their problems onto you…'*. This confirms the extent of the unmet need in the older adult community.

Some attendees of drop-in meetings were also keen to offer personal views about the increased prevalence of mental health problems, reflecting on recent social history, and changes witnessed in their lifetimes. They cited reasons such as slum clearances leading to the social separation of different generations, fractured social cohesion, social mobility, the fast pace of life, and the ironically alienating consequences of advances in communication technology. The range and strength of such opinions was, in retrospect, an early indication that enthusiasm to discuss the social causes of mental illness would occasionally eclipse a specific focus on mental health stigma during the focus group.

8.2.2. Group focus activities

Pre-session questionnaire on awareness of AS initiatives

Only one participant said they were aware of an anti-stigma campaign; this however appeared unrelated to organisational anti-stigma, and may have been a pro-wellbeing, rather than

specifically AS, initiative. This reflects a broader lack of understanding about the difference between mental health organisations such as Mind, and AS campaigns such as TTC. Three participants however offered reasons for not engaging with AS campaigns, all expressing in various ways that they had never heard of the campaigns: *'I am not aware of any campaign which targets stigma.'* Such statements, made 12 years after the start of TTC, and two years after the 2017 HT launch, is a manifest, though individual, testament to the failure of the 'social movement'.

The striking lack of awareness reflects the absence of older people from AS demographics. Since the focus group consisted exclusively of older people who seek, through their U3A membership, to be socially well-informed, and who invest considerable time in achieving this, their responses demonstrate the failure, not only of AS campaigns, but of all mental health campaigns involved in challenging stigma, to reach older people.

1. Opening discussion: what is stigma? (freeform talk, no cards)

- *Um I don't know the dictionary definition of stigma but I assume that it's negative … that you view… you are viewing someone in a negative way*
- *It's somebody putting you in a box…*
- *I think…you might not think that there's anything wrong with you…but if somebody draws attention to something…either physical or mental...then you perceive it that you're in the wrong… And you don't actually feel wrong but …there's that thing that has been called attention to… It sort of…it creates stigma in you*
- *I think it's if you… are afraid of stigma you're afraid of other people thinking less of you…in your interactions with them*
- *I think also each generation has different forms of stigma…*

Understandings of stigma were varied and vague, suggesting that the group were unsure how they 'should' define it. The use of 'you' to render their responses abstract, rather than offering personal observations, is marked at this point.

2. How important is stigma in mental health, compared to stigma in other 'human conditions'?

- *I've found that homelessness was a big one…probably have my highest number…because it's a trigger for… homelessness…it's a trigger for all sorts of other stigmas…*
- *So the degree of stigma is higher I think for something* [a facial disfigurement] *than for hearing and…you're not really blaming someone for their hearing …whereas something like homelessness…I think that people attach blame to that.*
- *…one of my colleagues here was saying if you've got a physical disability there's nothing you can do about it …is it the perception of the public if you've got mentally (ill) you can do something about it it's just a matter of…you know* [sucks through teeth] *'pull yourself together', all those clichés?*
- *Well for me number one where I personally would have a negative feeling…and that's the ex-offender* [4/6 people agreed]
- *Well I think I was going to go for this one actually I think being an older person is…attracts a lot of stigma* [laughs] [met with denial by some others]
- *I think I must be very tolerant because …you know I don't feel that these days it's a negative about any of it…but an ex-offender… I would always have a question.*
- *I think…with me…it's* (my) *forgetting…It always comes out even if I'm being with a few friends you know it might come up…*[describes a distressing verbal attack]
- *A physical deformity…I think stigma is attached to that…a physical disability…no*
- *I don't think poverty for me is…if someone's in poverty I don't feel they're…*

The group did not deem mental illness especially important in attracting stigma within the 'hierarchy' of social states, but instead decided that being an ex-offender attracted the most stigma. The main comment about mental illness (underlined) is expressed as a question, as if seeking affirmation.

Most participants still avoided speaking from personal experience, and abstracted or modalised their statements (*'would have a negative feeling' 'attracts a lot of stigma', 'people attach blame to that'*). One participant however, who had been subjected to verbal discrimination, spoke

more personally. A more reticent participant, speaking about poverty, was prevented from fully voicing their opinion because of the dominance of another group member. The statement *'I've found that homelessness was a big one'* was based on experience of voluntary work, not of homelessness. The second comment in this group twice refers to the notion of 'blame' (underlined). Therefore, without using the term 'stigma', the perception of culpability for a particular condition, which can be said to lie at the heart of stigma, is being expressed through the notion of blame.

3. Which type/s of mental ill-health are most likely to provoke stigma?

- *I'm not educated enough to know what the symptoms are* [referring to schizophrenia and psychosis] *other than that the person is behaving in a way that either I find unacceptable or…*
- *What's the difference really between mild depression and anxiety? It's all too easy to label somebody 'oooh he's depressive' but in fact he actually has acute anxiety.*
- *Meet them on the street and their behaviour…because you don't, you're not used to it, you can find quite intimidating and frightening, you got schizophrenia or aggressive and shouting and balling at you.*
- *Schizophrenia is one of the most, because often you hear about awful you know, murders and you know people are obviously mentally ill but I think it is associated with violence* [general agreement].
- *You often get…psychosis… schizophrenia means, I think, terrorism… a bit nasty.* [43]
- *You know…if you're wary of people because of…whatever they've been labelled with…is that a form of stigma? You think, you know I've got to be careful here, I don't want…*
- *I think severe depression is one that attaches a lot of stigma because I think a lot of times people's reactions is 'oh for goodness sake snap out of it!' you know* [laughs]

[43] Ellipses here provide a concise version of an utterance, or indicate a significant pause. However they may also, as in this case, denote a verbatim utterance which finishes without full expression of an idea or opinion.

it's that people can er…put it right themselves but are just choosing not to…but psychosis is… I don't really know what psychosis is …

- *But a clinical depression that is an imbalance of er hormones and chemicals in the body isn't it…*[suggesting this was therefore without blame]
- *I'd say anxiety.*
- *I think I'm on that spectrum obsessive compulsive* [selects card, laughs] *obsessive compulsive I think I'm on that spectrum* [looks ashamed] *but there's no stigma attached to it whatsoever* [laughs]. [refuted by 1]
- *But don't you think people who have that disorder* [OCD] *are initially perceived as being very efficient…and very boring.*
- *I have to tell you – yeah – when I saw her* [referring to someone encountered in a workplace, and known to have OCD] *walk through my door I'd say 'oh god not again' you know… if we're not necessarily accepting stigma as being negative but just as a recognition then yes…I was stigmatising her because I was recognising that she had a condition…but if I could have done I would have banned her.*

The tendency to abstraction continues, accompanied by hesitation to commit to or complete an opinion, represented by hedging and incomplete sentences. The group agreed that schizophrenia and psychoses were the most stigmatising mental health conditions, and they associated schizophrenia with violence. There was confusion about what each condition offered for discussion meant, and some participants conflated depression with anxiety. Interestingly, identifying clinical depression as an organic imbalance absolved the sufferer from blame. It had been explained to participants that they were being asked only to think about what the word (diagnostic term) alone suggested to them. Respective opinions that severe depression and anxiety attract stigma may reflect personal experiences. A further participant disclosed having a mental health condition, obsessive compulsive disorder (OCD), and while appearing embarrassed, simultaneously declared there was no associated stigma. Another group member defended people with OCD by characterising them as 'efficient', but then added that they are 'boring'.

4. What are the main concerns/worries for someone experiencing mental ill health?

- 'Safe space' was introduced as a 'new card'. *'…where I work a lot of them have...mental health issues… what's helped them is having a safe space.'* [Subsequent discussion decided that outside a 'safe space' was where people experienced stigma.]
- *Will I get better?*
- *Am I ever going to be normal again?*
- *I think if you can see an end goal then you're not too worried…*
- *It's difficult to choose between access to timely help and the right sort of help* [laughs].
- *It is the initial feeling of stigma…I need help…what will people think?*
- *I think people are ashamed…yeah ashamed.*
- *I think it depends a lot on your personal circumstances you know if you are…in a workplace you might be very anxious if you'd been diagnosed with mental illness…or … you might be very er anxious about the reaction of your workmates…*

The clearest agreement here concerned prospects for recovery, which was associated with accessing help. Worries about other people's reactions, demonstrated by *'people are ashamed'* and *'what will people think?'* suggest self-stigma is also important. One participant however, identifying as a professional with expertise to offer via their voluntary work, was dismissive: *'Stigma? No-one's ever raised that'*. In this set of responses the participants are becoming slightly more able to use 'I' and to contextually refer to themselves.

5. Where does stigma come from?

- *From all of them I think* [referring to the card options: self; friends and/or family; colleagues; employers; mental health professionals; other health professionals; the general public; government; the media; other]
- *I think… I think you stigmatise yourself… 'why is it me?' Yes, 'what's happening to me…how'm I going to manage?'*

- *As for government well …they're too remote from me 'til it impacts on me like… they stop my pension…if they said to me 'well I'm sorry but you've got mental health problems so you don't need as much of a pension …'*
- *It's not properly funded is it by central government?*
- *Well I think…it's an age old thing that has …it started when man first started to communicate and live in communities well perhaps been forever …in primitive forms if you have got one person who's holding back the community …they're going to stigmatise and say 'don't bother'… 'don't bother about him, don't take him on the hunt, we'll go without him and catch the reindeer or the antelope'…or whatever it is…and that is…preservation…having stereotyping, categorising, discriminating… I think it is a fundamental human… way that we sort the world, and it's not that it's negative, that its wrong, because a lot of discrimination is very positive, it is so you can help them.*
- *I think the depressing thing is that all of these are significant…you know I think probably one of the most damaging is employers'…stigma…because you know it could mean that people are overlooked or don't get a job that they would be they'd be perfect for and would be very good for them mentally as well.*
- *We're putting down – it's a fundamental to human nature.*

The responses here are becoming markedly more personalised. This discussion activity is also notable for the group's choice to agree that stigmatisation is an innate human characteristic. This was not an offered suggestion but a 'blank card'. The specific mention of employers was notable however, especially following an earlier comment about concerns about reactions to mental illness in the workplace. The card option offering the choice 'government' as a source of stigma was not fully grasped, and although one participant highlighted lack of funding for mental illness, the speaker did not elaborate on how inadequate funding for mental health services creates stigma.

The group's only proponent of the idea that stigma has a positive function created some tension in the group; *'a lot of discrimination is very positive so you can help them'.* Elsewhere, the suggestion *'I think you stigmatise yourself'* confirmed the significance of self-stigma seen in v.

8.2.3 Responses to videos

Each video was introduced by name, and the group was told which organisation had produced it. As anticipated, the group criticised video content: *'it's unrealistic' 'awful', 'it's been very… badly…thought up',* but also praised it: *'I thought it was great!'* The greatest criticism was directed at output from HT: *'I think it's an advertisement for the Royals'* or *'…a lot of bigwigs getting together raising money...but…me…I've got mental health problems'* and *'I'm not sure how much value royals bring to a campaign'.*

Video 1: ***60 second ad.*** **(TTC, 2011)**

Fig. 22: Screenshot from '60 Second Ad.'

This short video had been used as a TV advert, increasing the possibility of familiarity with focus group viewers. Its wider media presence likely influenced the size of its YouTube audience (77,777 views as at 2/9/19). Its creation was outsourced to external commercial video production company, Stitch Editing, who work with corporate clients (British Airways, Samsonite).

The video is set in a workplace, and uses humour to confront stereotypical views of mental illness by depicting absurd extremes. An officer worker who has returned to their job after absence through mental illness behaves bizarrely, using his shoe as a phone, and crawling into

the photocopier to go ‘home’. This behaviour is contrasted with a second scenario depicting a same character as a rational person coping well with their return to work.

Responses: there was only one positive reaction to the video. Characteristic responses contained evaluative adjectives/adjectival phrases: *‘demeaning’*, ‘*badly thought up’*, *‘not funny’*, *‘extreme’*, *‘great’*, *‘awful’*, ‘upfront’. The use of humour was roundly criticised and deemed offensive. An interesting response identified the enduring confusion concerning the audience of AS campaigns and their materials: *‘it seems to be aimed at the person with the mental illness… rather than…the employer modifying their behaviour.’*

Video 2: *World Mental Health Day 2017* (HT, 2017)

Fig. 23: Screenshot from World Mental Health Day 2017

This video adopts a reportage style to cover a formal reception at which people associated with the HT campaign, including its royal founders, gather to ‘celebrate’ the day, and HTs’ endeavour within the AS landscape. It focuses on the HT figureheads; Princes William and Harry, and the Duchess of Cambridge. Some individuals are briefly interviewed, and youth is emphasised, both by prevalent representation of marathon runners, and by the presence of

Adele Roberts (‘Team Heads Together’) a London-based DJ, who stresses the importance of online help because *‘that’s where young people speak to each other’*.

Responses: dismissive, brief, and wholly negative. The group felt the video’s function was to promote the Royal Foundation, and they decided its audience would be supporters of the royal family, not themselves. This antipathy was strengthened by suggestions that people in such privileged positions could not usefully identify with the struggles of a ‘normal’ person with mental illness.

Video 3: ***Andrew’s Story – Schizophrenia*** **(Rethink Mental Illness, 2015)**

Fig. 24: Screenshot from Andrew’s Story

Rethink explains that Andrew has lived with schizophrenia since his twenties, and frames what follows as *‘his story of overcoming discrimination and finally getting the right support’*. In this gently confrontational first-person testimonial, an older person briefly relates their decades-long experience of schizophrenia, ultimately offering hope while challenging stereotypes. Unusually, it combines testimony with a challenging creative device; Andrew wears a literal label, ‘Nutter’, applied to his forehead in makeup, which he progressively wipes away as his brief narrative challenges perceptions and media representations, and relates how receiving treatment has helped him to rebuild his life. This format could be described as ‘photovoice’ (Tippin and Maranzan 2019), a category of video intervention noted in 1.3. The voice is

Andrew's, and he is onscreen throughout, but does not speak directly to camera, which moves around his face as he symbolically removes his label.

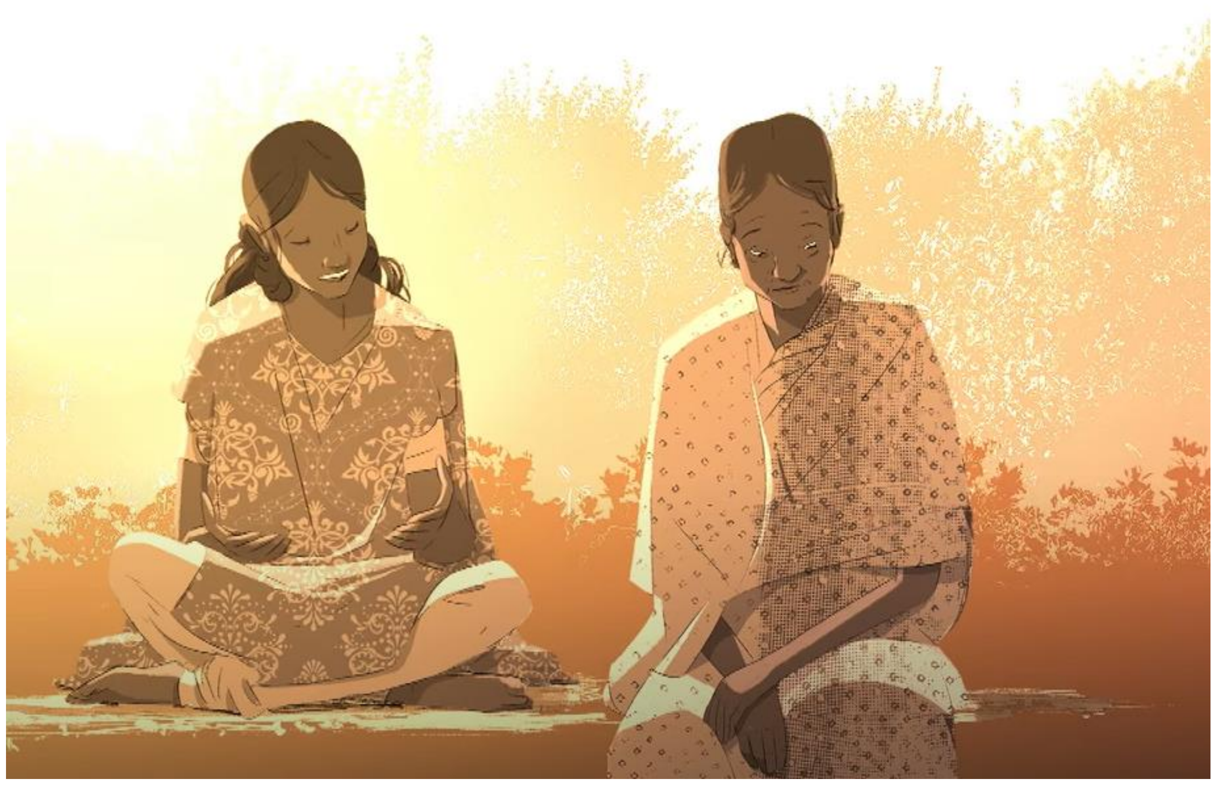
Responses: participants were divided; one responded dismissively that they understood no more about schizophrenia than they did before watching it, but an opposing view was offered, and gradually joined by others: *'I thought the words were interesting. I've learned something about schizophrenia…'*. The group ultimately felt very positive about the video, deciding they had been challenged by it, and all were shocked by the on-screen statistic that 1 in 100 people in Britain have schizophrenia. A reflective *'Mm, you certainly do need more* [awareness/information] *about the general people who's got it not the ones who go on to do crimes',* was doubtless intended to be an enlightened and positive comment.

For one participant, the earlier association of schizophrenia with violence, terrorism, and being a *'raving lunatic'* was strikingly modified to *'…it's something that afflicts an ordinary person'*. The earlier, perhaps intentionally inflammatory comments about schizophrenia and terrorism, were not at the time refuted by other group members, reflecting the dominance of certain group members.

Interestingly, assertions about the need for self-help arose during the group's discussion of schizophrenia, despite schizophrenia being one of the mental illnesses most difficult to address through self-help. This may suggest that the self-help message, with its origins in the rhetoric of responsibilisation, and which is consistent across mental health campaigns, is being heard, even by people who do not believe they are 'part of' the campaigns.

Video 4: ***Let's Talk About Depression – focus on older people*** **(WHO, 2017)**

Fig. 25: Screenshot from Let's Talk about Depression



I selected this WHO video both for its distinct animated form, and because although it echoes the themes of TTC and HT by promoting talking as the 'answer' to depression, it does not propose conversation within a framework of activities, in the way TTC does. It deals specifically with older people, in whom it overtly identifies loneliness and lack of independence as key causes of depression. It is conspicuously multi-ethnic. Characters are depicted wearing, and surrounded by, muted shades of brown or yellow, which contrast with the contrived bright and cheerful or saturated colour palette more typical of online mental health materials. The video depicts older people in a variety of settings, including residential care, and presents a simple, cross cultural message.

Responses: I asked the group what they noticed was different in this film. One surprising response was objection to, and confusion about, the colour or race of some of the people depicted (*'There was a couple of people that looked like… well I don't know…from Asia is it?'*). The American accent of the voiceover also *'grated'*. In such ways, some participants revealed not only their views on mental illness stigma, but accompanying racism and intercultural hostility. These opinions are presented in a guileless way and with the assumption that they are shared. As with negative statements towards people with schizophrenia, other

group members were not quick to challenge such views, although one participant quietly stated that they liked the 'global approach'.

The majority initially found the video superficial and unsatisfying, and were unsure of its intended audience, both in terms of ethnicity and whether it was aimed at carers or people experiencing depression. This gradually evolved however into praise for the video's simplicity and clarity, perhaps representing group attempts to erase the earlier racism.

Video 5: ***The Stand-Up Kid*** **(TTC 2012)**

Fig. 26: Screenshot from The Stand-Up Kid

This video was shown as a TV 'commercial' in 2012. In the dramatized narrative, a senior school pupil enters a class in progress, after absence from what the audience is led to assume is a serious depressive episode. He faces sarcasm from his peers and hostility from his teacher, before standing on his chair to take a literal and metaphorical stand to give his account, shaming the room, and ultimately inspiring a further disclosure from another pupil. The video references social media posts and Facebook statuses. This title had the largest number of views (1386788

on 3/9/19) of any AS video on YouTube, eliciting strong and disparate audience responses, and also provoking by far the greatest number of YouTube comments of the selected videos, (1,402,199 at 4-12-19, nearly 30x the viewing figures of another major TTC video, *In Your Mate's Corner* (46,985 views on the same date). Its popularity on YouTube likely reflects the fact that the video's target demographic mirrors the age demographic (15-25) which most frequently uses YouTube (Statista, 2021), 77% of whom regularly access the platform.

Responses: with one exception (see 8.2.4), the group found the film 'unrealistic', a view shared by YouTube commenters. Both audiences suggested the video was 'staged', and criticised the behaviour of the main protagonist. Some focus group comments suggest generational cultural differences, for example referring to the effects of *'all this social media stuff'*. The group agreed that a video *'for older people… would…have to be something different.'*

8.2.4 What would the group want to see in a mental health anti-stigma campaign?

One participant suggested the final video, *The Stand-Up Kid*, exemplified how anti-stigma videos should be: *'You have to be… Anglo-Saxon, it has to be punchy, it has to be like that – that is great!'* Describing something as 'Anglo-Saxon' might typically refer to profanities of Anglo-Saxon origin, but in this case, the participant referred instead to its authenticity, and the direct and confrontational manner in which depression was addressed.

In the post-session email responses, another participant suggested the videos the group had viewed were not aimed at 'us' and that such 'generic adverts' would not succeed in tackling stigma. There was thus an assumption that older adults should be included, sadly suggestive of a lack of awareness that AS is not interested in older people.

The group agreed that anti-stigma initiatives must be tailored to resonate with each demographic group, and that specific mental health conditions should be targeted individually. A further post-group communication specified the importance of acknowledging the wide-ranging nature of mental health issues. This is interesting since it aligns with, but did not stem from, my observations of the damaging homogenisation of mental illness in AS.

The view that *'a way of decreasing stigma about mental health is more openness in society generally about mental health'* accords, superficially at least, with the standard exhortation to 'talk'. One suggested that improved attitudes to age were a useful model. A further participant

made a pertinent point in suggesting lessons could be learned from the shift in attitudes in the LGBT+ community: *'Well if you go on a gay pride march and you'll see'*. Foucault pointed out (1978:101) that once a group is discursively identified, the power of that naming then makes possible the formation of a 'reverse' discourse, through which the 'deviant' group may demand its legitimacy and naturalness be acknowledged. While this has not been wholly achieved in sexuality, it is easy to understand the participant's meaning.

One speaker asserted that anti-stigma campaigns and videos are: *'stage one…stage two is where we see Heads Together in Sheffield city centre.'* Another added *'or at our…you know leaflets in our doctors.'* I have noted that online public health campaigns automatically exclude a sector of the older population, and the opinions above confirm a broader mode of dissemination is required for a genuine anti-stigma endeavour. There is no conflict here with U3A members complaining about being given patronising self-help worksheets post-diagnosis (2.4,7), since the two comments concern distinct materials, with the individual who would welcome 'leaflets in our doctors' referring to general information about the stigma of mental illness.

8.3.0 Focus group and YouTube audience responses: comparison and thematic similarities

Table 12 describes a majority positive or negative evaluation from the quantitative results from YouTube comment analysis, and compares it with the majority (or consensus, if reached) response from the focus group, for each video they watched:

Table 12: Majority response to videos: comparing focus group and YouTube commenters

Video title	*Focus group audience*	*YouTube audience*
60 Second Ad.	Negative	Positive
World Mental Health Day (2017)	Negative	Equivocal
Andrew's Story	Positive +	No evaluation
Let's talk about depression	Positive	No evaluation

The Stand-up Kid	Negative +	Positive +
		('+' indicates strength of evaluation)

Table 12 demonstrates the lack of core consensus between the two audience types in terms of the basic parameters, approval and disapproval. There is also a huge difference in the number of comments contributing to each type of audience response.

Two further features emerge; the video which in the focus group prompted the most vehement criticism and negativity (*The Stand-up Kid*) attracted the greatest proportion of positive evaluations in the YouTube audience. Meanwhile *Andrew's Story*, which attracted just a single, supportive comment but no explicit approval of message on YouTube, was the most influential video shown to the focus group, whose views were significantly challenged by viewing and discussing this simple video. After a single showing of a film which remains almost unnoticed on YouTube, participants who entered the focus group with negative attitudes about schizophrenia, left with different ideas. It is important to note that TTC has described schizophrenia as the mental illness to which attitudes are most entrenched.

I identified thematic tendencies which represented attitudinal positions shared by the focus group and the YouTube commenters, and I illustrate these below with quotations (not all of which refer to videos) from the focus group. These are of interest given the significant demographic and contextual differences; the large, anonymous online audience of YouTube commenters, and the personal setting of a small focus group with older adults.

(a). Criticism of, or lack of sympathy towards, people with mental illness:

'You have to…expect the people who have these conditions to…help themselves a bit…because if we're going to regard mental health issues in the same light as physical health then there has got to be some self-help'.

'… if I could have done, I would have banned her'. [of a person with mental illness visiting a commercial setting]

(b). Stigmatising attitudes towards people experiencing psychosis or schizophrenia:

'So in my mind schizophrenia IS violent'.

'The only time I hear the word schizophrenia is where terrorists…somebody does a terror thing and then they say well of course he actually has got schizophrenia'.

(c). Criticism of the mental health service provision.

This is an area of particular interest, since such criticisms are not permitted within the editorial constraints of TTC.

'You need an awful lot more psychiatrists and you're never going to get 'em…'

(The function of diagnosis is) *'…to allow psychiatry or the government or… in the health service to push people to one side feed them tablets keep them out of harm's way as much as possible…and in the meantime avoiding the real issues'.*

'if anybody with schizophrenia was watching that they would feel profoundly…depressed …because it ends up with something about how scarce…proper support is!'

'they've had to pay privately, the waiting list(s) for psychiatric and counselling have been terrible'

[Referring to discharge from mental health units] *'I mean the actual backup counselling services are …is shocking, just shocking.'*

(d). Failure to grasp the message of some (but not all) videos:[44]

' …well it's time to talk it's time to change…that's what?'

'*you've got a white one to start with then you've got a black and then you've got an Asian…'*

'What's the purpose?'

'…but then it stopped after it said, 'let's talk'?'

'what they are, are these ads trying to educate the population or educate those who have depression…I'm getting confused with them now'

8.4 Reflection

Considering the influence of the group demographic on its dynamic, participants' membership of U3A was important in informing the group's functioning. When groups are drawn from pre-existing social groups, their interactions inevitably reflect those which would occur in the pre-

[44] Confusion over message appeared greater with the focus group than the YouTube audience.

existing group (Bloor *et al*. 2011). In this case, participants knew each other socially, but may not have habitually interacted.

Members of U3A are acculturated to attending lectures and courses, reflecting their desire to learn a topic or skill. Therefore some expectation persisted that this was a learning experience, rather than an opportunity to contribute to research by sharing opinions; the event became framed within their familiar U3A experience. That this included committees was reflected in the utterance '*Shall we give it a chair, a chair…do we need a chair? Come on, you be chair.'*

Aligning with their engagement in social activities, U3A members tend to reject perceptions of later life as a time for quiescence. Accordingly, during recruitment I found some members especially keen to be seen as strong and resilient, which may explain views suggesting a need to 'get on with it' or to accept notions that older age is accompanied by wisdom which renders people less susceptible to mental health problems. This may have been a factor in some dismissive behaviour, which could be construed as a micro-outgroup construction within the group.

The wish to be perceived as 'strong' may also explain why none of the participants disclosed any form of disability which should be taken into account. During the event, hearing impairments presented barriers to comprehension for some, leading individuals to nod and 'parse' discussion points. Neither modification of voice, repetition, or adjustment of video volumes entirely mitigated the consequences for the group dynamic.

Participants were the experts whose 'knowledge' I sought, but the group had a tendency to direct responses to me, as they would in a class. Despite assurance from Bloor *et al*. (2011) that it is planning, not experience, which produces a successful focus group, the planning for this group, involving exhaustive explanations of its nature, did not prevent lapses into a 'Q and A' structure, nor a tendency for 'off-topic talk'. I nevertheless obtained rich data which contribute significantly to the research, and some of the most interesting responses emerged at points of digression.

8.5 Critical commentary and van Dijk's ideological square

The focus group findings can be summarised as follows:

(i) The group found stigma difficult to describe or define, although they identified, and were familiar with, self-stigma. There is a distinction to be drawn between 'self-stigma' defined

as the consequence of a stigmatising action, and when defined as an inherent shame, or fear of a stigmatising response by others. The group referred mainly to the latter.

(ii) The most stigmatising social state or characteristic was being an ex-offender. Significantly, mental health conditions were not deemed automatically or significantly stigmatising when considered among other social states.

(iii) Schizophrenia and psychosis were identified as stigmatising mental health conditions. These also evoked the most stigmatising attitudes from the group, even when individuals did not know what these illnesses meant; this illustrated their wider lack of understanding about mental health problems. Some group members demonstrated clear stigmatising attitudes, and a desire to conceal their stigmatising views by re-framing stigma as *'noticing a difference in order to help them'*.

(iv) Worry about prospects for recovery was identified as the main problem facing someone with mental illness, although concerns about *'what people would think'* (i.e. the expectation of stigma, associated with self-stigma) were also noted.

(v) Stigmatisation was deemed an inherent human trait, not derived from a particular social group or area of social life. This conforms with the view described in 3.6.2 of the universality of categorising tendencies.

It was hoped that, through the group's ideas about stigma and mental illness, it would be possible to understand how group members identified themselves in relation to mental health and stigma. The main emerging narrative did indeed concern their preferred identity. In the earlier stages of the event, group members constructed an identity which positioned them apart from people with mental illness, who were consequently 'othered'. In my commentary on the discussion activity considering which types of mental illness are most likely to provoke stigma, I have noted that one participant absolved people with 'clinical depression' from blame by viewing depression as an organic imbalance. This is part of a pattern in the responses which demonstrate the way group members perceived that either different social states, or different types of mental illness, can be reduced to the question of 'blame-ability'. Deviant or socially aberrant behaviour, including violence or shouting, is also easier to blame, because it sits outside of established parameters for 'normality'. This is reflected in responses such as *'…their behaviour… you can find quite intimidating and frightening… shouting and balling at you'*.

Overall, a set of semantic oppositions can be identified which run through these responses (normal/abnormal, blameworthy/innocent, and internal/external, social/clinical). Together

these set up parameters for social judgment which Foucault (1978) would readily recognise with respect to the way in which acts and characteristics become associated with categorisation of individuals and groups. Just as sexuality became inscribed in diagnostic medical discourse in the 19th century, the broader classificatory logic of what constituted 'normality' or 'abnormality' was subjected to discursive scrutiny in a manner we now accept as commonplace.

The group's views concerning blame are also not dissimilar to what Van Dijk (1998) calls the 'ideological square', whereby social actors are construed as either within, or beyond the realms of, social inclusion. There are some exceptions, for example the opinion that stigma was associated with a physical deformity, in which blame can play no role. But this was an observation of what *others* think; in the participants' own views, there is greater utility for van Dijk's concept.

The dichotomous construction of 'us' and 'them' is commonly identified in discourses of 'group conflict or competition' (van Dijk, 1998: 275). Van Dijk proposes a theoretical framework consisting of an 'ideological square' to reveal the ways in which an ideologically positive 'us' and an ideologically negative 'them' are discursively reproduced. Van Dijk (1998: 276) highlights *'the distribution of agency, responsibility or blame'* as among the discursive strategies used to fulfil the ideological square, and proposes an ideological discourse structure for the 'square', described in 5.9.5. I consider this structure below, in relation to the whole of the focus group transcript (Appendix 1.6).

(i). I noted in 3.8 that irresponsibility is a key element of the way people with mental illness are characterised. Responsible actors are self-motivated to fulfil the criteria required of them (Bivins, 2006). By highlighting 'us' as responsible actors, the positive attributes of 'us' are emphasised, consistent with the first component of the ideological square, in which positive information about 'us' is expressed (van Dijk, 1998).

'I think I must be very tolerant because I don't…I don't…you know I don't feel that these days it's a negative about any of it…'

'Don't worry I haven't got a mental illness because of this' [a childhood incident]

(Another group member responded *'Far from it'*)

'I think I'm fairly well adjusted you know'

'I see somebody who perhaps is blind my instinct is to help them'

'I had a birthday card come…which said er I'm so glad I've got you you've saved me a fortune in…what's… in therapy'

The statements above variously construct the participants as tolerant, mentally well, helpful, and socially useful; the last two concern social responsibility specifically.

(ii). Blaming others for their 'faults' relates to the second component of the ideological square; expressing or emphasising negative information about 'them' (van Dijk, 1998). Statements in this section refer to a range of possibly stigmatising conditions, not only mental illness. The first statement unambiguously attributes blame, while the second attributes it by implicature:

'it's that people can er…put it right themselves but are just choosing not to…' [of depression]

'I think obviously diabetes is if you are very very overweight…'

Other comments reflect the way in which negative information was attributed in a vague or indirect manner. A negative construal may also be achieved through a lack of information. Below, '*My aunties were very…*' is not followed by an adjective or verb phrase. Instead, a negative evaluation is constructed by recalling the reaction to their behaviour:

'My aunties were always very… they were suffering from their nerves and you kind of kept them at arm's length'

Similarly, below we are left to imagine the inferred negative behavioural attributes by the combination of the *'real full-on thing'* and knowledge of the irritation it caused the speaker.

'I used to have a customer …with OCD but the real full-on thing…when I saw her walk through my door I'd say oh god not again you know'

In the underlined sections below, statements were abstracted, rather than personalised, distancing the speaker from the opinion. This way of constructing a negative emphasis of 'them' therefore overlaps with the fourth part of the ideological square – supressing what is negative about 'us'. However in the example with a section expressed in capitals, the opinion is personalised by the anger represented by capitalisation:

'the vast majority of people think it's [schizophrenia is] *when someone's a raving lunatic who runs amok in a shopping mall'* [45]

[45] The focus group took place two days after a mass shooting at a shopping mall in Thailand. I have not found suggestions that the perpetrator was experiencing schizophrenia.

'severe depression is one <u>*that attaches a lot of stigma*</u> *because I think a lot of times* <u>*people's reactions is*</u> *oh FOR GOODNESS SAKE SNAP OUT OF IT you know'*

'<u>*there is the perception that*</u> *you're overweight you don't take any physical effort…exercise'* [of diabetes]

'something like homelessness…I think that…<u>*people attach blame*</u> *to that'*

Other negative statements are hedged or modalised, as in the underlined sections of the quotes below:

'an ex-offender <u>*I would*</u> *always have a question mark'*

'type 2 is <u>*um…almost*</u>*…your own fault and…a consequence…of lifestyle so yeah I do think diabetes is a sort of invisible stigma to it'*

Similarly, rather than overtly suggesting use of illegal drugs is a causative factor in schizophrenia, and that therefore addiction equates to form of causative culpability, the participant frames their suggestion as a question:

'what…to what extent do illicit drugs play a part in the in - if there is an increase in schizophrenia?'

A nuanced way of constructing negativity was also seen in cynicism for 'politically correct' ways of talking about various social groups:

'You know you've got a blind man am I allowed to say blind these days?'

'I don't know whether I dare use this word…I don't… in here…<u>*normal*</u> *children'* [met by general sniggers].

(iii). The dimension of assigning duties to others echoes the third component of the ideological square, in which information that is positive about 'them' is suppressed or de-emphasised (van Dijk, 1998). Social actors who are 'accountable' possess 'a developed moral sense' and understand social conventions (Bivins, 2006: 23). However if the individual or group respond to external pressure rather than acting autonomously, the positive connotation of their accountability is diminished.

[The first three statements below refer to disabilities, and last two refer to mental illness]

‘they need to be self-sufficient to survive a tough world’

‘…sorry people who do have a disability they also do have to learn that they do have it and that they’ve got to get on with it because no matter how hard we feel about it for them we can’t change it and we’ve all got to get on with this’

‘they may have to appreciate that they engender feelings in others that they may not themselves welcome’

‘but a lot of these conditions…you would hope that the vast majority of them the degree at which they have the conditions is within the realms of erm….being able to handle it yourself…’

‘you have to to some extent expect the people who have these conditions to …help themselves a bit…because if we’re going to regard mental health issues in the same light as physical health then there has got to be some self-help’

(iv). The fourth part of the ideological square, suppressing what is negative about ‘us’ (van Dijk, 1998), might also involve the construction of a positive ‘us’ by denying blame (van Dijk, 1992), or through avoidance of blame (Hansson, 2015). The examples below fall into two groups; the ‘us’ which is construed positively through strategies which legitimise their stigmatising attitudes, several of which were offered by the same participant, and the ‘us’ construed positively because it denies the possibility of a mental illness (here, specifically OCD).

‘a lot of discrimination is very positive, it is so you can help them’.

‘I was stigmatising her because I was recognising that [they]*had a condition’* [response: *‘no that’s alright’* [i.e. solidarity]

‘stigma…I think is a nasty thing…but from that point of view I think it’s necessary because you need to be able to stigmatise people and to see the negativity of it so that you can offer them… a way forward…’

‘They’re what’s called reasonable adjustments aren’t they you’re making a reasonable adjustment to that condition’

'well I've got problems with saying is it stigma or is it recognition…because …if you recognise and don't do anything about it you've ignored it…so you need to be able to differentiate you need to be able to categorise'

'we're just forgetful…I just can't remember if I turned that stove off or not… I must go back and look' [i.e. checking things because of forgetfulness, not because of OCD]

'It's called old age innit?' [as above]

Not all statements and comments fit neatly into van Dijk's ideological square, as the examples below demonstrate, but the framework remains a useful way to analyse the group's primary construction of ideas of 'us' and 'them'.

'I'm not apologising for it I'm just saying that's how I dealt with it' – no attempt is made to suppress the negative 'us'

'Just because we're sitting here doesn't mean that we haven't got it' [schizophrenia] – accommodates the possibility of the negative 'us'.

'it's something that afflicts an ordinary person…' [schizophrenia] – attributes no blame, and frames the person as 'ordinary'.

In view of my emphasis, during recruitment, that I sought the views of people with experience of mental health difficulties, it was surprising when othering was accompanied by, or revealed by, the reluctance to allow mental illness to be a constituent part of participant identities. However, the expansion of what constituted 'experience', described in 5.4.2, may be reflected in the responses given.

Although the group present initially as signalling simultaneously their compassion towards, yet their separation from, mental illness, there was a dynamic progression *towards* a position of disclosure of experience of mental illness. Yet othering of people with mental health problems outside the group was persistent, in some group members. The group's heterogeneous identity in relation to mental illness reflected its position in relation to stigma. One participant repeatedly asserted that stigma was no more than a necessary or beneficial recognition of a person's difference. Framing stigma as beneficial may have represented an attempt to render stigmatising attitudes as acceptable to others in the group who held different views. For example, the admission '*yes I was stigmatising her'* was prefaced by defining stigmatisation as a helpful action which led to offering 'them' a way forward. In this way, stigmatising

attitudes were framed as compatible with presenting as a compassionate, 'right-thinking' individual.

Commencing the session with a discussion asking group members to offer their own definitions of stigma revealed a lack of understanding of stigma as a concept, which the group struggled to describe. Lack of knowledge too was a persistent theme, with some speakers suggesting they were unqualified to offer an opinion: *'I don't know the dictionary definition…'.* The statement '*I'm not educated enough to know what the symptoms are'* was perhaps a defensive statement related to the event's location and its nature as a contribution to research; participants were never asked to describe symptoms. Some participants appeared to fear getting something 'wrong' despite assurances that all their views were valuable, and that this was a discussion, not a test of knowledge.

Lack of knowledge was however important in relation to the agreement that schizophrenia is the most stigmatising mental illness. Group members freely acknowledged they did not know what schizophrenia was, but their opinions were not abstracted or generalised; paralinguistic features such as recoil indicated these were personally held feelings. Such reactions demonstrate the power of cultural associations of schizophrenia with criminality, violence and terrorism.

My use of card options introduced ideas to prompt discussion, and through one such card option the group decided, surprisingly, that being an ex-offender was the most stigmatising social condition. This option was just one of a list of illustrative social states, and making a new suggestion on a blank card remained a possible choice. Interestingly, the social group 'ex-offender' remained homogenous and unexplored; I had been interested to learn whether anyone might suggest the nature of an offence would determine the extent of stigmatisation, given the context of a discussion which included exploration of differing levels of stigma in different types of mental illness.

A further objective of the focus group was to understand whether core messages of mental health campaigns were reflected in participants' attitudinal positions. I was interested especially in the drives towards self-help and parity with physical health problems, and the framing of mental health 'conversations' as a solution. The only substantial evidence of 'support' for these key messages was acceptance of the need for self-help and self-reliance, although self-help in the absence of professional help was accompanied by some resentment: *'For the common folk it's 'help yourself dear!'* This resonates with comments during

recruitment expressing dismay at provision of self-help resources alone. There was however some conflation of self-help and seeking private help, with one speaker voicing concerns about help from unregulated sources: *'...what about the charlatans ...is there enough policing of it to make sure the self-help is really self-help and not someone else's self-interest?'*

While TTC denied the need to address older adults as part of AS, the characteristics, attitudes and behaviours which TTC sought to change could all be identified among the members of this small group: a lack of understanding about stigma, a lack of knowledge of mental illness, and culturally embedded stereotypes. Yet within the context of a single, non-educational, non-interventional scenario, several group members left declaring they had a changed understanding of schizophrenia.

Valuable insights were obtained from opinions which were not part of an activity but were conversational sequelae; such 'off topic' moments offered included the unironic, unconsciously stigmatising *'don't worry I haven't got a mental illness'*. At these unguarded moments discursive microstrategies also emerged; presuppositions (of shared racist attitudes), insinuations (*'And my mother said 'well we did think she was a bit…''*), and implicatures; '*older people will get mental illness perhaps for physical reasons',* in which dementia is implied but not named.

Among the post-group email communications, one writer expressed gratitude for the opportunity to take part, expressing their belief that mental illness is a major epidemic, the impact of which affects whole families. They voiced their despair that *'our Dickensian mental health service is totally unable to comprehend or address the problem'*. The writer went on to explain how this opinion was based on personal experience of a range of serious problems: *'so you see, we…have a real-life interest in mental health'*.

8.6.0 YouTube comment analysis

The campaign is partially conveyed via visual media including videos, and the public are asked to engage with these media. Therefore this aspect of the research in part concerns ***RQ8: How is the campaign premise conveyed to the public, and what is asked of the public?*** Since the videos are also part of AS discourse, their exploration also contributes to answering ***RQ4: What is the ideational and ideological content of AS discourse?***

Individual questions are then required in response to the data, as described in 5.9.7, with respect to the extent to which comments suggest the message of the video was understood, received positively or negatively, and whether more nuanced or attitudinal positions can be construed from comments.

I described the method for this analysis in 5.9.7. As seen in Table 3 (5.5), comment analysis included two videos which were not part of the focus group screening[46], *Mental Health Minute* (2018, HT) and *In Your Mate's Corner* (2017, TTC). The former was initially a radio presentation, here promoted by HT:

Fig. 27: Mental Health Minute (2008) promotion by HT.

It appears in video form on YouTube as a series of different coloured screens upon which words appear as the celebrity speakers talk in turn:

[46] Both were 'contingency options', for screening had time permitted.

Fig. 28: Mental Health Minute (2018) on YouTube

In Your Mate's Corner had greater 'status', as it had been screened as a television advertising campaign, and formed the cornerstone of the eponymous TTC campaign 'burst'. Set in a (male) workplace, it positions itself as contemporary through its modern urban hip-hop soundtrack, which itself attracted several comments. It appears to intentionally represent an ethnically diverse working class male demographic.

Fig. 29: Screenshot from In Your Mate's Corner (2017).

Concerned friends visit their 'mate' (in overalls) at work. His workstation becomes a metaphorical boxing ring.

Fig. 30: Closing shot from In Your Mate's Corner, 'posterised' for the TTC website.

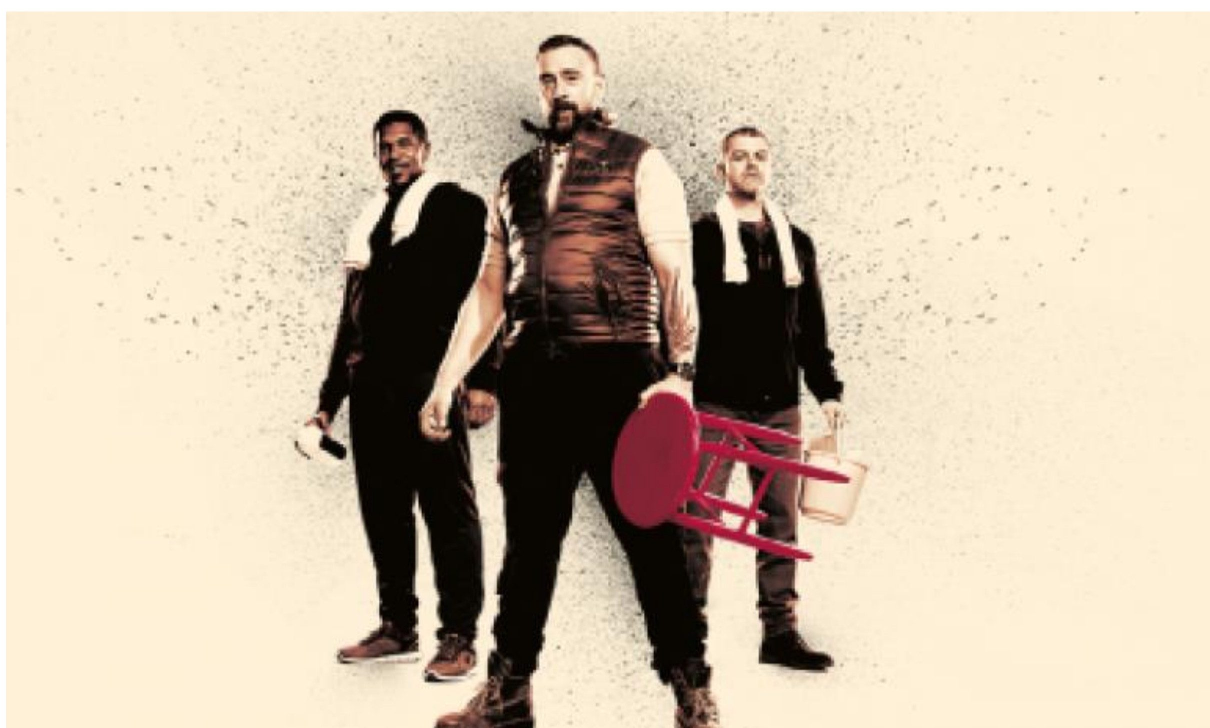


Fig. 31: Branded version of In Your Mate's Corner

Recontextualised, with a grittier urban context and featuring youths unrelated to the video.

Text introducing *In Your Mate's Corner* on YouTube,*'1 in 4 of us will fight a mental health disorder this year, so if your mate's acting differently, step in',* uses metaphors of combat and intervention, which are extended with the boxing theme which informs the title and reflects the content. Use of '*this year*', seen early in 2017, gave a sense of urgency and a connection to resolutions for the year ahead. Use of 'disorder' is interesting for its intertextual associations with 'drunk and disorderly', while the use of 'acting differently' has an imprecise meaning; it aligns with the workplace surveillance tactics encouraged via workplace Champions, The Pledge, and by Mental Health at Work. The video and the campaign it was part of is discussed by an interviewee in Appendix 2.3.

8.6.1 Coding

Here I present the codes which I attributed by following the analytical method described in 5.9.7. Coding required careful consideration of context, the position of a comment within the 'thread', and even awareness of characteristic output of repeat commenters. Codes were often assigned through implicature; with reference to Table 13, *'This needs more views'* is POS, despite making no direct evaluation, yet *'this was depressing'* is ambiguous; it is suggestive of an ER, but the viewer's response to the video and its message could be either POS or NEG. *'That was powerful'* however is less ambiguous, since its context allowed attribution of POS.

In lieu of inter-tester reliability checks, codes are the result of multiple iterative decisions. Additionally I reviewed the coding at a later date to identify discrepancies, ambiguities and errors: on conclusion of this review, categories were confirmed, and allocation of codes to comments was finalised.

Table 13: YouTube comment codes and description

Code attributed	***Description***
POS (POSITIVE)	Supportive of the message/video. [assigned when there is a reference to efficacy as well as a positive adjective]. May be implicit '*this tells the truth!*' or *'this deserves way more attention'*

	'I burst into tears watching this' is not necessarily POS in the absence of further comment (but is an ER - Emotional Response)
NEG (NEGATIVE)	Includes statements that the video is factually wrong, unappealing, inaccurate, ineffective. Need not imply lack of sympathy for people with MI. Includes comments such as *'I can't understand his accent'*.
SUP (SUPPORTIVE)	Supportive message, usually from/to an individual: *'You are not alone'*. Occasionally to an assumed collective audience. Sometimes expressed by TTC.
DR (DIRECT REPLY)	Direct reply to specific comment/s or to the video poster. Only assigned when sufficient evidence of addressee. Includes use of an addressee's real name, rather than username.
UA (UNKNOWN ADDRESSEE)	A response to specific content, when the addressee is not known. Commenter may know addressee personally. Some UA may be directed to the perceived general audience.
TTC (or HT, etc.)	Reply or comment from source organisation.
MOD (MODERATION)	Comment by TTC/posting body to publicly correct a response, re-focus a discussion, explain the video's purpose, or justify a deletion. Distinct from general comments (above), and from *'Sorry to hear that'* from TTC to a person in distress, which is SUP.
PROM (PROMOTION)	TTC, SUP, or MOD comments which also promote TTC further resources, providing a link/URL, or hashtag.
PE (PERSONAL EXPERIENCE)	Relating personal experience not explicitly about mental health; adverse life events, physical health issues. Includes the experience of being a teacher - a significant theme in *The Stand-up Kid* comments. Includes PE of close others.
PEMI (PERSONAL EXPERIENCE OF MENTAL ILLNESS)	Relating personal mental illness experience (May be oblique, using 'you' instead of 'I'; '*you feel so hopeless*', '*you try to laugh it off*'. May have confessional feel. Explicit and detailed, or implicit; *'I wish I had the courage to do that', 'I've been there', 'welcome to my reality'.* Includes PEMI of close others.

O (OPINION)	(Non-advice). A personal view, even if it constitutes a misunderstanding. Broad category including expressions of fact, that hope is needed, or providing a point of view. Frequently unrelated to the video. Subtly different to explanations.
I/A (INSTRUCTION/ADVICE)	Explicit, typically an imperative, e.g. *'do…'*, *'leave this video!'*, *'See your doctor'*. Occasionally modalised *('you could contact…')*. May also, when empathetic, simultaneously constitute SUP. Meanwhile *'please don't say that adults aren't part of the problem',* (a call for an attitude, not an action), is *not* viewed as INST/ADV.
EXP (EXPLANATION)	Usually about mental health, e.g. types of depression. May clarify a previous comment by same commenter. Includes EXP by TTC/posting body. Includes unverified assumption of expert status, and includes misinformation.
Q (QUESTION)	Can be divided a requests for information, or for action/behaviour change. May be rhetorical: *'who needs friends like that?'*, or a challenge: *'where do you get your statistics from?'* or *'why aren't we all taught about this as kids?'* Comments which are grammatically Q's but semantically agreement, i.e. use tag questions (*'It's horrible isn't it?')* are not included, nor are challenging requests; *'kindly show me where I said (that)?'* May signify more than one question in a single comment.
ER (EMOTIONAL RESPONSE)	Specifically in response to the video (*'it hit me', 'I'm crying'', I hate it', 'it makes me feel…'* (In contrast, *'I applaud this'* is not ER, but POS). ER not assigned in response to paralinguistic additions (e.g. heart emoji). Occasionally associated with comments made by others, e.g. sadness at trolling.

V (VIDEO)	About the video itself; a specific element, phrase or frame. May use 'this' or 'it' (Including example such as *'it reminds me of…'*) Includes many comments within an on-topic thread which the video prompts.
AGE	References to older age (rarely, simply adulthood) in relation to experience of/attitudes to mental illness.
AGG (AGGRESSION)	Attack or rudeness. Insults, profanity, denial of others' right to a different opinion. Incorporates a spectrum of force, from needless spite to violently abusive tirades: *'You are a sick person and I hope you fall down a well and have your eyelids removed.'*
COM (COMMENTS)	(Meta) comment/observation on the comments, or of commenters' behaviour. Useful as a gauge of mood.
IT/ID (INTERTEXTUALITY/INTERDISCURSIVITY)	Presence of intertextual elements such as campaign slogans or titles (*'It's Time to Change!'*) or verbatim repetition of a scripted element. Includes some interdiscursivity, where an external text is evoked, especially in *The Stand-up Kid.*
U (UNCLEAR)	Broad category encompassing unclear meaning, sarcastic humour (*'What's the punchline?'*), off-topic comments (religion), vacuous comments (*'lol'*), vague cynicisms, correction of own spelling, or ambiguities. May be assigned a further code; UA, or T. U comments do not contribute to understanding genuine perception of the video.
TROLL	Subcategory for the most offensive or facile U's, or for pointless random slurs such as *'gayyy'*.

8.6.2 Results and observations

Table 14: Number of comments per category in each video

CODE	60-Second Ad (11)[47]	Stand Up Kid (468)	MH Minute 2018 (8)	World MH Day 2017 (2)	Andrew's Story (1)	WHO (5)	In Your Mate's Corner (28)	Total
POS	3	108	4	1			10	126
NEG	1	61	0	1			0	63
V	4	244	4				13	265
U	3	57	4			2	0	66
T	2	8	0				0	10
DR	1	71	0				7	79
UA	1	78	0				0	79
AGG	1	32	0	1			0	34
Q	1	54	0	1			2	58
EXP	1	77	1			1	3	83
PE	0	21	1				1	23
PEMI	0	103	1				3	107
ER	1	40	1				2	44
TTC	0	9	0				4	13
SUP	0	18	0		1	1	5	25
PROM	0	4	2				2	8
AGE	0	10	0				0	10
MOD	0	3	0				1	4
IT/ID	0	17	0				0	17
INS/ADV	0	28	0				1	29
C	0	11	0				0	11
O	4	180	0	1		3	2	190

Table 15: Ranking of categories

Category	*Frequency, high to low*
V	265
O	190
POS	126
PEMI	107
EXP	83
DR	79

[47] The number of comments, in brackets, is the number prior to any deletions by posting bodies.

UA	79
U	66
NEG	63
Q	58
ER	44
AGG	34
INST/ADV	29
SUP	25
PE	23
IT/ID	17
TTC	13
C	11
AGE	10
T	10
PROM	8
MOD	4
All codes	1344

Observations from Tables 14 and 15:

- Under 50% of comments concerned the video itself.
- There were exactly twice as many positive reactions as negative reactions; this agrees with Siersdorfer *et al*. (2010) who found, globally, more positive than negative YouTube comments.
- 21.6% of all comments were coded PEMI.
- 73.4% of all comments were opinions, representing a large body of ‘expert’ but not always factually correct views.
- No comments were common to all, and no video contained all of the categories.
- Aggression towards other individuals was more common than support.
- The proportion of comments to views was much lower than observed in the literature, which could be interpreted as a marker of low impact.

8.6.3 A case study: characteristics of comments and commenters in *The Stand Up Kid*

As explained in 5.5, I necessarily restrict my descriptions of comments to those from a single video, *The Stand-up Kid* (SUK) as a case study. Among the selected anti-stigma videos, this title prompted the greatest number of comments on YouTube, and even provoked a discussion of age. With respect to the motivation for its storyline and context, it may be no accident that the narrative concerns a boy's absence from school; this ties in with TTC's central focus on absenteeism and presenteeism in the working population. In Appendix 3.1 I provide a transcription of the video, and in Appendix 3.2, a verbatim transcription of the comments, along with the coding which assigned to it in accordance with Tables 13 and 14.

Comments encompassed cohesive and thoughtful observations, accounts of mental distress, and facile one-word contributions (*'wut'* or *'gayyy'*). In this largely ungoverned medium, some contributions are illogical or offensive; their heterogeneity reflects the diversity of the cultural space. Comments were peppered with ambiguities: *'SLOW FUCKING CLAP I'm sick of sitting silently in the sidelines while mental health jokes are told and it kills me'*; this is POS by implication, as the video message is that mental illness is not a joke. Non-standard language use, which may reflect commenters' youth, suggesting at least that SUK reached its target audience, rendered some comments barely comprehensible.

Number of views does not indicate understanding or approval of the message, but does reflect the impact of the video as a stimulus for discussion or expression of opinion. Similarly, the number of comments (486) does not equate to 486 individual commenters, since I identified some challenging and multiple commenters. The high number of PEMI (103) might either suggest there is therapeutic value in expressing something in the digital realm, that there are insufficient alternative outlets, or it may simply reflect the ease with which young people speak about their problems.

8.6.3 (i) Moderation, deletions, institutional input

The video's poster has the right to remove comments, and deletion sometimes interrupts the coherence of comment threads. Consequently comments which, from context, are replies (*Excuse me!!...*) have no obvious addressee. Deletions challenge interpretation; *'well, that was awkward'* may refer to the video scenario or to a deleted exchange. This affects attribution of codes, resulting in a greater number of apparently random (U) comments.

Deletions did not go unchallenged:

I think you should listen to feedback on these campaigns if it really is about breaking the taboo... Surely the whole point of these campaigns is to open up discussion? So if you remove my comment it is frankly a bit hypocritical. ... it seems you are only keeping comments that absolutely agree with your pitch. And im no 'troll' - im someone who has been through severe depression.

Another commenter (inaccurately) accused TTC of deleting all negative comments. Deletions do confirm however that institutional constraint and control of the discourse, noted in Chapter 6, particularly 6.2.3, extends to video comments. Yet deeply unpleasant comments are permitted, unfortunately suggesting protection of the TTC brand was the primary aim of moderation. The excerpt above does not seek help, but provoked input from TTC explaining the help offered by Mind, Rethink, and Samaritans. Yet when need was very apparent, TTC seldom intervened, only rarely offering SUP to commenters in distress. Similarly, no moderation followed this or other evocations of the concept of danger: *'Good thing he didn't have a gun! You seem to think the rest of the world should manage his illness…The teacher ... doesn't stop him, putting students in danger.'*

The low level of monitoring by TTC, and selectivity of intervention, permitted an initially positive discussion to largely disintegrate into vitriolic chaos. In the face of incoherent nastiness, the more reasoned comments diminished over time.

Veletsianos *et al*. (2018) call for 'early warning' algorithms to allow timely interventions on YouTube. This however raises the issue of how such moderation, just as with mental health stories, may also be ideologically motivated; something I found no consideration of in the literature.

8.6.3 (ii) Aggression

Confirming findings by Ernst *et al*. (2017), aggressive comments tended to beget more aggression, resulting in long running disputes. One particular commenter repeatedly instigated aggressive sequences. When challenged about their own mental health, this 'primary aggressor' disclosed experiencing suicidal feelings when younger, but their disclosure did nothing to ameliorate their aggression; they shifted instead to an insistence that since they had overcome problems, others were weak if they could not do the same. They repeatedly characterised the protagonist as a 'school shooter':

'Look at how that kid's acting! Turning on his class, punishing them with his words for what he merely thinks is a cruel world. He's got all the earmarks (sic) of being a school shooter…Run now before it's too late!'

'This is a potential class shooter. He is a ticking time bomb ... It's the most retarded PSA ever.'

These responses illustrate how for some commenters, their own mental ill-health precludes objectivity; the video's main character is consistently calm, unthreatening, and merely stands on his chair to command attention while he quietly explains his experiences to both teacher and class, describing how their comments made him feel. Since dangerous rhetoric about 'shooters' reinforces negative stereotypes, an anti-stigma organisation has a responsibility to remove such comments.

8.6.3 (iii) Did the commenters understand the video's message?

Discerning negativity or positivity was far easier than inferring understanding. Because of repeat commenters, negative comments were proportionally more numerous than in other videos, but still less frequent than positive ones. However, negative comments were expressed with greater force, confirming findings from Thelwall and Sud (2012), and provided more information about the sentiments the videos provoked. Comments conveying lack of understanding were more salient than those which suggest people grasped the message, which were typically qualified in some way:

'I do get the point but they could've made it A LOT clearer, the only person who "jokes" about mental disorders within this entire clip is the person with the mental disorder'.

The multifunctionality of comments meant that even a positive response (underlined below) could be framed within sarcasm, or criticism of another comment:

'So you want to ignore the demographic of kids who may be suffering from depression and anxiety all for the sake of avoiding it becoming a trend? <u>This could save lives</u>. Allow younger people who are in the dark about their mental illness (to) reach out and find help. But no, I guess we're better off not letting that happen, lest we get a few copycats acting like they're depressed.'

Attitudes to mental illness were variable. It is unfortunately *possible* to dismiss the character's experience (depressive illness) because it primarily inferred. A number of comments reflect this problem: *'what mental illness did he have, he seemed normal to me.'* Several viewers also

believed this was a real scenario, filmed covertly or coincidentally, or ‘planned’: *‘This looks a bit "staged" with all the camera angels (sic)’.* Such misconceptions, which prompted corrective responses (*‘This isn't a true story. But* (that) *doesn't mean that the message isn't real’*) may reflect a pervasive aspect of media culture involving habitual viewing of real events, and identifies an impediment in claims by Ito-Yaeger *et al*. (2021) of the particular suitability of videos to convey anti-stigma interventions to young people.

The relatively high proportion of ‘V’ comments confirms that people are responding to the video itself, but many do so to suggest the behaviour of various (literal) actors are unrealistic, or to express confusion about and criticism of the scenario: *‘im so confused where the discrimination takes place’,* or *‘What the fuck did this have to do with mental illness? No one even said anything to him about being mentally ill.’* Both comments demonstrate an inability to understand what had prompted the protagonist’s reaction; the viewer *sees* sarcasm but must *infer* further bullying and prejudice from the script. The video makers assumed a level of audience sophistication - the ability to make contextual inferences and work with implicature – which was often absent:

Okay so I don't understand this, I mean a few things: Why does he start that speech like what makes him so pissed off, is it just that no one knows actually where he has been? What is the offending joke? is it the "are you a comedian?" and it hurts him because he's actually the opposite? And more importantly what does he mean at 2:01 "it just makes it a little harder", what makes what harder?

Other commenters in turn objected to the tendency to criticise the scenario: *‘So if I were to read only the comments before watching the video, the entire message would be 100% lost…’*

The comment below confirms the value of seeking focus group responses, to learn whether such incomprehension was specific to the online audience; it was not (see 8.2.3. and 8.3.0); overall the focus group responded with greater negativity than the YouTube audience.

‘He's victimizing himself, if he has a mental problem then work to make it better otherwise being late and a delinquent is no excuse. If hes really serious then he needs an aid to follow him around and make sure hes on schedule.’

Responding to a suggestion that the main character was an entitled *‘brat’*, a commenter replied, *‘It's because of people that think like you that people are not getting the help they need. They*

rather just stay away from it'. This recycles and promotes the shared TTC/HT view that stigma prevents help-seeking.

Some comments however were simply dismissive, or shallow generalisations: *'teachers really are just shit'*, or *'this is a pile of rubbish alot (sic) of the things today kids catch from tv or mixing with bad kids'*.

8.6.3 (iv) Comments on age

Arising from a video ostensibly unrelated to older age, ten comments focusing on age present strong opinions about older people. The teacher character (played by an early middle years actor) played a relatively minor role in the scenario, but became representative of ignorant adulthood, and 'anti-teacher' sentiment developed into anti 'older person' sentiment, temporarily characterising the comment thread as 'ignorant older people versus victimised youth', arriving at the idea that only younger people have mental health problems, since *'the older ones… They've learned to ignore those who would poke fun at them… the older ones, most of them understand why they are this way.'*

Another suggested not only that adults' ignorance stems from their inability to understand things they have not experienced, but that adults *'don't really grow up and tend to be really cruel, except their cruelty has matured and is more painful.'* The commenter graciously conceded, *'there are also a lot of people that with age gain experience,'* Others insisted; *'please don't say that adults aren't part of the problem'*.

Such opinions provoked:

'Suicide is very high among baby boomers right now. Get your facts straight if you're going to go spouting like you know them.'

'You just tend to hear more about it because adolescence is when the mental illness emerges. By the time you are an adult it is possible you have it under control by using medicine or therapy or whatever'.

Collectively however, responses suggested that young people 'own' mental health problems. The genuinely puzzled *'it doesn't make sense that younger people tend to suffer with mental illness more than older people'* suggests a consequence of campaigns' emphasis on younger people may be the misconception that mental illness really is only a problem of the young.

The above comment provoked challenge:

'Where did you get your statistic that younger people suffer from mental illness more than adults? A lot of mental illnesses can't be properly diagnosed until your late teens to early twenties anyway.'

The emphasis on young people in AS campaigns has not gone un-noticed among older age groups:

'More ageism from the ttc camp. Are the rest of us not supposed to be able to see straight?' Use of 'more' suggests the commenter feels this is a trend. Another complained:

'its things like this (the video)*… can* (lead) *children into thinking they have a mental illness when they don't, they just absorb into the glorification of it and see it as some 'cool' thing, i think mental illness campaign awarenesses should be more mature instead of appealing to a younger audience which* (they) *may influence.'*

The familiar, aggressive, commenter, themselves an older adult, offered: *'if my grandson were in that class I'd want him to run the fuck out before this fucker started shooting*. This older person with both stigmatising views and a demonstrably problematic mental state - and others like them - remain outside the target demographic of AS, and act as an important reminder that the creation by AS of a binary of 'mentally ill non-stigmatiser vs general public stigmatiser' is simplistic and false.

8.6.3 (v) Intertextuality

The social media tendency of repeating/quoting a line from a video or a written piece of text, seen in *'Are we a comedian as well now, Michael?'* (spoken by the teacher) often identifies text which resonates with a viewer, yet in common with campaign-specific fragments, does not help us to understand sentiment.

References to external named texts were all derived from youth culture, ranging from *Harry Potter* (*'Someone cast Wingardium Leviosa to lift up this man's spirits!'*) to television dramas, *Waterloo Rd*., *Misfits*, *Skins*, and the US musical comedy drama *Glee.*

It is unclear whether SUK was intended to contain an intertextual reference, or for what purpose, but commenters' mention of the film *Dead Poets' Society* (1989), *('Ohh, is that a Dead Poets Society reference?'*) echoed my own observation. This film contains a scene in which pupils respond to the dismissal of their teacher, Keating, by rebelliously standing on their desks. In doing so they follow the example of Keating, who had stood on his own desk, explaining *'I stand upon my desk to remind myself that we should constantly look at things in*

a different way'. In SUK, the act of standing on a desk to express a personal truth draws inevitable parallels with this film, and viewers made a connection. Ironically the death by suicide of the film's main actor, Robin Williams, in response to Lewy body disease, raised the profile of mental illness in older age.

8.6.3 (vi) Political, cynical and controversial responses.

In this section I refer to relevant responses to all of the videos, and indicate when they are not responses to SUK. Most comments indicated a face-value appreciation of AS campaigns, yet a few expressed forthright views:

This is a useful campaign, but my guess is that no one will mention the suffering caused by successive governments and their demonisation of the vulnerable as lazy and workshy. Mental health is not the same as physical illness, those with power have a vested interest in getting you to believe it is. GOOGLE, power threat meaning framework.

The instruction '*GOOGLE*' refers to work by Johnstone and Boyle (2020) which examines patterns of emotional distress and behaviour, and promotes alternatives to traditional models of psychiatric diagnoses by considering power relationships.

Harshly opposing views were also present: *'Propaganda to pity kids who can only help themselves'* invokes the language of political communication, but does not suggest what might motivate such propaganda. The following meanwhile exemplifies the challenge which the asynchronous nature of responses presents to interpretation:

'Another one that can't handle the truth and doesn't know his ass from a hole in the ground. Keep buying the government line, fool.'

The same commenter had previously asserted *'First thing we've got to do is stop enabling by glorifying them'*, where *'them'* is people experiencing mental distress. We can discern nether what the commenter believes the government line to be, or even which government is referred to.

Two responses to the animated WHO video *Let's Talk About Depression* counter the notion that animated materials neutralise both negativity and positivity (Thelwall and Sud 2012); The first uses positivity as sarcasm, in a manner observed by Veletsianos *et al*. (2018):

'Yes I have posted this on Facebook Page !! Lol n Laughter as everyone joins the "Let's Talk" Campaign !!'

'Nobody really cares about us folks unless you have a big bank account and the leftist(s) *want us all to die'*. Here *'us folks'* presumably means older people, the subject of the video, although it is unclear why generic 'leftists' wants anyone to die.

A response to HT's *World Mental Health Day* (2017) gave the most pertinent challenge:

'Is this some kind of sick blind joke? The government, the DWP and atos are pushing mental health sufferers over a cliff edge and into suicide whilst they all turn a blind eye and bury it under the carpet'.

It was after this comment that the comment facility was blocked.

8.6.3 (vii) Replies, discussions, and their triggers

31.1%[48] of comments were replies to previous comments; higher than Thelwall and Sud's (2012) determination that 23% of comments are replies. I identified disagreement, and the desire to identify unknown facts, as the main triggers for discussion. The few commenters to *Mental Health Minute 2018* however did not respond to each other at all, but commented as if directly addressing the campaign's 'Principals', suggesting their interest was more in the royal family than in mental health (see section 6.4.1 on HT audience with respect to genre).

8.6.4 Concluding points from YouTube analysis

I provided coding results from my analysis of seven videos, and a commentary of findings from *The Stand-up Kid,* which also provoked the most focus group discussion. Its data undeniably skews quantitative results, given its high number of aggressive comments. Yet the single YouTube comment for Andrew's Story skews them too; importantly, the selected videos were not intended to be comparable to each other, to other YouTube videos, or representative of their genre.

This work has shown that qualitative analysis of comments responding to campaign videos produces profoundly diverse and interesting results. Effusive and emotionally positive reception sits with aggression and hostility. This presented an obstacle in determining whether the commenters 'received' or agreed with the message, since it was frequently the medium,

[48] From combining the numbers of Direct Response (DR) and Unknown Addressee UA categories.

form, or other commenters which prompted comment, with the message relegated to secondary importance. Lack of comprehension could more frequently be inferred than comprehension.

I was also interested to discover whether comments demonstrated any recognition of the use of AS as an essentially diversionary policy intervention. As described, limited but strongly expressed comments about inequality, austerity, and mental health funding came close to this recognition, the most perceptive of which resulted in the blocking of further comments to that video.

TTC was proud of its campaign analysis and evaluation, yet if it analysed the responses to *The Stand Up Kid*, it neither signalled this, nor addressed the consequent conflict and lack of understanding. It did however remove the video from YouTube entirely, thereby erasing all the comments. *The Stand Up Kid* was later re-posted within a different context[49].

[49] Released to accompany Comic Relief on BBC TV.

CHAPTER 9: Interviews with Policy Facilitators

The interviews involve asking a range of questions which are not, in themselves, the research questions, but which contribute to answering them, in particular the following RQs:

- ***RQ2: What does the language around the campaigns reveal about the (explicit or more opaque) function of AS campaigns?***
  RQ3: Why is the concept of stigma afforded such importance as part of mental health policy?
- ***RQ5: How is the practice of anti-stigma self-evaluated and legitimated as a policy response by its architects (or its enactors)?***
- ***RQ6: How does this discourse of stigma define the nature of the policy problem?***

9.0 Introduction

This chapter presents the findings from three online interviews with key senior stakeholders in the field of anti-stigma, each of whom can be regarded as policy implementers or facilitators. The interviewees all primarily 'represent' TTC for the purpose of the interviews, although one is more closely associated with Mind, and the others worked both with TTC and either Rethink or Mind. The interviewees are anonymous, but when discussing the findings I identify interviewees respectively as **'Mind', 'TTC1 and 'TTC2'**, to help the reader understand different speaker perspectives. Use of bold lettering distinguishes between references to the interviewees and references to organisations, and questions are also identified using bold text; these may be questions semantically, rather than necessarily grammatically.

Findings from these diverse conversations can be organised organically into two areas of discussion and analysis; first, that which concerns the idea of anti-stigma, associated organisations, and the interviewees' perspectives about their work, and second, that which specifically concerns the way that various people or social actors are talked about. This in turn is considered in three categories; people who are mentally ill, the public, and older people.

Discussion of the interviews includes exploration of several key themes which emerged from the analysis, as represented by subheadings which are neither questions nor responses. In

interpreting the data, intertextual and interdiscursive links between the informants' responses and other mental health discourses or structures are critically explored. While themes inevitably reflect the nature of the questions posed, for example, with respect to interviewees' perspectives about the reasons for the institution of TTC, responses to questions generated their own themes, both topical and linguistic, some of which I explore through targeted linguistic analyses using the interview corpora. For example, when exploring how interviewees describe what their organisations do, how they do it, and what they might do in the future, I investigate the material processes which mark the way the interviewees describe AS work, and examine use of modalisation in their commitments to current or future actions.

Some questions were 'questions in common', asked of each participant, while others were tailored to maximise the opportunity to speak with an individual with a specific role or expertise. For questions asked of each participant, and transcripts of responses, see Appendices 2.3, 2.4, and 2.5. Before turning to findings, I consider contextual aspects; as discussed in 5.9.6, the context of situation is an integral element to the analytical approach of this data.

9.1 Contextual issues

The context of situation[50] for these interviews, in common with those of Hermes (1998), includes the interactions involved in contacting interviewees and scheduling the interviews. This means practical considerations are reviewed in terms of their potential impact on content. Qualitative interviewing typically takes account of researcher positionality, the researcher-participant relationship, co-construction of data, and reflexive practices, and these elements are discussed either below or within the findings.

While interviewers often hold a position of greater power in relation to interviewees, in this case the interviewees held the greater power, in respect of their institutional positions and having granted their time. Yet this is tempered by their respective responsibilities to uphold publicly-conveyed organisational ethe. Wetherell and Potter (1992) found interviewees in a study of racist discourse wished to present themselves as non-racist, and it is reasonable to assume interviewees contributing to this research would wish to present, at the very least, as non-stigmatising. Participants may also be unsure, even having been provided with information about the research, of the interview's direction, and despite their vast experience as

[50] Halliday's (1978:10) '*construct for explaining how a text relates to the social processes within which it is located*'.

interviewees, a researcher using a critical approach to language may represent a potential threat, even if the researcher's positionality (critical of the founding premise of AS) was not, intentionally, apparent.

Thanks to an introduction to Mind, facilitated by my supervisor, I was granted rapid access to key figures within TTC. This rapidity was itself informative, confirming my understandings of the cross-organisational fluidity of the UK's main mental health organisations, as my email communications were openly copied with others across three organisations (Mind, TTC and Rethink). Consequently a previously unknown individual proactively offered to take part. It is impossible to determine the extent to which the concerted dissemination of my request for interviews, and the positive responses, were driven by altruistic or public relations motivations.

9.2.0 Anti-stigma, the organisations and their work

9.2.1 Influencing people and policy

The existence of AS campaigns has been justified by their aims to influence public attitudes. While campaigns clearly describe the influence they seek to have on those who stigmatise, there is less clarity on the existence of parallel intention to exert influence on government with respect to mental health funding, or whether campaigns are driven by any perspective on mental health inequalities.

Interviewees were therefore asked whether anti-stigma efforts could be 'upstream' of politics; exerting influence to change political thinking and policy, and whether this was an aim of their work. **TTC1** suggested AS creates an attitudinal environment of *'support and sympathy'* for people with mental health problems *'which… enables certain policy changes to go ahead'*, but cited the Scots anti-stigma campaign See me Scotland as an example, without claiming any parallel in TTC, adding *'I don't know if we're really trying to…exercise any sort of hegemony'*. They emphasise instead that TTC holds itself responsible for outcomes concerning stigma and discrimination, which are only part of what a *'quite different-looking society in mental health terms would look like'*. The participant suggested this would be a *'pub conversation'*, reflecting *'would a society with no stigmas and no discrimination be compatible with one …which has a pretty low level of services?'* Having located this question in a different context, the interviewee was then able to deny that a society containing structural injustices and inequalities can co-exist with *'good attitudes and good treatment'*. Referring to a pub

conversation can be seen as a mechanism for creating distance between the opinion offered and TTC; it provides both a contextual gap, and the connotation that a pub conversation, fuelled by alcohol, is unreliable and perhaps inadmissible.

TTC2 first confirmed their hope that TTC influences policy, before suggesting that the more complex answer is that TTC succeeded (itself an assumption) because it adopted a multifaceted approach, with a known and targeted audience, at an *'umbrella national level'*. Consequently the campaign *'suddenly…starts to take a life of its own'* and its multilevel approach *'empowers people to demand change and difference'*, an effect they compare with the Black Lives Matter movement. Importantly in this framing, it is 'people' who must still ultimately demand change, not the campaign. This fits the familiar pattern of responsibilisation. TTC *'doesn't need'* to undertake political campaigning, because that is undertaken through the work of its two organisational partners, Mind and Rethink. This response reflected the speaker's wider denial of the political relevance of AS; they depict a very active, complex and worthy endeavour which successfully effects change, yet is remote from issues of political influence.

Yet **Mind**, whose organisation, according to **TTC2**, carries out political campaigning, denied that their organisational objective is to change government *'but to change people'*, and that their work *'in this space'* (the metaphorical space in which campaigning for policy change is undertaken) is direct to the public. Government has a role to play; in funding TTC and in terms of *'the actions that it chooses to take in relation to people with mental health problems'*, but Mind's overarching interest is in the *'relationship between people with mental health problems and other people'*.

9.2.2 Raising awareness

The drive to 'raise awareness' is a familiar trope, embedded in mental health (and particularly AS) campaigns. As raising awareness is a prime component of the influence AS aspires to exert, **I asked how interviewees define awareness raising, and how useful they really perceive it to be.** Acknowledgement that raising awareness has limited value would constitute admission that a key strand of AS is a pointless, or at least misguided, endeavour. Responses complemented those about campaigns' intended sphere of influence (above).

TTC1 immediately responded, *'one thing that awareness-raising can't change is access to services'*, citing quantitative findings from a TTC poll of 4,000 people, which found that

'access to services and quality of services was…the number one priority, unsurprisingly.' They suggested however that raising public awareness and gathering support for stigma-reduction *'helps with other, sort of influencing objectives an organisation might have'*, agreeing that this relates to the idea of culture being upstream of politics. They then assert that TTC is *'definitely adjacent to politics… because we are interested in influencing policy, and…one way that we try to do that is…to mobilise people with lived experience'*, adding that this is a *'fairly… standard civil society-like model'*.

TTC2 suggested that many programmes purporting to practice AS in fact only raise awareness, so they are unlike TTC, which seeks to change not only attitudes and knowledge but also behaviour. Once people develop greater understanding of mental illness (i.e. their awareness is raised), they need a 'nudge' to model appropriate behaviour. I have no reason to believe that this was an intentional reference to 'nudge' (Thaler and Sunstein, 2009) which, as I note elsewhere, is a relatively institutionalised policy instrument.

Mind, confirming the value of awareness-raising activities, emphasised the need to take a *'long view'*: their experiences suggest adults over 20 have rarely had any mental health awareness training, which, for the speaker, confirms that stigma and discrimination *'in previous generations'* have been a barrier. Younger people however are now primed by *'some sort of conversation'* about mental health at school, i.e. by awareness-raising, which the interviewee defines as *'basically influencing the knowledge part of the…suite.'* The speaker believes that while initiatives such as Mental Health Awareness Week are important, they seek only to improve knowledge and understanding, rather than attitudes or behaviour, which is why *'we articulated the need for distinct, anti-stigma campaigns that target…attitudes and behaviour'*. This diverges somewhat from the perception above that awareness-raising lacks only behavioural change.

The more significant contrast here however is that only the first interviewee understood and unequivocally responded to the question's meaning; that society could be impeccably informed about mental illness yet, without treatment when they experience it, how does raised awareness help? Other interviewees' failure to acknowledge this point speaks of the way that entrenched underlying precepts which guide campaigns may prevent even senior staff from looking, or speaking, beyond their set organisational modus.

9.2.3. Mental health inequality

Interviewees were asked what connection they saw between what they did, in their role or as an organisation, and society as a whole. This led to the planned prompt**: I'm thinking about health inequalities and mental health inequalities.**

Interviewees defined mental health inequality in a variety of ways. **TTC1** perceived it, very specifically, as the much-discussed disparity between treatment (in the broadest sense) of physical illness compared to mental illness. **Mind** declared that their *'primary lens is the inequality experience'* for people with a mental health problem, stating that those with more serious mental health problems experience *'inherent'* stigma and discrimination and are more likely to die early, to be unemployed, or to have problems with the criminal justice system, and that discrimination is exacerbated for those experiencing pre-existing discrimination; *'if you are a young black man...suffering from schizophrenia for example'*. This response most strongly aligned the concept of mental health inequality with race and ethnicity, and the speaker was clear that their organisational strategy is informed by *'a very clear overarching goal around tackling inequalities'*. Part of their job, to *'give a voice to the voiceless'*, was historically rooted; while half a century ago the 'voiceless' were in asylums, *'now it's asylum seekers'* or the BAME community.

TTC2 addressed the issue of inequality proactively, describing TTC's awareness of their responsibility to confront mental health. They used the specific term 'intersectionalities'; areas of multiple disadvantage which either predispose to mental ill-health or render an individual's experience of it more extreme. Only this speaker considered the diverse causes of social inequality, specifically naming poverty, and its relationship with mental illness.

9.2.4 What were the reasons for the launch of *Time to Change*?

The reasons for the existence of AS as a policy response are of significant interest to this research as part of the 'hidden discourse'. Interviewees' replies were not necessarily expected to be wholly patent, but I anticipated some useful insights. Explanations of the campaign's genesis were plausible, but ignored both the political context of the campaign's creation and the question's political implications. Not all interviewees could explain the stimulus for a major AS campaign:

> *It's difficult though to see what, why, what exactly at that moment in 2006, and the campaign starting in 2007, really...persuaded the government to invest in this…around that time there was ... a sort of turning towards public health campaigns in a number of different areas, and this was …this was one of them…Effectively there was evidence* (**TTC1**).

This implies the existence of government funding, or influence, before its publicly known involvement from 2011.

The fullest account of the stimulus for TTC, from **Mind**, described four causal factors; an evidence-base from New Zealand, the *'increasing voices'* of people with lived experience, Comic Relief's desire to fund an appropriate cause, and the willingness of the partner organisations to collaborate. **Mind** suggested these factors together meant that an interesting idea, which was *'clearly wanted by people'* could then be delivered *'at scale'*. The institution of the campaign is in large part therefore legitimised by statements expressing *'we did it as a response to need'*.

Assertions which mirror the 'rationalised' *'people told us'* justifications for the campaign (7.2.2 (iii)) arose when interviewees discussed reasons for the campaign's creation or subsequent actions and activities. Generalised reliance on *'people told us'* is suggestive of a culture of professional legitimacy, in which a collective form of authoritisation exists. Such justifications are problematic, however. The 'people' referent can usually be identified only vaguely, as survey respondents, whose data have been processed such that a statistical cry for help is created. Legitimation here is thus intimately related to the use of 'evidence' whereby survey data are translated into a need, and re-framed as direct cries for help. Yet *'people told us'* implies literal *ad hoc* communication, from concerned individuals, and by direct mechanisms. This tendency to legitimate policy actions in terms of a declared (and sometimes fabricated) need is noted by Mulderrig (2011) in her analysis of the language of policy imperatives, in which controversial policies are presented as a response to a need, or a duty to act. Proposals in the interview data which represent the existence of TTC as a response to a putative need mirror this finding.

9.2.5 Acting on the evidence?

Valorisation of 'evidence' and 'evidence-based' actions is frequent across the interview data, both in justifying both TTC's initial institution, as seen above, and its subsequent activities. This understanding was not based on a response to a specific single question. I therefore describe below some questions which prompted responses citing evidence, demonstrate the ways in which 'evidence' was used, and provide direct responses and summative commentary.

(Questions are shortened or paraphrased)

***Q.* Why are older people not represented in TTC?**

(i) *…the attitudinal surveys that we run seem to suggest that old people don't have particularly worse attitudes towards mental illness…and I think there is a little bit of ageism in it where it's like 'oh yeah, it's just intolerant old people' who voted Brexit and don't like, you know… people with mental health problems and are very sort of selfish and um inward looking, and I don't, I mean <u>I don't think this is supported by the evidence</u>…* (**TTC1**)

This is contradictory; the statement suggests first that older people do not have poor attitudes to mental illness, and therefore that their inclusion in the campaign is unnecessary, but then that the organisation suggests their attitudes are intolerant. Worse than the contradiction however is the 'reported speech' element, describing stigmatising and ageist attitudes among TTC staff, but which the speaker themselves did not support on the basis of the lack of evidence.

[As part of an extended response to a question about the genesis of TTC]

(ii) *'What's happening now is <u>as the evidence accumulates</u>, we're sort of passing on what we've learned and what we've done'* (**TTC1**).

***Q.* What determined the shift in target demographic towards a focus on working class men?**

(iii) *We decided to move to focus on men C1-C2D 25-44 because <u>we looked at the evidence I guess</u>, looked at the attitudes that people held, and that group held slightly worse, not worse, slightly more stigmatising attitudes* (**TTC1**).

Here *'I guess'* qualifies the statement. This might imply a speaker does not know, but given this interviewee's position, this is unlikely. The self-correction from *'worse'* to *'more stigmatising'* is also revealing in terms of organisational attitudes.

***Q.* Does Mind intend to extend services for older people?**

(iv) *'we would absolutely like to expand services like My Generation* [51] *because… the evidence base has shown that they're really beneficial'* (**Mind**).

***Q.* What has been the most notable impact of the Covid pandemic on mental health?**

(v) *increasingly the evidence is telling us that in all three cases* (people with current mental health problems, people at risk, and the general public) *…there has been an impact, interestingly the overall impact on the public…is probably slightly less than we were necessarily expecting, erm the public have proved to be quite resilient?* (**Mind**)

(vi) *'some of our evidence is telling us that...public awareness of mental health has been heightened as a result of Covid'.*

The substantive answers here, that the public were coping surprisingly well, but that public awareness of mental health increased during the pandemic, are interesting in light of the following chapter, which concerns mental illness and stigma during the Covid-19 pandemic, and in which statements from Mind (10.3) contradict the picture of resilience.

***Q.* What drives the organisational differences between Mind and TTC, specifically with respect to the use of 'stories' by TTC?**

(vii) (TTC) *is heavily driven by … a combination of lived experience articulation of stigma, and very specifically stigma, and also really utilising the, erm learning from, er …audience led social marketing techniques'…*

(viii) *it's actually a very sci…I mean it's* (TTC is) *one of the most evidence-based pieces of work we do erm because it has … a very strong, it gathers evidence… all the time about the… I'm very much hoping you're having a good old dig in the evidence because one of the things that worries me is that we create all this great evidence and people don't really look at it.* (**Mind**)

[51] A well-received but limited initiative for older people run by Mind in Wales.

Q **If the rationale is to target the groups least exposed to mental illness, and who demonstrate the least favourable attitudes, then what is being done to address *self-stigma* in those who already live with mental illness?**

(ix) *the work of Time to Change Champions and the creation of platforms to encourage people to, 'come out' to talk about their experiences for the first time…and again I think our evidence base tells us that those personal interactions have been as powerful* (in self-stigma as public stigma)

Q **As TTC depends on contact-based work, what is happening during Covid, for example to the work of Champions?**

(x) *I do think we're really interested to see the effect of digital action in terms of you know does that have the same effect and I mean I know that people… have looked at this and I think there is some quite interesting evidence around that.*

Q **What were the reasons for the inception of TTC as Anti-Stigma, rather than a greater push for better services?**

(xi) *'New Zealand was giving us an evidence base, because you know people were actually quite sceptical about can you… actually change people's minds on this'.*

Q. **The Five Year Forward Plan for Mental Health set a target of a 5% improvement in attitudes to mental illness. Is such an aim is an acknowledgement that only limited success is possible through AS campaigns?**

(xii) *To make a shift by more than you know, especially given although you know this is relatively a well-resourced programme, it's still nothing compared to the amount of money …that will be spent trying to persuade you to buy…soap powder. So…the kind of marketing and resources at our disposal is* (relatively small), *and in fact I think we did do a bit of evidence based work that it's one of the most cost-effective attitudinal shifts of all times.* **(Mind)**

Examples (x) and (xii) demonstrate how, even if unsure of the evidence, referring to it serves to divert the conversation towards an emphasis on achievement, rather than a response to the question.

Example (viii) demonstrates it is not only the *use* of evidence which is important, but others' knowledge that it has been created. The consistent use of 'evidence' as a linguistic shorthand

to describe data gathered and used in a particular manner, drifts somewhat from the term's true meaning, as an available body of information supporting the truth of a particular proposition. There are also implications for campaigns' use of lived-experience accounts, especially since these too are presented as reducible to abstracted evidence. The addition of 'evidence' is a semantic mechanism for adding authority and weight, and provides instant legitimation. Yet none of these examples specify the evidence; it may be contextually traceable in some instances, but is not named. The reification of 'evidence' could in Marxist thought be deemed to represent its commodification, conforming with a wider pattern in AS in which commodification (of stories, of the labour of people with lived experience) is an assumed norm. For **TTC2** the semantic equivalent of 'evidence' was the evaluation activity which measures campaign efficacy or attitudinal change:

> *One thing that I think has been incredibly important to us has been making sure that we are absolutely evaluating, and spending lot, a fair amount of resources and time, to get the evaluation right.*

Elsewhere, campaign evaluation was discussed by scattered reference to surveys *('our survey showed…'*).

9.2.6 Inter-related but conflicting organisational identities

Both the interview data and the pre-interview communications with interviewees demonstrated that many key staff in the mental health sector work across organisations. The public knowledge that TTC is 'run by' Mind and Rethink does not convey the extent of this inter-relatedness. All TTC staff members are employees of either Mind or Rethink, producing ideological fluidity but also some clashes, allowing a 'not us' mentality ('we aren't responsible for that; they do that'). Interviewees admitted to varying degrees of inter-organisational conflict, speaking of *'ruffles'* or *'tensions'*, or admitting to cross-sector competition for the same *'pot of money'*. Initial reading of interview data suggested individuals ally themselves with, or distance themselves from, any of the three organisations depending on how that organisation is being presented. The utility of analysis of the pronoun 'we' in exploring these relationships was explained in 5.9.1 and demonstrated 6.2, which showed that in the website data, exclusive 'we' was dominant. I used the interview corpora to analyse its use in this data.

(i) Analysis of 'we' types

Given the nature of the interviews, in which individuals discuss the activities of their organisations in response to questions, a high frequency of 'we' was expected, and it was indeed 2-3 times as prevalent in each interview corpus [52] as in the reference corpus.[53]

Repeating the analytical criteria for 'we' types that I used for the website data (6.2), I found exclusive 'we' was again dramatically dominant (69.95% [54] of 'we' in the combined interview corpus), which here too can be construed as an expression of authority, knowledge, and expert status. Additionally however, in the interview context, exclusive 'we' may reflect interviewees' wish to present a considered, often curated, organisational opinion (the 'corporate line') rather than a personal one, often through variations of *'we at Time to Change'*. Exclusive uses such as *'as we call it'*, referring to a term the interviewee deems technical, complex and therefore part of a specialised discourse community, excludes the interviewer and represents a subtle power move.

(ii) Reflection of organisational identity

Hesitation naturally conveys the sense that a speaker is taking time to formulate their response. Some of this reflection is of particular interest for the way the organisational identity is invoked at these times: *'how would I respond to this? I think …the argument that we make as Time to Change is…'* (**TTC1**), or *'how would we, how would we approach this as TTC?'* (**TTC1**). This simultaneously signals the awkwardness of the question for the interviewee and, despite use of exclusive 'we', paradoxically infers a personal distance from TTC; the organisational response might not be their own, but there exists an official 'line' which they feel obliged to convey.

Elsewhere, while discussing the efficacy of tools used to evaluate AS, the reflective response was an admission that **TTC1** tacitly agreed with my challenge to the reliability of CAMI, a survey tool I mention in 3.7.2: *'I'm asking questions as well so what would I say about this…?'*

TTC2, responding to a question about the government's wish to maintain economic productivity, stated '*I suppose I'm going to answer this in a roundabout way'*. Here, the deliberation was consistent with the care this interviewee took to avoid speaking about the government.

[52] 2.2% of the combined interview corpus (IC), and 3% of T2
[53] BNC Spoken, (2014), 0.78%.

[54] 347 of the 496 uses.

9.2.7 Organisational activities: working, running, making sure

(i) Work

The interviewees were happy to discuss the work of their organisations, and one was especially keen to emphasise the range and success of its activities. At times an overtly promotional public relations 'script' was provided in response to different questions, and a tendency to list as many areas of campaign work as possible, whether past, present or future; *'…race, gender, um equality…deprivation…you know, those are…those are pieces of work that we now need to pick up and start running with in the future.'* Such responses however also reduce sectors of the population to pieces of work; unintentionally de-humanising language which aligns with the managerial discourse style elsewhere in the interview data.

This prompted me to examine the combined interview corpus for the lemma 'work', which I found presented as a key part of organisational identities. Only 32.72% referred to being in or out of work, whether something works (is effective), or were part of phrases such as *'we have a responsibility to work collectively'*. Therefore 67.73% of uses of 'work' referred specifically to the organisations' anti-stigma work, perhaps representing an organisational insecurity associated with justifying the existence and value of TTC. Many elements of campaign activity (surveys, sub-campaigns, or specific objectives), were more likely to be referred to as 'work' than as a named activity: *'there's a definite piece of work to do there'*. 'Influencing' however was itself a named type of work: *'the intelligence that we're gathering is feeding into the work that, <u>influencing work</u> that they're doing at a political level'*. The frequency of references to organisational work conveys valorisation, but positive evaluation was occasionally more explicit: *'brand was never as important as the work that went on behind it.'*

Such embedded valorisation of organisational work is especially interesting viewed in relation to the cross-sector emphasis on mental health at work, and the broader neoliberal policy environment emphasising maintenance of productivity. To identify other verbs which represented this 'work', I examined frequent verbs in the interview corpus which were material processes[55]. Analysing the evolution of UK policy discourse from Thatcher to Blair, Mulderrig (2011a; 2011b) notes a marked shift toward the use of material processes in place of mental and verbal processes (such as explain, realise, state), which creates a dynamic-sounding managerialist style, and is a linguistic characteristic of neoliberal governance. Two of the most

[55] Halliday (1994:109-43) presents material processes as one of 6 process (verb) categories: material processes are processes of 'doing'; for example, make, create, establish, set up.

key material processes used in the interviews included ‘make’ and ‘run’. A brief review of their use in the interviews is informative:

(ii) Make, run, and the lexis of business

The most frequent modifier of ‘make’ was ‘sure’, used in a range of contexts. The examples below are all types of causative. These are part of Mulderrig’s typology of managing actions, which involves grammatical structures which include, but are not limited to causatives, and which construe attenuation of agency. The grammatical subject of a Managing action is not the direct agent of a process, but instead in some way *manages* other actors in accomplishing various actions. They are typically realised through verbs and verb phrases like ‘enable’, ‘make sure’, ‘give opportunities to’ and express differing degrees of power and control over others’ actions. Mulderrig (2011b) proposes these are a key linguistic resource of management and, by extension, of neoliberal governance, and her typology of roles in managerial discourse (2011:60) identified ‘make sure’ and ‘ensure’ as the most frequent managing verbs used by actors in the Overseer role, denoting a steering of practices and ‘guaranteeing an abstract vision of excellence’ (2011b:60). Below are examples from the interviews:

‘(I) try to make sure that we're hitting all the output and, erm, financial targets.’

‘we've got to make sure that people aren't saying sort of 'well, I'm feeling a bit depressed today.'

‘...making sure that we embed this change, in organisations, in culture, in society as a whole’

‘*we've got to maintain the work that we've done already, and then make sure that we bring those people with us’*

‘*how do we make sure that we maintain that change?*’

Surprisingly, ‘ensure’ only occurred once: *‘our organisational purpose is obviously you know to ensure that everyone with a mental health problem gets support and respect’.*

Quantification and qualification of the progress made was also typical: ‘more progress’, ‘as much progress’ and ‘good progress’ (excerpt below). Material processes have the added feature of admitting as their grammatical object (Goal) another process (in nominalised form). This has the effect of further abstracting from the actual events, hiding agency and thus lines of accountability, while at the same time giving the impression of concrete or dynamic activity

(by virtue of the semantic qualities of material processes). This is a typical feature of managerialist discourses (Mulderrig 2011b).

> *we've made <u>more progress...we've made good progress</u> in terms of stigma experienced by people from black and minority ethnic communities but… there's more to do, and so <u>the progress has not really been sufficient</u>.*

Speaking of campaigns' influence on public perceptions of people with schizophrenia and bipolar disorder:

'it's an interesting question about whether we had hoped that we would have made <u>more progress</u> by now'

Use of 'run' typically provided a more power-suffused alternative to 'completed' or 'undertook', and is also a metaphor which endows the discourse with a sense of dynamism from its borrowed semantic domain. In *'the attitudinal surveys that <u>we run</u>'*, 'we' also subtly emphasises the value of their own surveys, although as 7.2.2 demonstrated, 'commissioned' was often more accurate.

Similar choices such as *'the phase that we've run'* and *'we ran the programme'* contribute to constructing the managerial nature of the discourse, especially when combined with lexis characteristic of marketing or business, such as *'warm audience'*, *'wastage'*, *'audience segmentation'*, and the prominent use of 'invest/ment', a term which carries implicit expectation of a financial return, rather than 'fund/ing' or 'spend/ing'. The speakers are acculturated to business attitudes and language. Needlessly complex language was also used (*'consult into'* rather than 'give advice'). As part of a pattern of avoiding the word 'government', one interviewee responded using *'corporates'* when asked a question about 'government', suggesting a reluctance to connect AS with anything other than the rest of the sector and associated businesses.

The conflicting and inconsistent use of certain process verbs and lexical choices can be related to the campaigns' identities; they do not represent the NHS or provide mental health care, and TTC was not a charity but a particular type of business; it had a budget, mechanisms of financial oversight and constraint, and a nebulous 'product'.

9.2.8 Shifting attitudes: space, trajectories, movement

Anti-stigma work was presented as ‘shifting’ and ‘influencing’ its target demographic or audience, so these material processes too were significant, and both are clear examples of the language of ‘nudge’ (Mulderrig 2018a; 2018b; 2019). The objects of ‘shift’ were accordingly the public, or attitudes, or both:

‘…in any attitudinal shift... shifting the public...by one percentage point...is...if you think about it in numbers, equates to an awful lot of people’

‘*the Five Year Forward View*[56] *contained a pretty straightforward kind of set of recommendations about shifting... to shift public attitudes’*

Vague or convoluted statements indicated a wish to avoid misrepresenting themself or their organisation:

> *In terms of the public face of Time to Change, it's very led by, you know it's influenced by trying to deploy the messages and techniques that will enable the change that we want to see, in those people who are receiving those messages.*

How then were these shifts to occur? Having observed the frequency of the concepts of space and movement in the transcripts, I examined these notions by reviewing concordances of specific nouns, ‘space’, ‘place’, ‘journey’ and ‘route’, and of verbs of movement; ‘bring’ and ‘take’.

Space was most informative, and was used in one of three ways:

(i). As the area occupied by the sector:

‘Work done across the <u>mental health space</u>’

‘the work that we're trying to do <u>in this space</u>’

‘New Zealand were doing good sort of interesting work <u>in this space</u>’

‘sometimes <u>in these spaces</u> you need a really major injection of effort and energy to create this big shift’

‘*the… purpose of Time to Change is to really act as a sort of a snowplough, to kind of <u>create the space</u> for others’*

[56] The Five Year Forward View for Mental Health (2016).

(ii). As the metaphorical, and primarily technological, space in which people with mental health problems can feel secure:

Referring to people becoming more open about mental health problems: *'We create the space for that to happen.'* This is followed by the caveat, *'our strategy has absolutely not been to force people into that space but it's been to create the space for people to do it in a safe and comfortable env...you know in a way that is hopefully safe for them.'*

Referring to the need to move Champions' activities online during the pandemic: *'Can people be empowered to do other things in other spaces?'*

(iii). As the metaphorical area in which need was located:

Within a hedged, reflective statement about the need for respect being intrinsically connected with the quality of relationships within the community: *'...so that's where the… in that space that the whole sort of, what was not, what were people not getting in that space?'*

When used without concrete meanings, 'place' could also be used metaphorically, but more to denote the mental circumstances in which someone discloses mental distress:

'But it is often the place that people, it may be even just a place that, a gateway starter to open the conversation for what might actually really be going on with somebody'

How then were people to arrive at the desired space or place? Interestingly, *route* did not concern metaphorical movement of people, but TTC's to use people's experiences of mental illness rather than behavioural insights/ 'nudge':

'...it's more taking a route… through people with lived experience, sharing their stories'.

However, 'journey' was used as a metaphor for the process of changing baseline attitudes to mental illness:

'we do our Time to Talk day for our warm audiences, those people who are already on the journey'.

'we said right okay we want to bring men along again...on that journey'

The example above shows how the verb 'bring' involved metaphorical reference to attitudinal movement, rather than concrete meanings, as also seen below:

'we need to make sure that we're bringing along with us those people who are most severely impacted by stigma and discrimination'

'we've got to maintain the work that we've done already, and then make sure that *<u>we bring those people</u>* [57] *with us'.*

The transitive verb 'deliver', familiar in corporate and government discourses, was also related to the idea of movement and space; in the current context it describes how something (the message) is brought to the target audience; *'…to look at what had we achieved so far with the target audiences we wanted to deliver to'.* This interesting construction omits a noun describing what is being delivered. 'Deliver' was also used in this extraordinarily modalised statement on the possibility of TTC targeting older people (first entry, Table 16).

9.2.9 Including older people: 'We would if we could'

Informed by the modalised interview responses to questions about why older people were not represented in TTC, whether there were plans to include them, or (for Mind) to increase provision specifically intended for older age groups, I examined the interview corpus for further low modality responses, to determine whether there was a pattern of avoidance to commit. In particular, I sought to identify whether irrealis statements, in which a promise of a future action is excessively hedged (a concept introduced in 2.5.2), were present. These did not exclusively refer to future actions related to older people, as Table 16 demonstrates.

Irrealis statements in this data were most likely to occur when a potential event is conditional (the event depends on another condition; 'we would do x if y'). De Haan's (2012) claim, that descriptions of what constitutes irrealis, which he terms 'reality status', are so variable that it may not be appropriate to call irrealis a typologically valid category, is worth acknowledging.

Examples were identified using concordance lines containing 'would', 'should', might', 'if', and 'future'. I also analysed 'work', having found that campaign activities are most frequently referred to as work (9.2.7.i). I then explored each context to determine which instances concerned descriptions of future campaign activities, to examine the level of commitment expressed. To identify solid commitment, I also examined the frequency of 'will'; of 39 instances, only 3 refer to future actions, all of which were hedged.

Examples of irrealis/heavily modalised commitments to actions, and uses of 'will', are shown below.

[57] People experiencing deprivation who also have poor mental health.

Table 16: Examples of irrealis statements in interviews:

Statement refers to/topic	*Quotation*	*Comments*
Possibility of TTC including older people	*'But it's yeah I mean it's more if we could design it and if we could deliver it and we could think about the outcomes that we would want to achieve then I don't think there's any reason strategically why we wouldn't do it.'*	Multiple modalisation, zero commitment.
Inclusion of older people in anti-stigma work	*'I don't think it would be ruled out in the, but I think it's just the wider context there is a focus on erm, children and young people… because it seems to be part of a wider education piece…'*	Neither irrealis nor truly a conditional commitment; demonstrates the difficulty in classifying irrealis statements. Lack of cohesion adds to a sense of awkwardness and avoidance.
As above	*'you might have some of the age-related charities who might want to take that on'*	Modalised by two uses of 'might', while 'take that on' presents the work as onerous. Use of 'you' rather than 'we' creates distance between the speaker and the action.
Lack of representation of older people across mental health campaigns (not only AS)	*'there is almost a kind of attitudinal swing that we might want to look at which is around, er, really fighting to speak up for older age people who are experiencing mental health problems'.*	Also modalised by *'might'*, and *'look at'* is far from concrete action. Suggests potential action would be driven by attitudes of the absent actors responsible for the *'attitudinal swing'* (rather than because the campaign agrees on a need).
Anti-stigma directed at older people being addressed by other age-specific organisations	*'we would really hope that we could take all of our learning and be able to kind of 'consult into' creating something which would address that.'*	Despite the intensifier *'really'*, commitment is weakened by the hedged *'would'*, *'could'*, and 'hope'. The source organisation is elevated by reference to *'all of our learning'*.
AS campaigns talking about treatment received within mental health settings	*'this is one of the things we're thinking of in the future'*	Hedged and ambiguous; will they enact it in the future, or just think about it in the future?
As above	*'health care and the health system is a big job and one that needs to be tackled at some point and we're thinking about that in the future'*	Similar use of '*future*' to the above. Sense of avoidance is intensified by referring to the size of the job, which needs to be *'tackled'* rather than 'done' or 'undertaken' (signalling its difficulty). Use of *'at some*

		point' removes temporal commitment.
On lack of organisational acknowledgement of people's difficulties accessing treatment	*'if we did that, we...and that would in and of itself be valuable, it doesn't… help us to deliver what we've been asked to deliver, by our funders...'*	Conditional commitment, and initial acknowledgement of its value, is followed by negation of consequential value.
As above	*'our organisational purpose is obviously you know to ensure that everyone with a mental health problem gets support and respect and so therefore we will absolutely, you know, you know we explore many avenues'*	The adverb 'absolutely' without a closely associated verb reduces commitment. Lack of coherence softens the assertion of the sentence, and further reduces commitment to any action beyond exploration.
The prospect that a disclosure of schizophrenia would not end a conversation	*'That's what we really need, and that's my… big vision I think for the future'*	'I think' affects modality, and although a 'big vision', intensified by being 'really' needed, it is positioned in the indeterminate future, not afforded urgency.
The interviewee's wish to involve younger schoolchildren in AS	*'I just think there's so much work we could be doing there'*	Wistful expression of potential, rather than commitment.
Focus on different social groups	*'…higher prevalence of schizophrenia, psychosis, or borderline personality disorder, coupled with a variety of intersectionalities around race, gender, um equality, deprivation you know, those are pieces of work that we now need to pick up and start running with in the future.'*	Listed needs appear to constitute a substitute for commitment. The timeframe is interesting; it is necessary to *'pick up on it'* now, but only *'start running with it'* in the future. Use of 'running with' falsely evokes a sense of speed.
The evaluative tools of TTC; the interviewee was asked about the need to update the wording of campaign survey tools	*'there might come a time or an opportunity when we can refresh some of the language a little bit.'*	The statement is first modalised by *'might'*, then made temporally loose, and further weakened by the verb choice *'refresh'* rather than *'change'*. Only *'some'* of the language is involved, and when further qualified by a *'little bit'*, there is no commitment.
Discussing tools used to evaluate success of TTC (specifically CAMI)	(After initial defence of the survey tools), *'yeah it is a little bit outdated'* and there are *'social scientific reasons why you want to have that more up to date'*	Use of *'you'* instead of 'we' is a further drift from organisational commitment to update the tool, and perhaps acknowledges the interviewer's position.

The continuation of anti-stigma work	*'as long as we think and indeed others think that there is a need then you know we will sustain that ...'*	Vague commitment is rendered conditional by *'as long as'*.
As above	*'...tackling stigma and discrimination will al... will you know be a core part of what we do...'*	This too is hedged, *'always'* is not fully voiced, diluting the time commitment of the action.
As above	*'there's certainly more work, there's still more work to be done'*	The agent who might undertake the work, and the timeframe, are absent.

Other types of non-irrealis hedging were also seen; examining collocations of 'you', use of 'you know' was especially prevalent in T3 (70.16% instances of 'you') and was representative of the large number of hedged statements in this particular corpus. However, the excessive hedging in T3 may be context-specific, or may simply reflect this individual's idiolect, i.e. it is an habitual speech strategy of familiarisation or inclusion.

Anomalous uses of 'you' which contextually mean 'one' were also seen, and obscure the agent of an action. In the following example, contextually the only appropriate pronoun+ contraction was 'we're' or 'they're': *'You're marshalling a set of arguments for why the government needs to invest more and more in…good quality mental health services'*.

Table 16 confirms lack of commitment to future actions to be an important feature of the interview data. Some statements are constructed with multiple markers of hedging and conditionality, which together suggest efforts to avoid being seen to prevaricate, especially when referring to inclusion of older people in anti-stigma work, improved services for older people, future anti-stigma work, addressing access to treatment or stigmatising treatment, social 'intersectionalities' in stigma, and changing the language of campaign evaluation tools. Although inability to commit to vital activities may have been related to the then uncertain future of TTC, Mind and Rethink prevail, and staff work across at least one other body.

9.3.0 Talking about people

9.3.1 How are people with mental illness referred to?

To understand how people with mental health problems were referred to in the interview corpus, I identified the referents of 'they' who were social actors with mental health problems. These referents were notably free of evaluation, as could be anticipated in this context, but they were strongly characterised by an absence of specificity in terms of the type of mental illness

which they were experiencing. The descriptor closest to a diagnostic label was '*serious mental health problems*'. Descriptive terms were euphemistic, with references to feeling *'down about something'*, having *'symptoms of a mental health problem'* or *'experience of mental health problems'*. This prompted me to further investigate the interviewee's lexical choices when talking about people with mental illness.

(i) 'Lived experience' or 'mentally ill'?

In 7.1.1. I analysed the use of the lexis used in TTC and HT to describe mental illness, and observed a shift from an organisational 'norm' of 'mental health problem' towards a reframing of mental illness, such that 'mental health' was used in contexts where 'mental illness' made more sense. I also found that 'lived experience of mental illness' was shortened to the frequently meaningless 'lived experienced'.

I investigated how these findings compared to the interview data, as a prelude to exploring the usage of further, more specific terms. In the interview data too, the most characteristic use was the 'normative' *'mental health problem'* or descriptions such as *'people with lived experience of mental health problems'*. Further, around 50% of uses of 'lived experience' did not specify the nature of the experience. I found that '*experience*' and '*experiencing*', for example '*current experience of mental health problems*' functioned not so much as a respectful adjunct but as a diluent, which can be construed as consciously or unconsciously devaluing mental illness; an 'experience' may be inferred as invalid because of its subjectivity.

I also identified the same misleading use of 'health' in place of 'illness' as in 7.1.1, e.g. *'people who experience mental health'*. The use of 'mental health' when people mean 'mental illness' therefore not only appears prevalent in contemporary, social mediatised discourse of identity and wellbeing, but has thoroughly infected organisations whose role it is to unpick and specify the nature of mental illness, understand its aetiology, and in some cases to formulate adequate welfare responses to it.

Some speakers struggled to formulate descriptions of people with mental illness; *'this person as a human, like living embodiment of these previously more or less abstract categories, suffers from anxiety or a mental health problem, or schizophrenia…'* in which schizophrenia is implicitly separate to a mental health problem. People were described in various ways as having mental health problems which, although 'serious', were un-named: *'people with more severe and enduring mental health problems', 'people with serious mental health problems',*

or *'people who are most affected by, most seriously affected by mental health problems, mental illness.'*

(ii) Diagnosis-specificity or homogenisation?

To learn more about the extent to which interviewees associated people with a specific condition or diagnosis, I identified terms in the interview corpus which constitute a diagnosable state. Among very few identified illnesses, the most-discussed condition was schizophrenia (10 uses), confirming its position as an exemplar of extremity. The only other named diagnoses were anxiety (2 uses), depression (5), and borderline personality disorder (1). This corresponds with the expressed organisational determination to avoid diagnostic specificity, at least in TTC.

One reference to people with schizophrenia was particularly awkward: *'somebody who's described or whose symptoms are described as symptoms or behaviours associated with schizophrenia'*. This precision is suggestive of care not to express something in an offensive manner. Such tendencies to avoid explicitness are confirmed by the absence of the adjectival descriptions 'psychotic', 'schizophrenic' and 'depressive', and may be an ironic consequence of falling victim to stigma rhetoric, rather than 're-claiming' it. There is a mismatch between the supposed drive towards parity between mental and physical health, and the absence of diagnostic terms. While not all diagnoses conform easily to the same morphological shift, if parity was truly sought, 'psychotic' would be a description as acceptable and factual as 'diabetic'.

The use of 'experience', highlighted in the previous section, also functions, through *'people who experience schizophrenia'*, as a means by which to avoid the adjective '*schizophrenic'*. At the other end of the experiential scale, 'mental distress', a further downgrading or devaluation of illness, was used as an abstract concept also noted in 7.1.1.

I suggest in 7.1.1 the semantically diminished descriptive terms reflect the campaign's decision to avoid diagnosis-specificity. During the interviews, when discussing the media tendency to present mental illness as a homogenised entity or experience, one interviewee responded that TTC was *'very clear at the outset not to be 'diagnosis-specific'* but rather to focus on the impact of stigma and discrimination on people's lives. The importance of avoiding reference to diagnoses was repeated: *'when we first began we were very very clear about* (being) *non diagnosis-specific because... (we wanted to capture) the impact on people's lives.'* This was an important finding, which suggests the origins of an influential language practice in TTC. I maintain that avoiding diagnosis-specificity may have played a significant role in creating, or

at least maintaining, the homogenisation of mental illness which appears prevalent across multiple cultural domains and in public understanding.

Explicitly homogenising utterances also occurred in the interviews; *'people with depression, anxiety and so on'*. The interviews did not dispel my understanding that mental health organisations use an unspoken two-tier conceptualisation of mental illness, in which depression, anxiety and the myriad *'and so on'* represent the face of mental illness to be addressed through 'conversations', while schizophrenia represents the problematised and insoluble extreme. This also mirrors findings from the focus group.

(iii) Dangerousness, fear of serious mental illness

Interviewees freely acknowledged the difficulty of reducing stigma towards schizophrenia (contrasted with the generalised *'mental health in broad terms'*), admitting campaigns' inability to bring about significant attitudinal change in this area. Acceptance of the entrenched nature of stigma towards 'serious mental illness' was accompanied by the admission that more progress in this area had not necessarily been expected, along with the surprising statement that *'the danger stranger (sic) is something which is you know embedded'*. A later statement was somewhat reparative, but still closed with use of a startling trope:

> *The job that the campaign and others have done over the recent years has basically been… to help people understand that…this kind of stranger violence is extremely rare…people increasingly understand that that is extremely rare and that you shouldn't assume that everybody with schizophrenia is necessarily going to be… axeing you in the back.* **(Mind)**

Since it was acknowledged both before AS campaigns and as part of TTC's foundational research (*Stigma Shout*, 2008) that schizophrenia was associated with the greatest stigma, then to be a genuine anti-stigma initiative, TTC might arguably have achieved greater success had it been situated within Rethink, and with specific focus on schizophrenia, psychoses, or personality disorders. When probed about this option, one interviewee responded first that they were unable to say why TTC had to be a separate organisation, adding:

> *Obviously Rethink is specifically the National Schizophrenia Fellowship and is…more associated with more severe mental illness and Mind is positioned probably more as a pan mental health organisation so... you might think that this means that Rethink would be pulling Time to Change's work towards more severe stuff…but that's not always*

> *what's happened, because… maybe Rethink have their own… specific campaign or… bit of work which they don't want Time to Change's campaign to encroach on* (TTC1).

This exploratory response is again suggestive of inter-organisational tensions. TTC may have improved attitudes towards '*anxiety, depression and so on'*, but the desperately needed attitudinal changes towards schizophrenia or psychoses remain. An interviewee even described the organisation's early decision to work with the target demographic deemed the most straightforward in which to effect change. This speaks of an organisation acting, from the outset, to avoid the greatest challenges:

> *…what we did in the early days was to target those people who we felt were most likely to change their knowledge attitude and behaviour or be most open to changing that…and we did a whole load of research on this before we decided on who the demographic was, that we took kind of working age adults… loosely speaking to 25-45 year olds* (TTC2).

Just as a school may seek to shed those who perform badly from their roll, in order to achieve statistically greater success, or retain their league table position, so TTC appears to have grasped the low hanging attitudinal 'fruit', initially at least. One interviewee claimed that avoiding diagnosis-specificity had *'worked well'* for TTC, but that now, in their 15th year, their research found:

> *…pockets of people who aren't benefiting from the programme that we're delivering, and that people…who are most severely impacted by stigma and discrimination, so …<u>not that we want to get into diagnostics</u> but…for example, higher prevalence of schizophrenia, psychosis, or borderline personality disorder, coupled with a variety of intersectionalities…'*

Discussing the problematic nature of stigmatisation of severely mentally ill people, especially concerning a public fear of violence, a speaker's response conveyed how alien this subject was, in contrast to the comfortable terrain of Champions and Pledges: *'every time there is one of those... dangerous ...if one of those things happens...and of course they do still happen but because they're very rare they always get news.'* The absence of a noun or verb after 'dangerous', and use of 'those things' together avoid the directness which could be expected in this context.

(iv) Use of stories, use of people with experience of mental illness.

The interview data confirm the importance to campaigns of using the experiences of people with mental illness, although this is achieved without the lemma 'use', but rather through synonymous phrases and analogies, such as describing the *approach* of TTC as:

'driven by…a combination of lived experience articulation of stigma…and also really utilising the… learning from ...audience led social marketing techniques'.

The nominalised *'articulation'* negates the need for the verb 'use', and *'utilising'* is corrected to the softer, more appreciative *'learning from'*. Another interviewee referred to *'sharing their stories…'*, with its connotations of free will and generosity. Clearly the campaign could not operate without people who are, or have been, mentally ill:

'In terms of the education piece, in terms of the campaigning government, in terms of media, at the heart and soul of all of that ...is people's personal experience.' Elsewhere, people with lived experience were 'mobilised', a military metaphor aligning with references to *'our army of Champions'*.

Descriptions of 'stories' in the interviews share a lack of acknowledgement that those whose testimonies are used may be unaware of the manner in which they are used; as a tailored blend of censorship and commodification, as discussed by Lupton (2013; 2014). Unintentionally revealing statements conveyed organisational attitudes to using people's 'stories', and by extension, using people. There were admissions – some vague, and some very direct – that the 'story' content is constrained, both to appease funders and to construct a more positive message. After some hesitation, an interviewee candidly admitted why 'stories' were not permitted to challenge lack of funding for mental health services or the inability to obtain treatment: *'I think there is…a partial restriction on what we are able to say about government…because of our funding from DHSC'* (The Department of Health and Social Care). Thus 'story' content was restricted not, as the website claimed, because of campaign 'aims and objectives', but because these topics were prohibited either by government, or because government was a funder.

Outside the context of websites and blogs, an interviewee described an instance of *'supporting and training'* volunteers with experience of mental illness, during which they were encouraged to restrict their accounts of their experiences. In a project whereby people offered their perspectives of 'personal experience' to medical students and trainee psychiatrists, it was

perceived as too great a risk to allow the volunteers to describe their experiences truthfully: *'people who don't want to hear that message find an excuse not to, by saying 'well effectively you're just perpetuating my negative stereotype of who people with mental health problems are…''.* The volunteers were therefore trained, *'not to sanitise'* their stories, but to restrict them to salient points, so that the hearers would not respond with '*denial that that even happened'*. It is hard to understand how presenting attenuated versions of mental illness, to the very people entering professions positioning them to affect positive change, is in the interests of stigma reduction. This is consistent with the editorial constraint of 'blog' content, whereby positive stories of recovery aided through the community-based conversations which TTC promoted, were encouraged. Therefore despite the claim that the approach of TTC was firmly evidence-based, in part through its learning from lived experience, if such evidential data is, at best, co-constructed, then the data is skewed, and so is the world view it helps to construct.

9.3.2 The public and the people

One interviewee both excluded people with mental illness when referring to the 'public', and elsewhere deflected the issue of a need to put pressure on government to increase funding by saying the government are also the public. This suggests the government and public belong to an 'in group', while people with mental illness constitute the out group.

In this one corpus, not only was use of 'public' more frequent, but the majority of uses, often explicitly, exclude people with mental illness, as in the following:

'remember that the target audience here is not people with mental health problems but the public...and the public had really had not thought at all about, they really hadn't thought much about mental health at all'

The above extract is clear that 'people' experience stigma, while 'the public' need to improve behaviour and attitudes.

'Our evidence is telling us that… you know erm people... public awareness of mental health has been heightened as a result of Covid.' A correction to 'public' aligns with its use elsewhere.

The interviewee did use public more widely, for example when referring to 'public services' or 'public communication', but when discussing 'public attitudes', people with mental health problems are again excluded.

This led me to question whether interviewees' use of 'public' more generally excluded referents with mental health problems, while use of 'people' included them. This would create an interesting linguistic distinction between those who do, and do not, have mental health problems.

I found that in the other two corpora, the term 'public' was used less, because more specific descriptions represented the various social groups who might have been the referents of 'they'. However, in all the interview corpora, I found that 'people' only includes people with mental illness when specifically stated, and that when 'people' and 'public' are used in the same sentence, then 'people' will represent the group with mental illness. When only 'people' is used (i.e. the same sentence does not contain 'public'), these people may or may not have a mental illness. By subtle implicature the public, meaning the population at large, appear to be a more valued group, and 'people' is a shorthand for those who may have a mental illness.

(i) Anti-stigma through stigma? The attitude towards the target demographic

In a campaign targeting the people in society who stigmatise most, it is important to consider the attitudes held by the deictic centre (the campaign) towards this social group. This complements the analysis of social actor representation in 6.3.

The grammatical objects of 'target' were either 'men' 'group' or 'people':

'we then specifically targeted, our paid-for advertising, to target men'.

The gerund 'targeting' was used too: *'there's a whole range of ways targeting helps you to, to make sure that you're reaching people'.*

Despite a lack of explicit evaluative statements, unless couched as reported speech, the identification of the target group as a specific socioeconomic class (i.e. working class) can be seen as a further form of homogenisation. One interviewee emphasised the importance of

'not berating people…because we're…essentially looking at the segments of the population that hold 'worst' attitudes …essentially working class men (and it's very important) *that there isn't an idea of blaming people… who have the bad attitudes'* (**TTC2**).

Their clarification that not all TTC staff shared this view indicates negative attitudes towards the target group existed within the campaign. Another speaker's emphasis of the need to avoid saying '*in our external presentation*' that '*here are the groups we've identified as having the worst attitudes, these are the ones that we want to correct their behaviour or socially*

engineer…that group of men…' (**TTC1**) confirms divergence between internal attitudes and *'external presentation'*.

A further statement, *'One thing about anti-discrimination is if you don't do it well then you're essentially saying …these are the bad people…in the wrong way and of course that's a very individualistic approach…which we try to avoid…'* (**TTC1**) suggests that there is a right way to label a group as 'bad', which requires effort to achieve. This is troubling if the 'fault' of this group consists of poor education and limited socio-cultural breadth.

One interviewee candidly spoke of using a *'Trojan horse approach'*, a strategy described as trying to change behaviour in *'helpful ways'*, rather than necessarily talking directly about mental illness. This approach could be deemed disingenuous, but contributes to the narrative of avoiding being seen to demonise working class people.

9.3.3 Attitudes to age, and the lack of focus on older people

It is important to distinguish between the lack of services to support older people who have mental health difficulties, and lack of inclusion of older people by AS campaigns, which do not target people *with* mental illness, but those with less proximity to it. TTC did not, overtly or primarily, target people (of any age) with mental illness in order to change their behaviour, but it did recruit them to enact attitudinal change in others who do not have mental illness.

As older people are marginalised both by lack of services, and by their apparent irrelevance, on all counts, to AS campaigns, interviewees were asked about both aspects of this marginalisation. One responded, as noted in 9.2.5, that TTC's attitudinal surveys do not identify older people as having *'particularly worse attitudes'* but then admitted to a hedged *'little bit of ageism'* in the organisation, and described frankly discriminatory attitudes on the part of campaign staff towards older people. The interviewee admitted witnessing professional situations in which staff had *'betrayed their prejudices'* in this respect.

One response, provided below, suggested working with older people was not good value for money, citing the Impressionable Years Hypothesis (Krosnick and Alvin, 1989), which theorises that attitudes are immovable after the age of 30, to justify the exclusion of older people. Yet this hypothesis belongs to the realm of political persuasion and voting behaviour, and its migration into an ostensibly apolitical, and socially beneficial campaign is troubling.

It was also suggested that older people, characterised as *'previous generations'* (whose relevance has thus passed) cause the attitudinal lag experienced in current attempts to change attitudes; *'because of the stigma and discrimination in previous generations, we're playing this enormous catch up exercise'*. Rather than acknowledging the effects of the underlying political-economic landscape, or even the absence of previous educational interventions, the age group itself is held responsible. An attempt **(TTC2)** to deny the invisibility of non-working age adults in anti-stigma initiatives by reframing the situation as simply a prioritisation of young people, only serves to strengthen the arguments I will make in my concluding chapter concerning the economic motivations for TTC.

IAPT, which was established in 2008 and publicised as a major and positive change in mental health service provision, also initially disregarded older adults. **Mind** confirmed that IAPT was established only as a *'working age adult'* service, admitting this *'has been argued on an economically beneficial ...basis'*, explaining that if people in work receive speedy access to psychological therapies *'they will get back to work quicker and therefore they'll be more productive to the economy…'* The interviewee conceded there was never originally any intention that IAPT would be available to older people, but that services henceforth would be *'age neutral',* as confirmed by the new NHS Long Term Plan (2019). Yet inspection of this plan reveals that although mental health, and 'healthy ageing including dementia' are among areas in which it will 'go further', the document appears to make no specific commitments to mental health for older adults. It cites 'demand drivers' in health, include the growing elderly population, but does not acknowledge unmet needs in elderly mental health. The Plan's statement that it '*does not, of course, describe everything the NHS will do in these and other improvement areas over the coming five and ten years*' (NHS Long Term Plan, 2019), is a useful caveat, defusing both accusations of omissions and later realisations that an initiative failed to materialise, in the manner I briefly discuss in 3.3.

When I asked interviewees directly whether the maintenance of economic productivity was a key motivation for the government's prioritisation of AS and mental health care in younger people, all denied this was true. However, asking the same question from a different perspective; establishing whether reduced focus on older people is because this group is no longer economically active, somehow led to acceptance, and that the *'discourse around the generation of change'* is that *'you get better value for money…if you change young people's attitudes… because they will be enacting those attitudes throughout the whole course of their*

lives…' (**TTC1**) whereas older people will hold those views for fewer years (i.e. will die). This is a striking explanation for the preference of the term 'investment' over 'funding'.

The modalised responses characteristic of discussions about age during the interviews, especially in response to questions of the future inclusion of older people in the TTC target demographic (Table 16), left any such actions in a firmly hypothetical realm, and it is reasonable to assume this applies equally to Mind and Rethink.

I also received a conditional response to my question about plans for wider provision of services such as My Generation, a structured programme of community-based mental health support for older people in Wales, managed by Mind, which appears to have been popular with service users. **Mind** stated that *if* further funding was available, then Mind *would like to* expand such services, because *'the evidence base'* has shown it to be beneficial. Such modalised responses have been explored above in 9.2.9.

Corpus exploration of interviewees' descriptions of older people with mental health problems revealed examples whereby the problem was referred to, rather than the people, thereby abstracting the issue, and *'older people's experience of mental health'*, even in its widest context, offers no indication of whether either their experiences, or the state of their mental health, was good or bad. Stating *'we can become very dismissive of older age mental health problems'* comes close to acknowledging institutional failure, although the ambiguous (possibly inclusive) 'we' just avoids this.

9.4 Concluding discussion

These findings were the result of three in-depth conversations with different professionals, in which meanings were inevitably co-constructed. My questions drove the subject content of the interviews, speakers responded as they wished, and while some textual analyses are informed by corpora, my interpretations are in all cases subjective.

The findings of the interview data confirm, and thereby strengthen the validity, of several findings from the website data. For example, they contribute to confirming ways in which AS as a discourse and as a social practice, is itself stigmatising; it ignores or marginalises many categories of mental illness, uses and commodifies those who experience it, and potentially normalises and trivialises anxiety and depression. Avoidance of diagnosis specificity effectively backgrounds more serious mental illness, as a consequence of homogenisation and

simplification. Meanwhile working class people, implicitly blamed for attitudes they may have been unaware of until their awareness was 'raised', themselves become stigmatised. Older people are simultaneously marginalised both by not being cost-effective or productive, and for creation of an attitudinal climate.

The website data suggested that older people are largely absent from AS, and that there is instead a notable focus on working age people. This informed my use of a focus group with older people, in which notable but not generalisable findings were that group members lacked understanding of mental illness, and some group members exhibited stigmatising behaviour. This superficially suggests older adults might benefit from anti-stigma initiatives. Yet since *'old people don't have particularly worse attitudes towards mental illness',* we might surmise that stigmatising attitudes only merit intervention when associated with a demographic relevant to economic productivity.

Direct comparison of the focus group participants with the interviewees was never intended; they are very different groups of people, and different questions were asked of them. The findings from the focus group did however inform some interview questions, particularly with respect to probing the absence of older people from AS. This absence was reflected in the group's lack of awareness of the existence of TTC before their participation in this research - after nearly thirteen years of national campaigning by TTC.

I also presented a group consensus view to the interviewees; the focus group decided that stigmatisation was a fundamental human characteristic. When I offered this opinion to the interviewees, each refuted it in different ways. Their denial is understandable, since if stigma is almost innate, then AS is rendered a pointless endeavour. A TTC interviewee explained how TTC defines stigma:

> *…it has three domains, so you have knowledge, attitudes and behaviour… So I don't think there's any necessary reason why people would have a lack of knowledge or hold prejudicial attitudes towards people with mental health problems, or discriminate against them indeed.*

The interviewee suggested the last decade has shown that social attitudes are *'quite changeable',* and added *'maybe there's a sociological question that your focus group participants were touching on which is very difficult to answer, which is you know is it a feature of human societies that people will essentially categorise others'.* Implicitly therefore the groups' conception of stigma was somewhat dismissed by being framed as a sociological

'question', rather than the fairly broad theoretical consensus to which Hinshaw (2010:29) refers (3.6.2).

The exclusion of a social group from AS is relatively easy to legitimate; it can be construed as a compliment that a particular group does not need to be the subject of attitudinal or behavioural change. If however a social group were excluded from a charity of organisation which offered more practical help, there would be a more obvious moral and ethical question to answer. This is why the lack of commitment to Mind's 'My Generation' campaign is important. A brief exploration of the forward strategies of Mind and Rethink Mental Illness show that this lack of commitment is not isolated to TTC, and that there is indeed a cross-sector moral and ethical question to answer; these organisations, which are mental health charities and not AS organisations, both very largely ignore older people. *Mind Strategy 2021* (Mind, 2021b) declares a focus on adults, young people, the workplace, and their commitment to become an anti-racist organisation. The text suggests no focus on older people, although other semiotic modes, specifically photographs, suggest at least an interest in older people, given the photographic representation of a radiantly happy older couple. Rethink's *21 Strategy* (Rethink Mental Illness, 2021b) starts with a full page image of a smiling older Asian woman gathering herbs. It too declares an anti-racist and multi-ethnic agenda, but lacks apparent textual mention of older people. Here, as with Mind, text which describes objectives relating to 'everyone' or 'people' could semantically include older people, and yet workplaces are still a clear focus. Only the organisationally distinct Mental Health Foundation has a landing page which includes a leading item on later life; but the accompanying text/link *'the total cost of dementia to the UK is 26.3 billion'*, which both emphasises the cost burden and presents dementia as the only mental illness associated with older adults, could deter a website user from accessing the balanced content which follows. Together, the focus group findings and the interview data suggest older adults are being ignored and stigmatised, and it appears this is true not only of AS initiatives but of the mental health sector more widely.

The website analyses identified that two of TTC's key functions were its own self-evaluation, and the mobilisation of individuals and businesses to perform its work through the Champions and Pledge programmes respectively. The interview data confirm this presentation of TTC primarily as an evaluator and moderator/facilitator. The interviewees' emphasis on the work of the campaigns may be precisely because of these evaluation and moderation roles; staff in key positions may also be acutely aware that recruiting mentally ill people to create an un-

remunerated labour force could attract legitimate criticism, and that it is therefore in the campaign's interest to emphasise their own work.

The public relations repertoire evident in the rhetorical strategies which interviewees employed is unsurprising since these are professionals accustomed to speaking in accordance with a corporate 'line'. Yet this did not prevent some candid responses and important disclosures. For example, from a question on interviewees' lived experience emerged a significant statement about the origins of avoidance of diagnostic terms in TTC, which I believe has been significant in contributing to homogenisation of people with mental illness, both in the campaign and beyond. An entrenched avoidance of specificity about diagnoses does nothing to advance the understanding of schizophrenia or personality disorders, and therefore hinders reduction of stigma towards people who live with these illnesses.

In retrospect, the admission that funders were reticent to make commitments (*'at the moment …they're all a bit busy doing other things'*) was likely related as much to the imminent withdrawal of funds as to pandemic priorities and working arrangements. Indication that the demise of TTC was anticipated include the statement that tackling stigma and discrimination would be a core part of *'what we do in the long term whatever happens to Time to Change'*.

Some possible reasons for the withdrawal of government funds, within a landscape of policy shifts, are explored in the next chapter. In addition however, TTC2 in particular had expressed the need to explore further areas of anti-stigma, moving to explore deprivation, 'intersectionalities' and stigma within service provision. The Mind interviewee, while not venturing to suggest that the 'system' itself is flawed, also acknowledged problems with welfare and people's *experience* of the welfare system.

The future operationalisation of a Phase IV incorporating concerns for deprivation would risk a situation in which the campaign might truly become a counter-hegemonic social movement, creating a threat to neoliberal governmentality. If the 'snowplough effect' exerted by TTC (Mind interviewee, Appendix 2.5) were to be repeated within the context of a new agenda with a more overt concern with inequality, especially if matched by repeated determination to 'reach' high volumes of people, the challenge to neoliberal governmentality would be uncomfortably real. The desire, however hedged, to extend the work of TTC into areas beyond its original remit suggests that individuals who directed TTC were genuinely motivated to implement social actions which benefit people with mental illness. This serves as a reminder

that neoliberal technologies depend upon ‘decent’ people whose career trajectories have usefully steeped them in managerial language and dogma.

Chapter 10: Coda: Covid. What happens to the stigma concept?

What effect did the Covid 19 pandemic have on the themes which have emerged through this thesis so far? Revisiting the relevance of ***RQ3: Why is the concept of stigma afforded such importance as part of mental health policy?***

10.0 Introduction

This chapter is primarily a commentary in which I examine some key critical themes emerging from my thesis, in the light of the Covid-19 pandemic. I describe the way in which some government agencies and charities respond to the impact of the pandemic on mental illness and associated stigma, in relation to these emerging themes. In the process, I uncover data suggestive of some new policy directions. While I note prominent linguistic patterns and features where relevant, and support the commentary by excerpts from relevant data, this is not a text-analytical chapter.

The data are neither exhaustive nor indeed representative, but are selected in response to the themes which I identify, which include:

- The drive to responsibilise the public for maintaining their own mental health (and in tandem, the creation of distance between the public and NHS mental health services).
- Partnerships between campaigns and commercial entities.
- The use of data provided or created by users of digital mental health platforms.
- Normalisation of mental health problems.

These themes can all be framed as part of the neoliberal public health policy drive to reduce the cost to the state. Use of individuals' data meanwhile reflects, as a minimum, the growth of surveillance technologies and use of metrics, and as I explore in 10.4, may represent further specific corporate benefits.

I review the way TTC responded to the pandemic prior to its closure, and also examine Mind's response, as the UK's largest mental health charity. I consider the government response by examining the content of two web texts: the Government's website *Guidance for the public on the mental health and wellbeing aspects of coronavirus (COVID-19)* (March 2020, updated 22-2-21) which is now closed and re-directs to the second website I consider, *Every Mind Matters* (PHE and subsequently NHS). I then examine Boris Johnson's appointment of Dr Alex George as Young People's Ambassador for Mental Health.

Prompted by the way that both websites direct the public towards a variety of apps, and that George is social media influencer, I investigate the prolific growth of digital mental health provision during the pandemic, specifically two contrasting online services, *Kooth* and *Replika,* before drawing my findings together in a concluding discussion.

10.1 Response, and closure, of TTC

The pandemic gave content a clear additional topical focus represented by the practical need to move events online; 'Time to Talk Day' for example became *'a line-up of free online events'.* Yet the majority of content was remarkably unchanged; tips, metrics from the campaign's ongoing (commissioned) research, and recycling of previous campaign slogans (now particularly 'Ask Twice') were almost wearyingly familiar. The purposes of quantification appeared increasingly trivial, and beyond signalling the continuation of data-gathering activities; the example, the utility of data showing that 30% of men felt they were not able to talk *'at the places they usually would, like football matches or at the pub'*, is unclear.

New and salient advice not to attempt to 'fix' people's problems may suggest recognition that an untrained person could cause harm, and represents a shift from the previously dominant rhetoric, *'you don't have to be an expert'*. The use of rhyming slogans for this advice; *'Be a friend, don't mend'; 'An open ear reduces fear'* is reminiscent of WWII propaganda slogans, *('Lend A Hand On The Land', 'Make Do and Mend'*). Such propaganda messages were then issued by the Ministry of Information, whose functions continue under the auspices of the Cabinet Office (progenitor of the so-called 'Nudge Unit'). Notably, government messaging on the pandemic itself was replete with such slogans ('Hands, Face, Space'). In TTC, the 'no fix' message is repeated in video tips from Champions and celebrities, including *'Don't try and fix it; often listening is enough'.*

Across pandemic era materials in TTC, stigma reduction appears to have become secondary to concerns about wellbeing or the increased incidence of mental illness. The stigma concept is revived sporadically, but often with respect to self-stigma – as seen with the *'An open ear reduces fear'* slogan, rather than the public stigma which was the primary focus pre-pandemic.

One fresh signatory to the TTC Pledge for businesses stated, *'we need to keep talking and not let ourselves get complacent, so that stigma doesn't creep back in.'* Stigma here is reified, the abstract is made sentient, mobile, and opportunistic.

The content of several blogs suggests they may have been subject to less editorial scrutiny than usual. The strongest evidence of editorial laxity is seen in this criticism of the government:

I had no trust in the government prioritising health over economy. Boris Johnson missed six Cobra meetings on Covid-19 from as early as January… the government's pandemic response plan had been long abandoned, and the UK's PPE stores were severely lacking (TTC blog contributor).

This blog, more broadly attributing heightened anxiety to failings in government Covid policy, would have been unthinkable at the peak of TTC's activity.

It was during the pandemic, on 26-10-2020, that TTC announced its forthcoming closure, after 15 years of activity. Its content latterly suggested a campaign which had reached a critical point where its claims of success clashed insolubly with its claims that it was needed. Both things could not be true.

The closure announcement reported an improvement in public attitudes by 12.7% (5.4 million people) *'since the campaign launched'*, and improved intended behaviour towards people with mental health problems in 11.6% of the population. The presentation of these 'headline' figures comes with tacit acceptance that positive changes are not attributable solely to TTC. Further results include an increase of 10% in public knowledge 'around' mental health, unquantified improvement in print media reporting of mental health problems, and unquantified reduction in discrimination reported by people with mental illness. Given the campaign's habitual quantification of behaviours or attitudes one might deem unmeasurable, any absence of quantification suggests the improvement felt by the very people for whom the campaign supposedly existed was in fact minimal. Such minor impact after 15 years of partially public funding confirms the importance of having explored the campaign's functions and effects more deeply.

In describing its successes, TTC presents the period before its existence as a time of darkness, when *'mental health problems were truly taboo'.* It relates how 9,000 champions, 1600 employers, and 3,000 secondary schools had been part of its *'social movement',* and its director speaks of the *'outstanding improvement in the way we all think and act about mental health'.* Yet if this thinking and acting is not being truly felt by people with mental illness, what was the point?

The statement continues: *'We know that in times of financial hardship, attitudes towards people with mental health problems tend to deteriorate'* and consequently the progress made might be lost. This persists in both framing stigma as the key problem, and ignoring the role of 'financial hardship' on mental illness itself. The responsibilising message of TTC also endures to the end of its operation: *'Since the impact of the pandemic on our mental health is still unknown, it has never been more important <u>to look after ourselves</u>…'.* One of the justifications for the initial foundation of TTC endures too, as we are told again that it was set up *'in response to people reporting that the attitudes and behaviours of others towards them could be as difficult, if not more difficult, to deal with than the mental health problem itself.'*

Following the closure of TTC, visitors to its website are still encouraged to take action, by 'being a champion every day' without training or organisational backup, but by 'speaking out' to challenge stigma using tips and branded online materials.

10.2 Response from Mind

The Mind website offered a comprehensive coronavirus information 'hub', albeit operationalised through *'tips to <u>help yourself</u> cope',* or *'ways to <u>support yourself</u>'.* The reason for a notable focus on children, young people and students, and copious information for parents, becomes apparent with the statement *'Our information for children and young people has been developed with funding from the Bupa Foundation',* alongside the Bupa 'Foundation' logo. In January 2020, Mind entered a 3-year partnership, whereby its 'information programme' for children and young people became funded entirely by Bupa UK Foundation, creating *'a brand-new set of information resources.'*

On the linked Bupa site, Bupa describes the 'worrying' statistic that over 14% of young people (1 in 7) have a diagnosable mental health problem (Mind, 2020), and that to *'empower Britain's young people to live happier, healthier lives (they and their families) need expert information*

and guidance…'. It would be naïve indeed to assume BUPA's interest here is humanitarian. Bupa states: *'Together we're sharing free resources with and for children and young people… using language they understand…'* and that *'We want to help young people get the mental health support they need, when they need it.'* Mind adds, *'We know that young people experiencing mental health problems for the first time may struggle to know where to go for support.'* Yet in truth, people are not ignorant about where they should be able to go, but the state does not serve them, as contributors to Mind's website have described. There appears to be a clear nudge towards a binary option; resilience and self-care, or the private sector.

Describing the joint work of Bupa and Mind, Bupa states *'Together, by 2022 we want to help 2.5 million young people and their families access the information they need to look after their mental health'*. This combination of a target date, a quantified target group, alongside a vague objective, is familiar. Repetitive use of *'Bupa UK Foundation'* allows both parties to dignify their alliance, creating a theoretical distance between Mind and Bupa by positioning the partnership within Bupa's 'charitable' division. Yet this is unmistakably a major marketing initiative by Bupa, which has a similar 'partnership' with the cancer charity, Macmillan. This resembles, on a larger scale, the insidious blending of charity and commerce which Brookes and Harvey (2015) described in their analysis of the Diabetes UK/Tesco campaign (4.2.1).

A Bupa 'news' item quantifies findings on specific problems affecting young people's mental health during the pandemic. The news text is extracted from a Bupa-commissioned market research report, *Teen Minds: Living Through a Pandemic and Beyond* (Bupa/PCP Research, 2020). The report appears largely intended for a parent (purchaser) audience, and notably for a demographic with higher social capital than in comparable TTC materials. Its emphasis on deterioration of young people's mental health during the pandemic is reinforced periodically by agreement from Mind: (*'Our research shows similar trends…'*). Such cross-substantiation boosts credibility in both directions and is a form of legitimation. Yet some data suggest not pathologies, but simple human responses to the social consequences of pandemic: *'47% have struggled with being 'stuck' in the family home for long periods of time'*. As a product of research however, such data can more legitimately be framed as problematic and presented alongside genuinely concerning data about pandemic coping mechanisms including disordered eating and self-harm. By foregrounding negative or frightening possibilities, an overall picture is constructed which could be sufficiently alarming to encourage custom. According to

Gagnon, Jacob, and Holmes (2010: 254), fear is regaining momentum in public health promotion, and is '*symptomatic of a broader political context where public health campaigns are inadequately funded and relegated to private enterprises that apply advertising techniques to non-commercial issues*'. This appears to apply precisely to the pandemic partnership of Mind and Bupa. Findings by Mulderrig (2018) (see 4.2.1) that the use of nudge in C4L instrumentalised parental fear and guilt resonate with the guilt-inducing tactics seen in the Bupa text.

The Mind interviewee (9.2.5) stated that although the pandemic had affected mental health, the impact had not been as extreme as expected, and the public has been 'resilient'. This clashes with the picture Mind presents of the consequences of Covid on mental health need with respect to its Bupa partnership. The same interviewee suggested however that *public awareness* of mental health had been heightened by the pandemic. Such awareness creates increased opportunities for mental health businesses, by instilling fear.

The partnership with Mind grants Bupa access to a new demographic, including people who will face a choice between financial hardship or further guilt when reacting to statements which describe the need to receive help *'as soon as possible* (because) *early diagnosis can have an impact on the long-term prognosis.'* This strong commercial nudge is one of several in Bupa's mixed-genre 'report' which skilfully textures pandemic mental health statistics with publicity material, information and market-driven advice. The report's section, *'Starting a mental health conversation',* recontextualizes aspects of AS rhetoric, and is accompanied by this document's first mention of stigma. Stigma appears to have been a concept of great utility, familiarising the concept of 'the conversation' about mental health. Within this new commercial context however, the 'conversation' is a pathway to private mental health care. The *Teen Minds* report (Bupa/PCP 2020) suggests *'we have all got much better about discussing our mental health',* and claimed much of the stigma '*which once surrounded these issues'* has disappeared. This presents stigma associated with mental illness as an issue which is already historical and redundant.

10.3 Response from Government

10.3.1 *Guidance for the public on the mental health and wellbeing aspects of coronavirus*

The website offered basic, practical advice for maintaining mental health, and the familiar theme of responsibilisation continued through an emphasis on people helping themselves through simple actions. By acknowledging a wide variety of situations and social groups, individual experiences are validated, especially in combination with links and resources for these groups, including older people. Indeed the website's most notable characteristic was its heavy reliance on links to a variety of other websites or commercial and third sector apps.

The public were reassured of the normality of feeling worried or scared, and were urged, *'Talk about your worries'*. For anything more problematic, people were directed via a link to *'NHS recommended helplines'*. The use of 'recommended' suggests a mechanism of forefronting and embedding valorisation of the NHS, while simultaneously guiding readers towards reliance on non-NHS resources. The link led to a (not Covid-specific) page, *'Get support from a mental health charity'*; these were indeed not NHS or state services. The website repeatedly directed readers towards sources of help which it recommended, but did not provide. After primarily self-help strategies, a plethora of websites, self-referral to NHS IAPT is the next option, typically alongside emphasis that these services are free. The reality that 'NHS' IAPT is predominantly purchased, not provided, by the NHS, was never patent.[58]

The push away from state-financed services is evident at all levels; a text box advises seeking urgent help from the NHS in case of crisis, yet the heading 'Urgent help in a crisis: 'If you need help during a mental health crisis or emergency' links, astonishingly, to an A-Z of charitable/third sector organisations. The entirety of this government guidance was withdrawn on 19 July 2021, and the public are directed instead to *Every Mind Matters.*

[58] The initials IAPT, sometimes pronounced as an acronym, have now entered common use as a noun, and the grammatical context of constituent words, Improving Access to Psychological Therapies, is typically irrelevant.

10.3.2 *Every Mind Matters*

Every Mind Matters (EMM), first launched in 2019, was rapidly tailored to respond to the COVID-19 pandemic. EMM was first run by PHE (now by the NHS), and has numerous 'partners' familiar from, and including, HT, Mind, Rethink, and until its closure, TTC. The site's press release on 18-01-21 announced *'The new campaign launches to support the nation's mental health, as half of adults say they are more worried during this current lockdown than in March 2020'.* The underlined text echoes the legitimising use of 'people told us' by TTC, and indeed its content stylistically might suggest some common authorship.

Although described as a 'campaign' there is no specific objective, but the implicit and explicit message is that an abundance of help exists for mental health difficulties, through the lists of third sector and charity resources, and the repeated direction of readers to IAPT. In this sense alone, this initiative could be the defacto in-house (i.e. with more overt government origins, and bearing the NHS logo) replacement for TTC, but without the policy focus on stigma.

In 4.2.1 I discuss the CDA study by Brookes (2021) of the *Better Health—Let's Do This!* policy document. The landing page of the *Better Health* website directed people to find *'simple ways to lift your mood'* with '*Every Mind Matters*'. The sites are now united, with shared branding, in turn reflecting an integrated perspective which positions both physical and mental health within the realm of individual responsibility. As Brookes (2021) points out, this model allows illness and social 'ills', including poverty, to be formulated as risks for which individuals are responsible, and can therefore be blamed for mismanaging. The contemporaneous promotion of this integrated concept and de-funding of TTC is suggestive of a policy and ideological shift. Furthermore, despite supposedly being (re)launched in response to the pandemic, relatively little EMM content at that time was pandemic-specific, making the timing of this 'relaunch', roughly midway between TTC announced its closure and the time it ceased to function, especially pertinent.

Your Mind Plan Quiz is a key feature of the site, and most pages carry the exhortation to undertake it. Completion of the (free!) 'quiz', consisting of just five questions, results in emailed 'personalised' suggestions, *'Your Mind Plan; top tips and advice for you'* which functions as an ersatz prescription. Six possible advice outcomes are either activities or apps, and if these measures fail, the individual should refer themselves for IAPT.

Fig. 32: Every Mind Matters branding

Following its absorption into the larger 'Better Health' initiative, the branding of EMM appears as below:

EMM discusses causes of mental illness; in the context of Covid-19, loneliness, and caring for others, are obvious sources of strain. However, the pandemic forced the government to confront, in its communications, the consequences of financial and housing insecurity for mental health. *'Worrying about your financial situation, work issues or your housing situation can have a negative effect on your mental health.'* Yet the word 'poverty' is replaced by 'money worries' which responsibilises the individual, and trivialises situations which may be extreme. The acknowledgement of the consequences of poverty within the context of the pandemic is specific, demarcated, and precludes an association between the government and poverty, or with the pre-existing landscape of austerity. Accordingly, the absence of governmental responsibility for social remedies is also notable. Instead, third sector organisations will provide solutions, or at least 'support'. This is an NHS branded site, yet the NHS here is an information resource, not the source of help. Indeed the site functions to draw attention away from NHS-provided services other than IAPT, and with some reluctance, CYPMHS (previously CAMHS).

Some (social) problems are presented as immutable (*'beyond our control'*), and therefore people are required to be resilient. As in the main Covid mental health website described in 10.4 (ii), a combination of acknowledgement and simplistic explanation assumes of its readers a low baseline of self-awareness and understanding of the social world. Amid copious tips, the availability of 'support and information' is reiterated frequently. This recalls the findings in 7.1.2, in which I found 'support' to be synonymous with information. When 'money, work and housing' are discussed as causes of poor mental health, self-management is emphasised via links to non-government sources also offering predominantly self-help. This reflects the site's wider function, as a resource directory, steering focus away from government and state.

EMM contains a small section on *'Discrimination and Mental Health'*, but does not mention stigma. Significantly, it does not discuss discrimination in relation to mental illness either, but rather, how the effects of discrimination in other areas of life may negatively impact mental health. Examples of discrimination includes *'losing out on a job or promotion because of who we are or what we believe in',* and readers are told, *'There are many ways the law can protect us from discrimination'*. This echoes the model I observed in the US National Institute of Mental Health (NIMH) in 3.7.1, and represents a move away from social framing of stigma and towards legislative framing of discrimination. As part of a pattern becoming typical in the site, the definitions and explanations are sparse, but the links to 'support' encompass so many aspects of life and individual characteristics (age, race, religion, sexual and gender identity, pregnancy, and learning disabilities), that an impression of social awareness is created. The co-linkage between different websites and sources of 'support' appears to have reached a stage whereby each website lists all the others, simply excluding the link to itself, in the manner of a mental health chain letter. Together they seem to deal with all possible major sources of mental distress, such that no individual need demand any help from the government at all. The ubiquity of pushing people to the Samaritans has led to anecdotal evidence of appalling overload on their service, resulting in unanswered calls which have led to suicide.

A significant section is dedicated to parents, yet much of this content is patronising or constitutes general parenting advice: *'How to start a conversation with your child'.* Parents are urged to look after their own mental health too, but the link to further advice cycles back to the homepage, with its superficial quiz, and the assurance of prolific help. The message is therefore no longer that stigma prevents help-seeking, but rather to render absurd any accusation that service provision is inadequate, both by convincing people that their feelings are 'normal' (a weak AS message), and that there is in any case so much help 'out there' that there is no cause for concern. This 'normality' may refer to experiencing anxiety or 'feeling low' in the pandemic.

The section directed at young people includes conspicuous attempts to use an assumed universal vernacular of youth (underlined below), by offering for example *'tips, tech and advice to help you <u>chill and de-stress</u>',* or recommending '*a <u>cheeky workout, having a kickabout</u>,* This recalls the determination of the Mind-Bupa partnership (10.2) to use '*the language of young people*'.

Unlike TTC, the EMM website contains a section for older people, suggesting, *'free NHS psychological therapies…are just as effective for older adults'.* Yet we know Layard's original conception of IAPT was not available to older adults. In stating these therapies are 'just as effective', EMM implies there has been low uptake among older age groups, and that therefore, again, this group are culpable. The short section in EMM dedicated to older people is preferable to exclusion, but is characterised by responsibilising rhetoric using familiar 'democratising' language: *'There's lots you can do to improve things'.*

The target audience of EMM is unambiguously people with *'mental wellbeing difficulties'*, and this is not, overtly, a behavioural change campaign. Yet its educational content remains comparable to behaviour change initiatives, and the covert, nudged messages of responsibilisation, self-care, and reliance on sources of non-state help, are evident. The pandemic was an ideal context in which to effect the switch from encouraging people to seek community-based conversation (via Champions or each other), to drive 'services' further online through greater reliance on apps. The realm of wholly digital 'support' allows the greatest cost reduction of all. There is however no acknowledgement that many people in poverty may not have access to smartphones, and may not have adequate, or any, internet access. Throwing 'support' online is therefore divisive, potentially accentuating the sense of helplessness already experienced by people in poverty. The fallacious nature of organisational and government assumptions of universal access to online resources during the pandemic had already been highlighted when children in poverty could not be taught online as they lacked either a device, or broadband at home.[59]

10.3.3 The appointment of Dr Alex George

On 3-2-21 a Downing Street press release announced that Boris Johnson had appointed Dr Alex George as Youth Mental Health Ambassador. The post would involve advising government, raising the profile of school-based education on mental health, and more broadly shaping children's mental health 'education and support' as part of 'building back fairer' from the pandemic. George is described an A&E doctor and online campaigner, whose social media

[59] The Department of Education then further cut the number of laptops available through schools during the pandemic (Ferguson and Walawalkar, 2020).

following among young people meant he was well placed to *'signpost the support that is already available'*, and provide input and feedback to government. His unpaid role, associated with the Department for Education, is independent of government.

> *Children and young people have heroically adapted to save lives and protect our NHS. This has understandably had a huge impact on their mental health, so I want to shine a spotlight on this vital issue… I'm delighted that Dr. Alex George will be working with us as we do everything in our power to improve people's mental wellbeing* (Boris Johnson, 3-2-21).

Dr George was a former cast member on the 'reality' TV series *Love Island 2018* (ITV2), a performative and intentionally judgmental dating show in which on-screen sexual behaviour is expected of participants. George's intense activity across multiple social media platforms is sufficient to describe him as an 'influencer'. Having built a media and social media presence, he opined on subjects ranging from sexual health to property renovation. The death of his brother by suicide in 2020 directed his concern towards mental health. George requested a meeting with Johnson in an open letter via Instagram, appending a photograph of himself holding a handwritten sign; *'Boris Let's Talk Mental Health Matters'*,[60] George later posted, *'WE DID IT!! You called and the PM answered!! I have been appointed as the Ambassador for Mental Health'*.[61] George is neither a paediatrician, a teacher, nor a psychologist, but during 2021, being an NHS 'hero' afforded unquestioned elevation.

George created a YouTube video to mark the occasion of his meeting Boris Johnson. Below I provide excerpts and commentary from my transcription. The video (George, 2021,*'Dr Alex meets Prime Minister, Boris Johnson. I am officially the AMBASSADOR FOR MENTAL HEALTH!'* 11:18), suggests the transition from social media influencer to government adviser would not be an easy one.

> *Welcome back to my YouTube channel…to another episode …erm, today is the biggest day of my life, erm, …I am today going to meet the Prime Minister of this country, Boris Johnson, erm, I can't really believe that I'm saying that, like, it's, it's, it just blows my mind…*

[60] *Mental Health Matters* is a provider of support services and talking therapies with which George has no known association.

[61] He consistently refers to himself with this title, and on Instagram as Ambassador for Mental Health @10downingstreet, rather than with the actual role title, Youth Mental Health Ambassador.

His statement below suggests he is unaware of the work of other campaigns. George refers to his 'campaign' but does not name it; rather, the message and the branding is the man himself. His objectives appear to be an uncomfortable blend of grief and desire for celebrity.

> *…Obviously a lot of <u>my campaign</u> has been around schools…and the three key areas that I've talked about is for teachers, support for teachers and training for teachers around mental health … and also support for, for er, for children at school, especially with what's happening* [i.e. the pandemic]

He uses a screen reveal technique to display his suit for the occasion *'What do you think? Thanks Ede and Ravenscroft!'*, using product placement behaviour which is standard for social media influencers. *'Come on team! … Let's go!'*

Within the interview:

> AG: *<u>Breaking down that stigma isn't it</u> … you know I work in A&E, and I've seen people come in who have you know really been struggling with mental health and I'm the first person they've talked to … you know we have made some steps clearly…but we've got further to go and of course this pandemic means we've got so much work to do and I'm hungry and I really want to help…*

This is the only mention of stigma in the interview, the video as a whole, or the government's press release. George's mention of people coming to A&E, a lost opportunity to emphasise that mentally ill people attend A&E because they have no other way to access mental health provision, is consistent with a naivety in his approach, which will present no threat to the government.

The interview demonstrates the interlocutors' mutual inability to speak clearly and cohesively. While we are accustomed to this from Mr Johnson, in George it may reflect the mismatch between his social media 'personality' idiolect, and his new role within an alien discourse community.

> BJ: *…er it's fantastic that er you know you want to use all your experience … and to maybe to reach out to people who feel who find themselves feeling that sense of er, whatever it is that drives people to <u>despair</u> and showing that there is…another way and I think that…hah, there are so many different categories and…some of it is…going to be about therapy, and help…*

Ultimately Johnson references 'despair' above, but not depression, and he does not reference what, other than the pandemic, might be causing either 'despair' or mental illness in the 'category of people' he refers to below:

> BJ: *But the big, the big flip is, that I like about what you're saying and the big switch is from thinking about mental health is a positive thing you can…we can all …improve, and so it's not just that there's a* *category of people* *who…suffer from… you know what we, everyone would call, call, mental health problems, but there's that everybody actually can benefit from taking their mental health seriously…*

As the interview progresses, the lack of an informed perspective on mental health and the shared inarticulacy is apparent:

> AG: *You know everyone, everyone has mental health and it isn't a bad word it isn't a bad thing... mental health can be about resilience, about building yourself up, feeling positive, about mindfulness… …*
>
> BJ: *But I believe strongly that erm therapy and help can make a huge difference to people and that…we're putting a lot of investment into er, mental health care services, but sometimes I think people can be helped by something as simple as listening to somebody such as yourself talking about it, er… reaching out to them, er… …*

Following the interview, the video continues in George's home. *'Guys I'm back! Erm, I'm just back from number 10 Downing Street, and I am, I'm absolutely like, I'm speechless…It's been unbelievable, you know you get there ... they check your bags and everything…took my phone and everything, as like security procedures are'.* He describes waiting *'where actually Margaret Thatcher used to do a lot of her work from'.*

George's appointment may be a matter of mutual opportunism; George presented himself, and was perceived as a fit for an era of 'personality'-driven policy making. His appetite for self-promotion, and perhaps even his enthusiastic gaucheness, could be deemed useful, and his social media presence is an accreditation of sorts. With 2 million Instagram followers, he, unlike a complex social media campaign, costs the government nothing to disseminate a curated view. His role as a one-man torch-bearer for government rhetoric on mental health is a novel extension of the use of celebrities to promote mental health messages, with the fortuitous addition of physician status. However the wisdom of appointing a former dating show contestant as an advisor on mental health education remains questionable.

George's familiar but meaningless *'everyone's got mental health'* message, his promotion of self-care, and belief that mental health is entirely controllable, suggests ironically both that he is a product of the generation that grew up exposed to the output of TTC, but also that he, in common with Johnson, is unaware of the heavy involvement of both TTC and HT with schools.

10.4.0 Digital mental health

In 10.3.1 and 10.3.2. I described how Government websites during the pandemic guided people to use apps as standard tools in the (self) management of mental health. The pandemic has provided convenient legitimation of a new norm, and a digital mental health sector has expanded seemingly unchallenged within a social context where remote accomplishment of daily tasks has been a marker of social responsibility.

Prior to the Covid-19 pandemic, high demand for state mental health services persisted despite the responsibilising message of AS which directed people to websites and to a lesser extent, apps. The use of apps in public health was established in areas such as weight control prior to the Covid pandemic; for example the C4L app described by Mulderrig (2017a). Lee *et al*. (2018) noted that following initial focus on weight control, apps were becoming commonplace for the promotion of a broader range of health-related behaviours 'in the general population without diseases' (2018:2838). They cite their huge cost advantages, compared to phone or clinic-based interventions, as the key reason for their use, and highlight their potential in 'stress and depression' to help individuals assess their symptoms and obtain information. This emphasis on information resonates with the findings of the current study.

During the pandemic the use of apps increased by 40% (data.ai, 2022), becoming normalised among a much wider section of the population, colliding with the social responsibility to use both the UK government's test and trace app and the NHS app showing vaccination status. A brief search (Apple App Store, 2021) yielded over 100 mental health apps, many of which are promoted via social media platforms. They include online 'therapies', only some of which offer access to a qualified professional. The absence of affiliation of nearly all apps to NHS services means the user's GP will be unaware of outcomes, and many providers are not based in the UK. The dramatic expansion of commercial forms of digital therapeutic intervention, made available via NHS funding, has also happened stealthily during the pandemic:

10.4.1 Kooth

Kooth (2020:17) publicises four ‘selling points’: no waiting lists, no GP referrals, no access limits, and no cost to the individual. It was the first public digital mental health company to be listed on the London Stock Exchange. According to *Our Purpose* (Kooth 2020), a document for potential investors, Kooth has contracts with 77% of NHS Clinical Commissioning Groups in England, and is already the largest digital mental health provider to the NHS for the 10-25 age group.

The government’s failures in mental health care provision have been a ruinous ordeal for many individuals, but for Kooth, especially in response to the ‘marked effect of the COVID-19 pandemic on mental health’, they present ‘addressable markets’; extraordinarily lucrative opportunities for ‘growth’ by more fully meeting the demand for NHS services, and in addition, an estimated £150 million p.a. awaits from UK corporate employee wellbeing initiatives. Significantly, and perhaps not coincidentally, many businesses are now acculturated, primed, and financially motivated to purchase employee wellbeing services following their engagement with the TTC Pledge. A combination of the long term pre-existing supply void, the pandemic, and a receptive government, provided fertile ground for opportunistic commercial provision.

10.4.2 Replika

‘The AI companion who cares’ is a different but equally disturbing extension of the digital mental health marketplace. This AI-led interaction launched in 2017 but was promoted aggressively during the later stages of the pandemic, especially to young people active on Tumblr, the microblogging and social network site which, as a space used predominantly by young women to explore emotions and identities, offers clear marketing opportunities. Replika is variously described as a ‘being’ which can be directed into a variety of relationship roles, as an aid to mental wellbeing, or as a tool to address loneliness through its ‘uncanny valley’[62] aesthetic and communication style. This both gives it broad marketability and the potential to cause, rather than ease, mental distress, especially for those already vulnerable.

[62] The feeling of discomfort or distress when people experience A1 which closely resembles a human-like state aesthetically or behaviourally; in this case when using the avatar interface.

Fig. 33: Screenshots from Replika (Replika, 2021)

The genesis of Replika is bizarre. In *Be Right Back* (2013), an episode of *Black Mirror*, the Channel 4 science fiction anthology series written by Charlie Brooker, a bereaved young woman communicates with her deceased 'partner' through AI technology which 'learns' his communicative style through his social media content. Brooker's writing was informed by his knowledge of ELIZA, the early AI natural language processing program at MIT (Weizenbaum, 1966). The creator of Replika, Eugenia Kuyda, was in turn inspired by *Be Right Back* to employ a computational linguist, and subsequently created Replika. Thus a digital mental health app was a complex result of both recontextualization and intertextuality, and also shows Replika to be a product of the uncritical consumption of a piece of social critique.

During the pandemic the public have been nudged to uncritically embrace a commercial field which may exploit lack of regulation, and where lack of patency at the level of the public-facing interface may provide an experience which is at best misleading, and which leaves unanswered questions about data harvesting. In the case of Replika, concerns of associations with Yandex, a Russian-based company with a focus on machine learning and data services, owned by oligarch Arkady Volozh (Newton, 2020), has highlighted the caution necessary in the evolving sphere of digital mental health technology.

The style of interaction reflects the user's contribution to AI 'learning'. Replika does not sell user data to other companies, but the company itself benefits, employing users' 'lived data' to further develop its AI interface to become more 'human'. This constitutes both free labour and data harvesting. There is anecdotal evidence during the pandemic that unless the user 'taught' their Replika about pandemic social norms, the AI suggested that the user should, for example, go out and meet friends, during lockdown. There are clear potential dangers for this style of interaction, both during and beyond a pandemic.

10.5 Discussion

In this chapter I have described and commented on some of the institutional and commercial responses to the increase in mental health problems during the Covid-19 pandemic.

TTC valiantly persisted with its established formulae, but as it prepared to close, a diminished emphasis on its *raison d'être* seemed apparent, along with a hint of editorial laxity, allowing some criticism of the government which would no longer fund it. In the other texts too the AS message largely disappears, replaced in EMM by a minor consideration of multi-cause

discrimination, framed against a background of legislative protection. I believe the AS message in the preceding years however significantly compounded the impossible pressure on mental health services during the pandemic.

The neoliberal objective of reducing the cost of state mental health services has been achieved over a number of years and prevails. The Covid-19 pandemic has made clearer that the current and future mechanism for cost reduction favours, where possible, a binary model of responsibilised self-help and apps, or private mental healthcare. The established, pre-pandemic behavioural nudge away from reliance on the NHS was conveniently reframed as, subsumed within, and rendered more acceptable by, the pandemic exhortation to *protect* the NHS. With respect to private mental health services, parents are a particularly soft target, and the unfamiliar terrain of the pandemic, with its associated uncertainty, was an ideal time for Bupa to capitalise on parents' fears. Following publicly funded moves to raise awareness and make the subject of mental illness more 'acceptable', the private sector can move to capitalise on the demand which state services are unable to meet.

Bupa and Mind wanted to provide 2.5 million young people and their families with *'the information they need to look after their mental health'*. 'Information' is of course a semantic relation of 'education', and both have been a functional metaphor for attitudinal and behavioural change, and a mechanism of nudge, in the operation of TTC. 'Information' and 'education' have also been recurrent features of this research; from the findings in 7.1.2 that 'support' meant both of these terms, to an interviewee's comments on the poor level of public education. Education is also framed broadly as 'awareness', one of the pillars of AS. It is therefore interesting that Ambassador Dr Alex George is attached to the Department of Education, not Health. Just as textual analysis in this thesis provides examples of the linguistic divorce of the concept of illness from mental health problems, an accompanying policy shift can be discerned which removes much of the 'mental health' agenda, in young people particularly, away from the political realm of health, and re-sites it within education, where responsibilisation can be even more easily applied within a curricular structure. It is significant that nudges in public health should move into the realm of education; the rhetoric of self-improvement has limits; the 'tips' become tiresome and cyclical, but education is a theoretically infinite realm, offering huge scope for creative behaviour change interventions inculcated throughout schooling and with fresh cohorts always on the horizon. While the overall emphasis on information rather than care can be regarded as an extension of the

awareness-raising activities of TTC, the Ambassador's digital credentials also facilitate the situation of mental health concerns within the digital realm.

With the socioeconomic consequences of the pandemic prevalent in news media, the government was forced to confront the causative relationship between social environment and mental illness, but did so without accepting historical responsibility, guiding people to understand their 'rights' and to learn to manage debt. EMM directed the public away from the state sector even in emergency situations, and towards tips, apps, the third sector, and 'NHS' IAPT. Covid provided an opportunity for increasing and justifying the use of cheap, remote apps. Meanwhile the existing market for private remote therapy apps grew, either contracted by the NHS or by individuals. In a confusing marketplace, many apps offer vague 'wellbeing' solutions, and monetise 'client' data, or even use it for creation of AI, in a disconcerting extension of the already controversial concept of the use of data from mental illness stories. As early as 2014, prior to the proliferation of apps, Lupton observed medical literature increasingly referred to the 'prescribing' of apps to patients (2014c:609). She cautioned that while some app developers may have appropriately qualified editorial staff, many do not apparently draw directly on medical expertise in the construction of their apps (2014c:619). She further noted the need for analysis of the way the digital data generated by apps are circulated, transformed and repurposed (2014c:618).

The data economy is a growth area in neoliberal capitalism; strategic maximisation of the value of data is a trend in advanced neoliberal economies forced to transition away from production and seek profit from services and intangible assets. Major financial consulting companies, including Deloitte and PwC, produce corporate guides to monetizing data, reflecting the perception that the 'smart' move is to harness and invest in data analytics, AI and 'big data'. Complex schematics projecting the parallel flow of data alongside money have been designed, for example by The Bennett Institute at the University of Cambridge (2020). From 2017, when *The Economist* announced that the most valuable global resource was no longer oil, but data, this concept was recontextualised across financial publications such as Forbes (Bageshpur, 2019). Some media sources pointed out the infinite and re-usable nature of data versus the finite nature of oil. It is in this context that we should therefore start to regard the use of mental health apps as an integral part of the marketization of health provision.

Covid became a fortuitous event in the denialist discourses in mental health, providing an escape route in the face of growing public understanding that so many mental health problems are the legacy of austerity, especially when compounded by further financial precarity during the pandemic. The pandemic meant that the virus itself could be become the caretaker scapegoat for mental health problems, exonerating the government and its policy choices. The need to attribute blame to stigma, and those who stigmatise, becomes obsolete as blame shifted to the pandemic, the vicious metaphorical 'mugger'. Because the need for the diversionary discourse of the stigma of mental illness simply dissolved, the withdrawal of TTC funding is logical; AS had served a purpose, but its message had lost its political capital. Covid may therefore herald the end of the policy utility of the concept of mental illness stigma, and an attempt to replace it, even temporarily, with an unambiguous shared viral enemy which society can grasp with an ease that was never the case with the stigma concept as enacted by TTC.

CHAPTER 11: Thesis Conclusion

11.1 Introduction

Section 7.3, which is in many ways complementary to this chapter, served as an important staging post in the thesis structure, gathering from the textual analyses the evidence for a narrative of neoliberalism, which I build on here. Similarly, in this chapter, I draw on, but do not repeat, my findings from chapters 8-10, concerning participant research and the pandemic.

In this final chapter therefore I first revisit the research questions, discussing briefly how they enabled me to uncover the 'missing' discourse of AS, and introducing some key conclusions. I link these conclusions to my main findings, then consider the role of HT in relation to TTC, before reflecting on some of the negative consequence of AS, both for an excluded social group (older adults) and an included social group (young people). I then examine the role of education in a proposed future for anti-stigma work, suggest future CDA research, and finally summarise my findings in closing.

11.2 Research questions revisited

The research questions which guided my analysis in this research (introduced in 1.7, explored in 2.4, and appended to areas of analysis), were significantly directed towards uncovering the 'missing discourse' of AS, and together they have worked to facilitate this objective. It became clear at an early stage of the research that the campaigns, in particular TTC, had both explicit and opaque functions (*RQ2*), which I explore throughout this chapter. *RQ3* asked why the concept of stigma was afforded such importance as part of mental health policy; I discuss this in 11.3. In common with several other questions, *RQ4*, which concerned the ideological and ideational content of AS, was informed by all of the findings, including the interview data, rather than through a single form of textual analysis. The contextual literature (Chapter 3) was also integral to the interpretive process, confirming the importance of working within the logic of different disciplines. For example, when considering *RQ6,* which asked how this discourse of stigma defined the nature of the policy problem, it was necessary to situate the textual analysis within the recognition that policy is based on political imaginaries which are an

exercise in complexity reduction, as discussed in 3.3 considering the work of Jessop (2009) and Fotaki (2010). This transdisciplinary perspective guided my interpretation of the policy 'problem' as a falsehood, and a substitute response for the true social problem; the insurmountable need for mental health services. The reality that the social problem was insoluble within neoliberal governmentality demanded the creation of a substitute problem.

In practice, and in interpretation, the RQs also become inter-related and interdependent; for example *RQ6* was intrinsically related to *RQ5*, which concerned the legitimation of the campaigns. Together these contribute significantly to unpacking the 'missing' discourse of stigma. *RQ7* concerned the extent to which the discourse of AS is inflected and constrained by discourses which serve neoliberal objectives; analyses have demonstrated that AS, particularly as enacted by TTC, has both overt and covert functions, and that the latter serve a neoliberal public health agenda.

Responding to *RQ8* (how the campaign premise was conveyed to the public, and what is asked of the public), analysis revealed that TTC conveyed its premise, through multiple semiotic means, in an exhortatory manner, asking the public to join the 'growing movement'. Its approach to the public was authoritative, benevolent, but ultimately deceptive in its foregrounding of the shiny carapace of concern. What is asked of the public is variable and confusing, as I have noted repeatedly; TTC supposedly targets non mentally ill people, asking them to change their attitudes and behaviour, yet the greater targets are people with experience of mental illness who undertook the 'contact work' of AS, as I explore in 11.7. This ambiguity was also uncovered by *RQ9*, which asked who the campaign's targets were, and how they were represented linguistically; textual analysis of social actors confirmed that whilst the official targets were the stigmatisers, again, the targets of greater importance to the campaign's function were its supposed beneficiaries, people with mental illness. The final linguistic question, *RQ10*, concerned the extent to which official AS discourses represent the lived experiences and needs of those experiencing (or who have experienced) mental illness. Data from the focus group made it clear that these discourses in no way represented that specific (ungeneralisable) group, and highlighted that despite the trumpeted 'reach' of TTC, it left many untouched. TTC-mediated discourse presents a primarily appreciative and positive reflection of AS discourses through curated 'user' voices, despite allowing only partial representation. Such contrasts confirm the value of triangulation.

I also identified four areas for critical reflection in 2.4, which evolved as part of the iterative process, and were developments from the linguistic questions. *CR1* asked *'to what extent is the overarching aim of AS a response to productivity concerns, rather than the wish to improve the lives of people with mental illness?'* The extent to which AS appears to be a response to productivity concerns becomes apparent from Chapter 6 and has been a dominant element of my interpretation of the data. This is not to deny the utility of some elements of TTC and HT; from TTC website data a picture emerges of AS as a social practice from which people derived fellowship, community, and purpose. The value of this should not be ignored, and partially responds to *RQ10* with respect to the *needs* of people with mental illness. Similarly, the aim at least of many dedicated staff who co-created the AS discourse of TTC was wholeheartedly to improve the lives of people with mental illness. I further note the 'blamelessness' of staff in 11.3.

A second area for critical reflection concerned the consequences of AS, for people with mental illness, for the 'public', and for government. As noted above, there were undoubtedly positive consequences for individuals who engaged with the TTC campaign.[63] In terms of the primary declared objective of reducing stigma against people with mental illness however, the final consequences were negligible with respect to the final result of *'reduced perception of discrimination'*, as discussed in 10.1. It is not possible to attribute the claimed effects on the public, such as an attitudinal improvement of 12.7% (see 10.1), to TTC alone. Informed by my research, I regard the greatest consequence of AS to be the economic benefit to government; something which was unsurprisingly absent from the diligent (public) presentation of metrics by TTC. Further negative consequences, such as the homogenisation of mental illness (9.3) are discussed further in 11.8. Through lexical analysis I identified the contribution of AS to the maintenance of the linguistic reframing of mental illness as mental health (see 7.1.1 and 9.3.1(i)), and in 11.10.1 and 11.10.2 respectively I discuss the negative consequences of AS on young people, and conversely the negative consequences of its exclusion of older adults.

My third area for critical reflection asked how anti-stigma efforts might be improved, in light of the findings. I discuss this in 11.11. Finally, *CR4* asked what a further campaign, namely HT, contributed, and how it differed to TTC. Its differences have been explored from Ch 5 (e.g. 5.3.4) and its contrasts noted throughout analysis. In 6.2.4 I also provide examples of the convergence and divergence of HT and TTC, as revealed by analysis of 'we', finding a key

[63] Far less can be said of HT, which did not evaluate their campaign's results or significantly engage with people who have experience of mental illness.

difference in HT to be a lack of specificity in terms of what HT asks of people, and lack of mental health knowledge. I offer summative observations in 11.9.

The above summary of my enquiry demonstrates how the multiple, but subtly different questions asked of the data have directed me towards novel insights with significant implications. Below I explore these insights thematically.

11.3 'AS': why and how?

In 7.3 I described how textual analysis of the two websites revealed that the narrative of AS, as realised by TTC and HT, is a solid expression of neoliberal policy. Analysis of social actor representation (6.3) revealed the emergence of both overt and covert campaign functions. A tenet of neoliberalism is its covert nature; understanding of its machinations by the general population would risk creating a hegemonic threat, and it is therefore in the interest of the operators of neoliberalism that while specific types of 'awareness' are to be raised, awareness of neoliberal modes of operation is to be prevented. This lack of awareness may extend to staff. I do not claim that employees of TTC, even at a high level, necessarily set out to operationalise a neoliberal agenda. The campaign's less explicit goals are masked both by the campaign's mode of enaction, and in particular by the use of well-intentioned and dedicated people, whether these are staff, or people who engaged with the campaign or gave their labour voluntarily. I have no wish to criticise or discredit either group, and it is important to acknowledge that both groups - since TTC always emphasised its 'lived experience leadership' - could be termed an 'ideological shield' which deflects and deters criticism of the campaign. As Mulderrig (2017:1) points out, '*public health campaigns tend to be immune to critique because of assumptions that their goals are laudable*'.

As noted in 1.4, 7.3, and elsewhere, the campaigns were founded on the assumption of the problematicity of stigma. In presenting stigma as a crucial problem for people with mental illness, and one worthy of a dedicated campaign, then by logical extension, unavailability of treatment is not a significant problem. TTC initially legitimised its campaign by stating 'people told us' that the stigma associated with mental health problems could be as distressing as the mental health issue itself, and was a barrier to seeking employment or to disclosure. Irrespective of what 'people told' TTC however, the stigma of mental illness was not a major

public priority, but rather, it was framed as such so successfully by social marketing that it became one.

In the context of neoliberal governance within which TTC arose, it is the economic threat posed by widespread mild to moderate mental illness to capital growth which is most likely to have motivated the creation of AS initiatives. The entrenched connection between AS and the political economy has become visible from two perspectives; the influence of austerity policies on mental health, and the subsequent 'burden' of mental illness on both government spending and economic productivity. Together these represent clear economic motivations for the policy enacted through TTC.

Conceptually linking these motivations with a campaign with ostensibly beneficent objectives is not, superficially, an obvious step. Yet as I have noted, the nature of both neoliberalism and behavioural economics are subtle and covert. I suggest that just as the policy aims of TTC were subtly enacted, distraction from its truer purpose was achieved with equal subtlety, possibly even through its initial funding by Comic Relief and The Big Lottery fund – names with positive public associations of entertainment and worthy endeavour; there is no equivalent positive public connotation with government funding. Interviewees were unable to explain why a completely new campaign was needed, when the stigma of severe mental illness might have been addressed more appropriately via Rethink. I suggest that a purportedly distinct brand, with core initial funding ostensibly from Comic Relief, facilitated the construction of a relationship with the public which allowed it to emphasise its 'social movement' identity, without any apparent connection to government.

Both TTC and HT have become known as campaigns, suggesting a generic relationship to each other and to other campaigns. But while HT self-defines as an 'initiative' which includes both an anti-stigma campaign and a fundraising element, TTC repeatedly referred to itself as a 'growing social movement'. This self-definition can be viewed as a hegemonic textual move, and a way of asserting a shared vision and agenda. Yet social movements are typically *counter*-hegemonic, as Melucci (1980) observes. They are forms of collective resistance against the established, hegemonic social order, and are typically populated by minority, oppressed or marginalised groups. So this identity interdiscursively borrows from the discourse of resistance, perhaps as a strategy to create appeal among the widest possible audience, including people who identify with the communities of true resistance in mental illness - as I also suggest when discussing use of 'stories'. In using this definition however, TTC created a linguistic

exemplar which established from the outset its belief that it could manipulate its audience through subtle textual moves. TTC's preference for 'growing social movement' over 'campaign' may represent an attempt to create a perception of distance from a political stance, since a 'campaign' is usually defined as a group of activities intended to achieve a political or business aim. Contemporary (social) movements in contrast possess 'not the force of the apparatus but the power of the word' (Melucci 1996:1). Yet TTC did use the force of the apparatus; in this case the apparatus of neoliberalism; but it also used the 'power of the word', cultivating and embedding the discourse of AS in the service of that apparatus. As Melucci (1996:4) asserts however, the solidarity networks that constitute contemporary social movements are entrusted with powerful cultural meanings, and are *distinguished* from political actors or formal organizations (Melucci 1996:4), and in this sense we can see how estranged TTC was from a real social movement.

It was then necessary to disseminate messages about the nature of stigma which would garner widespread public support. Two ideal candidates were the twin notions that stigma stops people from seeking help, and causes as much distress as the mental health problem itself. These simple messages achieve three things; they make the experience of mental illness itself less important, they obscure the importance of the funding of state mental health services, and consequently diffuse criticism of the government. These foundational principles provided a secure basis from which to subsequently enact more covert policy goals concerning maintenance of worker productivity and reduced service costs.

In Phase 2 of the campaign (2011-2015), significant funding received from government was accompanied by three outcome measures to evaluate the role of TTC in partially instrumentalising the policy, '*No Health Without Mental Health*', which included the objective that 'fewer people will experience stigma and discrimination' (Department of Health, 2011; 2012). These outcome measures concerned public attitudes, mental health-related knowledge, and mental health service users' experiences of discrimination (Henderson *et al*., 2016). It was by this stage much easier to frame ongoing objectives, and even the government itself, as benevolent through the campaign's established identity. This resembles Brookes' (2021) identified of a discourse of the government as a benevolent entity in the government's *Tackling Obesity* policy paper (4.2.1).[64]

[64] Although in that case, government as funder and source of policy was overt from the outset.

A broader social objective of some mental health organisations is mental health ‘literacy’, which encompasses understanding how to maintain positive mental health, decreasing stigma, understanding mental illnesses and their treatments, and knowing when and how to seek appropriate help (Kutcher *et al*. 2016:155). Stigma is just one element of this more rounded approach. Arguably, what is good for the population’s mental health overall is good for economic health too, yet only a campaign designed to focus on ‘stigma’ alone could constitute the basis of an integrated mechanism to target productivity so directly.

I propose that the concept of stigma in mental health was intentionally re-activated - literally taught – to enable TTC to have utility as a policy intervention. This is supported by several research findings; for example the focus group found stigma hard to conceptualise and discuss, and Stigma Shout (Corry, 2008) also found a lack of public comprehension of stigma. Accordingly an interviewee stated that when TTC was launched, the public’s lack of comprehension meant they were not ‘ready’ to talk about stigma.

Yet while the asylums have been emptied, the fear and prejudice associated with them is a deeply embedded cultural ‘knowledge’, and its conceptual resurrection was simple to operationalise in the guise of benevolent discourse. It is a strategy which I suggest simultaneously legitimises the wider existence of (mental illness) stigma in society, and thereby the inequalities which underpin systemic social stigma. By placing a disproportionate focus on just one type of stigma, the power and breadth of the stigma ‘machine’ as conceptualised by Tyler (2020), is backgrounded and perceptually diminished. Meanwhile by drawing attention to the stigma of mental illness, and diverting attention from the wholly inadequate levels of mental health services, AS re-frames the nature of the problem experienced by people who experience mental illness.

11.4 Smoke and mirrors

I described in 3.8 how the literature on mental illness stigma focuses on severe mental illness, and primarily on public stigma, and that research demonstrates that both of these are derived from fear of dangerousness. TTC used tools (e.g. CAMI) appropriate for measuring attitudinal change towards severe mental illness, but did so within a framework whose objective was not to address stigma enacted against severely mentally ill people or, by extension, dangerousness. Corrigan (2018) lists the stereotypes which contribute to mental illness stigma as

dangerousness, people's responsibility for their own illness, and incompetence. By 'removing' dangerousness, we might therefore frame AS initiatives as a response to these second and third stereotypes, which can indeed be observed in its enacted pillars; responsibilisation and education/awareness-raising.

While AS diverges from stigma literature in its lack of focus on severe mental illness, it converges with it in its focus on public stigma and self-stigma. In doing so it serves to divert attention from the massive structural stigma which is associated, bi-directionally, with lack of treatment and health inequality. Yet the final outcomes of TTC (10.2) suggest its concern for mental illness 'stigma' was never for the personal consequences but the systemic; why else would the perceptions of decreased discrimination among people with mental illness be barely quantifiable, in the context of a dedicated 15-year campaign which so firmly believed in the quantifiability of attitudes? The summative result, '*a reduction in discrimination reported by people with lived experience'* (TTC, 2022), substantiates my findings from analysis; that TTC was less 'about' mental illness stigma, and more about the economic problem of 'lower level' types of mental illness, their prevalence, and their economic consequences. Neoliberalism caused the problem, had no intention of addressing the problem, so applied a neoliberal policy 'fix' to the problem.

This thesis has not sought to evaluate the efficacy of TTC with respect to its declared objectives or methods. However, having explored the campaign's linguistic strategies of legitimation (7.2.2) it is valid to view its internal tools of evaluation as integral to the legitimatory mechanisms through which it was able to position itself as both successful and necessary. This success validated, at an early stage, its authority to position stigma as the central policy problem of mental illness.

I have described how by avoiding diagnoses, and by reframing 'mental illness' as 'mental health' the discourse of AS had a homogenising effect, which diminished illness and therefore the need for treatment. A further effect of diagnosis-avoidance was to legitimise the use of the CAMI (Community Attitudes to Mental Illness) scale (1979), a tool I mentioned in 3.7.2, which was developed for survey work in the specific context of deinstitutionalisation. CAMI aimed to understand the potential for communities to accept people who had for many years been institutionalised by serious mental illness. TTC used CAMI as one measure of campaign efficacy. Yet within the mental schema created by TTC, the CAMI survey questions now refer to the public attitude towards a person with, for example, a history of depression and anxiety.

Consequently, its use in a different socio-temporal context potentially skews results in favour of a greater level of positive attitudes, thereby presenting TTC as disproportionately effective. Therefore when TTC (2019) claimed a 12.7% improvement in public attitudes since 2008, this may reflect the use of CAMI, as well as the nature of the sample demographic, and broader cultural changes unrelated to AS campaigns.

Apart from the contextual specificity of the survey tool, its questioning is culturally anachronistic since it was designed in 1979, and based on even earlier antecedents. CAMI is therefore one of several elements which combined to make TTC easier to evaluate as successful. That the entirety of TTC's evaluative tools were either outdated, or tailored to its data by a stable of paid evaluators, weakens the veracity of evaluative findings, together with the inexplicably looser positive evaluation of self-reported positive experiences of people living with mental illness, which should surely be the most prized objective of a true anti-stigma initiative.

A further element which made TTC appear superficially more successful was the campaign's intentional early focus on attitudinal change among people who would be easiest to influence. Despite prolific output, which paid serious attention to notions of target demographics and market segmentation, the web text and interview data reveal that initial efforts were directed towards people who were easiest to influence. In analysis of the representation of social actors, the 'stigmatisers' selected by TTC were those whose attitudes and behaviours were *'most likely to improve'* (7.3.3), while young people were said to respond *'particularly well'* to message repetition. Interview data (9.3.1) substantiated this, with a statement confirming that, in the 'early days' TTC targeted '*people who we felt were most likely to change their knowledge attitude and behaviour'*.

11.5 Help, what help?

If a primary message of AS has been that stigma prevents help seeking, the logical goal of AS is therefore to enable all who want 'help' to seek it. Yet such objectives are counterintuitive; a campaign which benevolently emphasises the role of stigma as a barrier to help-seeking can only result in a greater cost burden, if the campaign is successful. The NHS was already unable to cope with the demand for mental health services even before AS, so why encourage more people to seek help? If however we work within the logic of a neoliberal agenda, and regard a

major function of TTC as being the gradual transformation of what constitutes help, there is no ideological or economic conflict.

The 'help' most readily accessed during the life of TTC has been IAPT, frequently purchased by the NHS from commercial providers. The initiative commenced in 2008 for people of working age, but since 2010 has become available to all adults. Layard (2006) designed IAPT as a 'zero cost' policy solution, through its explicit goal to increase the nation's productivity. This golden egg of neoliberal mental health policy is even accessed by *self*-referral. The reality has become problematic and controversial, with claims that sessions cost three time more than the DoH had expected (McInnes 2014), and that in 2021 nearly 1 in 7 appointments were carried out by unaccredited counsellors (Moore, 2021). The theoretical provision of 'stepped care' CBT in IAPT, whereby the level of therapy progresses in intensity according to individual needs, failed to materialise; Davis (2020) found 73% of people receiving IAPT have only 'low intensity' therapy, such as guided self-help, or computer-based CBT. Only 4% transfer to 'high intensity' levels.

The collective claim of AS that stigma prevented help-seeking could only compound the already insuperable pressure on state mental health services, and rapidly accrue similar pressure on the limited capacity of IAPT. Thornicroft (2011) criticised a report from the Centre for Social Justice for its failure to mention that the majority of people with a mental disorder in the UK do not receive appropriate care. From this perspective, the prospect of *any* treatment (i.e. IAPT) is preferable to none, and thus Thornicroft repeated his support for IAPT, which he reiterated in 2018, presenting it as a panacea-like solution; he applauded its evidence-based intervention protocols, and its quantifiable access rates.[65] But noting the lack of evidence of the strong returns on investment from increased productivity which Layard and Clark (2015) promised would result from reduced 'presenteeism and absenteeism', Thornicroft (2018) advocated the acceleration and expansion of IAPT, to include comorbid *physical* conditions. Such approaches confirm, if confirmation were needed, the presence of a cynical neoliberal heart beating at the centre of mental health 'care' policy today.

The strain on IAPT was then heightened further through an extension of its use (NHS 2018) to people with long term physical conditions or whose medical symptoms are unexplained, thereby allowing a greater proportion of the NHS 'burden' to become part of the theoretical 'net zero' cost of IAPT. This policy move also frames people's physical experiences within the

[65] By 2016, 950, 000 people per year received 'assessment and advice', and over 537 000 received therapy (Baker, 2017).

realm of the psychosomatic, and presents the potentially dangerous risk of failure to investigate physical symptoms using more costly clinical tests.

Long before the pandemic exerted extra pressure on IAPT, TTC offered a *defacto* solution to its overburdening in the form of Champions, although they were never publicly framed in this way. After training, Champions were intended to embody a long term, self-sustaining culture of community and workplace 'support'; this would have constituted a second zero-cost solution, operating at a different level of need, and similarly embracing a neoliberal agenda of reduced reliance on state services and vast cost-reduction. The collapse of the Champions network during the pandemic may have highlighted the weakness of reliance on exploiting an extended contact model of anti-stigma to serve as a multifunctional cost-reduction tool; IAPT at least had mechanisms for continuation via phone and online.

Yet textual analyses of TTC user voices demonstrated not a vague need to be empowered to *seek* help as the campaign urged, but to *obtain* help. A significant number of (early) 'stories' illustrate desperate struggles to obtain often very specialist treatment, the burden of care placed on families (*'it took us 6 years before we found the treatment that was right for him'*), and hopelessness ('*as a family we are lost, stuck'*). Lack of treatment, in combination with austerity, leaves a devastating trail, including the shameful reality of people driven to treat serious mental illness themselves; *'we tried to cure it diy due to inadequate therapists'*. Here 'it' was Dissociative Identity Disorder (DID), for which the thought of a 'DIY' cure is terrifying. An interviewee, aware of the acute lack of services, volunteered the opinion that awareness-raising does not change access to services, even citing a TTC poll which found that *'access to services and quality of services was…the number one priority, unsurprisingly.'* This concurs with the opinions of the focus group; participants wanted not just any help, but the right help. The interview statement strikingly exposes the deceit of an expensive, extensive campaign about 'stigma'.

11.6 The nudge to responsibilisation

In 7.3.2, I suggested that the use of Champions to create a shift away from reliance on NHS services and towards self-management is a clear example of nudge, which as Mulderrig (2017:2) describes, involves adjusting the way in which messages are communicated, to influence choices by manipulating a demographic's (limited) rationality. By subtly adjusting

the decision-making environment, and changing the way options are framed, the choices which policy makers require are made to appear more appealing. Mulderrig (2017:5) summarises nudge as 'a biopolitical technique which generates expert knowledge about wellbeing, segregates, and appraises (and potentially stigmatizes), and then devises strategies of intervention designed to shape more compliant citizens'. When TTC claims it did not use 'nudge', perhaps by this they meant they did not outsource decisions about the strategies by which they sought to change behaviour to the Behavioural Insights Team (BIT).[66] The widespread uptake of nudge means it is no longer novel or arcane, but has easily replicable principles and techniques, such that it has become commonplace in major public health campaigns and need not be outsourced. Further, even if TTC itself did not consult the BIT, PHE was a client, and the DOH, DWP, and the NHS are all guided by its input too. Clear alignment exists between the practice of nudge and TTC's enactment of behavioural change.

During phase 3 (2016-21) TTC described targeting a 'cooler' audience, to effect attitudinal change in people with greater distance to mental health issues. This 'cooler audience' was working class men aged 25-44 from social grades 'C1C2D'. Interview data however suggests the focus on working class men started after a 'massive strategic review' in 2014-5, earlier than the neat division implied by funding phases. The NRS (National Readership Survey) scale of social class, whereby C1 equates to lower middle class, C2 skilled working class, and D working class, is entirely occupationally based, and was used by interviewees and in the website data. The NRS scale, designed to provide audience research to facilitate print-based advertising, is now theoretically defunct, but the notions of class which it established persist, and when the campaign associated 'C2D' with greater levels of stigmatising behaviours, it could do so without patently criticising 'working class' men, since this class scale functions as a type of code. The wish to avoid patent criticism was clear from interview data (9.1.5). TTC used the grades to make simple demographic divisions; ABC1 (middle class) and C2DE (working class), resulting in largely covert generalisations about large groups of people.[67] Class E however, ('non-working') which does not distinguish between people who are unemployed or in receipt of state pension, was absent in the data. Just as Mulderrig (2020) confirmed working class people as the targets of C4L, and of nudge, TTC also targeted 'working class' people, but its specific focus was attitudinal and behavioural change in people *in work,* whose current productivity was at stake.

[66] The successors to the British government's original 'Nudge' Unit based in the Cabinet Office.
[67] In impact reports however, this second group is listed as C1C2D; this spans supervisory to low skilled occupations.

TTC claimed it used the COM-B model of behaviour change (Fig. 4, 5.2.1), which uncontroversially suggests behaviour is the product of interaction between capability, opportunity, and motivation. In doing so, TTC may be diverting attention from knowledge of nudge, including its potentially negative associations, just as emphasis on stigma diverts attention from the inadequacy of mental health services. In turn, focusing specifically on the stigma of mental illness, enacted primarily by the public, diverts attention from the systemic and multifaceted stigma machine (Tyler 2020) driven by neoliberal capitalism.

This chain of strategic deception inflects TTC from its very creation. I suggested in 2.1.3 that a public with increasing awareness of the austerity-driven and intersectional effects of social stigmas was manipulated. While undoubtedly stigma enacted against people with mental illness is a genuine problem, the use of the stigma concept in AS is a simulacrum, seeding in the public consciousness a primary association of stigma with mental illness, foregrounding this type of stigma as an isolated entity, while ignoring the stigma of, for example, poverty. This unilateral focus effectively halts a potentially destabilising mass understanding of social injustice, by localising the concept of stigma. Thus by understanding just one of the conditions which allowed the campaign and its discourses to come into being - the institutional appropriation of stigma as a concept - we gain a vital insight into the importance of the attitudinal and behavioural changes sought by TTC, and their potential role in ensuring the stasis of more challenging attitudinal positions which might present a counter-hegemonic threat.

Discourses of individual responsibility in health have been referred to as ‘structural violence’ (Sakellariou and Rotarou 2017:1), because they compromise access to healthcare and subordinate the needs of people to the needs of markets. As I discuss in 3.1, Foucauldian biopolitics and concepts of governmentality are evident in the contemporary neoliberal requirement that individuals take ever greater responsibility for their own health, with concomitant reduction of the state’s roles and responsibilities as market forces take its place. Responsibilisation does not exist in a vacuum, but is part of neoliberalism’s self-serving design.

In 6.1, I noted how examples of recontextualization of mental health discourse by TTC website users could not be specifically attributed to TTC. Such examples however clearly illustrate public acceptance of responsibilising messages:

'When (name redacted) *was ill…within our family I don't think we took her seriously enough, we didn't give the full support … I think was the stigma'.* In regretting their lack of support, the family accept that they were responsible. Without AS, one also wonders how likely this family would be either to blame themselves or to invoke (their own) stigma as the cause.

'we r (sic) *humans who's a lot of us have had shit since we were kids 'n' don't know how 2 deal or cope with it.'* This leaves us all too able to interpret the 'shit' as, at least, poverty and deprivation. It is strikingly clear that this writer too has accepted that it is their responsibility to 'deal' or 'cope' with it.

'As those of us who have a diagnosis well know, we can live happy, productive and healthy lives, <u>*we just have to work a bit harder*</u> *on the inside to ensure the outside ticks along nicely.*

Since responsibilising discourse is found in both mental and public health campaigns (4.1), it is not possible to attribute the public uptake of the message of responsibilisation to a specific campaign, but rather that this reality has become 'taken for granted', or as Jessop (2009) might put it, routinised to the point of sedimentation.

TTC, its Champions, Pledge, brand and materials, its training and events, can all be viewed as a system, in terms of Rose's ideas of technologies of performance (Rose 1999:153). I described (3.1) how technologies of performance are the tools used to render more governable the activities of governmentality which require maximum productivity and minimum waste. Technologies of performance make it easier for the prescribed techniques of individual psychological practice to be followed, through which a state of 'autonomous selfhood' can be reached (Rose, 1990:90). In Rose's terms, the self-help practices which this entails, the 'psychotherapies of normality' are the technologies of responsibilisation. Through this responsibilisation, TTC engages fully with the neoliberal demand that its adherents make their lives the object of 'practices of self-shaping' (Rose, 1999:96) (3.4.1).

11.7 Ambiguous campaign identity and the multiple roles of Champions

When an organisation patently depends on the use of people *with* mental illness, in a campaign which targets people *without* mental illness, in order to benefit people *with* mental illness, the ensuing confusion about the campaign's purpose and functions is unsurprising. I suggest that

confused perceptions surrounding the campaign's identity and purpose increased its need to demonstrate its organisational worth and validity through positive evaluation of its effects, by creating large amounts of data, as my analysis of the campaign's linguistic strategies of legitimation (7.2.2) demonstrates.

One reflection of the public confusion about campaign identity is the evolution of 'stories' to become, in part, a functional support forum. While the interviewees repeated the website's assertions that TTC was specifically an anti-stigma organisation, whose target demographic was people whose distance from mental illness meant they had the least understanding of it, in reality the people most targeted, and most valued, were those with experience of mental illness. Textual analyses of the website demonstrated the vital importance of 'stories' and lived experience; indeed the 'voices' of this social group were so integral to the corpus that it was necessary to adapt my analytical methods to accommodate the linguistic texturing of identities (5.8.3 and 6.2.2). The importance of Champions was also confirmed by interviewee statements such as *'…we simply couldn't run without…* (our) *Champions'*. Many 'stories' from Champions were never committed to writing, since they were part of the conversations in their unpaid activities in multiple social contexts, including talking to people in need of 'support'; the latter highlights Champions' multifunctionality. Just as analysis by Mulderrig (2017) (4.2.1) found the C4L campaign 'used' children as the active agents of the campaign, TTC, through its policy of *'lived experience leadership'* used people with mental illness as active agents, who invoked a form of expert knowledge and presented the required behaviour change solutions.

In 1.3 I described the intergroup contact hypothesis (Allport, 1954) as the basis of anti-stigma interventions which use contact between the stigmatised and the non-stigmatised to reduce stigma, and that a key aspect of TTC's operationalisation of 'contact' was its use of Champions. Yet as textual analysis has made clear, Champions' role was more complex than this. It may be possible to trace the underlying, justifying ethos of their use to the recovery movement, which examines what a person *is able* to do, on the basis of personal, social, or environmental strength (Corrigan 2018:36). It is through this model that the category of mental health 'providers' has been extended, in various contexts, to include peers; broadly, people with their own experience of mental illness. The concept has been met with concerns that peers' own mental illness, and lack of professional expertise, jeopardises care, and there is insufficient evidence that they are helpful in controlling stigma (Corrigan 2018: 36). This concept helps to substantiate my assertion that the role of Champions was always far more complex than simple contact; they were patently the unpaid deliverers of the message; more covertly they were low

level mental health workers to benefit others and prevent their descent into absenteeism, and third, they were engaged in a therapeutic social activity intended to make themselves more resilient and less likely to become (re) reliant on state mental health services, by promotion to expert status. It remained necessary however to maintain the central campaign tenet of targeting people most distant from mental illness, in order to sustain the concept of contact intervention, but the prominence and value of Champions makes far more sense once their multiple functions are revealed.

The intergroup contact approach is immensely convenient for those who would seek to positively impact productivity, by fighting 'stigma', at minimal cost. The cheerful but exploited Champion is parachuted in to chivvy on the sluggish or disillusioned worker at risk of absenteeism and disengagement. The Employer Pledge meanwhile justifiably makes the worker feel surveilled and under pressure to disclose details of their personal lives which they might prefer to keep personal.

The enduring emphasis on contact by TTC is however interesting in the light of recent research into what works to reduce stigma. A meta-analysis of 80 anti-stigma interventions by Thornicroft *et al*. (2016) did not find social contact to be the most useful means of achieving medium to longer term attitudinal improvement. This strengthens the evidence from textual analysis that stigma reduction was not the core objective of TTC; why else would it continue for a further six years if its greatest aim was indeed to reduce stigma? A partial answer is to be found in work by Sampogna *et al.* (2017), a team also including Thornicroft, who found the *social marketing* element of TTC had been effective during the study period (2009-2014), and endorsed further population-based social marketing campaigns as a stigma reduction strategy. Yet the core work of TTC with respect to its Champions continued, and we can see even more clearly this 'stigma reduction' as performing a primary function unrelated to stigma, and more inextricably linked to the service of economic productivity.

11.8 Parity, diagnoses, and homogenisation

When parity of esteem, the principle that mental health must be afforded equal priority with physical health, was committed to law by the Health and Social Care Act 2012, NHS England was mandated to achieve it. This concept, which I first discussed in 3.8.3, presents an immense policy problem, given the obvious inadequacy of adhering to this principle through a selective

focus on equality of societal regard, while ignoring equality of funding. The focus on equality of societal regard, however, which can be viewed as another side of the AS coin, conveniently allows the variable aetiology of mental illnesses to be ignored. While some mental illness may have neurobiological causes, in very many instances, predisposing factors are the miserable sequelae of the political economy of neoliberal governance.

Amid the legal commitment to parity, if only of esteem, TTC's intentional avoidance of diagnosis-specificity is therefore puzzling. 'Mental illness' is rarefied and perceptually diminished (7.1.1), together with other lexical features such as the salience of '*support',* instead of 'treatment', and the removal of diagnostic divisions. These findings were broadly substantiated in the interview data (9.3.1), such that overall, analysis revealed a set of linguistic mechanisms which together counter any progress towards parity.

This appears to be a significant contradiction in mental health discourse, particularly since in 3.8.3 I explored how the medicalisation which parity legitimates in the field of mental illness offers opportunities for capital growth. Yet paradoxically, only through lexical dilution and de-medicalisation, in which mental illness is predominantly presented as a vague and often temporary emotional malaise, could TTC propose its productivity-boosting policy solution through the cheapest of initiatives, conversation.

Unsurprisingly, parity has not been realised; mental illness receives only 13% of NHS spending, but constitutes 28% of the disease 'burden' (Centre for Mental Health, 2021). If mental and physical illness were truly to be afforded parity, the cost implications from the perspective of neoliberal health policy would be unacceptable; so while in an American model of health funding, parity benefits capital growth, in the UK, there is a vastly different fiscal landscape to negotiate before reaching the stage of capital growth from parity. With this is mind, the reframing of mental illness as 'non-illness', as I found in my analysis, offers a remedial, conceptual policy response, without challenging the law; in seeking to change public behaviour and attitudes, AS fundamentally and literally redefines mental illness, demonstrating the power of lexical choices. In economic terms, if the burden of this newly defined non-illness is shifted to the public, and in particular those who experience the non-illness, the percentage disease burden can be drastically reduced by a combined process of denial and trivialisation.

Without illness there is no diagnosis, and vice-versa. The interview data suggesting that avoidance of diagnoses was intentional aligns with the TTC website, which despite using a few diagnostic terms, in stating that '<u>*some people*</u> *find it helpful to see their experience as an illness'*

frames this as an unusual position. Yet removing diagnoses may remove a means by which people understand and communicate their experience. By homogenising people, perceptions of mental illness are homogenised.

Ignoring diagnostic categories is thus another mechanism by which mental illness may be trivialised within a superficially inclusive mode of operation, and sustains the policy agendas of those who seek to further de-fund mental illness; if an experience is not specific, it has neither form, symptoms nor trajectory. It therefore cannot be a significant problem, thereby further supporting the logic that it may legitimately and ethically be solved by simple social interventions. Lack of open discussion of the true breadth of mental illness dismisses conditions not defined as depression or anxiety; the latter are deemed, perhaps erroneously, easiest both to 'cure' and to reduce their associated stigma.

Yet analysis of 'we' in TTC user content demonstrated that, while TTC preferred not to differentiate between diagnoses, the people who have diagnoses often choose to identify themselves, in part, through named mental illnesses, and even to discuss diagnostic details, such as the distinctions made by psychiatrists between different types of personality disorders. To do so is not only a right, but the exchange of such information between similarly diagnosed individuals is an important aspect of addressing patient-practitioner power differentials.

The homogenisation of mental illness may result in more problematic attitudes towards people with severe mental illness such as schizophrenia, rendering them a more extreme outgroup. It is therefore unsurprising that TTC did not significantly reduce schizophrenia-related stigma, and that they *'hadn't necessarily expected to'*. People with schizophrenia are not the walking worried, lumpen proletariat in which AS seeks to guarantee economic productivity. Responsibilising, self-help strategies have very limited utility in illnesses such as schizophrenia, and this arguably explains TTC's failure to address stigma towards schizophrenia, which has no place in the operational cost-reduction cycle of AS. The predominant representation of mental illness by AS as an amorphous, easily (self)-managed problem somewhere on the anxiety-and-depression axis, inevitably leaves schizophrenia as a misunderstood and distant entity. Accordingly, although schizophrenia was the mental illness most named in the research corpora, it was typically problematised, and represented as a resistant and enigmatic phenomenon.

11.9 What about Heads Together?

This research examined two campaigns, TTC and HT, but as I have noted consistently, the use of HT data has often been comparative. In 7.3.6. I compared the emerging narratives of the two campaigns following website analysis, and this section complements that discussion. HT appears to have fallen automatically into the patterns of neoliberal AS rhetoric so well established after a decade of TTC. I propose that HT, although a less important campaign than TTC, played a powerful role in legitimising TTC simply by disseminating a similar message, even though TTC does not 'use' HT as linguistic strategy of legitimation.

The Mind interviewee spoke of their hope that TTC had a 'snowplough effect', clearing the way for other organisations to fulfil similar roles. I suggest HT is just such an organisation. A significant contrast between TTC and HT was that HT had neither a clear target demographic nor specific pathways of enactment. Its 'public' initially appeared to be a more privileged group, although a later emphasis on football is a more themed variant of TTC's focus on working class men. However, the Heads Up materials, which commenced in 2019 and peaked in 2020 when the FA Cup was renamed the Heads Up FA Cup, have not been subsequently updated, suggesting the focus of the Royal Foundation and its principals is elsewhere.

In 6.4.5 I suggested the discursive hybridity seen in TTC indicates that the public mental health sector has been colonised by genres which are representative of neoliberal ideologies, and that consequently the intended outcomes of public sector activities support neoliberal policy goals. However I suggest further colonisation of the formerly more marginal third sector has also occurred, with a 'taken for granted' embedding of neoliberal ideologies, resulting in uniformity across public to third sectors in mental health.

I have discussed how mental health organisations and the discourses they create are functionally interconnected by personnel who work across different organisations. Further, I suggest that, like a large corporation, variance in packaging and branding may obscure our understanding that the products available to us are all produced by the same company; similarly, if we strip away branding across the mental health sector, including AS, and consider language alone, there is remarkable standardisation of message (certainly across Mind, TTC, HT, Rethink, and now EMM). We can assume that when a body is 'partnered' by, for example, Mind, the influences may be significant. HT, which had no expertise, just a sense of 'duty' and a need for reparative royal PR, offered an ideal opportunity for ideological and interdiscursive colonisation.

I suggested in 11.3 a picture of, if not misdirection, then 'under-information' over the funding and influences of TTC. In turn, as a 'royal' campaign, HT could not be overtly political, but the naivety accompanying its intentions allowed it to take shape as a product of the cultural and ideological landscape created by TTC, and the unseen influence of its partners. Its intertextual expression of attenuated versions of TTC messages position it almost as a subsidiary; in the terms of CPE, it became a 'flanking and supporting mechanism'[68]. It was in fact HT which, latterly, largely propagated the help-seeking trope, and it too had a parallel focus on workplace mental health through its linked site, Mental Health at Work (MHAW). Before providing links to MHAW, HT highlights the cost of mental illness to UK businesses (£35 billion)[69]. MHAW itself is curated by Mind. My analogy of a differently packaged product made by the same corporation is especially resonant: in MHAW, businesses do not 'Pledge' but make a simpler 'Commitment', with less fanfare but the same principles, and similar opportunities for promotion through business logos appearing on the website. Rather than the complex individual plan required of businesses for the TTC Pledge, the Commitment entails adherence to six basic standards drawn from *Thriving at Work* (2017), the Stevenson/Farmer review on mental health and employers. Mind therefore inexplicably duplicates the Pledge initiative, in something akin to a macro example of Fairclough's 'overwording', here strongly suggestive of ideological endeavour. MHAW is also accessible from Mind's website, which states that Mind developed MHAW, but that it was funded by HT.

11.10.1 Negative consequences of AS: young people

My analysis has repeatedly shown the extent to which young people were targeted. If, as I propose, one of the campaign's concerns was to embed emotional resilience and productivity within the younger, working age and pre-working age population, and to frame this *through* mental illness stigma, then the persistent focus on youth makes perfect economic sense.

Gradual social reframing of AS as 'raising awareness' has important implications, since the latter is suggestive of a broader, weaker objective than stigma reduction. Work by Mulderrig (2017) into the reframing of obesity is pertinent; just as Mulderrig describes use of social marketing to engender public responsibility for the complex problem of obesity, AS attempts to reduce the complexity of mental illness. Patalay and Fitzsimons (2020), as part of the

[68] (Jessop 2013). See 3.2.
[69] The HT page and its figures have not been updated; this is the 2015 figure.

millennium cohort study, reported that 7% of 17 year olds have ‘recently’ attempted suicide. I propose that such statistics are, in part, the hard consequence of applying awareness-raising to mental health. The ‘raising awareness’ trope has genuine utility for physical health problems in which early screening and diagnosis results in more successful outcomes. But the interminable raising awareness of mental illness has entailed a colonisation of everyday language by the discourses of mental health and illness. Because so much AS is enacted via social media, and directed towards young people, the very culture of adolescence is permeated with ideas about mental illnesses. I do not simplistically suggest that raised awareness in itself ‘creates’ mental illness or mental distress, but rather that among groups of young people interacting online, to ‘have’, and discuss, a form of mental illness, may confer a form of social capital within the competitive online world, and may afford greater accommodation and in-group ‘membership’. It is then ironic that the ‘Ambassador’ for young people’s mental health (10.3.3) was chosen for his social media ‘savvy’, which in reality constitutes expertise in the very social media competitiveness which, in the context of mental illness, means that young people with longer term, severe, or diagnosed mental health problems are forced to present online at a higher level of distress in order to remain visible, and simultaneously find themselves corralled within the homogenised ‘walking worried’ youth towards the new gold standard of care, IAPT and a waiting list.

11.10.2 Negative consequences of exclusion from AS: older adults

WHO (2020) estimates that globally, 7% of older people experience a depressive illness. Since in mid-2019, 12.4 million people in the UK were aged 65+ years (18.5%) (ONS, 2020), the number of older people with depression alone is, conservatively, 870,000.

My work with the TTC texts has shown that Champions, engaged to undertake to social contact work of AS, enjoyed a sense of community, mutual support and social engagement. There may have been *some* older Champions, but they are not semiotically visible in TTC. Perhaps older people were seen as unreliable conveyors of the brand message, but such exclusion meant, over a decade and a half, that both their time and experience went untapped, and they did not benefit from potentially enriching social engagement.

The lack of representation of older people in AS prompted me to carry out the focus group. I suggest this demographic is disregarded by population-scale neoliberal policy initiatives because they are perceived as economically inert. Their under-representation or absence in

mental health campaigns reinforces two perceptual problems of mental ill-health in older age; that depression is a natural consequence of age, and that it is dementias which pose the greatest threat to older peoples' mental health. This is a further aspect of homogenisation in mental health discourse. Younger people are economically significant and therefore a worthwhile 'investment'. They are also perceived as more aesthetically pleasing; within the landscape of perpetual work on ourselves (Rose 1993), the influence of aesthetic perceptions should not be ignored. Contemporary attitudes are characterised by valorisation of things, and people, with a high perceived aesthetic value. Elias (2017) reminds us that neoliberalism requires of us not only affective and emotional labour, but makes us all aesthetic entrepreneurs, a role increasingly difficult to perform with increasing age. Longevity, and even wisdom and experience, are not only poor competitors, but are also misunderstood: the journalist Cathy Newman lends her support to the charity Young Minds, which quotes her as saying; *'The older you get, the more resilient you become, because you realise that what doesn't kill you makes you stronger'.* This well-intentioned statement reinforces the rhetoric that older people should 'know better' than to have mental health problems. Such perceptual indices suggest that societal attitudes to older peoples' mental health are tainted by further homogenisation. Older adults need to be addressed both as a demographic which may stigmatise, as suggested by the focus group data, and as a demographic which is, systemically, stigmatised.

Just as non-dementia mental illness in older people, especially depression, is largely ignored,[70] so is the likelihood of it being accompanied by *self-stigma*. TTC praised its Champions for their role in combatting self-stigma, but its minimal engagement with older people meant that the older mentally ill person will have benefitted the least. AS campaigns not only ignore older people, but from interview data there is some evidence that they may stigmatise them too, and even explicitly blame older generations for the stigmatising attitudes which supposedly made anti-stigma campaigns necessary. Yet older generations are inevitably as much the product of their acculturation as younger, more stigma-averse generations are now; if the young hold less stigmatising attitudes, it is because they have been subject to multiple cultural and educational influences. For some, this may have included learning from the life experience of grandparents; AS emphasises the importance of the family, but ignores the potential role of informed senior figures within it.

[70] As noted in Chapter 9, failure to differentiate between dementias and non-dementia related mental illnesses in older people may contribute to the relative invisibility of the large number of people affected by both.

Yet the tech-heavy (app-based) recommendations central to responsibilised solutions may be problematic in practice for older people. The focus group I conducted was not an AS intervention, but the impact of impaired hearing and sight on the group, and their minimal engagement with online media, highlight the difficulties some older adults face in attempting to engage with public health interventions blended with social marketing and increasingly reliant on digital media. The continuing expansion of inexpensive, impersonal digital interventions described in 10.4. functionally excludes many older people, creating genuine risk that this large and important social demographic will become increasingly alienated unless their needs are considered as specific issues of cultural communication and accessibility. If culture is upstream of politics, as broadly accepted by the interviewees in 9.2.1, then without intervention, the invisibility of this growing demographic in anti-stigma campaigns will likely be mirrored in their invisibility in service provision for the foreseeable future.

11.11 Education and a proposed future for anti-stigma

Fairclough (2013:235) asks whether the social order 'needs' the social wrong, and how problematic discourse can be challenged. An early objective of this research was to include a solution-focused stage, in accordance with the emancipatory goals of CDA, by creating an anti-stigma toolkit offering research-informed linguistic applications to develop policy and service provision. It is clear now that stigma reduction will derive far less from nuanced linguistic guidelines than from fundamental shifts in the political economy.

I believe work to genuinely counter mental illness stigma had already largely succeeded within the 'middle ground'; the space occupied by people with depression and anxiety disorders or OCD, whose problems make life hard for them and perhaps others too, but which do not pose a threat, except, sadly to themselves, and to productivity. If an anti-stigma campaign was needed in 2007, it was one to counter the stigma against serious mental illnesses, and could have been operationalised by directing extra funds to Rethink, which as the former National Schizophrenia Fellowship was ideally positioned to operate such a campaign. The intersection between mental illness and criminality, even if this intersection is created in large part by various media, sustained by legal definitions such as 'criminally insane', remain serious problems. This is why TTC's homogenisation of mental illness, its failure to address schizophrenia, and its focus on the working age or pre-working age population, caused me to question how stigma reduction could be its core concern.

In 2.3 I stated my aim to identify what a purely anti stigma initiative might take, and how it might be operationalised, were it not constrained by neoliberalism. Yet this is almost impossible to conceptualise, and one has to ask whether in the absence of dominant market forces and extreme inequality, such an initiative would even be needed. To reiterate, neoliberalism constrains anti-stigma by re-constituting it as AS, with its focus on productivity, cost reduction, responsibilisation, commodification of stories, and the free labour provided by people with mental illness or experience of it; importantly the latter is legitimised by extending contact theories of anti-stigma to their absolute limit. By occupying the discursive space which deserves to be legitimately occupied by wholly anti-stigma initiatives, neoliberal discourse, as represented by AS, has hindered the true anti-stigmatising potential of wider mental health discourses.

However one vital component would be removal of constraints on the voices of people who experience mental illness. A TTC interviewee suggested mentally ill people are voiceless. If their voices have been silenced by the socio-political system which drives and maintains inequalities, then little short of drastic systemic change is needed. Because TTC provided only a censored, prescribed voice, it could never lead the change it claimed to seek. Since even a TTC interviewee stated the greatest priority for people with a mental illness was obtaining help or treatment for their condition, the censoring of 'stories', such that - in all but the early stages of the campaign - contributors were forbidden to discuss treatment or its lack, constitutes disempowerment and control, which are antithetical to the aims of genuine stigma reduction. In 6.2.3 I highlighted similar control over the expression of Champions by 'scripting.' A further key component of anti-stigma unconstrained by neoliberalism would include the positive inclusion of older, 'non-productive' adults.

Similarly, while TTC sought behavioural and attitudinal changes, these were changes designed to align with neoliberal imperatives of responsibilisation and the construction of the ideal citizen. Yet these changes were packaged as altruism, and within this package a seam of public motivation to behave with kindness and dedication was revealed. Since the people who responded did so without knowledge of their manipulation, there is every reason to believe that a more patently constructed campaign unbounded by the deceits of neoliberal governmentality would be at least as effective in its public response. Without the tight bonds between productivity and 'faux' anti-stigma, a more genuinely inclusive alternative could take shape.

I also stated in 2.3 my aim to conceptualise a better set of possibilities for stigma intervention with respect to mental illness *within* the context of the social reality of neoliberal society. How would an intervention which does not privilege market forces work? The immediate response is to question whether this is even possible, since market forces permeate all areas of life. An entire intervention not tainted in some manner by market forces remains unfeasible. Yet individual elements which are unrelated to market forces can and should be operationalised – and perhaps for this very reason such elements were omitted by AS. For example, a model is required which involves education about more severe forms of mental illness, specifically forms of psychosis, schizophrenia, and personality disorders.

Education has been a major component of AS, operationalised under the umbrella of 'raising awareness'. I described in 10.6 an apparent policy shift towards a more patent and generalised positioning of mental health education, away from health, towards (institutional) education. While it is reasonable that education about mental health and mental illness should take place in secondary schools or even earlier, if this 'education' constitutes only the familiar exhortation to talk about problems, and not to judge others on the basis of a mental health issue, this is inadequate. Discussions of the different types of mental illness would help, but what is needed is a much broader social education, which informs people about social structures, inadequate government funding, and reasons for inequality. 'Civics' programmes of the type described by Finkel (2014), would at their best be structured to advance political understanding, engagement, and empowerment, and if carefully designed would specifically incorporate understanding of stigma as a systemic issue. This is my informed proposal for anti-stigma as a whole, and its design is beyond the scope of the current research.

The overarching political climate in which such a programme could be permitted, and could flourish is antithetical to the needs of neoliberalism, and to the powerful stigma machine described by Tyler (2020). For these reasons it would be dishonest for me to produce an AS 'toolkit'; doing so would be adding my voice to the disingenuous promotion of the idea that simplistic bottom-up solutions, linguistic or otherwise, are the solution to stigma. Hinshaw is more cynical still, and while he concedes that policy may facilitate attitudinal change, he asks whether the real change is in *what is acceptable to express* (2010:34): can anti-stigma ever succeed, or rather, are people simply steered to conform to the perceived attitudinal in-group?

11.12 Future work

Two key activities of TTC were the creation of data which legitimated the campaign, and the quantification and dissemination of results. In any campaign, such focus creates distance between the organisation and the people it represents, and its purported objectives. This pattern of behaviour extends beyond anti-stigma initiatives, and is part of a policy trend whereby plans, strategies and initiatives are cyclically written, launched, discussed, and then immediately lose value. For example, in the exhortations of the Five Year Forward View for Mental Health (NHS 2016) or the promises contained in the NHS Long Term Plan (2019), once each need is acknowledged, named and measured, the task has been 'done'. The apparent tacit acceptance of this long term mismatch between expressed intentions and subsequent achievements needs to be challenged. I note in 3.3 and 3.9 the recognition by writers such as Fotaki (2010:711) and Hunter (2003) of a cycle of failure to realise policy objectives, representing a systematically problematic relationship between policymaking and policy implementation. I propose that C(P)DA work to track this pattern of hiatus in mental health policy documents specifically, comparing the repeatedly expressed desired state with subsequent policy enactment, would be a valuable endeavour to expose this policy behaviour.

11.13 Closing Discussion

TTC achieved something extraordinary. By managing to set aside notions of inequality, it persuaded people who had been or still were mentally unwell, in many cases as a consequence of austerity measures, that the real problem was not their experience of mental illness, but stigma, which, through their own work, they could eliminate. Their presence as an unofficial, unpaid part of the mental health 'workforce' deflected attention from grossly inadequate state provision. In communities or workplaces, the Champions disseminated the message that depression and anxiety was not only 'normal' (since 1 in 4 people have a mental illness) but that conversation was the real answer. Since Champions could offer this too, then in the neoliberal vision of mental healthcare, incipient mental illness was stopped in its tracks and lower level mental illnesses resolved, as these conversational interventions were deployed in the manner of a visionary innovation. As mental illness became normalised, state provision of mental health services became simultaneously 'abnormalised', and the near absence of traditional 'help' was legitimated by the new offer, a combination of Champions and IAPT. This allowed market-driven health services to step in and heroically fill the void.

I have proposed that my analysis reveals a key aim of AS to be increased productivity, but in its disingenuous framing of the stigma concept, including the message that stigma prevented help seeking, TTC contributed to making a pre-existing problem – the lack of help - almost insurmountable during the pandemic, facilitating the commercialisation of mental health care, and thereby facilitating capital growth. In 2.1.3 I note how Fairclough (2015) highlights the objective of capital growth as the fundamental problem underpinning many of the areas of social life which CDA seeks to explore. The economic twin of capital growth in neoliberalism, reduction in state spending, is also a key consequence of AS policy as enacted by TTC. Within a neoliberal governmentality, achieving cost reductions to state mental health services is an objective enacted at great cost to the public, and TTC is among the multitude of incremental changes which together constitute a neoliberal 'mission creep' of cost reduction technologies. It is not possible to prove that, among the more covert policy aims for AS, was an objective that by normalising mental illness to the extent that demand for state services would be fatally and finally flooded, only market intervention could truly address the problem, in the manner of disaster capitalism. Yet even accounting for the Covid-19 pandemic, the ever-strengthening market for private mental health services did not occur by chance, but has been created.

In the workplace meanwhile, through the Pledge and specific workplace Champions, workers were offered a salve to ameliorate discontent. Following analysis it is not unreasonable to suggest that an important part of TTC was a specific policy response, not to the problem of stigma, but to the recognition that austerity had caused a vast burden of mental illness. The cost of responding to that burden through state mental health services was unacceptable, but the policy 'problem' of stigma was a feasible creation which the public would readily endorse. The overt narrative, that TTC sought to create a behavioural and attitudinal shift, found ready public acceptance since the nature of the shifts was assumed in the public imagination. These assumptions were aided by the elaborate contextual packaging which the campaign provided. Allowing for assumptions to develop provided operational space for the broader nature of the intended shifts to differ, in their entirety, from those which followers were superficially led to understand. The actual attitudinal and behavioural shifts were primarily vehicles in the service of reduced state financial responsibility for mental health, and the protection of productivity, with stigma-reduction an essential part of the mix. A public campaign to reduce use of NHS services and increase productivity needed a vehicle, and stigma was an apposite fit.

Thus I propose AS campaigns were never intended to address the real stigma associated with mental illness, which is twofold; public stigma associated with severe mental illness, which

primarily stems from fear of dangerousness and lack of understanding, and a much more fundamental systemic stigma which is entwined with austerity and cuts to mental health service funding. If the public had been educated about this, the systemic stigma 'machine' would have been left dangerously exposed. Instead TTC sought easy 'fixes' which were far less about stigma than about creating the opportunity to build an unpaid non-professional workforce providing soft 'therapy' by people who have 'been there', in order to further reduce the cost of mental illness. This cost reduction is achieved on two key fronts; by maintaining workplace productivity, and by directing people further away from NHS services. The real behavioural change entailed a number of integrated 'moves' of neoliberal governmentality. The homogenisation I describe in 9.4, 11.7 and elsewhere, facilitated the operationalisation of these moves, which are dependent upon the construction of mental illness as something lumpen, indistinct, and minimally problematic.

A complex picture of responses to mental illness stigma has emerged through this research, in which I identified AS initiatives which, in failing to critically engage with social and health inequalities, whether by design (TTC) or ignorance (HT), contribute to sustaining a neoliberal agenda, and to stifling understandings of what most imperils mental health. Managerial decision-making tools are at work within a world of clinical algorithms and funding accountability. Far from empowering people with mental health problems, such technologies of rule contradict the principles of mental health 'literacy' (Teghtsoonian 2009). It is easy to agree wholeheartedly when Tyler and Slater (2018) remind us that as stigma is formed and reinforced under conditions of unequal power, anti-stigma campaigns are themselves sites of social struggle. Responsibilisation is confirmed as one of the perfidious bedfellows of neoliberalism, and requirements to perpetually work on the self are parallels to the capitalist demands of perpetual growth, and are just as illusory as a route to the common good.

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APPENDICES

Appendices Part 1: Focus Group

Contents:

1.1 Research information

1.2 Consent pro-forma (information sheet and consent form are both as approved in ethics application no. 030819)

1.3 Questionnaire/pre-group activity

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Appendix 1.1 Focus group research information

Invitation to participate in a research study of anti-stigma campaigns in mental health

You are being invited to take part in a research project. Before you decide whether or not to participate, it is important that you understand why the research is being done, and what it will involve. Please take time to read all the following information carefully, and discuss it with others if you wish, before deciding to take part. Please ask if anything is unclear, or if you would like more information.

1. The project and its purpose

The study is part of a PhD research project at the Department of English/Linguistics at the University of Sheffield. It is funded by the Arts and Humanities Research Council (AHRC) through the White Rose College of Arts and Humanities (WRoCAH). It is supervised by Dr Jane Mulderrig and Professor Brendan Stone. The project has been ethically approved via the University of Sheffield's Ethics Review Procedure, as administered by the Department of English/Faculty of Arts and Humanities.

This research differs from many previous studies of stigma, which have been carried out by social scientists rather than linguists. This study, *A critical discourse analytical study of anti-stigma campaigns in mental health*, examines role of language in our understanding of stigma as a problem. The research focuses on campaigns designed to reduce stigma in mental illness. It is hoped that the findings will contribute to providing more effective anti-stigma measures.

The part of the study in which you are invited to participate seeks to discover how older mental health service users feel about anti-stigma campaigns in mental health, and about the materials which these campaigns use, such as videos. Although part of a 3-year project, your involvement is only required on a date (to be confirmed) between November 2019 and April 2020.

2. Why have I been chosen?

In trying to understand and reduce stigma, it is important to understand the ideas and opinions of mental health service users; policies or campaigns are not always designed in consultation with the full range of service users. You are being invited as a member of the local community of mental health service users. Older adults appear to be less 'visible' in mental health policy and anti-stigma campaigns, so their opinions are especially valuable.

3. Do I have to take part?

Your participation is entirely voluntary, and it is up to you to decide whether to take part. If you do choose to participate, you will be asked to sign a consent form, including your consent to the session being (sound) recorded. After signing however, you can still withdraw your involvement in the study; there are no negative consequences of withdrawal and you do not have to give a reason. If you wish to withdraw from the research, please contact ljrees1@sheffield.ac.uk

After participant involvement is completed, the views and opinions you have provided will become part of a set of anonymous data. The identity of all participants will be protected; participant names are not made available to anyone, and will not be published in any form. Once the data have been collected, it is only possible to withdraw from *further* involvement with the study, or the collection of *new* data based on your views or opinions.

4. What information is being sought, and what will I do if I take part?

This study focuses on the language used in and around mental health campaigns. The opinions of mental health service users are an important part of this. It is important to recognise that the *way* you express yourself is not being evaluated; this research seeks to understand your views and responses. This is not clinical research, nor is it a therapeutic process. You will not be asked to disclose details of your own past or current mental health difficulties. As a participant you agree to attend a focus group session as described below. In agreeing to take part, you are saying that you feel generally happy to share your opinions. No requirement for ongoing involvement is anticipated, but you may ask to be informed of the ultimate findings of the study.

The focus group: more details

The focus group will include activities which enable the researcher to understand your views on mental health stigma. There will be opportunities to respond as an individual, and to discuss things with the group. If you wish to share your personal experience of stigma, this would be welcome, but you are not asked to disclose anything which makes you feel uncomfortable. First, you will be asked general questions, concerning your views on stigma in mental health, your opinions or awareness of mental health anti-stigma campaigns, and your ideas on how stigma should best be addressed.

You will then watch 4-5 short videos produced by mental health campaigns (average length under 5 minutes each), and will be guided to respond (for example, what you like or dislike, and how useful you think the video is). You may watch the videos more than once. You will be able to suggest how such videos might be improved. The process will take a maximum of 2 hours. You will be able to claim local travel expenses. With your consent, the group session will be (sound) recorded.

5. What are the possible disadvantages, risks, or benefits of taking part?

No foreseeable disadvantages or risks are involved. The video materials you will watch are all publicly available and may already be familiar to you. It is possible however that the session might cause distress to some people, simply because of the subject focus. If you become distressed, you may of course leave the activity. This study is supervised by academics from the University of Sheffield, but only has one researcher, not a team. However, during the focus group, an associate will be available if you need to leave during the activity and wish to talk to

someone or just sit quietly. You may also ask a relative or friend to accompany you; they would be able to wait in a designated area during the research activity.

Whilst there are no immediate benefits to participation in this project, it is hoped that this work will play an important role in giving a voice to older mental health service users. You also have the opportunity to be kept informed of the findings of the study.

6. Confidentiality and use of data

All data collected during this study will remain strictly confidential and accessed only by the researcher. Transcription and storage of data will be anonymised. Your personal data (data which could identify you) will only be used for communication with you before the study. It will not be retained, shared or processed. Any identifiable personal data, (i.e. linking you to the data you provide) will be destroyed as soon as the information from the study has been collated and transcribed; a likely timeframe of approximately two months after the focus group. If you choose to be informed of the research findings, or of their publication in any form, your contact email will be retained for this purpose.

You will not be identified in any reports or publications without your explicit consent. If you agree to data being shared with other researchers (e.g. as a data archive) then your personal details will not be included except at your request.

The only foreseeable instance in which it could be necessary to disclose a group member's identity is in the event of a participant becoming acutely unwell while attending the focus group. In this case, it might become necessary to provide the participant's name to a health/mental health professional in order to obtain appropriate support.

Audio recording

The researcher will seek your permission to make an audio recording of the group. Sound files will be kept securely in a password-protected file on the university network, and will be accessible solely by the researcher. Files will be deleted permanently as soon as the data have been anonymised and analysed. Audio recordings will not be broadcast, shared or placed in an archive without your explicit consent.

7. If you require further information

Please contact the researcher, Lucie Rees, by email: ljrees1@sheffield.ac.uk. Alternatively, you may contact one of the research supervisors, Dr Jane Mulderrig j.mulderrig@sheffield.ac.uk or Professor Brendan Stone b.stone@sheffield.ac.uk. All can also be contacted by phone via the Department of English office: (0114) 222 8480 or (0114) 222 0220.

These contact details can also be used if you want to complain about your experience as a participant. If a complaint arises which relates to use of personal data, information about how to make a complaint can be found in the University's Privacy Notice: https://www.sheffield.ac.uk/govern/data-protection/privacy/general.

Thank you for taking part in this research, or for your interest. If you participate you will be given a copy of this information to retain, along with a copy of your signed consent form.

Appendix 1.2 Consent pro-forma (focus group)

Anti-stigma campaigns in mental health: Consent Form

Please tick the appropriate boxes	**Yes**	**No**
Taking Part in the Project		
I have read and understood the project information sheet dated 10/09/2019. (If you will answer No to this question, please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)	☐	☐
I have been given the opportunity to ask questions about the project.	☐	☐
I agree to take part in the project. I understand that taking part will include attending a focus group, which includes watching and discussing anti-stigma videos produced by mental health campaigns. I agree that the focus group will be audio recorded.	☐	☐
I understand that my taking part is voluntary and that I can withdraw from the study at any time; I do not have to give any reasons for why I no longer want to take part, and there will be no adverse consequences if I choose to withdraw.	☐	☐
How my information will be used during and after the project		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	☐	☐
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.	☐	☐
I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
I give permission for the focus group data that I provide to be deposited in White Rose Research Online [an academic data repository] so it can be used for future research and learning.	☐	☐
So that the information you provide can be used legally by the researchers		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	☐	☐

Name of participant [print] Signature Date

Name of researcher [print] Signature Date

Project contact details for further information:

Researcher: Lucie Rees ljrees1@sheffield.ac.uk University of Sheffield School of English, Jessop West, 1 Upper Hanover Street, Sheffield S3 7RA Tel. +44 114 222 8480

Supervisors: Dr Jane Mulderrig j.mulderrig@sheffield.ac.uk

Head of Department: Professor Joe Bray j.bray@sheffield.ac.uk

Appendix 1.3 Questionnaire/pre-group activity (spaces for writing removed)

Awareness of campaigns with a focus on mental health and anti-stigma

- Please list any mental health *anti-stigma* campaigns which you were already familiar before becoming involved in this research (i.e. you have heard about them, and generally know what they do).
  This is not a test; if the answer is 'none', that's fine!

- Have you *engaged* with mental health campaigns which target stigma? This involvement might mean just reading parts of a campaign website, or creating a 'blog' on a campaign website, or becoming a mental health 'champion' through a campaign website. Please circle:

  YES/NO

- If you are happy to say more about your interaction with these campaigns, please describe the way/s in which you have been involved.

- If you *have* been involved with a campaign/their website, was it a positive or negative experience for you? Why?

- If you have *not* been involved with a campaign, is there a particular reason for this? (Possible answers: didn't feel it was relevant/didn't feel it would achieve anything/didn't have time/didn't agree with the way they work).

Thank you! Please initial.

Appendix 1.4

[The document below was not provided to attendees; this was my 'running order' document, to guide me and retain structure]

Focus Group Format

On the table:

1 phone to record, 1 phone for timekeeping, voice recorder, pens, paperwork, cards, vouchers, water.

Forms/sheets/paperwork:

- Contact form for update on research outcomes
- Travel expenses
- 'Warmer'/arrival activity – campaign awareness; extra copies but also to collect
- Points to consider while watching videos
- Cards for ranking activities

11:00 Welcome and 'Housekeeping'

Charlie, refreshments 12.00-12.20, toilets.

Explanation: The session will be in two parts:

Most of Part 1 consists of discussion activities, then we will start to look at the videos. [It should be possible to watch each one twice – but this is not a memory test, it's about impressions]. Then in Part 2, we will watch the rest of the videos, and we'll finish with an open discussion on your views on how you think anti-stigma campaigns could be improved, or your further thoughts about the videos.

Before departure: *Expenses, wishes about keeping in touch, thank you.*

About your responses:

- *Most of what we do is talking, so please speak clearly for the recording.*
- *Although today you are a group, you are also individuals, so you might not agree with what others say; you don't have to reach a consensus. If you're thinking something, please say it!*
- *There are no right or wrong answers; what is important is your honest opinion.*

PART I

Activities 1-5: Stigma and mental illness. [Timescale: 11:05 to 11.55]

1. **What does the word 'stigma' mean to you?** *There is no 'correct' answer – I'm not after a dictionary definition* (*You can discuss it, or offer individual ideas*) [**5 mins**]

2. **Spoken question re. evaluating the importance of stigma in MH:** *The following 'human conditions' may be associated with stigma: which condition or situation do you think results in somebody experiencing more stigma? READ THE CARD OPTIONS*

Instructions:

i. Put the cards into two groups: one group for the most stigmatising situations/conditions, and the other for less stigmatising situations or conditions.
ii. Decide on the ***most*** *and* ***least*** *stigmatising – i.e. one card from each pile. Try to think aloud. [Could write the number on the card: 1 = most stigmatising].*

Would anybody like to say something about why you made the choices you have done?
Did anyone disagree? ***[8-10mins]***

3. **Spoken question re. whether different forms of MI lead to different experiences of stigma:** *Do you think some types of mental illness are more likely than others to result in the person experiencing stigma? This is another card activity: you are discussing which mental illness type is likely to result in most stigma. READ THE CARD OPTIONS – and there are blank cards.*

Instructions

Arrange the cards in order of most to least likely to result in stigma. Then write the corresponding number on the card; for example, write 1 for the type of mental illness associated with <u>most</u> stigma) **[6-8 mins]**

4. **What do you think is the *main* concern for someone experiencing mental ill-health?** *4 possible examples suggested (and there are many more you might think of): READ THE CARD OPTIONS*
Instructions:
Discuss it, with the aim numbering the cards in order of the greatest concern (so 1 = the biggest concern).

Take as many blank cards as you like and write on them too, and make them part of the ordering process) **[6-8 mins]**

5. ***Who do you think is responsible for creating stigma?***
There is no correct answer; it's about what you think.

READ THE CARD OPTIONS. For 'other', you can write on the card and involve it in your selection.

Instructions:

- *Sort the cards into those which you think are more responsible for stigma, and those which are less responsible for stigma (or not at all).*
- *Then from the two groups you have made, try to select the one which is most responsible, and one which is least responsible.*

- *Can you explain your choices?* **[8-10 mins]**

  Was self-stigma important?
- *If you think people self-stigmatise, why is this? Where does self-stigma come from, in your opinion?* (obviously the 'self' – but how does an intrinsic thing like that arise?) *Do you think it 'counts' as stigma, or do you think stigma is only what other people do to us?*
  [4 mins]

Mental health campaign videos:

Hand out 'Points to consider' sheet.

The sheet provides some points for you to think about for each video. Just take a minute to familiarise yourself with this. But there are further discussion points too for specific videos, so it may be that you only return to talk about these general points at the end. [**1 min]**, while lining up first video.

Video 1: '60 second ad' [6]

Initial impressions?

1. *Is it helpful to use humour? Or does this kind of 'spectacle' only confirm stereotypes of people with mental illness, i.e. that 'crazy' behaviour is to be expected?*

2. *What does the video tell you about who experiences mental ill-health, and why?*

3. *Some YouTube commenters felt this video was an entertaining 'commercial'. What do you think of that response?*

[If ahead of time, watch Video 2 before break].

[REFRESHMENTS/BREAK: APPROX 11:55-12.15]

Part II 12:15-12:45 [main] Video Section

Video 2: World Mental Health Day 2017 [8]

Initial impressions?

1. *Imagine you know nothing about mental health. What would this video tell you about who experiences mental health problems, and about what is the best way to help?*

2. *What do you think is the purpose of this video, and who does it help?*

3. *How do you think a mentally unwell person watching this would feel? [Encouraged, hopeful, and determined to speak to more people, or alienated and even angry? How relevant would the film feel to them?]*

Video 3: Andrew's Story 1.11 [8]

Initial impressions?

1. *The written introduction to the video invites the viewer to 'watch his story of overcoming discrimination and finally getting the right support'. Do you think it does this?*

2. *How do you feel about the use of make-up across Andrew's face? [Is this effective, silly, a clever idea that people can relate to? – how would you describe it?]*

3. *What was your reaction to hearing the word 'nutter'?*

4. *Do you see any similarities with the 60-second ad, in terms of confronting a stereotype? If so, what stereotype do you think was being challenged?*

5. *Is stigma created by the idea that mentally ill people are violent? Or do you think that this idea is outdated and no longer relevant?*

6. *Andrew mentions the media. How important do you think newspapers and TV are in influencing the way we see mental illness?*

7. *Do you think press reports rely too much on mental health to explain criminal or violent acts?*

7.b Has this ‘blaming’ mental health become worse in the current era of terrorism? If so, what could be the reason for this?

Video 4: Let’s talk about depression: focus on older people (WHO) [8]

Initial impressions?

1. *This video emphasises loneliness and isolation as the cause of depression in older people. What message do you think this conveys about the many reasons for depression, experienced throughout life?*
2. *What did you notice about the colours used in the film? What effect do you think they have?*
3. *The film tells us, ‘the first step is talking’. What about the next step? Is it unnecessary to suggest that people need to be told to talk about their problems?*
4. *How did you think older people were portrayed? How did this picture of older people make you feel?*
5. *Why do you think animation was chosen for the film? Is the use of animation a good thing?*
6. *Who do you think is the target audience of this film? I it a general public awareness film, or intended for older people themselves, or for carers?*

Video 5: Stand up Kid 3.07 [8]

Initial impressions?

1. *Has anyone seen the film ‘Dead Poet’s Society’? If so, did you notice anything familiar in this video?*
2. *Did anyone think, even if briefly, that this was ‘real’- a recording of an authentic event? If so, why?*
3. *Did anyone think it was ageist? If so, why?*
4. *Some YouTube commenters on this video suggested that when people are older, they ‘have it (mental ill-health) under control’ and have learned to cope with mental health problems. How would you respond to that suggestion?*

Closing Discussion: Age in mental health campaigns 12.45-12.55 [10 mins]

a. Questions on screen – simplified version below

i. *From the materials you have seen today, do you think that 'older' people are included in the campaigns? (in other words, are the campaigns only or mainly for younger people, of working age).*

ii. *If you think older people are not 'visible' in the campaigns, why do you think this is?*

iii. *If a group is not represented or included (referred to, mentioned, depicted), what effect does this exclusion have?*

iv. *Do you think this exclusion is in itself stigmatising?*

b. Reducing stigma in mental health

What do you think is the best way to reduce stigma?

- What should individuals do?
- What should 'society' do?
- What sort of campaigning should there be?
- What should the anti-stigma videos be like?

12.55: Close

[Checks: is everyone feeling okay?

If anyone wants to put something in an email they didn't want to voice out loud – perhaps about your own experiences of stigma - it will be treated confidentially, as with everything else].

Forms (travel, ongoing contact, collect any campaign awareness sheets).

THANK YOU – *vouchers.*

Appendix 1.5 Card options for ranking activities

Note: all activities also offered multiple cards printed with the heading 'BLANK FOR YOUR OWN SUGGESTION'

Activity 2 card options

[Discussion objective: to learn the group's views on the importance of stigma in mental illness, compared to its importance to other states, conditions and experiences – which situation attracts the most stigma?]

AN INVISIBLE DISABILITY e.g. autism, or a hearing impairment	A PHYSICAL DEFORMITY e.g. a facial disfigurement, or a congenital difference
EXPERIENCING MENTAL ILLNESS	BEING AN OLDER PERSON
A PHYSICAL DISABILITY e.g. being a wheelchair user	A PHYSICAL CONDITION SUCH AS DIABETES
A PHYSICAL CONDITION SUCH AS DIABETES	BEING AN EX/OFFENDER
HOMELESSNESS	POVERTY

BLANK FOR YOUR OWN SUGGESTION	

Activity 3 card options

[Discussion objective: to explore opinions on whether different types of mental illness are associated with different levels of stigma]

PSYCHOSIS	SCHIZOPHRENIA
MILD DEPRESSION	PERSONALITY DISORDERS
ANXIETY	SEVERE DEPRESSION (INCLUDING BIPOLAR)
OBSESSIVE-COMPULSIVE DISORDER (OCD)	BLANK FOR YOUR OWN SUGGESTION

Activity 4 card options

[Discussion objective: to stimulate discussion of the main concerns experienced by someone with mental ill-health - is stigma important?]

STIGMA (ACTUAL)	WILL I GET BETTER?
ACCESS TO TIMELY HELP	*FEAR* OF STIGMA (‘WHAT WILL PEOPLE THINK?’)
ACCESS TO THE RIGHT SORT OF HELP	BLANK FOR YOUR OWN SUGGESTION

Activity 5 card options

[Discussion objective: to elicit the group's ideas about where stigma 'comes from']

SELF	FRIENDS AND/OR FAMILY
COLLEAGUES	EMPLOYERS
MENTAL HEALTH PROFESSIONALS	OTHER HEALTH PROFESSIONALS Please specify; not the name of an individual, but the group to which they belong
THE GENERAL PUBLIC - EVERYONE	GOVERNMENT
THE MEDIA	OTHER Please state: not the name of an individual, but the social or professional group to which they belong, or an organisation

Appendix 1.6 Focus group transcription

Note: Blue type represents my input, and use of square brackets indicates a summary/paraphrase. All participant contributions are verbatim. No specific transcription protocol is used, since this is not conversation analysis. Where relevant however, overlapping speech is shown.

Activity 1 *To evoke perceptions of stigma*

The first thing to do I think is I'd like to just get you talking about what you think stigma is, what does stigma mean to you? We're here to talk about stigma - but what does it actually mean, what is it?

G1 Um I don't know the dictionary definition of stigma but I assume that it's negative … that you view… you are viewing someone in a negative way

Mm

And yes, absolutely, I don't want a dictionary definition, it's just.. .how you perceive it.. so yes, it is viewing someone in a negative way, on the -

G2 It's somebody sorry

No you go on

G2 It's somebody putting you in a box…

G3 I think…you might not think that there's anything wrong with you…but if somebody draws attention to something…either physical or mental...then YOU perceive it that YOU'RE in the wrong…

Mm

G3 And you don't actually feel wrong but …there's that thing that has been called attention to…

G3 It sort of…it creates stigma in you

[PAUSE]

And that's another thing we're going to come on to later… the idea of SELF stigma…and where does that come from…

…

Anybody else want to say anything about what stigma is…?

…

Okay, alright. Now, we have some

G4 I was going to say…other people have said it really but I think it's if you… are afraid of stigma you're afraid of other people thinking less of you…in your interactions with them (4.47)…

…

…and is that the same as self-stigma?

[Mm, Yes, multiple nodding]

G3 I think also each generation has different forms of stigma…

G3 You know…um…somethings that…um…people worry about being ostracised by now…never came into my psyche…when I was growing up…

G1 yeah… if er what in one generation what could be negative…in another generation could become a badge of honour…

G3 And you're not alone…

[When contributions cease, I move on to explain card activities].

Activity 2 *Evoking how important stigma is in mental health compared to stigma in other human conditions - aims to discover whether MH stigma is important or whether the policy problem is misplaced.*

[Researcher give instructions, introduces cards, explains what to do, checks understanding]

G1 is that to us, or to…other people? If we had them [those conditions] or our perception of other people?

[Researcher recaps instructions, and reiterates that the participants own views, or experiences, are sought]

G1 are we regarding stigma as negative?

G2 Yeah… 8.50… as a negative way of treating somebody

G6 to G5 Quiet inaudible talk

… …

When you're thinking about these…because your IDEAS matter…it's not just the end choices that you make it's… how you get there…do speak out nice and clear

G5 Oh…right, yes

… …

G2 I've found that homelessness was a big one

Right?

G2…probably have my highest number…because it's a trigger for… homelessness…it's a trigger for all sorts of other stigmas…

G4 being an ex-offender… Is that what you said… sorry my hearing's terrible

G2 No it's okay in fact I was going to put that down as another one

Yeah, yes, mmm [group agreement]

G5 That's exactly what I was going to do

G2 I started suffering from hearing loss, just diagnosed, yeah recently started suffering from it yes

And in fact hearing loss would come under the 'hidden disability' category

[Group: Yes! Mm]

G4 yes absolutely

G2 we've got poverty what's the other one sorry

G5 physical disability…such as being a wheelchair user…

G6 Mm, physical disability being in a wheelchair isn't really…

G5 And invisible disability, autism or hearing impairment oh yes this one

[inaudible]

G2 What's that one sorry?

G5 autism [overlapping talk renders conversation inaudible: **G5** explaining and re-reading to **G6**]

[Offer spare sets of identical cards]

G2 No no this is alright these are alright it's only there's not many are there?

[Low level muttering, reading through card options]

G4 Some of these are obvious to anybody in the street aren't they?

G6 [inaudible]

G4 …and some of them are hidden…

G2 well…no go on

G4 well some of these are obvious like homelessness or…er…a facial disability they're obvious to anyone in the street passing you in the street

[overlapping talk]

G4 …all all the time whereas others of these are hidden like I've got a hearing impairment but [laughs] you know you really wouldn't know it unless I

[group agreement]

G4 I indicate I haven't heard you…

Sure

G4 …or you see my hearing aid, you know? So I think some of them…all the time with stigma…some of them are invisible

G2 No I agree

Do you think that if something is invisible that it doesn't result in stigma?

G2 No I think it does, because – sorry go on

G4 it does no sorry I was going to say a hearing impairment I can…kind of mask…er you know it's… I guess sometimes what people are saying to be quite honest you know [laughs] and I kind of modify my expressions in my speech… the person is speaking to me. That's… if I say I have a hearing impairment, that's a bit of a stigma but if you've got a facial dis…disfigurement that's visible all the time

[agreement]

G4 So the degree of stigma is higher I think for something like that [a facial disfigurement] than for hearing and also you know people think it's just age or something… … you're not really blaming someone for their hearing though I think sometimes people aren't very patient you know about it whereas something like homelessness…I think that…people attach blame to that

[inaudible]

G2 It is 'cause I actually worked with rough sleepers and it's interesting how people perceive…them as they walk past all…all age groups from young to old…

Yes

G2 it's really interesting the perceptions I've started doing it…no-one asks why they're there they just think they're there because it's their decision

[agreement]

G2 So they've got mental health problems, they've got drug problems, some ex army…some have real mental health issues that they can't cope with er…what do you call it, er, …what do you call it an environment in which they can be clean or dry

Mm?

G2 But it's interesting what the perceptions are…really interesting… we've been moved quite a lot by the council

Oh!

G2 who've been shocking with us…we're now stuck in…and it's quite interesting…and the actual rough sleepers I'm not you know you know who I deal with are actually very respectful you know, getting food or whatever…but people's perspectives is really interesting

Yes. Okay…

G2 They're not violent I mean they may be violent with each other sometimes but not on the street…but it's people's perception I think I was quite shocked by actually…comments made

[inaudible background, explanations **G5** to **G6**]

G2 …and particularly people walking past who are all backgrounds who've got money…I don't mean wealthy money

Yes

G2 I mean are working…spitting

[gasps, intake of breath]

G2 No I'm serious…yes spitting knocking their cups over…comments are made on a reasonably regular basis actually. It's been quite an eye opener to be honest

[agreement]

G2 A real eye opener and I mean they clearly have issues I mean really…

G3 I think most people who've passed a homeless person think 'must be their fault'

G2 Yeah and I think that's absolutely right and the---the silence is okay it's when one in ten are making quite nasty comments…really nasty comments you know…quite interesting

[express how seeing people's attitudes can be surprising and shocking]

G2 absolutely

G1 think it's shocking when you witness that because you think…you know.. this is the society I live in, these are people I might associate with

G2 and many of them have mental health issues there's a large amount of obviously drugs and alcohol issues but when you trace them back a lot of them have [draws breath through teeth] very very erm… problematical childhoods and upbringings you know and when you start chatting to them they're quite honest about it [surprise]

Mm

G2 you realise its…they haven't made a lifestyle choice 'I'm gonna live on the streets tonight… 'cause it's…easy'

G5 The council, the council tells us not to…give money or

G2 No I agree with that, no no,

G5 That presumably makes us feel even worse…

G2 No I think that's okay 'cause I think...we…that's what we're told, not to give money out…the …the issue with the council is they they…[stumbles]…they want to hide it they're basically moving us all over the place…they keep moving them and putting them in worse and worse conditions and they don't really care about [them]…what they want to say is '*it's not there it's not our problem*' and I mean obviously then…publicise '*we really care we're really caring*' 'cause you don't see them in the city centre…all they keep doing is moving us around to worse and worse locations

G5 Mm

G2 which makes them very vulnerable

G5 Yes definitely

G2 It's a different issue anyway entirely but they've got a lot of mental health issues anyway

Well yes, it is part of the same thing-

[agreement]

It's part of stigma… [lost opportunity to steer adequately]

G2 fascinating debate between the big city, issue sellers and those sleeping rough and begging, cause big issue sellers 'cause it's a…I didn't realise it's a business…I really had no idea

Yes –

G2 it's an absolute business I had no idea it's a business and these kids who are lads and lasses who are… trying to come clean trying to earn a living by…flogging these magazines you know they have to borrow the money first

Yes – I think we

G2 It's a MASSIVE business and the guy who owns it and then sold it and made a fortune and of course what's happening is they were saying recently is the big issue guys and women cause more's online they're getting less and less money more and more people are giving money to the people on the streets so your rough sleepers who are doing the drugs and drink…are getting more than the guys and girls who are selling the big issue…to try to earn a living to get to keep in a…keep dry…keep out of alcoholism…trying to get back on the straight and narrow if you can call it that [inaudible] it's a fascinating debate when you talk to them…quite a lot of, er, conflict between them

G6 I think it's very difficult to tell, is it at all if anybody's wanting you to give money or…will you buy one of these and that sort of thing

G5 'Tis isn't it

G6 And you don't know…you even if you walk away you think oh now…perhaps he was really…

G2 The good thing is one of one of the guys I work with he - one week said he was gonna in his head gives five pounds for everybody who begged to him and I can't remember the figure he got to at the end of the week like he said if I carried on doing this it's not a lot of money…. and it is a lot it's a huge amount, on a week going by meeting people…anyway…hobby horse…we're talking about stigma…

Yes - how are we getting on with the cards then?

G2 oh god sorry I'm… just

No it's fine, let's –

G2 On my hobby horse I do apologise

G1 I think that we could be in danger of…having a full discussion about any one of these things

G2 Mm

We could – so

G1 and I'm not in any way trying to

G2 No no I agree with you I realise I was on my hobby horse and apologies. Sorry [sniff]

It's fine, but it's right we need to keep focused…I think it's in the nature of what you're talking about that inevitably… you know you're going to go off at tangents, and they're interesting too.

G1 I think there are varying degrees…erm…within society…of stigma…erm…and it's all down to our perception of it and not the recipients… 'cause they are what they are

G2 Mm [agreement]

G1 they've either got a physical deformity or they haven't…or they're homeless…nothing's going to change there…it's how people are looking…and it's how…it's it's the people giving the stigma…it's the perception they have…how…vehement… …

Yes

G1 the perceiver is…about that particular subject either positive or negative …erm…. Yours (to G2) is a very positive attitude towards homelessness for instance

G2 Yes

G1 Erm…and I think that if you've got…a CHILD who has a physical disability or one that isn't or can't be seen such as autism or…. whatever then you're going to be more…positively inclined and wanting…erm…to see improvements in perceptions

[General agreement]

So if somebody's 'exposed' to a stigmatising issue in their close circle then they're more likely to have the social awareness to enable them to not be negative?

G2 Can I ask a question? No sorry sorry carry on

No it's okay…

G2 We're all probably not the same age here and when I was young and was it the same with you [to all] that people who had a disability went to separate schools, er there was the deaf school when I was growing up…there was people who had physical… they weren't in my class as it were, when I was growing up…there was no nobody had a physical disability such as wheelchairs and the like they were in separate school…is that…from what I understand now from procedures that's all changed now … is that.. has that helped to get over that stigma of PHYSICAL disability?

G1 The rights and wrongs of integrating people with any kind of disability

G2 Mm… …

G1 into mainstream…isn't the issue here…

G2 Right. I wonder if

G1 Whether we should integrate them or not I don't think is what you're wanting –

G2 No what I was trying to say I do apologise is what I'm saying… has that reduced the stigma of those people? Within – for different generations. When I was at school it was separate –

G1 I think from one point of view it can have but in another…from another point of view it can increase it because –

G2 I know

G2 You're going to get…erm…people in mainstream education and their parents… of the…I don't know whether I dare use this word…I don't… in here…'normal children'

G1 Right

[General sniggers]

G1…is is their tuition going to be diluted by the amount of time which is having to be spent with children with some kind of disability AND the people who need to be teaching these people –

G2 Mm-

G1 with disabilities whether it be a physical one or a mental one…erm…they need special training… … a normal teacher in a normal school wouldn't be equipped…and for those…people who do have some kind of, er, disability, it it could possibly be…more comfortable for them to know that they're not just on their own…they're not the odd man out, you know, I mean I - can I can speak from experience to some extent in that as a child I was completely deaf…totally deaf…had operations and that's it take her away mum she's okay now…it..I wasn't okay just because I could now hear a bomb drop behind me

[Assent, mm, yes,]

G1 The directors of the school I went to and I'm not going to dive for us too far into this one...and my parents were told that I was… backwards

G2 Mm

G1 And my mother said '*well we did think she was a bit..*'

G2 Mm

[Awkward laughter]

G1 you know…this is a hard story and I'm actually not I'm not traumatised by this at all in fact I can see the funny side you know so I'm okay don't worry I haven't got a mental illness because of this

G3 Far from it

G1 erm

[laughter]

G1 I think I'm fairly well adjusted you know

G2 Yup

G1 but you know so I'm not really in favour of integrating and I think whereas it's wrong to be stigmatised but how do you differentiate between people with conditions …whether it be a negative or a positive condition…how how…you know you do need to differentiate to give them help

Yes, a good point –

G2 more adequately…not just adequate…but to the best of your ability

G3 All these SATS has created more stigmatism 'cause if you've got a child that you perceive is holding back or the school is saying you know they don't meet this criteria or that criteria…you as a parent might think ooo…wish we just had an ordinary class

[Mm, agreement]

G3 But these SATS I think are erosive

G2 And do you think pupils have a similar perception then?

G3 Well they've got pressure from home

G2 Have they?

G3 Pressure from school…to get to that level…you know

G2 Oh I see right

G3 And if you do a bit more…you can get to that level…I mean when they first bought them in I thought, fine, have a…measure…but if my child is below that measure what are YOU going to put in to being my child up to that measure…

G1 But not every child can be brought up to that…

G3 No they can't!

G1 because there's a natural limit…I just think…

So returning to the things printed on the cards, do want to write on a blank card, and add low educational attainment as a possible stigmatising condition?

G1 I don't think so no

G3 Well I don't know it's fine I mean not everybody can get five GCSEs at C and above and I'm all for the second chance in education…but those people are perfectly adequate to do a job if there was a job to do that you could start with that level of attainment but so…many people leave school without being able to read

[agreement]

G3 you know I don't think you, we…people here understand how low the level is that they can't even pick out a tabloid or they can't

G2 Mmmm [sniff]

G3 they can't go up to a road sign and read it…they have to learn the signs…and there is a lot of people

G1 But we have to we need to be able to recognise that…I mean is it stigma or is it just recognition?

That's a good question – what do you think – is it stigma?

G1 Having to be able to recognise if I see a person in the street struggling to know whether it's safe to cross the road I need to be able to recognise that in someone so I can say can…do you want to take my arm? You know you've got a blind man am I allowed to say blind these days – visually impaired

Yes –

G3 It's not just an impairment though is it

G1 I mean once upon a time you know we've got the beep beep beeps on the crossings…we've got the little bobbles under the feet at the crossing to tell us that we are there…but you know once upon a time they weren't there and if you saw a blind man crossing the street you went up and took his arm and you didn't think ooh now am I stigmatising him by recognising –

G4 But I don't think blindness is a disability that has stigma attached to it

G2 No I agree

G4 …I think generally people are very compassionate

G2 sympathetic

G4 and sympathetic…but that's for people who are blind whereas not so sympathetic towards other disabilities as I say…hearing you know…[laughs] they get fed up of repeating stuff so but I think blindness I don't think there is any stigma attached to

Is that do you think because there is no possible blame?...there is no possible personal 'lack'?

G4 Yeees and I think too the sight of somebody being so helpless in…dangerous and difficult circumstances evokes sympathy with people

Yes. Okay, let's –

G6 I would always say something to someone if they…like if…they wanted to go…I would wouldn't I? [to **G5**]

G5 Yes

G6 You know I would er say you know come on are you going over and nobody's ever said to me no I'm alright or …

G5 Well and I had the reverse and that's a reverse thing that if I see somebody who perhaps is blind my instinct is to help them but sometimes they don't want to be helped because-

G1 No

G5 they need to be self-sufficient to survive a tough world

G1 Fair enough

G5 and they may have a go at me [laughs] for interfering but you have to ride along with that –

G1 sorry people who do have a disability they also do have to learn that they do have it

G5 they do

G1 and that they've got to get on with it because no matter how hard we feel about it for them we can't change it and we've all got to get on with this

G5 they may have to appreciate that they engender feelings in others that they may not themselves welcome

[General agreement]

G5 but… they're genuine feelings

G2 Is there any evidence whether the Paralympic games changed people's perceptions of disability [to me]

I don't know… it may well have done, but I haven't looked into disability because my focus is mental health stigma

G2 Okay, right okay

What I'm in interested in is –

G2 What I'm asking really is the military…you know from wars the guys coming back – has there been any changed perception or I don't [inaudible]…is there any evidence that the military who are

on the streets or who have got mental health issues---whether the perception of them is any better now (28.27) post the three wars that they've been involved in?...or not…has there been any evidence?

I think… there was some American evidence, er suggesting that post- you know, after the two Gulf wars

G2 Yes

there was an improvement

G2 But short lived

Yes

G2 Okay that's what they tell me yes… … is that because…one of my colleagues here was saying if you've got a physical disability there's nothing you can do about it you know was it is it the perception of the public if you've got mentally (ill) you can do something about it it's just a matter of…you know [sucks through teeth] pull yourself together all those clichés

Mm

G2 whereas if you've lost an arm or a leg or you're blind you can [inaudible] is there is there any evidence of that? [29.27]…is there

It seems to be the case yes, and that's why these different cards are on the table, because some of them are physical and some of them are mental health, and you're trying to unpick how much does the idea that *mental* health problems *especially* result in stigma – for example you said [G2] people really should just, you know, 'get over it sort yourself out' –

G1 Well it's a question of degree there isn't it?

It is… and we'll move on to *degree* of mental health problems, but I'd just like if we can just to draw this part to a close by coming to some decisions about your cards …where –

G1 Well for me number one where I personally would have a negative feeling…and that's the ex-offender

Okay

G5 I'll go with that one too

G2 How do you want us to do it then do we do we …as a group? Do we go yes no yes no or –

[expressed a wish to reach a majority decision]

G2 shall we give it a chair a chair…do we need a chair come on you be chair [to G5] Somebody put one up and

[multiple cross-talking]

I think in reality we could be talking all day –

G1 Is this looking at something that you think it's perhaps what we are

No no its not. [I pick up a card, and indicate the others] These are all human conditions, or states, or attributes. What you are talking about at is how stigmatising each condition is

G2 Is that us or what we think the public think?

G4 Sorry… how much that er… attaches – has has stigma attached to it?

G2 From our point of view or the public's

In your opinion. This is all about *your* views

G2 Our individual opinion

G1 I…

G2 Go on then

G1 In my opinion there is only one… in my opinion

[Significant cross-talking - individual utterances not discernible]

G1 [lifts a card] …that was about diabetes and I was thinking what's this what's that got to do with..

G5 It's how you think about the people with diabetes

The point is that if you look at the one that says 'physical conditions', you might think 'well nobody's going to be stigmatised for having diabetes', but other people might think differently

G1 No course not no

G4 I don't think that's true…

Well there you go! So these opinions are what I want to know

G4 [laughs] I think obviously diabetes is if you are very very overweight, and…

G3 No! I'm not overweight

[Crosstalk] – **G4**, **G3**, and **G5**

G4 No but often it is, you know it can be

G5 You're the exception there

Have you experienced stigma because of diabetes? [to G3]

G3 No I haven't encountered it but there is the perception that you're overweight you don't take any physical effort…exercise

[Crosstalk]

G3 and people say stupid things like 'take care of yourself'

[laughter, crosstalk]

G3 [inaudible] I'm going to throw myself off the building

[laughter, crosstalk]

G3 people have a better understanding if you're Type 1

[general agreement]

G3 Type 2 is um…almost…your own fault and …a consequence…of lifestyle…Type 1…often very early and the intervention…erm, so yeah I do think diabetes is a sort of invisible stigma to it

G4 Yes that's right

Okay I think we're going to end up being pushed for time if we carry on much longer with this one, so maybe we can just… [to G1] we've had your suggestion for something that's stigmatising …does anyone else want to point out ONE which they think is most or very likely to result in stigma …and one which you think is barely on the scale…which is not important…

…

G5 and **G4** start simultaneously, **G5** backs down

G4 Well I think I was going to go for this one actually I think being an older person is…attracts a lot of stigma [laughs]

Okay

G1 Sorry but I don't encounter it

[Crosstalk]

G4 I I oh yeah…I feel though I mean at the checkout there I am fumbling for my change and these other people and oh god

G3 But it's also the government …we are the people that are blocking the housing

G4 Yeah… blocking the beds

G3 Er excuse me…I didn't go abroad…bringing up children …you know surviving with a massive mortgage

G2 [sighs, inaudible muttering]

G3 I mean if my children moan about their mortgages I say come on! Let's look at the real figures…that there is a government sort of outpourings about we're the lucky generation …we've never had it hard

G2 Not true

[Crosstalk, laughter]

G3 and we're blocking… we're blocking hospital beds

G2 It was alright for you…you had the good times…that's what I always get…you had the good times…and it's done as a joke but it's not…but after half a [inaudible] you get quite… if you carry on with the discussion

G1 I don't mind it when young people say it because they're they're just inexperienced you know they'll get there one day

G5 They will

G1 they won't change it

[General agreement]

G2 So which is the one we think is least stigmatised then?

Yes, that's what we want to get to

G2 The least…

G5 right personally I think being an older person doesn't stigmatise me frankly I can understand that it might…

[Crosstalk, dissent]

G2 So that's the least one…

G1 well for me I think physical deformity I don't think…

G2 least one

G1 … people are stigmatised these days at all

G5 I …I find

G2 Which …which one sorry which one I couldn't hear

G4 the physical deformity

G1 I find people very very helpful towards other people now…yeah well I work in a pub…you know so that …we've just renovated the pub and where people …..er er we've got a dropped bar you know so that people in a wheelchair can you know…we've had…I mean people come from the council

G2 Mm

G1 to tell you what's got to be done to make it accessible for people and things like that

G2 So in your industry then have you found it's changed over time then? Have you been in that industry quite a long time then?

G5 which industry?

G1 well I before that I was… I had a shop over twenty years on [redacted] road and I wanted to change the frontage and the council came round and told me that I've got to have this slope into the shop and I said don't be ridiculous

G5 [laughs]

G1 and I …how can I possibly so that in a little shop like this it's it's silly

G6 Oh these…

G1 I said are you really telling me that if I see somebody outside…in a wheelchair that can't come in that I'm gonna leave him there when I could have his money?

[laughter]

G1 I'm going to go out there…what can I get you love?

G4 I… a physical deformity…I think stigma is attached to that…a physical disability…no I think

G5 That's how I feel…that's how I feel

Is there any other 'no', just before we finish this part?...any other 'well no, it's really not an issue'?

…

G5 I don't think poverty for me is…if someone's in poverty I don't feel they're…

G1 I think I must be very tolerant because I don't…I don't…you know I don't feel that these days it's a negative about any of it…

Okay

G1…but an ex-offender I would always have a question mark

Okay…right, thank you!

G3 I personally can't make my mind up on any of them

That's fine

G6 ..experiencing…

G5 experiencing mental illness

G6 I think…with me…. …It's forgetting…

It always comes out even if I'm being with a few friends you know it might come up you know…that I had one didn't I the other week

G5 You did

G6 I'd arranged a lady to come to my house and then we'd go with my car to where we were going and picking another one up and er…I went…for the one…the second one and we went to join in and its its U3A lot who I…we all went…and she came in…about half an hour this lady who'd come in to my house and I'd gone already and er…so she came up and as she walked in the door…of this café and I was there and she just leant down to me and she said er ISN'T IT TIME THAT YOU DID SOMETHING ABOUT THIS

[Gasps]

G6 really really and I could feel me eyes coming

G2 I bet you could yeah

G6 you know and er I hadn't anything to do but if she'd said [name redacted] you were supposed to be wait… you know…she'd got a car she came up in the car you know but it was really…it really upset me …you know…just to say [visibly upset]

G3 I wouldn't have been quick witted enough to have turned round to her and given her a mouthful back

G6 Well I I can't think quickly enough…

[Crosstalk]

G6 At the time… …

So [to G6] do you think that one of the things we could include among things that cause stigma is …having memory lapses, something like that?

G6 mm, yes mm

G5 Oh yes

Thank you

[Express and explain the need stay more focused on the task with the next activity]

Activity 3 *The types of mental illness – which is most likely to result in stigma?*

[Reads cards – slowly listing. Very clear, emphasising focus on the topic].

[Low level crosstalk]

G5 schizophrenia…

G2 you got schizophrenia there?

G4 No! [laughs]

G2 psychosis

G5 how would you describe psychosis?

[Explain they don't need to know definitions or descriptions, I'm not there to teach, and if I gave a description it might change their answers]

G4 I don't know

[Crosstalk]

G2 I suppose you've got…severe depression, schizophrenia, what's the other one sorry?

G5 psychosis and schizophrenia

G3 I'm not educated enough to know what the symptoms are other than that the person is behaving in a way that either I find unacceptable or…but where's the crossover

G4 Well most things…

G3 what's the difference really between mild depression and anxiety? It's all too easy to label somebody oooh he's depressive but in fact he actually has acute anxiety

So you think that the labels we give to people or the diagnoses that people have… do you think they're a problem?...

…

G2 [blows out breath through cheeks] when you do deal with individuals it's are they

G3 it's whether you

G2 It's how you interact with them as I say where I work you've got a lot of personality issues and problems but rather …we all… you get used to it…meet them on the street and their behaviour…because you don't you're not used to it you can find quite intimidating and frightening [sniffs] you got schizophrenia or aggressive and shouting and balling at you

[agreement]

G2 it's quite you know 'cause you're not used to it

G3 well that lady that shouted at [G6]…is she schizophrenic?

G6 she didn't she didn't say it loud

[Crosstalk]

G3 well that's what makes it

G5 it's ignorance

G6 yes that's what's ignorant

G5 oh yes a very ignorant person

G6 absolutely leant down I don't think the others knew…what she'd done because she kept right down…and said it …and then I could feel me [laughs] me eyes go you know and I thought and er…mind you.. I thought…and it

G5 well

G6 it stopped our friendly…whatever

G2 which one for you is the most stigma, stig…

[Crosstalk]

G4 schizophrenia is one of the most because often you hear about awful you know murders and

G2 Mmm

[agreement]

G4 you know people are obviously mentally ill but I think it is associated with violence

[Crosstalk]

G1 You often get…psychosis.. schizophrenia means I think terrorism… a bit nasty … but then again I don't really know what I'm talking about

[Explain that this is about how they feel about the *words*, and the ideas they have about them, rather than knowing the details about the illnesses]

GI How you perceive it

[Crosstalk]

GI You know if you're …if you're wary of people because of…whatever they've been labelled with…is that a form of stigma? …you think, you know I've got to be careful here, I don't want…

… I think you can also colour other people's ideas and perceptions can't you by how you…

…

[agreement]

G1 whereas it might be you that's at fault and thinking you totally misunderstood them

G4 Also I think severe depression is one that attaches a lot of stigma because I think a lot of times people's reactions is oh FOR GOODNESS SAKE SNAP OUT OF IT you know [laughs]

So that speaks to the 'blame' idea, doesn't it?

G4 it's that people can er…put it right themselves but are just choosing not to…but psychosis is I don't really know what psychosis is so I don't…

G1 but a clinical depression that is an imbalance of er hormones and chemicals in the body isn't it?

… …

[Filled gap by acknowledging *one* view of depression is that it is related to an imbalance in brain chemicals, or can be helped by medication which affect brain chemicals, but that a lot of things might lead to somebody experiencing depression]

G1 I think that most people…at some time in their lives…are going to suffer from…anxiety…depression…whatever

[agreement]

G1 …in varying degrees because of whatever your life throws at you

[agreement]

G1 and that itself is acceptable because it's the ability for people to feel anxiety…it's the ability of people to) produce adrenalin which can galvanise you into doing something about it… … I'm taking it from the wrong angle again I'm thinking about the actual thing rather than the stigma…so I'm sorry

That's fine…so are there conditions here [indicates cards on table with named mental health conditions] which you think are not…*not* a problem in terms of stigma?

G2 I'd say anxiety

[Crosstalk]

G4 [picks up card] I think I'm on that spectrum obsessive compulsive [laughs] obsessive compulsive I think I'm on that spectrum [looks ashamed, upset]

[Express solidarity by disclosing own diagnosis of OCD]

G4 but there's no stigma attached to it whatsoever [laughs]

*general crosstalk unpicked as:

G2 there's not

G5 I'd differ with that

G4 I always have to do my housework on Friday morning and everybody just laughs oooh [name redacted] it's housework day you know but

G1 I have to turn my stove off three times you know before I leave my house

G3 but don't you think people who have that disorder are initially perceived as being very efficient

G2 They are yeah

G3 and very boring

G1 but there are varying degrees…I used to have a customer come in my shop with OCD but the real full-on thing

G2 Ah right okay yeah

G1 and she'd come to the counter and she asked for something and it wasn't until I'd put it to her that she'd go into her bag to pick out the purse to open it

G2 yeah been there

G1 to close it up to put it back to put that away to ask for the next thing…and then she had to take out the purse take out the money

G2 mmm, yeah

G1 yes and I have to tell you – yeah – when I saw her walk through my door I'd say oh god not again you know

[laughter]

G1 and I would say to people you know do you want to come round love and I can serve you in between

G3 yeah

G1 I've got a living to make I've got children to feed

[Agreement]

G2 Yeah

G1 if we're not necessarily accepting stigma as being negative but just as a recognition then yes I had…I was stigmatising her because I was recognising that she had a condition

G2 no that's alright

G1 That very very greatly affected …I'm not apologising for it I'm just saying that's how I dealt with it

G2 A reasonable adjustment

G1 I had to-

G2 They're what's called reasonable adjustments aren't they you're making a reasonable adjustment to that condition

G1 …but if I could have done I would have banned her!

[laughter]

G2 That would have been stigma!

G1 I would have said to her look love you…I really haven't got time for this

G5 you could have exploited the opportunity by inviting her round at half past six in the evening after you'd closed and –

G1 I didn't want to - I'd be there til midnight

G3 I think we all know people who have this condition in all sorts of ways…

[Reflect on people saying, 'I'm so OCD', making it 'normal']

G2 It has yeah

G2 they're not really

G5 they're not really

G1 no they're not

G5 [inaudible crosstalk] It's called old age innit?

G3 they're just on the bandwagon

G1 we're just forgetful…I just can't remember if I turned that stove off or not… I must go back and look

G6 Oh I'm like that I always go –

G4 But it can be even very mild it's slightly disabling you kind of wear yourself out checking the stove or you know [laughs]

[agreement, sympathy]

Activity 4 *The concerns/worries for someone who is experiencing mental ill-health: aim to understand how important stigma is.*

[Introducing the activity. Clear, repeating, emphasising need for staying with the task]

G5 [crosstalk] important ones…

G4 The most important is… [inaudible]

Crosstalk [while **G5** re-iterating to **G6**]

G2 can I add one? Safe space…where I work a lot of them have mental…mental health issues one of the things we talked about what's helped them is having a safe space Safe space is a safe environment where they can deal with issues and learn and to make them feel better…chat about it [inaudible] …stigma no-one's ever raised that you know when groups chat about it they have all sorts of whole range of issues but safe space knowing that they can go there there's no problems from the estate or their families and then they're probably going to live a life and feel better and have friends in the community

That's an interesting idea, because if people need a 'safe space', that suggests that outside of that space is a problem?

G2 oh it is yeah, good point yeah

G5 safe space [adding to blank card]

Thank you…are there any other things that you want to add to a blank card, anybody?

G1 what sort… what are you meaning?

Explanation: all of the cards have printed on them different things that somebody who's got a mental illness might be worried about. So suppose yesterday you're diagnosed with a mental illness. What are you going to be really bothered about? Is it going to be how soon you can some help… is it going to be will I get the right sort of help… is it going to be 'will I get better' [Repeat explanation of card options]

G1 Will I get better

G3 Yes… am I ever going to be normal again

G1 I think if you can see an end goal then you're not too worried about which route you're going to take…

G4 and it's difficult to choose between access to timely help and the right sort of help [laughs]

G2 very much

G4 you know because…

G2 cause what they find is they get their drugs quite quickly but it's the back up the [inaudible] helpful environment

[Crosstalk, inaudible]

G3 …are drugs the way forward though

G2 one of the issues that they talk about is –

G3 it's easy to give a pill

G2 mm and then they leave them I mean the actual backup counselling services are [intake of breath] if you got a [inaudible] family and friends is shocking just shocking [cross talking continues during G3]

G3 just putting your hand up and saying I have a problem… you can be doing a job… extremely efficiently …you can have a good outdoor you know out of work environment and yet that doesn't mean that you haven't got mental health issues

G2 Oh yes that's absolutely

G3 it is the initial feeling of stigma…I need help…what will people think

G2 mm okay

[Crosstalk]

Okay so does anyone else think that stigma, or fear of stigma, are important worries for people with mental health problems?

G1 well I've got problems with saying is it is it stigma or is it recognition…because if you don't…if you recognise and don't do anything about it you've ignored it

G2 [sniff] er [grudging]

G1 so you need to be able to differentiate you need to be able to categorise

G2 [sniff]

G1 and you need to be able to view people's infirmity disabilities whatever…conditions…you need to be able to view them as something which can be improved …and that in itself is saying if you're wanting to improve it you need…you are viewing that that negatively … because otherwise why would you want to improve it…

Right…

G1 so it's got to be a negative state…anyway so I think…stigma…I think is a a nasty thing…but from that point of view I think it's necessary because you need to be able to stigmatise people and to see the negativity of it so that you can offer them… a way forward…

Okay

G1 I don't know I may be…I just…

No no it's interesting

G2 Mm

Any thoughts from anybody else before we move on?

G4 well the stigma one I think it depends a lot on your personal circumstances you know if you are…you know in a workplace you might be very anxious if you'd been diagnosed with mental illness…

G2 true

G4 or if you had a mental illness you might be very er anxious about the reaction of your workmates…

G4 erm …

G2 [sniff]

G1 and and the thing is that a lot of people are very good at keeping it to themselves… …and so that you know that one person says to this person yeah but you don't know how I feel I'm terribly anxious and I'm really depressed and this one says well you know what…I am too

G2 [snort – laughter?]

G2 so you know…

Why do you think people keep it to themselves?

G3 I think people are ashamed

[Crosstalk]

G2 Sign of weakness… it used to be when I was growing up seen as a sign of weakness

G3 Yeah ashamed

G2 It was a very competitive environment and if you show [swallowed] showed any… but what's happened is as time has gone on you get sportsmen now writing books about how they felt…black dog…and various sports men and women have wrote about…it's quite enlightening that's.. for me has brought a different perspective…perception…perspective…

Mm-mm

G2 on these conditions that weren't there when I was growing up certainly wasn't

[Crosstalk]

G1 my aunties were always very…they were suffering from their 'nerves' and you kind of kept them at arm's length

G3 the vapours

G2 Yeah yeah

[agreement]

G4 You don't really hear that phrase now

[Crosstalk, laughter]

G4 I think it's helpful that you know high profile people like you're saying – and Prince Harry's the obvious one but other people too I think that is helpful

G1 mm [agreement]

G4 because it does…well there's a chance I think that it will increase tolerance and understanding…and that it's you know that it's not so hidden any more hopefully you know I think people… [inaudible]

G3 I don't think celebrities coming out and saying they've got mental health helps you or I because they are so removed from my life

G5 mm [agreement]

G3 and they've got money and access to everything…if I've got… … I've got to sort it out…and fortunately I've got a husband to speak to…on some subjects

G2 [laughs]

[General laughter]

G5 stigma of being a male

G3 yes, but for the common folk it's help yourself dear

Mm [Agreement]

G2 yes access is a terrible…

G3 celebrities… …not so sure

Mm, okay, let's -

G3 unless they tell you something I didn't know about it that helps

[Explain: final activity before coffee – and diplomatically express that we are running behind planned time]

Activity 5 *Where do you think stigma comes from?*

[I clearly explain the activity and the objective, and emphasise the increasing need for focus]

[Discourse markers suggesting understanding]

Quiet utterances [inaudible] **G5** explains to **G5,** group name the cards again

G3 all these things are...it's a degree

G2 mm [agreement]

G3 I mean you know…

G4 they come from all of them I think…[laugh]

[Crosstalk]

G3 employers have got a huge number of tick lists that they can go and access you know but usually line managers have got absolutely no idea

G4 No no

G5 I don't know…

G3 I think… … I think you stigmatise yourself… … why is it me?

G4 yes

G3 …what's happening to me…how'm I going to manage

G2 being on your own really

G3 as for government well …they're too remote from me til it impacts on me like… they stop my pension… …

[Crosstalk]

G3 if they said to me well I'm sorry but you've got mental health problems so you don't need as much of a pension … so you can't really tell with all of these

G4 It's not properly funded is it by central government

G2 [Inaudible] council no… … people I know who've got who've had young teenagers who've had issues for all sorts of reasons…they've had to pay privately the waiting list for psychiatric and counselling have been terrible

[Agreement]

G3 well I've got a friend's whose daughter is actually a millionaire and they've found it so difficult to actually get [him/her] classified as autistic

G5 right

G3 so money doesn't always help

G2 that's the council services…..

[I encourage group to think about the question]

G1 Well I think…it's an age old thing that has …it started when man first started to communicate and live in communities well perhaps been forever you know because it -you-if there's …..in primitive forms if you have got one person who's holding back the community …

G5 Mm

G1 they're going to stigmatise and say don't bother you know don't bother about him don't take him on the hunt we'll go without him

[Agreement]

G1 and catch the reindeer or the antelope…or whatever it is…and that is…preservation

[Crosstalk]

G2 Yes I agree with that yeah

G1 having … having [inaudible] stereotyping categorising discriminating… I think it is a fundamental human … … and it's not that it's negative that its wrong … because a lot of discrimination is very positive it is so you can help them …so yeah I think it's just a fundamental…

[Any other views? Anybody agree or disagree?]

G5 [inaudible] modern thing of pressure

G2 what's that [mentions name of someone not in the group] said

G5 peer pressure… …I'm thinking there's a young-old divide here, you know

G2 Yep yep

G5 older people will get mental illness perhaps for physical reasons

G1 Mm [agreement]

G5 as much as anything… but younger people with the high pressure high technology

G2 Mm [agreement]

G5 ever-changing world we're in

G2 Mm [agreement]

G5 where there is not… where there's a load of social media but none of it's necessarily relevant…and of course they're growing up in a society that's ever changing and we…which possibly parents don't even fully understand either… …I think peer pressure is an important…

[Crosstalk]

G3 I think a lot of people don't have job satisfaction they're able to do the job but they don't actually feel they've got job satisfaction

G1 I mean sometimes that's just er an outright luxury… I mean at the end of the day all you're doing a job for is to get the goodies to take home and feed your kids

[laughter]

G2 yes and no

G1 No no no I mean that is it

[crosstalk]

G3 I'm sorry but I've spent twenty years thinking to myself 'this job is killing me'

G2 Really wow

G3 sitting here…doing the job…

[Crosstalk]

G1 I felt that about the [names former business] I were up half past five in the morning at half past four when the alarm went off I thought ooh god not again

G2 [laugh] I couldn't no

G1 yeah!

G3 but people do have this entitlement feeling… well I think that having a very bright child and 'oh they're going to be a doctor' and god when they get there the reality of it is awful

G2 I'll tell you a story about that…

G4 I think the depressing thing is that all of these are significant

Okay

G4 …you know I think probably one of the most damaging is employers'… stigma ...because you know it could mean that people are overlooked or don't get a job that they would be they'd be perfect for and would be very good for them mentally as well you know

[agreement]

G1 can I write on a blank one? 'fundamental human'?

Please do…and then we'll go for coffee…I'm sure you'd all like a break.

G3 I think what's worse is employers having a quota…like [inaudible] having an older person female older person… I'm afraid government and civil service have been awful with that you know

[Noise in the room as people gather themselves to leave for coffee]

G2 we're putting down – it's it's a fundamental to human nature

Thank you. Let's go for coffee

[Personal chat, U3A announcement by MH]

Part 2

G3 do you mainly have U3A people or…

[I explain I am conducting a single focus group as part of wider research, and that U3A were receptive, which I think is because its members have enquiring minds]

[Agreement]

G3 Sheffield U3A is very very polarised as well… it's Sheffield 10, Sheffield 11 and Sheffield 7…you don't get other people

I've found it an impressive organisation.

G2 oh yes 3,000 members yes and what it is I think – what my colleagues were saying earlier it really reflects the north south split in the city where academia is where if you look at the likes of the secretary they're trying to get the north in but [inaudible] less degrees, less middle class…

[Significant crosstalk, cake, toilets, parking; waiting for all group members to return]

Video 1 60-Second ad

[Introduce video, remind participants they have paper/pens to note impressions on, and remind them it is not a test of memory]

[Play video]

Okay…could everyone hear that?

G4 I could have had it a bit louder [laughs]

[I ask if they would like to watch again with louder sound]

G1 yeah

[Replay video]

First impressions?

G3 awful

Okay…can you say why?

G3 I think it's demeaning the two caricatures [sic] and also he calls him boss at the end…a boss would know whether he had been off etc. … would hope if I was the boss I would feel comfortable to have a general chat with somebody who is my member of staff… I think it's demeaning the two characteristics

Okay

G4 it seems to be aimed at the person with the mental illness [laugh] rather than…the employer modifying their behaviour [laughs]

Mm, that's interesting

G5 I thought it was great… upfront… in your face tell it like it is

G1 Yes I thought

G5 I know how that guy would feel well not the one who [inaudible]

G1 yes the one who…[inaudible]

G5 the co-worker the co-worker who was talking

[I ask what they felt about the use of humour, and explain that people who viewed this video on YouTube have called it a 'really funny ad' for example]

G2 I wrote I just wrote too much humour…strapline…at the end was okay

G3 What's the purpose?

G1…well it's time to talk it's time to change…that's what

[agreement, yeah, mm]

G3 I'd cut out the first two caricatures, they're not funny, they're demeaning

G1Yeah they're a bit extreme aren't they

G4 well yes…and it seems to be.. it seems to be aimed at the person with the mental illness and not…I mean presumably the purpose of it is to make employers react in a more sympathetic way towards colleagues who have been off with a mental illness but it seems to be aimed at the person *with* the mental illness – DON'T BEHAVE IN A BIZARRE WAY if you're asked how you are, you know? [laughs]

G3 yeah that's aimed at perhaps, erm, a management erm, you know you get to a certain grade or something you have to go on management training ..if that's the

training video for management that it's time to talk is one of your…aims then I don't think that's good…I really don't…I don't find it funny

[I ask if anyone thinks it might actually confirm stereotypes about people with a mental illness]

G1 Mm

[Agreement]

G4 yes I do, definitely [laughs]

G1 No I just think it's been very… badly…thought up

G6 What did he say?

Tell me…which character…the boss, or the person who has been ill?

G6 er no the er the one who's been ill

[Very quiet talk from **G5** to **G6**]

G6 cause he was the one that didn't you know.. he was nasty about it but it's not that is it, it's… …[cognitive inability to engage with the material]

[I explain carefully to G6 that nobody was being nasty in the video, but that we see a person who has returned to work after being mentally unwell, and their behaviour is extreme. The idea of the video is to highlight that people's expectations about the behaviour of someone has been mentally ill might be just as absurd]

[Agreement] Someone [? G3] suggests the video is 'too clever'

Video 2 HT World Mental Health Day

[I introduce and play video]

Okay…what did you think of that one?...

G1 well he won't be doing anything for a while [ref. to the former Prince Harry]

[laughter]

G3 if not…ever

[Agreement]

What do you think was the purpose of that video…who do you think it was for?

G1 well it was just to highlight this… organisation that…Harry William and Kate have…I think it's an advertisement for the…what…

Heads Together? The Royal Foundation?

G1 To to promote the Royal Foundation

G2 [inaudible] advocates for the advocates but for the general public no impact

G5 I guess it was the royal …foundation presumably working with others…to create this Heads Together thing which is a global approach to mental health issues… but it's audience wasn't people with mental health conditions

G2 No

G5 it was –

G2 Or people who general public who should be aware of it

[Agreement]

G2 …to advocates or people who should get involved in their …charity or whatever it is…

G3 fundraising

[Agreement]

G5 Trying to get other organisations and influencers on board to drive it

G2 yeah

So a public relations exercise you think?

[Yeah, mm, assent]

[I ask how somebody who was mentally unwell would feel when watching it – for example encouraged, or hopeful, or whether they environment they can see in the meeting might make them feel rather different]

G1 well you're going to run the whole gamut of experience there aren't you? You know with all the different people and all the different problems they've got everybody's going to see it differently…some people are going to say 'ooh, where do I find that place' and some people are going to say na na I'm not in their league

G3 it's stage one…stage 2 is where we see Heads Together in Sheffield city centre…or at our you know leaflets in our doctors'

[Pause, quiet]

G3 I mean for me yes…a lot of bigwigs getting together raising money…yes it's got to be done…but…me…I've got mental health problems [*disclosure*]

G1 Oh, right? Oh…

G2 doesn't help me [*another shift towards disclosure*]

G3 doesn't help my life situation I mean… in the future…campaigns… but at the moment as of today…tomorrow…if somebody's in crisis

G5 that's true

G3 I'm not sure how much value royals bring to a campaign

Okay, thank you. Let's move on to the next one

Video 3 Andrew's Story (Rethink)

Impressions …what did you think?

G3 I don't know any more about schizophrenia after watching that than I did when it started…

Okay…the written introduction to the video says that it invites the viewer to 'watch his story of overcoming discrimination and finally getting the right support'. Do you think it does that?

G4 What? No it's the format was very dull I thought [laughs]

G1 Mm

G3 the only time I hear the word schizophrenia is where terrorists…somebody does a terror thing and then they say well of course he actually has got schizophrenia

G1 I wasn't aware that..,

G3 So in my mind schizophrenia IS violent and it's associated with violence

What did you think of the use of the make-up on his forehead, the word 'nutter'? Do you think that was clever, funny, silly…?

G5 powerful

G3 he didn't quite get it all off… [*could over-analyse this*]

[laughter]

G1 [to **G3**] it's because you're OCD

G3 [inaudible response]

G2 nutter… if he'd actually spoken the words I think that would have been better

G4 and I think if anybody with schizophrenia was watching that they would feel profoundly…depressed …because it ends up with something about how scarce…proper support is!

G5 I thought…I thought the words were interesting. I've learned something about schizophrenia…

G2 Yes

G5 …that the vast majority of people think it's when someone's a raving lunatic who runs amok in a shopping mall [71]

G2 Yes

G5 it's not …it's something that afflicts an ordinary person

G2 It seems like

G1 Yes one in a hundred…that amazed me…that's scary… that is scary

71 The focus group took place two days after the widely reported mass shooting of 20 people at a shopping mall in Nakhon Ratchasima, Thailand by ex-soldier Jackraphanth Thomma. I found no subsequent reports which suggest he was experiencing schizophrenia.

G3 Mm, you certainly do need more about the general people who's got it not the ones who go on to do crimes

G5 I mean if that's saying to the general public and people listen to it maybe they will have a greater understanding that …there's something out there that people might want to know a bit more about

[Yes…so do you think the majority of the public believe that people who have schizophrenia are violent?]

[General agreement - yes]

Do you think that opinion has changed in any way, over, say, the last 20 years?

G6 well what was it like 20 years ago?

[I attempt to unpack the group's assertions about terrorism; probably inadvertently 'leading' the next response, giving the example of the way that in order to avoid labelling somebody as a terrorist, news sources might talk about the mental illness of a perpetrator]

G1 Mm…and that could just be an easy peg to put it on…couldn't it? And take away people's responsibility

G3 Years ago you assumed that people if they had such a…profound…mental health they'd actually be in a secure unit

[Agreement]

G2 True

G3 and nowadays

G5 care in the community

G2 '79 wasn't it

G3 Just because we're sitting here doesn't mean that we haven't got it

G4 Oh, no

G1 and again it's down to degrees isn't it…I think…I found that very worrying saying that 1 in 100 people have got schizophrenia and if erm out of the rest of them the 99 so many have got anxiety and so many have got depression and so many I mean

G4 Mm, there are different types aren't there because often some of the violence incidents well I don't know but there's paranoid schizophrenia isn't there so there does seem to be different types…but in truth I didn't get all of that…

G5 It also leaves a lot unsaid I mean which is…is one in a hundred a much higher prevalence than it would have been 40 years ago…what…to what extent do illicit drugs play a part in the in- if there is an increase in schizophrenia?

G2 Yeah

G5…and as a societal issue, the guy's a victim, not just, you know unfortunate in that way

G3 which, at what point do you actually get labelled schizophrenic…

Does a label come with a diagnosis, do you think?

G3 Yes…have we got better at diagnosing it or have we got better at labelling it?

G5 I think it's become a bit of a dustbin

G1 a bit of a catch-all

G5 to allow to allow psychiatry or the government or anyone in the health service to push people to one side feed them tablets keep them out of harm's way as much as possible

[Agreement]

G1 and there's -

G5 and in the meantime avoiding the real issues

G3 lock 'em up

G5 yes so just push them to one side – but don't solve the issue…because it's going to cost too much money …you need an awful lot more psychiatrists and you're never going to get 'em… and you need some real thinking about -

G3 I just don't know how to cope with them

G1 but a lot of these conditions again it is a question of degree and a lot of them you would hope that the vast majority of them the degree at which they have the conditions is within the realms of erm….being able to handle it yourself…you know there are all sorts of things…my brother's got one leg that's half an inch shorter than the other he's not disabled…he's managed it…er…we don't hear very well, I do just fine. I don't have a problem in saying to people I'm sorry but can you look at me when you speak

G5 Yes, indeed

G1 I don't I don't have a problem with that and so you have to to some extent expect the people who have these conditions to whilst ever they can…to help themselves a bit…because if we're going to regard mental health issues in the same light as physical health then there has got to be some self-help

[I note that mental health campaigns encourage the idea of self-help, and ask if they think that is a good thing]

G1 I think it's down to degree

G5 Mm it could be but where's the portal to enter the self-help world? And well self-direct yourself to where you need to be? Mental health is a very diverse issue

G3 You've only got to open the like Sunday Times weekend and it's self-help to get thinner to get mental…er mindfulness is the buzzword

G5 True…and then what about the charlatans .. is there enough policing of it to make sure the self-help is really self-help and not someone else's self-interest…Yes I was going to say we're very good at allowing charlatans to creep into the situation

G3 Mindfulness

G5 And then we have to deal with it

G3 It's everywhere…in schools and

G4 [laughs]

G3 You know we go to tai chi and we there…some of the people are very much into mindfulness…Yeah

[Agreement]

G3 no harm in it mindfulness but it's just…bandwagon

Video 4 Older people: Let's talk about depression (WHO)

[Introduce video, and explain will use highest volume].

Did you hear that, or hear it enough?

[Group agrees that they could hear it]

Okay. Right …what do you think about that one?

G1 well I agree I er I had a birthday card come from my stepdaughter which said er I'm so glad I've got you you've saved me a fortune in…what's… in therapy

I've heard somebody else say we're all each other's therapists now

WW Yes!

G4 it's very therapeutic talking to someone you know about any problem really

G1 it is

G4 and sometimes when you're talking to somebody you articulate something that you didn't realise you thought don't you? [laughs]

G1 and with it…the answer comes as well

G4 mm sometimes yes

G3 if you can make that step into joining something …like U3A…then if you have got depression, loneliness…

G4 Mmm

G3 … it will help – it won't take it away completely… but making that step… you need somebody to make you do things like you co-opting me [to **G1]** to come to this today you need someone to do things like that …I would never have gone into U3A but me neighbour organised croquet and from croquet…come to this, to that…

G1 But at the drop-ins for the U3A sometimes… you're there as a meeter and greeter and the people who come in very clearly have come just to offload their problems onto you

G5 Yes

[Agreement]

G1 they haven't come to find out about the U3A at all ….they come

G2 it's become a group in itself hasn't it tea and chat

G2 I thought it was far more targeted than the royal one

G1 What did you say [to G2]

G2 I said I thought it was far more targeted than the royal one… it's short.. let's talk…I thought on that level it worked okay

G5 Yes

G4 Very good

[Background crosstalk **G5** to **G6**]

G1 Yes, I think it was…because it gives you a er a reason…what's the word I'm looking for

[laughter]

G1 yes it gives you answer, what something you do…

Okay

G1 a remedy

So it's not just 'oh woe is me everything's terrible', but 'well, start with this'?

[Agreement]

G5 I sort of felt I liked it but I was disappointed

G2 Right

G5 I thought oh, here's something that's simple

G2 Mm

G5 I'm feeling depressed and this is going to tell me…in a few minutes…the steps that I could take…to improve how I feel…and it wasn't really aimed at me at all ...it's aimed...it's the World Health Organisation it's not aimed at me as an individual, it's aimed at groups or …I don't know, governments?

Well I was going to ask everyone who you think it's for – is it for anybody, is it for people who are lonely and isolated, or is it for carers?

G1 I thought that was speaking to everybody

G2 I thought it was very gener- generic

G4 Mm, mmm

G5 but then it stopped after it said 'let's talk'

G3 Yeah

[agreement, mm, yes]

G5 is that what you were thinking when you talked to me just now [to **G1**]

G6 What, U3A?

G5 No is that what you were thinking

G6 no I was saying about how now it's not what it was meant to be and I think that is…I think that's a place…they go there to have a chat, that's what it means…and suddenly it's all the walkers, the …I

don't know what everybody does and it all changes now and I've been really annoyed and that's why I'm not going down any more

G5 Well you

G5 but erm

G3 I've never been to the drop in

G2 I can't really tell what they are, are these ads trying to educate the population or educate those who have depression? Is it for people who are maybe depressed or lonely is what they should do or is it people like me and you should talk to people who may be depressed and chat with them…I'm getting confused with them now

G6 someone to talk to ? [*increasingly confused*]

G2 Who's the audience they're targeting who's it targeted at…it's a bit lost to me now I'm like what're you trying to do…

G3 If it's the depressed person they haven't given any answers… If it's somebody who could help the depressed person, still doesn't really give any answers except timely reminder that if you know somebody talk to them…

What did you think, watching that video, about the way that the older people were portrayed?

G2 Patronising

G3 Yeah…also the American accent, that grated…

G4 [laughs]

Did you notice anything else about it that was different to the other videos? [to evoke animation, care settings, muted colour palette, multi-ethnic approach]

G3 There was a couple of people that looked like… well I don't know…from Asia is it? In the background? I thought …well …you know… [sighs] is it aimed for them …if not why isn't it…you don't know what nationality it's aimed at really either…

G4 But it's the World Health Organisation! I think it's meant to have a global impact and I…I liked it I - it was very simple, and [laughs]

G3 I liked it but it didn't…

G4 And a very clear message and I … you.. get the impression that's the first step…let's talk, you know and I certainly feel that could be beneficial so I think it had quite a lot of impact

G1 I thought it did too

Maybe it was the better for being simple?

G4 Yes oh…definitely

G1 yes I thought it did and with regard to what segment of society was being targeted you've got a white on to start with then you've got a black and then you've got an Asian…well appeared to be Asian… so I thought it was global

G4 Yeah, yeah…

G1 Very inclusive

G3 Perhaps we're just wanting more out of the ads

G2 Mm, mm, mm

G3 because we're here to discuss it

[I point out that often mental health campaigns and videos use bright cheerful colours but that this one uses muted browns]

G3 Humph 'you're old so you're going to be depressed'

Video 5: The Stand Up Kid (TTC)

[I introduce the video, explain it is the final one] Let's take a look. I don't think I can get the volume any higher

G4 No

What do you think about that one? What were your general impressions?

G4 it was sad…

G3 I'd like to think that the class was quiet, but knowing what it's like in classes they'd be throwing something at him and the teacher would be shouting at him to sit down…

Mm, so you don't think it's realistic?

G1 Yes, it was staged, it was staged…it was powerful it said what it wanted to say but I agree with [name redacted] that I don't think there'd have been any teachers would have had enough about them to sit there and let 'im say what he had to say [*reflects YT comments*]

[Crosstalk]

G4 or that the classmates would have listened in respectful silence

[Agreement]

G3 it's unrealistic but thought-provoking

G1 it is very thought provoking and I think what is concerning is …these days is because we're hearing so much about it all this social media stuff which is impacting on this sort of thing and exacerbating it…making it grow

Mm

G1 erm, very much worsening the situation

G6 I mean it didn't meant to be that's what it was like

G1 didn't what love?

G6 it wasn't that any any in the real life they wouldn't be stand perhaps standing up and doing it but that was just to see one here and it made [*experiencing cognitive difficulties*]

G1 Well someone with what he had you wouldn't think that they'd have the werewithal [*sic*] to be able to take command of that situation and do what he did

[*aligns with YT comment*] … I mean it would be lovely to think that's they were able to say you know look here I've got something to tell you I've got a very important message

G6 Oh yes

G1 But I mean the whole point of having mental illness is that you are not able to communicate these feelings

G6 No

G1 And to get it out there

G6 He was hoping that they, one eventually, that they'd clap and say it was o – you know – but er…

G1 I mean you can only hope that people take on board the fact that people aren't able to stand up and make that statement and that we're all ready to accept or, or to understand that within groups there are going to be people with mental health issues that aren't able to identify themselves

G6 Mm

G3 Difficult if I had problems like that boy I don't think I'd go onto Facebook and change my status to 'still skiving' –

G1 No but everyone – he might have done that…the fact that you wouldn't do it…all people are going to

G3 but why didn't he say 'I'm not well', or…

G1 because he was him and not you I mean and his way of dealing with it was his way of dealing with it and this guy would do something else and this guy would do something else [points around table, angry] and –

G3 yeah I understand that but

G6 but it didn't mean anything really

G1 That was just his way of putting it out

G6 It was just for us to see

G1 The producer who made that decided that was that way that he was going to put it out

G5 if that were part of a campaign over a long period of time with different aspects of mental illness in a similarly punchy way…I think that would be a very positive campaign …not just for people who suffer from whatever it is but from the people who kind of walk on by because they've not been told what to do…

G3 you mean the negativity of the teacher when he

G5 Absolutely

G1 'Oh he's back!'

That video is very clearly…it's about young people's mental health, so do you think that something like that, which was shown on TV, do you think it has a broader message, or does it sort of exclude older people? Do you feel that it has anything to say to you?

G5 You have to have ..I don't know…different target groups. That is for young people and they would relate to that. Parents would relate to that …teachers would be ashamed if they thought they were like that…so it has a wider appeal but no if you were doing one for older people or, I don't know, a stammerer for example, it would…have to be something different

Okay

G2 Yeah I agree

[Express the need to address the final discussion quite quickly as our room is needed]

If you were running a mental health campaign how do you think stigma should be addressed…in society… by us…in campaigns…any ideas?

G2 What he said

[Agreement]

Addressing different videos to different groups?

G2 Yeah it's more complex…

G5 Yeah I feel

G6 It's like you said…no sorry sorry

G5 no you have to be… Anglo-Saxon, it has to be punchy, it has to be like that – that is great!

Okay

G6 But different groups because that one to me I just got well no it's not for me but [inaudible] people it was targeted for…what they got out of it

Did you –

G4 No sorry I was going to say I think a way of decreasing stigma about mental health is more openness in society generally about mental health

Okay

G3 I think we can take an example about elderly people and how much more that's spoken about you know

G5 Well if you go on a gay pride march and you'll see…

G2 Fair enough

G3 I haven't seen much of that…

[CLOSE]

(Some participants expressed further ideas by email).

Appendix 1.7 List of documentation issued to focus group participants

(a) Introductory document: in order to present clear and consistent information to all interested individuals, copies of the text which had formed the basis of my spoken introduction to the project during recruitment was made available for interested parties to take home and process in their own time. For some, this constituted a more accessible introduction than the formulaic Participant Information Sheet.
(b) Contact sheet: completed at recruitment meetings as part of expression of interest, permitting email follow-up if needed.
(c) Participant information form, as approved by ethical committee and guided by the UREC guidelines (2018). Made available in 16-point version.
(d) Carefully informed consent forms were signed by each participant and a copy was provided to participants.
(e) Confirmation of the focus group date and time, detailed instructions on nearby parking, directions to Jessop West, and to the focus group/screening room and 'breakout room'. This was either handed personally to participants at the second drop-in meeting, or sent by email.
(f) Pre-activity questionnaire designed to ascertain participants' awareness of anti-stigma/mental health organisations and level or engagement, if any, with such organisations (noted here as some participants did this before attending)
(g) 'Observation suggestions' for video viewing.
(h) A 'Staying in Touch' form, allowing participants to express whether they would like to be informed about main research outcomes.
(i) Expressions of gratitude: vouchers were distributed on leaving, and an email of thanks was sent on the same day, expressing no expectation of response but inviting further contributions by email if desired.

Appendices Part 2: Interviews

Contents:

2.1 Research information sheet

2.2 Consent pro-forma (information sheet and consent form both as approved in ethics application no. 033968)

2.3 Interview transcript T1, incorporating interview questions

2.4 Interview transcript T2 incorporating interview questions

2.5 Interview transcript T3 incorporating interview questions

Appendix 2.1 Interviews Research Information Sheet

Invitation to participate in a research study of anti-stigma campaigns in mental health

You are being invited to take part in a research project. Before you decide whether or not to participate, it is important that you understand why the research is being done, and what it will involve. Please take time to read the following information carefully, before deciding to take part. Please ask if anything is unclear, or if you would like more information.

1. The project and its purpose

The study is part of a PhD research project at the Department of English/Linguistics at the University of Sheffield. It is funded by the Arts and Humanities Research Council (AHRC) through the White Rose College of Arts and Humanities (WRoCAH). It is supervised by Dr Jane Mulderrig and Professor Brendan Stone. The project has been ethically approved via the University of Sheffield's Ethics Review Procedure, as administered by the Department of English/Faculty of Arts and Humanities.

This project, *A critical discourse analytical study of anti-stigma campaigns in mental health*, explores stigma from a linguistic perspective, whilst drawing on existing social scientific work. The research focuses on campaigns designed to reduce stigma in mental illness. It is hoped that the findings will contribute to providing more effective anti-stigma measures.

You are invited to participate in the part of the study which seeks to discover the opinions and ideas of key individuals involved in mental health policy or campaigns, with respect to mental health stigma. Although part of a 3-year project, your involvement is only required on a single date (by mutual agreement, but preferably no later than June 2020)

2. Why have I been chosen?

In trying to understand and reduce stigma, it is important to understand the ideas and opinions of those who create or influence policy, in tandem with the views of service users. You are being invited as an individual with significant expertise in, or knowledge of, mental health policy-making.

3. Do I have to take part?

Your participation is both voluntary and optional. If you do choose to participate, you will be asked to sign a consent form, including your consent to the interview being (sound) recorded. After signing however, you can still withdraw your involvement in the study; there are no negative consequences of withdrawal and you do not have to give a reason. If you wish to withdraw from the research, please contact ljrees1@sheffield.ac.uk

After participant involvement is completed, the views and opinions you have provided will become part of an anonymised data set. Once the data have been collected, it is only possible to withdraw from *further* involvement with the study, or the collection of *new* data based on your views or opinions.

4. What information is being sought, and what will I do if I take part?

This study focuses on the language used in and around mental health campaigns. The opinions of individuals who have a role in mental health policy are an important part of this. This research is not clinical research, nor is it a therapeutic process. As a participant you agree to be interviewed as described below. By agreeing to take part, you are stating that you feel generally happy to share your opinions. No requirement for ongoing involvement is anticipated, but you may ask to be informed of the ultimate findings of the study.

The interview: more details

The purpose of each (1-1) interview is to enable the researcher to understand your views on mental health stigma.

Although this research primarily involves applying text analytical methods to websites and campaign documents, interviews with key individuals involved in mental health policy will ensure a balanced perspective. Interviews will also complement a focus group discussion on stigma with a group of people who have lived experience of mental ill-health.

It is hoped that the interview will be a fluid conversation, broadly about stigma, and specifically exploring ideas such as:

- The extent of mental illness stigma in contemporary society and the 'use' of stigma as a focus of public (mental) health campaigns.
- Some apparent contradictions in the objectives presented in key advisory reports, and the relationship between such contradictions and stigma.

With your consent, the (video) interview will be (sound) recorded. The length of the interview will be decided by mutual discussion, but a minimum of 30 minutes is offered as a guide.

5. What are the possible disadvantages, risks, or benefits of taking part?

No foreseeable disadvantages or risks are involved.

Whilst there are no immediate benefits to participation in this project, it is hoped that this work will play an important role in exploring the issue of mental health stigma in mental health policy. Other sources of data for this project are either textual, or are provided by people with lived experience of mental ill-health. Your policy perspective is vital in providing a balanced view. You will also have the opportunity to be kept informed of the findings of the study.

6. Confidentiality and use of data

All data collected during this study will remain strictly confidential and accessed only by the researcher. Transcription and storage of data will be anonymised. Your personal data (data which could identify you) will

only be used for communication with you for the purposes of conducting the interview. It will not be retained, shared or processed. Any identifiable personal data, (i.e. linking you to the data you provide) will be destroyed as soon as the information from the study has been collated and transcribed (within one month of the interview). If you choose to be informed of the research findings, or of their publication in any form, your contact email will be retained for this purpose.

You will not be identified in any reports or publications without your explicit consent. If you agree to data being shared with other researchers (e.g. as a data archive) then your personal details will not be included except at your request or with your permission.

Audio recording

The researcher will seek your permission to make an audio recording of the interview. Sound files will be kept securely in a password-protected file on the University network, and will be accessible solely by the researcher. Files will be deleted permanently as soon as the data have been anonymised and analysed. Audio recordings will not be broadcast, shared or placed in an archive without your explicit consent.

7. If you require further information

Please contact the researcher, Lucie Rees, by email: ljrees1@sheffield.ac.uk. Alternatively, you may contact one of the research supervisors, Dr Jane Mulderrig j.mulderrig@sheffield.ac.uk or Professor Brendan Stone b.stone@sheffield.ac.uk. All can also be contacted by phone via the Department of English office: (0114) 222 8480 or (0114) 222 0220.

These contact details can also be used if you want to complain about your experience as a participant. If a complaint arises which relates to use of personal data, information about how to make a complaint can be found in the University's Privacy Notice: https://www.sheffield.ac.uk/govern/data-protection/privacy/general.

Thank you for taking part in this research, or for your interest. If you participate you will be given a copy of this information to retain, along with a copy of your signed consent form.

LR 20-4-20

Appendix 2.2 Consent pro-forma (interviews)

Anti-stigma campaigns in mental health: Interview Consent Form

Please tick the appropriate boxes	**Yes**	**No**
Taking Part in the Project		
I have read and understood the project information sheet dated 20/04/2020. (Please do not proceed with this consent form until you are able to answer 'yes' and are fully aware of what your participation in the project will mean.)		
I have been given the opportunity to ask questions about the project.		
I agree to take part in the project. I understand that taking part involves being interviewed by video link (e.g. Google Meet or other approved application), to discuss aspects of mental health policy relating to stigma. I agree that the video interview will be audio recorded.		
I understand that my taking part is voluntary and that I can withdraw from the study at any time; I do not have to give any reasons if I no longer want to take part, and there will be no adverse consequences if I choose to withdraw.		
How my information will be used during and after the project		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.		
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs except at my request or by agreement.		
I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.		
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.		
I give permission for the interview data that I provide to be deposited in White Rose Research Online [an academic data repository] for future research and learning.		
So that the information you provide can be used legally by the researchers		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.		

Name of participant [print] Signature Date

Name of researcher [print] Signature Date

Project contact details for further information:

Researcher: Lucie Rees ljrees1@sheffield.ac.uk University of Sheffield School of English, Jessop West, 1 Upper Hanover Street, Sheffield S3 7RA Tel. +44 114 222 8480

Supervisors: Dr Jane Mulderrig j.mulderrig@sheffield.ac.uk Prof. Brendan Stone: b.stone@sheffield.ac.uk

Head of Department: Professor Joe Bray j.bray@sheffield.ac.uk

Appendix 2.3 Interview Transcription T1 (TTC1)

Note: The transcription of all interviews does not involve a formal transcription protocol since this is not conversation analysis. Rather, the intention is to convey an accurate verbatim account of what each interviewee said. Interviewees' words are written in italics. I include a few paralinguistic features where relevant. My questions are written in bold. Unless especially relevant I do not include discourse markers, or utterances which signal active listening in my own speech ('yes', 'right', 'ah', 'I see', 'mm', 'sure'). Where I paraphrase or summarise my own or an interviewee's utterance (for example because it is of no substantive importance), I enclose it in square brackets.

Interview questions are integrated within transcripts to accurately present the differing form of questions for each interviewee, and to include occasional *ad hoc* questions.

[Start of interview 1]

Maybe it's not surprising that Google Meet doesn't work with these laptops…maybe they don't recognise…Maybe you can tell me a bit about the research… or we can just get started. Yeah I've got until 3

[Brief explanation of CDA…and referring back to the Information Sheet. Linguistic research, CDA. Introduces nature of questions]

Great. Just one question before we get started. Should I, em, is it more useful for you for me to present the TTC kind of corporate line, erm, or is it, sort of , what I think? I guess things will be similar in many cases but not exactly…

[Explain value of interviewee's own views rather than what is available via texts]

Ye….es…I think so although they… they… probably wouldn't get into some of the more…

I guess some of the …more technical…not more technical questions but perhaps questions that you might be interested around…language…So I'll just say what TTC thinks…and can add little erm, addenda.

I am interested in you personally especially as you have this background in political science, and I feel that's going to give you a slightly different perspective than the corporate line maybe.

Mm…Well yeah, I'll just do the TTC line and then say if I think there's anything … maybe there's some stresses around that in terms of what the movement thinks and what I actually think.

Alright, thank you. I think you'll find some of the questions are phrased 'what do *you* think' –

but it's up to you whether you'd like to mean the 'royal we' in the way that you respond. Or your own personal view. There are three groups of questions, firstly those which I am asking to all of the interviewees and then, those which relate specifically to TTC, and then a few more which are a bit technical, a little bit political, and I suspect those ones at the end are the ones where your own expertise and position is going to be the most relevant really.

Cool. Sounds great.

Thank you, So first the questions I'm asking of everybody…

How would you define your job and your function, both within TTC and Rethink, or more broadly?

Umm. Yes I'm the [role redacted] at TTC England and um, so TTC England is erm, the national anti-stigma campaign er run by Rethink Mental Illness and Mind, um and so I'm technically employed by, Mind, so…that side so yeah, so everybody in TTC is employed either by Rethink or by Mind…We're not technically an incorporated charity so it's a partnership between the these two large MH charities which is somewhat interesting in itself but they found themselves able to come together around stigma and discrimination and form a partnership in that specific area, um and what the programme manager role is essentially the financial output and risk, er, control of the whole programme, so there's all, there's different teams that we have , different projects, social marketing, children young people erm, community leadership, um and I essentially sit across those teams and see what they're doing.….and try to, to, try to make sure that we're hitting all the output and, erm, financial targets that we have.

Okay…is there any sort of clash between your TTC role and your Rethink role? Does it…are they complementary…does it work?

Yeah so, it's kind of interesting question because so my …so (laughs) so the [role redacted] is in Mind, so that's - Mind has the central management team which is the director, head of programme management and so on. Um, also has the community leadership team which is the largest staff team and that's all of the kind of networks and work with people with lived experience and it also has the PR and comms function…and on the Rethink side there's staff there in social marketing, children and young people, evaluation……as well, and the digital team …so you have this kind of split across two different sites…or…normally, obviously everyone's working from home at the moment but umm Rethink is in Vauxhall and Mind is in Stratford so it's it is…there's a lot of partnership working…because everybody's employed by one organisation or the other so I'm, I'm a Mind employee…so yeah, I mean I think there's obviously the two organisations do have different interests and they are mostly able to be negotiated… but yes…there are some points in tension.

Thank you. **How do your…personal values influence your job and what you seek to achieve through it?**

Mm.

Good er, good question… I mean I would say that some people see anti-stigma work as quite directly political erm probably with a small p…erm quite often because they have lived experience of having had or having a mental health problem and they've experiences stigma or discrimination so they see TTC as a vehicle for challenging and ultimately erm, ultimately changing that…erm personally I…I, I don't know, I think it's erm …I think…I'm I like to work in the third sector, I think the…having some sort of mission in your work, which isn't straightforwardly profit but there is a social change you want to see… definitely motivates me.

Are there any sort of political values, any brand of political thinking which affects the way that you approach your role?

[Laughs]. *…Erm…this is not the TTC corporate line…but my …I mean my personal…my political background, erm, I would say…does inform my work at TTC particularly around …I think…its…the way that TTC works it's really important that we… [sighs] …I guess that, mm. I'm trying to think how to put this in a, in a diplomatic way and I think I am quite atypical probably within, within TTC? I'm not sort of suggest [sic] that everybody thinks in the same way that I do…I think it's really important that we, when we're doing our…our…essentially attitudinal change work? That we're not, we're not sort of berating people…the whole stigmatising attitude…and I think that is obviously something which we come up against quite a lot because we're often …essentially looking at the segments of the population that hold, er quote unquote worst attitudes and trying and do something about it…so it's*

very important that we don't essentially, it's men, 25-44 C1 C2D so essentially working class men., um…

And I think it's really important that we don't…that there isn't an idea of blaming people… who have the, the bad attitudes.

Yeah, that's interesting, that's something I was going to come onto, you know about …**is there a danger that by selecting a specific campaign target demographic that, that you're …that there's an element of blame…or ultimately that that group could be seen to have 'failed' if they haven't improved?**

Mm.. well yeah, I mean the… the danger possibly in extremis is that you have, um you have some problems. I mean this is I think the case in all anti-stigma work…is that you have problems which are essentially structural and …and which relate to…certain social conditions…that are causing mental distress erm, and then that…kind of erm structural cause is …is given sort of given second string or is put to one side in favour of looking at interpersonal interactions…and of course one thing about anti-discrimination is…if…[sigh] if you don't do it well then you're essentially saying these are the bad … these are the bad people in the wrong way and of course that's a very individualistic approach and um I think that's something which we try to avoid at TTC…and, erm, and I think it's important that we don't sort of say…and often in our external presentation we're not sort of saying 'and here are the groups we've identified as having the worst attitudes, these are the ones that we want to correct their behaviour or socially engineer erm, in fact in the way that we present the attitude change work with …that group of men -44 C1 C2D…is very much as, erm 'here's what it is to be a good friend, because we know that...that obviously having a stigma around mental health means that people feel less able to discuss it even when it refers to them or to their close friends… erm, so we try and have that Trojan horse approach…it's not directly talking about this issue but it instead it's trying to change behaviour in a way that's going to, gonna help.

Mm. Okay, thank you, that's useful. We sort of brushed slightly past the er…**I think you were slightly inferring that you personally don't have experience of mental health stigma or lived experience of MH problems**…and I'm just…

Umm…I, I this is again very atypical of TTC but I erm, I don't want to say one way or the other.

Oh no, absolutely…no sorry, I should have prefaced all of this conversation by saying that if at any point you don't want to answer anything that's entirely your right and we'll move on, so, I apologise

*No no, you definitely don't have to apologise I think it's a very valid question…because one of the things that we talk about is…erm.. lived experience and…but my feeling is that …that it's not a question of staff representation…as much as it is having decision-making mechanisms within TTC? Erm…which feed into a wider movement of people with lived experience…*so…

Erm but again…that I would say is atypical of TTC so [laughs] Don't extrapolate from that… because I think that actually some people are… particularly sincere people within the organisation, are…will talk about their lived experience to use that quite powerfully to, to influence and to um to engage in the work at TTC.

Yeah, I'm sure. I'm sure it's sometimes seen as something which sort of validates a particular initiative or particular viewpoint I imagine?

Mm, mmm yeah

Yeah. Okay, thank you. **What connection do you see between what you do in your own role or as an organisation …and society as a whole? And I'm thinking really about health inequalities especially mental health inequalities**

Oooh, erm…yeah good question… I mean…hmm…I would say…the TTC corporate line…taking TTC as an organisation..I think we don't want people to be...to feel ashamed…to feel less than…because of their mental health…and I think that's…you can…there's a whole range of reasons why mental health stigma is…is a harm to society…it causes people to not seek help? It causes people ...erm and often as a consequence of not seeking help …they…may be more likely to end up in crisis care because it doesn't…stigma doesn't solve mental health problems it just hides them and buries them until they're...they can then…er recur or erupt in more serious ways um and I think that is an important…it's an important sort of part of living in a… living in a society, that we have respect for…our fellow citizens and I think we…if we take the analogy with, er with physical health then…I don't think people are...actually this is something which did happen to me I had a cycling accident which was entirely my fault…and very badly broke my arm…erm was off work for six weeks…was on holiday had to kind of have er, have surgery…and I was in France yeah in the south of the south of France…it was not the holiday that I'd hoped erm, but, I didn't have any …there wasn't any stigma attached to this even though it was undeniably my fault I was cycling downhill kind of too recklessly, erm being a bit silly [draws breath] erm but, but I think if there is an equivalently serious mental health problem that requires somebody to have six weeks off work, people…then will look down on them… and I think that's…there's an element of social justice in that, I think there's a… …a lot of feeling that that's just unfair, that's just the way …that things shouldn't be that way, I think people at TTC are quite motivated to… to change that.

Yes…absolutely…okay. Thank you. I think a lot of these questions may overlap, and your answers may overlap …so I apologise for that.

Sure

What I'm thinking is, in the attempt to reduce mental illness stigma, do you think that it's society that needs to change first? And what I'm thinking of here is the notion that culture is upstream of politics, so you know do you think that anti-stigma campaigns have the power to have a sort of 'trickle-down' effect on a political attitude?

[Sigh] That's a…a very good question, erm…I think a lot of these questions are really getting at [sigh] things which to be …well to be honest we don't you know we don't think about in the day to day delivery of an anti-stigma programme that much. There are some quite big questions.

How would I respond to this? I think the first thing I would say would be that the argument that we make as TTC um is that the… er… actually that it's the attitudinal environment basically having support for people having support and sympathy for people with mental health problems…which… enables certain policy changes to go ahead…so we…in the Scottish programme See Me Scotland, they put it in that anti-stigma work is foundational because you need to have that foundation of fundamental, kind of, public support umm in order to…umm…in order to change policy……I [sighs] mm, I think it's a…I think it's an interesting point the idea of culture being upstream of politics is…I don't know I don't know if we're really trying to sort of …to…exercise any sort of hegemony …but…if that's the appropriate word for this…for this context, umm, I think instead it's …[sigh] the, the outcomes that we hold ourselves responsible to are ones around discrimination and, and erm stigma… So, in some ways they are only part of what a kind of…umm…quite different-looking society in mental health terms would look like and… and maybe, and this is the challenge which, you know, I would say it's one of …it's more of a pub discussion that we have, you know, because it doesn't really link to what we do day to day but it's something that people are interested in …and we talk about…um …which is basically…would…a lack of would a society with no stigmas and no discrimination be compatible with one …which has a pretty low level of services i.e. can you have sort of some sort of structural …injustices or structural inequalities while you also have have, er, erm good treatment, good attitudes and good treatment … … so yeah, erm, again, I think it's a question which …which I think gets more

at some of the, erm, the sort of the next step on questions that we don't probably even get to think about all that much…as a programme.

Okay thank you. I ran a focus group erm, on mental health stigma with some older people, erm, and most of those participants were of the belief that to stigmatise is essentially…just a fundamental human trait…now, do you think that that's the case, and if it is, then how on earth do we really hope to address it?

Er.. yeah I don't think that's I don't think that's true. I think I would, I would definitely reject that …idea I mean so the way that we understand stigma at TTC… is that it has three domains, so you have knowledge, attitudes and behaviour…So knowledge…the social problem of ignorance of one of the lack of knowledge, questions of, of prejudice… erm that's related to, to attitudes…and then questions of, of discrimination related to behaviour…So I don't think there's any necessary reason why people would have a lack of knowledge or hold prejudicial attitudes towards people with mental health problems, or discriminate against them, er, indeed.

…so I think the….. the changes that we've seen over the last decade would seem to suggest that erm people's attitudes are …social attitudes are quite changeable…erm I mean maybe there's a there's a sociological question that your focus group participants were touching on which is very difficult to answer…which is ..you know... is it a feature of human societies that people will …essentially…erm categorise others.

Yes, I think that's what they were getting at, these, almost evolutionary ideas that those who are different …will always be in some way singled out, even if it just stems from a ..sort of …a functional 'lack' in their daily living. It was just an interesting finding, and I was, you know really interested to hear what you felt about that, I was quite surprised, but I think also in some ways it, it possibly ties in with some of the other things I'm going to be asking you about, about the reach of campaigns and…to what extent they are reaching older people who may be a little bit sort of unreconstructed in their thinking and actually would benefit so much from [intake of breath] the 'education'. So I'll come back to that in a bit but …I'm glad to hear you have an optimistic erm view about it

Mm…yeah, I mean, personally

[CONNECTION LOST/ RE-ESTABLISHED]

I'll start from the beginning. **We're often encouraged to raise awareness over various social issues, problems in social life, and I can see that, you know the value of education as part of raising awareness is very clear but what do you think are the – in mental health and mental health stigma especially – what are the limitations of, of raising awareness, how far can that go, how important is it?**

Mm…well I guess the…one thing that awareness…raising can't change is access to services.

And we …we did a large bit of quantitative work with people with lived experience of mental health problems, up to 4,000 people were asked what are your priorities, and it was…access to services and quality of services was the number one priority, unsurprisingly. Umm…and so, I mean there is a limitation, there's there's definitely …I mean that's obviously not the aim…of erm… …these sorts of programmes…but I don't know if there's a …yeah…I mean I I think the argument would be ..at TTC that we would make is that the…as I said previously that raising awareness and getting public support for something like…like reducing stigma…

…that helps with other, sort of influencing objectives an organisation might have?

Mm, mm…and perhaps we're returning again to the business of culture being upstream of politics, ultimately….maybe?

Yeah, yeah

Okay, thank you

I think we definitely work in that kind of ...erm we're definitely adjacent to politics in in one sense, because we are interested in influencing policy, um, and…I think the way that, yeah, one way that we try to do that is try to…to mobilise people with lived experience…behind our campaigning objectives…and I think that's a fairly sort of standard civil society-like er model ...so yeah.

Okay, thanks. Do you think it's fair to say that the…you might not like quite a lot of these questions (small laugh) but they're things that I am grappling with and trying to understand…**Do you think that the drive to, erm, to maintain economic productivity is, is really a large part of the government's motivation for helping people with their mental health?**

Err...I'm not too sure I could answer that, I don't know probably enough about, about the current government's priorities and ways of thinking…I mean there's, there certainly is a link between, er, mental health and productivity…And we've seen these arguments become more prevalent and probably more [sigh] more widely received, erm…in the last five years, um, particularly, and I mean this is, you know, I think it's sort of, it's, it's one of the registers that often mental health campaigns or organisations have, which is essentially looking at the economic costs…of mental ill health in your workforce, in your business, and I think it's not unrelated that the employers' aspect of TTC as an intervention has been… it's been really ...the demand has been really really high and well-received, erm, [draws breath]...but whether, you know I don't think I can answer it more specifically about the government.

Sure, no. Fair enough. Erm, I suppose partly what's behind this question is that I've noticed that many mental health organisations and campaigns, tend not to target older people, especially – you know not uniformly anyway, across the UK, and I just wondered what you thought were the reasons for that because my own feeling is, as you probably gathered, that this is, you know that older people are not productive economically and that therefore they can put aside a little, erm, because –

I'm ...I see where you're coming from…and I think that's a…logical argument, it could, it could well be true, but actually… in my experience I would say there's a slightly different reason for focusing, for not focusing on older people…and this is the kind of discourse around…generation of change, generation for change…which is essentially that you get better value for money…if you change young people's attitudes…because they will be enacting those attitudes throughout the whole course of their lives…whereas older people - and I'm not saying I agree with this – whereas older people erm, you get less years of those attitudes being, being er current or being held.

Erm, and it's almost like, I think this is also combined with a – I would say a liberal political disposition to focus on education in the widest sense in terms of sort of reforming, erm, people's attitudes… so sort of starting ...the idea is essentially that if you can get to them young enough and if you can say the right things, then that is essentially that person for the rest of their life is holding the right sort of attitudes, and that's being tolerant, being open, so ...I think it's more that there's a prioritisation of young people than a…but I mean there could be both playing at the same time, but it seems to me that the – in fact the attitudinal surveys that we run seem to suggest that old people don't have particularly worse attitudes towards mental illness, um… ...and I think there is a little bit of ageism in it [laughs]…where it's like 'oh yeah, it's just intolerant old people'…who voted Brexit and…don't like, you know don't like, erm people with mental health problems and are very sort of selfish an um inward looking, and I don't, I mean I don't think this is supported by the evidence despite some, you know, I've seen in

professional situations where people have betrayed, maybe their prejudices? Or that certainly their …assumptions…in this area.

Okay, that's interesting, thank you. Alright, moving on now to questions which are more specifically about TTC, erm, and I was wondering firstly, **what do you see as the main stimulus for the initial creation of TTC?**

Yeah good question, I mean the, within, from an organisational point of view, the… TTC England followed on the heels of a programme in New Zealand?…which preceded, preceded it, and also one in Scotland, so there was perhaps a bit of pressure in terms of erm, so this would have been 2006…before I joined…TTC… erm, so yeah, it would have been, there was a bit of pressure, like this is happening internationally, umm…I think it was …yeah, I mean it's difficult though to see what, why, what exactly at that moment in 2006 …and the campaign starting in 2007… really…persuaded the government to invest in this. I think it's essentially, umm, my take, and this is not, I don't think this is necessarily correct, is that around that time there was you know a sort of turning towards public health campaigns …in a number of different areas…and this was …this was one of them. Though, no, I don't really know though. Effectively there was evidence…

Perhaps it was just the zeitgeist?

Yeah, yeah…I don't think it's very helpful but that I think would be interesting to unpick that.

It would, and I'd love to be able to do it, I'm curious why, you know why stigma was prioritised as something to use essentially as a policy strategy for mental health, you know why stigma…I find that interesting, you know, and where did the idea come from then, having identified stigma, where did the impetus come from to address stigma through …you know, essentially social marketing…

Yeah [draws breath] good, good, good question, I think the, erm, there are people who will be able to give a much more succinct er, answer to that, who were, who were there? ... part of those ... conversations but I think it's, I think the only thing that I would flag up there or would maybe contribute is that …the international element, that there's…there is a, there's a global anti-stigma alliance, an organisation of national anti-stigma programmes and there is…you know that's what happening now is as the evidence accumulates, we're sort of passing on what we've learned and what we've done and the arguments that we've found successful in fundraising with governments who want to kind of grow in all new national programmes with the deliberate intention that they can then have that programme in their country.

Okay thanks. I know you said you weren't there at the inception of TTC, erm but I was wondering …why it was launched through its own website rather than sort of within one of its parent er bodies, Mind or Rethink, and the reason I'm interested in that is that I think – I mean, you'll correct me if I'm wrong – but **I think that there's general acceptance that more severe, mental illnesses such as schizophrenia, attract greater amounts of stigma and so because of the sort of heritage of Rethink I was wondering, was it ever considered that to actually position the anti-stigma campaign within Rethink?**

Yeah, I mean …this is a good question, I, I don't think I can necessarily answer *…the question of why TTC was a separate organisation, but erm it certainly has been a consistent theme within TTC's operation… that obviously Rethink is specifically the National Schizophrenia Fellowship and is, but is more associated with more severe mental illness and Mind is positioned probably more as a pan mental health organisation so there's on the one hand you might think that this means that Rethink would be pulling TTC's work towards more severe …stuff…erm, but that's not always what's happened, because of course maybe Rethink have their own, erm specific…campaign or, or erm bit of work there which they don't want TTC's …campaign to, to encroach on…so it really, it depends a lot on the situation and on what they're, the partner organisations are doing in that point in time?*

So it's, this is a continual kind of renegotiation process.

Okay. That's interesting, thank you. **I couldn't talk to you without mentioning Erving Goffman** [laughs]

[laughs]

He wrote about the potential to alleviate stigma through, and I quote, 'benevolent social action' …do you think that ultimately that's something that underpins the aims and objectives of TTC, does it all come down to that – benevolent social action? That TTC is essentially having to …not push necessarily but to guide people towards community, to re-building community, and essentially just being kind and decent and civil?

Mmm…Yeah I think the idea of benevolent social action is an interesting one, and I think that it's probably one that TTC would to a certain extent reject. Yeah, because I think there's a …there's a different narrative around what we do, which is that it's about empowering people with lived experience to share their stories …and it's through, it's through social contact, so it's about somebody who has lived experience of a mental health problem, sharing their, their story and then it becomes very difficult – without that experience the *whole stigmatising attitudes because they see this person as [a] human, like living embodiment of these previously more or less abstract categories, suffers from anxiety or a mental health problem, or schizophrenia, and then realise/d ah, actually all these kind of prejudices or worries that I might have about…dangerousness, or about…any of these other stigmatising attitudes, then are suddenly much more difficult to, to hold…so I think the …we don't probably go in for that …that kind of… line, it's more about having an engaged and mobilised social movement which is trying to …trying to…yeah it's a good question though…what is the, what is the way that we…describe or understand stigmatisers …*

I think it's erm, I think it's, ah, mm..mm, it varies a lot …some people are quite convinced that people who discriminate – or who maybe have discriminated against them - umm, are ignorant, are …essentially irredeemable…to a certain extent, and so it is more conflictual, and some other times it's about ignorance or about kind of a lack of awareness, understanding or experience? Such that the…you know it is about… kind of just persuading people and making them realise that …and looking for that lightbulb kind of moment…

when they suddenly realise, 'ah, might have been wrong' [small laugh] er, 'I've held these attitudes which I now know to be…wrong'. So yeah, it's a good a good question though. I think a lot of …I'll say it again, a lot of these questions are things that we don't perhaps, sort of deal with …because we have quite a…we have I would say much more of a, um, empirical, positivist, behaviourist kind of …approach, 'here's what we can measure, here's what we can change'. So…yeah, it's coming at it from a very different angle.

Okay, thank you. Er, I guess some of the other questions will similarly be things that are a bit too 'mm', not quite the day to day TTC mental framework, I mean one thing that I'd really like to ask about – and you may not want to answer it – is **do you think there's a sense that anxiety and depression have almost kind of been rebranded as 'stress', and that, erm, as a result some people might think that anxiety or depression can be resolved simply by supportive contact…or conversation?**... **and consequently if it fails to resolve the situation, people might actually self-stigmatise, because they feel they have failed to be helped. Does that make any sense?**

It does, it does. I mean…how would we, how would we approach this as TTC, I think one which we would…we would sort of celebrate and think is a good thing is that people are talking about anxiety and depression more, and kind of having these words which are no longer treated you know, with extreme caution, but there is certainly a problematisation of just everyday erm…worry and I think that,

you know Covid is a good example of this that people are…it's a natural understandable human response…essentially, it's essentially a traumatic, you know very objectively stressful situation…

Yes, it's a mass shared trauma isn't it?

Yeah, and I think what we haven't really addressed probably as an organisation is where we …is how we respond to, I think to the more general argument …to the…mental distress or mental states in general that are a response to, to trauma or to certain environmental factors…

because this is, this is something that I think some of our more quote unquote radical Champions would be saying within the movement, and that, that, I don't know if that fully answers the question, but certainly it's something that we are thinking about, which is how do we deal with the…simultaneously with something which is good, which is that the stigma around anxiety and depression is going down, but also on the other hand there seems to be …erm everyday life being medicalised and these words being, kind of dropped in …in ways that maybe they don't apply or maybe they take something which, you know, there are certain situations where um being…melancholic or being worried is appropriate. We don't, you know we don't necessarily want to say that's a problem.

Yeah. Okay. Thank you. **Very general question, now, zooming right out again. What change, that's been achieved by TTC since it began, are you most happy with? What has it really done that makes you think 'yes, excellent, we got there'?**

So…I don't think it's something that TTC can fully take credit for …certainly the mass national change in attitudes, erm…where we're talking about 5 million people having improved attitudes to mental er health problems, or to people with mental health problems, and we, you know, we know that it's …we have a scale, a 27-item scale where we measure, stigmatising attitudes to mental illness and we know that since 2008, attitudes have improved; it's one in 8, 12.7 % erm improvement…and I think that's sort of stands head and shoulders above any other achievement, er to the extent that can be fully claimed by TTC because it's, it means that things have got, have got better…not completely better, and not necessarily completely due to TTC, but certainly, within even…certainly 12 years ago, there's already been some, some I think a shifting …we sometimes talk about sea change, umm, er but, yeah, difficult to be precise about any of these things, but I think that's the general feeling and we're …we're definitely moving with the times more…or following closely behind.

A sea-change would be good; that was what I was going to lead on to really, you know, **do you see real long-term cumulative shifts in public attitudes or do you tend to get sort of post-burst 'yay, it's brilliant' and then it dips …it's that 'sea change' that's so important, isn't it?**

Yeah. Yeah, so we measure every year or every other year, erm, a nationally representative sample, and have seen a basically constant, with a blip around 2008, 2009…which we would attribute to the, to the recession…um but a really general increase…so what we…I guess we extrapolate from that, or what we…our conclusions are is there is, it's a sort of slow continual process of change, there probably isn't a tipping point where we're going to see from one year to another a real …qualitative shift, but there is, there has been a period of sustained, like, media attention on mental health…

Yes, that's really noticeable isn't it?

Yeah…and so we think there is, you know…things can obviously backslide, attitudes can …could harden, if we're looking at a potentially long term recession…or…I mean the current situation is interesting in that sense because on the one hand you might have some factors which might make attitudes towards mental worsen, um particularly a difficult economic situation…but on the other hand you have potentially people having proximity to mental health problems which…er they didn't have before. There could be a widespread, sort of…I think people now are.. maybe understand what anxiety is more than they used to…

Yeas, I'm sure that's right…

…so, but and it would be, I think, a little while before we pick up on the effects of that and disentangle it from...a whole load of other things which are also going on at the moment.

How important is it for you, in the campaign, to have a particular target demographic rather than to…essentially try and target the whole broader population, you know why not population level, why is it homing in on a particular group? And how do you identify the group that you want to look at either for a burst or more broadly. How does it work?

Yeah, so in the movement from phase two to phase three at TTC, that's basically…we're currently in phase 3 so about 2016-2021 funding, um we decided to move, to focus on men C1-C2D 25-44 because we…looked at the evidence I guess, looked at the attitudes that people held, and that group held slightly worse – [laugh] not worse…slightly more stigmatising attitudes…and I guess then it's a strategic question, do you focus on the…and the reason why that group held, or holds, slightly more stigmatising attitudes is because they identify as having a lower proximity to mental health problems so they will, they don't see or they don't have close interactions with people with mental health problems, so I mean that's kind of you can unpick that…umm…

Perhaps a bit of macho self-denial going on there?

Yeah, yeah no exactly. So I guess the rea…it was a strategic question …we decided, how can we …this, how can we target this group, and we eventually came up – sorry to repeat a little bit from the previous question - but we came up with a creative approach in the social marketing which was… not to talk directly about mental health but to talk about something adjacent, specifically being, being there for your friends…and 'in your mate's corner'…um and the idea there is that you don't have to …you can model the sort of behaviour and get people to intervene in a way that's very helpful…very beneficial…without necessarily having to deal with this stigmatised or challenging topic head on…so there was a conscious effort to prioritise this group with lower levels of proximity to mental health problems, and um… and that I think was a change from well in fact it was a change from the previous 2 phases…of TTC…and so it was basically, it was a conscious strategic decision and…while also having the digital and social media umm approach being kind of as wide as possible so the idea is that…you still have that…aspiration to change national attitudes …with the social marketing …the social marketing is only one aspect of what we…

Yes, indeed. Yeah. I was interested in the 'Be in your mate's corner' I thought that was pulling in so many elements in a very concise way …and use of the word 'mate', not 'your friend' but 'your mate' it's pub talk...being in your corner, you know, you're looking at boxing, blokes who like watching the boxing. I thought it was a clever way to bring it to them, really…

Yeah, and the idea was, you know if your mate's acting differently, be in their corner and step in and help them in in their…if they're having to go through a fight of some sort…

Yes, and that's a metaphor that people can really get hold of **and it made me wonder about how you know how consciously you look at the language that you use**…

Yes, yeah very consciously, so this was the, erm, social marketing team who designed this, umm in conjunction with agencies so…with marketing agencies [small laugh] you know from the marketing and social marketing they really you know they went through the whole process of designing, focus-grouping, responding, developing, umm so you, it's quite a, I think it's quite a substantial bit of creative work from that team.

Okay, thank you. Erm, **there are several questions returning to my personal interests in older people and why they aren't a major consideration in the campaign, but I think really…you've covered that really, I suppose my only other question on older people was whether there are plans**

in the future to reach out more to older people or absolutely not, for the reasons you've given me…i.e. in essence, it's not the best use of time and funds? Because you're growing something from the bottom up.

Yeah I, I mean I don't know, I think the… there are, there's the impressionable years hypothesis which is that if you have attitudes…basically your attitudes are solidified when you're thirty, between 18 and…I don't think this actually is true but it has quite a lot of traction

It wasn't true of me I have to say. I have changed a huge amount

Well. I feel… yeah so I don't think it would be ruled out in the…but I think the, it's just the wider context there is a focus on erm, children and young people, both because it seems to be part of a wider education piece, but also because I think the um, you could say there is a wider social anxiety around the mental health of young people and the pressures under which they're put…umm that tends to be the focus. I don't think it's um, I don't think it's necessary for TTC, I think it, I think we…also we obviously have a big social media following and that the demographics of that following tend to skew a bit younger, also female as well. Umm, but it's yeah I mean it's more…if we could design it and if we could deliver it and we could think about the outcomes that we would want to achieve then I don't think there's any reason strategically why we wouldn't do it. I just think it's erm…that there hasn't …the assumption is almost that you start with the youth, whether that's right or wrong, I think that's where the sector is at the moment, probably in terms of attitude change.

[Discussion of remaining time available: interviewee has further much more 'day to day' meeting scheduled. Apologises for long answers]

You mentioned very briefly earlier the idea of people sharing their stories, mental health stories, and that's been important in mental health activism for ages, but I was interested in that TTC seems to have a different way of seems to have created a different type of story by saying to people, you…what was the wording exactly – the editorial policy seems to be that people are not invited to talk about mental health treatment or systems or anything like that, and the campaign explains that by saying 'this is because of our aims and objectives' and I couldn't quite understand how, if the campaign aims and objective are to reduce discrimination, then how could a post which, for example talks about discriminatory treatment, be counter to the campaign aims?

Mm…[intake of breath]…good …good question…I think there is and I know this doesn't fully answer it a partial restriction on what we are able to say about government …because of our funding from DHSC…I mean, hmm…

I suspected that was probably the case and it's a bit of a difficult area, whether you invite people to give their stories in a really holistic sense or not, and I can see why 'not' would be the case…

There's a, I mean one of the sort of the real challenges of delivering the campaign is how we situate ourselves with relation to healthcare professionals and and specifically the mental health system because it's a source of help and support and assistance for a lot of people.

But …in all the qualitative work that we do and a lot of the quantitative work, we find it's a site where discrimination happens, and particularly with people with more …severe and enduring mental health problems will often report some quite shocking treatment …from professionals, psychiatrists…very often…and I think what we're hoping to do in the next phase of TTC is to tackle this is a bit more of a concerted and collaborative way …if we can because yeah…I mean we actually did some work and did – that survey I mentioned earlier – which said that services were the number one priority – also found that in terms of the locations of discrimination it was mental health erm services was the number

one…prioritally [sic] for us to address so how do we go about doing that – hopefully working with psychiatrists …

Yes, that sounds great, yeah

Yeah, I… I take your point though to a certain extent that we…it's um…it's a part of people's lived experience of having a mental health problem and can be a negative part as well, and I think …I think earlier in this if you go through all the blogs there were…there are some earlier ones which deal with more directly

Okay thank you I might go back and have a look at all these as well…I think it's very interesting, the whole business of people's stories in mental health. Just...in closing, I think we've really only got time to ask you about…maybe two more things…and you might not want to answer this… it's your right of course not to, but **I'm interested in whether…whether TTC benefits from insights from the Behavioural Insights Team, and how…has it been beneficial, and generally how …if you want to make it a more general answer, what do you think is the value of behavioural economics in anti-stigma?**

Erm…I wouldn't say I know everything about behavioural insights or behavioural economics erm…but as far as I am aware of the …of that general approach to behaviour change …I don't think it's really one that we take we're you know we haven't engaged in any sort of nudge interventions…I don't think it …it's not something which as far as I know really …it's a kind of social engineering maybe that's what the approach (is) there and I don't think much as we would like to sort of get people to act in a different way, I think it's important to change the attitudes…we definitely have this theoretical model of behaviour as enacted attitudes so you know the reason why people are behaving in a certain way is to a certain extent important so it's not just about getting a certain outcome it's also about I guess… respect and…people feeling valued…which…which I'm not saying that behavioural insights doesn't – you know blocks that - but I think we're…it's more taking a route more through people with lived experience, sharing their stories…I think it's a slightly different …

It seems what you're saying is that what you're trying to do is a bit softer, a bit warmer and a bit more supportive rather than trying to direct people…

I yeah I think that's …it is quite

I was looking at the way that campaigns are evaluated and clearly the importance of quantification ...but it strikes me as being really a difficult thing to do, and you know I've been looking at these various ...things like the survey tools, the MAKS one and the CAMI one…and I just wondered do you feel that these current tools are effective? Is there a plan to design new tools – I was looking at CAMI and I thought … the wording of some of the statements on the scale seems really archaic, and I wondered if such language might actually end up skewing results?

So…there's quite a lot in that question…

Yes there is and I'm sorry I'm just packing it in because we're about to close, I do apologise

Yeah yeah yeah no no no. It's something I definitely can do deal with and I'm asking questions as well so what would I say about this…I think the …we definitely have reasons for using er CAMI, MAKS[72] *and RIBS*[73] *so reported and intended behaviour scale…*

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[72] MAKS: Mental Health Knowledge Schedule (Evans-Lacko, S. *et al*., 2010).

[73] RIBS: Reported and Intended Behaviour Scale (Evans-Lacko, S. *et al*., 2011).

and the comparability with previous years is important …I think the idea, some of the … in general …don't hold…I mean so people often say what you just said which is that the language is archaic, 'isn't it actually stigmatising in itself almost?' and I don't agree with that, I think you're measuring attitudes which are there in the population and if these are the terms in which people think of people with mental health problems then you want to know that … … erm having said that I think the …you know there might come a time or an opportunity when we can refresh some of the language a little bit…yeah it is a little bit outdated and …

Yes, it was designed in the '70s wasn't it?

Yeah, there are social scientific reasons why you want to have that more up to date …erm I guess on the more general point around quantification, I think we, because we…we're not quantifying, erm mental states, we're not trying to have a…happiness index or anything like this…we're …we are asking people's social attitudes and I think these are…these are …more or less quantifiable…I think that's… something which from a social scientific point of view…a sociology point of view is, is more or less, erm, more or less acceptable...I guess the major problem that we have is around discrimination …because we can't measure it objectively – we can measure more or less objectively the attitudes somebody holds …validated onto the item scale, but you can't be there when the discrimination happens so you have to do it one of two indirect ways, one is that you ask people for self-reported experiences of discrimination and then you are subject to an interesting I think phenomenon whereby what gets defined as discrimination is dependent at least in part on people's expectations, so if you increase people's expectations of how they should be treated as you could argue that TTC has done, then you might see an increase in discrimination because people expect to be treated better…so that's one of the challenges of self-reported discrimination the other way that we can do it, to measure discrimination is to look at intended behaviour so people's desire for social distance as we call it so how… like how averse to various forms of social interaction i.e. with a person from a specific category, the category in this case being someone with a mental health problem…

but also actually in the abstract terms …we also have some data on somebody whose symptoms are described as…basically symptoms of depression…somebody who's described or whose symptoms are described as symptoms or behaviours associated with schizophrenia…and you find that there's a much higher desire for social distance from somebody with schizophrenia than with depression. Erm...so we do...I think we make a best case of, kind of a best good faith effort to do this but it's probably worth saying that in some ways discrimination is more important in a way because …attitudes are… they're held on behalf of the whole population towards people with mental health problems …but they might not be enacted and they might not directly…an improvement in attitudes might not directly improve the life of somebody with a mental health problem - there, you're really talking about somebody experiencing less discrimination, that's the sort of the real thing that beneficiaries of the campaign would want? In some ways, it's that realised er benefit. So it's yes it's definitely a challenge around measuring and evaluating …

[Closing pleasantries, expression of thanks. Interviewee expressed that they found the questions an interesting change from their usual meetings]

Appendix 2.4 Interview Transcription T2/TTC2

So, let me know what I can do to help?

Thank you, I'd just like to ask you some questions really, I mean you've had the sheet telling you … about my research…and I've got really two groups of questions, there are some which I'm asking of all the interviewees … and then some which are more specifically about TTC.

Yeah

There might be a bit of overlap in them...and there are quite a few questions so…it's not as if I'm hoping to tackle each in great depth but really just to get your of impressions and your first thoughts on things. And of course you're not obliged to answer anything, you might think, 'no, I just want to move on', in which case of course that's your right. So, is that okay?

Of course, yeah

Thank you...okay I'm aware that you are the [role redacted] at TTC, but how would you sort of define your job and your function, either within TTC or more broadly?

*Yeah okay, so we are …TTC is not a …it's not a charity in and of itself so it's a campaign that's run by Mind and Rethink Mental Illness so my role is basically…er…so …there is a reason why I'm going through it in so much detail…s*o*…so if we were a charity um then I would be the CE…and we have a system that er has a kind of governance system that has er what would be a quasi-board of trustees…which run the programme so as it stands at the moment I report into the, erm the CE of Mind, but I work in Rethink…and so I have...and so it's all a bit complicated so yes so effectively in terms of what…of trying to give you a kind of analogy of what I do, effectively it would be a CE of a small charity…if, if we were a charity.*

Yes. But you're not. Yes, I get it.

Yes exactly

Does that sort of working across different platforms, you know does that create any challenges…are there clashes given different identities and perspectives?

[Muffled laughter, wry smile] Yeah, I mean you know you know, we are, you know for all other intents and purposes, you know Mind and Rethink are effectively in many ways competitors for pots of money but for, but on this er…this topic area I think that I mean we've been working together as aa partnership since 2007…and on this particular topic area I think there are such a lot of commonalities in terms of what people who experience mental health problems said were problematic for them, that …that this was so important to both partner organisations that they came together to work on it? Erm, together? It's not…it's not always easy, erm, and er, and part of my job is to make it as easy as possible for both CEs to feel comfortable with how we're delivering the programme…and we have a quarterly reporting structure both for the funders which is Comic Relief, Big Lottery Fund and the Department of Health…but also for the scrutiny of…what we call the senior management group which is what would have been the board of trustees…So at every turn we try as much as possible to the…the expected challenges …to [smiles] smooth out some of the ruffles, erm and to make sure that at the end of the day we're working towards making sure that everybody's er you know not feeling isolated or ashamed about their experience of mental health problems and …that kind of keeps us going.

Yes, okay, that makes sense, thank you. **How do your personal values influence your job and the way you …seek to tackle it, and I guess I'm thinking particularly…it's always a difficult one to**

approach, but your personal political position… you know does…is that relevant within what you're trying to do?

That is…a very pertinent question, um …right now actually… 'caus er…and I say that because it's …so for me, erm, my values are, as an individual, are about er…making sure that …er that nobody goes voiceless, that's… that's ..always been my thing …and so being able to create a forum or a way in which we can shine a light on things which are hidden…or are hidden away…erm, and being able to advocate and give voice to people who might not feel in a position to do that themselves…is important, but also to be able to…to change the status quo…[audio cuts out] they don't have to be the advocate but that others can be…can do that for themselves, so that that that's so I suppose the … the values sit there…I also have my own personal experience of mental health problems and that …feels very important to me erm…not that I believe that… that the role needs to have somebody in it who has personal experience but it does help…

Yes, that's something I was going to move on to, you know, a lot of people in the sector seem to be informed by their own lived experience …and it must in some ways feel…make it more of a passion really, rather than a job and …inevitably maybe validate the kind of choices that you make?

Yeah, and I would definitely say that that's the case, I think, I think for me the big caveat the watch-out for that is that everyone's experience of an issue is different… and there are lots of there are lots of people …my personal experience is around erm depressio…and there are lots of people who experience depression differently from me because of 'cause of you know their cultural background…or because the life opportunities that they've had …erm…all sorts of things will impact on how that same diagnosis…not that we want to be diagnosis-specific…but will be experienced by other people ….and then the other thing is I can't necessarily speak from personal experience for everybody, so the experience of somebody who is, erm, who might be sectioned …because of their experience of schizophrenia for example…I've never had to deal with that, so I can't … I can't represent that, but I can have some empathy towards it.

Yes. Absolutely. That's a good point isn't it, that you can't represent everybody, but… there is this sort of tendency I think maybe in the media to sort of homogenise mental illness as one thing, as one experience, and it just so isn't that.

Yeah. And I think the work that we've been doing around stigma and discrimination is…over the years has been quite interesting because when we first began we were very very clear about non diagnosis-specific because the thing that we wanted to capture was the impact on people's lives, of stigma and discrimination…and I think that's, I think that's worked really really well, after all we've been, this will be our fifteenth year, and that's worked well, but we've just done a piece of research which, which is about...okay so, are, are there pockets of people who aren't benefiting from the programme that we're delivering, and I think that we have very clear indications that the status of stigma and discrimination towards people with erm, with what we're calling...who are most severely impacted by stigma and discrimination, so …not that we want to get into diagnostics but…for example, higher prevalence of schizophrenia, psychosis, or borderline personality disorder, coupled with a variety of intersectionalities around race, gender, um equality…deprivation...you know, those are…those are pieces of work that we now need to pick up and start running with in the future.

Okay, that's interesting, because along the line I was going to ask about, you know, what's next for TTC…and one group in society that I'm particularly interested in that I feel can often be under-represented is older people…and I wonder if you have plans in the future to …to make that a sort of target demographic if you like?

Okay so…erm...so again interesting er for us in terms of target and who our true beneficiaries are…so, so essentially our target audiences are people who might not be close to the topic of mental health… so

we're trying to get to them, get it on their radar, get them thinking about it differently, recognising their own part in it…and then trying to find a way in which we can almost be galvanising them to championing the cause to go forward. Current currently we work with sort of er 25-45 year olds and also we do some work with young people in sort of secondary school and college age…now there was a very… in terms of changing people's attitudes, behaviours and knowledge, there was a kind of definite decision made in the early days, to kind of focus on that middle group…because we were looking for people who could, erm, trailblaze if you like, who we felt we could more easily change their attitudes of…and once you've changed the attitudes and you've created the status quo you can then influence those people outside of that…who might actually maybe didn't respond to your messages in the first place, they've maybe got very entrenched in their thoughts…they've got very particular, erm, ideas around mental health and people who experience mental health …and so, that's slightly different for us, than, erm, than maybe then thinking about, erm older people's experience of mental health…now. Having said that…[slight shared laugh]…for me, one of those intersectionalities, is around, is around age …so …I think that we can become very dismissive of older age mental health problems, and erm there is almost a kind of attitudinal swing that we might want to look at which is around, er, really fighting to speak up for…older age people who are experiencing mental health problems…who the rest of society think it's just part of the aging process so there, there's a definite piece of work to do there…we haven't traditionally done that and again in terms of our current future thinking that's not, that's not where we're thinking of going in the same way as…my, my passion is …has been the children's and young people's but that's been the bit that I set up …of TTC, back in 2001, and for me, my…the missing piece in that piece of the age range puzzle …is kind of under, secondary school age, because…I just think there's so much work we could be doing there…

I suppose like planting seeds, isn't it?

Totally! Oh absolutely! Absolutely, and they come through and they have different expectations, and you know, never will a workplace, you know, um in the future not be able to talk about what they're doing for health…mental health …that's great, and that's because we've been…w- 'we' not just us, but because the sector's been working to kind of build that up…er and so yes, it, one could argue that there is a missing piece, whether or not TTC is the right vehicle to deliver that I don't know...erm one of the things that we've been doing a lot over the years is er trying to, erm take our learning and er, kind of inject it where people…ask us to do that…so we work with lots of people, other people within the sector or outside of the sector who want to do behaviour change campaigning…and we try as much as possible to, to just pass on all of that knowledge, and, and hopefully help to create, a… er…way in which there's that there's almost like that sector learning or outside of sector learning…so I can imagine that you might have some of the age-related charities who might want to take that on...in which case we would really hope that we could take all of our learning and be able to kind of 'consult into' creating something which would address that.

Yeah. Well that's very exciting… I hope that that happens… it's just so important to me, and work that I've done with a focus group with older people with lived experience of mental illness suggests they do feel a little bit disenfranchised - a little bit out of the loop and they don't perhaps engage much online either. And as well as having a high prevalence of er mental illness problems they are also some really embedded attitudes…so its's a very interesting area for me.

Okay thank you er …I was going to ask you what the connection is...that you see between what you do, as an organisation, and society as a whole, and I'm really thinking about health inequalities and mental health inequalities there, but in some ways I think you've …you've kind of addressed that in the things that you've just been talking about, and you've also addressed having personal experience of mental health stigma…so perhaps, just moving on to the idea of how we reduce stigma in mental illness…**do you think that it's society that has to change first, and what I'm thinking of here is that idea that…that culture is upstream of politics…so, with that in mind, do you think that anti-stigma**

campaigns will…have the power to sort of trickle down an eventual change in political thinking and policy… or is that something you want to do, or think you need to do?

Okay, so I think the short answer to that is yes! The more complex answer is …erm so one of the things that I talk about a lot in terms of the work that we've done with TTC is that we have only really I believe been a successful as we have because we've taken a sort of multifaceted multi-level approach to this so it's not just about …erm you know the social marketing side of things, putting together a film getting it out on, you know, wherever, sometimes TV but sometimes not…t's not just about, erm putting er the voice of Champions – these are our people that we train up, er to speak out…it's not just about doing that piece of work, it…it's really trying to make sure that we are...that first of all we know who our audiences are…that we do stuff that targets those, but that we are doing stuff at that kind of umbrella national level so the social marketing stuff is a really good example of that…that we're doing stuff within communities within workplaces, um within schools or…with that you know youth and …er youth age…so that we're creating change there at the same time …as well as lots of the grass roots stuff that happens because we've got community-based hubs across the country…and we've got individuals who are running their own.. campaigns we…therefore are able to work with corporates to say...what would you like to do on Time to Talk day or what do you want to do as part of our marketing thing… so that suddenly it starts to take a life of its own …so there's that whole multi-level stuff …then, then I think what happens is you empower to demand change and to demand difference…so so everything, the whole ...er and you look at a classic example of this is the BLM stuff…that's just …look at that! Look at how that just exploded!…and people …it's not like people haven't been talking about this for ages…for years and year and years …and suddenly…we ...people sat up and took notice, now …the thing that we then have to do is to make sure that we are …using opportunities like that when they arise…and really…using them to absolute best advantage...and then the other thing that we do, that we...erm personally don't so, but the beauty of having two campaigning charities behind us…..is that we...we work, should be working seamlessly with them ...to make sure that we ..that what we…that the intelligence that we're gathering is feeding into the work that - influencing work that they're doing at a political level...so…I just feel like there needs to be this entirety, and we're lucky that we don't necessarily have to have ...political campaigning arms, because we have that already provided to us …by the work that happens by the two partners.

Yeah, that makes sense, okay thank you. Er, **I just mentioned a little while ago that I ran a focus groups on stigma and I found that most of the participants expressed the idea that …to stigmatise is essentially…it's like a fundamental human trait, and I wondered whether you agreed with that because, I mean if so that's rather depressing…and I mean you might think well why on earth ..how can we possibly hope to address it? I wondered what your feelings are on that?**

Well, I mean you know there is that there is lots of research out there isn't it that sort of states that that's er that that's a truism …erm I…I...per, part of me thinks that that's that's a that's' a very easy get-out clause…for not thinking more deeply about issues and in this case obviously about mental health and how we think… think about people and how we treat other people…I..I think that er, and we see this, and we're gonna as it comes...as we get out of this er, or when we get into this recession proper …that we - we saw this back in 2008, we saw a real hardening of attitudes during financial crisis because people do do that thing where they become very insular erm and there's a lot more com, competition for resources…and those attitudes harden, so that is, that is probably quite true, that it's a human trait …if you're… if somebody is saying that it's a human trait and therefore I shouldn't do anything about it, then then I don't agree with that …I I think that we are, we have licence to choose how we conduct ourselves and how we think and to try to really examine…erm, our response to each other as human beings, and that's fundamentally what this is all about…So, I kind of want to very strongly reject that …and, er, I would say that some of the work we've done over the last fifteen years kind of says that you can undo that thinking ...you can get people, even though this cause isn't

necessarily…directly relevant to them right at this moment in time, you can get people to feel, er, more empathetic to others, to be more tolerant etc. I do believe that it's not a fait accompli.

Mm, yes, that's very good to hear. Thank you. **We're often encouraged to 'raise awareness' of various issues in social life, and I can really see the clear value of education in attitudinal change and so on, but in mental health and especially stigma, what do you think are the limits to what raising awareness can achieve?**

…[draws breath] ..erm…so…I think there are, I think there are lots of programmes out there that talk about themselves as being anti-stigma programmes that are actually about awareness raising…and I define that quote separately to the work that we're trying to do and I say that very er strongly because er again coming back to the kind of multi-faceted stuff, you know you can change… you can change attitudes ...and and…we can change knowledge without necessarily positively changing attitudes or how people will behave [draws breath] … and so it has its limitations, and so …w…education is really really important because people often need to get up to a certain understanding…before they can start to implement some of the changes that you want them to make…if...and sometimes if you educate people and raise awareness they'll say well that's really lovely I now know about it, but I now don't know what to do with that…so you also have to give them a little bit of kind of nudge around okay you know, this is the kind of behaviour we might want to get you to kind of emulate?

So, so for us that's always been really important that we don't stop at awareness and knowledge, that we then think about how to we move peoples.. to think differently about things, how do we change people's attitudes and how do we make sure that we maintain that change…and then we want people to take action so we, we want people to be, erm, thinking and behaving differently…and sometimes that's a call to action around being in your mate's corner…sometimes it's simply about not doing the thing that might instinctively be your response, but thinking more carefully about how can I er how can I hold this person in positive regard, regardless of whether they've just told me they've got a mental health problem or not…and some of that does need erm…almost the herd mentality…so, sometimes in order to feel…it's a bit like what we're talking about at the moment isn't it, with wearing masks, you know…sometimes you need everybody else to be wearing the mask too in order to feel comfortable…wearing it...so you don't want to be…often there are lots of people who don't want to be the outliers…erm, but that they will come on board when the kind of critical mass says…that it's actually not acceptable to behave negatively toward someone with a mental health problem.

Yes I see that, that's interesting… it's all very easy to think that education is the answer, and of course as you've explained it's a lot more multi-faceted than that.

Yeah, and for us I think erm, so both in terms of the education piece, in terms of the, the campaigning government, in terms of media, at the heart and soul of all of that is…is people's personal experience, so, so the massive piece of work that we simply couldn't run without…is our kind of army of champions who are willing to say ...I've had experience, it's felt like this, I …think it would be better if it was like this…or just being able to kind of share 'this is my experience of...er of a diagnosis of depression, or, this is how I look after my mental health, or this is what happened to me when I was sectioned, and this but here was really really negative, but you might want to think about doing things differently by doing this, and that would have helped enormously so...it's the storytelling, and the personal experiences that becomes really important in terms of what we're trying to achieve going forward…and what people …see and what they therefore associate…having a mental health problem …with…so you know, again you know, media, films, have a really big role to play in not er perpetuating stigma and discrimination…because if that's the only place that people are going to get their facts…then we have a really hard job to try to undo that because they have that little bit of knowledge…which actually is often a dangerous thing.

Absolutely, okay. Thank you. Certainly a different train of thought here. **Do you think it's fair to say that the drive to maintain economic productivity is an important motivation at the government level for it wanting to help people with mental health problems?**

Errr…ohh…that's a difficult one to answer! Er…I suppose I'm going to answer this is a bit of a roundabout way…er…in every in every piece of work that we've done, whether it be going into schools, or er going into corporates, the thing that we've had to do is to really try to figure out…there's two things that you go in doing...it's the right thing to do you should do it …there's a bottom line…erm, and sometimes you have to use both of those to…to get people to sit up and listen, so if we go into corporates lots of them are just like…there's an individual in there who's so passionate about this that they want to make the difference…or we go and in say 'if you don't …the cost to your business if you don't do something about mental health in your organisation is going to be this'…and that will make other people, er sit up and take notice so …the questions around is it…is the drive solely around economic productivity? The answer could actually be yes, and that be okay…

As long as you get where you need to be getting?

Yes! Exactly!

Whatever hooks people in?

Yeah. Exactly. So it is, I think it is a difficult to just say yes, and we should [unclear] be, you know…berating them about …I think actually...yeah. And, and for lots of people, er er you know…being economically productive is also good for their mental health, so if… if we're getting to the stage where people feel like they're no longer being excluded from …work, because of their history of or current experience of mental health problems…you know that's not a bad thing either

No indeed, and I suppose the better businesses are doing, the more likely they are to be more accepting and less prejudicial in their recruitment?

Yep

Okay, thank you. **Do you think it's true that, in the way that …mental illness is talked about that in some ways anxiety and depression, which as we both know can be very serious mental health problems….do you think they've sort of become slightly attenuated in the language and kind of re-branded as it were, as 'stress', and do you think that's a problem?**

Er… so we often talk about language as being really important so …er so we talk about not erm trivialising people's experience of mental health problems and I think that there is a danger er, and this is a danger that we're really conscious of, that in raising awareness of, and getting people to think about 'who do you know who might experience a mental health problem?' …well it could look like this, this, and this, and lots of people can identify with periods in their life when they've been anxious about something…Or periods in their life when they've been down about something, so the connectivity to someone who's experiencing clinical depression or anxiety is kind of closer…erm but then we've got to have this big watch out which is that we've got to make sure that people aren't saying sort of 'well, I'm feeling a bit depressed today' because that really kind of belittles the experience …

Exactly yeah

…and so that is a definite, that's a definite danger and…erm.. and yes I think er…stress can be an incredibly debilitating experience, too…but it is often the place that people...it may be even just a place that…a gateway starter to open the conversation for what might actually really be going on with somebody…so from that point of view it's a difficult one.

Okay, thank you. Er, moving on to talk more about TTC specifically, although we seem to have been doing that anyway already –

Yeah, sorry [laughs]

No, thank you! Thank you for that. I suppose these... these things that I'm going to ask you now are a bit more 'nuts-and-boltsy' about how it works and how it worked at the beginning and in the setup of TTC. **I was wondering what you see as being the main stimulus for the initial creation of TTC, and why, why stigma was prioritised, how did that come to be given priority as a policy strategy in mental health?**

Erm…do you mean in the wider sort of sector...or in relation to how it came about to how TTC was born so to speak?

How TTC was born but if you have broader insights then I would value those was well…I was really thinking about how it, you know, who said … '*let's create this thing*', you know how did it come about, what was the…what were the forces behind that?

Yeah, so initially I think, and I think that I'm at risk of repeating myself, that, forgive me if I do, erm, but right at the beginning, erm, as I say, both Mind and Rethink in terms of the beneficiaries that they erm, were set up to kind of serve, people were coming to them, or the sense was, that people erm, people's experience of stigma and discrimination actually became more debilitating to their…ability to get on with their lives than the symptoms of the mental health problem that they had...so, we, erm, we came together as two organisations to try and pull this together, to try and say what can we do to change that status quo and we, we modelled ourselves… or we took an awful lot of learning from some of the other anti-stigma programmes, mental health anti-stigma programmes that had been set up across the world…er… See Me Scotland and er the Like Minds Like Mine campaign in New Zealand um and also lots of the Canadian-based campaigns and in fact we are currently part of the kind of global alliance of anti-stigma programmes…so that's …there's a whole group of us who are all doing this in various countries erm so we looked to them to look at what they'd been doing and that's really where it began.

Okay thanks. **What was it that prompted the decision to give the TTC campaign – why was it important to give it its own website rather than becoming part of - you know a wing of - one of the established parent organisations Mind or Rethink, and especially there I suppose I'm thinking about, if Rethink was originally, had a strong focus on schizophrenia, and if we accept that schizophrenia and other more severe forms of mental illness tend to attract greater stigma, was it ever thought that Rethink might be a…good place in which to position the campaign?**

Erm, I think there was kind of...there was a bit of a practical element in it which was that the two organisations you know wanted to run it but…so therefore it would have been a bit weird if it was predominantly in one and not the other…so there was a kind of practical bit…I think also the fact that you…I think again there was…it was important to set us up something that looked at… that looked very specifically at stigma and discrimination…that then wasn't caught into doing the other things that…the brilliant stuff that both of those organisations do…so it was very much - we are - this is definitely what we are...and this is definitely what we're not… and the ability to kind of …er...to create its own brand and its own website…right from the very beginning, even though we'd done that. We were not really that interested in raising awareness of the brand itself…the important thing was making sure that… that people knew what calls to action were…so….that's always been very interesting to me, that we've never really wanted to…er… the brand was never as important as the work that went on behind it.

Okay…that's interesting, because I was going to lead on to ask **what you think it gains from having its own branding and what…perhaps more importantly what do people gain from aligning with the brand of TTC - and I suppose you've answered that by saying it's about the identity, it's about defining what you want to do.**

Mm...and that independence I think… so you know the ability to be able to sort of … yeah to be completely independent of any preconceptions people might have had about either of those organisations…um, and it's.. having said that it's now become so well known for what it does, both within and without the sector I think as well …that we do actually have quite a few like for example corporates who want to come along and support the work that we do so I touched a bit on that in terms of you know our Time to Talk Day, or our In Your Corner campaigning…so people see, people do see the value of…of erm… of a proven setup superficially around anti-stigma, so it has become quite, it has become quite a you know, has become a life…has created a life of its own …in some ways.

How important do you think it is to have a target demographic rather than to campaign at a whole population level, and how do you, how did you first go about identifying who to go for, wither for a particular burst or in general? How does that work?

Erm…if you have all of the money in the whole wide world…[both laugh] it's brilliant to be able to do a programme that just does everybody erm so what we er did right at the early er days was realise we didn't have all the money in the world and [sharp intake] and that we really needed to make sure that money worked as hard as it could for us. Se one might argue that what we did in the early days was to target those people who we felt were most likely to change their knowledge attitude and behaviour or...or be most open to changing that …erm, and so… and that was where we got to the…and we did a whole load of research on this before we decided on who the demographic was… that we took kind of working age adults…so you, loosely speaking 25-45 year olds erm both men and women - and we didn't do any further real segmenting of audience apart from that to begin with oh and apart from we did B, er sociodemographic groups B, C1 C2… to begin with…and then we, erm, so we ran the programme like that, 2011 we brought in the children and young people's element of it er which was a different demographic and then we did a massive strategic review in about 14… 2014-2015 to look at what had we achieved so far with the target audiences we wanted to deliver to and what was still left to do…so what we'd found was we'd made a lot of progress, erm, in terms of our adult audience, but what we hadn't done is…so...men start slightly lower than women in terms of their baseline attitudes and behaviour…and they basically have gotten better over the years but we've not really closed that gap…so then in 2000 and...well we did the strategic review in 2014, 2015, erm, we said right okay we want to being men along, er...again…on that journey so we then specifically targeted our paid-for advertising, ..to target men but the programme itself didn't stop working with everybody else…so this again , this is where the kind of multitude of different ways in which we reach at TTC and target people, becomes important…so, so our paid for advertising…is, is really er targeted to reach men where they are but obviously we do our Time to Talk day for our warm audiences, those people who are already on the journey who are already, you know, fired up and want to do something…TTT day gives them the opportunity to do that ...so our In Your Corner campaign is aimed at men…and then our owned channels are aimed at the general population…Our, our sort of digital channels tend to be targeted at those people who are our core follower base so oftentimes people with lived experience, so there's a whole range of ways targeting helps you…to, to make sure that you're reaching people through, in the right channels, as opposed to lots of wastage…where if you take a scattergun approach, you, you might hit some of the target audience but actually …a lot of the stuff will just fall by the wayside, so it's a really good way of being abler to do that, and then, the the final thing is that if you've got a target audience it's more, much easier to evaluate the impact you've had on that target audience …because you can ask people if they've seen it or if they recognise it, did it make them want to do something differently, have they taken action ? And so we can see… that that change has happened.

Yes, are you getting through to them? That's interesting, it's very easy at first glance not to be aware of the whole patchwork of things that are feeding into each other, but you've explained that really well, so thank you. Erm,…I think we've also really covered my, my bugbear about older people erm, not

being a major consideration and you've talked about how hopefully there'll be plans to make that a focus later. Just looking briefly at the idea of sharing mental health stories, **it's been a really important part of mental health activism for ages, erm, but one thing I noticed on TTC is the, the sort of editorial policy rather than having a sort of holistic, tell it all kind of approach, in terms of excluding - or at least not welcoming - stories which are specifically about mental health treatment and systems and policy, and the website explains that this is because of the campaign's aims. But that made me think that okay, with the aim of ending mental health discrimination …how then does that…how would it be counter to those aims of somebody wanted to talk about discriminatory treatment…that's what I'm getting at. Does that make sense?**

It does, it does, erm, and this comes back to targeting actually, and back to evaluation, so …we're set up to look at… to change the way that friends, family, and community attitudes…that's what we're set up for…and we were set up for that because when we first went out and we did a massive piece of research erm with 4000 people with personal experience and 1000 carers to find out what their… what the social need was and what people felt were the …experiencing most stigma and discrimination and the …top three or four was friends family…workplace and erm in the community… within that there was also health services…so we were…we chose to go down the community-based family-friends and work colleagues and so therefore - again this is back to making sure that the stories we tell and the issues we cover resonate with the audiences we are trying to change...so whilst I completely agree with you …talking…and this is one of the things we're thinking of in the future…talking about treatment within mental health settings for example or the attitude and behaviour of healthcare professionals…doesn't mean that that's any less important…but if we did that…we…we...and that would in and of itself be valuable …it doesn't help us to deliver what we've been asked to deliver by our funders…er which is around family, friends, community, and organisations and work colleagues…so it's really that simple… it doesn't mean that those things aren't important, and again some of the work that's done by the two partner charities covers some of that sort of stuff…yeah, but we do recognise that that health care and the health system is a big job and one that needs to be tackled at some point and we're thinking about that in the future.

Okay, thank you, that does explain it because I couldn't work it out and I wondered, is it that TTC doesn't want – you know, just wants those to be positive experiences only, and I thought no, that can't be right…

But…but that is an interesting thing around, you know almost the, the positive experiences only…so for a lot of people, erm, the stories that we share are often about hope and they're often about the fact that people have recovered, and we want to sort of say, we're trying to say to people, that, that erm…because some of the myths around mental illness are that once you get it, or in the early days anyway, you know you've got mental health problems they never go away…and actually you are a lesser person if you've got a mental health problem you know… you wouldn't be left in charge of your neighbour's kids… you know… you wouldn't be expected to have a job…you know all of those things…and so the way in which we erm counteract those myths is to replace them with people who are achieving all of those things…and achieving them well… the slight downside of that is that you might come across as being a little bit too positive because people have awful awful experiences…and oftentimes when we're getting people to come with us to do training and support, particularly let's say in an…in the very early years before TTC I ran a project that was going into medical schools for example, and working and bringing people with personal experience with me to talk about the experience that they'd had…in the health system… to trainee psychiatrists and to medical students…frankly if they'd really told you know, if they'd really told the story in that way that it felt for them and was experienced by them, the risk is, that people who don't want to hear that message find an excuse not to, by saying well effectively you're just perpetuating my negative stereotype of who people with mental health problems are…so, we worked with them and trained them really, erm…trained and supported them, to - not sanitise their story - because we can't take away the awfulness that happens to some people, but we can help them to couch it in such a way

that they are able to bring out the, the salient points that mean that people want to hear more ….rather than go…that does not resonate with me and I'm in denial, I'm in denial that that even happened. So it's quite delicate balance to kind of get the storytelling to do the job that you absolutely need it to do, but it doesn't take away from the fact that people often have horrendous experiences, I mean really awful horrendous experiences.

Yes, really shocking. And it's not so simplistic as I perhaps thought it was, it's obviously very finely tuned to get that …the right balance in the narrative that you want to develop.

Yeah. And it's so nuanced, I think this is the thing around anti-stigma work, you know that I've picked, I've sort of learned over the years, is that it's so nuanced, and actually trying to explain how nuanced it is ...is quite difficult because often people don't have, you know, an hour or whatever it is, to completely understand it? You got to try to get that across, so anyway, but yeah, so yeah.

The more I learn about it, the more fascinating it becomes…because it's complex and it's …it's a kind of weird machine [sighs]. I think really just the final few questions, I mean we could talk for ever, and you don't have that much time, and I'm very grateful for the time you're giving me.

That's fine!

Just looking at what TTC has achieved, since the beginning are you confident now that there is evidence now that there really are, long term cumulative shifts taking place in public attitudes and knowledge or is it mainly that you see post-burst improvements; what are you most happy with really?

Erm so, so I think that we can confidently say that we're seeing long term change, so at the very beginning we, we worked, we continue to work with the institute of psychiatry and - I always want to say neurology – but, I think it's neuroscience, at King's College, so they've done our evaluation for us, our top line evaluation for us…so they look at, changes in erm knowledge attitudes and behaviour scores for us and we know that we've seen a kind of 12.7% increase in positive attitudes, and post-burst we look at people's willingness to take action, so the kind of behaviour-based stuff, so the, the one the other one thing that I think has been incredibly important to us has been making sure that we are absolutely evaluating, and spending lot...a fair amount of resources and time, to get the evaluation right because ...this is too much money and too important not to be able to know we're making a difference…so I definitely do think that there accumulative changes…I think that if we look back 20 years, and it's not all down to us, but you know we did…capture erm attributable kind of data too, but if you look back to 20 or 30 years ago, you wouldn't have had a royal, talking about their personal experience…you wouldn't have had people standing up in parliament talking about, you know MPs talking about their experience, we would have had, we probably would have had, erm, celebrities talking about it but I think people were much more reluctant to begin with, so we are much more open to the topic of mental health…and I don't think that we can put that genie back in the bottle, and neither should we…and, and so I think that the biggest risk, and that we've got to mitigate by making sure that we embed this change, in organisations, in culture, in society as a whole, in empowering people who've had experience in mental health problems to step up and speak out and feel proud to be able to do that, challenge that when they see it and hear it, in terms of stigma and discrimination…the risk is, is that if you do, and this is a big question, if you do nothing more, if in March next year when our current funding comes to an end, there is no more work on stigma and discrimination, from TTC or example…do you risk some backsliding? And that is a million, literally, a million dollar question...and one that I suspect that we would see some fallback, because you can't expect ...especially now... it's sort of inevitable isn't it…

You suggested earlier… a rise of individualism and a hardening would be the very worst time to change things?

Absolutely

Do you think that you will be part of the sector for the longer term or is it something you're fighting for?

So, as with all of the sorts of things, the work that we've been doing in the last year or so has been …we went out with another survey of 5000 people and 1000 carers, we did a whole heap of stakeholder and desk research to really figure out the next…what we should do next, so I think we've got a clear remit? About what we should do next? Erm, and the need hasn't gone away, and that was taken last year before coronavirus. We're going to have a whole new cohort of people who have never experienced mental health problems before but will, and they're going to have a whole cohort of people who sit around them, who hopefully will have more positive attitudes than if Covid had happened 15 years ago …but there's going to be a whole group of people who …also we're going to have to talk to them about their knowledge attitudes and behaviour, towards those people who now coming into their lives are experiencing mental health problems…and for me I think the big, the big piece of work that I think needs to be done, is that we need to make sure that we're bringing along with us those people who are most severely impacted by stigma and discrimination. I think that the work we've done up to now, has been absolutely spot on, because we were, we needed to, we were at a stage where mental health wasn't on many people's…we live in this echo chamber, don't we? But - it wasn't on everybody's radar in the way that we hoped it could have been…It's now on more people's radar, but there are still people who experience schizophrenia, psychosis, BPD, who have got, inter…you know very severe intersectionalities, who might come from, er you know backgrounds that are more er…culturally diverse, who might be experiencing deprivation on top of those experiences, and that's I think the next big thing for us, we've got to maintain the work that we've done already, and then make sure that we bring those people with us, so that we can genuinely say that everybody who's experiencing a MH problem, doesn't need to feel afraid about that…doesn't need to feel afraid about other people's actions and reactions to them…that we can all feel that we can feel confident about having a conversation with somebody who says. 'I've got schizophrenia' and it not being a conversation ender…but one that just continues. That's what we really need, and that's my, that's my big vision I think for the future. So fingers crossed, so we're writing the bid, but at the moment nobody wants to talk to use from our funders, because they're all a bit busy doing other things [laughs]

Oh god, that's …just agonising

Watch this space!

[I express thanks, draw interview to a close, friendly farewell]

Appendix 2.5 Interview Transcription T3/Mind

[Greetings, thanks]

Well erm I'm really pleased that you're doing this piece of work, so this is entirely a pleasure for me, so erm that's fine and I'm sorry I haven't got more time to talk. I'm sure you'll be gathering lots of different information from lots of different people, so erm, yeah…

I have and you're rather the culmination of it

[both laugh]

Okay, right [laughs]…presumably then you've got some really clear things you want to ask me

I have, in fact the problem is that I have too many things to ask for the time that's available so what I'm thinking is we kind of need to go for breadth rather than depth, so I'm afraid it's going to seem a little bit quickfire …just to get the information that I really value from you, so it's not intended to be impolite or a grilling style, it's just making the best use of your time.

That sounds perfect

Okay thank you. Well there are general questions, and others which are more relevant to Mind or to publications you've written or to TTC, and I just need to say at the outset that of course you're not obliged to say anything on a certain, subject, you may just think 'off limits, let's move on'

Sure, yeah, yeah

Thank you. **So first of all, how do you define your role and your function, both in Mind and with other organisations?**

Er so, um well I'm the [role redacted] of Mind, and as such I have a kind of strategic responsibility both for Mind as a national, I mean a very specific responsibility for Mind the national charity, but also for erm the Mind federation which is a network of about 120 local or independent organisations that affiliate under the Mind brand, so not the running responsibility for what happens in those organisations but I am, I do have a strategic responsibility for them, and as, I suppose as the [role redacted] of the largest MH charity...I er, I think we have a responsibility to work collectively and collaboratively with other organisations across – well, not just across the mental health space, but for the purposes of this question, inside the mental health, er arena, so, because we, broadly speaking, share the same aims visions and objectives which is to improve the quality of lives of people who have mental health problems and in some cases work with even wider audiences than that but you know I take a very, I've always taken a very holistic view that you, it's not about the organisation it's always, it's got to be about a cause as well, and the cause comes first.

Okay, thank you. **Do you think there are…I was sort of wondering about how …these organisations connect with society as a whole in terms of inequalities but specifically mental health inequalities?**

Do you mean the mental health organisations more generally or Mind specifically?

Let's say Mind specifically

Okay, so, so again at a national level we have a very clear overarching goal around tackling inequalities, it's one of the five pillars of our organisational strategy, and I think you know in a way it's

also more than that, it's a, it's deeply rooted in our history and heritage because we've, you know in a way we've all been given...and you know part of our job is to give a voice to the voiceless, and you know back in the fifties and sixties that was people who were in asylums and now it's asylum seekers…or you know people who are black and ethnic minority…So I think we've always had a track record in that, I think we are …acutely aware that we haven't done enough, but …we haven't been as successful as we would like to have been, but …that doesn't mean that it hasn't been and organisational, you know a key part of our organisation. And then at the local level, I think one of the great strength of the local network I think that because they are local organisations run by local people for local people, that they are almost, well they are by definition, embedded inside their communities, so you know, the local Mind is really I think ...really at their very best...are...have deep roots within their communities. So, you know the best example of that for me…especially at the moment with you know that Mind in Tower Hamlets and Newham do, especially with the Somali and Bangladeshi communities is...which is...so Michelle who runs the local Mind was telling me that 70% of people who use their services are from a black or minority ethnic, Asian, mainly Asian community, um, as are 70% of their staff and volunteers…so, you know, they are really embedded in their communities.

Yes, real grass roots representation isn't there?

Yeah, and I think the other main point to make of course is that when we're talking about inequalities…our primary lens is the inequality experience…by people with a mental health problem. So the people with mental health problems' experience, inherent experience…and many people talk about, and obviously we're talking about stigma and discrimination later, but they also, you know, people with serious mental health problems are 20x more likely to die early, more likely to be not in work…more likely to have problems with the criminal justice system, so they …er… this is a group that experiences…discrimination, you know in and of themselves, but …which is then exacerbated if you also have, you know, if you are a young black man with a ...suffering from schizophrenia for example.

Yes, yeah, okay. Um, this is a bit of an odd one, but you'll see where I'm coming from. **In the attempt to reduce the stigma of mental illness, do you feel that it is society that has to change first, and what I'm thinking about there is, this idea that you know, culture is upstream of politics, and that – what I'm thinking of is therefore – can, do the mental health organisations, are they able to sort of have a trickle-down effect on government on policy, in that way?**

Yeah, I think, I think our, our objective is not to not to change government but to change people [laughs] and people, people are er, so if you define if you want, if society is made of people so we are, you know, the work that we're trying to do in this space is direct to, to the public…um, er…clearly government have a role to play in er, in the case of TTC in funding…er the programme and also government as government has a role to play in terms of the actions that it chooses to take in relation to people with MH problems, but um er um, our overarching interest is in the relationship between people with mental health problems and other people [some awkwardness, wry smile].

Thank you, that makes sense. **I ran a focus group on mental health stigma, with people who had experience of mental illness and mental health stigma, and they felt that stigmatisation is essentially a kind of fundamental human trait…now is that something you'd agree with, or would you reject that? Because if it's so fundamental then how are we supposed to address it?**

Well I mean there a quite a lot of things that people have got the capability of doing, …and they choose …to do it or not…So, so yeah, absolutely, we, you know, absolutely human being have got the capability to, um … ...show stigma against or discriminate against other, fellow human beings, and absolutely, that's something that we all have the innate capability of doing, but, er we also have the capability to not do that, because we live with our neighbours, you know, we, er you know we operate in a community, we will, we may...internalise opinions about individuals or groups of people but not articulate them, so behaviour...so this is why the, you know, erm successful anti-stigma campaigns look at knowledge

attitudes and behaviour, yeah? Because you have to, you have to work on all three if you're going to make progress, but unquestionably…you can reduce stigma, can you completely eliminate it [moves head from side to side in deliberation] probably not? But can you, er, can you significantly reduce it? Absolutely.

Yeah, okay, thanks. **What do you think about the idea…we're often encouraged to raise awareness of various problems in social life, and I'm wondering with mental health stigma what do you think are the limitations to 'raising awareness'?**

… …

I mean I suppose it partly comes down to what you were saying just know, that there are these three strands to stigma reduction, but it seems that the whole 'raising awareness' has become a really kind of embedded trope [smiles in response to smile] and I wondered how useful you think that is.

Well…erm, er …I think, I think we have always…taken the view that…it is important to do awareness-raising activities, because… and particularly in this sort of…phase…for want of a…you know you have to take a long view…you know, taking a long view...quite often I go out and about and quite often I do presentations and talks with you know groups and one of the things I often ask a groups of, mainly, adults, is, you know, put your hands up if you had any mental health education at school, erm and very very [shakes head] it's very very rare for anybody under the age of, over the age of 20…to say that they had any mental health awareness training at all…so we're playing an enormous catch up exercise because of, I mean because of the stigma and discrimination in previous generations, we're playing this enormous catch up exercise where we're trying to change, we're trying to work on, you know…actually have dialogue with the whole of the population …interestingly young people, if you go and have a conversation with a group of young people, they're more likely now to say, yes they have had some sort of conversation about mental health at school because, you know...because some of this stuff is percolating down, it is percolating…so I think you know there remains a role for awareness-raising activity, but I also think that, and I think increasingly that will inevitably become more and more targeted, as we get a better and better, as we see better and consistently, sound levels of knowledge...because aware…in my mind, awareness-raising is basically influencing the knowledge…to influence the knowledge part of the…suite …and that to me is the distinction between a, you know World Mental Health Day, or Mental Health Awareness Week, but ...all of which are, of course they are, they remain really important, but they are, they are trying to improve our knowledge and understanding, they're not really trying to change our attitudes or behaviour, and that's why you, we you know we articulated the need for distinct, anti-stigma ...anti-stigma campaigns that, that target, you know that seek to try to influence attitudes and behaviour … [laughs] *and that's a little bit of a dancing on the head of a pin…for lots of people, because lots of people tend to look at these campaigns and go well they all look the same to me...but…they're not.*

No, I can see that... there's quite a lot of confluence and overlap, but I can see that there are individual characteristics in different campaigns. …**Thinking more specifically now about Mind and reports and publications you've worked on like the Thriving at Work Review and the Five Year Forward View for Mental Health. Um, reading the Thriving at Work Review there's quite an emphasis understandably on the economic costs of mental illness…I wondered whether an emphasis on costs can be a mechanism through which government funding…for mental health services, can be increased...or do you think conversely that the drive to reduce the burden of mental illness is one of the government's prime motivations in workplace mental health?**

Erm… [holds face] *yeah that's an interesting question I mean the...one of the reasons...I think the reason why we wanted to focus on cost was…because...um… people didn't understand the cost* [laughs] *so there was an absence of understanding of the issue…and I think that was as much as a driver, for, if you want to use this phrase, the boardroom...of companies…as it was necessarily for er, a kind of*

driver…for government to increase investment in mental health services …however, once you start talking about the economic costs ...to the country, and not just the individual costs to individual employers, you are, you know you are, we are absolutely making a broader point about the necessity to invest in mental health…in the round, and mental health services are part of that, and you know I think one of the things we've seen, we've observed, over the last particularly the last few years, is as people become more aware of mental health and mental health problems, that they are, amongst the public, there is an increasing sense of well, you know, concern ...and at times outrage...that the experiences of people with …of the NHS… for their mental health is so much worse than their experience when they go for physical health support. So I mean and that's driven by, so then people want to know why ...and you know you're marshalling a set of arguments for why the government needs to invest more and more in… in effect, you know, good quality mental health services.

Mm, okay. I suppose because there does seem to be an emphasis on working age people I feel that often older people are often not targeted for support or at least not uniformly, and ..clearly there's plenty of evidence of the prevalence of depression for example in the over 65s and of the lack of services available for them...and **I saw that Mind had a project called *My Generation* in Wales and…**

Mmm, Mmm, very cool

…that seemed to be very successful …and I wondered whether…are there plans to roll out something on a more nationwide basis for older adults?

Yeah, I think um...I think your assertion is broadly right, that erm non-dementia-related issues amongst older people are often under…under played erm and I think the really big shift, the big policy change for this …is embedded in the long term plan, where there is a very explicit commitment to all age, er all-age services, and the best example of that is that when IAPS (Increasing Access to Psychological Therapies) was set up, way way back now, it was really only a working age adult service? And the reason for that was that it has been argued on an...economically beneficial basis…i.e. if you get speedy access to psychological therapies for people who are in work they will get back to work quicker and therefore they'll be more productive to the economy…and the original argument was not focused on improving the mental health of older people…now that now changed, so, you know...so services are you know, age…er neutral, I think that's the word we use now. Erm so I think, I think that's a big shift…and erm you know yes, if further funding was available then we would absolutely like to expand services like My Generation because I think they've, they, the evidence base has shown that they're really beneficial.

Absolutely, well that's good to hear. Okay, I suppose again this (question) relates to who is prioritised and who is not…I was just looking at the Mind website the other day and inevitably it leads with Covid, and **I'm wondering if perhaps this has led to a change in priorities in terms of who will get support, because if we have a lot of people with pre-existing problems who are badly impacted by covid, and a whole lot of fresh depression and anxiety which are the result of Covid; what do you think the implications are from in in terms of the spread of services, you know, how is this going to be dealt with?**

Well, um that's why it's top of our campaigning list! I mean I think, um I think in many ways you know what we wanted to …what we wanted to help people think about was the mental health dimension of coronavirus and that's been, that applies you know across our three core areas of the impact on the public…people without mental health problems at the moment, the particular impact on those people who are at risk of developing mental health problems, and then the impact on people with ac – existing, pre-existing mental health problems, and I think you know increasingly the evidence is telling us that in all three cases there has been ...there has been an impact, interestingly the overall impact on the public, on the…is probably slightly less than we were necessarily expecting…erm the public have proved to be quite resilient? Erm, if the ONS data is correct, erm however ..however there are definitely

the at risk group, which is a big group, have fared…again the other ONS data that was published last week suggests that we are seeing, you know, an increase in new cases, and more people moving from, if you like, struggling, to being unwell…and um then finally our survey showed very clearly that people, for people with existing mental health problems that their mental broadly speaking got worse…you know and that is beginning to play out, in some of its presentation now, so I think, you know, um what does this mean for us as an organisation? I mean first of all it requires us to you know to be really clear in our articulation to government about what they need to invest in, and that's hence our five tests, erm, but secondly erm we have to think, and organisations generally have to think about what we can do, but the you know the slightly disturbing reality is that what we see coming down the line is an is almost certainly an increase in, a further increase in the prevalence in MH problems, and so, you know we have to support the you know further gearing up or services and others to be able to cope with that increase in demand at a time when resourcing is incredibly tight.

Yup, yeah. It's worrying isn't it. **And with PHE being dismantled and reframed and so on, will that have an effect on mental health services do you think? Or do you think that certain activities will be preserved, and ringfenced, and there won't be any changes?**

Too, too early to say I'm afraid, at this stage, erm it's fairly unclear, but I think, I do think, I mean there's a really strong need for a very, you know for a public mental health programme, whatever shape or form, whatever happens to the organisations, and I think the task here is really to articulate that, you know, what that public health programme needs to look like in the next, you know four five, so yes, that's what we're doing…we're working on at the moment.

What do you think could be the implications for the UK as it leaves (the EU) …as it becomes excluded from those European frameworks of (mental health) strategy and policy …things like the ROAMER project[74]…will it still try to be aligned with those principles? Or are things going to fall apart… how do you see that panning out, with Brexit?

Erm I…health as you know is substantively devolved…has been substantively devolved in European, you know in the European union, erm I think there is an interesting question about …the work, you know the ability to work collaboratively on thing like public mental health and um obviously on tackling things like stigma and discrimination there are some good things already existing, like the GASA, the global anti-stigma alliance, and they, you know I think they're working very well together, so …I think probably in that sense, Brexit is likely to have less policy impact …on mental health…I think there's a much deep question on the impact of people and communities that is, you know, that is being, that will be played out over the next couple of years, and the impact of people's mental health in that context I think is you know…is important

Absolutely, yes. **One element of Mind's public engagement is about members of the public sharing their stories online and that, it seems to me, has always been an important part of mental health activism and of giving voices to people…but I've noticed that Mind, unlike TTC, is far more open in terms of what it allows people to express. For example it allows people to express their difficulties in accessing treatment, or experiences of inequality, in a way that TTC doesn't, and I just wondered how those different…editorial roles if you like, about peoples blogs and stories had evolved…was that a conscious difference?**

Erm, yes...that's an interesting question. I think er, I think…

Mind is more holistic is what I mean.

[74] Roadmap for Mental Health Research in Europe, Funded by the European Commission.

Well I think what Mind well yes I think first of all there's an...it's important to be clear about the nature of the relationship which is of course that TTC is a campaign, owned by Mind and Rethink Mental Illness, so therefore it's not, it's purpose is not to do the same as Mind and Rethink Mental Illness, its purpose is to be very specific on tackling stigma and discrimination, and whereas Mind is obviously, you know we've got a broader waterfront and our organisational purpose is obviously you know to ensure that everyone with a mental problem gets support and respect and so therefore we will absolutely, you know, you know we explore many avenues and you know as you see… as you see we cover a lot of ground … so I think in the context of … of where and how we *operate, and how the TTC team operate their approach... it is heavily erm driven by erm …by a combination of lived experience articulation of of stigma, and very specifically stigma, and also really …utilising the, erm learning from, er …audience led um social marketing techniques… so you know it is, I mean it's actually a very sci…I mean it's one of the most evidence-based pieces of work we do* [laughs] *erm because it has you know a very strong, a very strong, it gathers … evidence… you know all the time…*

Yes indeed

…about the… I'm very much hoping you're having a good old dig in the evidence because one of the things that worries me is that we create all this great evidence and people don't really look at it because I think it tells such an interesting story about what does and doesn't work and…you know but also the approaches and I think that in terms of the public face of TTC it's very led by, you know it's influenced by trying to deploy… the messages and techniques that will enable the change that… we want to see, in those people who are receiving those messages. So, you know, and so, whether you know in the history …I don't know if anybody has given you, I don't know, have you talked to [names redacted]? I'm sure you have.

Yes, I've spoken with [names redacted]

Right, so you know I …in the history of the TTC sort of story you'll see that the tone of voice of the campaign in its early days…was very, you know was very ...kind of, you know was quite, some people found it was quite gentle and too soft, in inverted commas soft…and that's because when we went and talked to people about their exp…to the public…and remember that the target audience here is not people with mental health problems …but the public...and the public had really had not thought at all about, they really hadn't thought much at all about mental health at all, let alone the idea of the concept of mental health stigma and discrimination so we, what we try to do in TTC is to you know to start off by introducing you know some pretty basic ideas which are more in the knowledge - you know the 1 in 4 ads all these kinds of things - were more in the knowledge phase because we knew at that point that the pubic weren't even ready for a conversation about mental health stigma, they just weren't ready they couldn't connect to it ...it was too much...so you then build on that into the phase, the phase that we've run where there's more explicit discussion...of people's experiences around stigma and discrimination and equally...for the public… we learned that the way to improve behaviour and attitude change well...I'm being very generalistic here so you know but [waves hands in front of face] was to ...show them the right things to do so it's not that...you know, it's not, going back to the original point you know I think what we found was that there wasn't a… that once you had opened up the awareness, there was a sense of going…of people saying, oh okay, I understand this now, but I don't really know what to do?

So how can we do the right thing, so you know, be In Your Mate's Corner…or whatever it might be...help me do the right thing for the people around me, and as you just, you know I'm sure you'll have seen, the most positive impact, in terms of attitude and behaviour scales, have been on the way that people relate to friends and family and people around them so ...that's [laughs] that's quite reassuring because that's sort of what we've tried to do in the campaign...we've said to people here are the things that you can do to help your friend…You know or your family member.

Yes, okay thanks. **If the target demographic for various campaign bursts or whatever in TTC are always geared towards those people who are less acquainted with mental illness, who have less exposure to it - and I can understand that they're an obvious target demographic - but what then happens to the idea of self-stigma? How is that then dealt with in parallel?**

Yeah I mean I think self-stigma is a huge issue and I think that's something we've really seen in the context of Covid, with people self...so not just self-isolating as...alongside the rest of the population but actually in many cases, you know, going further in their isolation...in their sense of isolation …and so that's ...part of that is self-stigma so yeah I think sitting alongside that has been you know that's why the work of, I mean inside TTC, the work of TTC Champions and the creation of platforms to encourage people to, in inverted commas, come out to talk about their experiences for the first time, and I think that has been ...in...and again I think our evidence base tells us ...that those personal interactions have been as powerful, so you know as more people become more prepared to become more open...at an individual level...then others are encouraged to do the same ...so...and so we create the space for that to happen but we do that in a way that enables people to, you know that does enable people to do that, so, but you know we're not forcing people, our strategy has absolutely not been to force people into that space but it's been to create the space for people to do it in a safe and comfortable env…you know in a way that is hopefully safe for them…and you know to create an element of protection, if something goes, if something goes wrong.

Yes. **You mention the Champions, um and they're obviously a hugely important part of the strategy and the way that you roll it out in TTC. Now there will have to be shifts in the way that those Champions operate, under Covid, to be safe: how do you mobilise this, this his force, this network in the community, how do you then shift the way that works. Or will you have to re-think Champions altogether?**

Yeah I mean I think it's been really hard I mean a lot of um, a lot of the essence of the concept of social contact is the ability for you to have a face to face conversation with somebody...and a human based face to face conversation as opposed to a kind of screen-based one, but er you know I do think we're really interested to see the effect of digital action in terms of you know does that have the same effect and er and I mean I know that people like Graham Thornicroft have looked at this and I think there is some quite interesting evidence around that, erm, but I don't, yeah, I mean I think our sort of starting point would be can we, can people be empowered to do other things in other spaces? But in ..and obviously this is all a question of you know how long, how long we are going to operate in the current way we're operating, I think in the, if it, if it doesn't go on for too long, I would hope that we haven't lost ground, if you know what I mean. I think we'll be able to pick things back up, and certainly some of our evidence is telling us that erm you know erm…people. Public awareness of mental health has been heightened as a result of Covid.

[Interviewee has further meeting, suggests continuation later in the day: arrangements made] End of Part 1.

Part 2

[Restart, greetings, thanks]

I just wanted to talk a little bit about the way mental health campaigns are quantified, because I appears everything is quantified whether it's the Mind report in the last couple of years quantifying success in various aspects of its...strategy; certain percentages achieved, a certain percentage yet to be achieved...and it occurs to me that maybe the need to quantify success, as part of proving the worth of an organisation in order to secure funding, has sort of driven you all down the route of maybe being a little bit more corporate in your behaviours than you might actually want to be?

Laughs

Perhaps you can't possibly comment!

Well if that's not a leading question [smiling]. *Erm...I mean er, I think there's, I suppose the slightly…I suppose the way I'd reflect on that would be that you know we try to tell our story in a whole variety of different ways...and you know some of what we do is, some of the way in which we tell our story in...things like our corporate report, the…you know, there are both regulatory and ...to some extent yes, donor expectations about reporting…you know, numbers you know…whether finances, or number of people reached, or achievements or whatever, so I think, I think those you know, the annual report and those kinds of corporate reporting mechanisms are there to sort of achieve that and you know I don't, I don't think that's a bad thing because you know donors… you know charities don't exist without their donors and so donors want to see the differences that you're making and for some people that's measured by a stor…you know an individual story and for other people that's measured in a more numerical way. So I think, I think what we try to do, in our, you now we certainly try to do this across our public communication, is to talk about what we're doing at a number of different levels so our, our social media field I think has got a lot of human content in it which is telling a similar story but doesn't have the same…emphasis. You know so I think it's a bit to me it's slightly horses for courses and I think, I don't think we should be too, you know we're a large - in the eyes of most people - we are large charity and people… there is quite a high expectation, an increasing expectation in fact of accountability so we have to be accountable in a whole variety of different ways and I don't...I actually think that's a good thing, really.*

Mm. No that makes sense, okay thank you for answering that so honestly…some of these questions are a little bit challenging.

[Laughs]

One thing I've been trying to get to grips with is, the specific stimulus for a specifically anti-stigma campaign, for TTC, you know people tell me 'that's what people with mental illness were telling us was a problem', and yet so much of what I hear and read is that a lot of people who have mental illness...really the thing they're most concerned about is getting access to the right kind of support in a timely way, so that confuses me, and I've also been told… 'well it was important to keep up with the global movement', a kind of global turn, if you like, towards anti-stigma…but I'm just wondering how you see it?

[Laughing, inaudible muttering]

How did stigma become something to address through policy, if that makes sense?

Yeah, erm, that's a very …there's a lot, this could be very long answer so…

It's an important one for me so I'm happy to listen.

[Amused] I think, I mean I think, so there are ..so at its heart there are two kind of ways of looking at this you know that...broadly speaking the way we translate it is to think about people getting support and respect…so totally agree...that for many people…many many people with mental health problems say the most important thing is I get good quality ...er… right place right time...right quality access to services and of course that's really important...and so that, in the context of what we're doing is a really big part of what we're doing all the time, you know that's ...we're [always] trying to push that on further. Erm, but on the respect side, what we've done and I haven't got the numbers to hand but I'm sure we could dig them out somewhere but consistently, what people were also telling us was that yes they do want access to good quality treatment but they don't want…but that's...simply a means to an end, the end is being able to live a life as an equal citizen in our society and so on that side of the fence, if you like, are things like access to a job, decent housing, er...good quality relationships with your

family and your friends, etc., so that's where the, in that space that the whole sort of, what was not, what were people not getting in that space, what was it about what people were not getting…er well actually what one of the biggest problems was …the impact of, of stigma on people's lives, and some, whether that was institutional stigma if you like, or personal, you know, people's personal experiences, so you know that's, that's the sort of genesis of it um, I think we, as an issue, as a kind of concept, obviously it's not new, it's not unique to mental health, it's something that exists, has existed in many other sort of both social movements but also...health movements, to some extent, so it wasn't, it's not new to mental health, but I think in mental health it's always been, well not always but it's something that has become …became increasingly clear once your, once you work your way...as we started to work our way through the closure of the asylums, I mean this goes way back …The closure of the asylums, the kind of way that things like community care was covered as a topic, the kind of association of violence and mental illness, all of that, all that …all connected.

So there was, and so, I suppose where do we go...somewhere in the 90s I suppose, there were a couple of …there were some early attempts to do something about this, and er whilst – and it is certainly true to say that New Zealand - the work that was done in New Zealand pre-dates the work that was done in England, but NZ was really the only place doing.. it wasn't a global I mean it certainly wasn't a global movement…but New Zealand were doing good sort of interesting work in this space and so, so you know I'd attribute the shift from this being something that people talk about to being able to have a programme to four, four things, one was the fact that New Zealand was giving us an evidence base, because you know people were actually quite sceptical about can you, can you actually change people's minds on this, can you make a difference, you know?

So that was the first thing, so New Zealand was giving us hope that it was possible, the second thing was the increasing rise of the voice of people with their own lived experience who were more prepared to talk about their experiences, so…a kind of growing group of people who wanted to do more work and you know the, one of the original partners for TTC was Mental Health Media, a really great user-led mental health charity that gave people a voice in the media, so that was a really important part of the programme...um, the third bit was …the third dimension was a bit of a …was an opportunity, were Comic Relief were looking, actively looking for a ..er a kind of programme of bigger ambition from what they'd funded, because they'd funded mental health pro- advocacy programmes in the past...initiatives in the past, but they just hadn't got...they hadn't really had any effect …and then the fourth thing was the sort of confluence of people from different organisations who were prepared to get together and say, hang on a sec, we're not going to – none of us are going to go this on our own, we all need to work together ..and we need to kind of put aside our 'brand' interests if you like and we're going to do this in partnership, so you know I think it was those four things together that created the conditions to then go from, you know, something that was a good idea to ...and was interesting and was clearly wanted by people, to something that you, that we could then get funding for and deliver at scale

Okay, that's really interesting because obviously I knew that Comic Relief was a key funder, but I didn't realise that they'd been part of the generation of the whole thing.

Yeah, yeah, I mean they're a really good example of you know really proactive funder partnership relationships.

Okay, well that's really interesting, so thank you for that. **Could I just ask a moment about the FYF view for Mental Health which I know proposed quite a lot in terms of stigma; are you happy with… what has happened since the FYF view? What have you seen accomplished in that time that has been important, or you what do you think still needs to be achieved. As it was *Five Years* Forward it's a good time to sort of have a retrospective on that…**[75]

[75] Published 2016; interviews conducted towards the end of the 5-year policy period

On stigma or more broadly?

I think stigma specifically

Okay erm… well, you know the FYF view contained a pretty straightforward kind of set of recommendations about shifting…to shift public attitudes, and I mean I think that er… you know the data to date suggest that positive upward movement has continued, so that's very encouraging. Er we've got another erm, er… the next wave of evaluation is toward the end of this year, so we will see whether that positive ...you know, the kind of continuous positive – I'm sure you've seen the graph?

Yes [nod]

…continuous positive shift is sustained, erm …so I think on that, on that sort of score, we can, you know I think we can be reasonable happy that erm, you know there's been a kind of added momentum in some ways to some of, you know some of the intentions that were in the FYF view, so erm obviously there was the sort of impact of other, mental health campaigns like the Heads Together campaign and so on and so forth.

Yes, **I was wondering how helpful you thought HT is**

Yes, a lot, very helpful, erm and they all they create, and I'm sure somebody may have used this analogy before, but you know the sort of purpose of TTC is to really act as a sort of a snowplough to kind of create the space for others, very much to create the space for others, for other actors to come in and I think that's been more successful than I think we would have thought, with a lot of organi- …you know with lots...of which HT is perhaps the best example, but lots of other people really kind of er, you know the work of ITV at the moment… so lots of other organisations kind of taking on some of the, at least some of the awareness-raising…so I think in a sense that's a more, you know we can be more positive about that. I think ..I mean I think there are clearly two or three areas where there is more work to be done, so one, one I think is in terms of people's experiences of – and I mean I'm using this phrase very broadly – public services – and I think particularly, there's a particular touchstone around welfare…and people's experiences of the welfare system, so I think there's…you know, we haven't made as much progress there as we would have liked ...erm I think the second thing is you know, we've made more progress...we've made good progress in terms of stigma experienced by people from black and minority ethnic communities but we are still nowhere near where we need to be, so you know, again, there's more to do...and so the progress has not really been sufficient.

And then I think the third, the third area is I think we're still, and this is what people are telling us, I think we're still feeling as though those people who are most affected by, most seriously affected by mental health problems mental illness, are still the people who are most likely to experience stigma and discrimination, so I think, you know we've made progress, but we haven't and again this is borne out by some of the research that people like Graham Thornicroft have done ...that there is still, there is still a bit of a gap between the way the public thinks about mental health in broad terms, and you know broadly speaking people are much more positive and sensitive about people with depression, anxiety and so on and so forth, but there are still gaps in terms of people's perceptions around people with schizophrenia and bipolar disorder for example …

Absolutely

…and I mean I think I, I think that's the area where we haven't really made...yeah and I mean whether we made, whether we...it's an interesting question about whether we had hoped that we would have made more progress by now...I think that's…I mean I'm not sure that's necessarily the case…but I think those are definitely the areas where we haven't ...where we're not where we want to be.

Okay. **One thing I notice is, quite often in reports or recommendations to improve attitudes, quite often that the goals that are established surprise me as being quite small?**

[Laughs]

[Laughs] **There was one recommendation that through mental health Champions for example, er, there was an aim to improve attitudes to mental illness by at least a further 5% and I read that and thought gosh why so small? Is that a sort of acknowledgement that here is actually only so much one can do, and that is maybe partly to do with this - on the one hand homogenisation of the 'mass' of mental illness, and then the still the fear and fear of violence associated with schizophrenia? Is that a major stumbling block, this problem of fear of violence?**

Erm well I think those are two questions, I think in terms of the measurement scale I would, you know it's better to talk to the folk who set those scales up who know them in detail because it's a longer conversation but I suppose in any attitudinal shift… shifting the public…by one percentage point…is…if you think about it in numbers, equates to an awful lot of people so then you have the, so to take…I can't do maths in my head but it's near enough somewhere between one and two million people per point shift, so you're shifting a lot of people to get to that 5%, so you basically have to shift 10-12 million people, you know it's that kind of number…I mean it sounds...it's a bit more complicated than that but it's…

No, I can see how it works on a population scale.

Yeah, so you know, er, in polling terms it's very diff...I mean you know.. it's tough, it's tough! To make a shift by more than [laughs] *you know, especially given although you know this is relatively a well-resourced programme...it's still nothing compared to the amount of money that you will receive …you know that will be spent trying to persuade you to buy er, ...you know, soap powder. So…so you know the kind of marketing and resources at our disposal is a relatively small proportion, and in fact I think we did do a bit of evidence based research that it's one of the most cost-effective attitudinal shifts of all times.*

That sounds very impressive!

So you know…per pound spent, you know …and on your second point, yes, I mean I think, I think there are you know I think there are some...and it's back to the point about, you know where...how far ...what's the limit here. I mean I think there are some…there are deeply rooted...deeply seated, you know fears...of...you know quotes...the other, aren't there?

True

You know which is …in this context the danger stranger [sic] is something which is you know embedded, is deeply embedded both psy I mean you know...both psychologically and kind of contemporaneously...so that is gonna be hard, that is always going to be hard to shift. I think the job that the campaign and others have done over the recent years has basically been to recognise that…to narrow the gap and to help people understand that violence...you know this kind of stranger violence…is extremely rare…and so I think people increasingly understand that that is extremely are and that you shouldn't assume…that everybody with schizophrenia is necessarily going to be ...you know axing you in the back...and I think that's the shift, you know, is that people are…because of course every time there is one of those…dangerous…if one of those things happens, and of course they do still happen, but because they're very rare they always get news… unfortunately.. you know there's no news programme that says somebody...a person with schizophrenia lived a life today and didn't kill anyone. So we get, so there will always be heightened attention, and I think it's all about how you help people to get that into a context really…

Yes, I guess…I mean **it's my perception also that in the media there's this sort of lazy leaning towards referencing somebody's mental health problems when they commit a violent act because that's somehow politically preferable to instantly going towards say [a label of] terrorism… and I think that's perhaps been problematic in people's understanding as well?**

Yes, yes completely agree, and that's also why we and others do a lot of work with the media…you know, which most people don't necessarily see, but it's behind the scenes stuff where we're encouraging responsible reporting you know, er working with editors and others to, absolutely as you say erm you ..kind of help them not jump to the easy but lazy conclusion that somehow this must be some 'madman' which is the default position and also to report things like suicide very sensitively, and we've seen a massive change in the way in which media report suicide...driven by...the work of TTC and Samaritans and us and others, so there's that's transformed in 15 years…because, you know, there used to be very long and lurid ...er you know explanations of the way that somebody took their own life and that...you very...hardly ever see that now

And the linguistic change away from reference to 'committing' suicide

Indeed, so that's only taken...what's that, it was decriminalised in 1963..that's…that's sixty years it's taken nearly, to shift the ling, the language… …so we're doing [laughs] *we're not doing you know we're not [doing well] in some areas.*

Given the scale of the TTC effort and that there is still an enormous amount to do…I mean how long...again these are two questions really and I suppose they are my last ones because they are both important...**how long do you see TTC being a core part of the sector in the way that it is at the moment, and …and I'm sure a lot of this depends on funding, and is in the balance, and also, what are your next strategic steps - or what of those are you able to share with me?**

Yeah, I mean um...so I think on the first question, I think, um, er that it's really important that we continue to look at the, um, you know the overall picture and see where you know where there is work that still needs to be done, and for us as Mind, tackling stigma and discrimination will al…will you know be a core part of what we do…in the long term, in the lord term whatever happens to TTC if you see what I mean… and sometimes, sometimes campaigns er, you know …sometimes in these spaces you need a really major injection of effort and energy to create this big shift, and then…actually the way in which you sustain it is through different routes. So I don't.. and I ...obviously ...we are indeed… the answer to your question is indeed all about funding…er, so you know there's certainly more work...there's still more work to be done, and erm, so…I've now forgotten your second the second bit of your question…?

Yes sorry it was over-long. I was asking if TTC is going to be a long term part…

Ah yeah [awkward look]…

and you've just sort of answered that really by kind of inferring that it might be absorbed within …say Mind or Rethink…as a sort of maintenance phase…am I correct in thinking that?

Yah I mean I think I'd describe than in er… [Interviewee talking about rain on their washing outside. I offer to close. Interviewee prefers to complete. Both laugh] *erm I'm I think er, I wouldn't quite er, you see I would put that differently because I think … I think our organisation's work…we work on tacking stigma across a whole variety of different platforms so you know the media work is done by our media team …it's not necessarily being done by the TTC team, so there's work that goes on all the time…and TTC is a sort of a, you know, a visible sign of...additional resource that was able to secure, to turbocharge that work…and if we can… as long as we think and indeed others think that there is a need then, you know we will sustain that .but if… it's not possible to sustain it...then you know the work goes*

on but in a different way…you know because we're not really ...this is…the most important thing is the change, not the brand, if you know what I mean?

Yes I was going to ask, **how important *is* the brand?**

Not, I mean ...it's hugely important in being a vehicle to drive change in stigma and discrimination, but it isn't a… it's a means to an end.

[Interview winds down, discussion of project, expression of thanks for their time. Interviewee volunteers further discussion and expresses interest in CDA]

Appendices Part 3: YouTube Comment Analysis

Contents:

3.1 Transcription: *The Stand Up Kid* (TTC, 2017)

3.2 *The Stand Up Kid* (TTC, 2017): Comments and codes

Appendix 3.1 Transcription: The Stand Up Kid (*Time to Change*, 2017)

[Text from TTC introducing the video: How many teachers does it take to change a lightbulb? Introducing Michael, the 'stand up kid'. Watch the clip to see if he makes you laugh...]

Teacher: *Ok, Pygmalion by George Bernard Shaw. Can you open your exercise books please?* [sits down] *You've got a 1500 word essay to do. I'd like you to choose one of the themes from the board and start to plan it.* [door opens and Michael enters as teacher speaks]

[pause]

Teacher: *Ah, the wanderer returns. That's another two weeks behind. See me after class.*

Pupil 1: *So where you been this time?* [Michael passes him and walks to his seat]

Pupil 2: *Somewhere warm?*

Michael: [with touch to pupil 2's shoulder suggesting he is joking] *Yeah, your mum's bed.*

[laughter from class]

Teacher: *Ok, ok. Settle down.*

[Michael takes his seat, takes books from his bag]

Teacher: *Are we a comedian as well now Michael?*

[Pause. Michael looks at the teacher, does not speak]

Teacher: *As I was saying, choose one of the themes on the board and start planning your essay…*

Michael: *Yeah, I've got one for you.*

[Class turns to see. Michael is standing on his chair]

Michael: *How many teachers does it take to change a light bulb?*

[Laughter. Teacher does not laugh or respond, looks irritated]

Michael: *No? Alright. How many depressed people does it take to change a lightbulb?* [addressing his peers, who look more serious now]

Michael: *Doesn't matter, it's always dark innit?*

[Laughter, pause] Michael holds up one arm at an awkward angle]

When you wake up and you got a dead arm. You can't control it, you can't make it do anythin'… [pushes his limp arm with his other arm to make it move] [pause]. *Imagine that, in your whole body. In your mind. Your whole life… Remember when I was off school? Remember all the jokes? 'What options you choosin' Michael? Gettin' out of bed? Stayin' awake? Comin' to class?'*

[Class looks serious and awkward, contemplative] [pause].

Only that's when I was so… low… … getting out of bed wasn't an option for me.

[Pause, silence from class].

Even on Facebook… changed my status to 'still skiving'.

[Awkward laughter from class, looks of reflection].

It's funny innit? [laughs shakily] … *It just makes it a little harder… Sometimes it's already too hard* [pause 12 sec].

I mean, you lot are my mates, right? ... ... Right? [more softly]

[Guilty looks from some classmates] [Pause 5 secs, sits down, class silent, pause 10 secs. Teacher in shot now but silent, looks sheepish].

Silence continues, Michael sits down.

A classmate silently stands on her own chair, and appears to be about to speak, to make her own testimony.

SCREEN TO BLACK. Text: 3 of your classmates will experience a mental health problem [some background noise of a shifting but silent class]

Think twice before laughing along, mental illness is no joke. Make a stand and help spread the word. [Followed by banner and branding as before, but with addition of the DoH logo and the words 'Funded by the Department of Health'

Appendix 3.2 *The Stand Up Kid* (TTC, 2017): Comments and codes

[468 comments posted, 457 appear after deletions].

Comments are presented verbatim, without correction of spelling, grammar, or punctuation. Coding is shown in bold at the end of each comment, in accordance with Table 13 (8.6.2).

1. "A person with depression would never do this." All the more reason to raise awareness. **DR** [*to 120: shows temporal distance between comments/responses to commenters*], **NEG, O, V**
2. My teacher wouldn't have stopped yelling at me to sit down if I did this. **O, PE, V**
3. Not gonna lie this is the only decent mental health video they've ever showed us in PSHE I like it **PE,V, POS**
4. Thanks (name redacted), glad you like it! **TTC,V**
5. I wish i had this to show to my old college tutors... **V, POS** (*indirect*)
6. "Be kind, for everyone you meet is fighting a hard battle." — Socrates Although this is clearly a staged video, the age-old message it contains is very authentic. Bravo. **POS, V, O**
7. this video hits me right in the heart not only because its sad and sucks, but because he expressed the exact same way i feel right now, last year i failed 3 classes because i didnt show up often, and this year isnt better. I'm kind of just staying home in bed not doing anything because its too hard to leave my house**. PEMI, V, ER**
8. Hi (Name redacted), I'm sorry to hear you're having a bad time. Our friends at Rethink Mental Illness and Mind have advice teams that may be helpful. You can find more information here: http://www.time-to-change.org.uk/what-are-mental-health-problems/help-support-services. Take care, (name redacted) at TTC. **SUP, TTC**, **DR** [to comment 7)
9. This hit hard because I took about three months of school recently. I was weak, I couldn't get out of bed. I couldn't handle even the thought of going to school. But when I finally built up the strength; the courage, to get back this is exactly what I got. My teachers were the worst, they told me I was pathetic for not being there. They told me to get out of my head already and be normal like everyone else. **PEMI, ER**
10. That's awful. You're truly doing a great job there. The way back is a long and a rough one, and I could only wish that people didn't respond in such a childish manner. I didn't understand mental illness until it dragged me deep down, but I'm pretty sure I never insulted someone who had clearly been thru something (whether skipping school on purpose or not). I wish they understood that 'getting out of your head' is the most impossible thing to do for someone with anxiety/depression. If we could get out of our heads, we would've done it a million times already, the problem is that we can't. 'your head' is always there. You're never alone and there's not a moment that you're able to escape it. It's how I'm trying to explain it now, your life is this small balloon and there's this needle just inches away circling around it. You know everything is about to blow up but you don't know when and you cannot control it. Your mind is some sort of time-bomb, destroying everything you love from the inside. You end up with shattered dreams, burned friendships and no one that loves you. It's lonely in a way I never knew I could be lonely. And heck it hurts... **DR** [to 9], **PEMI, SUP, EXP**
11. Adults never understand, they always say "your only 16 (or however old you may be) you're not depressed you haven't even lived yet" which is one of the major

reason why people don’t come out and speak out because they don’t want to be ridiculed by other people because others always assume that their problem(S) are worse than yours, it’s like people take pride in feeling like shit and want to be the centre of attention for negativity 😩**O**

12. Metal illnesses aren't taken seriously because they are invisible to non sufferers. Only those who have suffered themselves can understand it and not even they can spot it in others most of the time. It's a terrible, alienating, experience of isolation from everyone you know and love. They're constantly told to just "snap out of it" or "think positively" which only makes them feel more like sick freaks. It's an internal suffering which makes finding others who understand much more difficult and leads to an endless cycle of hopelessness. Those of you who feel this way, never forget that You Are Not Alone. **O, A/I, PEMI**
13. Hi all, as per our social media policy we've had to remove some comments that have been abusive to other commenters, or have used stigmatizing language. Stand Up Kid is a scripted video, not a video of a real life classroom - it plays out a fictional scenario which highlights the difficulties that young people with mental health problems often face. Best, Time to Change **TTC, V, MOD, EXP**
14. Bloody hell! Why don't people know more about this? Why aren't we ALL taught about this as kids? What's so scary about it for schools to shy away from it year after year, generation after generation? If we could all show a little compassion! It's Time To Change. **Q, O, POS, IT/ID**
15. People undermine the human mind like it's nobodies business. People will chatter forever about how cancer is a "battle" and dump ice on their bodies to simulate the numbness of ALS, yet treat depression like unicorns and fairies. When their are more suicides than homicides in America, who pays the price? When you suggest we get off our ass and forget our woes, who has to struggle? It seems that unless you've suffered a mental disorder yourself, it's fucking invisible. There's a reason he's standing up. There's a reason people find that ridiculous. Put two and two together and you'd realize that if the problem was so important, why would someone have to go through this to state their claim? They shouldn't have to. **O, Q, V, POS**
16. We need more videos like this **O, POS, V**
17. USER MC I can't concentrate in school. I'm always tired. My brain is numb. I'm only half aware of my surroundings. I get stressed out from it and that results in anxiety and chest pains. I only briefly feel happiness or joy very rarely. Because of all this my grades have dropped and my dad is on my case. He only thinks it's chest pains. Push through it you'll be grand he says. Only I'm not grand. I feel worse now. People need to speak up whether it's mild or serious depression. I'm not even sure I have it because I feel it's only mild but you need to speak up. Trust me keeping quiet doesn't help and will. Not. I have yet to speak up... **PEMI, O**
18. Last year, I was in a similar situation likes yours. My mother would literally pull me out of bed and push me out of the car when I was screaming and crying. I didn't go to school half of the time because I couldn't leave my bed, my grades began to fall. I spent an entire year thinking I was just going through a state of being sad, that I didn't have clinical depression. Then, over the summer, I had a panic attack, and anxiety all of the time. I finally chose to go to the doctor, to get on medication, and to go to therapy. I am now in a school that I only go for three hours a day, with individualized learning instead of a classroom. Standing up and telling yourself that it's okay that you're not okay, and that you need help, will be the best thing you ever do for yourself. Get the help you need. Fight for yourself. **DR** [to 17], **PEMI**, **A/I**

19. USER MC its horrible isn't it? i dont even know what caused. my mum died last year but i felt no grief or sadness. i got the attacks too about 2 or 3 months after her death and since then have been to a couple sessions of therapy but it seems its coming back with a vengence. it could be a subconscious grieving buti will have to take your advice and find out. thank you. you're a very strong person. **DR** [to 18], **PEMI**
20. [username redacted] I hope you're doing better. **DR**, **SUP**
21. USER MC A year on...and its just getting worse. Attempted suicide three times. Just lost my last close friend tonight. I have watched this 4 times and counting because it seems this is the only thing i can relate to. I have lost myself altogether,remnants is an overstatement of what remains. Everything i hated about people,about how to be, how to treat people, i have done this year. Used girls, fought guys, argued every little detail with people. A week back to school and three teachers approached me about being "oppositional"...its christmas break now...i was only going in two/three days a week anyway. I stopped caring about people,their feelings,what i did to them,what i did to myself, if you cant even respect yourself, if you cant even treat yourself caringly, be In touch with your mind- lets put it like this; your in a flying simulator GAME. Your co pilot. Occasionally get to take over something or do a job. But you don't care if you do it, its a game,you will respawn.you don't think about consequences because you don't care. You just lack empathy. Your just hoping something will happen. I became an asshole, treated people worse than i treated myself. Isolated myself from people then. And when people asked or got serious i would either make a joke,lighten mood...or get verbally aggressive and some cases with guys physically,especially when they disrespected girls,the hypocricy of me. 2015 is the year i tell depression to go fuck itself and get it out the pilot seat and i tale over, the real me **PEMI**
22. This film too me represents the truth. **POS, O, V**
23. Crying so much omg **ER V**
24. I've never seen anything more moving. Honestly. **POS, ER, V**
25. I think this is probably the best video I have ever seen. This scene - his monologue - is pretty much what I've wanted to say and do for the longest time. Even though you try to laugh it off so it doesn't seem like a big deal, it is. Most importantly, it isn't a joke, **POS, PEMI, V**
26. Awww this is beautiful 💜 **POS, ER, V**
27. I have been as low as you can get, no job, no girlfriend, no car, in debt and still living with my parents. I thought the world was my enemy and that there was something out there stopping me move forward. I realised it was myself, I was the one who allowed the feelings of depression creep in and I was the only one who could fight through it so instead of allowing depression to set in I did positive things for myself. I exercised, I was proactive in my job hunt and I made sure depression wasn't going to take full hold of me. Here I am 5 years later with a career I'm proud of, out of debt, my own place and a smile on my face. The choice is yours, no matter how bad it feels or gets remember that everyone is fighting a battle not just you so don't expect help to come you have to help yourself! Get off your ass and fuck negative thoughts, feel strong and you will be strong and when you're strong nothing can stop you. **PEMI, A/I [Next 14 comments are all responses – not always clear to whom]**
28. Although I agree with everything you said, don't forget that there is a difference between situational depression and clinical depression. Some people require serious cognitive therapy or even drug therapy to get them out of their cycles of thought

and damaging mental habits as well as chemical imbalances in the brain. This is why people like Robin Williams; who have money, family, and are generally loved by most people, are driven to suicide. It's a disease of the mind that can't just be snapped out of. **DR** [to 27], **O**

29. Absolutely. There is a HUGE difference between just letting yourself wallow in self pity (situational depression) and not having any control over how you are feeling (clinical depression). **DR** [to 28], **O**
30. It's all in your head...literally **IR** [to whom is unclear], **O**
31. (redacted but not current username) You will mate, I believe you get out of life what you put in so stay strong keep trying and you will succeed. **SUP, A/I**
32. Robin Williams's case could of been things we didn't know was going on in his private life to. Heaps of things could of driven him to it. I've been suicidal and there was definitely a reason why I was, that no one knew about. It's a shame we'll most likely never know the true reason to why Robin did it or if it was just depression on its own. **O, PEMI**
33. You're not recognizing the extreme differences between situational depression and clinical depression (major depression disorder). You had situational depression. You were at a bad spot in life and you were able to get out of it through hard work and determination. That's great for you. However, by assuming that all depression is like yours you only perpetuate stigmas about mental illness and especially TRUE (for lack of a better word) depression (clinical depression). I have have been diagnosed from many different doctors over the years with having major depression as well as a host of other, serious mental health problems. I could tell you my whole story, but all you NEED to know is that you should NEVER tell someone who is clinically depressed it's "all in your head" or believe that, like you, they can "snap out of it". Those things are NOT true for clinical depression. NOT. AT. ALL. Saying those things will only make you sound incredibly ignorant and can make the person feel worse. It takes me about 1.5-3 hours EVERY morning to get out of bed. And that's if I actually CAN get out of bed that day. It takes me 1.5-3 hours JUST to get mentally prepared to deal with how much of a struggle it is to just do daily tasks like take a shower, eat, brush my teeth, etc. Then,when you add on going to classes and having to socialize (I also have severe social anxiety that, thanks to the right medicine and therapy, I am able to block a lot of it out) it can become such a high, insurmountable wall that simply getting over it takes ALL the energy you have available to you that day. So you immediately go home and get in your bed and/or stay in your room the rest of the day. Just because you used all your allotted energy for the day doing just the necessities. Clinical depression is much different than the situational depression you experienced. I hope that my post will help you realize it. The only way to end the stigma and discrimination surrounding mental illness is through education. Please, do some research on your own into what major depression is and how it effects the person suffering with it, as well as learning the best ways to help, and how to approach talking about it with, the person who suffers from major depression disorder (clinical depression). **DR** [to 27], **O, PEMI, A/I**
34. I appreciate your plight but have to say that living with your parents is not "as low as you can get." It's just a social faux pas after a certain age, and we always care about what others think about us. I don't know your particular situation but in reality being able to live with parents who can pay your overhead while you put yourself together again is a hell of a privilege. If anyone's in that situation, and I know many are because of increasingly insurmountable student debt, try to see the

positive that you have parents who can help you get on your feet. One day you won't have them. **DR** [to 27], **O, I/A**

35. [From writer 27 to 34] It was as low as I've ever been so I know nothing lower. I had zero cash and was lucky to have my parents there for me. I'd also been made redundant twice in the economic crash between 2008 and 2010. I understand it could have been a lot worse but that isn't to say I wasn't deeply depressed because of my situation, I could see no light at times and got into drugs as a coping mechanism. I'm now stood on my own two feet because I dragged myself out of the mess. Just because I wasn't diagnosed clinically depressed doesn't make it any less of a challenge to put things right!! **PEMI, DR, EXP**
36. [Name redacted] of course not man! And I don't wanna sound like negating your feelings at all, just throwing my $0.02 to anyone who may think going back to live at home is the end of the world - we're fortunate to have such a high standard of living that that would be considered a fall in the first place. Good for you for getting back up. DR to 35 [also from writer of 34] **O, EXP, SUP**
37. You are absolutely right that clinical and situational depression are different. You are also right that no one with depression can "snap out of it". The one thing that I will say that is slightly disagreeable is that there is also a difference between 1.Those with clinical depression who have a choice to not get out of bed every day, and 2.Those with clinical depression who choose not to get out of bed every day, might not know how to get out of bed, struggle to get out of bed, and even wonder what the POINT IS of getting out of bed every day BUT they *literally still have to get out of bed/are forced to. I'm not saying that one person is MORE depressed than the other. What I'm hoping to impart is the same understanding that YOU were imparting ---- depression may look different from person to person, but that doesn't make one type of depression better, easier, worse, greater, or harder. And for the people who don't live in certain cultures where we can literally not get out of bed, we still hurt as bad as you do and we dont want to wake up each morning. But we dont have even a literal chance to do otherwise. **DR** [to 33], **O, PEMI**
38. Any pay student loans **U**
39. I don't know why I just saw your response. I really appreciate the point you are making and I completely agree that there is a difference. I also semi-agree that no "type of depression is better, easier, worse, greater, or harder". The reason I only semi-agree is because I believe that having actual, diagnosed or undiagnosed, Major Depressive Disorder is entirely more difficult over time than situational depression and also much harder to stabilize, as it is an actual brain disorder caused by various chemical issues in the brain. I do, however, understand, as well as have seen, situational depression take people just as far down as Major Depression. Like I said, though, is that with an actual mental illness it persists as a life-long battle against your own brain and thoughts. While, on the other hand, situational depression, once you overcome it, generally won't bother you again, as it is not a mental illness, rather it is a massive drop in your mood that is caused by the situation you are in your life. I hope that makes sense. I understand that there are people who can't get out of bed, but to survive they don't have the choice. That's survival instinct kicking in. Its really hard when that is what you have to do. I am not in such a bind where my very survival depends on myself getting out of bed every day, but I do have to account for the long period of time it takes me to get out of bed by setting my alarm very far in advance of when I have to leave. If I did not have the problem of having such a difficult time getting out of bed, as if the many reasons it is there didn't exist in my life, I could wake up 30 minutes before my class, get up, get dressed, drive 15

minutes to my college, park, and make it to class right on time. I'm not sure exactly where I'm going with this, but I'm trying to get to the point of saying that, in those instances and others, you often have to make extreme sacrifices somewhere else in your life to be able to get out of bed every day when you absolutely have to and do not have a choice. To do that, you have to make some kind of concession somewhere else. Again, I hope that makes sense, as I often word things weird and people misunderstand what I'm saying. Sorry that it took me 7 months to respond, too. Haha. **DR** [to 37], **O, PEMI, EXP**

40. [Redacted to 39] well said, buddy **SUP**
41. Good on ya, Well done, I bet your so proud of yourself? <3 I hope your future is bright and is more powerfull than the dark. **DR, SUP** [to 27] **[end of responses to 27]**
42. Years later and this video still hits me hard. Thank you for this. **V, POS, ER**
43. Absolutely love this vid. :) **V, POS, ER**
44. I love this a lot. I can relate to this so much. I'm going to try to get my school to play this on the morning announcements. **V, POS, ER**
45. Wow . Love this! **V, POS, ER**
46. "Are we a comedian as well now Michael?" **V**
47. thanks :) **V, POS**
48. Thank you for uploading this. **V, POS**
49. Thank you for this video. **V, POS**
50. thank you [name redacted], for sharing this. this is why you're so amazing **V, POS**
51. I understood just ,, Facebook,,!!! :')) [different user, saying that they understand the the previous user referred to someone who shared the video on Facebook] **U**
52. This is an incredible video. Thank you so much for sharing. **V, POS**
53. I applaud the video as it does show how school CAN REALLY be for some and years ago myself included - actually existent to an extent even today. As i go through life everyday now nearing my thirties, I have found more patience to just watch and listen to how people really are to each other. Growing up is tough, What I have seen to be a big hiccup in society is the constant Fear and Attitude towards others regardless of who they are be it age, race, weight, nationality, wealth or debt ETC... We are all Human, It makes life so much harder when We are against one another in any fashion -except non-lethal sport. Live and Let Live **V, POS, PE, O**
54. This is one of my favourite adverts ever **V, POS**
55. Thank you for making a video that explains what I go through in a 3:07 minute video. Honestly it could take days for me to explain. **V, POS, PEMI, IR**
56. this is amazing **V, POS**
57. Could someone put this into text, cuz the guy just mumbles through half of it, making it hard to hear. **V, NEG** [but ? hearing impairment]
58. saw this at school, powerful :) **V, POS**
59. Thank you for making this. **V, POS, IR** [to TTC]
60. Made me cry .. my gawd this is perfect **V, POS, ER**
61. thank you **POS, V**
62. This video hits really close to home for me and what ive been going through recently **V, PEMI**
63. I cried at the end !!! **V, ER**
64. I'm memorising this to tell my friends and family **V, POS**
65. the end gave me goosebumps. this is so powerful. **V, POS, ER**
66. Man I love this, speech is a doorway an' all **V, POS**

67. This video made me tear up, since I had the same thing happen with a teacher who made jokes of me coming late to or missing class. Thanks for this video, it really means something. **V, POS, ER, PEMI**
68. This must be one of the best shorts I've ever seen in my life. Such a strong message, written beautifully. Well done. **V, POS, ER**
69. I found that I never wanted this video to end. Thank you. **V, POS, ER**
70. Im glad that i just used 3 minutes of my life watching a little english kid stand up on a desk, mutter something, stand there for 10 silent seconds, repeat. **V, NEG**
71. so right :/ :) **U**
72. I'm so glad I found this. **V, POS, ER**
73. Absolutely love this. **V, POS, ER**
74. Thanks **V, POS**
75. I wish I'd known someone as brave as this when I was in high school. **V, POS, PE**
76. If he had pneumonia the whole class would be smothering him like "oh my god I hope you're okay we're so glad to have you back get well soon etc.." which is worse than being teased a little to someone who actually has a mental illness. We don't want people to feel sorry for us or treat us like we're sick, we just want to be accepted for the people we are, same as everyone else, and not pitied. **V, O, PEMI**
77. Nice video with a great message. **V, POS**
78. I love how they didn't subtitle his 'innit' **V, U** (sarcasm – ref. to accent of character)
79. Reminds me of high school. Girls taunting me endlessly about how ugly I am etc. on a daily basis for no reason, people telling me I should kill myself etc. Teachers accusing me of being high or falling asleep in class, because I have dopey eyes. Coming up to my desk and smashing it with a ruler to "wake me up" even though I was already wide away, just with dopey eyes, lol. High school was messed up. **V, PEMI**
80. how would this make u laugh its serious **V, IR** [to ?], **O**
81. Welcome to my reality.. [opaque] **PEMI**
82. brilliant! **V, POS**
83. I'm kind of too sad to cry **V, ER**
84. I have just cried watching this. My fiancé took his own life last November suffering with depression. It most certainly is time to change and talk about this illness!!! **V, O, POS, PE, ER, PEMI**
85. Would you be happy if I put this as a resource on my website please? I have a group who work with young people where mental illness is very high and think this will be of huge benefit to share with them. **V, POS, Q**
86. Hi [redacted], it's fine to embed the video on your website - we don't have a problem with that. Best, Time to Change **TTC, DR** [to 85]
87. Oh my god, I can't stop crying. **V, ER**
88. wish I had the guts to do this. powerful video. **V, POS**, implicit **PEMI**
89. can anyone write the guy's speech please? i can't understand it clearly :(**V, NEG** [second to mention audio problem – not apparent to me]
90. This advert is so relevant, this is literally how I have felt in the past. I still struggle with it now but I have found a little more motivation to actually get out of bed and do something. But it is hard, incredibly so. And sometimes you will slip up, sometimes you will hit a wall. And sometimes you feel like you have no other option than to just simply give up because it's pointless. Life is worth living, but also there is so much more support that needs to be given within mental health services. That's not to take away the work you guys are doing, but there are mental

health services that need a lot of improvement and it is so important to find the right one. **V, POS, O, PEMI**

91. When I was in senior high school, I missed 2 weeks a month and eventually had to drop out. My teachers weren't aware I had depression and thought I was just ditching for fun. I hadn't been diagnosed back then. It was very hard to explain to him that I just couldn't get out of bed. I cut myself at night and didn't sleep until 5 or 6 a.m. And when I did sleep, it was for 12 hours and I'd feel too tired to get out by the time I wake up. It was so hard to explain. **PEMI**
92. Dammit, 2:19-2:26 made me choke. **V, ER** [*refers to segment when the boy falls silent, then says 'I mean, you lot are my mates, right?'*]
93. great psa!! **V, POS** [*note use of psa – U.S. commenter*]
94. Fuck! I feel like I wanna cry, I remember how did it feel like... **V, ER, PEMI**
95. Beautiful. **V, POS**
96. Stan your ground! **A/I**
97. This is so empowering **V, POS**
98. Glad you think so, [name redacted] **TTC DR**
99. I want to give him a hug. :c ***V, ER***
100. burst into tears watching this - i wish i had the bravery to do this **V, ER,** implicit **PEMI**
101. Being depressed is not being sad. As he said on his desk, it's when you're stuck like a dump in yourself: You can't move, you ask yourself "Why? I ain't got time now." Day after day, you still have those moments where you're just stuck. Then you start thinkin' about it, about yourself and all around...you'll came to a point where you think about your whole life. Until you start being stuck in your mind too, because you'll think "Why thinking about that asshole? You're a big dump, and it won't help." And then, your donne...you're totally striked down by the depression. If you're a lucky one, somebody will notice it. Otherwise, you'll be stuck with yourself in yourself. **O, EXP, V, PEMI** implicit
102. I guest teacher at a great school where professionals/teachers have these discussions with students. I am a guest teacher who suffers from depression and is compliant with treatment and fortunately have great results. Not all are so fortunate. This was a great, guessing staged video and would love for all students to see it. For those who are so quick to judge in a negative way towards the student, fear and lack of understand Mental Illness is very common. No worries - friends and good people are many and will always be there for you - just reach out or stand on your desk :0 **O, V, POS, PEMI**
103. we watched this In assembly **V**
104. matt damon? **V, Q** [*assumed ref to appearance of actor*]
105. damn I thought he was gonna break out into the robot **V** [*ref. to arms hanging limp, swinging etc*]
106. What's the punch line? **V,U** [*ref to reflective, uncertain end*]
107. I experienced something similar to this when I came back to college after time off due to anxiety/agoraphobia. A lot of people in my class would call me a 'skiver' or 'lay about' and were incredibly ignorant because they didn't understand the situation. Absolutely fantastic video, well done. **V, POS, PEMI**
108. It's sad to see that people make of fun people with mental health issues. in high school I used to stand up for those kids and defended them not with violence but with talking and explain to them how it would feel if they had a mental illness or someone close to them has a mental illness and told them let that just sink in for a minute **O, PE**

109. Ofc, I fought depression for around 4 years (skipping one year) up until this year. I'm glad that I'm over it because it really does destroy your life. I never cut or skipped school, but I did do obsessive things, scratched my face until it was red from blood, stopped taking care of myself, crying every night, threatening suicide, etc. Now I can't even listen to sad or rock music like before because it just doesn't fit me anymore (and it's saddening) honestly I love being happy and my friends. **PEMI**
110. should do this in my class **V, POS** (implicit), **O**
111. This needs more views. **V, POS**
112. That was depressing **V, U**
113. Very powerful **V, POS**
114. I watched this video in schools and I can relate... I hope we all get over anxiety and depression together ! **V, PEMI, O**
115. This video describes me so perfectly... **V, POS, PEMI**
116. So if I were to read only the comments before watching the video, the entire message would be 100% lost. Most people are disregarding the fact that this is a scripted PSA and attacking the actual event. Ugh. **COM**, **V**
117. He's not that funny. He's actually kind of depressing... Thank you, I'll be here all week! **V, U**
118. Omg :'(I always get shit for being off school but it's for the exact same reason as him!! So much truth in this video <3 **V, POS, PEMI**
119. Im kind of in love with this. **V, POS, ER**
120. A person with depression would never do this. **V, NEG, O**
121. how do you know **DR** [to 120], **Q**
122. [name redacted] they can become withdrawn/reserved. **O**, **DR** [120 to 121], **O** [*note 'they'*]
123. That's not the point of this. It's to say how they feel inside **DR** [to 120, 122], **E, V**
124. Yes, you can, in fact that describes to a T how I feel on some of my OK days. You are entitled to your own opinion but this is an advert to spread awareness, it's not a literal situation. By this opinion you are concluding that the old O2 cat advert (where the cat talks) is a real-life situation and you are saying the cat would really talk and do all of which it is doing in the advert. No. Just because this advert is about depression it does not mean to say someone would or would not do this. it is opinions like this which stigmatize people's views and outlooks on various topics, be it: Political. Sexual Orientation. Mental Health. We see someone parked in a disabled place with a badge and they get out and there is nothing wrong with them at all, then they get our they're severely mentally disabled son. Some won't see the Hydrocephalus or the autism or the epilepsy so some will tut or roll their eyes and that is exactly what is wrong with people today. The passing judgements with no knowledge on which to base this opinion, this judgement on. [Same commenter as 123] **DR**, **V, POS, O, PEMI, EXP**
125. [name redacted] Of course they wouldn't you idiot, it's trying to demonstrate what happens inside people's heads who suffer from such illnesses **V, O, DR** [to 120], **E**
126. probably because bullies try to make them quit to keep inflicting the pain on them **DR** [to 125], **O**
127. [name redacted] EVERYONES EXPERIENCES ARE DIFFERENT **O, DR** [to 120]
128. [name redacted] that's why this person is so brave **V, DR** [to 120], **O**

129. I always laugh and crack jokes, but I never really feel anything sometimes. I wish I could tell my family and friends, but I feel like it will ruin the relationships **PEMI**
130. i think it depends on the person **DR** [to 120], **O**
131. How the fuck do u know dickhead **DR** [to 130], **U**
132. As someone with depression, people might do a version of this. Obviously this is a dramatisation, but the point stands. **O, PEMI, V, POS**
133. hell yeah bud **DR** [to 132], T, U [same commenter as 131]
134. There's subtitles. **V, EXP, DR** [*to commenters who could not hear clearly*]
135. You know I think? I think we all have it so good, that we've all become a bunch of whiny buggas. I grew up getting molested, hit, and everything else under the sun. Want to know my secret to becoming successful and happy as I am today? Being strong. **O, PE**
136. Lol **DR** [to 135], **T**
137. Random **U**, poss. **DR** [to 136]
138. I've been living with anxiety and depression for about a year now, and it's the most difficult thing. I care to much and worry to much about everything, but then I just don't care. So I lay bed all day, worrying about me friends and my homework and work. **PEMI**
139. This is beautiful and so true. **V, POS**
140. you can click the CC button for subtitles, I had to do it also since I couldn't understand either **V, EXP**
141. Thank you. Just thank you. Everyone should see this. **V, POS**
142. This is such a good video **V, POS**
143. This is a way more common problem than people think it is. I myself have Bipolar disorder, and before I was diagnosed with that I had depression and severe anxiety. I battled through my school days, and constantly had to be the brunt of teachers and students snide remarks about where I had been and how I was a bunker, and you know what? That made me want to not be in school even more. One thing i'd dread was walking into school and being made to feel like shit because I could not attend normally like everyone else. Me and my parents would constantly go up to my school to try and explain the situation to them and put certain measures in place so school would be easier for me, but still the teachers did not understand it (apart from the odd one or two) when I left highschool many of my teachers told me I wouldn't get anywhere, that because I hadn't attended I wouldn't acheive anything and i'd only get anywhere if I put in more "effort". You should of seen their faces when I left with and A* ;) Don't let peoples ignorant comments define you, because you are just as capable and intelligent as everyone else. **PEMI, O, A/I**
144. Four years ago I had teachers ask me what was wrong with me when returning to class after several weeks absence even though they had been notified of my situation (even after saying 'I was ill' they quizzed me further in front of entire classes of my peers), teachers telling me i had an attitude problem, and being told i was lazy and letting my work down. They absolutely are often part of the problem. **PEMI, O**
145. This video is just perfect **V, POS**
146. ** pardon that. I meant how much time you put into coming back and arguing. **U, DR** [*response to ? not found – perhaps deleted*]
147. HI, GOOGLE [name redacted] STIGMA TO SEE MY EXPERIENCES OF LIVING WITH A MENTAL ILLNESS. **PROM, PEMI**

148. I had to watch this at school **V, U**

149. please , can somone help me? how do i talk to somone? **Q, T**

150. a+ **DR, U** [*pos. response to trolling*]

151. This hit me, man. I have Depression too. There's a lot of work that needs to be done to stop stigmatizing mental illness. **V, POS, ER, PEMI, O**

152. your attempt at being funny failed **IR** [to ?T] **U**

153. This channel is gold. Keep it up **U, T**

154. honestly with someone that had depression issues (still has them) i understand this. not in full detail, its impossible to even know that. because that would be psychoanalysis, he doesnt even comprehend it in full detail. basically, jokes are fine, but remember to be a good person and mean well, and make sure they know you mean well. in present time he may take these jokes as nothing. but they build up to become his metaphors in this video. the event of how people reacted to the jokes however, did not build up. although you shouldnt make fun of such things (yes i know everybody has depression) but depression is a build up. not a feeling of sadness, but rather a dark feeling that seeks no purpose in anything you do. and it builds and builds of little things and when it comes out. no one is able to explain it. anyway. just remember, people deal with stuff like this. and to people that dont have it, dont understand it. depression isnt sadness, its something darker, something unexplained. to depict the difference. sadness is a emotion given to a event, depression could be random, and could be triggered by an event, but its full purpose has nothing about the event and then changes to more personal deeper matters that are irrelevant to everybody else. for example. people get sad when their cat dies, and thats sadness, depressed people get sad when their cat dies, and instead of thinking about the cat, they go into personal scales against themselves and end up about how kids are at school. so jokes are fine, but be aware that people cant control or explain these things **V, O, PEMI, EXP, I/A**

155. bit melodramatic, this. **IR, O, NEG**

156. Skiving – Skydiving **U**

157. i can't even tell you how many times i felt like doing this in class and just didn't have the courage **V, PEMI**

158. After watching this video and reading some if the comments, I actually started to cry. Depression isn't something to laugh about or make jokes of. It's something that takes out a piece of you that you'll never get back. I was lucky. I had some understanding teachers that helped me pull through high school. If it wasn't for them, I wouldn't be here today. **V, ER, COM, O, PEMI**

159. everyone needs to watch this **V, POS, O**

160. I think we need more promotional videos like this, whether staged or not, they could be quite effective, I think. **V, POS, O**

161. Yoooooooooooooooo **U**

162. Powerful. **V, POS**

163. I wish i had the balls that this guy does **V, PEMI**

164. if only real life worked like this **O, V**

165. im so confused where the discrimination takes place **V,O**

166. This has actually happened to me. **V, PE**

167. Depression is not easy and there are many different types. You've got depression that comes on due to environmental factors. Sometimes those can be changed. Sometimes it's not that easy. You've got depression that comes on due to vitamin deficiencies. That can be really difficult if you don't realize where it's coming from. It can be difficult to figure out, though often a doctor can help you

pinpoint that. You've got chemical and hormone imbalances, and those can be the worst, especially if treatment fails you. I had an ovary removed and for months after I would cry without provocation. I didn't know how to fight it because there seemed to be no real cause. I talked to people, to doctors, I downloaded apps on my phone that sent encouraging steps for me to take against depression. You might say, "oh well, you had a reason didn't you? Major surgery, that's understandable." But the thing is: it doesn't just come from nowhere. Everyone has their reasons. Just because you don't understand it doesn't make it less real. If you've always been able to fight it, then congratulations. That's wonderful. But expecting that everyone's mental state is like yours and can be handled if they take the exact same steps you do is the very definition of being self centered, being unable to see things from another's point of view. I'm not saying that you have an obligation to take care of such people, or even to be their friend. But don't lash out at them just because you don't understand. **O, I/A, PE, PEMI**

168. True **IR** [unknown addressee] **U**
169. why are you talking to me ew lol **DR** to **UA**, **U**
170. So effective. Well done. **V, POS**
171. Excuse me? I've been severely depressed for the last 5 years. I felt like I couldn't move every morning I couldn't get out of bed because I just couldn't face another day, I just couldn't face another day of putting my mask on and pretending everything was fine. This video helped me begin to explain that to my friends and my family. Besides which surely your first job is not to judge people or make assumptions, you don't know whats behind some peoples smiles. **V, POS, PEMI** [+ ‘excuse me’ appears **IR** to **UA**]
172. Brilliant to see this! I think its fantastic. It really hits the point home! It had me in tears! This is what so many young people have to got through every day of their lives. Think about it! **V, POS, I/A, ER**
173. I think it was partly the taunts from his classmates and the teacher. I think he wants people to understand what he is going through. I think mostly it was the teacher saying he was another 2 weeks behind and obviously not understanding. Also I think that is supposed to refer to him having to put on a brave face everyday. People are taught to never show any weakness. He has to put on a brave face and it gets harder and harder everyday to not break down. I think that is what he meant. IR to **UA, O, EXP, V**
174. 3 of your classmates will experience mental health issues, that's like half my class lol. **U, O, V**
175. Being a frequently depressed person myself I found the lightbulb joke absolutely histerical. **PEMI, V, POS**
176. Powerful. **V, POS**
177. I used this ad for my English assignment in 2016. We had to choose an ad and do an analysis on it. I remember watching it and just realising how hard it hit me. I never got help for my mental illness up until I was 19 & it was the hardest thing I've ever been through. Thinking about my assignment and this analysis I did, I gradually got help which was the hardest thing I've ever done... I remember i couldn't even tell my doctor about it, I just burst out crying. People say that I'm just being a typical teenager, that I'm just lazy, etc... but it's so hard to explain. I hate being in bed and not doing my work & I can't explain it back then. Thank you so much for this ad. It took a while for me to get help and I did it. My life is so much better now, not perfect but better. :) I am 21 now, my relationship with my family is

so much better and I am doing well in uni. Hoping to be a mental health nurse one day. **PE, PEMI, V, POS, ER**

178. does anyone know the name of this actor? **V, Q** [*elsewhere 'matt damon' may be a DR*]

179. I'm 21 years old-i've been depressed since since my early teens. I used to get into a lot of trouble in and out of school- used to use allot of drugs like weed and uppers.Noone ever thought i was depressed - they just thought i was a kool type of kid that just 'didn't care'. Is it so hard for people to see that self destructive and manic behaviour are signs of depression or bipolar.I've just recently been diagnosed with fast cycle bipolar. I'm now studying to be a paramedic.I want to help others **PEMI**

180. I feel this deep in my core. **V, POS, ER**

181. That was so corny **IR, U**

182. Deleting any negative comments? Oh yeah boy. So well made bruh **V, U, NEG, T**

183. 'changed my status to still...' what does he say?? **V,Q**

184. One of the biggest reality checks I ever got was when a very good friend of mine admitted she had been on medication for severe depression for quite a while. I remember the shock and I just couldn't reconcile this fun, vibrant person with someone who was mentally ill. I think it's great correct information on depression and mental illness is finally coming out, honestly when I was in high school I just assumed it was the kid dressed in all black. Great ad, aamazing actor. **PE, V, POS, O**

185. Oh, nice! Now you're being a bully. Lovely. Do you feel like a big man now? Why do you think I stress that I'm a 40 year survivor and reassure teens all the time that it does get better? How about you tell her that you've talked to a grandma who was suicidal 40 years ago and says it gets better and that she's happy she lived. If I was afraid of living, I'd be dead. I got over that fucking fear a long time ago. Tell her it gets better when you leave home and control your own life. **DR** to **UA, PEMI, AGG**

186. well it is britian haha **U, IR**

187. Really well done..that's something that not everyone remembers. **V, POS**

188. wow, that guy is a good actor... **V, POS**

189. i dont get it. do you want them in spacesuits or? **IR, U**

190. Good job kid **V, POS**

191. I would never be able to stand up and do for myself and do something like this without balling me eyes out and stuttering. And I'm a 19 year old dude. Haha **V, PE, O**

192. I dont undertsand anything ? **V, NEG** [? *sound*]

193. I couldn't understand half of it!!!!! Gahhh. The first 3 seconds when the teacher introduces himself just sounded like gibberish. Even with headphones on the words felt slurry **V, NEG** [*sound*]

194. This deserves way more attention. **O, POS**

195. [Name redacted]? Are you here? **DR, U, Q**

196. What does the teacher say just after Michael says, "In your mom's bed"? **V, Q**

197. https://youtu.be/wFzcDGaHp3k [ref to YouTube video channel 'Silent Witness', no longer available]

198. A very poignant message this one. And I have to ask something else: Why is it that when a person is depressed, really depressed, very few people are willing to

help them. But when a person is about to kill themselves suddenly everyone steps forward. Why is that? **V, POS, Q**

199. l2british **U**
200. Tat is soo sad I am cry as we speak **V, ER**
201. honestly though if you havent been diagnosed dont pretend you know what its like **O, I/A**
202. damn they're all pale **V, U,O**
203. impeccable acting **V, POS**
204. People who are depressed enough kill themselves - John Doe. Precisely your self righteous lack of compassion, kindness, and fellow feeling is why he did what he did, so you could reflect on precisely the behaviour you are exhibiting. Words kill. Words like yours. Thank grace I got help and am still here to alk about it. Open your heart John Doe. No one is immune. **V,O, I/A, PEMI,**
205. I couldn't understand his accent... **V, NEG**
206. " Film it in an inner city college. with real sufferers." that's just ignorant. Depression can exist anywhere, can't believe you manage a mental health unit**. V, O, DR**
207. read the text then .... **V, I, IR** [likely to 205]
208. I quit high school in 03 because I was being bullied so much everyday I also had a huge depression that I felt like not being here (living) was the answer I'm finding I'm ok in this world now but I still can hear some of people said about me big time when I'm downing myself words hurt so much more then I think people realize **PEMI, O**
209. that's a little excessive, don't you think? **U**
210. Well that was awkward. **U**
211. This is incredible. **V, POS**
212. This is probably a 6th Form class, their age and the fact that they dont wear uniforms :-) **V, O, EXP**
213. all the fucking awards **V, U**
214. Just leave. [poss to 213 if 213 is sarcasm] **U**
215. there are many good teachers but there are also teachers who are unsympathetic to students who obviously have issues and they don't help, what's more, they make it worse for the student. This is why parents need to be their kids advocates, but kids you need to let your parents know what is happening. And if your parent is no help then find someone you can trust and someone that is available to help. I have seen so many smart kids failing because their parents didn't push them, or supported them, or worked with the teacher to make their child succeed... communication is the key. You may think it sounds like BS but it can make a big difference in your life. **O, I/A, EXP, PE**
216. So it's all the teacher's fault then? **IR, Q, V**
217. because he's an actor **V,U, EXP**
218. I don't know how exactly you go about seeking help in the UK, but I'm sure you can find out through Time to Change. What I can say is, once you take this step, don't get discouraged easily - it is not an easy process, although it can be instantly rewarding as well. It takes time to get long time results. And being open with your family and friends, however difficult at first, is crucial. Good luck! **O, I/A, SUP**
219. My (ex-)bestfriend used to make jokes about depression and cutting. I already felt pretty bad about it at the time but I felt like utter shit everytime she did that. It felt like she was laughing at my problems as if they didn't matter. She never got to

know about my depression. Now I'm better and she didn't even notice the difference. She didn't even notice one of the biggest marks in my life so far and I never felt like I could tell her all because she laughed. Think before you speak. **PEMI, I/A**

220. Quick! Someone cast Wingardium Leviosa to lift up this man's spirits. **V, U**
221. I see a lot of comments about laying in bed the whole day. I couldn't, I was forced to go to school, and school was the main problem, not that i wasn't smart enough, no. it were the people at school who made my life a hell for 6 years. i have been depressed for years without anyone knowing, if i had told someone they'd make fun of me for being weak or w/e. showing weakness was the worst possible thing. it does get better tho, I still have problems resulting from it even though it was years ago. **O, PEMI**
222. I'm so sorry to hear that [name redacted], seeing the devastation that suicide can have on friends and loved ones isnt something that you often think of when your in that state of mind. Seeing comments like that gives me motivation to ask for help and get better so i can spread the word that it's okay to ask for help when your in that place. I hope that the pain will ease with time. X **DR** [? to 221, but username doesn’t relate to name used by 222 to address a commenter – unfound], **SUP, PEMI**
223. Yet, he's somehow magically able to stand up on his chair (rather over-dramatically) and tell off the whole class -- the innocent with the guilty. There's only one bully in this video and he's the star. I'd worry he had a gun. **V, NEG**
224. not sure I like the new season of skins. **V, T**
225. I doubt I'd see anyone in my lessons doing this, but It was great to watch. **O, V, POS**
226. There are English subtitles. Press the button that says CC right next to the settings button. **IR** [to any of several comments about audio], **A/I**
227. i didn't laugh. oh yeah its because I resonated with it. **POS, V, PEMI**
228. Exactly. Pretty much that, actually. And that's the awful part. **IR** [to 227], **O**
229. Clearly you haven't grasped the concept of depression yet, I take it. **IR, O, U**
230. Ohh, is that a Dead Poets Society reference? **V, Q,**
231. Yes I get the message, and live by it, that standing up and helping to normalise mental health so that its problems aren;t added to by stigma and others getting in hte way of recovery I was really hoping the teacher might be the one to apologise and to applaud or something that showed his support.... but he was portayed as the enemy. WHat message is that to show young people who already don;t feel safe? **V, NEG, O, Q**
232. You know what that DOES to a person!? when people mock and laugh at you for something like mental illness? Not only do we need help, we need someone to listen and answer us when we're calling out for help, whether we're shouting or thinking about it! **V, O, PEMI**
233. stop the trolling omg just stop if you don't think this video is very good then just leave **V, COM**
234. So, is this [name redacted] getting the point, or totally missing it? **Q, UA**
235. wat **U**
236. You know its a fictional teacher don't you? I don;t mean that harshly I just mean don't assume all teacher are like this becuase of one video. Hopefully another one will be made where its the teacher fighting for that student, fighting agains the world of bullying and ignorance instead of being showed as the enemy. :(Teachers

have mental health problems to you know, they are not robots who exist to help the researchers of Waterloo Road **V,Q, O, EXP**

237. thats literally retarded **IR** [to 236], or **U**

238. When you have a Mental health issue, you don't feel like doing anything, just dying. You sit there and cry knowing you can't change anything no matter how hard you try. You sit there and think about how it must be to be happy and fine. You may have some ups but the rest of your life is down and you wish your life was a roller coaster and would just run out of momentum so you didn't have to keep going, but you have to. (1/2) **O, PEMI, EXP**

239. teachers and college professors are big time losers **O**

240. u have never seen a school where they dont use unifroms? **IR** [to 212 – only ref to uniforms]

241. I wish I could tell the people how bulky me I have suicidal thoughts PEMI

242. Bully [spelling correction by 241] **EXP**

243. Hi [name redacted], I'm so sorry to hear you are being bullied and you are experiencing suicidal thoughts. Have you reached out for any support? Take care, [name redacted] at Time to Change **TTC, Q, SUP**

244. A lot of schools don't have uniforms **IR** [to 240 and/or 212] **EXP**

245. To them, making excuses is also sometimes suicide. My friend has suicidal thoughts for a long time now, and I don't know how she's still here, but she is strong. Now, you may think that suicide is a cowards way out. That the people who are afraid of life and reality can escape it all by dying simply! I thought the same way, but it's way different than that. People who kill themselves have far more balls than you and I together. You need to have balls of steel to take your own life. So shush. **PE, I/A, EXP, O**

246. I don't really get it **V, NEG**

247. So, what, you need to actually be "diagnosed" to know what it's like? What about all those people who are too afraid to talk to anyone about how they feel and in the mean time are feeling like they're dying inside? They don't know what it's like, you think? **IR,Q** [? to 201]

248. its cus they are british and britain tend to have uniform **V, IR** [to 244, 240, 212], **O**

249. Well, I used to think I was normal and lazy too, but then somebody explained to me what depression actually is. Cheers. **PEMI**

250. Yes, you are. Kindly show me where I ever said such a thing. Kindly show me where I didn't say it was hard. You sound like you're encouraging "your friend" to commit suicide. I'm the one saying that there's reason to hang on. It gets better. Hang in there. Really. **IR** [**UA**, but possibly 245], **AGG, SUP, O**

251. i got sent home for trying this but atleast other peoople started doing it !!!!! **V, O, POS, PE**

252. Oh I forgot to say that there is other celebrities that have mental disorders. She was just the first one to pop to my mind. **U, UA**

253. Your comment is relatively short and I have read it about 3 times. Also, if you act through anything even though there is fear, it doesn't make you less cowardly, it only makes you more brave. Fear is what keeps us going, what helps us survive. Some people are not as strong as you are. I know my friend, in this case, better than you and she is not afraid of life, she is afraid of people around her, because through her whole life she has been treated like shit and is not comfortable anywhere. IR [? to 250], by 245 **AGG, O, PE, EXP**

254. It's so good to see people expressing their feelings in this comments section - this is by far the most civilised I've seen YouTube. Though I'm only indirectly affected by mental illness (via two close family members) this means a lot to me ans awareness about mental illness needs to increase tenfold. **PEMI, O, POS, COM**
255. My depression has gotten so bad over the past couple of years that I've stopped doing a lot of my schoolwork. I always get my teachers yelling at me for not doing it, but sometimes it's just so hard. I physically don't have the energy to do much of anything anymore, but I'm still forced out of bed every day and made to go to school regardless. **PEMI**
256. How many teachers does it take to change an attitude? As a teacher, (you know, the one is video who is cold, uncaring, arrogant and totally ignorant.....) who also sufferes with mental illness I think the portrayal of a classroom here is a real shame. It portrays the adult as being part of the problem when I don;t know a simgle adult working in schools who is shouting out about getting more help, more resources and more information about mental health into schools **V, PEMI, NEG, O**
257. Wut. **U**
258. this talking about depression, how it feels like. Depression is feeling like you can't move at all and how his friends were making jokes about him not going to school and stuff **V, O, EXP**
259. Depression with a high suicide rate from what it seems like. **O**
260. This is so wonderful, so many more people need to understand that a mental illness is actually something to be concerned about, it's not a joke. Ever. **V, O, POS**
261. if you haven't experienced this and you don't know what it's like then you have no right to comment saying negative things about this video. If you don't agree with what it's saying simply leave this video. **O, I/A, COM, V**
262. I'm a person who fell ill when i was 15, missed a lot of school and ended up being taken out of education by my doctors. This video is incredibly helpful. I faced constant harassment and invasion of my privacy due to my absence, and the jokes and shitty teachers are all very real things. Mental illness destroys families, but also people's educations. If i had seen this, it would have not only helped me a lot but perhaps encouraged everyone around me to be less difficult and unhelpful. **V, POS, PEMI, O**
263. In school I had a real issue with coming in and sitting in classes, I used to skip school a lot and lie about where I'd been. Truth is I have severe anxiety and being around that many people who I don't trust just gave me constant panic attacks. Teachers didn't see that. Several of them laughed at me while I was having an attack. My friends made fun of me and said I'm doing it on purpose to get out of lessons. This video is so fucking powerful. **PEMI, V, ER, POS**
264. This ad alone, sums up what happened to me last year, missing so much of school, just sitting at home, doing nothing. It's bad, and I'm glad an ad like this exists, so people can understand that this is a real thing, no bullshit. **V, POS, PEMI**
265. Look. How you ever felt like you just been punished so much only for being someone you can't help being? If you haven't, then it is why you fear so much. I know. And it sucks. All those people that attack you on the daily basis and sometimes it's people that you love. I don't know you and you don't know me. It's okay to not know how it feels. But it's not okay to be so condescending and worse, prejudice. God wouldn't want us to abandon each other (Oh yeah. I went there)so why should we? you kno? **IR, PEMI, O, Q**

266. One teacher I had in particular called my lazy because us wouldn't work. I have social anxiety disorder and the class revolved around interaction with other people. It on top of other things led me to self harm and suicidal thoughts... **PEMI**

267. That's the best you've got? When presented with a valid argument, you resort to ad hominem attacks? Do you really expect to be taken seriously? Lol. Welcome to the internet, I guess. **IR** [**UA** – possibly earlier deleted comment/s from 268], **Q, O, AGG**

268. I think you are agreeing with me,there is no demographic in mental health.My gripe is why make the vid look like an ep of Misfits.Young people dont need patronising they need help.They look like they will all break out in song at any minute like in Glee...i showed it tomy pts and only two out of twenty thought it was a true reflection of their plight IR [possibly to 267] **O, V, NEG**

269. The whole social idea is that there is not any understanding in terms of those who suffer depression; like if this guy in question had pneumonia and had been out of class for two weeks, the mood of those who'd greet him would have been totally different. This ad challenges the "don't bother" approach to mental illness (as much of the majority of people don't understand it to a workable level) and pushes the idea that change needs to be done for the better. That's what you're missing. **O, EXP, V, POS**

270. I can't understand a word that kid is saying **V, NEG** [*sound*]

271. What pissed him off was that everyone was making jokes about him being off when he was obviously off because he was so depressed it was too hard for him to do stuff like go to school, and he meant "it just makes it a little harder" about all the jokes because he's already hurting enough and it hurts more everyone's making jokes about something they know nothing about V**, EXP, O**

272. Everyone should see this video **V, POS**

273. YES!!!! because you know they were "obviously" meant to know that he was depressed when he posted on facebook that he was "still skiving" and making jokes in class to seem happy -_- **V, IR** [? To 271], O, EXP

274. They are in sixth form so they do not have to wear school uniform any year below that in the uk you have to wear uniform **V, O, EXP, IR** [e.g. 240,212, 244]

275. There should be more videos like this **V, POS**

276. You know what I see mostly on this page. A whole lot of people complaining about bullying whilst bullying any commenter that disagree with them. What a bunch of hypocrites! **O, COM**

277. They couldn't have put it simpler **V, POS**

278. a while back I had a major illness. I missed a lot of school in that time, quite a lot of jokes were made about me. A lot of it was just banter, messing around. But when people don't know what is actually happening it is so painful. You have no one to talk to, and quite a few times I felt like doing exactly like this guy did. I was lucky enough to recover, but the jokes still go on. All it took was one simple facebook post to shut it up in the end. This video is so true,I can fully relate to it **V, POS, PEMI**

279. Okay so I don't understand this, I mean a few things: Why does he start that speech like what makes him so pissed off, is it just that no one knows actually where he has been? What is the offending joke? is it the "are you a comedian?" and it hurts him because he's actually the opposite? And more importantly what does he mean at 2:01 "it just makes it a little harder", what makes what harder? I'm not a native speaker nor am I depressed so I didn't quite follow... **V, NEG, Q**

280. I'm not saying that teachers are a problem, (I myself have a few wonderful ones), but the advert is making a very general classroom environment to make it more relatable. most teenager with mental health problems don't see their teacher as an ally, just someone who piles on the work, regardless of situation. This might not be the teacher's fault, but the whole point was to put the viewer in the teenager's shoes **V, POS, O, EXP**
281. Ha **U**
282. Suffered since 8. But I agree with you. There is a culture of a misery out there. The same went for anorexia/bulimia subcultures in the 90s . You are what you think think really. I've spent so many years of therapy changing how I think and it really helps a lot. I don't think this vid is cool at all though. I don't really like it. I want people to understand but I don't want pity. This vid is very off putting for me. **V, NEG, PEMI, UA, O**
283. the other thing is the pressure to "get it together" by the time you're an adult, so even though many adults still suffer from mental illness, they're forced to conceal it. that does not mean it's under control, it just means it's hidden. **O, EXP**
284. shit. hit close to home. **V, ER**
285. Since when was laziness a mental illness? **O, NEG**
286. thumbs up if reddit brought u here **U**
287. gayyy **T**
288. u know what for like four months i had a reallly shitty time because i was really depressed and i missed a lot of school and all my teachers were pestering me about it and they forced me to interact with other people and when i came to school for like two periods because i just couldn't take it anymore after that my teachers and classmates were like "oh finally back yeha? hahaha" and no jsut no man like that was the worst moments of my life ever and i was only 13 years old and i wanted to die. **PEMI**
289. BORING! **V. NEG**
290. Fact is you deserved the fail. **U, UA**
291. SLOW FUCKING CLAP I'm sick of sitting silently in the sidelines while mental health jokes are told and it kills me **PEMI, V, POS**
292. Why do you assume he is acting? **V, Q**
293. Don't think. Just do **I/A, U**
294. this video makes no sense ..... **V, NEG**
295. Hmmmm, becuase youtube isn;t just a popularity contest..... But I do agree the video is awful and looks like a comedy.... **UA, O, V, NEG**
296. i hate when teachers are so irogant **O, V**
297. Bullhshit! It IS the coward's way out. It takes far more balls to live than it does to die. First thing we've got to do is stop enabling by glorifying them. IR [to UA but likely 253, 245, 185], **O, NEG, AGG**
298. what mental illness did he have, he seemed normal to me **V, Q, O**
299. Either that, or he actually knows what it's like. **IR** [? to 298], **O**
300. Another one that can't handle the truth and doesn't know his ass from a hole in the ground. Keep buying the government line, fool. [*From writer of 297 and other AGG comments*] **O, AGG, UA**
301. ImmortalHD at 2:04 ? **V, U**
302. This is a useful campaign, but my guess is that no one will mention the suffering caused by successive governments and their demonisation of the vulnerable as lazy and workshy. Mental health is not the same as physical illness,

those with power have a vested interest in getting you to believe it is. GOOGLE, power threat meaning framework. **V, O, EXP**

303. In the video people make serious faces. In the real world they will drown you out laughing and shouting, "Somebody take this idiot off the desk please" **V, NEG, O**

304. No one "needs" to commit suicide and I really hope that's not the message you're sending her. The old saying is true. It's a permanent answer to a temporary problem. And it is temporary. [same user as 300 etc.] **IR, O**

305. i was depressed as a child and no one knew i was supposed to be happy all the time and i got dirty looks if i asked any odd questions or had any emotions like anger or sadness no one understood no one seemed to care as long as i did what i was told. i am better now but this needs to be addressed people need help not scorn **O, PEMI**

306. So now you're bullying a fellow commenter here? Just because they disagree with you? [same user as 300, 304] **IR** to **UA, Q, AGG**

307. Last I checked no one has ever changed the world by doing what the world has told them to do. **O**

308. I think they're trying to portray even older people don't always know. Often a lot of older people are who you look up to for support and help and they (even professionals) will brush it off. For teens it's estimated severe depression and mood disorders are brushed off as puberty. Even psychosis. We kind of expect kids to not understand, it's a way of showing that we're all human and need to learn and want to understand, not that older people should 'just get it'. Don't see it as a stab. =] **V, O, E, UA, AGE**

309. In high school I talked to people about being depressed. I even admitted myself to the hospital once because I couldn't take it. The most frequently asked question was "have you considered suicide." I told them "no;" I had in the past but I was determined to stay strong. I was still very depressed though - worse than when I HAD considered it. Oddly enough (or not very odd, hmm?), people started paying more attention when I wanted to die, even though I had already warned them about how I felt. **O, PEMI**

310. it sucks because hes an actor and i feel like this everyday :(**V, PEMI**

311. This is so true. You don't know if someone is depressed. That classmate that everyone makes fun of could have it. Take mental problems more seriously **V, POS, O, I/A** [*note use of 'have it'*]

312. Last year this one teacher absolutely hated me. I made one mistake in her class where she met with me afterwards to discuss. Mind you I usually am on the good side of teachers since I do my work, stuff like that. She basically spent the whole rest of the year going out of her way to always remind me of that one incident. I already beat myself up over that but she just made it so much worse. Plus she knew I was "ill" and didn't care at all. So yes teachers can act like the teacher in the video. **V, POS, PEMI, O**

313. Most of my teachers are understanding but I do have teachers that know about my situation and ignore it and complain that I'm a bad student because i'm not there all the time, but when I am there I get good grades (usually 90+ on everything) plus they don't give me the opportunity to make things up that I miss. My Phys Science teacher is very much like the teacher in this video. **PEMI, V, POS**

314. more people need to see this. there aren't many promos as good as this **V, POS**

315. Look at how that kid's acting! Turning on his class, punishing them with his words for what he merely thinks is a cruel world. He's got all the earmarks of being

a school shooter. I was screaming at everyone else in the room, run! Run now before it's too late! **V, NEG** [AGG commenter from 300, 304, 306, and earlier], **O, I/A**

316. Kind of defeated your own point by wishing he was tortured. **IR** [? to 315], **U**
317. You're the one trying to shut mine down. You don't know jackshit. I have experience with the disease. It runs in the damned family and this is not how depressed people act. Deal with the truth. [AGG commenter from 300, 304, 306, 315 and earlier] **AGG, O, PEMI, V, NEG, I/A, UA**
318. Bull. Not being diagnosed doesn't mean you don't have any issues. Maybe it means you can't afford the doctor. Maybe it means you're too afraid to go. **O, IR** [*to earlier comments re diagnosis;* 201, 247]
319. Teachers really are just shit. Last year I had a very strict, ex-marine as a history teacher and he hated my guts even though I'm usually a good student. He thought that I cheated on a homework after being sick for a week and yelled at me harsh enough to make me cry like a fucker. There were so many bad incidents in that class that I get flashbacks of how scared I felt, how my face heated up, how I got dizzy from anxiety, and how I cried in front of him and in the bathroom, avoiding class. **O, PEMI**
320. something like this happened at my school. we were all quiet. some cried. at the end we stood up and clapped. two more people came up and told us their stories. and we listened. **PE**
321. You are a sick person and I hope you fall down a well and have your eyelids removed. **AGG, U, IR to UA**
322. Literally. Literally retarded...*sigh*....LITERALLY. *soft whisper* no **U**, to **UA**
323. you may not. But I do. In fact, 17/18 teachers i had in high school. I suffered depression and chronic anxiety. My only escape was my art so whenever i felt low or about to panic, i would draw and let my mind wander. My teachers would snap at me asking "Whats wrong with you? Are you sick in the head?" and i would explain that when my anxiety or depression gets to high, i release it by creating. you know what they did? they ripped up my work in front of the whole class. **IR** to **UA, PEMI**
324. Not sure about this one. I have been a teacher and i've been through chronic depression. I know this is a fictional scenario but I think this is too far off the mark. I am not saying that to be disrespectful but I think you should listen to feedback on these campaigns if it really is about breaking the taboo... Surely the whole point of these campaigns is to open up discussion? So if you remove my comment it is frankly a bit hypocritical. One step in 'removing the taboo' is to not treat people like victims. I understand removing nasty comments but it seems you are only keeping comments that absolutely agree with your pitch. And im no 'troll' - im someone who has been through severe depression. **V, NEG, PEMI** * (previous comments removed?)
325. Hi [username redacted]. If you need someone to talk to, the Samaritans are always available on 08457 90 90 90 - the 2 charities that run Time to Change, Mind and Rethink Mental Illness, also have excellent advice lines. You can contact Mind on 0300 123 3393 or by emailing info@mind.org.uk and Rethink on 0300 5000 927. **TTC, SUP, A/I, DR to UA**
326. Hi, spread the word these girls are trying to help people through out the world, people who have problems that they cant talk to their freinds and family about can talk to these girls no matter what tye subject if its parenting advice, self esteem

problems, anxiety and any other questions you have the girls have experienced it all and ready to help you start living your life again. https://m.facebook.com/TheSolutionGirls A/I, PROM

327. Hi there, this video is a starting point for people finding out more about mental health problems. On our website, we've got lots of bloggers (of all ages, but at the moment, we're featuring blogs from younger people) who are sharing their experiences & how their mental illness and the stigma that surrounds it impacts on their lives and those of their families. We also link to Mind and Rethink Mental Illness so people can find out more about mental illness. Do google Time to Change to find us. **TTC, A/I, PROM**
328. i don't really understand what they're saying , would anyone care and break it down for me? **V, NEG** [*sound*], **Q**
329. You are saying the exact opposite of what this video is trying to portray. **IR** to **UA, U**
330. Oh and for the record lying in bed all day is not because of laziness in this instance but because of that depression or anxiety, or both. I would give to have my high school years back, so many absent days I might of well not of been there. **PEMI, IR** to **UA**
331. Mental illness doesn't care about class. "Real sufferers", don't come from a certain demographic of people. You come off incredibly uninformed with that comment. **O, EXP, IR** to **UA**
332. thats impressive. i am a shy person. and ppl still think im arrogant for not talking to them in school. that is unfair and makes me sad. im anxious, maybe in a social anxiety way i dont know how to deal with it. i'd love to have more self-confidence. **V, POS, PEMI**
333. It was filmed in a set on purpose therefore he is acting for a film. Neither you or I know him so one has to assume. You don't know him personally to even know that either. **V, O, EXP, IR** to **UA**
334. I completely dissagree. Adults don't really grow up and tend to be really cruel, except their cruelty has matured and is more painful. People don't understand what they did not experience. You need empathy to understand and most people really don't care to try to understand. However, there are also a lot of people that with age gain experience and develop empathy and understanding, so as you grow, you're more likely to find good friends, but the cruel people are always going to be there. **IR** to **UA**, **O, AGE**
335. its things like this can can paint the minds of children into thinking they have a mental illness when they don't, they just absorb into the glorification of it and see it as some 'cool' thing, i think mental illness campaign awarenesses should be more mature instead of appealing to a younger audience which may influence... and if anyone replies with the classic 'how would you know' i've been suffering with depression and anxiety for 5 years **V, NEG, PEMI** *
336. None of my teachers did crap to help me. Told me to get over it. Singled me out. Things were written about me on the walls of the bathroom and I got blamed for it. So please don't say that adults aren't part of the problem. **IR** [to ? 334], **PEMI, O, I/A, AGE**
337. It doesn't matter how many people love you, how much fun you're having at that time, you have a mental health issue that took over your life and you can't control your roller coaster you call life. You can't do anything and you have no other option but to live with it...(2/2) [*Cont. suggested but not temporally linked*]. **O, PEMI**

338. I dermatillmania.. it sucks having myself do that because of anxiety, and depression. **PEMI**

339. Are you fucking thick!! THE DUMBEST COMMENT AWARD GOES TO YOU!! **AGG, T, IR to UA**, [*? didn't understand previous user referenced a MH condition*]

340. Excuse me, [username redacted] we'd all appreciate if you could shut the hell up, thanks. Just watch the video and comment your opinion. You don't need to argue with anyone else, ok? Thanks. The reason I'm not tagging you is because I figure you'll see it anyway, considering how much time you put into into **DR** to **AGG** [from 300, 304, 306, 315, 317 and earlier] **O, C, AGG.**

341. Another aspect to this is how it seems in our empathy lacking times how most people like to write off a person who suffers from the illness as being "emo". **O, V**

342. this is a pile of rubbish alot of the things today kids catch from tv or mixing with bad kids **V, NEG, AGG** [*note use of 'catch'*]

343. Hi [name deleted], I'm afraid that mental health is very much real, as is the stigma that surrounds it. It is certainly not something you can 'catch' from TV. You can find out more about mental health here: http://www.time-to-change.org.uk/mental-health-statistics-facts Best, Time to Change **DR** [to 342], **TTC, EXP, PROM**

344. I hate when teachers treat you like that for missing school, Like he said, mental illness isn't something that people can spot easily in a person, but it takes over that persons mind, motivation, and their whole life. You don't think I'd want to do the right thing and go to school, make the right choices, and to stop disappointing people I care about? I respect all who are going through the same thing and are staying strong. **PEMI, O**

345. It's a fucking youtube video. **V, U**

346. This is so sad.. but I get pissed off as well. Because this happens every single day. How can a teacher be so ignorant to something so important.. ??? :'(**V, ER, Q, O**

347. This is a really special people to me. I also want to point out that many times the people who are the saddest seem to be the happiest at school and when you see them. On the inside we can all really be struggling. I Hope more people see this video. **V, POS, O**

348. I don't know what kind of mental illness you have, but my depression and anxiety has taken a toll on my physical form. Before I got it under control I lost weight and had dark circles around my eyes despite how much sleep I got. PEMI, IR

349. It needs to be taken less seriously. **IR** to **UA**. [Same user as 340, 300, 304, 306, 315, 317 and earlier] **T**

350. Exactly. So, given that it seems that everyone is out for themselves. No one is truly generous or charitable. They only want something down the line or are looking to minimize their own guilt. Would that be accurate to say? **IR** to **UA, O, Q**

351. I find it funny. Ironic even. Yes. teachers are very much part of the problem. They don't seem to understand that every time you all point us out in class, we feel it. Especially us. The one's with depression or trouble within our mentalities. When you make comments such as, "sorry that you're just too lazy to do it." or, "you just don't try do you?". That's not the case. Depression hurts. It's hard to deal with. It's...It's too much to explain...until you walk in our shoes...don't judge. **V, O, PEMI, I/A,**

352. CAN SOMEONE SEND THIS TO MILEY CYRUS PLEASE INSTEAD OF ANOTHER OPEN LETTER **V, POS**

353. Oh would people can it about the stupid uniforms, like is anyone really listening to a word this boy is actually saying? [**IR** to, e.g. 212, 240, 244] **Q, I/A, V**

354. The student is not misbehaving; he is taking a stand against the kids in his class. What he describes is exactly what depression feels like. Sometimes it is very hard to get up in the morning and go to school. What this teacher shows is that he is cold, uncaring, arrogant and ignorant. **V, EXP, O**

355. at my school, there was a kid who was struggling. he had issues at home as well, and one of his only friends also was in the class. he didn't do much work, but at least he tried. there was a day that he didn't bring his homework, and the teacher called him lazy and that he wasn't trying hard enough. he got up to get a tissue and cried, then when the teacher hurled the final insult at him he ran out of the classroom and into the streets. **PEMI**

356. it doesn't make sense that younger people tend to suffer with mental illness more than older people. **O, AGE**

357. Get professional help before you shoot up your school 'cause this kid is definitely on the verge of doing so. **UA, O, V, NEG, AGG** [Same user as 349, 340, 300, 304, 306, 315, 317 and earlier]

358. I think you're just ashamed to admit you're scared of living and try to act like a badass on the Internet by insulting everyone else that was through the same shit like you. The reason you overcame your suicidal feelings is the exact reason why you should be HELPING and COMFORTING people who are like when you were suicidal, not look up videos like this and insulting them. **DR** [to 357] **I/A, O**

359. I like this video, wish more people understood about mental health issues. It feels like a losing battle when you reach out for help on fb to be told by friends that posting about my self-harm only encourages others. It only shows their ignorance. I don't ask for help anymore and don't consider them friends. Who needs people like that? **V, POS, Q, PEMI**

360. They seem to be aware of his situation yet they still make fun of him for missing school, saying he's been 'on holiday' or 'skiving' when they know that isn't the case. It's not about people being openly disrespectful to his face, more about how they make his suffering worse by not caring and joking about what he has to live with everyday. A lot of people who suffer from mental illness have at least one person who doesn't quite get just how debilitating it is, in this case, it was the class. **V, O, EXP**

361. I've noticed that the really honest reviews are getting too many negative comments and because You Tube DOESN'T sponsor free speech. I mention that I'm a 56yo survivor of a suicide attempt and depression, that I was a suicidal teen who is now glad that I didn't kill myself, and all you people who are too PC to handle the truth that the main character in this video is scary beyond being depression spam with thumbs down. Well, if you're really PC, learn from a survivor. This kid is an asshole. **V, NEG, PEMI, AGG** [Same user as 357, 349, 340, 300, 304, 306, 315, 317 and earlier AGG]

362. I get some people are angry that this wouldn't happen but it raises the point people with mental health struggle. **IR, O, V**

363. Hi Eve, thanks for your comment. You are right in saying that Stand Up Kid is a scripted video, not a video of a real life classroom, which plays out a fictional scenario that highlights the difficulties young people with mental health problems often face. Best wishes, Dom at Time to Change **TTC, EXP** [*Positioned as*

response to 362 but username doesn't fit and others comment similarly. Comment deleted?]

364. No but this is so perfect. You don't understand how many teachers that have made my life a living hell when I came back to school. When it got really bad I'd be lucky to be able to go 2 out of the 5 days. There were few teachers that helped, but most would glare at me when I mustered up the strength to come in that day; not allowing me to make up work and making me the joke of the class. This is no joke. Living is already hard enough. I had to switch to online school just to try to graduate. **V, POS, PEMI, O**
365. Just because you don't understand something, doesn't mean it's necessarily bad. It's your opinion, not fact. don't be ignorant. **UA, O, I/A**
366. stfu. reddit doesn't need anymore publicity. **AGG, U**
367. More ageism from the ttc camp. Are the rest of us not supposed to be able to see straight? **V, NEG, AGE**
368. I think it makes sense. The younger people have to deal with being picked on for it at school everyday by their peers who are really clueless to the whole thing. Where as the older ones (Older meaning adult At least for me it does.) They've learned to ignore those who would poke fun at them. It isn't easy to do and can still hurt. But, the older ones, most of them understand why they are this way. Where the younger ones don't understand
369. why they can't be like the other kids. IR to 367, **O, EXP, AGE**
370. boring **U**
371. That's not true actually. Suicide is very high among baby boomers right now. Get your facts straight if you're going to go spouting like you know them. IR to 368, **O, I/A, AGG, AGE** [Same user as 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier]
372. You just tend to hear more about it because adolescence is when the mental illness emerges. By the time you are an adult it is possible you have it under control by using medicine or therapy or whatever. **O, DR** [to 370, 367, 268] **EXP, AGE**
373. Who says actors/actresses can't have mental disorders? For instance look at Demi Lovato, she is a famous person and has bipolar disorder. **IR to UA**, Oblique **V, O**
374. I never said he was attacking the other kids, he was bringing awareness. Who knows? His parents may be getting him help. This is a commercial anyways. It is supposed to bring awareness to mental disorders. **V, IR to UA, O**
375. please don't tell someone that they might be depressed because they asked something that you didn't like reading. **UA, U**
376. That's why people should be careful with their words and not jump to make jokes at someone's expense, just in case. You never know what happens behind closed doors. **V, O**
377. This looks a bit "staged" with all the camera angels. It's like TV. **V, NEG**
378. people at my school didn't even make jokes. They say "he has no reason to act that way" "what's his problem?" "It's so disgusting". **PEMI**
379. Propaganda to pity kids who can only help themselves. **V, NEG, O, AGG**
380. We are not asking for pity, we are asking for understanding. **DR** [to 378], **O, EXP**
381. The "propaganda" comment reminds me of that powerful advertisement "Heart Disease -- just another excuse for lazy people not to work". Its point was that with a physical illness, we understand. But mental illness can be just as debilitating. My daughter has mental illness, and when her depression reaches its

deep lows, she just CAN'T. She wishes she could, but she just can't. This isn't "Propaganda to pity kids who can only help themselves." That's the main and powerful point of this video. Don't ask them to help themselves. Don't ask them to "snap out of it", to "cheer up", to "think happy thoughts", "just get out of bed and you'll feel better". The video asks us to "make a stand", but first it asks us to UNDERstand. **V, IR** [to 378], **PEMI, O, EXP, I/A**

382. He's victimizing himself, if he has a mental problem then work to make it better otherwise being late and a delinquent is no excuse. If hes really serious then he needs an aid to follow him around and make sure hes on schedule. **V, NEG, O**

383. He is in no way victimizing himself. The teacher was making fun of him for missing school so often, and he explained to the class that mental illness is just as good a reason to miss school as physical illness. Would you say that having pneumonia is "no excuse" for being absent? I don't think so. And people like you are the reason that videos like this exist in the first place. Let's think twice before we make ignorant claims, okay? :) **V, DR** [to 381], **O, I/A, AGG**

384. I think the more people start taking other peoples depression seriously, the easier it is for sufferers to talk to people. like I was mildly depressed for a year, my friends just laughed at it thinking I was joking, but after many talks with family and a few check ups from the doctor I was back to my old self **O, PEMI**

385. A brilliant video, showing in an uncompromising way how people's attitudes to mental illness can be changed by sufferers speaking about the condition. Following how the Paralympics changed our perceptions of physical disability, is mental disability, short or long-term, the last taboo? **V, POS, O, Q**

386. I seriously dont get HOW ppl can joke about this. Trust me, if someone from your family was suffering from depression..I dont think you would joke about it. Actually, you wouldn't. So why do it here.. ? Anyway... The video was great..and what Michael said is what depression actually feels like. Ppl that suffer from depression need a lot of love and understanding. V, POS, Q, SUP, PE, O

387. I'm a manager of a mental health unit for young people and this vid is insulting. Its like a pop video and does not convey the way depression destroys families and the individuals who suffer from it. These things should show how to help people and normalise mental illness more effectivley. Students will watch this and think they have depression when they are just pissed off and fed up. Film it in an inner city college. with real sufferers.. Less PC more realsim. **V, NEG, O**

388. I'm a native speaker and have dealt with depression and I don't get the point of it either. Frankly, the first step to overcoming depression (I was a suicidal teen and I'm now about to turn 56 so I've some clue on it) is to deal with the world as is -- not as you want it to be. I'm all with not bullying messages but this left me going huh, what? Nothing said to him was that bad -- at all. At some point, it's the ill person's responsibility to take control of their illness. * [same user as 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier] **V, NEG, PEMI, O**

389. I do get the point but they could've made it A LOT clearer, the only person who "jokes" about mental disorders within this entire clip is the person with the mental disorder. I'm not saying thats right but i'm saying that it looks like he's bringing up the point with no reason to make him. Apart from someone asking him where he's been, which isn't really a joke **V, NEG, O**

390. Oh no, I'm not saying that a person who commits suicide is selfish. I was just bringing that in to the counter point because that sentiment of selfishness towards the suicidal is always thrown around. Which I disagree with. I don't think a person who commits suicide is selfish. **UA, O**

391. Seriously uncomfortable - certainly stabbed at my heart. The stigma can make the shit even shitter, and devastatingly lonely. Always worse when people in responsible positions, such as teachers, behave so ignorantly. **V, ER, O**

392. siacion. Han publicad [? ' …. Have published' – Span.] **U**

393. The American Prohibition of alcohol was a failure because figures of authority pointed to a substance and said it wasn't OK to enjoy anymore. A successful prohibition would be the prohibition on mental illness. We all, as a society, ignored a thing so intensely that we silently agreed that it wasn't ok to talk about anymore. Instead of pointing to it, we just avoided looking at it. We made a clear void in our own society that no one acknowledged for years. And we did it to ourselves. **O, EXP**

394. Little bit shit, that kid would have been sent out of the class as soon as he stood on his chair **V, NEG, O**

395. Everybody is like this in my class and I absolutely hate it. Joke about mental illness? Wow so funny! Joke about depression? Soo hilarious. I don't understand how people can be so insensitive and disrespectful. **O, PE**

396. Also, learn this. He's more liable to lash out at others than himself. Suicidal teens don't tend to call attention to themselves in this way. This is a potential class shooter. He is a ticking time bomb ready to go off and that is definitely not his teacher or classmate's fault. The so-called "bullying" here is nothing. Absolutely nothing. Some of us were really bullied in high school. This guy gets one slight tease and he's ready to freaking lash out. It's the most retarded PSA ever. [same AGG as in 387, 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier] [*Repeats point made earlier. Serious MI?*] **O, AGG, V, NEG**]

397. What the fuck did this have to do with mental illness? No one even said anything to him about being mentally ill. **V, NEG, Q, O**

398. Some people are so ignorant about mental health problems. The problem is people don't really know what it is really like to suffer from something like depression. It's serious, and if someone trusts you enough to tell you, or you think someone is showing the symptoms. They need to get proper help, just the same as you would with suffering physical symptoms. O, E

399. I'm sorry to say this but you're either depressed yourself and don't even know it, or are just plain ignorant. IR to UA ? 397 but not likely, AGG

400. I can't understand all the words. Still the point comes across, IF you're open to it. There's a difference between being irresponsible as observed from the outside & being depressed as experienced from the inside. There's a difference between not giving a shit & feeling paralyzed. From the outside it's hard to know whether someone is a jerk-off or mentally ill. Missing class because you have pneumonia or are clinically depressed is not being lazy. Must he kill himself before we acknowledge this? **V, POS, O, EXP, Q**

401. Quite so. But given that it would almost seem that the only reason people step forward to prevent someone from committing suicide is because they don't want to deal with their own guilt of "I should have done something" afterwards. So that also brings up another question. People say that one who commits suicide is selfish. But who is more selfish in this scenario? The one who kills himself or the one who doesn't want to deal with their own guilt and pretends to care? **DR** [to 399] **O, Q, EXP**

402. Only if drugs could cure this. Is there like a <u>therapist app</u> that anyone would recommend? **PEMI, O, Q**

403. mental health isnt an 'issue' in your life. IT BECOMES YOUR LIFE. you dont know what to do, its not about man-ing up and being brave. its about coming face to face with yourself (which is hard) and getting better. **PEMI, O, EXP**

404. Do you even hear yourself? You admit he is attacking the other kids in his classroom. Good thing he didn't have a gun! You seem to think the rest of the world should manage his illness. No, he should. With a doctor's help. His parents are the only ones at fault for not getting him that help. The teacher is trying to do HIS job. He isn't doing it well enough as he doesn't stop him, putting students in danger. He definitely isn't the hero the teacher in NE was. [same AGG as in 395, 387, 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier. Thematic repetition] **V, O, AGG, NEG, UA**

405. So what you're suggesting is the teacher should coddle them instead of preparing them for the real world? This teacher wasn't tough enough on his sorry ass. He should have not allowed this disruption in his classroom. He should have sent him to the freaking office minimum. [Same AGG as above] **UA, Q, O, V, NEG**

406. I have someone very close to me that struggles every day.....mental health is no joke and I think society needs to start teaching kids empathy not apathy and maybe just maybe we could start to reachout and help **PEMI, O**

407. He is... This video was created as a public service announcement... This isn't a true story. But, just because the video is not real, doesn't mean that the message isn't real. **V, EXP, O, UA**

408. What people don't realise is that depression is an illness that affects the brain, which is just another organ. It just affects you in a different way. It has also been proven that severe depression can be more damaging to your health than some physical illnesses and disorders. This video is brilliant. **V, POS, O, EXP**

409. A teacher wouldn't let a student do that. Illogical. And he made a joke in return so he has no room to be judging others. No one cares about his problems. **V, NEG, O**

410. I'm not "encouraging" her to commit suicide, I'm justifying her need to commit suicide. Trust me, if I've been in love with her also for some time, and if she committed suicide, I'd probably die alone, because I couldn't forgive myself for stopping her. **PEMI, EXP [IR**/contextually to main AGG. Refers to own comment earlier/the response. Temporally distanced. [Response to this comment from AGG: Yes, you are. Kindly show me where I ever said such a thing. Kindly show me where I didn't say it was hard. You sound like you're encouraging "your friend" to commit suicide. I'm the one saying that there's reason to hang on. It gets better. Hang in there. Really.]

411. I'm being a bully? YOU insulted these people by telling them they're cowards. YOU are the bully here. I will say this one more time, read SLOWLY: "Not all people are the same." It got better for YOU, I'm happy for you, but what if it does not get better for HER or someone else!? What if they can't imagine living another WEEK yet alone another few years until it gets better? You think telling them to "man up and stop being little bitches about it" is going to help? Come on... I rest my case. [Commenter in 409, DR to 'PRIME AGG'], **O, AGG, PEMI**

412. The teacher mildly scolded a kid who was late and who is continually late and absent. The teacher was not out of line. This brat -- yeah, you heard me right -- thinks he can just come and go as he pleases and no one has any right to do anything but coddle him and hand him everything on a silver platter. It's time he accepted responsibility for his own actions and managed his own illness instead of expecting everyone else to walk on pins and needles around him. ['PRIME AGG'

as in 403, 404, 395, 387, 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier] **V, NEG, O, AGG**

413. Are you serious? How about you stop being so narrow-minded? Just because he's depressed doesn't mean he's crazy. It's because of people that think like you that people are not getting the help they need. They rather just stay away from it. Face it. You can learn a thing or two about the broad spectrum of humanity. DR [to 411], **Q, O, EXP**

414. First world problems, I had a friend in the university from Syria, last week all his family were killed by an american air strike . Can you imagine all his 5 brothers and sister, father, mother, grandparents all dead. and he can't even return home to say good bye to them. **PE, O, NEG, Q**

415. wish I had the courage to stand up in my class and say that. Maybe you could? a lot of us with depression its cos of abuse, and abuse is like torture, like abu Ghraib, like Guantanamo, like most countries prisons and systems. there are Psychopaths, a small percentage of the population, and they create Sociopaths, and the rest of us get abused, its like a disease that spreads. WE need to spread the Understanding. thats true Religion. **PEMI, O, EXP, Q, V**

416. Im very sorry that happened. It's terrible the things that happen in this world. But most people don't have to go through that. Just because others have worse problems doesn't make ours any better. Mental illness isn't something we choose to have. And it's not something that we can just turn off because of worse things going on in the world. **DR** [to 413], **O, E, PEMI, SUP**

417. there's always someone who has it worse. f-off with your condescending attitude. the brain, like any other organ can get sick. why is that so hard to grasp **AGG, EXP, Q**

418. "If you are ugly from outside , try to not be ugly from inside too" Chinese wisdom. **UA, I/A**

419. "small brain means big mouth. usually compensated by quoting others for verbalization of own ideas is too complex." -me thinking. [same commenter as 417] **O, U**

420. I dislike people like this. Why most we compare struggles ? I'm sorry that happened to your friend but a mental illness is a hard thing to go through as well. **IR** [to 413] **O, Q, SUP**

421. You said he was telling off his classmates -- in other words, verbally attacking them, the innocent as well as the guilty. He makes them all pay with his onslaught of verbal abuse. There are only mildly "guilty" depicted here to begin with. The only bully shown is him and he acts in ways someone clinically depressed would not, drawing unwanted attention to himself. This commercial is misinforming about mental disorders. [Same AGG commenter as 411, 403, 404, 395, 387, 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier] **V, NEG, AGG, O**

422. Where did you get your statistic that younger people suffer from mental illness more than adults? A lot of mental illnesses can't be properly diagnosed until your late teens to early twenties anyway. **IR** [to topic of 356, 367-70], **O, Q, AGE**

423. So? Is personal responsibility totally out of the picture now? We make other people like teachers responsible for our behavior? No, I don't think so. I don't think this teacher was out of line to shame a misbehaving kid (for whatever reason) in front of the others and that's some pretty damned mild shaming. He's a teacher, not a social worker. His job is to teach, not help. You don't send your kid to school to have his little hand held; you send him to learn. [Same AGG as 420, 411, 403, 404,

395, 387, 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier] **NEG, AGG, U, O, V**

424. And when you think about people only helping because they don't want to deal with their own guilt you have to ask yourself this: who's more selfish? The person helping because they don't want to deal with their guilt or the person who is actually going through with suicide? **Q, U, UA**

425. Why do you feel the need to argue back to everybody's comments? The point of the video is to raise awareness, that's it. Everyone has their own opinion and we all understand that but you don't need to try and change everyone else's to yours. **DR** [to PRIME AGG], **Q, O,**

426. Why do you feel a need to shut me up? People are refusing to hear the truth instead of the PC bulletins hand-fed you by the most powerful governments of the world. The truth is a depressed kid is not likely to behave this way and a kid behaving this way is much more likely to be a school shooter than a suicide. Sorry the truth hurts and you can't handle it and all that. But next time you hear of yet another shooting and wonder why we can't stop them take a long, deep look in the mirror. DR [PRIME AGG to 424] [same AGG as 422, 420, 411, 403, 404, 395, 387, 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier] **Q, O, NEG**

427. They're teachers -- not shrink. Their job is to teach you, not analyze you. If you need help, YOU need to get in touch with a doctor. It isn't the teacher's job to "spot" it. They are not trained in it and shouldn't be trying to diagnose their students. **O, AGG**

428. Don't be so fucking disrespectful. Don't make jokes about depression. Are you so incompetent that you can't understand the point of this video? That you can't be a decent human being? [? to PRIME AGG] **Q, I/A**

429. You have no concept of depression as a mental illness then. People don't look at a terminally ill patient and say "just dig deep and push through, school isn't a big deal you can do it, go to work, stop being lazy about it and push through" depression is an illness, it's a debilitating disease. Your comment is so triggering and hurtful and you don't even know it. Educate yourself before you speak because you're ignorance could potentially send someone over the edge. [Likely **IR** to PRIME AGG (e.g. 425), **O, EXP, I/A**

430. There are so many cases that go undiagnosed. That is why there are so many suicides because someone who is not getting help is far more likely to commit suicide than someone who is. So many people keep it bottled up because they don't want to be judged if they show weakness. So yes people who are not diagnosed with a mental disorder is very likely to have a mental disorder and may go undiagnosed. **O, EXP**

431. Ignorant as fuck. **UA, U**

432. Frankly they shouldn't get away with disrupting the class. The teacher should have stopped him and if my grandson were in that class I'd want him to run the fuck out before this fucker started shooting because his anger at his whole class is way out of whack and volatile. He's the only scary one in this whole video. [PRIME AGG as 426, 422, 420, 411, 403, 404, 395, 387, 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier] Displaying **PEMI, O, AGG**

433. This is a really important issue, but sadly most people don't want to talk about it and some students even start bullying other people for their mental illness. And that's a shame because instead of giving them a light you push them down an abyss they can't get out of. **O, EXP**

434. So you want to ignore the demographic of kids who may be suffering from depression and anxiety all for the sake of avoiding it becoming a trend? This could save lives. Allow younger people who are in the dark about their mental illness reach out and find help. But no, I guess we're better off not letting that happen, lest we get a few copycats acting like they're depressed. [IR to 421, topic of 356, 367-70]. **Q, O**

435. The teacher in the video is not acting that way at all. He is criticizing a misbehaving student. He, frankly, isn't tough enough in that he doesn't stop him from disrupting the class and should. That's the fault I find with this teacher. [Same AGG as 431, 426, 422, 420, 411, 403, 404, 395, 387, 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier] **O, EXP, V, NEG**

436. I used to have really horrible anxiety. I don't know if I really really do or not, but I had it for so long and still get anxious in class, but not as much. It's like a numbing feeling through your whole body, and things get a bit fuzzy and you can hear your heart beat really really fast. Hard to breathe. I was bullied near every day in elementary school, and the anxiety started some time around 8th grade. I have trigger words, I'm defensive and don't attach to people easy any more. **PEMI**

437. I have tried explaining that, but to depressed people life is a curse. Because, if it was a miracle to them they wouldn't even think twice before killing themselves. But there is a tad bit of hope, because they DO think twice, and can overcome the sadness... You too, good luck. **UA** [? to 435 **O, EXP, SUP**

438. You aren't a doctor or a psychologist. Don't diagnose someone with something because they asked a question. There are people in this world who legitimately don't understand depression because believe it or not, there is a really large amount of people who don't see depression as a mental illness. **UA, O, AGG, EXP, I/A**

439. There seems to be a whole lot of people on this forum thinking the world has to coddle the depressed and walk on pins and needles around them. No. They need to learn to manage their illness and will die if they don't. No one has to hand them the world on a silver platter so they won't be suicidal. Bottom line -- no one is to blame for anyone else's suicide and all this nonsense is just blaming other's for your own actions. It'd ridiculous. PRIME AGG [434, 431, 426, 422, 420, 411, 403, 404, 395, 387, 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier] **O, AGG**

440. I understand what the film makers are TRYING to say but the message is all wrong. At the end of the video it says "think twice before laughing along, mental illness is no joke!" They weren't laughing at his mental illness. The guy told a joke about one of his classmates moms and they laughed. So, to answer your question, yes, Michael made me laugh. Look, we all have problems. Are we all supposed to now interrupt a class every time we have an issue in our lives? **V, NEG, Q, O, EXP**

441. One option is to go to your GP, they can refer you to a counsellor. If you don't feel that route is right for you, google search 'Mind UK Helpline', Mind is a very well established charity, and they'll be able to advise you on what to do. Hope this helps! **O, I/A, SUP**

442. OK, no they shouldn't be bullied but get real. The rest of the world doesn't have to stop and center themselves around your mental illness issues. I'm sorry but no they don't. Get therapy, get help, and live because life is worth living but you can't seriously expect the rest of the world to patiently stop and wallow in misery with you. Spreading depression is not the answer to curing it. So, no, don't bully but those who have it have to deal not stop the rest of the world from living. **UA** PRIME AGG [438, 434, 431, 426, 422, 420, 411, 403, 404, 395, 387, 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier] **AGG, I/A, O, EXP**

443. Who asks 'was you somewhere warm last night'? What a terrible video **Q, V, NEG**
444. Not the point. You don't seem to get the underline problem here. It's not that people were supposed to know he was depressed before he stood and talked, it's that people need to be mindful of others when they talk about metal illness as a joke of sorts. Whether it be a small joke or not, it shouldn't be a joke Mental illness isn't a joke. **UA, O, EXP , V**
445. A lot of comments here are talking about teachers and how they're horrible. I don't believe in that, I think there is teachers who simply don't comprehend that mental illnesses are an actual thing people suffer from. And it's not only the teachers-- it's the students. We live in a world where you can say "ew, she looks anorexic" or "omg she's so bipolar" and get away with it, which isn't right. You'd get the evil eye for badmouthing mental ilnesses, and I wish more people knew that it's wrong. **O, COM**
446. Sometimes people don't take depression seriously. There are people who say they're depressed, but they're not. They say that so then people will give them attention. Same with bipolar disorder or anxiety issues, many mental health issues. Mental illness is not just a thing in your life, but it is your life and it takes over. It becomes a mental illness when it gets in the way of your life. It got in the way of my sister's life, but now she's doing great. So just know that you can overcome it. **O, PEMI, SUP**
447. People with mental illness isn't funny. People with gonorrhea is. **T** [Chuckie pic]
448. Is that an order, creep and hypocrite? Fuck you. No one shuts me up and puts me in a corner. If I see misinformation being passed off, I will call it out. End of story. Most especially when it's as severe as this. Mental illnesses do have facets for differing illnesses. Suicides turn it inward, not outward. This same commercial has this kid not getting out of bed for days because of his depression. Then has him doing look at me attention. Not realistic. At all. **UA** [PRIME AGG as in 441, 438, 434, 431, 426, 422, 420, 411, 403, 404, 395, 387, 370, 361, 357, 349, 340, 300, 304, 306, 315, 317 and earlier] **AGG, V, NEG, O**
449. I actually want to do this in class. It's horrible how teacher's aren't fully aware or taught about mental illness. If a student was down, wouldn't it be nice for a teacher to just ask, "Are you ok?" **O, Q, V**
450. Hi [name redacted], thanks for your comment and wanting to stand up, literally, for mental health! You're right, that would be nice of the teacher to ask. Luckily, there is now increasingly more education in schools around mental health, yet we know more still needs to be done. Take care, [name redacted] at Time to Change **TTC, SUP**

[PRIME AGG BLOCKED NOW]

451. I get the message that this video is trying to pass, but i don't get what made him stand up and say these things. The teacher wasn't being an ass, he probably had no idea. How could he if he hadn't told him anything? It's only logical to punish a student for being constantly by not knowing he has mental problems. IMO the video failed to motivate the student to stand up. **V, NEG, Q, O, EXP**
452. [name redacted] "Are we a comedian now?" The video portrayed something that a majority of young people, and even adults like myself, choose to do to mask their depression. The actor chose humor, and when questioned by the teacher chose to answer. It wasn't a matter of the teacher being an ass, or antagonizing the student. It was an everyday door being opened and the student decided that since it was open

he would air out his home. I think the video flowed quite well and actually touched a little bit on how you don't really know who may, or may not, be afflicted with depression and how even a simple statement can cause them to react unexpectedly. **V, POS, O, EXP, DR** [to 450]

453. because the body language and what the teacher said made it look like and sound like he didn't really care. When you see someone like this, always, late, and depressed a teacher is also supposed to be a friend and see whats going on with the student. A teacher can be a student's role model. [Different **DR** to 450], **EXP, O, V**

454. [username redacted] The problem here is teachers are too quick to punish people with mental health problems, treating a student like shit because he came in late is no excuse. Besides, did you hear all of the snarky remarks his classmates made, that the teacher did nothing to stop? DR [to 450] **EXP, Q, O**

455. [username redacted] The teacher was okay, but before he opens his mouth this way, he should ask why are you not attending?!!! **DR** [to 450], **O**

456. You have NO idea what pressures teachers go through. A daily week working about 80 hours, of which 36 get paid. Marking thousands of papers, reading up and researching topics to teach, making hours of preparations for a mere 50 minutes of a lesson plan. Then, they have to deal with disrespect on all fronts: disrespectful students, physical abuse from parents, and the hatred of the public in general who make disparaging comments at any turn. It's no wonder then that there is a teaching crisis in the UK. The work grinds you down and exhausts you to the point that you want to put a gun between your lips. And to top it all of, they are expected to be experts in dealing with depressed students, students with ADHD, anger problems etc, all the while being monitored to an inch of their life to get grades up to standard. And all on a crap wage. Teachers have an immeasurable amount of pressure on them, such that when one student is late, their initial reaction isn't going to be "Are you depressed?" A teacher cannot be made to feel guilty in this scenario. They're not miracle workers. So before you go off on how horrible the teacher looks in this video, painting him out as the big bad wolf, think about how much HE has to deal with. **O, EXP, PE**

457. You are a horrible person... this is trying to raise awareness not get as many views as it possibly can... you try suffering from depression and see how you like it when the world treats your condition as something like a bad cold. UA, AGG, O, **PEMI**

458. The teacher and the kids weren't tuned into this guys problems. They all just thought he was a slacker and all made a little fun of him because of it. It's hard to detect true depression in someone even if you live with them. He got the message out. It would only be inappropriate to continue to make light of his issues after he revealed what was going on like he did. A teacher that was a real dick would have prevented him from getting his message out... **V, O, EXP**